Case No: TLQ/15/0090

Neutral Citation Number: [2016] EWHC 47 (QB)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15/01/2016

Before:

THE HON. MRS JUSTICE PATTERSON DBE

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Between:

SEAN HUNT	**Claimant**
- and -	
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	**Defendant**

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- -

Elizabeth-Anne Gumbel QC (instructed by **Fieldfisher**) for the **Claimant**
Jeremy Roussak (instructed by **Browne Jacobson**) for the **Defendant**

Hearing dates: 8-9 December 2015

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Judgment

Mrs Justice Patterson:

Introduction

1. This is a claim for damages as a result of alleged clinical negligence on the part of the defendant. The sole issue is liability. If liability is established it is agreed that the claimant should recover £750,000 less £100,000 received from his employers less CRU.

2. The claimant was born on 15 June 1967. He was employed as a machine demolition operator for Euro Dismantling Services (EDS). He was a highly skilled machine operator. In or around March 2008 he was instructed by EDS to work on a project in Coventry. As part of that employment he operated a Komatsu PC130 machine. His job involved breaking up concrete inside a cramped room. The work was very difficult to carry out and he experienced considerable jilting to the base of his spine and coccyx whilst at work operating the machine.

3. On 2 April 2008 the claimant complained to his site manager about the discomfort he was experiencing in using the machine.

4. On 10 April 2008 the claimant was obliged to stop work because of severe back pain. The following day he attended his GP and was prescribed antibiotics. He attended again, four days later, complaining again of low back pain.

5. On 28 April 2008 the claimant was referred by his GP for an x-ray.

6. On 30 April 2008 the claimant went again to his GP when he was sent straight to the Queen's Medical Centre in Nottingham. He was assessed, admitted and diagnosed with a large perianal abscess.

7. The following day the claimant underwent an operation for drainage of his abscess and a seton was inserted. A seton is a suture, usually a thin silicone string inserted into the fistula tract, which allows the fistula to drain and heal from outside. The claimant was discharged. The doctors told the claimant that he had a fistula and that an operation to resolve it would be required.

8. After the claimant was discharged home on 2 May 2008 he felt unwell and continued to suffer from anal pain.

9. On 19 May 2008 he returned to hospital where a sigmoidoscopy was performed.

10. On 17 June 2008 he saw Mr Abercrombie, consultant general and colorectal surgeon, at Nottingham University Hospitals NHS Trust of the Queen's Medical Centre campus when he signed a consent form for future operative treatment. The intended benefits of the operation were to "heal fissure". The risks were recorded as, "bleeding, infection, recurrence of the fistula, incontinence."

11. On 18 July 2008 the claimant returned to the Queen's Medical Centre and completed a patient assessment questionnaire. The proposed operation was described as "EUA, laying open of the fistula if low, change of seton if high."

12. On 28 July 2008 the claimant attended at hospital for the fistulotomy. What happened during that hospital visit and operation is the core issue in these proceedings.

13. The claimant contends that the surgery carried out by Mr Robinson was negligent in that he either divided the entire internal anal sphincter or the upper part of the sphincter was already divided or destroyed and the operative procedure carried out by Mr Robinson which was to cut the lower part of the sphincter was inappropriate in the circumstances. In acting as he did Mr Robinson had failed to ascertain that the upper part of the sphincter was divided or destroyed. By the end of the surgery the internal anal sphincter was divided.

14. The effect of the negligence, the claimant alleges, is that he developed incontinence and pain, required repeated surgery, and now has a permanent stoma. His case is that the division of the internal anal sphincter is the cause of his severe disability and the need for a permanent colostomy. He has been unable to work since 2008.

15. The claimant brought a personal injury claim against his then employer, EDS, in respect of the initial damage caused by his job. That claim has settled. His claim against the defendant relates to the additional complications and injuries suffered following the operation on 28 July 2008.

16. The claimant's evidence was agreed. He did not give evidence at trial.

17. The defendant called evidence on the facts and relied upon Mr Subramonia, Mr Abercrombie and Mr Robinson who were all cross-examined.

Factual Background in 2008

18. After seeing his GP on several occasions during April 2008 the claimant was sent on 30 April 2008 to the Queen's Medical Centre in Nottingham. He was diagnosed with a large perianal abscess. He was sent home that evening but told to return the following morning for an operation.

