Claim No: 3MA90025

Neutral Citation Number: [2016] EWHC 331 (QB)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
MANCHESTER DISTRICT REGISTRY

Manchester Civil and Family Justice Centre,
1 Bridge Street West, Manchester, M60 9DJ
(handed down at the RCJ)

Date: 22/02/2016

Before :

MR JUSTICE DOVE

- -

Between :

XYZ	**Claimant**
- and -	
WARRINGTON & HALTON NHS FOUNDATION TRUST	**Defendant**

- -

Darryl Allen QC (instructed by **Potter Rees Dolan**) for the **Claimant**
Charles Feeny (instructed by **Hill Dickinson**) for the **Defendant**

Hearing dates: 14th – 18th December 2015 and 5th – 7th January 2016

- -

Judgment

MR JUSTICE DOVE :

Introduction

1. This is a claim for personal injury and consequential loss arising as a result of alleged clinical negligence on the part of an orthopaedic surgeon, Mr Shackleford, who was employed by the defendant at the time of the matters with which the case is concerned. The action in particular relates to the treatment which the claimant received when she underwent spinal surgery in the form of a lumbar microdiscectomy. The claimant's contention is that she ought not to have had that operation, and as a consequence of having undergone the operation she has sustained consequential injury and loss.

2. The key issues in relation to the question of whether or not the operation was administered in breach of Mr Shackleford's duty of care to her are whether or not, bearing in mind the claimant's state of mind and the fact that she was receiving psychiatric treatment at the time, Mr Shackleford should have operated upon her without discussing the treatment proposed with the psychiatrist who was treating the claimant at the time in the light of a letter written by that psychiatrist to Mr Shackleford, and whether or not he ought to have obtained a second opinion. In addition, in relation to breach of duty, it is alleged that the claimant's consent to the operation was not properly obtained.

3. There is no suggestion that the operation itself was conducted negligently. However, there are issues raised in relation to the question of causation if it is concluded that there was a breach of duty for the reasons just stated. The questions in relation to causation are in particular whether discussion with the claimant's treating psychiatrist or the obtaining of a second opinion would have yielded the outcome that she would not have had the operation. If it is concluded that she would not have had the operation had the breach of duty not occurred then further important questions arise. Firstly, did the claimant develop Cauda Equina Syndrome ("CES") as a result of the operation? Further, what, in the absence of the operation, would have been the prognosis for the claimant's physical condition? To what extent are her somatic lower limb dysfunction and loss of sensation symptoms caused by the operation and therefore would have been avoided had the operation not been undertaken?

4. These questions, and the sub-issues to which they give rise, will need to be analysed below. They provide the backdrop for the consideration of the facts in detail which it is now necessary to set out. Whilst addressing the factual history I propose to resolve some of the purely factual disputes which arise on the evidence so that the factual framework for consideration of the issues in relation to breach of duty and causation is clear prior to assessing those issues.

The facts

5. The claimant was referred by her GP to Mr Shackleford at Warrington Hospital for lower back pain. She was first seen on 24th April 2006 by a colleague of Mr Shackleford in his clinic. It should be pointed out that there are no hospital notes for either this or any of the subsequent outpatient appointments which the claimant had prior to her operation. The system which the defendant employed was that the notes of what occurred at outpatients appointments were comprised in the letters which

were composed at the time to be sent to the patient's GP setting out the findings and conclusions from the clinic. As a result of the claimant's examination on this occasion it was concluded that she required an MRI scan. The outcome of that scan was set out in a letter dated 29th June 2006 from a Mr Bassi who was one of Mr Shackleford's colleagues. The letter provided as follows:

> "I reviewed this young lady in clinic today. She underwent a recent MRI scan of her lumbar spine. This does show dehydrated L4/5 disc with a central disk protrusion but no nerve root compression. There is also localised oedema at the posterior/inferior part of the L4 vertebral body suggesting trauma.
>
> As far as her symptoms are concerned, she remains in a lot of discomfort with regard to right sided lower back pain. She has no other symptoms. In particular she has no leg pain.
>
> Mr Shackleford has had a long discussion with Mum today with regard to management of this problem. She has been advised to persevere with simply analgesia for the time being. He would be reluctant for her to have surgery at her age."

6. The claimant was seen again, this time by Mr Shackleford, on 13th July 2006. Following seeing her in the clinic he wrote to her GP in the following terms:

> "I reviewed XYZ in the clinic today. Unfortunately, her back pain continues. Her MR scan confirms disc regeneration at 4/5 with moderate bulge and a slight apophyseal ring separation.
>
> I have discussed this with her and her mother in great details. I have suggested we try changing her to Tramadol rather than the Co-codamol, keep her active and I will see her again on 31 August when we can have a planned return to activities at school."

7. At this stage her problems were attributed to a sports injury, the claimant having been a keen sportswoman. She was referred to an anaesthetist's clinic by Mr Bassi on 31st August 2006 after she had seen him in the clinic and it was noted that her problems were still continuing and she was unable to return to her sporting activities. Mr Bassi's letter records Mr Shackleford's view that as a result of her age she was not a suitable candidate for any surgery. As a result of the referral she was seen by Mr Smith, an anaesthetist, in his Pain Relief Clinic. Following this visit Dr Smith noted as follows:

> "She takes Co-Codamol 8/500 and tries to limit these to 6 a day. She found it difficult to explain whether she had any constipation side effects from this because she is severely anorexic and doesn't have normal bowel function anyway. She has had a TENS machine, which was not very helpful. She is under a psychiatrist at Guardian House and Dr Briggs from paediatrics. She is losing a lot of school. She had the pain

> problem before she had the anorexia and her mum says that the anorexia is related to the pain problem."

8. She was seen by Dr Smith again in November. He had spoken to Mr Shackleford and it was suggested that the claimant should be fitted for a back brace to assist with her difficulties. On 21st December 2006 she was again seen by Mr Shackleford who recorded that there had been some improvement. He noted that there was no leg pain but that she had significant back spasm. He suggested that she should have another MRI scan in order to investigate her continuing symptoms.

9. The claimant was not seen again in hospital until 15th June 2007 following the repeat of the MRI scan which had been suggested. The results from that scan were to similar effect, namely that there were "signs of hydration in the disc and inflammation around the disk has decreased". All symptoms from which the claimant was suffering were restricted to her back. Her case was discussed again with Mr Shackleford and the plan which was agreed upon was one of "non-operative management" together with physiotherapy and the wearing of a corset. On 21st December 2007 Mr Shackleford saw her again and she was "still very reluctant to move her lumbar spine". Mr Shackleford planned to commission another scan of her back by way of investigation.

10. The claimant was again reviewed by Mr Shackleford's colleague, Mr Calleja, on 10th June 2008. His findings on that occasion were as follows:

> "I reviewed this patient in clinic today with the results of his (sic) MRI scan. This shows mild disc dehydration at L5/S1 but no evidence of nerve root compression and at L4/5 there is mild disc dehydration with a central to left sided disc bulge. The disc bulge is impinging upon the left L5 nerve root within the lateral recess.
>
> I have explained the findings to the patient. Clinically, the pain is in the left leg and this is worse than the back pain. She should like to have something done about this and, if possible, an injection to try to improve his (sic) pain. Straight leg raising is 50 degrees with positive tension and negative in the right leg."

11. Having discussed the claimant's case with Mr Shackleford she was put on a waiting list for a left L4/5 foraminal epidural and steroid injection which was undertaken on 21st July 2008. Following this procedure she returned and saw Mr Calleja again on 23rd September 2008. The outcome of that consultation is set out in a letter from Mr Calleja to the claimant's GP in the following terms:

> "This lady was seen in clinic today. She had a left L4/L5 foraminal epidural steroid injection 2 months ago and she says the pain got a lot better in the left for the first 4 weeks, even though the pain did not go completely away. She says that in the last 4 weeks the pain has gradually been going back to the same level as before.

> At the moment SLR is 50º in the left leg, negative in the right leg, positive tension signs.
>
> I have discussed this case with Mr Shackleford and we have explained to the patient that it is obviously a difficult problem to deal with as she has not only got a little bit of disc bulging but also quite a bit of disc dehydration mainly at L4/L5 and also L5/S1. The idea of surgery is difficult to offer to this lady as she is only 15 years old and Mr Shackleford has explained all this to her. For the time being we will try conservative management and we are going to try Pregablin 75mg twice a day to start with and see how she goes. Obviously if the pain in the leg gets worse we could give her forminal epidural injections and try to delay spinal surgery until she is older. She understands this so we will keep an eye on things and we will see her back in 3 months' time to see how she is getting on."

12. There is a dispute as to what occurred on this particular occasion. Mr Shackleford states that he was in the clinic and that he personally met both the claimant and her mother in order to explain the reluctance to operate because of the claimant's age, and also because of the risks of the operation which were heightened by the claimant's particular psychological sensitivity at the time. The claimant and her mother deny that there was any conversation with Mr Shackleford at that time. Indeed the claimant's mother refers to a contemporaneous diary entry in which she noted that:

> "didn't get to see Shack, was a waste of time going no sooner in than out."

The claimant states that all that was said during the course of the consultation, which did not involve Mr Shackleford, is that she was told that she was too young for surgery to be contemplated. Having considered the evidence I am of the view that Mr Shackleford is mistaken in his recollection of having been present and discussing in person with the claimant and her mother the difficulties with operations as a result of the claimant's age and the risks of any operation on that occasion. The contemporaneous documentation in the form of the diary entry is in my view highly persuasive. I would be wholly unprepared to accept that that diary had been subsequently fabricated and it appears to me highly likely that it reflects the fact that the claimant's mother was frustrated that they had not been able to see Mr Shackleford in person on that occasion. That of course has to be put alongside the letter which was written by Mr Calleja. In my view the letter sets out for the claimant's GP when it talks about Mr Shackleford having "explained all this to her" a record of the conversations which had occurred across the claimant's several visits to the clinic including earlier occasions when Mr Shackleford had rehearsed the difficulties of offering surgery to her bearing in mind her age. Thus whilst I am satisfied that Mr Shackleford is mistaken in suggesting that he had a personal conversation with the claimant and her mother on 23rd September 2008, the correspondence both on this occasion and previously supports the fact that he had previously discussed the problems of offering the claimant surgery bearing in mind her age on earlier occasions when she had visited his clinic.

