



Neutral Citation Number: [2019] EWHC 1642 (QB)

Case No: D90BS793

IN THE HIGH COURT OF JUSTICE

QUEEN'S BENCH DIVISION

Bristol District Registry

Winchester Combined Court

The Law Courts,

Winchester SO23 9EL

Date: 26/06/2019

Before:

MR JUSTICE GARNHAM

Between:

ZZZ

Claimant

- and -

Yeovil District Hospital NHS Foundation Trust

Defendant

Bradley Martin QC (instructed by **Langleys Solicitors LLP**) for the **Claimant**

James Counsell QC (instructed by **Bevan Brittan LLP**) for the **Defendant**

Hearing dates: 20th, 21st, 22nd, 23rd May 2019

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

MR JUSTICE GARNHAM

Mr Justice Garnham:

INTRODUCTION

1. On 25 October 2011, a collision between two motor vehicles occurred at the junction of Vagg Hill and Tintinhull Road, Yeovil in Somerset. A young woman, known in these proceedings as XXX, was a rear seat passenger in one vehicle. She was using the lap seat belt fitted in the car. The other vehicle was driven by a person known in these proceedings as ZZZ. XXX sustained serious spinal injuries in the collision and was taken to Yeovil District Hospital (hereafter “the Hospital”) by ambulance. She was assessed before being transferred for treatment to Musgrove Park Hospital (“Musgrove Park”).
2. In November 2012, XXX began proceedings against ZZZ for damages. On 18 March 2015, at the Bristol District Registry, the court approved settlement of that claim. Pursuant to that settlement, XXX was paid a lump sum of £3 million together with substantial annual periodical payments for future care and case management.
3. ZZZ, acting through her insurers, then commenced contribution proceedings against Yeovil District Hospital, an NHS trust. ZZZ alleged that when XXX presented to the emergency department of Yeovil District Hospital her injuries were indicative of a lap belt injury; that, nonetheless, no spinal precautions were taken in the emergency department; that on arrival she had voluntary movement of her legs but, within 2 hours, she had lost the ability to move or feel her legs; and that the likeliest explanation for that development was the failure by the Hospital properly to protect the spine.
4. This claim for contribution came on for hearing before me on 20 May 2019 at Winchester Combined Court. ZZZ, the Claimant in these proceedings, was represented by Bradley Martin QC and the NHS Trust by James Counsell QC. I am grateful to both counsel for their clear and economical advocacy and submissions.

THE EVIDENCE

5. I summarise below the factual, documentary and expert evidence I heard.

The Lay Evidence

6. Five lay witnesses were called to give oral evidence. Each confirmed their witness statements and was cross-examined upon them.
7. Julie Napier is a cardiology nurse at the Hospital who, by chance, was a witness to the accident. She explained in her statement how, on 25 October 2011, shortly after 9am she was driving to work on the Tintinhull Road heading towards Yeovil. As she approached the junction, she saw a red car pull out from a turning to her left and across the oncoming traffic. She told me, in evidence, that it appeared that the red car was seeking to go straight across the junction. In fact, the red car drove into the path of an oncoming grey vehicle on the opposite side of the road to Ms Napier. The two vehicles collided with considerable force and the red car was left on its side.
8. Ms Napier went to assist. She saw that the young woman driving the red car, ZZZ, was trapped in her vehicle as it rolled over. She saw the driver of the grey car, a Mr Cavalier,

getting out of his vehicle. She saw there were three young people sitting in the backseat of that vehicle, all very distressed. Two of those young people managed to get out of the car, but one woman was trapped. That was XXX. Ms Napier went to assist her. She was screaming hysterically and complaining about pain in her stomach. Ms Napier went into the vehicle to try to help. She was aware that there was smoke and a smell of burning in the vehicle and she feared that it might catch fire. She attempted to calm XXX, telling her ambulances were on their way. XXX told her that, in addition to the pain in her stomach, her back was sore.

9. As a nurse, Ms Napier recognised that there was a risk of further damage to XXX's spine in helping her to escape from the car, but she also appreciated the risk of fire. She decided to undo the seatbelt but keep XXX as still as possible while they awaited the ambulance. After a few minutes the ambulance and fire brigade arrived. XXX was extracted from the vehicle by means of a longboard and taken to the ambulance.
10. When XXX arrived at the Hospital she was triaged by a nursing sister who allocated her to Staff Nurse Lynsey Guy, the second witness to give evidence before me. XXX was handed over to her by ambulance staff at about 10.15. XXX was accompanied by her mother and a younger brother. When Ms Guy received her, XXX was lying flat on a trolley. Ambulance staff told her that XXX had been involved in a road accident "which had a combined speed of approximately 60mph". They told her that XXX had been a rear seat passenger with a lap belt and she had suffered abdominal injuries. She was also told that XXX had learning disabilities, although she was able to communicate with Ms Guy. Ambulance staff did not suggest to her they had any concerns about XXX's neck or back. Ms Guy was confident that had they had such concerns they would have told her.
11. Ms Guy completed the nursing section of the hospital admission form. She noted, as follows:

"Ambulance admission. Road traffic collision – combined speed? Patient rear seat passenger. Lap belt in situ. Complaining of pain in abdomen. 10mgs oral morphine given in ambulance to good effect. Learning disabilities"
12. She made a similar note in the nursing notes, although in those she added the words "combined speed approximately 60mph". Ms Guy also completed a set of entries on the observation chart for XXX. In those, she recorded normal power for XXX's left and right leg.
13. Like the other hospital witnesses from whom I have heard, Ms Guy was interviewed by hospital staff conducting a "serious incident review". The record of that interview notes that XXX was handed over to her by the ambulance crew and that Ms Guy took a more detailed handover from the crew. It was recorded that the crew told her that XXX had been involved in a road traffic accident "the speed of which was unclear". They were concerned that she had an abdominal injury as a result of her seatbelt. Ms Guy said that XXX was not on a spinal board when she was admitted and was not wearing a cervical collar. She was already on a trolley, but Ms Guy was not able to say how she had been moved there. She told the inquiry she was confident that the ambulance crew were "not concerned about her back or neck at all"

14. Ms Guy told XXX that she needed to take off her trousers because an x-ray might be required. XXX assisted in that process “by lifting her bottom off the trolley”. Ms Guy then carried out an initial full set of observations and tested the power in her limbs. She told me that XXX was able to push against Ms Guy’s hand with her feet. It was on that basis that Ms Guy was confident that XXX had full power in her legs.
15. Ms Guy told the investigators that the clinical presentation and the history she had obtained were consistent with the description of XXX’s condition given by the ambulance crew. XXX gave no indication of having a back injury.
16. Ms Guy told me she was not aware that there had been a telephone call from Ambulance Control to the Hospital before XXX’s arrival. Ms Guy was aware that the ambulance crew, or the consultant in charge, or the nurse in charge of the emergency department could make what is called “a trauma call”. No such trauma call was made in this case. She could not say where the information that the Claimant had been involved in a 60mph collision came from. She said when XXX lifted her buttocks to assist in the removal of her trousers she did so by “the minimal amount” necessary to enable the trousers to be removed, a distance she estimated at “an inch or so”.
17. Ms Guy said that at no time did she see XXX sitting up on the trolley; she was always lying flat. Ms Guy could not remember if she had a pillow beneath her head but said that those are not often used in the emergency department. Given that XXX had abdominal pain it did not surprise her that no pillow was used on this occasion. The sides of the trolley would be lifted, by perhaps a foot, so as to ensure the patient could not roll off the trolley.
18. Sally Bojas, the third lay witness, was a health care assistant working at the Hospital on 25 October 2011. She told me that as she was walking past the cubicle in the emergency department she heard a patient cry out. She looked into the cubicle and saw XXX lying on a trolley “having a sort of fit”. Her mother was with her and calmed her down and said she often behaved in that manner. Ms Bojas amended the admission form to add reference to a pre-medical history of epilepsy and to a drug (Keppra) which XXX is prescribed. In the nursing notes, she wrote against the time 10.50am, “Patient had small epileptic fit but Mum kept her calm and she fully recovered”.
19. In line with the hospital’s policy, Ms Bojas then conducted neurological observations on XXX. In particular, she checked her lower limbs. To her surprise, she was told by XXX that she could not move her legs, or she gave no response to touch. Although XXX’s mother suggested she was behaving in this way to gain attention, it was Ms Bojas’s impression that the symptoms described were genuine. She was concerned and reported the matter to a Dr Irbash who attended on XXX.
20. Ms Bojas’ entry in the observations chart recorded no response in respect of lower limb movement. She made an entry in the nursing notes against the time 11.15 which read “Patient says she is unable to move her legs. Dr Mohammed (Irbash) called and checked her legs with a needle. Very little response. Mum says enjoys attention? Dr Mohammed will review later”. In her interview with the Hospital’s investigators, Ms Bojas repeated that account. She explained she was in the cubicle when Dr Irbash checked XXX’s reactions with a tendon hammer and also tested her sensation with a needle. She commented “It did not look as if she was making it up”.