19. On 1 May 2008 the claimant was seen by a senior house officer (SHO), Dr Kandiyil, who noted the presence of a large 3x4cm posterior cavity and a superficial perianal abscess during the course of his examination. Because of his concern he summoned Mr Subramonia, the senior registrar on duty. Mr Subramonia is now a consultant colorectal surgeon employed by South Tyneside NHS Foundation Trust.

20. Mr Subramonia recorded that the rectal examination and the proctoscopy carried out by the SHO had shown a big cavity in the anal canal. Both the SHO and Mr Subramonia made operation notes and drew diagrams. Mr Subramonia's examination appeared to show an internal abscess cavity in the 6 o'clock position in the anal canal at the level of the dentate line from which the pus had already been evacuated. Mr Subramonia noted that the external abscess outside the anus at 6 o'clock position communicated with the already drained internal abscess cavity. He formed the view that this was a low fistula in ano below the level of the puborectalis with abscess formation.

21. Mr Subramonia's notes record that the external abscess was incised and curetted. A seton suture, which was required to maintain adequate drainage of the abscess cavity, was applied. The claimant was discharged from hospital the following day.

22. On 19 May 2008 the claimant was readmitted to hospital for a repeat examination under anaesthetic (EUA) with a rigid sigmoidoscopy. The surgeon, Mr Phyo, confirmed the presence of the seton and noted that the wound was clean and healing with granulation tissue. He drew a diagram and noted :

> "The wound was extended up to 2cm from the anal verge and although I can feel the upper fibres of puborectalis muscle, I could not feel the lower fibres. The seton was present and there was no sign of inflammation in the surrounding tissue. Rigid sigmoidoscopy was normal up to 20cm."

A follow up appointment was arranged at Mr Abercrombie's outpatient clinic on 17 June 2008.

23. On 17 June 2008 the claimant signed a consent form in which the proposed procedure was described as, "Rectal examination? Lay open fistula – if low, change seton if high." The form was signed by Mr Abercrombie and by the claimant.

24. On 17 June 2008, Mr Abercrombie carried out an examination and concluded that the fistula was low because he could see a track under the skin. He agreed that he would not expect a surgeon to cut the lower part of the internal anal sphincter unless he had confirmed the upper part of it was intact.

25. At the time the hospital operated a pool waiting list for patients so as to minimise the wait for operative treatment. The claimant was placed in the pool. When in the pool the operating surgeon would not necessarily speak to the examining consultant but he would have access to all the relevant medical notes.

26. Mr Robinson was the claimant's operating surgeon on 28 July 2008. He was also a consultant general and colorectal surgeon with Nottingham NHS Trust and had been since 2001.

27. Mr Robinson's operation note records:

> "EUA plus intersphincteric fistulotomy. EUA seton across intersphincteric fistula in anal canal in duration (swelling) posterior to anal canal. Fistulotomy with diathermy. No obvious proximal extension of internal opening. Aqua cell dressing. OPAJA 3/12."

28. Mr Abercrombie then saw the claimant on 14 November 2008. His note of that appointment records:

> "Still sore some leakage. PR – looks healed. Very narrow tender puborectalis sling. Palpable defect at the site of old fistula – keyhole type deformity. Leave alone. C6/12."

29. Mr Abercrombie's follow up letter included the following:

> "Showed quite a lot of scarring of the puborectalis sling which felt very narrow. Below this he clearly has an internal anal sphincter defect with evidence of a palpable notch posteriorly in his anal canal. I hope this simply represents healing. I don't think there is anything specific for me to do at present."

30. The following month the claimant presented with symptoms similar to those with which he had first presented, in April 2008, when the abscess was first diagnosed. The records indicate that the claimant was concerned that the abscess had recurred. The GP's letter of 4 December 2008 stated that, "Identical symptoms began a week ago with anal tenderness and pain radiating up the sacrum." The claimant was discharged by the defendant as, on examination, there was no evidence of abscess formation or any other pathology.

