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Case No: QB-2020-004128

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 31 March 2023

Before:

DEXTER DIAS KC
(sitting as a Deputy High Court Judge)

Between:

ANNE EDITH POWELL	<u>Claimant</u>
- and -	
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	<u>Defendant</u>

MS HEIDI KNIGHT (instructed by **Dale & Newbery, Solicitors**) for the **Claimant**
MR NEIL DAVY (instructed by **Hempsons LLP**) for the **Defendant**

Hearing dates: 17, 18, 19, 20 January 2023

Approved Judgment

This judgment was handed down remotely at 10.30am on 31 March 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

Dexter Dias KC :*(sitting as a Deputy High Court Judge)*

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2. It is delivered in 11 sections, as set out in the table below, to explain the court's line of reasoning.

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3. In this clinical negligence claim, Mrs Anne Powell, a woman now aged 65, was admitted into the Princess Royal Hospital in Hayward’s Heath, Sussex to have what is called “left revision total knee replacement”. She had a prosthesis – a metal implant – in her left knee that was causing her discomfort. The objective of the surgery was to put it right by replacing it. This was in November 2013 when she was 55. At some point, following surgical procedures she had between that November and the next June, an infection entered her body and could not be controlled. Her left leg had to be amputated above the knee in 2016. Mrs Powell is now largely confined to a wheelchair. She needs the help of her husband Colin just to have a bath. The impact on virtually every aspect of her life has been devastating. She says that this catastrophic result was caused by the negligence of Mr Sandeep Chauhan, a very experienced orthopaedic surgeon who performed surgical procedures on her in that period.
4. But was Mr Chauhan negligent? Did his negligence, if any, cause the injury and loss Mrs Powell undoubtedly suffered?
5. The specific negligence alleged is not a want of due care and skill in the surgical procedures themselves, but a lack of appropriate consenting. Put another way: Mrs Powell says that if she was advised as she should have been about the risks and limitations of the procedures Mr Chauhan offered her, and if she were informed of a reasonable alternative treatment, what is called “first stage

procedure” (the removal of the implant), she would have taken this option, and that would have eradicated any infection, and her leg would not have been lost.

6. Therefore, two issues sharply arise for the court’s determination: informed consent and causation. The onus rests on Mrs Powell to prove each of these issues to the requisite civil standard of a balance of probabilities. If she fails on either, her action fails. If she succeeds, parties have agreed the quantum of damages at £485,000. Thus, this is a liability-only trial.
7. Let me emphasise at the outset that we live in an age where informed consent and patient autonomy are given great priority. Quite properly. To “consent” a patient is not a mere technicality, a box-ticking exercise for insurance or compliance purposes. Instead, it goes to the heart of legally authorising the substantial and at times severe interference with the patient’s right to bodily integrity. The court takes such questions very seriously. It was put succinctly and starkly by Lord Steyn in *Chester v Afshar* [2004] UKHL 41 at [14]:

“Surgery performed without the informed consent of the patient is unlawful.”

8. For in our modern law, “medical paternalism” no longer rules (ibid. at [16]). This is what is at stake in this case. This ethos permeates modern medical practice. For example, in the General Medical Council’s latest guidance to medical practitioners (updated 9 November 2020), it states:

“Shared decision-making and consent are fundamental to good medical practice.”¹

Although patients lack specialist medical expertise themselves, they are the experts about what they would prefer. Save in certain emergency and exceptional situations, their right to bodily integrity can only be infringed with their clear and informed permission. They should be given the right information and the right advice about alternative treatments and risks, so they can properly choose. The determination of these issues is the exclusive focus of this judgment.

9. The parties to the action are Mrs Anne Edith Powell, the claimant, who has lived at all material times in Portslade on Sea, a community a little to the west of Brighton, where she lives with Mr Powell. She is represented by Ms Knight of counsel. The defendant is the University Hospitals Sussex NHS Foundation Trust, the employer of Mr Chauhan, who was for all relevant purposes Mrs Powell’s treating surgeon. He is an orthopaedic surgeon with very considerable experience in knee surgery. As Mr Chauhan puts it himself:

“I specialise solely in knee surgery. This has been my sole practice for the last 15 years and I have been the Lead Knee surgeon throughout this time.” (B52/§3)

¹ <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent> (accessed 2 February 2023).

The defendant is represented by Mr Davy of counsel.

10. The court is indebted to both counsel for their focused and effective conduct of this troubling and important case. There was much ground to cover. That the evidence was completed within the trial time allocated is in no small part attributable to the realistic and flexible conduct of the case by counsel and their responsible professional cooperation. It does them great credit.

§II. Brief chronology

11. To set the scene leading up to the events of January 2014 and their aftermath, I provide a brief tabulated chronology. I emphasise that I follow what the Court of Appeal said in *Re B (A Child) (Adequacy of Reasons)* [2022] EWCA Civ 407. McFarlane P stated at [58] that a judgment is “not a summing-up in which every possibly relevant piece of evidence must be mentioned” (Proposition (4)). Thus, I focus on what is important.
12. The documentation before the court included a trial bundle running to 445 pages, a bundle of medical notes extending to 2684 pages and full skeletons arguments from counsel both at the outset and conclusion of the trial. There was also a further reply from the defendant. The claimant chose not to exercise that equal right.
13. I must first explain some technical terms that will recur in the text:
 - **DAIR.** An acronym. A way of treating an infected wound. **Debridement:** treating wound by cleaning out and removing non-viable (necrotic) tissue. **Antibiotics:** targeted at bacterial organisms. **Irrigation:** washing out wound. **Retention:** retaining the implant.
 - **Two-stage revision** (knee replacement/surgery).
 - **First stage procedure:** removing the infected implant, washing out the joint, inserting spacer (cement, antibiotic-suffused).
 - Second stage procedure: antibiotic spacer removed, joint washed out, new implant inserted.
 - **“DAIR plus”.** A convenient shorthand adopted during trial. It denotes performing a DAIR and then the surgeon deciding whether to remove the implant during the surgery itself once more information becomes available intra-operatively.
14. Going back to the beginning, Mrs Powell first needed surgical intervention in 2005 following “a history of chronic pain in her left knee” (B53/§8, Chauhan). A selection of relevant dates includes the events below, organised in a table for ease of reference.

Date	Event
November 2003	Mrs Powell referred for orthopaedic opinion after 6-7 months' history of left knee pain and swelling.
2004	Mr Chauhan performs arthroscopy on Mrs Powell's knee.
April 2005	After experiencing continuing pain in her left knee, Mrs Powell underwent a partial left knee replacement (left Oxford unicompartmental knee replacement) performed by Mr Chauhan.
7 September 2005	Mrs Powell reviewed by Mr Chauhan who concluded she would need a two-stage revision "in all probability".
February 2006	This was converted to a total knee replacement, performed by Mr Chauhan. Her right knee was replaced on the same occasion, without further issues.
24 May 2012	The left knee prosthesis became loose. Mrs Powell was reviewed in clinic by Mr Chauhan, who advised that the implant required revision and replacement.
2013	
19 November	Mrs Powell was admitted to hospital where she underwent a left revision total knee replacement. A loose tibial base plate was found. She was discharged with a new knee replacement on 23 November 2013.
25 November	Mrs Powell attended her GP complaining of severe pain to left knee. Prescribed painkiller, Zomorph.
29 November 2 December 13 December	Mrs Powell further attended GP variously.
2014	