21. The note of the interview also records Ms Bojas saying how XXX had been unable to pass urine and how a member of staff placed an incontinence sheet “under her bottom to encourage her to go to the toilet”. She went on to say she was not aware of XXX ever having been sat up or placed on a commode. She added, however, that she thought that “a staff member may have tried to put a slipper bedpan under her bottom”. I received no further evidence to that effect and do not accept that that suggestion is accurate.
22. She was asked about XXX’s position on the trolley when she entered the cubicle. She said she could not remember whether she was on her back or on her side but in either event, she was lying flat. She could not remember if she was using a pillow but said that pillows were “like hen’s teeth” in the department. She said it was commonly the case that patients did not have pillows on the ward. However, she said that the beds include a mechanism by which the top third of the trolley could be raised.
23. Dr Mohammed Irbash was the next lay witness called. Dr Irbash was a middle grade locum doctor in the emergency department on 25 October 2011. He was approached by Ms Bojas who explained her concerns about XXX. She relayed to him that XXX had reported a loss of sensation and an inability to move her legs. Dr Irbash went to see XXX at 11.15hrs. His initial review was brief because he was in the middle of treating another patient. He received an inconsistent response when testing sensation on her lower limbs.
24. Dr Irbash returned to the patient some 20 or 30 minutes later and conducted a full assessment. He noted the bruising to the abdomen and what he described as “a seat belt injury”. He assessed her lower limbs and she reported no feeling. He asked her to move her legs, but she was unable to do so. In order to examine her back, he “log-rolled” her, so as to keep her spine in proper alignment. He noted tenderness in the mid thoracic and lumbar spine area. He conducted a rectal examination and found she had no anal tone. He sought x-rays of her spine and a CT scan of her abdomen (which would cover the spine). He left her lying flat on her back in the company of nurses. He told me that at no time did he see her being manoeuvred onto a bedpan, nor did he see her sat with her legs dangling from a trolley.
25. Dr Irbash said that if the Hospital had been told XXX had been involved in an accident with a combined speed of 60mph he would have expected there to be a trauma call. If he had had that information, he would have made that call. Had there been a trauma call, Dr Irbash thought XXX would have been seen earlier and transferred to Musgrove Park within 2 hours.
26. The locum consultant surgeon on duty, on 25 October, was Mohammad Nadeem, a general surgical speciality doctor. It was he that Dr Irbash telephoned seeking a review of XXX. Mr Nadeem attended with a Foundation Year 1 doctor, Dr Owen, who made the notes as Mr Nadeem examined XXX. That examination took place at about 12.20. Mr Nadeem told me that XXX was lying on a trolley. It was noted that she was reluctant to co-operate fully and appeared agitated. She was lying flat throughout the examination. Dr Owen’s notes made reference to XXX’s learning disabilities and the fact that she had been a passenger in the middle back seat of a vehicle involved in a collision at 30mph.

27. XXX was complaining of some discomfort in her legs and Mr Nadeem ordered investigations of the intra-abdominal injuries and recommended CT scanning of her abdomen and pelvis. Mr Nadeem then spoke to Dr Irbash who told him he was already requesting imaging and Mr Nadeem asked him to include an abdominal CT. They discussed concerns about spinal cord damage.
28. At 15.00 hrs Mr Nadeem reviewed the CT reports. He noted that the scan revealed “a fracture of the lower thoracic spine and severe compromise of the spinal canal and cord”. He was told she was being referred to Musgrove Park. Mr Nadeem emphasized that he was involved primarily to consider XXX’s abdominal injury, but he was clear that he did not examine her in any way which could adversely affect her spine. When he was recorded in the notes as observing that the patient was not willing to sit forward, he was not suggesting that she had been sitting up. He told me that had she not been lying flat he could not have properly examined her stomach. I accept that evidence.
29. Last amongst the factual witnesses giving evidence was Vicky Hobbs, a staff nurse at the Hospital. She said she began work that day at about 12 noon and on arrival was asked to look after XXX. She was told “that a doctor was with her as there was an issue with her legs.”
30. As she entered the cubicle she saw her colleague, Sally Bojas, and Dr Irbash examining XXX who was lying on a trolley. She recalled Dr Irbash testing XXX’s reflexes in her legs and feet and obtaining no response. She was present whilst the surgical team discussed their findings and plans as to treatment. Nurse Hobbs was charged with attempting to obtain a urine sample but XXX and her mother were reluctant to allow the insertion of a catheter. Accordingly, Ms Hobbs tried to get XXX to pass urine onto an incontinence sheet. She explained that these pads are slid under a patient’s buttocks but that it is possible to do this, not by lifting the patient, but by depressing the mattress. XXX was not able to pass urine onto the pad. Ms Hobbs said she did not attempt to use a bedpan and did not move the patient onto a commode. Nor did she move her into a sitting position; she explained that they would not have done that in the view of the doctors’ concerns about XXX’s injuries. Nurse Hobbs’ recollection was that XXX had a pillow beneath her head and at the end of the bed was “very slightly raised”.
31. The statement of Lucy Pippard, a staff nurse at the Hospital was read into the evidence. She too cared for XXX that afternoon. She recalled the patient lying flat on a trolley and did not see her moving around or sitting up. Ms Pippard assisted getting XXX ready for transfer to Musgrove Park. She was moved by “log-rolling” her onto a spinal board and a cervical collar was placed on her neck. Ms Pippard acknowledged that in the rush to get XXX transferred to Musgrove Park, she had made a mistake in the observation chart in that she recorded that XXX had full power in the left and right lower limbs when she did not.

Documentary Evidence

32. The documentary evidence in this case included the following:
33. First, the *Criteria for a Trauma Call* document. This identified the criteria employed by the Trust to determine whether a trauma call should be made. A trauma call would result in additional clinical expertise attending on the admission of a patient. The only criteria potentially relevant to the facts of this case were “any incident with 5 or more

seriously injured” and where the mechanism of injury was a traffic accident “with evidence of significant speed (over 40mph)”. The document provided that, where there was such evidence, “staff should consider a trauma call.”

34. Second, as noted above, the Hospital Trust conducted an internal investigation, a “serious incident review”, into the care and management of XXX. A copy of that review was sent to XXX’s mother on 15 February 2012. The review ran to 12 pages and included 19 annexes. Of particular note are the following observations in the report:

“(i) The ambulance crew notified the emergency department of the impending arrival of six patients from a road traffic accident, four of whom were young adults with learning difficulties.

(ii) The ambulance staff were not concerned about the clinical condition of any of them and therefore no trauma call was instigated.

(iii) The staff in the emergency department all commented that with hindsight a trauma call should have been initiated and if it had been, felt that XXX would have been assessed more quickly after her arrival. Staff were unclear about the guidelines for instigating trauma call, the guidelines were not on display in the department but they were available on all computers in the department.