31. The claimant's GP wrote to Mr Abercrombie on 9 December 2008 summarising the claimant's symptoms. Mr Abercrombie saw the claimant again on 30 December 2008. In his follow up letter dated 5 January 2009 Mr Abercrombie noted that the claimant continued to have anal discomfort and recorded that, on examination, there continued to be a very narrow scar in the puborectalis sling with a palpable notch just distal to it. Those findings were consistent with change following the fistula surgery. Mr Abercrombie did have some concern that there might be recurrent sepsis which could explain the claimant's symptoms of pain and swelling. Blood tests were taken which were normal. There was no evidence of sepsis detectable. He noted that there was an induration in the left buttock.

2009

32. The claimant was then referred for gastroenterology review. Nothing of relevance emerged.

33. The claimant was next seen by Mr Abercrombie on 7 April 2009. In his follow up letter to the GP Mr Abercrombie noted the claimant's ongoing anal pain. On examination he could not identify a fistula but did note an obvious defect to his external anal sphincter and that the claimant continued to have induration in his posterior puborectalis. He wanted to rule out ongoing sepsis and for that reason arranged an MRI scan and planned a further EUA.

34. On 30 April 2009 Mr Abercrombie undertook an EUA. His operation note recorded that the internal sphincter felt very fibrosed. There was an area of persistent poor healing which he described as a 0.3cm defect. He interpreted that as being the previous site of the internal opening of the claimant's fistula. There was a blind ending sinus at the level of the dentate line. He curetted that and noted a "gutter" from the previous fistula surgery. Mr Abercrombie considered the blind ending sinus to be the cause of the claimant's ongoing anal pain and, for a period of time, after the curettage the claimant's pain improved considerably.

35. By 17 June 2009 Mr Abercrombie saw the claimant again and noted that the relief from the previous curettage had been short lived. On examination he recorded a palpable defect but one that was much smaller. The following day he undertook a further EUA and curettage of the sinus. He recorded that there was sufficient laxity to consider an advancement flap. On that occasion the curettage was not successful and,

in his letter dated 26 August 2009, he recorded that the claimant was complaining of painful defecation. A persistent non-healing and painful pit at the site of a previous fistulotomy was an uncommon complication. Mr Abercrombie continued to consider that an advancement flap to cover the defect would be an option.

36. By December 2009 the claimant's GP had written to Mr Abercrombie indicating that the claimant was anxious to pursue an option of a defunctioning colostomy if that would help accelerate the healing of his rectal problems. Mr Abercrombie saw the claimant on 16 December 2009. He recorded that the claimant had developed a degree of incontinence.

37. A left iliac fossa colostomy was performed on 29 March 2010.

38. The claimant has continued to suffer from a range of problems subsequently, which I do not need to recite in this judgment due to the remaining issues between the parties.

Mr Michael Robinson

39. Mr Robinson is a consultant colorectal surgeon based at the Queen's Medical Centre in Nottingham where he has been employed from 2001. He gave evidence at the trial. He says that he cannot recall the claimant specifically. He made both his witness statement and gave his evidence based on his review of the contemporaneous medical records, in particular, his operation note, dated 28 July 2008, and his usual practice.

40. Mr Robinson signed the confirmation of consent form on 28 July 2008, the day of the procedure.

41. He was satisfied that he would have had a discussion with the claimant prior to the start of his operating list and that he had seen the previous operation notes on the claimant before he operated.

42. He gave evidence that the procedure was diagnostic and potentially therapeutic. He accepted that he cut the lower part of the internal anal sphincter. He would have checked the upper part by digital rectal examination although he had no independent recollection of so doing given the passage of time. Mr Robinson found that the earlier operation note of 1 May 2008 was unclear as to where the abscess was. He accepted that if the SHO was right in his description the abscess could have run the entire length of the anal sphincter. However, the 3x4cm could refer to breadth and depth of the access as well as length.

43. Mr Robinson accepted that his notes were not as full as they could have been. He should have recorded that the upper anal canal was normal but the fact that he did not note any abnormality told him that it was. The abscess had started in the area between the external and internal sphincter but it could track in different directions. If he had found an induration or abnormality he would not have cut. It is true that he made no note to that effect. Nor is there a diagram of where he operated. He regarded the case as simple and straightforward. It was reasonable for the SHO to call for a senior registrar on 1 May 2009. Mr Subramonia's note contained an assessment of a low fistula which was consistent with the findings that he made.

44. He did not regard the operation note by Mr Phyo as of equal importance as the note of the original operation. He was unaware whether it was available. He would, however, have looked at it before operating if it had been. In cross-examination he did not agree that the claimant presented as a complex case.