13. On 23rd December 2008 the claimant again visited the clinic and on this occasion saw another Registrar colleague of Mr Shackleford, namely Mr Stables. The outcome of that consultation was set out in a letter by Mr Stables to the claimant's GP in the following terms:

> "This young girl received good benefit from her left L4/5 foraminal epidural injection in July which lasted just over 2 months. Her symptoms have returned now and unfortunately have worsened. I have discussed treatment options with her today. She understands that surgery maybe an option in the future but she also understands that her symptoms may improve and she will not require surgical intervention. She continues to see the clinical psychologist in relation to her initial trauma and we would be keen to have all these issues resolved prior to considering any intervention. Both she and her mum understand this. I have discussed her case with Mr Shackleford and he is happy to place her on the list for a further injection and this has given her some relief. I have therefore listed her for an L4/5 foraminal epidural left side and we will send for her in due course."

14. There is again a dispute between Mr Shackleford and the claimant and her mother as to whether or not he saw them in this clinic. Mr Shackleford suggests that there was discussion between him personally and the claimant and her mother about the risks involved in operating on patients who had active psychological or psychiatric disease. This is, of course, reflected in the text of the letter written by Mr Stables but not directly attributed to Mr Shackleford. The claimant and her mother say that they did not see Mr Shackleford on this occasion and further deny that there was any discussion about the heightened risks of surgical intervention in patients with psychological or psychiatric conditions. Again, I am unconvinced that Mr Shackleford in fact saw the claimant and her mother on that day. When cross-examined about this occasion his evidence as to what had actually taken place was unclear. I have no difficulty in accepting that the claimant's case was discussed between Mr Shackleford and Mr Stables at some point around the time of that consultation. However, on the balance of probabilities I am satisfied that the claimant and her mother are correct when they suggest that they had no direct contact with Mr Shackleford on that occasion. That said, I am unable to accept the evidence of the claimant and her mother that at that time there was no discussion in relation to the involvement of the claimant's psychiatric problems in the question of whether or not there should be any surgical intervention. The letter from Mr Stables to her GP is clear that both the claimant and her mother understood that there would be a need to seek to resolve her psychological or psychiatric problems prior to the consideration of any surgical intervention. From that indication in the correspondence it is clear in my view that there was at that time discussion about the interrelationship between the claimant's psychiatric problems and the treatment she was receiving for them and the potential for her to have surgical intervention. The context of any such conversation would, of course, be based around the problems involved in undertaking surgery on a person who was continuing to receive psychiatric treatment.

15. A further foraminal epidural steroid injection was undertaken on 31st January 2009. Unfortunately the relief from pain which the claimant enjoyed as a result of that injection proved to be short lived. When she was seen subsequently by Ms Cadman, an orthopaedic physiotherapy specialist, she reported that she had in fact only received two weeks relief from her symptoms as a result of that treatment. She continued at that time to have pain in her left leg. Ms Cadman, following seeing the claimant, volunteered to discuss the claimant's continuing problems with Mr Shackleford.

16. The outcome of that discussion was recorded in a letter dated 24th April 2009. Mr Shackleford had reviewed the scans and did not wish to intervene further. He indicated that he would review the claimant's case in six months. Annotated on the correspondence recording this are two notes. The first is dated 30th April 2009 which records the claimant complaining of considerable pain in her left leg. The second is dated 5th May 2009 (and may well have followed receipt of a letter of 1st May 2009 advising that Mr Shackleford did not wish to consider further injection therapy at that time and proposed to see the claimant in October 2009) noting that the claimant's pain was worse and that she was sleeping on the floor. An appointment was made for her following these annotations, which Mr Shackleford explained were likely to have resulted from incoming calls, for the claimant to be seen at Mr Shackleford's clinic on 14th July 2009. In her evidence the claimant explained that at this time the pain was so intense that she was having to sleep on the floor and that it was keeping her awake at night. Her pain was having a serious impact upon her mobility leading to the need for her to use crutches and walking sticks in order to get around. Indeed, the pain reached a stage at around this time where she was having to use a wheelchair in order to get herself about the house.

17. As noted in the letter dated 23rd October 2006 the claimant was throughout this time receiving psychiatric treatment for symptoms from which she was suffering including anorexia. The problems recorded from 2006 through to 2009 included the development of symptoms which were investigated, on one occasion by a laparoscopy, for which there was no physical explanation and which could only be attributed to episodes of somatic illness. From 22nd February 2007 her treating psychiatrist was Dr Sarah Elliott. The diagnosis which was reached in relation to her psychiatric problems was that she was suffering from depressive disorder with prominent obsessional symptoms and anxiety. There was a concern in relation to her psychiatric symptoms that there might well be an emerging psychosis.

18. The claimant was treated with cognitive behaviour therapy accompanied by appropriate medication. Shortly after she had started seeing Dr Elliott the claimant confirmed to her that she was from time to time having suicidal thoughts. By autumn 2007 it became evident that there were disturbing events which had occurred in the claimant's past life that she was not disclosing to Dr Elliott or talking about. Subsequently and during the course of her treatment it became clear that the claimant had been the subject of sexual abuse involving in particular sexual assaults during the course of which her back had been kicked and she had been pushed over leading to the physical injuries and ongoing symptoms associated with her back. Thus the original premise that her injuries were associated with an incident whilst playing sport was incorrect; in fact her injuries had been sustained during the course of an extensive period of sexual abuse.

19. On 6th May 2009 Dr Elliott noted that the claimant's bad back had been caused by the sexual abuse of which she had been a victim, and was therefore a continual reminder of the sexual abuse she had suffered and a trigger for reminding her of that abuse. As it was put, graphically, every step she took reminded her of the abuse. The claimant was suffering with fear, anxiety and loss of concentration as a result of her illness. On 13th May 2009 Dr Elliott was asked to write to Mr Shackleford in relation to the continuing issues as to the treatment which she needed for her back. Dr Elliott wrote to Mr Shackleford in the following terms:

> "XYZ and her mother tell me that it is your intention to treat her back when her mental state is improved. However, I feel that any surgery should not be delayed because of her mental health problems as the limitation to her activities imposed by her back problems is in itself making her mental health problems worse.
>
> Please do not hesitate to contact me should you require further information."

20. Mr Shackleford saw the claimant again on 14th July 2009. On that occasion he states that he discussed with the claimant that her physical and psychological symptoms were probably feeding off one another and therefore the question of whether or not she should receive surgical intervention was complicated by the potential of her psychological or psychiatric symptoms affecting the outcome of the surgery. In his evidence Mr Shackleford explained that by this stage he was very concerned given the claimant's psychiatric and psychological history that she already had a chronic pain syndrome and that surgery might make matters worse rather than better. He further indicated in his evidence that bearing in mind the potential for spinal surgery to be a precursor of a lifetime of operations and chronic pain, and the benign long term prospects for the condition, surgery would also always be a last resort. The outcome of the review was described by Mr Shackleford in a letter to the claimant's GP in the following terms:

> "I reviewed XYZ in the clinic today. She is struggling worse than ever with back and left leg pain. Her last injection did not help at all and we are now at the stage where we may have to consider surgical intervention though I am very reluctant to go down this line given her age.
>
> We have had communications from the Psychiatrist to say that her back pain is causing major difficulties with treating her psychologically but I have explained once again to her and her mother that the 2 feed off the other as there is no straight forward way of dealing with her back pain and we need to still be cautious.
>
> She is to have a new MR scan and I will see her with the results."

21. In their evidence the claimant and her mother deny that there was ever any discussion of the impact on the claimant's prospects for having a successful outcome from her

surgery as a result of the psychological and psychiatric symptoms from which she was suffering. I am unable to accept this in relation to the occasion when they saw Mr Shackleford on 14th July 2009. I have no doubt that Mr Shackleford is correct when he recalls, assisted by the contemporaneous correspondence, that at that consultation there was discussion prompted by receipt of the letter from Dr Elliott about the adverse implications of the claimant's psychological and psychiatric difficulties and that the two were likely to be interrelated therefore rendering any surgical intervention less straightforward and heightening the risk of an adverse outcome were surgery to be undertaken.

22. As is evident from the letter following the consultation on 14th July 2009 a new MRI scan was ordered. Following the receipt of the results of that further scan, which showed no material change from the earlier findings of scans of the claimant's lower back, Mr Shackleford saw the claimant again on 7th August 2009. What occurred at that meeting is the subject of significant dispute in the case. The claimant's account of what occurred, supported by her mother, is that Mr Shackleford recommended lumbar microdiscectomy to her as a surgical procedure as the pain in her left leg was at that time causing real problems and this procedure would be safer than seeking to remove the claimant's disk. Both the claimant and her mother contend that there was no discussion of the risks of the operation at that stage, nor were they provided with any information about the potential problems created by the claimant's psychiatric condition. The claimant's mother relies in this respect upon the diary entry which she made following the appointment which simply noted that the operation would happen when Mr Shackleford had returned from his annual holiday but noted nothing about any potential risks which might be involved in undertaking surgery.

23. By contrast Mr Shackleford contends in his evidence that there was a detailed discussion about the pros and cons of surgery at this consultation. He states that the claimant and her mother were very keen for surgery to occur and that they advised that Dr Elliott had said that the claimant's potential recovery from her psychiatric problems was being undermined by the continual pain which would persist if the operation did not take place. Mr Shackleford states that he explained that the matter was not that simple and that he was concerned that the claimant would react badly to the surgery and questioned whether she would in reality obtain the pain relief which she sought. He says that he explained the risks which are involved in spinal operations. He states that he identified the risks of neurological damage (including paralysis, loss of bladder and bowel control) together with other risks of the operative procedure. He said that he explained that whilst the usual success rate in surgery of the kind which he proposed would be of the order of 90%, in the claimant's case the prospects of success would be lower than this because of her particular psychiatric presentation. Notwithstanding all of this advice Mr Shackleford states that the claimant and her mother were insistent upon surgery being undertaken and therefore he agreed to undertake the operation.