(iv) The trauma guidelines state that a trauma call should be instigated if there are symptoms or signs of neck or other spinal fractures (e.g. paresis). However, the numbness in XXX’s proximal femur documented by the ambulance crew was not thought to be related to a spinal injury and this was the only trigger that matched the trauma call guidelines.

(v) Of the five other patients admitted following the accident, four were discharged home the same day. One, who complained of a wrist injury and right knee pain was admitted.

(vi) The on-call consultant for emergency medicine said that the guidelines for initiating a trauma call were available in the department but their use is “often down to the discretion of the nurse in charge of the department. He thought a trauma call had been initiated for this road traffic accident, but on reflection accepts it has not”.

35. Third, I was shown the admission note made at Musgrove Park on XXX’s transfer. It includes the following:

“Review of her Yeovil admission shows that the RTA was approximately 9.30 this morning. She arrived at Yeovil A&E at 10.20 and had a CT scan. Interestingly, (XXX’s) parents say she complained of some pain when she was sat up in the

Yeovil A&E and her legs hung over the side of the bed. Since then she has been lying flat and has been log-rolled”

36. Fourth, the operation note of the treating surgeon, Mr Thorpe, at Musgrove Park included the following: “Findings were of unstable displaced flexion-distraction injury with T11 inferior articular processes locked anterior to T12 superior articular processes. Fracture reduced by traction and dis-impaction of facets”.

The Expert Evidence

37. Following the lay evidence, I heard from eight expert witnesses, four called by each party. Each party called an expert in emergency medicine and a neuroradiologist, respectively Ms Longstaff and Dr Stoodley for the Claimant and Dr Stevens and Dr Good for the Defendant. The Claimant also called a surgeon Mr Jamil and a neurologist, Prof. Schapira. The Defendant called a spinal injuries expert, Mr Thumbikat and a neurosurgeon, Mr Mannion.
38. All of the experts had taken part in joint discussions with those of similar disciplines. The result was three joint reports. The following material conclusions emerged from those joint reports.

The Emergency Medicine Experts Joint Report

39. The Emergency Medicine Experts, Ms Longstaff and Dr Stevens, agreed that the only trauma call criterion which XXX’s presentation might have met was ‘*d) Mechanism of injury – consider a trauma call for ... RTA’s with evidence of significant speed (over 40 MPH)*’. They agreed that the only evidence for this criterion being met is the admission note of Nurse Guy where she refers to a combined speed of 60mph. The ambulance crew had put ‘?’, i.e. unknown, in their contemporaneous record. Subsequent medical notes refer to a collision speed of 30mph.
40. The experts agreed that:
- i) a trauma call should result in a primary survey of the patient by a doctor within a few minutes, assessing for any abnormalities affecting the airway, breathing and circulation, a brief assessment of conscious level and pupil reactions of the patient, followed by a secondary survey consisting of a top to toe systematic examination for injuries, including the spine.
 - ii) the spine would be examined by log-rolling once the pelvis had been cleared of significant injury.
 - iii) in 2011, routine x-rays of the cervical spine, chest and pelvis would be performed together with routine blood tests as part of the primary survey. The experts note that Dr Irbash assessed XXX using a primary/secondary survey approach once he had been asked to see her because of her changed neurological symptoms.
 - iv) it was apparent that the emergency department (“ED”) staff were aware that XXX had signs of a seat belt injury (bruising, redness and/or abrasions following the pattern of the seat belt), that the information available on arrival

at the ED that XXX had been wearing a lap seatbelt together with the seatbelt signs pointed towards possible injury underlying the site of the belt, that XXX ought to have been immobilised if she could tolerate immobilisation; otherwise she would have been encouraged to lie still; and she should be log-rolled for any examination of the back.

- v) that management should have commenced once XXX had been handed over to the ED staff by the ambulance crew.

The Neuro-radiology Experts Joint Report

41. The neuro-radiology experts were Dr Stoodley and Dr Good. They agreed that:
 - i) the imaging disclosed an unstable fracture dislocation at T12/L1 level with bilateral facet dislocation.
 - ii) the fracture dislocation probably occurred at the time of the accident;
 - iii) it was a locked fracture dislocation, involving the superior end plate and transverse process of L1.
 - iv) on the limited imaging sequences available, without specific sequences to detect blood, there was no evidence of bleeding within the spinal cord; but that small anterior and posterior epidural collections of serosanguinous material were present.
42. Dr Stoodley said that the locked facet dislocation would make any further extension (posterior or backward) movement less likely following the 'index' event. He said that the facet dislocation was unstable and, in view of the complete ligamentous disruption, further anterior (or forward) movement (flexion) would be possible if the Claimant was in a flexed upright position.
43. Dr Good was of the view that further anterior movement was unlikely because the facet was locked up against the posterior aspect of the L1 vertebral body, preventing any further forward movement unless there was a considerable superior force on the thoracic spine followed by anterior force. She deferred to others regarding the forces the Claimant would have been subject to following the index accident.
44. Dr Good considered there was the possibility of a small contribution to the spinal cord compression from progressive serosanguinous oozing into the anterior and posterior epidural space following the index accident and that this was an unstable fracture dislocation with bilateral facet dislocation. She considered the facets to be effectively locked, preventing further movement unless there were considerable additional forces after the index accident.

The Neurology, Neurosurgery and Spinal Injuries Experts Joint Report

45. The remaining four experts met and agreed that XXX had suffered a flexion/distraction type injury, leading to tension band rupture and a bilateral facet capsular tear allowing the superior facet of T12 vertebra to "button-hole" through the capsular tear and override the inferior facet of T11, causing anterior translation/dislocation of T11 / T12. This was consistent with the accident and her wearing a lap seat belt.

46. The experts also agreed that:

- (i) in addition to the fracture, there was dislocation of the spine, due to disruption of the facets, leading to spinal malalignment at the injured level (referred to as 'translation'). That amounted to a type C fracture, (the most severe class of such fractures);
- (ii) XXX was at the severe end of the spectrum for these fractures, because the facets had dislocated and locked. The degree of anterior translation equated to approximately 50%;
- (iii) there was a fracture to the superior end-plate at T12 anteriorly. However, the most significant component of the injury was the facet dislocation with locking of the facets resulting in spinal malalignment/ translational deformity with kyphosis.
- (iv) the majority of patients who sustain an injury of this type of fracture will also suffer a spinal cord injury;
- (v) the purpose of spinal precautions is to reduce the chance of additional spinal cord injury in a patient who has already suffered an unstable spinal injury. A paramedic attending a trauma patient does not know whether or not a patient has sustained a spinal injury, and therefore adopts spinal precautions when there is suspicion of spinal cord injury, either clinically, or from the injury mechanism, or both.
- (vi) these are four mechanisms of spinal cord injury following an unstable spinal injury, namely mechanical damage and compression of the spinal cord; disruption of the blood supply; inflammation; and a combination of the above.
- (vii) a supraphysiological/pathological force is required to cause a fracture.
- (viii) a greater force is required to dislocate the facets than to cause a fracture alone.
- (ix) On the spectrum of stable versus unstable injuries, this was at the severe end of instability, given that the T11 vertebral body had translated so far anteriorly that the facet joints had dislocated and locked;
- (x) the fact that the fracture-dislocation occurred at impact meant that the spinal canal was narrowed and the spinal cord would have been compromised from the outset;
- (xi) the spinal cord would have been compromised to some degree at impact. The experts could not agree as to the extent of the compromise. None of them felt that XXX would have had normal power in her lower limbs after the accident;
- (xii) a factual finding that, on admission, XXX assisted a nurse to undress her by raising her bottom from the bed and pushed her feet against the nurse's hand, did not imply an intact spinal cord. It implied that there was still some spinal cord function, which was still capable of supporting voluntary movement in the legs; and