9 January	Mr Chauhan (and physiotherapist Rachel Hughes) review Mrs Powell at the fracture clinic. Mrs Powell stated that (the distal part of) her wound was becoming increasingly painful following the removal of sutures.
16 January	Readmitted and underwent DAIR performed by Mr Chauhan. No pus or necrotic tissue found (which would have been indicative of infection). Tissue samples taken. But not from canals.
19 January	Mr Karim (locum Senior House Officer) discussion with Dr Sierra, microbiologist on call. Microbiology results positive for <i>Staphylococcus aureus</i> in left knee.
21 January	Mr Chauhan reviews Mrs Powell. His note records “ <i>Staph</i> [meaning <i>aureus</i>] in left knee”.
22 January	Multidisciplinary Team meeting. Confirmation of polymicrobial infection in left knee. Bacterial organisms identified included <i>Staphylococcus aureus</i> (5/7 samples), but not <i>Staphylococcus epidermidis</i> . Referral to plastic surgeon. Referral form (compiled by ward doctors) records ““Consultant [Mr Chauhan] feels all metalwork needs to be removed.”
23 January	Mrs Powell reviewed by Ms Nugent, plastic surgeon.
28 January	Consent form completed by Ms Nugent. Further DAIR (DAIR number 2) supervised by Mr Chauhan, with wound closure with gastrocnemius muscle flap for calf and skin graft by Ms Nugent.
January-May.	Numerous courses of antibiotics.
8 May	Further consultation with Mr Chauhan. He wrote to Mrs Powell’s GP stating “her wound is not completely dry from her plastic surgical procedure.” Her left knee was swollen, painful and warm to touch.

15 May	Review by Mr Chauhan. Antibiotics discontinued.
22 May	Mr Chauhan reviews Mrs Powell. He notes generally wound healing well, but there was medial-sided knee swelling and Mrs Powell was slightly feverish. Mr Chauhan “would not be surprised” if an underlying joint infection existed. He arranged for blood samples and follow-up one week later.
29 May	Clinical appointment with Stuart Osborne, physiotherapist, who writes to GP that “wounds are improving, but [Mrs Powell] says over the last couple of weeks she has had some breakouts and some oozing around her lower calf scarring”. He notes she had come off antibiotics and “it does show that there is more infection going on in her leg.” Follow-up arranged.
6 June	Mrs Powell seen by Mr Osborne again. She had concerns about her left calf. Discharge from lower calf noted.
26 June	Exploratory surgery and knee washout performed by Mr Chauhan. No pus found. Polyethylene insert replaced. Six samples taken and sent for microbiology.
4 September	Mr Chauhan letter to GP, noting “Her wound is healing but she still continues to get excessive pain in the knee.”
3 October	First stage procedure of two-stage revision performed by Mr Chauhan. Prosthesis removed. Operation note records “infected joint, femoral bone loss, medial tibial bone loss.” Further antibiotics prescribed.
29 October	Discharge summary records “ <i>Staph epidermidis</i> was grown from 2 of the 8 samples from the operation.” The infection was identified in the canals.
2015	
8 January	Left knee biopsy.

June.	Left knee swollen again.
6 November	Left knee fusion (arthrodesis) performed by Mr Chauhan – joining together upper and lower bone in leg, femur and tibia. Mrs Powell could not cope.
2016	
16 November	Left leg amputation undertaken by Mr T Singh and Miss Harry, plastic surgeons.

15. I now turn to the legal principles that govern the facts of this case.

§III. Law

16. The law in its main dimensions is settled and uncontroversial between parties. Therefore, extensive citation from decided cases will assist not at all. However, a judgment is a public document, and the issues arising in this case are of legitimate public interest. Thus, the critical principles that inform the court’s judgment are set out in short order below. I consider four questions:

- a) Informed consent and the case of *Montgomery v Lanarkshire* [2015] UKSC 11;
- b) The negligence test for professionals in *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582;
- c) The “but for” test of causation;
- d) Thirteen (relevant) axioms of fact-finding.

(a) Informed consent and *Montgomery*

17. We live in an age where patient autonomy is taken very seriously. Gone are the days where we as patients are passive canvasses upon which medical practitioners develop and practice their skills. This principle was clarified with great vividness by the Supreme Court in *Montgomery*. Lord Kerr and Lord Reed, with whom the rest of the court agreed, stated at [87]:

“The correct position, in relation to the risks of injury involved in treatment, can now be seen to be substantially that adopted in *Sidaway* by Lord Scarman, and by Lord Woolf MR in *Pearce* [1999] PIQR P53, subject to the refinement made by the High Court of Australia in *Rogers v Whitaker* 175 CLR 479 which we have discussed at paras 70-73. An adult person of sound mind is entitled to decide which, if any, of the

available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."

18. Put another way, as Lord Bingham said in *Chester v Afshar* [UKHL] 41 at [1], was the patient "duly warned" of the risks (and limitations) that attended the surgery advised by the surgeon? Lord Bingham explained at [5] that the purpose of the duty was "to enable adult patients of sound mind to make for themselves decisions intimately affecting their own lives and bodies". If the surgeon does not inform the patient of the material risks and limitations and the reasonable alternative treatments, the medical practitioner is in breach of his or her common law duty of care.

(b) Negligence test for professionals: *Bolam*

19. In the modern world, we rely on the skill, experience and advice of professionals in many facets of our life. When things go wrong, how should the court judge whether the duty to use reasonable care has been breached? The test of negligence as far as it affects professionals was famously set out by McNair J in *Bolam*. It has come to be known as the "*Bolam test*". In those days, juries sat in negligence actions, and thus the oft-cited passage was in fact a direction of law to a jury. Shorn of the language of its time, it states:

"... [a medical practitioner] is not guilty of negligence if [she or he] has acted in accordance with a practice accepted as proper by a responsible body of medical [practitioners] skilled in that particular art. Putting it the other way round, a [medical practitioner] is not negligent, if [she or he] is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view..." (p.587)

20. The critical question was framed by McNair J as being whether the practitioner had:

"... fallen below a standard of practice recognised as proper by a competent reasonable body of opinion" (p.589)

21. Note that the "body" of reasonable or responsible practitioners is in the singular. What must follow from this? Applying the burden of proof, it is the claimant's task to prove that there is no responsible body of practitioners who would have done as the defendant had done. Failing that, even if the majority or a large majority of practitioners would have done otherwise, there is no negligence. This may appear a curious conclusion to many people. Its rationale lies fundamentally in the fact that very often these fields of professional specialism

involve great complexity and difficult judgements. If in a particular specialist niche, practitioners recognise that there are reasonable alternative treatments, a professional is not negligent because she or he advises or performs one preferred by the minority camp – so long as it is rationale and logical, as explained by Lord Browne-Wilkinson in *Bolitho v City and Hackney Health Authority* [1998] A.C. 232. Parties agree that there is no *Bolitho* question in this case.

22. Therefore, the focus of breach of duty (negligence) in this case is whether or not there is a responsible body of practitioners which would have acted as Mr Chauhan acted.

(c) Causation: “but for” test

23. Causation has been a frequently recurring and “troublesome” problem for the courts (*Cork v Kirby Maclean Ltd.* [1952] 2 All ER 402 (CA) at 406H, per Denning LJ (as then was)). In this case the applicable test is the simple “but for” test. It was stated in terms of medical negligence in *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428 (QBD). In that case, a man went to a hospital complaining of severe stomach pain. He was turned away by the doctor without examination. He later died of arsenic poisoning. While the defendant was in breach of breach of duty for not examining him, he would have died anyway due to the arsenic. He did not die but for the breach – the breach did not “cause” the injury. In *Cork v Kirby*, Denning LJ put it this way:

“If you can say that the damage would not have happened but for a particular fault, then that fault is the cause of the damage; but if you can say if it would have happened just the same, fault or no fault, the fault is not the cause of the damage.” (407B)

24. In some cases, this parsimonious and succinctly expressed test is too restrictive (*Fairchild v Glenhaven Funeral Services Ltd* [2002] UKHL 22 – especially in respect of mesothelioma claims following exposure to asbestos dust or fibres, where materially increasing the risk of injury becomes relevant). Other times, this test is too expansive (see Lord Bingham’s *SS Titanic* example in *Chester* at [8]). But here parties agree the but for test is precisely the right one.

