Case No: TLQ/15/0871

Neutral Citation Number: [2016] EWHC 1215 (QB)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26/05/2016

Before :

MR JUSTICE GARNHAM

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Between :

Mijin Zahir	**Claimant**
- and -	
Shailesh Vadodaria	**Defendant**

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- -

Mr Stephenson (instructed by **Slater & Gordon**) for the **Claimant**
Mr Davidson (instructed by **Kennedys**) for the **Defendant**

Hearing dates: 11th – 12th May 2016

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Judgment

Mr Justice Garnham :

Introduction

1. On 24 July 2010, Mr Shailesh Vadodaria carried out a rhinoplasty operation on Mrs Mijin Zahir at Highgate Hospital in London. From the time she came around from the anaesthetic after that operation, Mrs Zahir has been unhappy with the resulting appearance of her nose.

2. Revision surgery was conducted by Mr Vadodaria on 23 June 2011, but Mrs Zahir remained dissatisfied. She has subsequently undergone three further operations, these conducted by a second plastic surgeon.

The Procedural History

3. The Claimant issued proceedings on 2 April 2014, claiming damages for alleged clinical negligence in the conduct of the surgery. By his defence, the Defendant denied liability and raised the issue of limitation. By the time the matter came on before me, the limitation point had been conceded by the Defendant and the parties had agreed quantum. The result was that I have to consider only the question of breach of duty, and if necessary causation.

4. In its original form, the Particulars of Claim advanced nine allegations of negligence. The first two allegations concerned over-resecting of the dorsal septum and upper lateral cartilages leading to an alleged deficiency in the middle third of the nose (what is called a "saddle nose" deformity). Following the meeting of the plastic surgery experts that allegation was abandoned. There was one allegation of failure to advise but that has not been pursued (and in fact the Claimant's expert accepted in evidence that the warnings given were adequate). A number of the other allegations amounted to no more than allegations of causation and do not need to concern me further.

5. In substance there remains just two allegations of negligence; namely, that in the operation on 24 July 2010 Mr Vadodaria (i) over-resected the right lower lateral cartridge and, (ii) damaged the integrity of the alar rim. It is on those two grounds that the evidence and submissions in this case have been focussed. Mr Vadodaria denies negligence.

The Factual History

6. Mrs Zahir had been concerned for some years about the appearance of her nose. In early 2010 she started to research consultant plastic surgeons with the view to undergoing rhinoplasty surgery. She came across the names of two reputable surgeons, namely Mr Bisim Matti and Mr Vadodaria. Mr Vadodaria had a shorter waiting list and so she arranged a consultation with him on 30 June 2010.

7. The Defendant is a consultant aesthetic plastic and reconstructive surgeon practising in Harley Street, London. He qualified as a doctor in 1982 and obtained a MCh in plastic surgery from Bombay University in 1987. He came to the United Kingdom in 1993 and trained as a specialist registrar. He worked in the NHS for 11 years before becoming a fellow of the Royal College of Surgeons in 1999. He has been on the

GMC specialist register since 2005. He told me that he conducts 20-25 rhinoplasty procedures every year.

8. The Claimant says that she told him that she had three concerns about her nose. She says she told him that she "*did not like the bulbous tip and wanted my nose length reduced. I also explained that I have bumps on either side of my nose that I wished to be pared down. These were the only issues that I raised with Mr Vadodaria personally*".

9. Mr Vadodaria made a note of the consultation in which he recorded that there were four features of her nose that Mrs Zahir did not like: a hump (on the bridge of her nose), the bulbous tip, the length and the width of the nose. During the course of his examination of her, Mr Vadodaria also told Mrs Zahir that she had a deviated nasal septum, which was deviated to the right.

10. At the end of the consultation, Mrs Zahir agreed to instruct Mr Vadodaria to conduct the surgery, which was then booked for the following month. She again attended his consulting room on 21 July 2010, three days before the date set for the operation, for a pre-operative consultation. She says that he told her that the procedure would be straightforward; that he would simply remove the tip, shorten the length and file down the sides of the nose.

11. Mr Vadodaria's notes confirm that there was a deviation of the nasal septum to the right-hand side. They also suggest that the nose itself was not straight but exhibited a mild shift to the right-hand side. Mr Vadodaria also recorded in the notes that on a frontal view the tip of the nose was asymmetric. The notes record a dorsal hump from left to right and a right septal dislocation evident on the basal view. Mr Vadodaria also used the notes to record warnings he gave to Mrs Zahir about potential complications. Those complications included: asymmetry, minor irregularities, airway problems, secondary surgery and deviation. Both Mr Vadodaria and Mrs Zahir signed that sheet.