- (xiii) a clinically/radiologically transected spinal cord is to be regarded as a complete spinal cord injury.
47. Mr Mannion and Mr Thumbikat said that a window of preserved, but incomplete, voluntary lower limb movement, which then further deteriorated as the cord injury established (over a few hours) is not inconsistent with XXX having a diagnosis of cord transection.
48. In their view, the insult to the spinal cord was so severe that a complete spinal cord injury was unavoidable – the degree of anatomical distortion and the effects this would have on blood supply and venous drainage to the cord were incompatible with a functioning spinal cord. Therefore, they said, the failure to institute spinal precautions from the outset could not have caused further material injury to the cord.
49. Mr Jamil and Prof. Schapira disagreed. XXX was reported by the paramedic and Ms Napier, (the cardiology nurse who attended to her shortly after the accident), to have active movements in the legs. The initial hospital observation sheet recorded normal power in the legs. The nurse in the emergency department had reported that XXX assisted with the process of changing her by lifting her pelvis up using her heels as an anchor. They said that this evidence implies, if it is accepted by the Court, that there was at least significant and substantial residual spinal cord function below the level of injury. Mr Jamil and Prof. Schapira considered that, on balance, XXX’s neurological deterioration to complete spinal cord injury (“SCI”) in the Hospital was preventable, rather than inevitable, if a destabilising spinal injury had been suspected and a spinal immobilisation protocol instituted.
50. Mr Jamil made the point that, even in a patient with a SCI, failure to institute spinal precautions can lead to further injury, for example, from ascending insult to the cord. The other experts agreed with this comment, though Mr Mannion pointed out that, in XXX’s case, her clinical spinal cord level is at the level of the injury, and it followed that she had not suffered an ascending injury.
51. Mr Jamil and Prof. Schapira said that the evidence of voluntary function indicates substantial and significant residual cord function and is in keeping with mild or no apparent injury to the spinal cord. They assert that, while there may be some subsequent and temporary decline in function, for instance due to swelling, improvement and return of function may then occur.
52. By contrast, Mr Mannion and Mr Thumbikat were both of the opinion that the severity of the spinal injury was such, and malalignment so severe, that complete spinal cord injury was inevitable. They say that the presence of some voluntary movement, if the Court were to find that that was present, is not evidence of potentially salvageable function in the legs. In a cord which had been damaged at impact and was suffering ongoing traction / compression due to the severe deformity, there could be a short period before spinal cord function was completely lost, as the relevant mechanisms of damage became established. However, they also point to the absence of any formal examination, noting that the evidence in support of XXX being able to move her legs was from subjective observation, at a time when those clinical staff had not anticipated XXX to have suffered a spinal cord injury.

The Oral Evidence from the Experts

53. All the experts confirmed the accuracy of their reports and were cross-examined.
54. I heard first from Ms Peta Longstaff and then Ms Stevens, the emergency medicine consultants. Both are highly qualified and highly experienced practitioners who provided detailed and helpful evidence. I have no doubt that both of them were doing their best to assist the court when they gave their oral evidence. However, Ms Stevens was much the more careful and consistent witness and where their evidence conflicts I prefer hers.

Ms Longstaff

55. Ms Langstaff explained the advantages of making a trauma call. It would mean that a team of three expert doctors, an orthopaedic surgeon, a general surgeon and an anaesthetist, would be made ready to assist.
56. Ms Longstaff agreed when cross-examined that in 2011 there was no national guidance in respect of trauma calls and that the version produced by the Trust constituted reasonable practice by the standards of the time. She also agreed that if the criteria in sub-paragraph Criteria A-C were met, a trauma call should be made. By contrast, if Criteria D was met, staff should *consider* making a trauma call. She agreed that only criterion d) applied here. That applied if there were a road accident where the speed of collision was over 40mph.
57. Here there was conflicting evidence about the speed of the collision. The ambulance crew appeared uncertain about speed. At 10.35, Ms Guy recorded that the accident had a combined speed of 60mph and it appeared she was obtaining that information either direct from XXX or via XXX's mother. She agreed that the decision whether or not to initiate a trauma call, where paragraph d) was applicable, involved an exercise of judgment. The fact that the accident involved speed over 40mph was one factor which the Hospital had to consider. In the light of those concessions, Ms Longstaff agreed that her expert report required amendments. She could not maintain the assertion that a failure to initiate a trauma call because of the speed of the accident was mandatory and a failure to do so was a breach of duty.
58. Ms Longstaff maintained, however, that there were further considerations here which support the case for issuing a trauma call. First, the fact that XXX's body displayed the "seatbelt signs", bruising and redness in the abdomen area, which ought to have put staff on notice of the possibility of a spinal injury. Second, the fact that ambulance staff had contacted the emergency department at the Hospital to pre-alert them to the fact that a number of the injured in the road accident were being brought to Hospital, should have prompted consideration of whether the ED had sufficient staff to cope. She accepted, however, that that would not meet the requirements for a trauma call under the protocol.
59. She agreed, however, that there were other features which needed to be considered in making a judgment about the need for a trauma call. First was the fact that the only complaint of back discomfort, made by XXX to the ambulance staff, was limited to an observation that her back was 'sore'. Second, it was relevant that the ambulance crew recorded that they had palpated the spine without back or spinal pain being suggested.

Third, it was relevant that XXX was able to self-mobilise after the accident. Fourth, the fact that the tests done by Nurse Guy on admission suggested normal power in the lower limbs mitigated against this being a case for a trauma call. Each of these, she conceded, weighed in the balance against the need for a trauma call.

60. Ms Longstaff also said there was no evidence that she had seen that a trauma call had even been considered. Had it been considered it should have been made and there was no good reason why it was not done.

Dr Stevens

61. Dr Stevens agreed that, given the Trust criteria, there was an obligation on the hospital to *consider* issuing a trauma call once Nurse Guy was told that the accident involved a collision at 60mph. She said it was also relevant that the department was already busy and so could have done with extra assistance.
62. Dr Stevens said it was generally the senior nursing staff who would put out a trauma call. She said there were a number of ways of obtaining additional assistance without issuing a trauma call. For example, staff on paperwork duty could be called in to help. In her opinion, this was a capacity issue here and it was a judgment for the senior nurse in charge to decide as to whether the department was adequately staffed. She agreed there was no evidence in the written material that the judgment required under the guidance had in fact been exercised.
63. Nonetheless, she regarded the trauma call as something of a blunt instrument and she did not think it unreasonable not to make the call. Relevant to the judgment staff had to make was the number of casualties and the personal circumstances of the patient including the fact that XXX had learning disabilities.
64. Ms Stevens agreed that a high index of suspicion of spinal injury was required once there was a report of a road accident involving a lap belt. However, it was clear to her that both the ambulance and the medical staff had looked to see if there were signs of spinal injury. She would not expect the nurse conducting the admission examination to take a full history and conduct a full examination of every patient. Here the nursing staff had the reassurance of the observations of the ambulance staff and the absence of a complaint of pain. It was not reasonable to say that triage staff should go beyond the absence of back complaint and the absence of report from the ambulance crew to investigate whether there was a back injury. In her view, the ability of the patient to self-mobilise, and the absence of pain on palpation was highly reassuring. In the vast majority of patients with spinal injury there would be localised tenderness over the fracture.
65. Ms Stevens said that there was a conceptual difference between a trauma call and staff applying a high index of suspicion. It was clear that the patient was lying flat on a stretcher during her time in Hospital and being log-rolled to move her, and there was no evidence that the patient was moved in a way that was uncontrolled or likely to cause spinal injury.
66. Next, I heard from the neuroradiologists. Again, both are experienced and highly qualified experts. Again, however, the Defendant's expert was much the more careful and convincing and, where they disagree, I prefer the evidence of Dr Good.