45. If he had had any doubt that there was an abnormality in any way then he would not have proceeded. He had a low threshold for ceasing an operation in such circumstances. He maintained that he examined the claimant with considerable care. If he had had concerns about the original presentation he would have responded to them. If he had had concerns about the upper part of the sphincter not being intact or that the seton encompassed only the lower part of the sphincter he would have stopped and referred the claimant back to Mr Abercrombie.

46. Mr Subramonia, Mr Abercrombie and Mr Robinson all gave evidence to the court. They all impressed as honest witnesses doing the best that they could to recollect events some years after the operation and treatment.

Expert Evidence

(1) Radiology

47. Dr Burling, for the claimant, and Dr Tolan, for the defendant, agreed that on the radiological evidence as at April 2009 there was a defect along the entire length of the internal anal sphincter, save as to 4mm, in the opinion of Dr Tolan. That difference had no effect upon the function of the sphincter.

48. The two radiologists, therefore, agreed that the MRI of 22 April 2009 showed the division of the sphincter either completely or nearly completely.

49. They agreed that the MRI was of no assistance as to the cause of the division of the internal sphincter. The external sphincter was intact.

50. The length of the anal canal was agreed at 4cm.

51. The anal ultrasound of 6 September 2010 was agreed to show a defect running almost the entire length of the anal canal.

Consultant Colorectal Surgeons

52. The consultant for the claimant was Carolynne Vaizey. John Hartley was the consultant for the defendant. Both had comparable qualifications and expertise.

53. Ms Vaizey thought that there were two possible explanations for the state of the internal anal sphincter. Either:

    i) The sphincter was damaged before the operation and not cut at the operation; or

    ii) That it was cut during the operation.

    It was her view that the first was the most likely.

54. She came to that view based upon the operation notes prior to 28 July 2008. That of 1 May 2008 made clear that there was a large cavity at the back of the anal canal as drawn on the diagram. By the time Mr Subramonia attended at theatre the abscess had been drained and he was able to feel the cavity with his finger.

55. From Mr Phyo's note, although it was not entirely clear in its reference to "extended", it was sufficiently clear to show that the seton did not extend to the top of the wound which went up to the puborectalis. The lower half would have to be intact because of the seton around it. Any opening would have to be in the upper half.

56. She expected that Mr Robinson would have found the mechanism of the abscess unusual. The fact it had been drained before illustrates that some abnormality was detectable before the operation commenced. That was something that Mr Robinson should have ascertained. Most likely, in her view, was that the SHO had damaged the upper part of the anal sphincter and the rest had been divided through Mr Robinson's surgery.

57. It was very unusual for a sphincter to be damaged by sepsis. Although sepsis can cause pressure and break through sphincteric muscle that is when the abscess is not drained. Once it has been drained it would not cause muscle damage. Here, the claimant had a very big abscess in a confined space.

58. She rejected Mr Hartley's revised view because, first, it centred on an area of sepsis which had been cut, in other words drained, and when that occurred it would not cause damage, and, second, the timing of the incontinence suffered by the claimant. The evidence was that the incontinence came after July 2008 and not in the period after November 2008. The general description given by the claimant of becoming incontinent in his claim to the Department of Work and Pensions suggested strongly to her that the damage was done before November 2008.

59. The claimant had said, in his appeal dated 17 November 2008 against the decision of the Department of Work and Pensions dated 31 October 2008, as follows:

> "My surgical consultant has explained to me that due to the severe extent and internal damage the abscess has caused a large amount of muscle and tissue had to be removed in my previous operations. As a result of this I now have to live with faecal incontinence every day for the rest of my life. This has had an extremely stressful and devastating impact on my quality of life as at 41 years of age I now have to wear incontinence pads. Simple tasks such as leaving the house are very daunting and difficult for me as I need to be near toilet facilities wherever I go. I cannot go anywhere now without making sure I have my incontinence pads with me and I am in constant fear and anxiety of having incontinence in public places."

60. Further, there is no indication in any medical note from July to November 2008 of severe sepsis such as to destroy the internal anal sphincter as is suggested by Mr Hartley. The evidence was that there was a healing cavity with granulation tissue. The blood results were entirely normal. Mr Abercrombie who saw the claimant in

that period did not diagnose sepsis. If any surgeon felt that sepsis would cause muscle destruction then he would order further investigations. None was ordered.