(d) 13 axioms of fact-finding

25. This case involves fundamental disputes of facts between parties. Since they cannot agree, the court must step in and decide. There are numerous axioms of fact-finding, but here I identify those most pertinent to the determination of this case. There are 13 of them, starting from the most elementary, and borrowing from authority across jurisdictions, where relevant.

- (1) The burden of proof rests exclusively on the person making the claim (she or he who asserts must prove), who must prove the claim to the conventional civil standard of a balance of probabilities;
- (2) Findings of fact must be based on evidence, including inferences that can properly (fairly and safely) be drawn from the evidence, but not

mere speculation (*Re A (A child) (Fact Finding Hearing: Speculation)* [2011] EWCA Civ 12, per Munby LJ);

- (3) The court must survey the “wide canvas” of the evidence (*Re U, Re B (Serious injuries: Standard of Proof)* [2004] EWCA Civ 567 at [26] per Dame Elizabeth Butler-Sloss P (as then was)); the factual determination “must be based on all available materials” (*A County Council v A Mother and others* [2005] EWHC Fam. 31 at [44], per Ryder J (as then was));
- (4) Evidence must not be evaluated “in separate compartments” (*Re T* [2004] EWCA Civ 558 at [33], per Dame Elizabeth Butler-Sloss P), but must “consider each piece of evidence in the context of all the other evidence” (*Devon County Council v EB & Ors.* [2013] EWHC Fam. 968 at [57], per Baker J (as then was)); such “context” includes an assessment of (a) inherent coherence, (b) internal consistency, (c) historical consistency, (d) external consistency/validity – testing it against “known and probable facts” (*Natwest Markets Plc v Bilta (UK) Ltd* [2021] EWCA Civ 680 at [49], per Asplin, Andrews and Birss LJ, jointly), since it is prudent “to test [witnesses’] veracity by reference to the objective facts proved independently of their testimony, in particular by reference to the documents in the case” (*The Ocean Frost* [1985] 1 Lloyd’s Rep 1 at p.57, per Robert Goff LJ)²;
- (5) The process must be iterative, considering all the evidence recursively before reaching any final conclusion, but the court must start somewhere (*Re A (A Child)* [2022] EWCA Civ 1652 at [34], per Peter Jackson J (as then was)):

“... the judge had to start somewhere and that was how the case had been pleaded. However, it should be acknowledged that she could equally have taken the allegations in a different order, perhaps chronological. What mattered was that she sufficiently analysed the evidence overall and correlated the main elements with each other before coming to her final conclusion.”

- (6) The court must decide whether the fact to be proved happened or not. Fence-sitting is not permitted (*In re B* [2008] UKSC 35 at [32], per Lady Hale);
- (7) The law invokes a binary system of truth values (*In re B* at [2], per Lord Hoffmann):

“If a legal rule requires a fact to be proved (a “fact in issue”), a judge or jury must decide whether or not it

² *Ocean Frost* was a fraud case, but Mostyn J is surely correct that the principle of external verification must be “of general application” (*Lachaux v Lachaux* [2017] EWHC 385 (Fam) at [37]).

happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are 0 and 1. The fact either happened or it did not. If the tribunal is left in doubt, the doubt is resolved by a rule that one party or the other carries the burden of proof. If the party who bears the burden of proof fails to discharge it, a value of 0 is returned and the fact is treated as not having happened. If he does discharge it, a value of 1 is returned and the fact is treated as having happened.”

- (8) There are important and recognised limits on the reliability of human memory: (a) our memory is a notoriously imperfect and fallible recording device; (b) the more confident a witness appears does not necessarily translate to a correspondingly more accurate recollection; (c) the process of civil litigation subjects the memory to “powerful biases”, particularly where a witness has a “tie of loyalty” to a party (*Gestmin SCPS S.A. v Credit Suisse (UK) Ltd* EWHC 3560 (Comm) at [15]-[22], per Leggatt J (as then was)); and the court should be wary of “story-creep”, as memory fades and accounts are repeated over steadily elapsing time (*Lancashire County Council v C, M and F (Children – Fact-finding)* [2014] EWFC 3 at [9], per Peter Jackson J);³
- (9) The court “takes account of any inherent probability or improbability of an event having occurred as part of the natural process of reasoning” (*Re BR (Proof of Facts)* [2015] EWFC 41 at [7], per Peter Jackson J); “Common sense, not law, requires that ... regard should be had, to whatever extent appropriate, to inherent probabilities” (*In re B* at [15], per Lord Hoffmann);
- (10) Contemporary documents are “always of the utmost importance” (*Onassis v Vergottis* [1968] 2 Lloyd’s Rep. 403 at 431, per Lord Pearce),⁴ but in their absence, greater weight will be placed on inherent probability or improbability of witness’s accounts:

“It is necessary to bear in mind, however, that this is not one of those cases in which the accounts given by the witnesses can be tested by reference to a body of contemporaneous documents. As a result the judge was forced to rely heavily on his assessment of the witnesses and the inherent plausibility or implausibility of their accounts.” (*Jafari-Fini*

³ The *Gestmin* principles approved variously (but see next footnote), including *R (Bancoult No.3) v Secretary of State for Foreign and Commonwealth Affairs* [2018] UKSC 3 – see Lord Kerr at [103], where they were said to have “much to commend them”; however, the Court of Appeal subsequently stated that *Gestmin* is “not to be taken as laying down any general principle for the assessment of evidence ... [instead] It is one of a line of distinguished judicial observations that emphasise the fallibility of human memory” (*Kogan v Martin* [2019] EWCA Civ 1645 at [88-89], per Floyd LJ).

⁴ It must be remembered that *Onassis*, like *Gestmin*, was a dispute about recollection of business conversations, where typically there will commercial documentation. Ryder LJ sounds a necessary warning note about “simply harvesting obiter dicta expressed in one context and seeking to transplant them into another” (*Re B-M (Children: Findings of Fact)* [2021] EWCA Civ 1371 at [23]).

v Skillglass Ltd [2007] EWCA Civ 261 at [80], per Moore-Bick LJ);

And to same effect:

“Faced with documentary lacunae of this nature, the judge has little choice but to fall back on considerations such as the overall plausibility of the evidence” (*Natwest Markets* at [50]).

- (11) The judge can use findings or provisional findings affecting the credibility of a witness on one issue in respect of another (*Bank St Petersburg PJSC v Arkhangelsky* [2020] EWCA Civ 408).⁵
- (12) However, the court must be vigilant to avoid the fallacy that adverse credibility conclusions/findings on one issue are determinative of another and/or render the witness’s evidence worthless. They are simply relevant:

“If a court concludes that a witness has lied about a matter, it does not follow that he has lied about everything.” (*R v Lucas* [1981] QB 720, per Lord Lane CJ);

Similarly, Charles J:

“a conclusion that a person is lying or telling the truth about point A does not mean that he is lying or telling the truth about point B...” (*A Local Authority v K, D and L* [2005] EWHC 144 (Fam) at [28]).

What is necessary is (a) a self-direction about possible “innocent” reasons/explanations for the lies (if that they be); and (b) a recognition that a witness may lie about some things and yet be truthful “on the essentials ... the underlying realities” (*Re A (A Child) (No.2)* [2011] EWCA Civ 12 at [104], per Munby LJ).