24. Following the consultation a pre-operative assessment was undertaken by a nurse in Mr Shackleford's clinic namely Theresa Gerrard. When she gave evidence she indicated that she had no independent memory of seeing the claimant on that day and that is wholly unsurprising given, no doubt, the number of patients which Nurse Gerrard must have seen in the intervening period. She was able to confirm from documentary records that she completed various documents as part of her pre-

operative assessment on 7th August 2009. Within that documentation she noted under "expectations post-operatively" that the claimant "will read leaflet". Under "any comments" she noted that the claimant had stated that she "would prefer not to have a catheter as had prior history of assault". The leaflet to which the document which was completed by Nurse Gerrard referred is one which is entitled "Lumbar Microdiscectomy" and which was printed and provided specifically by the defendant in relation to the type of operation that the claimant was going to undergo. It contains information about the operation and the physical procedures which will be performed and goes on to advise of the risks of the operation in the following terms:

> "1. A few fibres of the nerve may be injured
>
> 2. Tears of the protective lining of the spinal nerve roots
>
> 3. Blood clots in the legs or lungs
>
> 4. Infection"

25. The claimant states that she was never given that leaflet and in that contention she is supported by her mother. The claimant says that she had never seen that leaflet until it was provided to her by her solicitors during the course of these proceedings.

26. The operation was arranged for 17th September 2009. The claimant was admitted to an adult ward notwithstanding the fact that she was 17 at the time. She says that as a result of being put on an adult ward she was told that her mother could not stay with her whilst she was being prepared for the operation on that date. After her admission to hospital she was seen by Karen O'Malley who was a nurse on the ward. One of the matters which Nurse O'Malley had to deal with was the question of the claimant completing and signing a consent form in relation to the operation. The consent form was filled out by Nurse O'Malley prior to being signed by the claimant. It was completed in the following terms:

> "**The intended benefits:**
>
> To improve left leg pain
>
> **Serious or frequently occurring risks:**
>
> Infection, nerve root injury, dural tear, bowel/bladder disturbance, major medical complications (heart attacks, strokes, blood clots in lungs / legs)."

27. Nurse O'Malley did not attend the trial because she has subsequently emigrated to New Zealand and it did not prove possible to set up a video link in order to receive her evidence. In any event she has stated that she has no independent memory of the occasion when she met the claimant in order to complete the consent form. What she advises is that it would have been her routine practice to explain to a patient that microdiscectomy is a procedure which is intended to deal with leg pain but not back pain. She would also, she says, have advised a patient as to the risks that can arise as a consequence of undertaking the surgery. By contrast, the claimant says that she was

simply given the form and told to sign it and that she was not taken through it nor were any of the risks specified on the form explained to her.

28. Setting out this period covered by the evidence from the middle of 2008 up until the date of the operation provides the context for resolving the factual issues in relation to whether or not the claimant was advised fully and properly in relation to the risks of the operation and therefore able to give her consent. The first issue which I have found easy to resolve is the question of whether or not the claimant was provided with the "lumbar microdiscectomy" leaflet. I have no doubt that she was provided with that leaflet by Nurse Gerrard. Whilst Nurse Gerrard accepted that there were some errors on the documentation which she had completed, for instance she had noted a "N" rather than a "Y" for the claimant's mental health, and she accepted that there were defects in the care which she had provided in that she should have taken a peak flow from the claimant because of the claimant suffering from asthma, these were in reality minor issues and can be accounted for without accepting that the totality of the information which was compiled by Nurse Gerrard was inaccurate or incomplete. This is particularly the case in relation to the answer which was provided in respect of post operative expectations. This is a narrative rather than a simple mechanical answer and one which has in my view been accurately completed by Nurse Gerrard in a form which makes plain that the leaflet was provided to the claimant. Whilst Nurse Gerrard accepted, candidly, that there was a possibility she may not have provided the leaflet, on the balance of probabilities I am entirely satisfied that she did. Furthermore that is reinforced by not only the careful note which she took in relation to this issue but also in relation to answers recorded in relation to the use of a catheter and the question of the claimant's previous abuse. I am unable therefore to accept the evidence of the claimant and the claimant's mother that she was never provided with this leaflet.

29. Turning to the evidence of Nurse O'Malley again I have no difficulty in accepting her evidence that, in common with all of the occasions when she would undertake the consenting procedure, that the claimant was taken through the notes on the consent form prior to her signing it. Without the benefit of hindsight the claimant may not, at the time, have appreciated the significance of the risks about which she was being advised or the process which was occurring when the form was presented to her. However I am satisfied that the claimant is mistaken when she suggests that she was simply expected to sign the form without there being any discussion of its contents.

30. The most significant contested element of this aspect of the case is that related to the advice on risk which was provided by Mr Shackleford. It is, of course, a serious and indefensible omission on the part of Mr Shackleford that there are no detailed notes provided of the consultation of 7th August 2009 apart from the following which is recorded in a letter from Mr Shackleford to the claimant's GP:

> "I reviewed XYZ in the clinic today. Although her MR scan doesn't show any worsening of the situation I think she is now in a state of mind where left leg pain is a major problem and she would like to have something done. She could therefore go ahead with a left L4/5 microdisectomy, we know nothing about the disc pain at this stage."

31. I also bear in mind that I have already concluded that Mr Shackleford's evidence has been mistaken in his recollection of some of his earlier interactions with the claimant and her mother. Nevertheless there are other elements of the proceeding documentation which support the view which I have reached that Mr Shackleford's evidence in relation to what occurred on 7th August 2009 is a reliable account. It is clear that, in particular, the interaction between the claimant's psychiatric and psychological symptoms and her back pain and the options for treatment of it were a matter which had been the subject of earlier discussion between the claimant and her mother and Mr Shackleford and his colleagues. This is in particular evidenced from the consultations of 23rd December 2008 and 14th July 2009. It therefore appears to me overwhelmingly likely if not inevitable that Mr Shackleford is correct when he describes the contents of the consultation on 7th August 2009 as involving a discussion of the potential for the operation to be prejudiced by the claimant's psychiatric problems since that would have been a development of what was in effect an ongoing discussion about that issue and a continuation of the advice which had been given in earlier discussions. In my view it is inconceivable that Mr Shackleford would have embarked upon relatively major spinal surgery without having explained the risks in relation to neurological damage and other complications which would arise from intervening directly in the claimant's spine. I accept his evidence that his explanation of the risks would have included a discussion of the risks of neurological damage including paralysis and loss of bladder and bowel control and that they would have covered the risks of infection, damage to the dura and further pain and spinal problems. Whilst Mr Shackleford presented in the witness box as a person who was inclined to be impetuous, and perhaps headstrong, failure to have explained these risks would undoubtedly have been unprofessional and foolhardy and as such conduct which I am unable to accept occurred on this occasion.

32. I am satisfied that the claimant and her mother are therefore mistaken in their recollection that there was no discussion of these matters. I am unprepared to speculate as to how that may have happened but bear in mind that this advice was administered at a time of considerable stress and anxiety for both the claimant and her mother, and furthermore during a period where it is clear to me that they were exceedingly anxious to seek to secure some means of medical treatment to resolve the physical and psychiatric symptoms which were causing the claimant considerable difficulties. Whilst I have no doubt that, understandably, seeking a concrete resolution to the claimant's symptoms through positive and direct medical treatment was a high priority for them at that stage I am unable to accept that the operation which occurred took place without them having received any advice at all in relation to the potential issues associated with the claimant's psychiatric treatment at the time, or the other neurological and general medical risks arising from the procedure. I shall return to the implications of these factual conclusions when considering the question of whether or not consent was properly obtained from the claimant.

33. The operation proceeded uneventfully on 17th September 2009. The claimant states in her evidence that from as soon as she came round she was unable to pass urine and had no sensation in her saddle area. When she was catheterised on 18th September 2009 she was unable to feel the catheter being inserted and when her saddle area was washed by the nursing staff again she had no sensation. In addition she continued to have a great deal of pain in her left leg which remained unresolved by the operation.

34. The hospital notes record that she was still catheterised and her bowels had not opened by 19th September 2009. At that stage she was seen by physiotherapists who started to mobilise her with a zimmer frame but she was only able to walk slowly and with considerable difficulty. This was as a consequence of her continuing to have considerable pain and also weakness in her left leg. It was noted that she had yet to pass urine and that it would be necessary for her to do so in order for her to be passed fit to be discharged home. In an attempt to facilitate her passing urine her catheter was removed. This was unsuccessful and she was recatheterised on 22nd September 2009 when one litre of urine was drained from her bladder. On the same day she saw Mr Shackleford and the notes record him advising that she was to be taught self catheterisation and then discharged. Although at that stage she had still not opened her bowels she was noted as declining medication in order to assist with that.

35. Whilst the medical notes state that the claimant was seen again by Mr Shackleford on 23rd September 2009 he disclaims this. Little turns on that discrepancy, since what is clear is that she was considered by the hospital medical staff to be suitable to be prepared for discharge. She saw a physiotherapist and it is noted that she could walk with a zimmer frame and under supervision just out of the room in which she was in and back again. She was also seen by the occupational therapist. She was provided with advice by the nursing staff in relation to her catheterisation and was discharged home. At this point she had still not opened her bowels following the operation.

36. In fact by the time she returned from an outpatient appointment on 6th October 2009 she had still not moved her bowels. At the outpatient appointment she was seen by Dr Calleja. He noted that she was constipated and Dr Calleja thought that this was due to the opiates that she had been taking. He examined her and found that in relation to her left leg she had diminished sensation across all dermatomes and noted "reflexes normal". Her pain it seemed had improved following the operation but at that time she was unable to undertake straight leg raising on her left side. In the notes Dr Calleja observed that he needed to discuss an examination of her rectum with senior medical staff.