61. She had never seen a case which involved damage as a result of sepsis after surgery. Neither Mr Phyo nor Mr Robinson nor Mr Abercrombie had seen any sepsis.

62. At the expert meeting between herself and Mr Hartley, they had agreed that, on the balance of probabilities, the upper internal anal sphincter had been destroyed before the operation. She understood the reference in the medical note of December 2008 to the claimant saying that he was incontinent on three occasions to be a reference to him being fully incontinent.

63. The explanation for the lack of reference to incontinence in the other medical records had to be seen in the context of what the relevant consultant had been asked to advise upon. For example, Mr Bowling, the gastroenterologist, had been asked to rule out inflammatory bowel disease. Her conversation with the claimant had led her to put in her addendum report that, whilst the claimant had pain after Mr Robinson's operation he was clear that that was never as bad as before the operation on 1 May 2008. It was of note that leakage of faeces irritated the skin and caused soreness.

64. She was of the view that the most likely cause of perianal pain was previous anal pathology. It was highly unlikely to have happened with drained sepsis. The claimant did not respond to antibiotics and his blood count was normal. Mr Abercrombie did not think that an MRI scan was needed before April 2009. The suggestion by Mr Abercrombie of a flap was inconsistent with ongoing sepsis.

65. Mr John Hartley was the consultant surgeon instructed by the defendants. He changed his opinion after the expert meeting. He did not find it credible that Mr Robinson could have inadvertently divided the entire length of the internal anal sphincter during the fistulotomy of July 2008. His first view was that Mr Robinson appropriately divided the lower part of the internal sphincter up to the level of the dentate line as treatment for a low fistula in ano. Either the upper part of the internal sphincter had a defect in it by July 2008 or the defect developed at some point between Mr Robinson's surgery and April 2009 when the MRI scan was performed.

66. Mr Hartley did not think it likely that the upper part of the internal sphincter could have been surgically divided before July 2008. Therefore, if the upper internal sphincter had a defect in it by the time that Mr Robinson operated the only explanation would be that it was damaged by sepsis. That had been Mr Hartley's view at the time of the joint experts' meeting.

67. However, further discussion subsequently with Dr Tolan had led Mr Hartley to conclude that a defect in the upper part of the internal sphincter identified on the MRI scan of April 2009 was likely to be caused by ongoing sepsis following the fistulotomy of July 2008.

68. If sepsis had destroyed the upper part of the internal anal sphincter between the initial drainage of the abscess and the insertion of the seton in May and the fistulotomy in July 2008 he thought it likely that the claimant would have been symptomatic during that time with severe anal pain. There was no evidence of that in the contemporaneous records. Therefore, he thought it more likely that the MRI

appearances of a fibrotic defect in the upper part of the internal anal sphincter developed between Mr Robinson's procedure in July 2008 and the time the MRI was performed in April 2009.

69. The likely explanation for the claimant's intractable pain following the fistulotomy was the development of ongoing sepsis within "a high blind track" which is a proximal extension of the claimant's fistula within the plane between the internal and external sphincters at the time of the fistulotomy in July 2008. It is a difficult and quite uncommon problem. A minute amount of pus within a confined space could certainly cause significant pain.

70. Ongoing sepsis was the cause of failure of the internal opening of the original fistula to heal. The pit at the dentate line at examination by Mr Abercrombie was found to be a woody hard feeling at the upper anal canal. A woody hard consistency is characteristic of chronic sepsis. Curettage of the pit produced temporary relief of the claimant's pain which is, again, in keeping with ongoing sepsis causing pain and being temporarily treated by drainage.

71. On the balance of probabilities the ongoing sepsis within the intersphincteric space above the level of the surgical division of the internal sphincter undertaken in July 2008 was the explanation for the fibrotic defect present within the upper part of the internal sphincter on the MRI in April 2009.

72. The predominant feature of the claimant's postoperative complaint was perianal pain. An ongoing undrained sepsis can be consistent with no abnormality detectable as a result of blood tests. It did not need to be a large volume to cause real pain.