- (13) Decisions should not be based “solely” on demeanour (*Re M (Children)* [2013] EWCA Civ 1147 at [12], per Macur LJ); but demeanour, fairly assessed in context, retains a place in the overall evaluation of credibility: see *Re B-M (Children: Findings of Fact)* [2021] EWCA Civ 1371, per Ryder LJ:

“a witness’s demeanour may offer important information to the court about what sort of a person the witness truly is, and consequently whether an account of past events or future

⁵ At [120], per Males LJ, “once other findings of dishonesty have been made against a party, or he is shown to have given dishonest evidence, the inherent improbability of his having acted dishonestly in the particular respect alleged may be much diminished and will need to be reassessed.” A dishonesty case, but I discern no valid reason a different kind of impairment to credibility, such as unreliability or inaccuracy, is not capable of the same approach. It is an application of the principle of judging evidence in the context of all other evidence.

intentions is likely to be reliable” (at [23]); so long as “due allowance [is] made for the pressures that may arise from the process of giving evidence” (at [25]).

But ultimately, demeanour alone is rarely likely to be decisive. Atkin LJ said it almost 100 years ago (*Societe d’Avances Commerciales (SA Egyptienne) v Merchants’ Marine Insurance Co (The “Palitana”*) (1924) 20 Ll. L. Rep. 140 at 152):

“... an ounce of intrinsic merit or demerit in the evidence, that is to say, the value of the comparison of evidence with known facts, is worth pounds of demeanour.”

26. I would finally add that I shall say more about the proper approach in law to the evaluation of conflicting expert evidence at §IX(b), so it comes immediately prior to my analysis of the microbiology expert dispute.
27. Having now outlined the chief governing legal principles, I turn to the issues arising in this case.

§IV. Issues

(a) Issues formulated by parties

28. Parties agreed a careful and comprehensive list of factual issues upon which findings were sought from the court. I set them out, as formulated by parties, save for insignificant textual editing.

Issue 1

Whether, prior to undergoing the procedure on 16 January 2014, it was mandatory to advise/inform the claimant:

- a. Of the alternative of undergoing a first stage of a two-stage procedure;
- b. That, if the infected prosthesis, cement and any necrotic material were not removed at that stage, it was unlikely that the procedure that was, in fact, carried out would successfully eradicate the deep infection;
- c. That there was a greater chance of success of eradicating the infection if she underwent the first stage of the two-stage procedure on 16 January 2014 rather than a DAIR procedure (the procedure which was in fact performed).

Issue 2

Whether prior to 16 January 2014 the Claimant was informed:

- a. that there was a significant risk that she had a deep infection of her left knee;

b. of the risk of recurrent or persistent infection and of the risk that if infection became established on the joint it would become more difficult to eradicate;

c. that it may be appropriate to remove the knee prosthesis in order to assist in the eradication of the infection depending on what was found during the procedure.

Issue 3

Whether, if the Claimant had been given the advice in 1 and/or 2 above (to the extent that it was not given), she would have opted for a first stage procedure on 16 January 2014.

Issue 4

Whether, prior to the procedure on 28 January 2014, it was mandatory to advise/inform the Claimant:

a. That, if the infected prosthesis, cement and any necrotic material were not removed at that stage, it was unlikely that the procedure that was, in fact, carried out would successfully eradicate the deep infection (it being accepted by the Defendant that the Claimant should have been advised that if a deep infection had already been present for more than around four weeks prior to the DAIR procedure on 16 January 2014, or if evidence of loosening of the implant or necrotic material around the implant was found during the procedure, then if the prosthesis, cement and any necrotic material were not removed, any deep infection was unlikely to be eradicated, but that this needed to be balanced against the risks and additional procedure involved in a two stage revision);

b. That there was a greater chance of success of eradicating the infection if she underwent the first stage of the two-stage procedure on 28 January 2014 rather than a DAIR procedure;

c. To undergo the first stage of a two-stage procedure as, without doing so, the chance of eradicating the infection was low.

Issue 5

Whether prior to 28 January 2014 the Claimant was informed:

a. That it was now known that there was a deep infection involving the prosthetic joint;

b. That the procedure which was in fact performed may need to be converted to the first stage of a two-stage procedure depending on what was found during surgery.

Issue 6

Whether, if the Claimant had been given the advice in 4 and/or 5 above (to the extent that it was not given), she would have opted for a first stage operation on 28 January 2014.

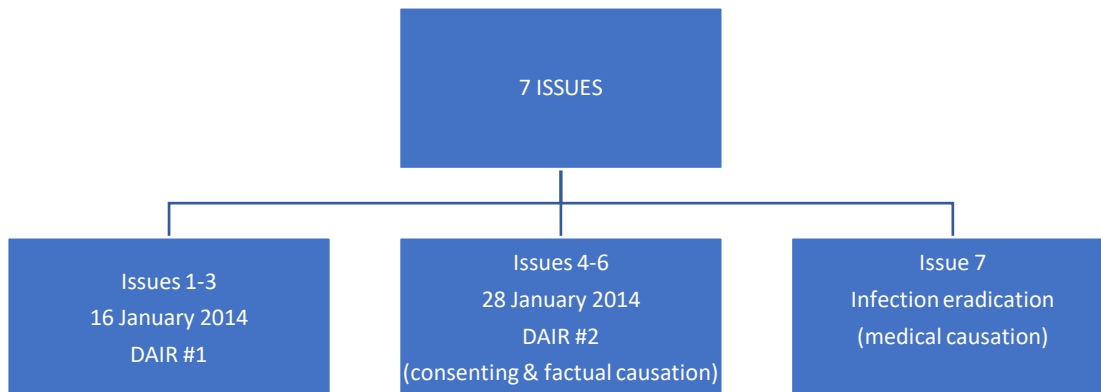
Issue 7

Whether the deep infection present at the time of the procedures on 16 and 28 January 2014 was successfully eradicated prior to the procedure on 26 June 2014.

29. I appreciate that there is a lot to consider. Thus, I simplify this ostensibly complex picture immediately below.

(b) *Introductory commentary*

30. To get a better grasp of the issues, it is useful to break them down into three subdivisions. Issues 1-3 relate to the 16 January (DAIR) procedure and the events leading up to it. Issues 4-6 similarly for the 28 January (second DAIR) procedure (factual causation). Issue 7 relates to the question of infection eradication (medical causation).



31. Let me say something about each of these groupings.

Issues 1-3

32. I explored with counsel the necessary logic of these questions posed to the court. Ms Knight agreed that if the claimant failed on Issue 1, the *Bolam* question about 16 January, she must fail on Issue 3, the but for/causation question. That is because she would have failed to prove that no responsible body of practitioners would have acted as Mr Chauhan acted (Issue 1). If so, the causation question falls away. But also note that the factual question about what Mrs Powell was actually told becomes irrelevant. Thus Issue 1 is the gateway to Issues 2 and 3. If that gate is shut, we move on to 28 January.

Issues 4-6

33. The defendant conceded Issues 4a. and 4b. This means the defendant accepts that it was mandatory (a) to advise Mrs Powell as at 28 January that without removing the implant the DAIR procedure was unlikely to eradicate infection in her knee and (b) there was a greater chance of eradication if she underwent first stage procedure.
34. Therefore, the remaining dispute was 4c – whether it was mandatory to advise first stage procedure as at 28 January 2014. The court actively monitored the viability of this matter as the expert evidence developed. Ms Knight undertook to review the matter and take further instructions.
35. Issue 5 poses an interesting question for the court. Since 4a. and 4b. are conceded by the defendant, it is accepted that Mr Chauhan was in breach of his duty of care. The question logically moves onto Issue 6 and the causation question of what Mrs Powell would have done if she had been informed, advised and consented as she should have been. Thus Issue 5 – what she was actually told – becomes irrelevant to that question, save that applying the maxim in *Arkhangelsky*, there is a potential relevance to questions of credibility. However, I judge that there is an important further matter. I discern a duty resting on the court to resolve important factual disputes between parties that have wider public implications where the evidence relied upon by both sides has been adduced and challenged fully at trial. Accordingly, it strikes me that there is a high public interest in knowing how this lady was in fact treated in circumstances where, as of 28 January 2014, the defendant *accepts* a breach of duty. I judge that there needs to be an independent authoritative public record of it. Mrs Powell's allegations about the inadequacies of her consenting by Mr Chauhan is a serious matter. Parties and the public are entitled to know what the court decides actually happened.