37. On 8th October 2009 the claimant's mother was very concerned about the claimant's condition and called her GP for assistance. The claimant still had not opened her bowels and her stomach was swollen. When she was examined by her GP he arranged for her admission to hospital that day. At hospital she was given a PR exam and the notes of that examination state as follows:

> "Loss of sensation in peri-anal area, had PR from GP – no sensation. Has some sensation when passing catheter."

38. A phosphate enema was administered to her and a small bowel movement was achieved. On 9th October 2009 she had an MRI scan in order to investigate whether or not there was evidence to support a diagnosis of CES. The findings of the MRI scan were as follows:

> "MRI Spine Lumbar Sacral:
>
> Comparison is made with the previous examination from August 2009.

> The L4/5 disc is degenerate and there is a posterior disc protrusion at this level. There has been a slight increase in the degree of posterior bulging on the left, into the left lateral recess. All the nerve roots in the theca appear generally crowded and there may be some nerve root compression in the left lateral recess. There is no exit foraminal stenosis.
>
> At L5/S1 there was previously a small central posterior disc protrusion. This appears unchanged and there is no evidence of nerve root compression.
>
> The rest of the lumbar theca and spine appear normal."

39. On 12th October 2009 the claimant was noted as complaining of perineal sensory deficit. On 13th October she was examined and it was noted that upon perineal examination she had no perineal sensation, no movement in the perineal region or anus and whilst there was normal muscle tone in that area there was no squeeze response. Later that day when seen by another member of the medical staff she is noted as having said that she had had a good recovery in terms of passing urine and leg pain after the operation and as having done well at home but that after three days she had suffered an episode of decreased sensation in her perineum and had not experienced any opening of her bowels.

40. On 15th October 2009 there is a note which was prepared for the purposes of the hospital records summarising the views of the various professionals who had been involved in the claimant's care and noting that Mr Shackelford considered that her problem could be described as "post-op neuropraxia – which may persist for four months". There was a neurological registrar who had been involved in her care at this point and a formal referral to neurology was pending in her case. She was also seen by Dr Elliott, her treating psychiatrist. After noting that she was very worried about her physical health Dr Elliott went on to record in the notes as follows:

> "XYZ appears much the same in her mood as she has over the last 12-18 months, she has suicidal ids but no plans to carry them out (again this is a usual presentation for XYZ). She has had a difficult history and the nature of her condition will be particularly distressing for her. She is anxious about whether she will recover and will benefit from continued reassurance. At present, XYZ is isolated in her room and this is increasing for the time as she has to ruminate on her worries…
>
> XYZ says that she is feeling nauseous and this is why she is not eating. This symptom may be physical or may be related to anxiety."

41. On 15th October 2009 she was seen in Warrington hospital by Professor Marson. He entered a note of his consideration of her case in the following terms:

> "She gives a very clear story of urine retention and perineal numbness post operatively. She cannot feel the bladder in situ.

This is all as a consequence of the surgery.

There is still time for significant improvement.

She does need further help from the continence service."

42. This consultation with the claimant led to a referral by Professor Marson to Mr Pigott, a consultant neurosurgeon at the Walton Centre. In a letter dated 21st October 2009 Professor Marson summarised the claimant's position as follows:

> "She was assaulted a year or two ago and left with back pain and more recently was found to have a lumbar disc prolapse. The main symptom was sciatica. She underwent an L4/5 microdisectomy just over 3 weeks ago. She gave a very clear story of having perineal numbness immediately post-operatively and no bladder or bowel sensation. This has not improved and she currently has a catheter in situ. She can't feel the catheter. She had been discharged home following surgery and had been admitted to the paediatric ward. She had been seen a couple of times on the paediatric ward by the orthopaedic team. A post-op MRI scan showed no evidence of worsening of her canal stenosis and no further surgery was thought indicated."

43. On 16th October 2009 the claimant was discharged home and was self catheterising in order to void herself of urine. She was referred to the Walton Centre where she was first seen on 27th October 2009. On that occasion she was noted to have left leg pain with sensation loss in the L2-S4 distribution. Whilst it is not altogether clear from the notes whether this was just on the left side Mr Summers was of the view that the note clearly referred specifically to left side in sensation loss when the notes were read as a whole. The notes also recorded that she had reduced anal tone. She was advised by the consultant who she saw that she had CES and was referred to the Cauda Equina ("CE") clinic. In her evidence the claimant states that she found the treatment and advice which she obtained at the CE clinic helpful. She was, as part of that treatment programme at the Walton Centre, referred to Professor C A Young. Professor Young wrote a letter to Mr Pigott describing the issues which were current with the claimant at that time as follows:

> "1. She is mobile with two crutches. She is due to commence physiotherapy shortly and social services are being asked to provide a second hand rail. She has just passed her driving test.
>
> 2. Bladder she is doing a bladder regime to do ISC seven or eight times daily, she has no bladder sensation and does not know the bladder is filling until she experiences abdominal swelling. She has nocturia once per night when she wakes anyway due to pain, on the nights that she does not wake up she may wet the bet. She is not entirely dry during the day and wears pads. There have been no urinary tract infections.
>
> 3. Bowels – is prescribed a regime of laxatives such as Movicol and Senna followed the next day by suppositories but two weeks ago she

discontinued that because suppositories gave her flashbacks to her previous sexual abuse. She reports that she has not been able to empty her bowels at all in the last two weeks.

4. Sensory – numbness left leg and perineal area.

5. Pain – back and left leg pain which is constant with exacerbations. Has painful leg spasms to no pattern. The pain keeps her awake at night and on a VAS she had reported 6-7/10."

44. At this time as a result of her pain and disability the claimant was mobilising on two crutches and using a wheelchair for any longer distances. Indeed in April 2010 she was noted as visiting the Walton Centre in a wheelchair. She continued to require help with nurses who called to undertake home visits in order to assist her with going to the toilet.

45. On 30th April 2010 the claimant attempted to get up from the couch in her home but was unable to do so. Her legs were unable to hold her and were painful with accompanying pins and needles and an inability to feel them properly. She was seen at Warrington Hospital but then taken in an ambulance to the Walton Centre. When she was examined she had paralysis of both limbs and no sensation from the level of lumbar vertebra L1 downwards. She had unresponsive plantar reflexes but brisk patella reflex with perianal paraesthesia. At the Walton Centre on 1st May 2010 an MRI scan was undertaken of her spine. The findings of the MRI scan were as follows:

"MRI Spine whole:

There is dehydration of the L4-5 disk in the central slightly left-sided disk bulge which does extend into the left root exit foramen but is not causing significant compression of the cauda equine. The remainder of the spine appears entirely normal. Normal appearances of the cranial cervical junction."

46. The view of the medical staff treating the claimant at the Walton Centre was that this scan showed no evidence of any Cauda Equina Lesion. On the basis that there was no neurological intervention required in the claimant's case she was then transferred back to Warrington.

47. Whilst she was an inpatient in Warrington, on 6th May 2010 she was seen on the ward by Mr Shackleford. He recorded this meeting and also further contact with the claimant at the hospital in a lengthy note which was compiled on 14th May 2010. The note provided as follows:

"On 30th April this year she was walking with elbow crutches and on pain management, was self-catheterising every 4 hours when she had sensation of wanting to void. She was manually evacuated because she had loss of sensation and coordination to defecate. She confirmed this to me on interview when I saw her on the ward on 6th May 2010. Unfortunately a note was not logged on meditech as the tape was lost. Her situation around 29th and 30th April was that she apparently had lost control of

both legs because of severe back spasm and has been unable to move or feel her legs since. There has been no change in her bladder or bowel function from before this. She was transferred as an emergency over to the Walton Centre where a further MRI scan was performed. This excluded any obvious change or new pathology. She was therefore, sent back to our ward A9 at Warrington and has remained in bed ever since.

I attended that ward on 6 May at the request of Mr Pradhan and I believe at that time, at the request of the patient as well. I spoke to XYZ and her mother in the first instance and requested to speak to XYZ on her own in the presence of one of the senior staff nurses from the ward. I broached the subject of her legal action against me and suggested that this made things difficult for the both of us. She did not express any concerns regarding this and felt that this was nothing personal. I have a conversation with her and asked her of the circumstances of her admission, her subsequent MRI scan and how she had been coping at home as I had not seen her personally for a long period of time. She was somewhat evasive about this but cooperative.

Examination today confirmed no sensation beyond the L1 level. No voluntary motor function below the L1 level but if anything, slightly increased tone particularly with an extensor equinous posturing. Reflexes were present and brisk, plantars down going. A perineal and rectal examination was performed with a chaperone present and XYZ was found to have anal sensation and voluntary contraction of her anal sphincter. No other intimate examination was performed or attempted. A detailed sensory assessment was not made bearing in mind the other findings. XYZ asked me what I felt was the cause of the symptoms. I told her that I was unable to explain them but it may well be that as this appeared to be a general neurological condition rather than a spinal condition and that this had been ruled out by her MRI scan at the Walton Neurological Centre, then neurology review by Prof Marson and the experts at the Walton Centre should be the next step. I informed her that in the interim, she should be mobile. We would ask the pain team to try and help with pain control and that we should attempt to continue to mobilise her. Throughout this examination, she was not in severe pain and appeared extremely calm and was not distressed. I suggested that if she wished, we could discuss things further between ourselves but this would be entirely up to her. She seemed at that stage to be receptive to this idea. Following this I interviewed her mother at her request to appraise her of the situation and answer any questions. She was extremely concerned that we were missing some major neurological disaster and I was asked to try and explain her current neurological status. I professed that I would not prefer

to be involved in this case at this stage as she was actively suing both myself and the trust and that I had not been privy to any of the tests or test results from the Walton Centre or information they had been given from there.