73. In cross-examination it was put to Mr Hartley that in his first report he had said that the history of incontinence did not match the condition of the internal anal sphincter because it had not been split. The position now was different. At some point the history of incontinence was such that it did fit. Mr Hartley maintained that he was surprised not to see more evidence of incontinence.

74. Mr Hartley did not accept that the operation was complex. The diagram on 1 May 2008 was not unusual. Mr Phyo's note could not be interpreted in any meaningful way. When he met with Ms Vaizey the situation was that the internal anal sphincter was divided. Fibrosis was present and the reasons for that were multiple.

75. He had revised his opinion after speaking to Dr Tolan. It was always his opinion that the cause of the claimant's complaints was ongoing sepsis. He was not troubled by the fact that it was not picked up initially on the MRI because there can be low grade sepsis. When Dr Tolan said that the changes could come after the operation that meant that the destruction of the upper anal sphincter after the operation was consistent with an ongoing inflammatory process. That was consistent with his opinion that the claimant had ongoing pain. He was not able to say when it did occur but it would have to have been completed by March 2009. He had not seen any other patient with a similar condition. It was unique in his experience. The situation was not that of a drained situation because the healing had allowed for granulation and for sepsis to build up.

76. His analysis was that Mr Robinson's operation did not eradicate the sepsis. In July 2008 the upper internal sphincter had no defect and was entirely intact. The ongoing symptoms in November and December 2008 fitted with his thesis. The fact that Mr Abercrombie recorded that he would review the claimant in a further three months did not concern him as sepsis can proceed in an indolent fashion; it does not necessarily show up on blood tests. The presence of ongoing sepsis fitted with clinical, pathological and radiological features.

Discussion and Conclusions on Liability

77. I have not found this the easiest case to resolve. I have enormous sympathy for the claimant but, as the defendant submits, the case is not decided on sympathy but on the evidence before the court.

78. There is clear evidence from the claimant which has not been disputed by the defendant as to his post-operative condition from July 2008 onwards. The defendant contends there is a conflict between the account of the claimant and the medical records. I am not convinced by that submission but, if there is, I prefer the evidence of the claimant. It was open to the defendant to cross-examine the claimant as to his condition and, in particular, his evidence on incontinence including its onset but the defendant chose not to do so. It follows, therefore, that the evidence of the claimant as to his ongoing condition, as set out in his witness statement where he says that in the days and weeks after the operation he was in constant severe pain and began to realise that he was becoming incontinent so that on some days he could not even leave the house is accepted. Most tellingly the contemporaneous DWP appeal documents of October 2008 provide the best evidence of his daily life, its quality and how it was affected by the operation. His account is consistent with the onset of incontinence after the July operation. That suggests that damage was done to the internal anal sphincter at an earlier time and around July 2008.

79. The medical records doubtless record accurately the claimant's answers to questions put to him and represent a snapshot of the claimant's condition. But they do not provide a continuing description of the daily experience of life on the part of the claimant. It is material that, when the claimant was making his appeal to DWP, he was completely uninfluenced by any thought of prospective litigation. I, therefore, accept the veracity of his contemporaneous account of his life in October 2008 and the months preceding. His account is set out above. The reference to being incontinent on three occasions recorded in the medical records in December I accept as a reference to being fully incontinent. It follows that there was clear evidence of incontinence and the problems that was causing by October 2008.

80. Mr Hartley said that he was surprised not to see more evidence of incontinence and its history was variable. That may well be his view but, as I have said, the contemporaneous account paints a different picture. Clearly there will be some daily variation and it may be that the fact that the claimant was on medication served to mask the incontinence from time to time, as Ms Vaizey said, which may also provide explanations for the answers given and recorded on the medical notes. I do not regard the two evidential sources, namely, the medical notes and contemporaneous account, as necessarily in conflict.

81. The evidence of incontinence points to a conclusion, on the balance of probabilities, that incontinence was present to varying degrees from the end of July 2008. There is no evidence that it was present before.

82. That has an implication for the revised opinion of Mr Hartley as that rested, to a significant degree, on the absence of, or inadequate evidence of, incontinence following the July operation. As set out I do not accept that was the case.

83. Mr Hartley's thesis depended further on a theory that the continuing perianal pain of the claimant was due to the sepsis present in April/May 2008 not being completely eradicated in the operations of 1 May, 19 May and 28 July 2008. The continuing presence of pain meant, according to Mr Hartley's revised opinion, that there was on going sepsis post the operation of 28 July 2008 which later developed so as to cause the pain suffered by the claimant and to cause the full division of the internal anal sphincter as shown on the MRI scan in April 2009.

