Managing Uncertainty in the Mechanism of Injury

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- Lessons from the recent cases of

-Saunders v Central Manchester NHS Trust 2018 EWHC 343 QB

-Collyer v Mid Essex NHS Trust 2019 EWHC 3577 QB

-Schembri v Marshall 2020 EWCA Civ 358.

Surgical cases often provide difficulties for Claimants because it is not always clear how the alleged negligent injury occurred – nothing being noted at the time and the injury only becoming apparent post operatively. In the first two of these recent cases Claimants failed on breach because they could not prove the probable mechanism of injury, let alone that it was negligent. This is quite common in surgical cases because of the limited evidence as to the surgery itself - usually just a short operation note.

Claimants also often have difficulty in proving whether and how a breach has been causative of an injury. In *Schembri v Marshall* the Court of Appeal give us a useful reminder of some important principles.

I set out in this article a summary of these cases, the principles they illustrate and some practical lessons to be learnt from them and my own experience in such cases over the last 25 years.

Saunders v Central Manchester University Hospitals NHS Foundation Trust

2018 EWHC 343 QB.

Before Mrs Justice Yip.

The Claimant was a 60-year-old undergoing elective surgical reversal of an ileostomy. He was discharged well at 3 days post op but there was a deterioration and readmission 5 days post op. His large bowel was found to be entirely ischaemic and removed. The mechanism of ischaemia was not readily apparent.

The Claimant had a past medical history of myocardial infarction, ischaemic heart disease, he was a smoker, had high cholesterol and hypertension. The surgeon was a senior experienced consultant.

The Claimant's case was that the mechanism of injury was ischaemia caused by the surgeon damaging the superior mesenteric artery by excessive traction or torsion through lack of proper care during the ileostomy reversal

The Defendant's case was that the mechanism of injury was that it was caused by pre-existing atherosclerosis causing arterial thrombosis resulting in mesenteric infarction and was coincidental and otherwise unrelated to the surgery.

The following were of note –

- Neither mechanism was described in the literature;
- The Judge reminded herself of **Barnet v Medway NHS Foundation Trust 2017 EWCA Civ 235** and the importance of not resorting too readily to the burden of proof being on the Claimant to find the case not proved. It was better to decide which mechanism is likely after evaluating the evidence;
- The Court can draw inferences to make findings of fact in the absence of direct evidence on the mechanism, rather than passing the burden of proof to the Defendant (Res Ipsa Loquitur);
- The Court can also find that all of the proposed mechanisms involved a failure of proper skill and care – see **Thomas v Curley 2013 EWCA Civ 117** – a bile duct injury case.

The Judge found the following -

- The timing of the onset of symptoms, proximity of injury to operation site, pattern and extent of damage, Claimant's anatomy and past medical history - all assisted in demonstrating the mechanism of the injury;

- The treating surgeon was *"a generally careful witness"*;
- The delay of 4 days between operation and onset of the deterioration and the fact that the surgery was anatomically remote from site of injury both went against a link with operation and the Claimant's mechanism;
- Of the two competing mechanisms, spontaneous thrombosis could not be excluded. The surgeon reported nothing untoward during procedure. The Claimant's expert evidence did not persuade Judge that traction or torsion were likely to have occurred;
- The Judge therefore was not satisfied that the injury was caused during operation, let alone through surgical negligence and the claim failed;
- In essence, in line with Barnet v Medway, the Judge had tried to find a likely mechanism but failed, so did resort to the burden of proof being on the Claimant.

Collyer v Mid Essex Hospital Services NHS Trust 2019 EWHC 3577 QB – December 2019

HHJ Coe QC sitting as High Court Judge.

The Claimant underwent an elective laryngectomy – the removal of his larynx for recurrent cancer. He had received radiotherapy to the area the year before. He was diabetic. Post operatively the Claimant was found to have almost complete paralysis of his tongue. It was agreed that this was caused by injury to both hypoglossal nerves (also known as the 12th cranial nerve).

The effect of this is that the Claimant was completely unable to speak as he could not form words with his tongue. It also made it very difficult for the Claimant to swallow.

Bilateral near total permanent hypoglossal nerve palsy (as here) had not been previously reported as a complication of laryngectomy, whether negligently or not.

The Claimant argued that the injury was caused by negligent surgery on the basis that -

- The total absence of previous reports gives rise to a presumption of negligence;
- The probable mechanism was inappropriate manipulation of the nerves, partial transection or suturing;
- Radiation neuropathy played no part as it does not occur until 4 years after the radiotherapy;
- The injury could not have occurred if the surgeon had been exercising all reasonable skill and care;
- After the operation the surgeon said that he was very sorry and had "just nicked the nerve";
- However the Claimant's expert agreed that the surgeon exercised skill and care if he carried out the operation as set out in his statement;

The Defendant argued that there was no negligence on the basis that -

- The surgeon had been a consultant for 25 years, had done over 100 laryngectomies without this complication;
- Surgery in the Claimant was more difficult than normal due to his comorbidities, short neck and quite densely scarred tissues;
- The surgery was complex but appeared to go well;
- Transection of the nerve would require the surgeon to be dissecting at some distance (1cm) from the normal location of dissection in the procedure (the suprahyoid muscles) and to have done so on both sides and to the same extent and missed the twitching of the muscles as would normally be apparent when he damaged nerves;
- There was no evidence that one let alone both nerves were included in the closing sutures and such a suggestion is implausible as the suture line was 2cm away from the normal location of the nerves;
- A plausible and probable mechanism is pressure from retraction – normally necessary at certain parts of the operation - on a background of hypoglossal nerves made more vulnerable by radiotherapy (known to cause some damage to the irradiated area) and diabetes (in the form of a peripheral neuropathy here affecting the cranial nerves);
- The bilateral nature of the injury itself suggests a generic factor;
- Alternatively, the injury could have been caused by compression from anaesthesia or changes in neck position.