…

Subsequently I briefly reviewed XYZ on the ward on 11th May and no progress was being made and I had a brief conversation with her this morning, 14th May but again no formal assessment was made.

…

On 6th May the date of my interview with XYZ and her mother, the next note is from Carol Grindley, nursing staff stating that the patient and the mother at 1100 am were not happy that I had not given her any answers, she was upset that I had expressed it may be psychological and I am accused of trying to get into her head. It is also stated in contradiction to the previous note that she was unhappy to speak to me alone without her mother and that she did not want this. I told her that it is clear that was an offer made to her at the time and it was not my instigation and she was in agreement and felt that this was a good idea. Why this has been communicated to the nursing staff and not back to myself during that day is of concern. There is a further complaint on the same day documented by the physiotherapist Harriet Ivanson in the afternoon. By this stage I had told the patient that the numbness and lack of movement was definitely psychological. This represented a significant breakdown in trust and increasing exaggeration of my opinion which never stated that. There is no mention from XYZ to the physiotherapist that I had recommended a neurological opinion because I was not sure and wanted to exclude all possibilities. The physio assessment at that time once again confirmed a concern as to the non anatomical nature of her neurological deficit. Further physio note confirms that the neurological status is exactly the same with no sign of pressure sores despite the patient being unable to move because of paralysis and severe pain. It is clear with further physio that XYZ was able to sit, has sitting balance and active hamstring contraction to assist with this. There have been noted inconsistent flickers of function in quadriceps and hamstring but not in the level of the ankles. The situation at present is that I don't think I am able or willing to provide any input to this lady's care. She needs to be under the care of Prof Marson and Tim Piggott from the Walton Centre and preferably in their unit."

48. The claimant's account of this encounter differs from this certainly in terms of its emphasis. The claimant states in her evidence that notwithstanding the arrangement having been that Mr Shackleford was to meet the claimant together with her parents

Mr Shackleford in fact came to see her on her own. The claimant states that Mr Shackleford was intimidating and was telling her that it was stupid to be suing him and she ought not to do so. He referred to her condition as "paralysed" emphasising the word by gesturing that he was placing it in speech marks and telling her that the problems she had were in her head. The claimant's mother, although not present at this time, says that this account was relayed to her straight after the meeting by the claimant and that a nurse had apologised to her for Mr Shackleford seeing the claimant without a chaperone being present.

49. It is important, initially, to observe that in reality in my view little turns in relation to the issues in this case on the differences between the parties in relation to the evidence in this respect. I have no doubt that Mr Shackleford was frustrated at the situation that confronted him and was exercised that he had been asked to see the claimant when she was threatening legal proceedings against him. In this context therefore, albeit probably unintentionally, I accept that his manner must have come across to the claimant as intimidating. That said, I accept the contents of the notes which he made in terms of the examinations which he undertook and the findings that were made at those examinations and his thoughts as to the diagnosis which arose from the available evidence. In cross-examination Mr Shackleford accepted that it would have appeared to the claimant that he had in fact turned up alone in the first instance when he saw her and that reflects accurately the claimant's account of what occurred. However, I accept that the contact between the claimant and Mr Shackleford went beyond that initial meeting and that initial exchange of views about the propriety of the claimant suing him and the nature of her symptoms and did include proper and professional examination of the claimant and findings and conclusions as a consequence. It is certainly clear that by this stage there had been a breakdown in trust between doctor and patient. I accept Mr Shackleford's evidence that the examinations which I am confident occurred were undertaken with another person present as he describes in the notes.

50. The claimant subsequently returned to the Walton Centre on 18th May 2010. On 19th May 2010 nerve conduction studies were undertaken by Dr Deshpande. The findings of the nerve conduction studies were as follows:

> "The sensory and motor nerve conduction studies were within normal limits in the right lower limb. There was no evidence of a significant generalised large fibre neuropathy.
>
> EMG evaluation undertaken in both lower limbs showed no evidence of active denervation or other neurogenic abnormalities, though the assessment of voluntary motor activity was not satisfactory due to decreased power in the limbs.
>
> Overall, the current studies do not show any evidence for a significant lower motor neurone abnormality in the lower limbs."

51. On 23rd June 2010 the claimant was sent to the Neurorehabilitation Unit at Walton in order for her to be educated and assisted in rehabilitating herself in the light of her symptoms. Following this she was discharged home on 23rd September 2010. In lay

terms the claimant has since September 2010 been a wheelchair user with no useful function in her legs albeit on occasion certain small or flickering movement has been seen within them. She has no bladder or bowel function and she has to self catheterise and manually evacuate her bowel on a regular basis. In addition to her physical symptoms the claimant has suffered significant psychiatric symptoms. The causes and diagnoses for these continuing symptoms are discussed in detail below in relation to other aspects of the case. However, in short, her condition has not improved since that time.

52. Shortly prior to the trial the defendant discovered on the claimant's publicly available Facebook account entries relating to an incident on 21st November 2015. What she posted on her Facebook account was as follows:

> "On Saturday I went to the canterlever bridge in Latchford Warrington. I climbed over the railing ready to end my life, and a lovely couple stopped me and to cut things short asked me to climb back over so I did. I stayed a few nights in Bury mental hospital and my life has changed so quickly since. I've realised life IS worth living and I'd like to personally say thanks to these people as they honestly saved my life, so please share as I wouldn't be here today writing this without them. If you're out there please PM me I would really appreciate it!"

53. In addition to this entry the defendant found photographs which depicted the claimant whilst on holiday sitting on the edge of some rocks out of a wheelchair and with no wheelchair in sight. This material caused the defendant to raise the question as to whether or not the claimant was in fact far more mobile than she had suggested and was in fact able to climb onto the bridge parapet which was shown in photographs as being some distance off the ground, as well as being able to move around the seashore unassisted when she was on holiday.

54. When the claimant gave evidence she was cross-examined about the photographs. She explained that the photographs had been taken when she had been on holiday with her brother in Malta. He had helped her to manoeuvre her wheelchair to a point from which she could alight from it and seat herself on the rocks, following which the wheelchair was moved away for the purpose of the photograph. She explained that she is adept at getting in and out of her wheelchair unassisted which is an essential skill in order to participate, as she does, in the sport of wheelchair basketball. Thus there was nothing untoward or suspicious about the photographs and they were not inconsistent with her account of her symptoms.

55. She was also asked what she had meant when she had written that she had climbed over the railing of the bridge and, after the intervention of the passing strangers, had climbed back over it. She explained that when posting on her Facebook account, and indeed in conversation, she would use everyday figures of speech which described actions which as a wheelchair user she would be physically incapable of such as, for example, "going for a walk". Thus she said it would be wrong for the entry to be taken literally. She explained that she had been able after parking her car to travel with her wheelchair to the edge of the bridge, and then by placing it alongside the railing pull herself up and out of her wheelchair with her upper body so as to sit on the ledge of the railings. She had then used her hands and arms to pull her legs up and

over the railings so as to leave her in a seated position facing the water whilst contemplating ending her life. It was whilst she was in that position that the couple who she described arrived at the scene and physically dragged her back off the railings so as to prevent her from harming herself. She explained that in fact after she had posted this message on Facebook she had been messaged privately by the couple who had saved her and had been in contact with them.

56. In the light of the defendant's reliance on this material and their attack on her credibility the claimant called as a witness Naomi Brennan who was one of the couple who had stopped at the scene on that night. In her evidence Ms Brennan claims that she had been out for the evening with her partner and they were driving home when they had seen the claimant on the ledge of the bridge. They stopped the car and she and her partner went to the claimant's aid. In fact it was a third person who had arrived at the scene who had pulled the claimant back off the railings. None of these people were known to the claimant at the time and were simply strangers seeking to intervene in her suicide attempt.

57. Having heard the claimant and Ms Brennan give evidence I am entirely satisfied that there was no substance in the allegations which were made against the claimant in relation to these issues or in the attack on the claimant's credibility which the defendant attempted to develop. Indeed by the end of the case Mr Charles Feeny, who appeared on behalf of the defendant, did not seek to feature this aspect of the case in his closing submissions prominently at all. I gravely doubt whether it was well advised for these matters to be pursued in the light of the evidence which then emerged. I have no difficulty in accepting the account given by the claimant and Ms Brennan of what occurred on 21st November 2015 nor do I have any difficulty in accepting the claimant's account of how the holiday photographs came to be taken when she was in Malta. In short I am entirely satisfied that the claimant's continuing symptoms are genuine and not in any way fabricated. As is in reality more than adequately demonstrated in the medical evidence to which I shall refer in due course her continuing symptoms have real and genuine physical and psychiatric causes. The existence of these causes is not, in general terms, in dispute. The defendant raising these points led to unnecessary expenditure of court time on a matter which was demonstrated by the claimant to be completely without merit.

Breach of duty

58. The first question which arises in relation to whether or not Mr Shackleford and the defendant were in breach of duty relates to the question of whether or not they did sufficient to properly obtain the consent of the claimant to the operation which she underwent. That issue, it was accepted, is effectively a factual dispute in relation to the evidence provided by the claimant and the defendant's witnesses. As I have explained above, I accept the evidence which was given by Mr Shackleford in relation to the consultation on 7th August 2009 and the evidence of Nurse Gerrard and Nurse O'Malley. In the event of those findings it is accepted by both Mr Summers and Mr Williamson that adequate and proper advice was given in relation to the risks and potential complications of the surgery which the claimant was to undergo. It follows therefore that on the issue of whether or not the claimant was properly advised so as to lawfully secure her consent to the operation I am satisfied that the defendant should succeed and the claimant's case be dismissed.

59. It is necessary to turn to the second way in which breach of duty is alleged by the claimant. These issues relate to Mr Shackleford's decision to operate. In broad terms they are as follows. Firstly, was it reasonable for Mr Shackleford to perform the lumbar microdiscectomy without directly discussing her case with Dr Elliott. Alternatively, was it reasonable for Mr Shackleford to decide to operate without first obtaining a second opinion on whether or not that was a suitable course of treatment.