Issue 7

36. The question the court was asked to answer changed during the course of the trial. The pleadings, skeleton arguments and indeed the conduct of the first two days of the trial were on the basis that the infections in Mrs Powell's knee were not eradicated. These fell into two categories. First, virulent and high-grade infections such as *Staphylococcus aureus*, that were grown from the samples taken on 16 January. Second, *Staphylococcus epidermidis*, that was first identified from the sample taken on 3 October 2014. The claimant's case was that *Staphylococcus epidermidis* was always there, as were the other pathogens. Since the DAIR procedure had a low chance of eradicating them, it is likely that it did not. These infections that could have been eradicated by first stage procedure in January 2014 then ultimately caused the loss of Mrs Powell's leg.
37. However, at the outset of Day 3 of the trial, Ms Knight conceded that the sole basis for maintaining infection causation was that *Staphylococcus epidermidis* existed in Mrs Powell's knee in January 2014 (albeit undetected then, existing in the untested canals). The case now advanced was that it was *this* infection that persisted right through until October 2014. This infection materially contributed to the loss Mrs Powell suffered. The claimant's new position entails that she concedes that the (highly virulent) organisms identified in January, *were in fact eradicated* by the DAIR procedure or procedures in that month.

38. This concession is important. It simplifies Issue 7. The dispute becomes exclusively focused on *Staphylococcus epidermidis*. It remains hotly contested.
39. It should be noted that parties agree that the causation questions are critical. If the claimant proves that a responsible body of medical practitioners would have offered Mrs Powell first stage procedure, she must further prove that she *would* have chosen first stage procedure or her claim fails. Her claim would fail because (a) she would have chosen and consented to the procedure that actually took place (DAIR plus), and therefore (b) the chain of causation from any breach of duty in consenting is broken. Put another way: proper consenting would have made no difference to outcome – in Denning LJ’s terms, it would have happened just the same.
40. Further, even if she succeeds in proving that she would have chosen first stage procedure, she must also prove that the *Staphylococcus epidermidis* infection found in October 2014 was present at the latest at 28 January 2014. That is because it is accepted by the defendant that the consenting at 28 January was in breach of duty. In such circumstances, there would be a causal link between the “negligence” (breach of duty) and the ultimate loss, her left leg amputation through infection.

§V. Assessment of witnesses

41. I outline here my overview of the evidence of the two principal protagonists in this case, the claimant Mrs Powell and her surgeon Mr Chauhan. The specific points that lead to these conclusions follow in the analysis sections of the text where they are dealt with in context.
42. I will later address the four experts who testified, two orthopaedic experts and two expert microbiologists.
- **Orthopaedics:** Mr Donnachie (instructed by claimant); Mr Sherman (D);
 - **Microbiology:** Dr Rothburn (C); Professor Masterton (D).

(a) Mrs Anne Powell

43. I found Mrs Powell to be a lady with a good grasp of what was happening and was able to provide counsel with detail when asked. Due to her disability, I arranged for her to give evidence from her wheelchair in the well of the court and ensured she could have regular breaks to make her comfortable. By and large, she stoically carried on. To me she seemed completely switched on and not daunted by court proceedings. She very fairly accepted that she had by 2013 built up a lot of trust in Mr Chauhan, who had treated her knee by then for almost ten years. She also accepted that she could not clearly remember all the details of the advice and options he gave her before various procedures because they were almost a decade before.

44. She was well able to stand up for herself. She was able to speak across counsel and contradict him. I accept entirely that she is an honest person, but her recollection at certain key points was found wanting, as I shall explain.

(b) Mr Sandeep Chauhan

45. Sandeep Chauhan is a quietly spoken and very courteous professional who showed no signs of revelling in his elevated status or the importance of his post. He comes across as modest and a successful professional without bombast. The essential question the court had to consider about him and his treatment of Mrs Powell is whether he properly consented her. I found that he lacked reflection on what had happened to his patient, particularly given the accepted deficiencies in his consenting of her (concessions on Issues 4a. and 4b.). That said, I found him to be an honest witness. When evidence in key respects conflicted with Mrs Powell's, I found that his account often had independent support. That strengthened my assessment of his reliability.

ANALYSIS PART ONE:

Issues capable of immediate resolution (1-4)

§VI. Issues 1-4

46. Having reviewed the evidence and taken instructions, Ms Knight confirmed the claimant's position in her (closing) written submissions (Cla/§1.3):

“The Claimant accepts that the allegations set out in **Issue 1** in relation to 16th January 2014 procedure cannot be sustained in light of the expert evidence and no longer therefore fall to be considered by the Court. It is further accepted that, in light of this, **Issue 3** also does not fall to be considered and that **Issue 2** is effectively now academic.”

47. This development was a consequence of the increasing convergence of the expert orthopaedic opinion as the trial proceeded. It was agreed that as at 16 January 2014, it was not mandatory to inform/advise Mrs Powell about first stage procedure as an option. That was because the suspected infection in her knee had not yet been confirmed and a body of reasonable and responsible body of practitioners would have proceeded exactly as Mr Chauhan did. Thus, Issue 1 falls way and therefore so as a matter of logical necessity does Issue 3.
48. As to Issue 2, I do not consider it proportionate to decide the factual dispute between parties about what Mr Chauhan actually advised Mrs Powell as at 16 January. It is different from the dispute on Issue 5, the consenting as at 28 January. In respect of that, there have been significant concessions about breach of duty by the defendant. Issues 4a. and 4b. (about 28 January consenting) are not now in dispute, the defendant having conceded them (see above for the implications of this).
49. As indicated, Ms Knight reflected on whether 4c. would be maintained in light of the expert evidence as it evolved at trial. I am bound to say I found it hard to see how 4c. could survive the expert evidence. In post-trial submissions, Ms

Knight conceded 4c. Thus, the claimant accepts that it was not mandatory to advise that first stage procedure should be undertaken at 28 January 2014 – first stage procedure was not the only surgical procedure that should have been performed at that point. It matters not at all whether Mr Donnachie or Mr Sherman would have advised first stage procedure. It is irrelevant how big or small the rival camps of practitioners might be advising first stage procedure as opposed to DAIR plus. All that matters is whether there is a responsible body of practitioners that would have advised DAIR plus. There is. That is the end of 4c.

50. I can therefore move on to the heart of the case, the disputes around Issues 5-7.

ANALYSIS PART TWO:

The Burning Issues (5-7)

§VII. Issue 5: information/advice as at 28 January 2014

51. There are two factual disputes between parties on this issue about the information and advice provided to Mrs Powell by Mr Chauhan as at 28 January 2014. I accept the submission of Mr Davy (Defupp/§3) that the factual questions contained within Issue 5 do not need to be determined for the court to decide the critical questions at Issues 6 and 7. That much is obvious. But that is not the end of the matter. I judge that it is a matter of public interest for the court, having received both written and oral evidence about this question, to make a finding about it in the context of the defendant accepting a breach of duty as at 28 January 2014. This is not a minor or trivial matter. It cannot be relegated to a forensic footnote. Instead, it is about the level of care and attention a member of the public has received from a senior medical practitioner. It is deserving of an answer.