Dr Stoodley

67. Dr Stoodley agreed that the locking of the facet joints meant that the upper part of the spinal column was not able to move backward following the index event. However, he said what was crucial was that the fracture dislocation was unstable. The fact that there was ligamentous dislocation meant that if XXX was flexed upright from a supine position, such as being sat upright, that would give rise to the possibility of the upper segments moving anteriorly. That would narrow the spinal canal and risk further compromising the spinal cord.
68. In cross-examination, Dr Stoodley acknowledged there were some errors in his report. He agreed he had missed the corner fracture at T12. Initially, he said he must have seen that fracture but had failed to report it. It was pointed out to him, however, that he had positively asserted that there was “no other bony injury”. He said that the reason he had not reported this fracture was that he did not regard it as significant.
69. Dr Stoodley agreed he had missed two other fractures. They were demonstrated by yellow arrows in the scans exhibited to Dr Good’s report. He pointed out that he was not asked to comment on the significance of any other fractures. I observe in passing that Dr Stoodley did not correct these errors when asked by the Claimant’s counsel whether he had any corrections to make, despite the fact that they were evident from Dr Good’s report.
70. Dr Stoodley agreed that the injury here was a bi-lateral facet dislocation with the facets lying in a locked anterior dislocated position. He further agreed that he had made no reference to the fact that the facets were locked in either of his reports. That was not, he said, because he had missed that fact, but because that particular aspect of the injury did not seem to him especially relevant. It was put to him that the fact that the facet joints were locked in their dislocated position was highly relevant to the stability of the spine after the accident. He responded that what mattered was that the whole injury was potentially unstable. The locked position of the facets precluded their posterior movement but did not prevent anterior movement.
71. Dr Stoodley agreed that the extent of the dislocation amounted to more than half of the width of the vertical body and that had the effect of narrowing the spinal canal. He agreed that the spinal cord was angulated and stretched. He agreed that the facet joints must have been locked at the time of the index event and must have remained locked until Mr Thorpe used significant traction to reduce the dislocation.
72. Whilst I am sure that, for the main part, Dr Stoodley was attempting to assist me, I confess his analysis was unconvincing. It was regrettable that he should have made the errors noted above and more concerning still that he had not volunteered corrections to them. Most importantly, I regard his explanation for his dismissal of the potential significance of the fact that the facets were locked as close to disingenuous. When considering possible movement of the spine after the initial insult, the fact that movement in one direction was functionally impossible was, at the very least, worthy of comment.

Dr Good

73. Dr Good gave evidence in accordance with her thorough and careful report. She was cross-examined at some length by Mr Martin but did not resile from any of her conclusions. She emphasised that she could only speak to the imaging but regarded it as highly likely there would be injury to the spinal cord as a result of the accident. She said the spinal cord became radiologically transected when the primary insult occurred. The facet could only be dislocated into the locked position if considerable flexion–distraction occurred at the time of the accident. She said the position of the locked facet joints remained unchanged until additional severe flexion-distraction force was applied.
74. Dr Good said that the scan would have looked the same at the time of the accident as it did at the time it was taken. She said an MRI might have changed in that period because, although the position of the vertebrae would be the same, there would be more oedema over time.
75. Dr Good explained that the injury was technically unstable but here, because the facets had jumped and locked, it was very hard to move the facets further anteriorly and almost impossible to move them posteriorly. Considerable force would be needed to move the facets back in place.
76. She said the MRI scan demonstrated a collection of blood caused by blood oozing at the time of the injury. She could not say that there was evidence of expanding hematoma but hematoma visible on the MRI did add to the insult.

Prof Schapira

77. Professor Schapira was an impressive witness in many ways, not least in his willingness to acknowledge the limitations of his expertise on facts such as these, and to defer to other experts when the topic took him outside his area of specialism. He made it clear that he is not an expert in spinal surgery but a neurologist with expertise in the function of the spinal cord. He said that the other three experts, Mr Jamil, Mr Mannion and Mr Thumbikat were experts in traumatic spinal surgery.
78. Professor Schapira agreed that the reference by the paramedics to XXX being able to move her feet, and her movement when she was being undressed in Hospital, implied residual cord function. These were voluntary movements and if the evidence about them was accepted they demonstrated that residual movement was possible. He said that the transformation from some spinal movement to complete trans-section within two hours could be explained by developing oedema or the fact that the patient was not properly immobilised.
79. He agreed that the accident caused injury to the cord and it was unlikely that XXX would have normal leg function thereafter. The cord would have been compromised from the outset. She would not have had normal leg function notwithstanding what Nurse Guy had observed. As to the rate at which the patient with spinal injury can deteriorate he would defer to others.

Mr Jamil

80. I say straight away that I regard Mr Jamil as a thoroughly unsatisfactory witness. I indicated that that was my preliminary view to Mr Martin. He recognised the deficiencies in his evidence and did not seek to persuade me that my preliminary view was incorrect. The result of my assessment of Mr Jamil is that I do not regard it as safe to rely on his evidence on any issue where he differs from the other witnesses from whom I have heard.
81. The deficiencies in Mr Jamil's evidence were both numerous and fundamental.
82. First, I have grave doubts as to whether he has the expertise necessary to provide comments on injuries such as the present. He told me he had not performed spinal surgery for more than six years. That in itself may be of no significance, especially in a case which related to treatment more than six years ago. However, I regard it as quite remarkable that he should have advised as he did, that this injury might be treated conservatively with bed rest and analgesia. As was agreed by all the other experts the only possible treatment for this condition was surgery. Mr Jamil sought to explain that by saying that he was referring to a patient with a simple Chance fracture, rather than a fracture dislocation with bi-lateral facet dislocation and locked facets.
83. He described that in evidence as a "silly mistake". In my judgment, it was a fundamental error. As Mr Counsell rightly submitted, either Mr Jamil did not appreciate that there was locking, (and it is notable that he does not refer to locking in any of the first three reports), in which case, he cannot be regarded as a competent witness in this regard, or he did appreciate it and failed to refer to it, in which case he would be in breach of his duty as an expert.
84. The fact that this was a locked dislocation was plainly relevant since one of the issues I have to decide is whether, despite the injury, the spine could still move. If it were locked it could not move posteriorly.
85. Second, it is apparent from his final report that he had by then appreciated that he was dealing with a locked dislocation. However, in that report he missed the fact that there were three fractures visible on the radiography. His explanation for that was that these were not important as these were not at issue. I regard that as a wholly unsatisfactory answer; any expert worth his salt would have recorded the fact of the fracture and explained why he did not think it was relevant.
86. Third, he asserted that the MRI scan proved there was no expanding hematoma. It is self-evident that it did not do so. As the other experts agree, the MRI scan showed some modest hematoma and it is quite impossible to tell from a single scan whether or not that hematoma was expanding.
87. Fourth, in the course of reports apparently directed towards causation, Mr Jamil volunteered his views relevant to breach of duty. Surprisingly, he did not defer on that issue to the experts instructed to consider breach of duty. More fundamental, it was apparent in the course of the evidence that Mr Jamil did not know what the test for breach of duty is in a professional negligence case. He only succeeded in articulating something approaching the correct test after it had been explained to him by Mr Counsell.

88. That piece of incompetence was underlined by the fact that in a county court in March of this year, Mr Jamil had again been unable to articulate the test he was applying when advising that another doctor was negligent. His explanation to me for his inability to describe the *Bolam* test on the previous occasion was that he had had a mental block whilst giving evidence. That was palpable nonsense since he had made the same mistake in the course of contributing to a joint report in that earlier case.
89. I also note with some concern that Mr Jamil appeared quite unable to appreciate, or at least to acknowledge, how serious these inadequacies were in an expert giving evidence to the court in a case relating to clinical negligence allegations. I regard Mr Jamil as a wholly unreliable witness.