12. Mr Vadodaria's notes also record the second consultation on 21 July 2010. Those notes indicate that Mr Vadodaria told Mrs Zahir about "*complications, limitations and revisional surgery*".

13. On 24 July 2010, Mrs Zahir attended Highgate Hospital for the operation. She tells me that she arrived at 6:30am for surgery which was due to begin at 8am. She explained how Mr Vadodaria came to see her once she had checked in and took photographs of her nose. She says she was away from her private room at the hospital for some three to four hours whilst the surgery was conducted. When she awoke from the anaesthetic she says she noticed immediately "*that both sides of my nose were different. Although my nose was covered in a plaster, you could see the shape of my nose. Both my mother and husband said it was very obviously asymmetrical*". She says she spoke to Mr Vadodaria at the end of the day when he told her that the surgery had gone well. When asked about the apparent asymmetry, Mr Vadodaria assured Mrs Zahir that the appearance was due to packing in the nostrils and that once that was cleared and the swelling had gone down all would be well.

14. The operation note prepared by Mr Vadodaria notes the deviated nasal septum to the right and records minimal trimming of the caudal end of the septal cartilage, reduction

of the osseo-cartilaginous hump, rasping of the bony bridge, minimal trimming of the upper lateral cartilage, left more than right, trimming of the cephalic end of the lateral wing of the alar cartilages and lateral osteotomy.

15. Mrs Zahir was discharged from hospital the following day and reviewed a week later on 31 July 2010. She was reviewed again on 4 August, prompted in particular by the fact that a skin reaction to the dressing which had developed. She was again reviewed at a dressing clinic on 10 August.

16. On 6 September 2010, the Claimant was reviewed by the Defendant. She says that at that appointment she told the Defendant that she was dissatisfied with the result. She says that Mr Vadodaria told her that her nose would settle over time but that she was increasingly concerned that the asymmetry was worsening. The Defendant recorded in his notes "*left side tip considered more prominent, very minimal bony hump*".

17. There was a further review on 25 January 2011, when according to the Claimant, she explained to the Defendant that the left-hand side of her nose was different to the right-hand side and that the length did not seem to have been reduced. Her overriding concern, however, was the asymmetry. According to the Defendant, by contrast, the Claimant reported satisfaction with the bony width and the reduction of the nasal hump. However, he said that she sought further reduction of the length of the nose and greater support for the nasal tip. Mr Vadodaria noted a soft tissue bulge on the left nasal tip and mild residual septal deviation. He offered a second opinion, psychological counselling and revision surgery.

18. By June 2011, the Claimant says, she was adamant that there had been no improvement and Mr Vadodaria offered to "redo" the procedure. She saw the Defendant on 8 June 2011. They agreed that the Defendant would repeat the septo-rhinoplasty, would carry out further rasping of the bony spicule, shaping of the nasal septal deviation and treatment for the prominence of the left nasal tip. The Defendant recorded discussing with the Claimant the limitations of surgery, the risks of asymmetry, surface irregularities, airway obstruction, unsatisfactory outcome and the need for a revision procedure.

19. On 23 June 2011 the Claimant attended the Highgate Hospital again where she underwent further surgery. Mr Vadodaria's operation note records submucosal dissection, unilateral scoring of the septal cartilage on the right-hand side, submucus reduction, transposition of septum to midline, depression of the right tip/alar junction, grafting of right alar cartilage with two small pieces of septal cartilage and creation of a columella strut using an excised piece of septal cartilage. The Claimant was discharged home the following day.

20. After that second operation the Claimant again developed a reaction to the plaster. She remained unhappy with the outcome of the procedure. She says her nose "*remained markedly asymmetric*".

21. At a meeting on 16 July 2011, the Claimant was reviewed by the Defendant who told her that the cause of the asymmetry was probably scar formation. He suggested there were three options; to wait for 12-18 months and observe progress, for the Defendant to arrange a second opinion, or for the Claimant to obtain her own independent

second opinion. The possibility of steroid injections to the tip were discussed but the Defendant made clear that he did not undertake that treatment.

22. The Defendant reviewed the Claimant for a final time on 4 August 2011. The Claimant had decided she would seek the opinion of another surgeon and instructed Mr Matti. She saw him for the first time on 18 October 2011. She then underwent three further surgical procedures under Mr Matti's care; the first on 11 June 2012, the second on 7 August 2013 and the third on 17 December 2014.