The operation note recorded an uneventful and conventional laryngectomy. There was a factual dispute as to whether the tongue paralysis was apparent immediately post operatively or 3 days later.

The judge summarised the law -

- **Rhesa Shipping v Edmunds and Fenton 1985 1 WLR 948 ("the Popi M") (HL)** – There was no obligation on the Defendant to prove their mechanism, it was always open to the Court to conclude that the cause remained in doubt, a judge must be satisfied on the evidence that the Claimant's mechanism is more likely to have occurred than not;

- **O'Connor v The Pennine Acute Hospitals NHS Trust 2015 EWCA Civ 1244** – eliminating other proposed mechanisms is not in itself sufficient to find the remaining mechanism occurred, that mechanism still has to be probable;

- To succeed here the Claimant had to prove that he had probably suffered his injury by one of his proposed mechanisms – manipulation, transection or suturing.

The Judge found –

- There was immediate post op paralysis and the injury was therefore sustained during the course of the operation;

- None of the proposed mechanisms by either side were found to be probable (the highest some got was possible);

- The mechanism for the injury remained unexplained and in those circumstances the Claimant has failed to prove his case on the balance of probability.

Schembri v Marshall 2020 EWCA Civ 358 – March 2020

Lord Justices McCombe, Holroyde and Phillips.

The Defendant/Appellant GP admitted negligently failing to refer the deceased to hospital with a pulmonary embolism where she would have been treated with anticoagulants +/- clot busting drugs. She collapsed and died at home the next morning. The trial judge found that, with appropriate referral by the Defendant GP, she probably would have survived. The GP appealed the judge's finding on causation.

The Court of Appeal approved the trial judge's "*common sense and pragmatic view*" of "*the evidence as a whole*" in which he looked at both the statistics and factors specific to the Claimant. In dismissing the appeal they also remind us of the following cases/principles in proving causation in clin neg cases –

- **Drake v Harbour 2008 EWCA Civ 25** – Merely proving an injury is consistent with a breach of duty does not establish breach if it is also consistent with other credible non negligent explanations, however –

- If a Claimant proves negligence and the loss was of a kind likely to have resulted from such negligence, this will ordinarily be enough for the Court to infer that it was probably so caused, even if the Claimant is unable to prove positively the precise mechanism;

- **Wardlaw v Farrar 2003 EWCA Civ 1719** – Judges are entitled to place weight on statistical evidence, but they must also look at the evidence specific to the Claimant;

- **Gregg v Scott 2005 2 AC 176** – Statistics will often be the main evidential aid in causation but are not strictly a guide as to what would happen to a particular Claimant.

Practice points for surgical breach cases where the mechanism of injury is unclear -

- Look for an obvious cause first - you might be lucky;

- If not, then look for all the potential/plausible causes and for those you can rule out;

- Remember you have to prove one is the *probable* cause (and that it amounts to negligence), proving the *most likely* cause is not enough;

- Alternatively identify all the plausible causes and prove that each of them would amount to negligence – the Thomas v Curley approach (above). I have secured 100% liability in a laparoscopic bowel injury case by proving that the 3 potential mechanisms would all amount to negligence;

- That is a much better approach than trying to rely on Res Ipsa Loquitur. Res Ipsa is rarely applicable or successful in clin neg cases;

- The Claimant's past medical history can be relevant. Previous surgery or radiotherapy to the area can mean the surgical field is scarred making iatrogenic injury less culpable;

- Proximity of injury to operative field makes a surgical injury more likely;

- A clear, detailed and unremarkable operation note can make a claim more difficult;

- The experience of the surgeon can be relevant. Having said that, my successful laparoscopic bowel injury case was against a surgeon who trained other surgeons on the technique;
- A delay between surgery and symptoms makes a link with surgery more difficult;
- Defendants are likely to challenge firstly whether the injury occurred during surgery, secondly the probable mechanism and thirdly whether it amounts to negligence. A Claimant needs to win on all 3;
- Claimants can lose these cases at trial not because the defence argument is preferred, but simply on the basis that the Claimant has not discharged their burden of proof – detailed preparation of lay and expert evidence on the mechanism is key.

Practice points for proving causation where the mechanism of injury is unclear-

- Prove a precise mechanism if you can;
- If you can't, prove that the outcome is precisely what is likely if the breach occurred;
- A good starting point is that the appropriate treatment is advised specifically in order to prevent that outcome;
- Ensure your experts have the statistics which are relevant to the issue;
- Make sure they consider all the factors relevant to your specific claimant;
- Ask your experts for their experience of outcomes in such cases;
- Ask them what they would have expected to happen with this claimant;
- And put all of these together to arrive at their conclusion;
- Invite the Judge to adopt the *"common sense and pragmatic view"* of *"the evidence as a whole" recommended by the Court of Appeal*.