Mr Thumbikat

90. In the starkest of contrast with Mr Jamil, I found Mr Thumbikat a highly impressive and credible witness.
91. He explained the pathology of damage to the spinal cord in detail and with clarity. He said that the initial area of damage is often very small. But over the following few hours that area of damage extends continually. He described how experiments with animals in the 1960s and 70s had demonstrated this phenomenon and how, more recently, MRI studies had showed similar progressions in humans. He described how the swelling of the cord occurs because of underlying macular damage which restricts the supply of oxygen to the cord leading to hypoxic damage. The result is that white cells and other inflammatory materials appear inside the cord. In time, they release chemicals which set up secondary damage.
92. Mr Thumbikat referred me to literature on this issue, notably “*Airway Management in Adults after Cervical Spine Trauma*” by Crosby, and “*The Cause of Neurologic Deterioration after Acute Cervical Spinal Cord Injury*” by Harrop and others. Both those two papers describe injury to the cervical spine but, as Mr Thumbikat explained, there is no significant structural difference between the cord at cervical and thoracic level, and the pathology is the same. As he explained, the medical literature suggests that a small, but not insignificant, percentage of patients with spinal injury whose condition is well managed will go on to develop paralysis. The evidence suggests that with fracture dislocation the incidence of delayed deterioration is greater. This was a case of serious fracture dislocation. He says the risk of secondary damage has been recognised since the 1970s and is now well established.
93. It cannot be argued, Mr Thumbikat contended, that the small numbers of cases in which such deterioration occurred means that the possibility of such changes is insignificant. On the contrary, Mr Thumbikat asserts, it is in cases of more severe injury that such deterioration is likely. It is true that much of the deterioration described in the literature involves rising levels of paralysis and commonly this takes significantly longer than the two hours in issue in the present case. But what matters, argues Mr Thumbikat, is that these cases demonstrate that it is perfectly possible for there to be less profound neurological symptoms immediately after an accident with worsening symptoms in the following hours.
94. As to XXX’s treatment at the Hospital, Mr Thumbikat was of the view that propping her up, even with a single pillow or on an inclined trolley, was “not ideal” and such

patients should generally be nursed supine. However, he did not think minor variations from the horizontal would be significant. The position would be very different if XXX had been sat up on the trolley with her legs over the edge.

95. Mr Thumbikat agreed that if there was available in this case the results of a detailed neuro-examination after arrival at Hospital that would assist because it would make it easier to determine whether XXX was neurologically normal on arrival at Hospital or was suffering from neurological deficit which was not complete, or if Nurse Guy had made a mistake and there was no movement in the legs. In his view, however, it was likely there was some movement since it was observed by both the ambulance crew and Nurse Guy. It was possible, in his view, to estimate the level of power preserved in XXX's limbs by reference to that which Nurse Guy describes her as being capable. It was Dr Thumbikat's conclusion that deterioration was both inevitable and spontaneous in the case of XXX.

Mr Mannion

96. If Mr Thumbikat can be described as being a very good witness, then Mr Mannion was quite exceptional. It was evident from early on in his evidence that he had a complete mastery of his subject. He had a singularly impressive curriculum vitae and is plainly a clinician of great experience and expertise.
97. Most importantly for my purposes, he had recent experience of treating precisely the condition from which XXX suffers. He had had to perform an operation similar to that which Mr Thorpe performed on XXX when he was last on call and he still has the patient concerned on his wards.
98. Mr Mannion told me that the question of stability and movement in this joint was the critical issue. He described how such fractures are graded A to C to describe their seriousness. C is the most serious and XXX's was a type C injury. He described how the injury XXX suffered so distorted the thoracic spine as to introduce a 'chicane' in the spinal canal. He said the spine was not obviously unstable in flexion because of the notch into which the upper vertebra fitted in the lower one, and the supporting soft tissues. He did accept, however, that the spine could still have pivoted at the point of injury. Nonetheless, he said the cord here was so fundamentally damaged that it was difficult to contemplate any more damage. If XXX was managed properly with spinal precautions she would have been left lying on a bed in the same position as she adopted at the time of the MRI scan.
99. He said it was possible that XXX could have some function in the spine for two hours after the accident and yet still suffer deterioration to the point of paralysis. Mr Mannion agreed that there are three possible explanations for the deterioration in XXX's condition after she arrived at Hospital. First, there could be a failure to take appropriate precautions to prevent further damage to the spine. Second, there could be involuntary spasm. Third, there could be the existence of what he described as "vestiges of function" in the spine after the initial insult. He discounted the possibility of damage caused by further movement given the locked state of the dislocation in the absence of very significant force. Given the description of the "small fit" suffered by XXX he did not regard involuntary spasm as a satisfactory explanation.

100. He said “final vestiges” was simply a description of what was occurring in the spine after the accident and, as to the mechanics of that, he agreed with and adopted, the reasoning of Dr Thumbikat.
101. Finally, Mr Mannion provided his own explanation for the progression of symptoms in XXX’s spine. He explained that the trauma effected to her spine in the accident was not a one-off event. Because of the deformity of the spinal canal that followed the dislocation, the insult to the spine continued throughout the period prior to reduction by Mr Thorpe. The cord continued to be distorted out of its normal position and pressure on the cord as it went around the ‘chicane’ remained throughout. The effect of that would be to cause continuing damage to the spinal cord.
102. In those circumstances, it was Mr Mannion’s view that paralysis was both inevitable from the time of the accident and the only cause of the deterioration of XXX’s spine during the day in question.

ANALYSIS

The Facts

103. Against that evidential background, I set out my conclusions on the facts of this case.
104. At about 09.17 on 27 October 2011, XXX was travelling as a rear seat passenger in a vehicle travelling out of Yeovil on the Tintinhull Road. It seems likely that the vehicle was travelling between 30 and 40mph. That would reflect the speed of traffic generally as described by Ms Napier who was travelling in a vehicle in the opposite direction.
105. A vehicle driven by ZZZ pulled out of Vagg Hill onto the Tintinhull Road, across the path of Ms Napier’s vehicle and into the path of the vehicle in which XXX was travelling. The two vehicles collided at speed.
106. XXX was wearing a lap seatbelt and as a result of the collision, she suffered a severe spinal injury. The lower spine was held in position by the lap belt. The spine above the belt was forced into extreme flexion so as to dislocate the facet joint in the thoracolumbar spine (as described in paragraph 56 of the report of Mr Mannion). Once so dislocated, the upper vertebrae, T12, became lodged with more than 50% anterolisthesis (forward movement of the upper vertebral body over the lower one) of T12 over L1. There was bi-lateral facet dislocation. This is an unstable injury and it can be assumed that there will be consequential disruption of the anterior and posterior longitudinal ligaments and annulus fibrosis and posterior interspinous ligaments (see the report of Dr Good).
107. Southwestern Ambulance Service attended the scene at about 09.22. XXX was very distressed and complaining of abdominal pain. She was extricated from the car on a longboard, given morphine, transferred to an ambulance and then transported to Yeovil District Hospital. The ambulance left the scene at 10.04hrs.
108. XXX was received by nursing staff at Yeovil District Hospital. Ambulance staff handed her over to the care of Nurse Guy at about 10.15. She was lying flat on a hospital trolley. Ambulance staff told Ms Guy that she had been involved in a road accident “which had a combined speed of approximately 60mph”. They told her that she had

been a rear seat passenger with a lap belt and had suffered abdominal injury from the belt. No concerns about her back or neck were reported to Ms Guy.