60. These issues must be evaluated against the appropriate legal test which was established in the seminal case of Bolam v Friern Hospital Management Committee (1957) 1 WLR 582. The essence of the test was distilled by Lord Scarman in Sidaway v Governors of Bethlem Royal Hospital [1985] AC 871 as follows:

> "a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice."

61. This test was further elaborated upon and expanded by the House of Lords in the case of Bolitho v City and Hackney Health Authority [1998] AC 232 in which Lord Browne-Wilkinson stated as follows:

> "the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the *Bolam* case itself, McNair J. stated [1957] 1 W.L.R. 583, 587, that the defendant had to have acted in accordance with the practice accepted as proper by a "*responsible* body of medical men." Later, at p. 588, he referred to "a standard of practice recognised as proper by a competent *reasonable* body of opinion." Again, in the passage which I have cited from *Maynard's* case [1984] 1 WLR 634, 639, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives -responsible, reasonable and respectable--all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.
>
> …in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that

> the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But 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.
>
> I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed."

62. Measured against that legal framework the rival contentions of the claimant and the defendant are as follows. Firstly Mr Summers on behalf of the claimant contended in his written evidence that whilst the claimant had pain on examination which was referable to her back, the MRI scan findings were inconclusive and not a strong indicator of the need for an operation, in particular given that the findings had not changed over a considerable period of time. His view was that the claimant was still young and that improvement was conceivable as she grew older. Whilst in cross-examination he was prepared to accept that the pain that the claimant was experiencing, the findings of the MRI scan and the claimant's failure to respond to the nerve blocks which had been administered for any length of time were all supportive of surgery, his central thesis was that the psychological problems from which the claimant was suffering were key if not overriding in relation to the decision of whether or not to operate. He grounded his views on the fact, which all experts including Mr Shackleford accepted, that psychological issues in a patient were a major factor adversely affecting the outcome of spinal surgery. In his view in the claimant's case the problems associated with her psychological symptoms were simply overriding and that no surgeon would have offered her surgery, and certainly not without first obtaining either a second opinion or alternatively consulting with Dr Elliott. A second opinion would most likely have indicated that surgery was inappropriate. In relation to Dr Elliott in her written and oral evidence she explained that had she known that the surgery which was contemplated might not work, or indeed might make matters worse, then that would have caused her to significantly rethink matters and encourage an alternative approach. Such an alternative approach

to the claimant's problems could have been through her referral to a pain specialist or pain clinic and/or the provision of cognitive support to reframe her attitude to her pain. Thus on behalf of the claimant it is contended that had a second opinion been obtained or a discussion occurred with Dr Elliott the operation would have been averted and not taken place.

63. Mr Williamson who gave evidence as part of the defendant's case concluded in his written evidence that in the light of the pain that the claimant was experiencing, and on the basis of the MRI scan findings and the failure of conservative treatment, the decision made by Mr Shackleford to offer her surgery was reasonable and "within the mainstream of modern surgical practice". In his evidence he explained his opinion that Dr Elliott's letter set out above was very important to the decision and clearly, although not a detailed piece of correspondence, an encouragement to Mr Shackleford to undertake the surgery. He went on to express his scepticism as to whether or not any discussion with Dr Elliott would prove fruitful. He explained that in his own practice he had had experience on several occasions of seeking to involve psychiatrists in the decision as to whether or not to operate. He explained the difficulty in obtaining the psychiatrist's understanding of the interrelationship between the patient's pain and their psychiatric morbidity. The discussions had never permitted a significant or helpful contribution to the decision as to whether or not to operate. Mr Williamson was similarly sceptical as to whether or not obtaining a second opinion would have added anything to the objective clinical judgment which was needed in the claimant's case. He explained that anyone undertaking a second opinion would have a very short period of time with the claimant in order to provide an informed judgment. By contrast Mr Shackleford was very familiar with the claimant and in a far better position to make a truly informed judgment in her case. In short therefore Mr Williamson regarded Dr Elliott's letter as providing in effect a "green light" for surgical intervention, and whilst he accepted that if there had not been any communication from the claimant's treating psychiatrist he would have been critical of the decision to operate, in that there was a positive indication from Dr Elliott and there was no requirement for any further enquiry. A second opinion would have added little or nothing to the objective clinical judgment required by Mr Shackleford. He therefore concluded that there was a responsible body of medical opinion who would have offered surgery to the claimant and proceeded to undertake the operation.

64. The disparity of views which has been set out above was reflected in the terms of the joint statement which was agreed between Mr Summers and Mr Williamson. For the reasons set out below I accept the evidence of Mr Williamson and I am satisfied that the treatment which the claimant received from Mr Shackleford reflected a standard of treatment accepted as proper by a responsible body of medical opinion and, further, that the treatment was reasonable and defensible bearing in mind the risks and benefits which were at stake in assessing its suitability. I have reached that conclusion for the following reasons.

65. Firstly, there were in the claimant's case several factors which supported the surgical intervention which Mr Shackleford undertook. The claimant had persistent and unresolved pain in her left leg. Surgical intervention was supported by the findings which had been made on the MRI scan. Other sources of treatment in the form of the injections which had been undertaken had failed to provide the claimant with any

persistent or long standing relief from her pain. Whilst it is correct to observe that the changes on the MRI scan had not progressed, which ameliorated the weight which could be attached to them as an indicator of surgery at the time when Mr Shackleford operated, nevertheless the existence of the findings of the MRI scan was some support for surgery. The principle objection to surgery was the claimant's psychiatric condition. It was her psychological sensitivity which was the main contra- indication to surgery.

66. Secondly, in respect of the claimant's psychiatric condition Mr Shackleford had a view from the claimant's treating psychiatrist before him to take into account. In that correspondence Dr Elliott stated clearly and simply "I feel that any surgery should not be delayed because of her mental health problems as the limitation to her activities imposed by her back problems is in itself making her mental health problems worse." In my view Mr Shackleford was entitled to approach that as a simple, direct and explicit encouragement for the operation to occur. I accept Mr Williamson's contention that there would be a reasonable body of competent medical opinion which would take Dr Elliott's statement as a "green light" for surgery to be undertaken.

67. Thirdly, whilst it is true to say that the letter does not specifically deal with any psychiatric implications in relation to the impact on recovery of the claimant's psychological situation I do not consider that that materially detracts from the point which has just been observed. In my view Mr Shackleford was entitled to assume that underpinning the letter was Dr Elliott's understanding in general if not lay terms that spinal surgery was a significant surgical intervention. Mr Shackleford was also entitled to conclude that Dr Elliott was fully aware that the claimant's physical symptoms were related to the trauma which she had sustained as part of the sexual abuse to which she had been subject. Indeed, Dr Elliott's witness statement says as much in terms. Whilst therefore the letter does not deal directly with the claimant's psychiatric symptoms as a counter-indication to surgery, in the light of the fact that Mr Shackleford knew Dr Elliott was treating the claimant for her psychiatric symptoms, he was entitled to assume that if Dr Elliott's perspective was that the effects of significant surgery would have a material impact on the claimant's mental wellbeing she would have communicated that alongside the message that he ought not to wait for her mental health to improve before operating. Thus the omission of any observation about the claimant's psychiatric symptoms amounting to a counter-indication to surgery was possibly positive support for surgery (on the basis that any suggestions there would be an adverse effect did not merit a mention in the correspondence) and certainly not a matter indicating that surgery should not be undertaken.

68. Fourthly, as a result of these observations the letter was in reality positive in respect of undertaking surgery. Whilst the letter offered the opportunity for further discussion that comment itself did not suggest that further discussion was required. In all the circumstances Mr Shackleford was entitled, as he did, to approach the letter as a positive support for surgical intervention without the need for further discussion with Dr Elliott.

69. Fifthly, and finally, I am equally unconvinced in relation to the suggestion that there was a breach of duty in failing to obtain a second opinion in relation to the case. I accept Mr Williamson's view that whilst there may be a reasonable body of competent medical opinion which would have sought a second opinion equally I am

satisfied that there would be a reasonable body of competent opinion that would not seek such a second opinion in this case. Mr Williamson's reasons for his conclusion are in my view impeccable. Firstly, the decision as to whether or not to operate was a question of clinical judgment and Mr Shackleford was entitled to conclude that he was the surgeon best placed to make any such judgment given, in particular, his detailed and extensive knowledge of the claimant's case which stretched over a number of years. This was not a technical question about the detail of the operative technique or a matter of interpreting radiology or any other clinical finding. Ultimately it was a question of balancing the various indicators both in support of and against undertaking the surgery. Seeking a second opinion would have simply been an act delegating that decision out of the hands of the person who was best placed to make it, bearing in mind that I am satisfied Mr Shackleford had regard to all of the relevant clinical factors affecting the decision. I am satisfied that a reasonable body of competent medical opinion would not have considered it necessary for him to have obtained a second opinion prior to making the judgement that the claimant should be the subject of the lumbar microdiscectomy.

70. It follows from what I have set out above that I am not satisfied that the claimant has established a breach of duty in this case. That, in effect, draws the issues to a close in relation to her case. However, in the light of the extensive evidence which was presented in relation to the other issues in the case I propose to go on to consider that evidence and provide my assessment and conclusions in relation to it. The global issues to which the evidence was directed were, firstly, whether or not the claimant developed CES as a result of the operation, and secondly what her condition would have been but for the operation having been undertaken.

Did the claimant sustain CES as a result of the operation?