23. Mrs Zahir told me that her nose is now considerably improved but she emphasises that the "*whole ordeal had had an enormous impact on my life*".

The Evidence

24. I heard oral evidence from the Claimant and the Defendant and from two expert plastic surgeons called on their behalf, Mr Peter Chapman, for the Claimant, and Mr Nicholas Percival, for the Defendant.

25. I found both the Claimant and the Defendant to be essentially honest witnesses. Both were on occasion guilty of trying too hard to get across their point of view but I have no doubt both were doing their best to assist me.

26. Both expert witnesses were impressive, but I found Mr Percival the more careful both in the preparation of his report and in his manner of giving evidence. For reasons that I set out below I preferred Mr Percival's evidence on what turned out to be the central issue.

27. Particularly helpful was a Joint Report produced by the two experts. The following was agreed between them:

> "*The alar cartilages form a structure not unlike 'McDonald's arches' and these support the rim of the nostril. They resemble the stiffener in a shirt collar and prevent the nostril from collapsing when breathing in during respiration. Damage to the arch integrity leads to collapse as is evident by the photograph taken by Mr Matti on 31-05-2012. Various different words have been used to describe the deformity of the lower lateral cartilage including depression, collapse, buckling and loss of integrity. They all effectively mean the ability of the cartilage to perform its function has been compromised.*"

28. The Joint Report also identified four central issues on which they disagreed. ("PC" indicates Mr Chapman's response to questions, "NP" Mr Percival's). First:

> "*PC. The [pre-operation photographs] are taken with a wide angle lens producing enlargement of the nose and the face is turned in AP view… Which gives an illusion of the tip deviating to the right and the right nostril being lower than the left. The nasolabial angle is 90 degrees and dorsal profile is prominent… It is not possible to identify septal deviation from the photographs. The tip appears wide but symmetrical.*

NP. Asymmetry of the nostril is visible in the worm's eye view with the right nostril being slightly lower and rounder than the left. The nasal tip is deviated to the right and the right nostril rim is lower in AP view. The extent of any septal deviation cannot be evaluated from the photographs…"

29. Second:

"*PC. it is clear from subsequent events that during the first operation on 24 July 2010 there was damage to the integrity of the right lower lateral cartilage leading to collapse of the alar rim, and nostril tip asymmetry. As this operation was an open procedure, such damage must be considered substandard and therefore negligent. The damage was the cause of the subsequent operations.*

NP. In my opinion there is no evidence to support the assertion that the first operation fell below the level expected of a reasonably competent consultant plastic surgeon. It is accepted that the outcome of cosmetic rhinoplasty operations cannot be guaranteed and in my opinion the outcome of the first operation was not so poor to be considered outside the range considered to be acceptable for this operation."

30. Third:

"*PC. There is no direct evidence of over resection of the right lower lateral cartilages at the time of the first operation, but it is quite clear that the integrity of the alar rim was damaged. Mr Matti quite clearly described 'collapse of right alar cartilage' in his operation note dated 13-06-2012.*

NP. There is no evidence of over resection of the right lower lateral cartilage and this is confirmed by Mr Matti's operation findings and photographs."

31. Fourth:

"*PC. The photographs demonstrate loss of alar rim integrity. Use of the term 'collapse' is perhaps slightly emotive, but it has the same meaning as buckling or loss of rim integrity. There is 'collapse'. On the balance of probability this collapse was caused by the first operation. The alar bases are not the same as the lower lateral cartilages.*

NP. The photographs demonstrate a buckling of the right alar cartilage. This has resulted in a 'collapse' of the right nostril rim. The cause of this 'collapse' (sic) are not known as nothing in the surgeon's operative note would result in this deformity occurring. Possible explanations for the asymmetry of the right alar are (a) healing, scar tissue causing distortion. (b)

> *cartilage damage during the operation. (c) pre-existing asymmetry. (d) scarring from a possible piercing on the right side. (e) buckling of alar cartilage. (f) failure to correct caudal septal deviation leading to a twisting effect on the lower lateral cartilages.*
>
> *PC considers (b) to be the most likely explanation from the list above given by Mr Percival.*"

32. One of the objectives of the surgery performed on 24 July 2010 was to narrow the tip of the Claimant's nose. This was to be achieved by shaving off cartilage. When doing so it was common ground that it was essential that the surgeon did not shave off so much as to damage the integrity of the cartilage and its ability to maintain the rim of the nostril. A breach in the integrity of the rim would be demonstrated by a kink in the nostril, as occurred here.