52. The two factual disputes are:

- **Question 1:** whether Mr Chauhan told Mrs Powell there was a deep infection involving the prosthesis joint;
- **Question 2:** whether Mr Chauhan told Mrs Powell that the DAIR procedure he intended to perform might be converted to the first stage of a two-stage revision procedure depending on what was found during the procedure.

53. By the end of her testimony, Mrs Powell accepted that she could not remember precisely what Mr Chauhan told her because it was “now nine years later”. That is not in the slightest a criticism of her. It is a function of the imperfect working of memory (*Gestmin*), the effects of the passage of time and the fact that Mrs Powell has had a lot to contend with. Further, she was speaking with Mr Chauhan when she was not in perfect physical health. She said that she “had a lot going on”: she had had three children, her mother had died and she had remarried. She found it very hard to put time and place together to remember details of what had been said, especially given all the procedures she had

undergone. Therefore, she accepted by the end of her cross-examination that “the risks may have been discussed with Mr Chauhan and they may not have been, but I can’t now remember”. Her evidence taken as a whole provides no solid basis for Mrs Powell to prove as probably true (as she must) the two facts on this issue.

(a) Findings of fact

54. Having listened to both the witnesses carefully, I have reached the following findings of fact about what happened at the key moments between them. In this, I also add what Ms Nugent, the plastic surgeon, told Mrs Powell.

9 January 2014 consultation

55. Mr Chauhan accepts that only one treatment was discussed at this meeting: DAIR plus an assessment of explantation inter-operatively (DAIR plus). Thus, first stage procedure was not discussed. He also stated that this consultation was the first element of a consenting process that would be completed in the hospital before the surgery. He accepted (D2/194) that the letter of Rachel Hughes was insufficient to record this part of the consenting process.
56. I find, therefore, that the first stage of the consenting process was insufficiently recorded on 9 January.

16 January consenting

57. The only record of what was discussed about consenting was the consent form (S108). Mr Chauhan accepts that it was in its material respects illegible. Further, he agreed that if what was written on the form at the sections on proposed procedure and risks was read out to Mrs Powell, she would not understand what it meant without explanation. This would be an inadequate way to proceed. In *Montgomery*, the Supreme Court has made clear the necessity of explaining the medical position without technicality and in a way the patient can understand. Failing this, the consent cannot meaningfully be described as informed. Lord Reed said at [90]:

" ... the doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible. The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form."

58. It was put succinctly in *Thefaut v Johnston* [2017] EWHC 497 (QB) at [59] by Green J (as then was) as “the need to de-jargonise communications to ensure that the message is conveyed in a comprehensible manner.” The form would not come close to doing the job. Mrs Powell’s case on this point is

that she was not told that removal of the prosthesis was an option at this juncture. I do not accept her evidence about this. I prefer Mr Chauhan's evidence that she was told that removal of the metalwork if clinically indicated was an option. The reason is that I find it implausible that Mrs Powell could come out of the surgery to find that the implant had been removed from her knee without her knowledge or consent. The improbabilities are important (*Jafari-Fini; Natwest Markets*).

59. Therefore, I find that Mrs Powell was told before the surgery on 16 January that the implant may be removed. She consented to that, if it proved necessary. However, there is no adequate record by this point to indicate that this was what she was told and what she consented to. In this there was a failure in adequate documentation of the consenting.

21 January consultation

60. Once more, there was no mention of first stage procedure being an option for the next procedure. There was no advice about the relative risks of first stage procedure compared to DAIR in terms of infection eradication. Instead, only DAIR with possible explantation (DAIR plus) was mentioned to Mrs Powell. At this point Mr Chauhan's "initial thinking" as he put it, was that the next procedure should be the first stage of the two-stage procedure – implant removal. But he did not tell her this was his thinking. That this was how he thought about her case is confirmed by the plastic surgery referral form dated the next day, 22 January. It was compiled by the ward doctors. They transcribe the relevant notes. It is recorded there that the 'Consultant feels all metalwork needs to be removed'.
61. Therefore, I find that at the consultation on 21 January, Mr Chauhan failed to properly consent Mrs Powell in not telling her about first stage procedure being an option as an alternative to DAIR plus. This is particularly puzzling because at this point his "thinking" was that the next procedure would involve prosthesis explantation, subject to further information.

23 January

62. Ms Nora Nugent, a consultant plastic surgeon, met Mrs Powell at the request of the orthopaedic team. Their meeting happened on ward at the Princess Royal Hospital, Haywards Heath at 19.30 hours. Ms Nugent's statement is not subject to challenge; she has not been asked to give evidence. Thus, its contents can be taken by the court as being factually accurate. At §12 (B105), Ms Nugent states:

"I considered that the Claimant required a gastrocnemius flap and a split skin graft after knee washout. There was also a possibility that the Claimant would require removal of the implant and I relayed this to the Claimant, but that was a decision to be made by Mr Chauhan / orthopaedic team."

63. At §15, Ms Nugent continues:

“The Claimant was informed (and I understand she had a separate discussion with Mr Chauhan) that the orthopaedic team would make a decision regarding the knee joint/joint replacement and whether it would be retained or removed. She was informed that removal of the knee prosthesis could be done at this procedure, but it would be a decision made by the orthopaedic team and not by myself. A provisional date of Tuesday 28.01.14 was mentioned for this procedure.”

64. I emphasise that I do not place weight on the bracketed words and what Ms Nugent “understood” about any discussions between Mrs Powell and Mr Chauhan – that is irrelevant. Yet Mrs Powell states that the possible removal of the implant was not discussed with her – by anyone. Ms Nugent’s evidence demonstrates that clearly Mrs Powell was wrong and an unreliable historian. The next point is that Mrs Powell insisted that no one alerted her to the risk of infection or that she had a confirmed infection. On this, Ms Nugent states at §17:

“I advised the Claimant of the risk of recurrent infection and of the potential need for further debridements. This was advised due to the risk of persistent infection and the Claimant’s comorbidities that affected wound healing and resolution of infection. These include diabetes, obesity, poor mobility, recurrent cellulitis in her legs, smoking, and previous postoperative problems.”

65. Again, Mrs Powell was wrong. The unchallenged evidence of Ms Nugent illustrates that vividly.

28 January

66. Prior to the surgical procedure on 28 January, Mrs Powell was given no new information. There is nothing in the records to explain why Mr Chauhan changed his thinking from first stage procedure (21 January) to DAIR plus a week later (28 January).
67. Thus, I find that on 28 January, the consenting process was insufficient as Mrs Powell was not informed of the option of first stage procedure nor of the different probabilities of infection eradication between them. Further, the medical records are inadequate to document how and why Mr Chauhan changed his clinical judgment within a week from first stage procedure to DAIR plus. However, I also find that if Mr Chauhan had done what he should have done and presented the two reasonable alternative treatments to Mrs Powell – first stage procedure and DAIR plus – he would have advised her that the best option for her would be the DAIR plus. Further, I find that this would have been rational advice for him to have given, supported by a reasonable body of competent practitioners.