71. As set out above the operation which Mr Shackleford performed was a lumbar microdiscectomy at the level of L5. The nature of that operation is that it involves in the first instance an incision through the skin, muscle and fat overlaying the bony structures and nerves of the spine. Having done this it is then necessary to move the nerve root, in this case the L5 nerve root, to one side where it is retained by a nerve root retractor instrument. Having done so it is then possible to identify and remove the protrusion which is impinging on the nerve root. Sometimes it will be appropriate to nibble away part of the bony structure as part of the procedure. The tension in the various structures, and in particular in the nervous system structures, varies from individual to individual. This consequentially affects the forces needed to be deployed in order to move the nerve roots and other features of the relevant anatomy in order to undertake the operation. Mr Summers surmises that it must have been the manipulation of the nerves by instruments involved in the operation which has caused the CES which he considers the claimant has sustained.

72. CES is a relatively rare complication of lumbar microdiscectomy. Mr Williamson's research indicates that from the academic literature it is a risk of between 0.08% and 0.2%. Mr Summers accepted during the course of his evidence that the percentage of persons undergoing the operation who sustain CES is very small. Nevertheless, whilst small, it is a recognised non-negligent complication of the operation. Whilst the literature does not specifically note that it can arise as a result of manipulation of the relevant nerves during the course of the operation it is not possible to rule such a complication out. Indeed Mr Williamson accepted that once non organic causes of

CES had been ruled out in the claimant's case, perioperative manipulation was the best explanation available, albeit he struggled to accept the precise mechanism of how such could occur.

73. The case made by the claimant in support of the contention that she sustained CES as a complication of the operation has been advanced by Mr Summers from the orthopaedic perspective through reliance on the mechanism of the operation which has been set out above. He surmises that during the movement of elements of the nervous system with operative instruments whilst the surgical procedure was underway the stretching or traction and manipulation of the nerves caused damage which has left the claimant with CES. Whilst in some cases CES arises as a complication of lumbar microdiscectomy as a consequence of post operative haematoma that can be ruled out in the claimant's case. There is a joint radiological opinion prepared by the experts in both sides of the case which agrees that there is no evidence of any such post operative haematoma in particular in the MRI scan that was undertaken on 9th October 2009. Thus Mr Summers' thesis is effectively the only explanation available for how the claimant may have acquired CES as a result of the operation apart from the non organic explanations relied upon by the defendant.

74. From a neurological perspective Dr Burt who gave evidence on behalf of the claimant places significant reliance upon the absence of bladder and bowel function immediately after the operation. In his view the timing of the loss of bladder and bowel function immediately following the operation is a telling indication that it was as a consequence of the operation that the claimant acquired CES. He also relied in his evidence on the anatomical authenticity of the claimant's symptoms immediately after the operation which he believed could not be faked without a detailed prior medical knowledge. The anatomical correctness of the claimant's symptoms is in his view further objective support for her CES having been caused by the operation. His opinion was further bolstered by two additional witnesses called on this issue by the claimant as follows.

75. Firstly, the claimant relied upon Mr Hamid who is a urologist. He undertook a pressure flow test known as urodynamics on the claimant. This test involved artificially filling the claimant's bladder with water and then voiding it whilst observing through electrodes the behaviour of her surrounding anatomy. During this test the claimant's bladder was filled to the extent of 580ml which is, in effect, completely full. She did not during the course of the test exhibit any urgency as a result of the extent of fluid in her bladder. She was unable to initiate voiding it once it was full. These findings led Mr Hamid to the conclusion that the claimant has an acontractile bladder which was due to her having CES. In effect he was able to demonstrate that she had no bladder sensation which was a symptom entirely consistent with her suffering from CES as a result of the operation.

76. The second additional witness was a gastroenterologist, Dr Emmanuel. When he examined the claimant he was unable to find any perianal sensation, or any voluntary anal contraction, although she did have rectal anal inhibitory reflex. This latter reflex was not indicative of not having CES or her CES being non-organic as the nerves which control that reflex were described by Dr Emmanuel as being wholly within the gut and not part of the spinal nervous system. Dr Emmanuel also undertook an anal and rectal electrosensation examination during the course of which he was unable to illicit any response. The administering of this test became a key feature of his

evidence. He explained that the extent of the current passed during the course of the test on the claimant would have considerably exceeded the pain threshold of any person with an intact nervous system in respect of the sensation within those areas. This test was therefore highly probative in relation to the organic nature of the claimant's deficit in terms of sensation in her saddle area. He was entirely satisfied that it would be impossible to simulate indifference to the test.

77. The other key feature upon which he relied was the absence of any perianal bellows reaction when he examined the claimant. Dr Emmanuel described this perianal bellows reaction as an involuntary response from a peripheral reflex which was not wholly or significantly under the control of the brain. Thus as a reflex with a degree of self containment from the brain's influence her absence of such a reflex was objectively indicative of an organic CES rather than her CES symptoms being a further feature of her conversion disorder. Dr Emmanuel also provided additional insight in relation to the potential mechanism of the operation causing the claimant's CES. He drew attention to the fact that the larger motor nerves which control movement of the legs for instance at L5 are thicker and myelianated or sheathed. By contrast the nerves at S2-S5 which are involved in sensation and control of the bladder and bowels and the surrounding area are un-myelianated and finer and therefore more vulnerable to damage. The more flimsy character of the nerves S2-S5 involved in bowel and bladder control as well as sensation in the saddle area rendered them more likely to be susceptible to damage as part of the operation process. Dr Emmanuel further explained that he had a substantial number of patients that he had seen and continued treatment with CES (some 40-50 annually with 400 presently under his care) and that the claimant had a constellation of symptoms which were typical of somebody with CES. He did not find anything unusual about her bladder symptoms nor did he consider her absence of faecal incontinence as being in any way surprising or an indication that she did not have an organic CES.

78. The defendant's case is that the claimant's CES symptoms are non organic and related to her psychiatric illness. In making this contention they relied upon the evidence of Dr Goulding, a neurologist, who contended that the claimant's bladder and bowel symptoms were a further aspect of her somatising disorder. There were a number of ingredients which led him to the view that this was the appropriate diagnosis. Firstly, he relied upon the leg symptoms which the claimant complained of shortly after the operation. He observed that it would be unusual for her to have intact reflexes but disturbed sensation in her left leg whilst at the same time having normal sensation in her right leg as was recorded in the hospital notes after the operation. He considered that her bladder and bowel symptoms, in particular during the immediate post operative period, would have been contributed to significantly by the opiates and drugs taken for her psychiatric illness which would have been likely in and of themselves to have significantly impeded her bowel and bladder function. In addition, the agreed position that the claimant's inability to use or feel her legs as a result of psychiatric illness further contributed to his view that the bladder and bowel symptoms were non organic and part of her somatic illness. Dr Goulding further relied upon the absence of dribble incontinence and faecal leakage both of which he considered were almost always present as part and parcel of an organic CES.

79. Dr Goulding addressed the issues raised by the claimant's evidence in the following manner. Firstly, in relation to Mr Hamid and Dr Emmanuel's evidence, he concluded

that the responses to the tests which they had administered could be equally consistent with the claimant's non organic symptoms. The responses to the tests depended upon her subjective reaction to them which was equally explicable as a consequence of her non organic symptoms as it was demonstrated that she had sustained an organic cauda equina injury. Thus he did not accept that Mr Hamid and Dr Emmanuel's tests demonstrated that the claimant had sustained an organic CES. In respect of the mechanism of the operation Dr Goulding noted that the operation was at the L5 level whereas the nerves associated with the saddle area are, as set out above, at S2-S5. Thus the relevant nerves which would have had to have been affected for there to be an organic CES were more centrally located in the cauda equina at the level where the operation occurred. He contended therefore that this anatomical feature rendered it very unlikely that any damage had occurred in the manipulation involved in the operation since the affected nerves at S2-S5 were some distance from the point at which the manipulation for the purposes of the operation was taking place.

80. It will be apparent from the contentions within the evidence that have just been rehearsed that this is far from a straightforward issue. Clearly Dr Goulding makes a strong case for the claimant's symptoms being explicable by non organic causes and for it being unlikely that the operation caused a physical injury to the nerves in the cauda equina which are involved in bladder and bowel function and sensation in the saddle area. Notwithstanding the strength of his opinion, on the balance of the evidence I am satisfied that the claimant has established that it is likely that she sustained an organic CES as a non negligent complication of the lumbar microdiscectomy which she underwent. My reasons for reaching that conclusion are as follows.

81. It will be clear from what has been set out above that many of the pieces of evidence adduced on this issue are capable of being equally consistent with an organic or a non organic causation of the claimant's symptoms. Further, in the light of the fact that CES is a rare complication of this operation and that the claimant is acknowledged on all sides to suffer from a somatic disorder which renders her vulnerable to the development of non organic symptoms it is important to seek so far as possible evidence which is unequivocal in relation to an organic cause of the claimant's symptoms. The radiological evidence which I have referred to above is no more than equivocal. I accept, as did Mr Hamid when he gave evidence, that the tests which he administered do depend significantly on the claimant's subjective reaction to them, and did not involve the stressing of her anatomy to a point where her responses could be said to be unequivocal. In seeking to resolve this issue I have found Dr Emmanuel's evidence particularly compelling and demonstrating on the balance of probabilities that the claimant's CES symptoms could not have a non organic explanation. As set out above, and as he described in his evidence, the extent of the pain which would be elicited by the electro sensation test which he undertook demonstrates to my mind with some force that it is highly unlikely that the claimant has a normal neurology in relation to her anal and rectal area. In particular his evidence in relation to the absence of perianal bellows reflex serves to demonstrate that the absence of such a reflex cannot arise as a result of her somatising illness. I have set out above Dr Emmanuel's explanation that the nerves which create this reflex are not significantly under the influence of the brain in terms of their operation and therefore his view that any somatising illness from which the claimant is suffering could not suppress the operation of the reflex. In my view his evidence is powerful

and positive support for the claimant having an organic CES. It is evidence which in my view it is difficult to explain away on the basis of the claimant's psychiatric illness.