33. That objective is achieved, according to the established principles of plastic surgery, by ensuring that the width of the rim is not reduced, by the "shaving" exercise, to less than 5mm. That is the "industry standard", as it was put in evidence.

34. The Defendant maintained that he used callipers to mark a line on the Claimant's alar rim 7mm from the edge of the cartilage and then cut up to that line. On that basis he was able to assert with some confidence that he did not breach accepted standards.

<u>The Competing Contentions</u>

35. The focus of the submissions of Mr Stephenson, for the Claimant, was the visible kink in the right nostril rim caused by buckling of the alar cartilage. He said that of the six possible causes identified by Mr Percival in the joint meeting, only three were realistic candidates as explanations for the kinking. They were: healing scar tissue causing distortion, cartilage damage during the operation and failure properly to correct caudal septal deviation. He said the scar tissue theory could be discounted because the kinking was apparent in the photographs taken on 4 August 2010, 11 days after the operation, and scar tissue would not have formed that quickly. He said the position of the nasal septum was "a red herring", because cartilage tended to return to its pre-existing position. That left intra-operative damage.

36. As to that, Mr Stephenson accepted that he could not precisely identify the nature of the damage. He accepted that the proposition that the cause of the damage was over resection of the cartilage was difficult in the light of the evidence heard at trial, but he maintained that the likelihood was that the defendant had improperly "manhandled" the cartilage causing damage.

37. Mr Stephenson suggested that if I did not find that intra-operative negligence was the sole cause of the damage I could be confident that it made a material contribution to the occurrence of the damage, applying the well-known principle in Bailey v MOD [2008] EWCA Civ 883. He referred in particular to the concluding paragraphs of the judgment of Waller LJ:

> "*I would summarise the position in relation to cumulative cause cases as follows. If the evidence demonstrates on a*

> *balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the claimant will have failed to establish that the tortious cause contributed. Hotson exemplifies such a situation. If the evidence demonstrates that 'but for' the contribution of the tortious cause the injury would probably not have occurred, the claimant will (obviously) have discharged the burden. In a case where medical science cannot establish the probability that 'but for' an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the 'but for' test is modified, and the claimant will succeed.*"

38. Mr Davidson pointed to what he said was his client's careful analysis of the problem presented by the Claimant in July 2010. He said Mr Vadodaria had explained to the Claimant the risks necessarily involved in the surgery and made it clear that success could never be guaranteed. He said I should prefer the expert evidence of Mr Percival over that of Mr Chapman. He said that Mr Percival's explanation of the likely cause of the kink in the nasal rim as the product of scar tissue, the deviated nasal septum and the attempts to correct that by moving the septum, provided a convincing explanation. He said there was no evidence to support the suggestion that the cartilage was inappropriately manhandled during the surgery.

Findings of Fact

39. Having heard the evidenced and the submissions I make the following findings on the relevant background facts.

40. First, there was much reference in the evidence to photographs of the Claimant's nose taken at various stages during the history. They were certainly useful as illustrations, but I accept the evidence of the experts that the value of two dimensional images in assessing the nature of a three dimensional form is limited.

41. Second, prior to this surgery, the Claimant did not like the appearance of her nose. It had plainly concerned her for some years prior to 2010 and I have no doubt that, as she asserted, she was "*highly motivated to have surgery*".

42. Third, as was agreed, the Defendant identified the risks and potential complications of the surgery during the consultation on 30 June 2010, and that those risks included asymmetry, minor irregularities, airway problems, over or under correction and the need for secondary surgery. It was agreed that this issue was reconsidered at the time of the second consultation on 21 July 2010.

43. Fourth, after the surgery on 24 July 2010 there was an indentation, or "kink", in the right alar rim caused by a buckling of the cartilage. Despite the evident post-surgical swelling to the nose tip generally, that kink was apparent within days of the surgery. It was still evident the following year.

44. Fifth, as was common ground between the experts, that kink was not there before the surgery. Mr Vadodaria suggested that one of the photographs did show a pre-existing kink; I reject that suggestion. In my judgment, the experts are right when they say that

that appearance of a kink was the product of shadow caused by the angle of the light when the photograph was taken.

45. Sixth, there was dispute as to whether the Claimant's nose was entirely straight, when viewed from in front or above, before the operation. Certainly that was not a feature the Claimant told the Defendant she disliked about the appearance of her nose, because it was not recorded in the relevant section of the form he completed. I accept that the Claimant was not conscious of any lack of straightness in her nose before the surgery. The Defendant, however, noted what he called a "*mild shift on the right side*" on the "*Bird's eye view*" section of his clinical records, and "*midline deviation on the right side*" and "*asymmetrical tip*" in the "*Frontal view*" section. I accept these were genuine clinical observations.