84. The problems with that theory seem to me to be:

i) there is no evidence of sepsis in the medical notes from July to December 2008, nor on examination by Dr Phyo or Mr Robinson;

ii) it depends upon the development of sepsis to such a degree as to break through and destroy the upper anal sphincter over an unknown period after July 2008 but prior to the end of March 2009;

iii) there is no literature, peer reviewed or otherwise, to support such a theory;

iv) any observations as a result of MRI scans or ultrasound scans which show small white spots or operative treatment such as curettage, all post March 2009, are of little assistance as the damage had occurred by then;

v) although sepsis can cause pressure and break through muscle the evidence is that that is when it has been in an undrained state. Here, there had been a big abscess in a very confined space but it had been drained in May 2008. Healing had then commenced as evidenced by a healing cavity of granulation tissue;

vi) both expert consultants, Ms Vaizey and Mr Hartley, agreed that postoperative sepsis causing destruction of the muscle would represent a highly unusual/unique situation which neither had come across before (except due to Crohn's disease which is not relevant here);

vii) there was no indication of infection in the blood tests carried out in either December 2008 or January 2009 or April 2009;

viii) at his consultation on 4 November 2008 Mr Abercrombie carried out rectal examination and documented quite a lot of scarring of the puborectalis sling which felt very narrow. The claimant had an internal anal sphincter defect with evidence of a palpable notch posteriorly. Mr Abercrombie found no evidence of sepsis. He arranged to see the claimant in six months time;

ix) on 30 December 2008 Mr Abercrombie examined the claimant and was worried that he may be developing recurrent sepsis but recorded in his letter,

dated 5 January 2009, that there was nothing on examination that he could improve surgically and suggested a review in three months time;

x) on 13 January 2009 a further letter went from the defendant to the claimant's GP in the following terms, "This 42 year old man was admitted with one week history of increasing pain in the perianal area, similar to a previous abscess he had in this area. However, on examination we could find no evidence of abscess formation, nor any other pathology. Blood results were all negative and the pain settled with simple analgesia. Mr Hunt was discharged with advice given should he feel that the pain was not improved."

85. Ms Vaizey was convinced that the MRI scan showed no evidence of sepsis but only granulation tissue. Dr Burling confirmed that there was agreement between the radiologists that no sepsis was shown on the MRI scan although that was not in their joint report. He maintained that the gutter deformity shown would cause fluid to collect but that was no evidence of sepsis. There was no imaging evidence consistent with worsening symptoms in December 2008 being due to sepsis. Dr Tolan agreed that he could not say from the MRI scan that one could see infection but the scan was consistent with the fibrosis observed.

86. Due to the absence of images prior to April 2009 it is self evident that there is no image evidence in support of Mr Hartley's revised theory. By April 2009 it is agreed that the upper anal sphincter was destroyed. Thus, there is no evidence of ongoing sepsis at the critical time (between August 2008 and April 2009) which fits with the clinical, pathological and radiological factors as asserted by Mr Hartley.

87. The other main feature of the claimant's condition was perianal pain such that by the end of November 2008 he had referred himself to his GP again. Ms Vaizey disputed that the only explanation for that was that of Mr Hartley. She asserted that the biggest cause was previous anal pathology. Absent evidence of an increasing history of incontinence her evidence was that it was highly unlikely that the damage was caused as Mr Hartley supposed.

88. I find that there are too many uncertainties and evidential gaps, as set out, for me to able to accept the revised theory of Mr Hartley. For all of those reasons I reject the revised theory on the part of Mr Hartley.

89. As Lord Justice Thomas (as he then was) said in **Ide v ATB Sales** [2008] EWCA Civ 424 at [6]:

> "As a matter of common sense it will usually be safe for a judge to conclude, where there are two competing theories before him neither of which is improbable, that having rejected one it is logical to accept the other as being the cause on the balance of probabilities. It was accepted in the course of argument on behalf of the appellant that, as a matter of principle, if there were only three possible causes of an event, then it was permissible for a judge to approach the matter by analysing each of those causes. If he ranked those causes in terms of probability and concluded that one was more probable than the others, then, provided those were the only three

> possible causes, he was entitled to conclude that the one he considered most probable, was the probable cause of the event provided it was not improbable."