(b) Answering the two Issue 5 questions

Question 1 - infection

68. There is a fundamental dispute between Mrs Powell and Mr Chauhan about what he told her prior to the 28 January procedure. Mr Chauhan states that he told her in terms that it was now established that there was an infection in her knee. Mrs Powell states that he said nothing of the sort. There is a clinical note dated 21 January 2014. It makes no reference to any information Mr Chauhan passed on to Mrs Powell. Thus, there is nothing in the records to support Mr Chauhan's account. But when I examine the evidence of Ms Nugent, it shows that about critical questions – possible implant removal, discussions about infection – Mrs Powell was wrong in her recollection. I cannot place much weight on Mrs Powell's account on these points. Indeed, by the end of her testimony she agreed, very fairly, that she could not remember what she was told or not told on which occasion. That is completely understandable. I cannot agree with Mr Davy that the resolution of the factual dispute between Mrs Powell and Mr Chauhan rests on whether the court "prefers the evidence of the Claimant or Mr Chauhan" (DefSupp/3a). Evidence must be looked at in context and not in separate compartments (*Re T; Devon County Council*). I judge the conflicting accounts of Mr Chauhan and Mrs Powell along with the undisputed evidence of Ms Nugent ("testing against known facts", *Natwest Markets*) and the canons of probability (*Jafari-Fini*). The factual errors Mrs Powell has made on Issue 5 reduces the weight I place on her evidence on similar disputed matters (*Arkhangelsky*). I then combine this with her concession that she was not sure what she in fact was told. I conclude that she has not proved the allegation she seeks to make against Mr Chauhan that she was not told about infection. I find Question 1 not proved.

Question 2 – possible explanation

69. For similar reasons, I am unable to place any or any sufficient weight on the evidence of Mrs Powell about the possible removal of the implant. I find it implausible (improbable in *Jafari-Fini* terms) that Mrs Powell may have gone into the procedure on 28 January and come round from the anaesthetic without the implant in her left knee when she had no idea whatsoever that this may be a possible outcome of the procedure. It is proved as a matter of fact that Ms Nugent told her about this exact possibility. It is inconceivable that this would not have been discussed with her surgeon. Even if, which I do not accept, Mr Chauhan said nothing to her about it in the first instance, as soon as Ms Nugent told Mrs Powell that explanation may happen, it is highly improbable that Mrs Powell would not have discussed this with Mr Chauhan.
70. Thus, I also find Question 2 not proved.

(c) Further findings on consenting

71. However, it would be remiss not to say something more about the consenting process. By the end of Mr Chauhan's testimony, it was clear that at no stage had he informed Mrs Powell about one of the reasonable alternative treatments for her – first stage procedure. He accepted that he should have done so. The court gave him the opportunity to reflect on what had happened and the fact that Mrs Powell had been deprived of the chance to choose a reasonable and legitimate alternative treatment. I found his answer unsatisfactory. He stated that he believed that he had given her the "correct treatment". There was no

reflection upon the fact that in this age of patient autonomy and choice, he had deprived Mrs Powell of the opportunity of considering what the experts agreed was one of the reasonable alternatives.

72. Mr Chauhan undoubtedly breached his duty in his consenting of Anne Powell. I find that insufficient priority was given by Mr Chauhan to ensuring that Mrs Powell was told of the viable options; not enough care was directed at ensuring she was provided with the necessary clinical choices. Her right to choose was not sufficiently respected in this respect. It was a failure.
73. His position was that she was given the “option” of DAIR with a surgical decision whether to remove the prosthesis on assessment during the operation. But that is a misnomer. It was not an “option”. No option was given to Mrs Powell. Instead, DAIR was presented to her as a *fait accompli*. The only variation in treatment would be whether it became necessary to remove the implant.
74. However, the failure went further. What was significant about the distinction between first stage procedure and DAIR for her was that with first stage procedure there was a significantly greater chance of eradicating the infection deep in her knee. I have found that Mr Chauhan did tell Mrs Powell about the infection. But he did not go on to tell her of an alternative treatment that the majority of surgeons would have advised, and which would have all but certainly eliminated the infection. None of this is to say, I emphasise, that when Mr Chauhan did perform a second DAIR that this was negligent. The expert evidence, as we shall see, does not support that: there is a responsible (reasonable) body of competent surgeons that would have undertaken a second DAIR on 28 January 2014. Mr Chauhan is among them. But Mrs Powell was given no choice between DAIR plus and first stage procedure. She should have been and was not.

§VIII. Issue 6:

what the claimant would have done if appropriately advised

75. I now analyse the first causation question – factual causation.
76. I emphasise that although a judgment is delivered in linear fashion, the critical analysis that underpins is a recursive activity. In particular, I have looked at all the evidence together and not in sanitised forensic silos (*Re T*). I have found that in important ways Mrs Powell was not a reliable historian on Issue 5 (her testimony was found wanting when tested against the known facts from Ms Nugent’s evidence (*Natwest Markets*)). This factual unreliability is not restricted to Issue 5 (*Arkhangelsky*), and this is put in the balance in my consideration of Issue 6, which I now examine in detail.
77. Issue 6 is unquestionably one of the cardinal questions in the trial.
78. This causation question turns on what Mrs Powell would have done if she had been properly *informed* about the reasonable alternative treatments open to her as at 28 January and properly *advised* by Mr Chauhan about what he believed

would give her the best outcome. The starting-point is what Mrs Powell says in her filed statement. She stated (B39):

“26. The discussions I had with the Consultant on both these occasions were very brief and lasted a few minutes only. I was not advised that, if the infected prosthesis, cement and necrotic material were not removed at that stage, it was unlikely that the procedures proposed would eradicate the deep infection to my left knee. Furthermore, I was not advised to undergo the first stage of the two-stage procedure on either of these occasions.

27. I wish to make it clear that, had I been so advised, even though the treatment involved would have been more complicated and I would have been in hospital for much longer with an extensive recovery period, it is likely I would have undergone the first stage of the two-stage procedure at that stage.”

79. Mr Chauhan only ever presented her with one possible treatment, that being DAIR plus. He believed as at 28 January 2014 that was the best surgical treatment for her. Thus, I have no doubt if he had laid out the two reasonable alternative treatments, he would nevertheless have stuck to his guns and advised her that DAIR plus was best for her. That obvious conclusion is reinforced by his trial testimony that if he had undertaken that exercise, he would have advised her to opt for DAIR plus and he to this day believes it was the “correct treatment”.
80. One must also consider the evidence Mrs Powell gave during the course of her own testimony. Inevitably, this critical question was canvassed while she was in the witness box. She gave two material answers about the issue. I set them both out.

Answer 1

She was asked by her counsel what she would have done if Mr Chauhan had presented her with the two alternatives of first stage procedure and DAIR plus. She said, “If I had been advised about those things I would have thought: if the implant had been removed I would have more chance of the infection being totally eradicated. With a two-stage procedure I’d open myself up to more risk. I wouldn’t know how I’d react.”

Answer 2

She was given an opportunity by the court to clarify her answer. Once more, she was asked what she would have done if Mr Chauhan had presented the two choices of first stage procedure and DAIR plus prior to the procedure on 28 January. She said that if Mr Chauhan had said, “Look, Anne, I think the best thing to do “this” (being one of the two treatment alternatives)” her response was, “I think 50-50 I would have followed his advice”.

81. To this we must add the attitude of Mrs Powell towards Mr Chauhan’s advice. Their doctor-patient relationship stretched back many years.