46. It is difficult in the extreme to ascertain from the pre-operative photographs whether or not the nose was perfectly straight. In my judgment, there was some deviation from the central line, apparent on a careful clinical examination, but it was very slight and would not have been noticed either by the Claimant or the casual observer.

47. Seventh, that deviation from the central line was, on the agreed evidence of the experts, somewhat accentuated after the first operation.

48. Eighth, regardless of the straightness of the nose as a whole, the Claimant did have a deviated nasal septum. The Defendant noted, amongst his clinical findings, that on a basal (or "worm's eye") view there was septal dislocation to the right prior to surgery. Mr Chapman agreed that "*looking inside the nose, there was deviation of the septum*". I accept that evidence. The basal view photographs do seem to me to show some asymmetry in the position and shape of the nostrils. More particularly, I accept that the Defendant's contemporaneous records of a deviated nasal septum were genuine and accurate. I accept that the Claimant might well have been entirely unaware of this prior to her first visit to the Defendant.

49. Ninth, of the six possible explanations for the kinking of the right nostril rim, three in my judgment must be rejected immediately. The Claimant denied ever having a piercing in the right side of her nose and there was no evidence she ever had. The Defendant accepted that. As was eventually accepted by all concerned, "buckling of the alar cartilage" simply describes the effect of the deficiency; it does not provide a cause. Pre-existing asymmetry cannot on its own explain the sudden appearance of the kink after the surgery.

50. The result of that final finding is that there are only three possible causes for the kink; namely, damage during the operation, as advocated by the Claimant, or scar tissue, and/or failure to correct the septal deviation, as suggested by the Defendant.

Discussion

The Allegations of Negligence

51. Only two of the original particulars of negligence were pursued at this trial: over-resecting the right lower lateral cartilage and damaging the alar rim during surgery.

52. In my judgment both experts addressed the wrong issue in their reports and in the joint report when they spoke of *the outcome* of the procedure being within, or beyond, the range to be expected of reasonably competent plastic surgeons. What matters is not outcome but surgical technique. The question I have to consider is whether the conduct of the surgery on 24 July 2010 fell below the standards of a reasonable body of competent plastic surgeons practising in 2010.

Over-resection

53. Mr Stephenson did not pursue this first allegation in his final submissions. In my judgment, he was right not to do so. The evidence had demonstrated beyond argument that the Defendant had not resected more cartilage than was required for the surgery, or more than was recognised by the profession as appropriate. I reach that conclusion for the following reasons.

54. First, the Defendant was adamant that he had marked a line on the Claimant's alar rim 7mm from the edge of the cartilage and had then cut up to, but not beyond, that line. It was common ground that removal of cartilage was acceptable provided a minimum of 5 mm was left intact. There was no grounds for doubting the Defendant's assertion that he used callipers to ensure that he left 7mm.

55. Second, on the evidence of both experts, there is nothing in the Defendant's first operation notes to support a suggestion that the technique used by the Defendant was inappropriate or unreasonable in any way. That conclusion did not change after the Defendant was cross examined.

56. Third, the operation notes made immediately after the second operation suggest there had been no over-resection.

57. Fourth, and crucially, the operation notes of Mr Matti, the surgeon who conducted the third and subsequent operations, give no indication that he found any over-resection when he operated. There is a detailed description of the operative technique deployed and the findings made, but no reference to excessive resection. According to the Claimant, he had told her that too much cartilage had been removed from the right side of her nose, but there is nothing in his notes during or after surgery to support that. His notes do record, under the heading "Diagnosis", "*Finding confirmed the collapse of the right alar cartilage*", but Mr Chapman shared the view that that probably recorded his impression of the appearance of the Claimant's nose before surgery commenced. I did not have the benefit of hearing from Mr Matti, but in my judgment it is very likely that what Mr Matti told the Claimant about cartilage removal was a pre-operative, clinical, assessment.

58. Mr Chapman accepted that if there was over-resection it was highly likely that Mr Matti would have seen it once the nose was opened, and then recorded it. That must be right. Mr Matti was conducting this surgery because his patient was reporting dissatisfaction with her previous surgeon and with the result of his work. If on opening the nose Mr Matti had seen evidence that the relevant cartilage had been thinned to the point where its integrity was undermined, he was bound to have recorded it. He did not do so. The only explanation for that is that there was no excessive resection to be seen.