90. Ms Vaizey contended that there were two possible explanations for the damage to the internal anal sphincter. The most likely was that the upper internal anal sphincter had been damaged prior to the operation on 28 July 2008 and Mr Robinson should have been aware of that possibility from:

    i) the operation note of May 1 2008;

    ii) the subsequent note of Mr Phyo of 19 May 2008 and his diagram which, even if it is difficult to discern, flags up that there may be a problem;

    iii) the record of Mr Abercrombie that the position of the fistula needed to be ascertained i.e. whether it was high or low.

91. It is not unreasonable in those circumstances for an operating surgeon to check the position. Indeed, Mr Robinson says that is precisely what he would have done. He has no independent recollection of the examination. That is not surprising after the passage of time. But there is no note of the examination that he carried out. His operative note is brief. Medical notes do not have to be full but they do need to set out in more detail than that which is contained in Mr Robinson's note of 28 July 2008 what the main findings and actions were.

92. The defendant initially denied that the internal anal sphincter was destroyed along its entire length. The defendant's revised explanation (produced on 4 November 2015) has contended that it was destroyed between the operation of 28 July 2008 and the April 2009 MRI scan. That carries with it an assumption that, as at the operation of 28 July 2008, the upper internal anal sphincter was healthy. There is no evidence that is the case and, indeed, there are contra indicators from the previous operation notes that it might not be.

93. The clinical picture, as set out, I find is consistent with the division/destruction of the sphincter occurring before or around July 2008. I have already found that the clinical picture is not consistent with the presence of sepsis post operatively such as to cause muscle destruction by March 2009. The uncontested evidence of the claimant I have set out above, in his appeal to the DWP. In his witness statement the claimant says that because of his pain and incontinence he went back to his GP and was eventually referred back to Mr Abercrombie who he saw on 4 November 2008. The only plausible conclusion that can be drawn, on the balance of probabilities, and in the absence of contemporaneous written evidence to the contrary, is that something was missed on the examination by Mr Robinson that took place on the 28 July that should not have been.

94. As the defendant sets out in its skeleton argument if the finding is that the fistula was low, as it was, given the community of medical evidence to that effect, the questions for breach of duty are:

    i) did Mr Robinson divide the entirety of the claimant's anal sphincter in July 2008?

ii) if he did not, but divided the sphincter only below the dentate line:

a) had the upper part of the claimant's internal anal sphincter been destroyed whether by infection or by the SHO at the first operation prior to 28 July 2008?

b) if so, was Mr Robinson negligent in failing to appreciate that fact and proceeding to low fistulotomy?

95. Given what I have set out above the answers are:

i) no;

ii) (a) yes, and (b) yes.

96. On causation the questions posed are whether the claimant became significantly faecally incontinent after 28 July 2008. I have found that he did.

97. Next, the question is did any such incontinence, rather than persistent pain, lead the claimant to elect to undergo formation of a defunctioning colostomy in March 2010?

98. The claimant says that, during 2009, he was in pain and constantly leaking faeces; he was very depressed. He was at the end of his tether. His GP told him that he would not suffer any leakage after the procedure and the pain in the area would probably settle down if he had a colostomy. The claimant then discussed the matter with Mr Abercrombie and considered a temporary colostomy. The decision to proceed with the colostomy was brought about, I find, as the claimant says, as a result of his two complaints.

99. The defendant has submitted that the claim fails on causation as it is only if the incontinence caused the claimant to have a colostomy that causation is made out: in fact, the claimant made the decision because he was suffering from intractable pain. I reject that submission. First, it is clear from the claimant's witness statement that he chose to have the operation because of the two factors one of which was the constant problem of incontinence. Second, the defendant has not established that, absent incontinence, the claimant would have had the colostomy in any event. Indeed it is of some significance that at the expert meeting between Ms Vaizey and Mr Hartley it was agreed that if the Court were to decide that the internal sphincter was fully divided along its length, as I have, a colostomy would have been unavoidable.

100. Accordingly, I give judgment for the claimant. As quantum is agreed, subject only to liability, I need go no further.

101. I invite the parties to agree an appropriate order and costs.