109. In my judgment, it is plain from the evidence that, at that point, XXX retained some spinal function. Whilst Ms Guy was undressing her in order to put her into a gown necessary for x-rays to be performed on her abdomen, XXX was able to assist her by lifting her bottom an inch or two from the bed so that her trousers could be removed. In addition, I find as a fact that Nurse Guy checked her lower limb power by asking her to push her feet against her hand. In consequence, Nurse Guy recorded on the observation chart for XXX that she had normal power in her legs. In fact, I am satisfied that she had some power but not normal power. I accept the evidence of all the spinal experts to the effect that given the nature of the injury it must have been the case that XXX's spinal function was already significantly impaired.
110. The Hospital had in place a trauma call protocol which set out circumstances in which hospital staff should make a trauma call in respect of a patient. It is common ground that the trauma call protocol was a reasonable one. I accept the evidence of Ms Longstaff and Ms Stevens to the effect, that on its proper application, the trauma call protocol did not mandate a trauma call being made on XXX's arrival at hospital. However, in my judgment, it did require *consideration* of a trauma call, once it was reported to Nurse Guy that the accident had involved the combined speed of 60mph.
111. In fact, in my judgment, it is unlikely the accident involved any such speed and as set out above the speed was probably closer to 30 or 40mph. However, for obvious reasons, the trauma call protocol cannot depend on a definitive resolution of the speed involved in an accident; it is sufficient that the responsible staff have information suggesting a high-speed collision. Nurse Guy had this here and accordingly she, or her managers, ought to have considered making such a call. No such call was made and there is no evidence that such a call was considered.
112. Instead, what happened was that following Nurse Guy's examination at 10.35hrs, XXX was left lying on a hospital trolley. I conclude that she was lying flat on that trolley at that stage and that the moveable sides of the trolley had been erected so as to prevent her moving or falling from the trolley. I reach that conclusion on the basis of Nurse Guy's evidence and that of the care assistant Sally Bojas, which I accept. XXX was complaining of significant abdominal pain and, in my judgment, it is unlikely in the extreme that she would have contemplated sitting up given that pain. She was certainly still lying down when Ms Bojas saw her.
113. XXX had come to Ms Bojas' attention because she was crying out while having some sort of fit. Ms Bojas observed her crying and shaking while her mother attempted to calm her down. Ms Bojas recorded that she had had a small epileptic fit, but this was not a full tonic-clonic (or 'Grand Mal') fit. Although Ms Bojas regarded the fit as very minor, she followed the Hospital standard practice of carrying out a neurological observation thereafter. During the course of that she checked her lower limbs. She was told by XXX that she could not move her legs and could not feel touch.
114. Ms Bojas recorded these findings at 11.15am in the admission note and in the patient observation chart. I accept that she immediately went to find Dr Irbash. Dr Irbash broke off his treatment of a stroke patient and immediately attended XXX. I accept the evidence that he tested her lower limbs but received an inconsistent response. XXX

was at the time agitated and Dr Irbash told her and her mother he would return shortly and would request x-rays. Having completed the treatment of the other patient he returned some 20-30 mins later by which time XXX was much calmer.

115. I find as a fact that Dr Irbash then did a full and proper assessment of the patient, which included assessing her lower limbs for sensation and movement. He examined her back by log-rolling her over. He noted that she was tender in the mid-thoracic and lumbar spine. He performed a rectal examination and discovered no anal tone. Accordingly, he requested x-rays of her chest, thoracic and lumbar spine and a CT scan of her abdomen. Further log-rolling was performed so that XXX's spine was protected and she was left lying on her back.
116. At about 12.20 XXX was further examined by Mr Mohamed Nadeem. He noted that she was lying flat. She was unable to move her legs. He requested a CT scan
117. Subsequently, XXX's care was taken over by Staff Nurse Vicky Hobbs. She recalled, and I accept, that XXX was lying on a trolley with her head slightly raised, either with a pillow beneath her head or by an adjustment of the bed of the trolley. I find as a fact that she was able to pass an incontinence pad under XXX but did so by depressing the mattress, rather than elevating XXX's buttocks.

The Musgrove Park Notes

118. As noted above, there is an entry in the Musgrove Park notes to the effect that XXX's parents reported to staff at Musgrove Park that at some time during XXX's treatment at Yeovil, XXX "complained of some pain when she was sat up in the Yeovil A&E and her legs hung over the side of the bed". There is a dispute between the parties as to whether this evidence is admissible and, if it is, as to the weight to be attached to it.
119. In my judgment, the report to this effect is inadmissible. Neither XXX's mother nor her father were called to confirm whether they did indeed say what they are reported to have said. The maker of the Musgrove Park note was not called. No witness statement was put before the Court which referred to this alleged report. No Civil Evidence Act 1995 notice has been served in respect of this entry. The Defendant has made it clear throughout that it objects to the use of the note to prove the truth of its contents.
120. In those circumstances, I disregard it.
121. Even if I had reached a contrary view, and admitted this note into evidence, the weight to be attached to it would have been minimal. As Mr Counsell submits, all the admissible evidence about XXX's movement that day goes one way. There was no occasion on which it is remotely likely that XXX would have sat up, or been sat up, into a sitting position with her legs over the side of the trolley. It is, in my judgment, inconceivable that the sides of the trolley, which had been raised to keep XXX in place, would have been lowered so as to permit her to sit up. Operating that lever is not, according to Nurse Guy an entirely straightforward business. XXX was complaining throughout of abdominal pain; it is unlikely in the extreme that she would have wanted to bend at the waist whilst the pain persisted.
122. It is right to say that Mr Nadeem said that he asked her if she could sit up (that fact is recorded in the notes made by Dr Owen and accepted by Mr Nadeem). However,

according to him, she declined to do so. Whether or not it was wise of Mr Nadeem to suggest she sat up is beside the point; what matters is that XXX demonstrated in her conversation with him, that she did not wish to do so and there is no evidence to suggest she was encouraged or required to do so or did in fact do so.

123. As Mr Counsell further submits, it is of interest to consider in this context the first report of Mr Jamil, dated 2 September 2012. That report was a condition and prognosis report prepared for the original damages claim brought against ZZZ. Mr Jamil reports that XXX's mother was with her within an hour of the accident; in other words, by about the time she was admitted to the Hospital. Mr Jamil reports what XXX's mother told him. She was apparently with her throughout the relevant period. There is no suggestion at all in that description from XXX's mother, as recorded by Mr Jamil, to support a suggestion that XXX was sat up with her legs dangling over the side of the trolley or sat up at all.
124. In my judgment, the weight to be given to this note, if it were admissible is very slight and is plainly outweighed by evidence to contrary effect, namely, that there was no occasion on which XXX was sat up in the way described.

Breach of Duty

125. On the contrary, in my judgment, the proper conclusion is that XXX remained lying flat on the trolley from the time she arrived at the Hospital until she left to be transported to the Musgrove Park. The only exception to that is, as noted above, that I accept Ms Hobbs' evidence that at some stage after 11.30, and therefore after it was recorded that XXX had lost all sensation in her legs, XXX's head may have been raised slightly to permit a pillow to be placed beneath it.
126. Evidence about the movement of XXX's spine whilst at the Hospital is important because a central part of the Claimant's case in these proceedings is that she sustained further damage to her spine as a result of the way she was handled and managed at the Hospital. In my judgment, on the basis of the lay evidence, there is nothing to suggest that XXX's spine was moved to any significant point at any time during her treatment at Yeovil.
127. Nonetheless, in my judgment, the Claimant has established that there was a breach of duty. When Nurse Guy was informed that the road accident had involved the combined speed of 60mph, she ought to have reported that to her superiors and they ought to have *considered* a trauma call. They did not do so.
128. In fact, it seems to me on balance that, had a trauma call been considered, it would not have been required. The mandatory requirements of the trauma call protocol were not met. Furthermore, in my judgment, the factors militating against making a trauma call set out at paragraph 59 outweighed those in favour of doing so. So, there was a breach in not considering making the call, but that breach had no consequence.
129. However, even if no trauma call was placed, XXX ought, in my judgment, to have been treated and handled on the assumption that she may have suffered significant spinal injuries. Ms Stevens came close to accepting that (see [63] above). The full range of spinal precautions should have been introduced so as to ensure, so far as was possible, that XXX did not move her spine. There was no conscious decision to do that. In my

judgment, that too was a breach of duty. What matters, however, is whether that made any difference given the way in which XXX was in fact handled and treated.