59. In those circumstances this allegation must fail.

Damaging the Alar Rim

60. Mr Stephenson expressly disavowed, in both opening and closing submissions, any reliance on the principle of res ipsa loquitor, recognising that that principle is applicable in only the most unusual of clinical negligence actions, of which, he agreed, this was not one. There are, as Mr Chapman accepted, no guaranteed outcomes in plastic surgery and the need for revision surgery is not in itself an indicator of negligence. In a discipline which is dependent on resecting millimetres of human tissue and predicting its precise manner of repair, it cannot be said that, because an undesirable outcome is the result, there must necessarily have been negligence in the performance of the surgeon.

61. It was common ground between the experts that as a result of the surgery in July 2010 there was asymmetry in the shape of the alar rims that was not present prior to surgery. It was also accepted by Mr Percival that what he saw as a minor deviation of the nasal tip pre-operatively had been exacerbated by the surgery.

62. There is, however, no hard evidence of any manhandling or mishandling of the alar rim, nor of any other action by the Defendant, that caused this damage to the cartilage. Mr Chapman provided no evidence of negligence in the conduct of the surgery beyond the bare assertion that the injury would probably not have occurred without negligence, which takes me very little further forward. He said he could provide no explanation for why he preferred option (b), "cartilage damage during the operation", as the explanation for the kinking and offered no explanation as to why the alternative favoured by Mr Percival was wrong.

63. Mr Percival told me that, although it was possible that a surgeon would damage the delicate cartilages of the nose during surgery, that was unlikely; he would have had no reason to touch any cartilage other than that on which the procedure was focused. If he did, Mr Percival said, the surgeon would immediately be aware he had done so. There was nothing to suggest that such damage had occurred here or that Mr Vadodaria believed it had.

64. Mr Stephenson accepted that he could not identify precisely what the Defendant did wrong during the surgery. But he says that "*something must have happened during the surgery that has led to the damage*" that can be seen in the post-surgery photographs. That seems to me, if not in substance a plea of res ipsa, then pure, unsupported speculation.

65. Mr Stephenson invited me to conclude that because none of the other possible explanations identified by the experts is satisfactory, the cause (or one of the material causes) must have been manhandling of the cartilage by the Defendant. In my judgment that is not the right approach. The burden of proof is on the Claimant to establish negligence and, absent res ipsa, that is not satisfied by showing that the Defendant cannot provide an explanation. That alone would be enough to dispose of this allegation.

66. In my judgment, however, there is a satisfactory explanation for the kinking. On this crucial issue, Mr Percival provided wholly convincing evidence.

67. Mr Chapman had said that, whilst scar tissue could cause buckling, the photographs demonstrated that buckling had occurred by 4 August 2010 and that was too quick to be explained by scar tissue. Mr Percival maintained that scar tissue begins to form as soon as the trauma effected by the surgery is over. He said it takes six to 12 weeks from inception to reach its greatest bulk. He agreed with Mr Chapman that it was unlikely that scar tissue alone could have caused the kink by the time the first post-operative photographs were taken. But, as he pointed out, this scar tissue was forming in a nose with a deviated nasal septum and which exhibited a minor degree of asymmetry before the surgery. In his opinion, it was the combined effect of the developing scar tissue and the uncorrected deviated nasal septum which led to the buckling.

68. I accept Mr Percival's evidence that unrepaired caudal deviations of the septum can, in the presence of developing scar tissue, lead to kinking in the nasal rim and that that can occur quickly after surgery. I further accept his evidence that the fact that such kinking occurred here does not point to there being negligence in the conduct of the surgery.

69. The kink that was seen in the photographs in August 2010 may have been exaggerated by the presence of generalised swelling. But once the swelling had gone down and the scar tissue had matured the Claimant was left with the kinking seen in the photographs taken prior to the revision surgery. That is consistent with the fact that in June 2012 Mr Matti noted "*excessive fibrous tissue scarring*" when he opened up the Claimant's nose.

70. No complaint is made about the fact the caudal septum deviation was not corrected in the operation in July 2010 and it follows that the cause of the kinking was not negligence on the part of the Defendant. In those circumstances, this allegation must also fail. In those circumstances, the issue addressed in Bailey v MOD does not arise.

Conclusion

71. The Claimant has not established that there was negligence in the conduct of the surgery on 24 July 2010 and, accordingly, there must be judgment for the Defendant.