82. Whilst I note Dr Goulding's observations in relation to the location of the nerves involved in providing for bladder and bowel function and sensation in the saddle area and his view that it would be unlikely that they would be damaged as part of the operative procedure nevertheless there is evidence which in my view can assist in an understanding of how such damage might, without any want of care on the part of the surgeon, arise so as to cause the CES symptoms. It is of significance that these nerves are finer and un-myelianated and given that, as Mr Summers explains, the operation necessarily has to involve the movement of structures involved in the nervous system it is not inconceivable that damage to the finer and more fragile nerves serving the saddle area is capable of occurring. Whilst Dr Goulding is undoubtedly correct that the nature of the drugs which the claimant was taking as part of her care immediately after the operation would have played a role nevertheless in the light of the totality of the evidence I am not prepared to accept that that is a sufficient explanation of the claimant's symptoms. I also consider that it is a compelling piece of evidence, which was in particular emphasised by Dr Burt, that the extent of the claimant's loss of bladder function immediately after the operation was such as to cause her to retain one litre of urine which had to be removed by catheterisation. This record in the notes provides further corroborative support for my conclusions on the balance of probabilities that it is likely that the claimant sustained an organic CES as a non negligent complication of the operation she underwent.

What would the claimant's prognosis had been but for the operation?

83. It will have been clear from the factual background which is set out above that the claimant has suffered, and continues to suffer, with significant psychiatric symptoms. Her history and diagnosis over the course of time has been aptly summarised and captured in the joint statement prepared by Dr Holden (the claimant's psychiatric witness) and Dr Faith (the defendant's psychiatric witness) as follows:

> "1. *Are you able to agree a psychiatric diagnosis in relation to the following periods of time (if you are not able to agree, please advise as to whether the differing diagnoses are significant or academic):-*
>
> *a. Leading up to her referral to and treatment by Mr Shackleford in 2006?*
>
> We are reluctant to give a definitive diagnosis of personality disorder in the context of young age (in childhood such matters would be covered by an Emotional Disorder of Childhood). However, we agree that she suffered an immature personality disorder characterised by psychological and psychosomatic features (e.g. mood disturbance, anorexia nervosa, somatoform disorder (Irritable Bowel Syndrome). We note that pain was cited as a reason for mood disturbance as it was inhibiting her ability to engage in sporting activities.

b. At the time of her surgery in 2009?

We agree at this time her problems were moving towards that of an Emotionally Unstable Personality Disorder – borderline type, but with many of the features previously present. We agree that, but for the surgery, she would, nonetheless, have become diagnosable when over the age of 18 as an Emotionally Unstable Personality Disorder borderline type.

c. April 2010?

In addition to the above she was developing what can be described a psychologically mediated lower limb dysfunction superimposed on the above problems. Dr Faith considers that the lower limb dysfunction was a further manifestation of the personality disorder. Dr Holden considers that the lower limb dysfunction occurred in the context of vulnerability of her personality disorder.

d. At the time of you respective examinations (Dr Faith March 2012, Dr Holden March 2013)?

We agree that her situation was similar with a psychologically mediated lower limb dysfunction presentation as a manifestation of somatoform disorder/dissociation conversion disorder. We agree that neither of us found her to be depressed.

e. At the present time (in so far as you able to comment)?

We have no reason to believe that there has been a fundamental change in her symptoms, behaviour or diagnosis, although we understand that there has been a modicum of improvement. We note however, the opinion of her treating Consultant, as it appears in a Tribunal report dated 28/10/14, that she considers that, in addition to the personality disorder, the Claimant may also suffer from psychosis and also, possibly, Post Traumatic Stress Disorder."

84. The question which then arises is as to the extent to which the operation and the CES which it caused has affected her current level of disability or, alternatively, what her condition would have been if she had not undergone the operation.

85. The starting point for considering this question is to record that there is a difference between Dr Holden and Dr Faith in relation to the claimant's diagnosis. Dr Holden states that the claimant has a somatoform disorder. Dr Faith's view is that she suffers from a conversion syndrome. The difference is, however, stated by the psychiatrists to be more than likely only academic so far as the court's task is concerned. The difference between the diagnoses has a bearing on the potential approaches to

treatment of the claimant, but is of little or no consequence in relation to the assessment of how matters might have turned out had she not had the lumbar microdiscectomy. The important point in relation to both diagnoses is that they are "reinforced by secondary gain and provision of care". It will have been apparent from the factual history set out above that there is no physical or neurological explanation for the claimant's inability to use her lower limbs and her loss of sensation in them (quite apart from that loss of sensation caused by CES). The symptoms of loss of use and sensation in her lower limbs are entirely due to her psychiatric condition and diagnosis.

86. Dr Holden's view is that the claimant's psychiatric condition has been exacerbated by her acquisition of CES. Had she not had the surgery he considers that she would have continued to have back and leg pain as well as irritable bowel syndrome, and that over time and without treatment her somatic disorder would have led to further problems such as, for instance, chronic fatigue or generalised pain in the form of fibromyalgia. He considers that had she not undergone the operation she would, in the main, have been likely to have avoided wheelchair use. Whilst he accepts that it would be impossible to predict precisely how her health would have progressed he is confident that she would not have been likely to develop such serious symptoms as those from which she now suffers in particular the loss of function and sensation in her lower limbs.

87. In her written evidence Dr Faith accepted that "if much of XYZ's symptomatology is physical in origin then this will have made a material contribution to the development of the psychological underpinning of her non-organic symptoms". In the joint statement which she prepared with Dr Holden Dr Faith stated that "in the absence of surgery she would more likely than not have suffered a different manifestation of her psychological symptoms but possibly not involving her legs although this could not be excluded given that she would have continued to experience low back pain and had already been making some use of the wheelchair". She indicated that the severity of those symptoms could not be predicted "but it would have been enough to achieve the secondary gain which she sought by becoming invalided".

88. When Dr Faith came to give her oral evidence she explained that she had adjusted or modified her views. She was now more concerned as to the extent of the involvement of the claimant's CES symptoms in her psychiatric illness and also the extent to which prior to the crisis in the claimant's symptoms on 30th April 2010 she was already suffering significant disability. Two features of her examination of the medical notes arose in connection with these matters. Firstly she indicated that she had been unaware prior to her more recent scrutiny of the notes that the claimant had been using a wheelchair and presented at hospital in a wheelchair after the operation but before 30th April 2010. Secondly her recent review of the notes suggested in her view that there was little specific focus by the claimant after the operation on her bladder and bowel symptoms and the loss of sensation in her saddle area. As a result of this reconsideration of her views she considered, firstly, that it was likely that the claimant would have been in her present situation irrespective of the lumbar microdiscectomy. Secondly, and in the light of the fact that the claimant has a psychiatric condition which is especially difficult to treat, as a result of the extent of her incapacity after the operation and prior to 30th April 2010 Dr Faith had formed the view that the claimant would have been likely to be the same in terms of her physical and mental condition

irrespective of the lumbar microdiscectomy. She thus formed the view that neither any potentially organic explanation for the claimant's CES or the operation itself had made any material difference to the final state of the claimant's condition.

89. In relation to this difference of view expressed by Dr Holden and Dr Faith I am unpersuaded that the claimant would have been in the same position whether or not the operation occurred. Dealing firstly with the involvement of the CES symptoms, and in particular issues concerned with bladder and bowel functions, Dr Holden, who undertook a further audit of the medical notes, was able to demonstrate that within the psychiatric records there are in fact references in the notes from consultations on 29th October 2009 and 5th November 2009 to her low mood in conjunction with her CES symptoms. These notes and the relationship between the CES symptoms and the claimant's mood may not have been quite as emphatic as Dr Faith might have expected. Nonetheless, in my view they clearly show, as Dr Holden explained, a relationship between the claimant's CES symptoms and her psychiatric illness. These notes reinforce the validity of Dr Holden's view of the physical symptoms namely that they have aggravated or exacerbated the claimant's pre-existing psychiatric condition.

90. It is difficult, bearing in mind the nature of the claimant's psychiatric illness as outlined in the joint statement quoted above, to accept that the significant debilitating incapacity of the claimant's bladder and bowel symptoms and the need for her to undertake self-catheterisation and evacuation of her bowels would not have had an impact on the claimant's psychiatric condition bearing in mind the clear and undisputed inter-relationship between her mental and physical health. Thus Dr Holden's thesis is in my view sound and entirely consistent with the mechanism of the illness which appears to be common ground. It fits well with the view that her CES symptoms have aggravated and exacerbated her psychiatric condition and also fits well with the origin and progress of the claimant's mental ill health over the course of time. In my view the fact that the claimant presented at hospital in a wheelchair prior to the incident at the end of April 2010 but after the operation does not in any way undermine Dr Holden's analysis that the acquisition of her organic CES had a serious impact on her mental health and instigated a significant deterioration in her related physical symptoms. The question that then arises is as to the extent of that deterioration which can be attributed to the operation and the organic CES which it caused.

91. In my view Dr Holden's prognosis in the absence of surgery again, is consistent with the known mechanism of the claimant's psychiatric symptoms. I accept his opinion that in the absence of surgery the claimant would probably have avoided psychiatric hospitalisation and, most importantly, would not have suffered the lower limb paralysis which she now experiences. Whilst, as set out above, she would still have had pain and irritable bowel symptoms, and she may well have developed some worsening of her somatic symptoms in the absence of effective treatment, she would by no means be experiencing as severe symptoms as she presently does had the operation and the organic CES not occurred.

Conclusions

92. In the light of the findings which I have set out above I am satisfied that the claimant's consent was properly obtained for the purposes of the lumbar

microdiscectomy and that the decision to undertake that surgery did not give rise to any breach of duty by Mr Shackleford whose treatment I consider reflected a reasonable body of competent medical opinion. For these reasons the claimant has failed to establish breach of duty and therefore liability. I am satisfied on the evidence which has been presented that the claimant is likely to have suffered an organic CES as a non-negligent complication of the lumbar microdiscectomy. Further, I am satisfied that but for the undertaking of the operation and the development of that organic CES she would have avoided the most severe symptoms which she currently experiences as a consequence of her psychiatric illness in particular the loss of function and sensation in her lower limbs.