Causation

130. As matters turned out, for reasons other than protecting her spine - notably the desire to avoid aggravating XXX's abdominal pain, XXX was nursed throughout the relevant period lying flat. I have rejected the evidence that she was required to sit up with her legs dangling over the side of the trolley. Furthermore, I have rejected the suggestion that on any other occasion there was any significant movement of her spine. Instead, I find as a fact that she was nursed lying flat, or nearly flat, on a trolley and her spine was not exposed to any significant extension, flexion or rotation.
131. It is true she had a minor fit of some sort. However, as that is described in the evidence of those who observed it, the movements of XXX's spine in the course of that fit were not traumatic or significant. None of the experts suggest that injury was sustained during the course of that fit, nor that the fit should have been treated in any other way than it was.
132. Because of my findings that XXX's spine was not moved to any significant degree, the Claimant is unable, by direct evidence, to establish causation. Mr Martin, on ZZZ's behalf, seeks, in the alternative, to make good his causation case by reference to the Court of Appeal decision in *Keefe*. I turn to consider that below, but first I address what seems to me a more fundamental difficulty Mr Martin faces.
133. It is my clear conclusion on the basis of the medical evidence that there cannot have been an event in the Hospital which caused or contributed to the injury sustained by XXX. In my judgment, the damage to her spinal cord was complete at the time of the accident and the paralysis which she subsequently developed was inevitable from the moment of the collision.
134. In reaching that conclusion, I accept the evidence of Dr Good, Mr Thumbikat and Mr Mannion. The nature of the initial injury was significant in two respects. First, the dislocation meant that from the moment of the accident onwards the spinal cord ran through a chicane of vertebra. It was continuously distorted and under pressure until it was reduced by Mr Thorpe at Musgrove Park. It was locked in position as a result of the nature of the dislocation.
135. In further consequence of the injury, it was impossible for the spine to extend backwards. I accept the evidence of the Defendant's experts, furthermore, that it would have been very difficult even to flex the spine forward. The ligamentous structures, although damaged, were still in place and would act against such movement. In addition, the facet at T12 was located in a nodule in the facet of L1 which would, to some extent, have inhibited flexion. It is true that rotation of the spine might still have been possible but, on my findings of fact, there was no occasion when such rotation might have occurred at the Hospital.
136. The Claimant's fundamental argument is that, in the absence of some additional insult to XXX's spinal cord there is no explanation why movement and sensation were detected on her arrival at the Hospital but had vanished by 11.15 when Ms Bojas and Dr Irbash examined her. In the absence of Mr Mannion and Mr Thumbikat that might,

indeed, have posed a genuine conundrum. However, the evidence of those two doctors provides a complete and, in my judgment, entirely coherent explanation.

137. It is wrong to see the trauma sustained by XXX's spine in the accident as a single event with consequential damage complete by the time the ambulance staff extracted her from the motorcar. On the contrary, as Mr Mannion explains, the trauma to the spine continues because the spine was locked in a contorted and extended position. The pressure on the spine remained and the damage to the spine continued and, in all probability, extended. As Mr Thumbikat explained, chemical changes in the spine continued after the initial trauma. I have no doubt, as all the experts agreed, that the spine was already compromised to some extent by the time XXX arrived at the Hospital. The condition of the spine worsened while she was there, but not because of any additional trauma for which the Hospital was responsible, but because of the structural and chemical changes that continued in the spine during that period. At 11.15 or thereabouts, those continuing changes meant that the remaining sensation and movement in the spine ceased.
138. For all those reasons, whilst technical breaches of duty occurred, they had no consequence. The cause of XXX's paralysis was not her treatment at Yeovil but damage inflicted in the accident.

Keefe

139. Against those findings, in my judgment, the principle identified by the Court of appeal in *Keefe* has no application.
140. In *Keefe v Isle of Man Steam Packet Company Limited* [2010] EWCA Civ 603, the Court of Appeal held that where a ship owner had breached its duty of care to take measurements of noise levels in its ships, the Court was to judge benevolently the evidence of the Claimant that he had been negligently exposed to excessive levels of noise on the ships, and the ship owner could not rely on the absence of measurements as evidence that the noise was not excessive.
141. Mr Martin argues that by analogy with *Keefe*, as a consequence of the Defendant's breach of duty here, no proper neurological examination was carried out on XXX at the Hospital. He says that, in addition, it is impossible to determine what would have been the outcome had spinal precautions been in place. He contends that the Court should be willing to accept, at face value, the nursing assessment that XXX had normal lower limb power on admission, and to infer that the deterioration to complete loss of limb power would probably not have occurred but for the Defendant's negligence.
142. I reject that argument. The circumstances of this case are very different from *Keefe*. It is common ground between the experts that XXX suffered some significant neurological damage in the accident so that her lower limb function would not have been normal. I cannot in those circumstances accept Nurse Guy's assessment of normal limb power at face value. Nor on the evidence, am I entitled to infer that the deterioration to complete loss of lower limb power would probably have not occurred in the absence of the Defendant's negligence. The hard, scientific evidence in the present case to contrary effect is compelling. Even if it could be shown that there was some movement of XXX's spine which complete spinal precautions would have avoided, such movement would not explain the deterioration that was sustained. The

sort of minor movements of XXX's body which conceivably might have occurred, and which comprehensive spinal precautions would have prevented, do not explain the loss of limb power. Furthermore, and in sharp contra-distinction from *Keefe*, there is here evidence which does explain the deterioration in limb condition. That is the evidence of Mr Mannion and Mr Thumbikat.

143. In those circumstances, *Keefe* does not avail the Claimant and her causation argument must be rejected. In those circumstances, this claim will be dismissed.

Quantum and Apportionment

144. It is unnecessary, for the purposes of this judgment, for me to go on and consider the subsidiary questions which would have arisen had I found both that the Defendant was in breach of duty and that that breach caused some injury or loss. In fact, the vast bulk of the evidence and the argument went only to breach of duty and causation. Quantum and apportionment received only the briefest of mentions in closing submissions.
145. In those circumstances, it would not be appropriate for me to provide a judgment on either topic. In outline, however, I would prefer the Claimant's approach to the quantification of the claim and the Defendant's to apportionment.
146. The schedule advanced by the Claimant in the contribution proceedings is agreed in part. It is agreed that the lump sum of £3 million, the NHS charges of £44, 056, the four periodical payments made to date and the costs of £555,000 would all fall within the sum subject to apportionment. The remaining elements of substance are future periodical payments.
147. As to these payments, it is common ground that there is no power in the courts to award periodical payments in contribution proceedings. Mr Counsell says that it would be unjust to assess the capital value of the future periodical payments based on the multiplier that would have been applicable if periodical payments had not been available in the personal injury proceedings. Mr Martin, in response, says that the assessment of the contribution is a matter generally within my discretion. Were this a matter on which this judgment would be determinative, I would invite further argument, and if necessary, evidence on this topic. For the present, I can do no more than express a provisional view that the appropriate course would be to adopt the multiplier dictated by the Lord Chancellor's direction as appropriate at the date the loss crystallised, namely the date of settlement.
148. As to apportionment, I see no possible basis, on the facts of this case, on which the case advanced in the Claimant's statement of claim, to the effect that the Hospital should pay the greater part of the total sum, could succeed. In fact, in closing argument, Mr Martin accepted as much.
149. It is common ground that if I was determining apportionment, I should have regard to the degree of relative blameworthiness and to the causative potency of the negligence of the Hospital on one hand and ZZZ on the other. In circumstances where I have concluded that the Hospital's error was of no causative significance, any attempt at that exercise cannot get to first base.

150. However, on any view of the evidence in this case, in my judgment, the degree of blameworthiness of a motorist who drives into the path of oncoming traffic on a busy road greatly exceeds that of busy nursing staff having to care for XXX, along with five other injured patients from that accident.

CONCLUSIONS

151. For the reasons set out above, this claim for contribution is dismissed. I will hear counsel on the necessary consequential orders.