DAC BEACHCROFT

# Court of Appeal provides valuable guidance on cauda equina syndrome claims

*Published 7 December 2020*

***Hewes v (1) West Hertfordshire Acute Hospitals NHS Trust, (2) East of England Ambulance Service NHS Trust & (3) Dr Tanna*** **provides valuable guidance from the Court of Appeal on cauda equina syndrome claims, and on the high bar for success when appealing a trial judge's findings on the evidence.**

## The Background

Mr Hewes had a history of low back pain, with radiologically confirmed disc protrusions in his lumbar spine. On 12 March 2012 he woke at about 5am and noticed that his groin had become numb. He spoke to Dr Tanna, a GP working for the out-of-hours service, at about 6am and Dr Tanna (realising that Mr Hewes had symptoms which might suggest cauda equina syndrome) recommended that he should go to A&E. Shortly afterwards, Mr Hewes' wife called the ambulance service and an ambulance was dispatched, arriving at their home at 7:21am and at the A&E department of Watford General Hospital at 8:19am. He was initially seen by an FY2 doctor in A&E, who referred him to the orthopaedic team, and then by the on-call orthopaedic doctor, who examined him, discussed him with an orthopaedic registrar, and made a plan for MRI scanning and bladder scanning. The scan was done between 1:33pm and 1:50pm and was reported as showing a massive L5/S1 disc herniation that occupied most of the central canal. Later that day Mr Hewes was transferred to the National Hospital for Neurology and Neurosurgery, where he was taken to theatre at 10:30pm for decompression surgery. Mr Hewes was, nonetheless, left with long term cauda equina-related symptoms. There had been a roughly 17 hour period between Dr Tanna having suspected cauda equina syndrome and decompression surgery having been carried out.

The Claimant alleged that (i) Dr Tanna should have contacted the hospital to ensure that he could bypass A&E and be seen straightaway by the orthopaedic team, (ii) the ambulance service did not prioritise his need for transfer to hospital appropriately, thereby causing delay in the transfer, and (iii) the hospital staff did not manage his care with sufficient urgency, thereby causing delay in the commencement of decompression surgery.

## The Decision at First Instance

The trial judge held that there was no breach of duty by any of the Defendants (apart from a 19 minute delay by the ambulance service in transferring the Claimant to hospital, which it had admitted, but which made no difference to the outcome). She also found that, in any event, the Claimant could not reasonably have undergone decompression surgery in time to make a difference to the ultimate outcome.

## The Grounds of Appeal

The Claimant appealed, arguing that that the judgment contained several factual errors, that the judge failed to deal with the totality of the evidence, and had failed to make a finding on what the Claimant felt was the central issue, i.e. that in cases of cauda equina syndrome time is of the essence, treatment must be provided as soon as practically possible, and the failure to do so in this case was "illogical and irrational".

## The Judgment

All of the Claimant's submissions were rejected by the Court of Appeal. The key points arising out of the judgment are as follows:

- The court emphasised that an appeal is not a means by which a dissatisfied party can "*invite this court to re-visit the whole case, and to stand in the shoes of the first instance judge*". In particular, appellants face a high hurdle when seeking to challenge a trial judge's findings of fact. The test, in that regard, is "*whether there is no evidence to support a challenged finding of fact, or that the finding was one which no reasonable trial judge could reach*". Laing LJ made it clear that first instance judges are in a better position to make findings of fact and to evaluate the evidence given at trial, for several reasons that are set out in the judgment, e.g. because the trial judge is able to evaluate witnesses as they give evidence (including the extent to which they were evasive), whereas appeal judges are not.

- Laing LJ also made it clear that trial judges are not always required to set out their assessment of every single piece of evidence in their judgments, nor are they required to decide every single disputed issue. Rather, they are required "*to decide the principal issues between the parties and give reasons for her decision which are detailed enough to enable*

*them to know why they have won or lost the case*".

• The Court of Appeal upheld the trial judge's rejection of the Claimant's argument that the only reasonable course of action open to Dr Tanna was to contact the hospital to try to arrange for the Claimant to bypass A&E. Indeed, Davis LJ commented that he was surprised that the claim against Dr Tanna was pursued at all. It is not mentioned in the judgment that, in a very unusual decision, Master Cook in fact struck out the claim against Dr Tanna in 2018 at an early stage of the proceedings, but that decision was later overturned on appeal by Foskett J. Laing LJ's view was that there were no grounds at all to criticise Dr Tanna, given that "*he took an accurate history from the Claimant, skilfully elicited a red flag for CES, diagnosed suspected CES, and have the Claimant sensible and reasonable advice, which was to go to the A and E department at the Hospital where an urgent scan could be organised and he could be referred to an orthopaedic doctor*".

• The Court of Appeal upheld the trial judge's conclusion that the Claimant had probably gone into CESR (cauda equina syndrome with retention) by 12:03pm, when he underwent a bladder scan and the volume was 621ml. The Claimant's expert neurosurgeon had argued at trial that he did not go into CESR until 3pm, because there was no evidence that the Claimant had any overflow urinary incontinence prior to that time, but the court held that the trial judge reasonably concluded that patients can be considered to be in CESR without yet having experienced overflow incontinence (not least because nowadays patients are often catheterised before any overflow occurs, but also because the extent to which a patient might experience overflow is due not just to the degree of nerve damage they have suffered, but also to the amount of fluid they have consumed). The trial judge was entitled to reach that conclusion on the basis of the evidence she had heard.

## Conclusion

The judgment of the Court of Appeal in this case raises several interesting issues relating to cauda equina cases in particular, and clinical negligence cases more widely. Most importantly, however, the court reaffirmed the principle that, although clinicians dealing with real-life patient care are required to act reasonably and rationally, they are not (in the words used by Davis LJ in the judgment) required to meet a "*counsel of perfection, bordering on strict liability*". Additionally, the judgment makes it very clear that appeals cannot be approached as if they are second bites at the cherry. Parties who are dissatisfied with the decisions of trial judges face a high bar if they seek to overturn those decisions, particularly where the trial judge's findings of fact and evaluations of the evidence given at trial are concerned.

## Authors


**Mark Ashley**
*Bristol, Leeds*
+44 (0) 117 918 2191
mashley@dacbeachcroft.com

**Ciaran Claffey**
*Winchester*
+44 (0) 1962 705502
cclaffey@dacbeachcroft.com


DAC BEACHCROFT