- In 2004 Mr Chauhan performed an arthroscopy on her knee. Her daughter was a nurse working in Mr Chauhan's clinic;
 - In April 2005 he performed a partial knee replacement on Mrs Powell;
 - In February 2006 she had total knee replacements, in fact on both knees, performed by Mr Chauhan;
 - In November 2013 he performed another replacement in the left knee.
82. Therefore, by the time we arrive at January 2014, Mr Chauhan had performed four surgical procedures on Mrs Powell. She had accepted his professional advice every time over that decade. She had not once gone against it. During that time, they developed doctor-patient relationship and she liked him. He called her Anne. She had, as she accepted, "built up a lot of trust" in him.
83. She said that she would in the past talk through Mr Chauhan's advice with her husband and at least some of her children, but as she put it, "generally" she would go with his advice. In fact, the historical record shows that at no previous point had she not followed his advice. Frankly, it is unsurprising that Mrs Powell gave the answers she did. The claimant's orthopaedic expert Mr Donnachie states that the decision about whether to choose a first stage procedure or a DAIR or DAIR plus is a very complex decision even for surgeons. This is supported by the existence of two schools of reasonable and responsible medical opinion on the question. Thus, it is completely understandable that Mrs Powell "wouldn't know what she would have done". Further, given that she has followed Mr Chauhan's advice uniformly and unreservedly up to January 2014 for a decade in multiple procedures, her answer of "50-50" following his advice is if anything an understatement of what would have been likely to have happened. When she turned her mind to it in the witness box and grappled with the respective risks of less of a chance of eradicating infection as against the risk of exposure to generic risk in what was likely to be two substantial surgical procedures, it is entirely predictable that she would not know what to do.
84. I find that her sworn testimony is far closer to the truth than what was stated in her written statement. As indicated, I found that she was not a reliable historian in respect of Issue 5. That must be weighed in the balance, but I emphasise that I do not place great weight on it against Mrs Powell: it is possible that she was wrong in respect of Ms Nugent (Issue 5, generally), but correct on Issue 6. The precept of Mr Justice Charles makes that clear (*A Local Authority v K, D, L*). My approach is that Mrs Powell's narrative error about Issue 5 makes it more marginally more likely that she is wrong about Issue 6. It certainly is not determinative of it.
85. Of course, and I remind myself, Mrs Powell must prove on the balance of probabilities that she would have chosen first stage procedure instead of DAIR plus. I will come to my conclusion about that shortly, but review the relevant factors first.

- (1) She would have given weight to the fact that the chance of infection eradication at 28 January was less than 50 per cent, but was not negligible;
 - (2) She would have given weight to the other and several risks that first stage procedure introduces as it is a “greater” surgical intervention;
 - (3) She would have given weight to the fact that first stage procedure almost inevitably entails second stage procedure;
 - (4) She would have given weight to the fact that second stage procedure carries the risk of introducing further infection;
 - (5) I find that it is part of the legitimate role of a surgeon to guide the patient with her or his opinion about the two mainstream options available as at 28 January, in what was a complex and difficult decision, even for surgeons;
 - (6) I find that Mrs Powell was likely to have been strongly influenced or ‘guided’ by the advice and guidance of the Mr Chauhan in that complex decision;
 - (7) I find that Mr Chauhan’s advice would have carried particular weight for her in respect of that particular decision because it was such a complex surgical problem;
 - (8) I find that she would also be likely to follow his advice because she always previously had done so and she had by that point built up a lot of trust in his clinical judgment and advice;
 - (9) As at 28 January, I find that Mr Chauhan’s advice would have been to opt for a second DAIR with the proviso that should he judge first stage procedure necessary (depending on intra-operative findings), he would proceed with that;
 - (10) I find that compared to choosing to reject her surgeon’s advice and insisting on first stage procedure contrary to his advice, it is far more likely that Mrs Powell would have wanted her treating surgeon to assess the situation once he had a far clearer picture of the prevailing situation during the procedure.
86. Therefore, I find it improbable that Mrs Powell would have rejected her surgeon’s advice to opt for DAIR plus and instead would have insisted on first stage procedure no matter what was found. What this comes to is that if the breach of duty had not occurred, and Mrs Powell had been informed properly about what her options were, it would not have made any difference to what actually happened (the result would have been just the same).
87. That is because I find that she has not proved on a balance of probabilities that she would have chosen first stage procedure. In fact, in my judgment, it is significantly more likely that she would have followed the advice of Mr Chauhan to have a second DAIR with the first stage procedure assessment

proviso, even if she had been advised of the less than 50 per cent chance of infection eradication with DAIR and the greater chance with first stage procedure (eradication likely). That is because there are a number of other serious risks attending first stage procedure and second stage procedure and she would have been guided by Mr Chauhan about what was best for her.

88. Therefore, the second DAIR would have gone ahead with her consent and Mr Chauhan would have assessed during the course of the operation whether to perform first stage procedure. This is precisely what happened. On 28 January a second DAIR was performed under Mr Chauhan's supervision. Mr Chauhan did not find that first stage procedure was indicated as the knee cavity "generally was clean around the prosthesis". Thus the knee was washed out and then the wound closed with plastic surgery by Ms Nugent. I find that this is precisely what would have happened if Mrs Powell had been properly informed, advised and thus consented.
89. As such, I find that the breach of duty involving the 28 January procedure did not cause loss and damage. The necessary consequence is that the claim fails for lack of causal connection.

§IX. Issue 7:

whether *Staphylococcus epidermidis* infection existed in January 2014

(a) Introduction to Issue 7

90. Issue 7 is about medical causation.
91. Parties advance rival and incompatible scenarios. Their significance is that they reach opposite and irreconcilable conclusions on the origin of the medical cause of the infection that led to the amputation of Mrs Powell's leg. Each claims a different date of introduction of the *Staphylococcus epidermidis* found in Mrs Powell's knee in October 2014. They are:
- **January (claimant) scenario:** *Staphylococcus epidermidis* introduced by 28 January 2014 and remained in body until identified in October.
 - **June (defendant) scenario:** *Staphylococcus epidermidis* introduced after 28 January (and possibly in June 2014) and identified in October.
92. The burden and standard of proof require the question to be posed in this way: has the claimant proved that the January scenario is probably true?
93. The common ground between parties is as follows:
- a. Polymicrobial infection (as distinct from *Staphylococcus epidermidis*) was introduced at or following the procedure in November 2013;

- b. If there had been first stage procedure on either of the two surgical procedures in January (16th and 28th), infection, whether polymicrobial or *Staphylococcus epidermidis* or both, would have been eradicated;
- c. There is no determinative factor or any determinative combination of factors indicating either January or June *Staphylococcus epidermidis* infection;
- d. *Staphylococcus epidermidis* biofilm forms after about four weeks and will continue to progress following introduction;
- e. The infection tends to form around the inanimate parts of the prosthesis;
- f. *Staphylococcus epidermidis* can cause a low grade infection;
- g. *Staphylococcus epidermidis* can present as a delayed onset infection;
- h. A delayed or low-grade infection is more likely to be acquired during implant surgery compared to the biopsy (June-type) procedure;
- i. Any *Staphylococcus epidermidis* introduced at or following the November procedure is unlikely to have been eradicated with the antibiotics used. (This is because antibiotics are targeted against specific pathogenic organisms and *Staphylococcus epidermidis* was not identified until October 2014. Thus, no antibiotics relevant to *Staphylococcus epidermidis* were given to Mrs Powell before then.)

(b) Approach to conflicting expert evidence

94. On the microbiology, there is a fundamental dispute between the experts instructed by parties. The proper legal approach to such evidential conflicts has been identified by the court in several cases. In *Flannery v Halifax Estate Agencies Ltd* [2000] 1 WLR 377, Henry LJ said:
- “where the dispute involves something in the nature of an intellectual exchange, with reasons and analysis advanced on either side, the judge must enter into the issues canvassed before him and explain why he prefers one case over the other. This is likely to apply particularly in litigation where as here there is disputed expert evidence” (proposition 3)
95. This approach was affirmed in *English v Emery Reimbold & Strick Ltd* [2002] EWCA Civ 605. Further guidance was provided by Lord Phillips MR at [19]:
- “This does not mean that every factor which weighed with the judge in his appraisal of the evidence has to be identified and explained. But the issues the resolution of which were vital to the judge's conclusion should be identified and the manner in which he resolved them explained. It is not possible to provide a template for this process.”
96. This is the approach I adopt in evaluating the expert dispute on infection and microbiology in this case: engaging with the issues of expert disputation and

identifying the factors I found “vital” to my preference for one scenario as opposed to the other – my conclusion.

(c) Assessment of experts

97. Mr Donnachie, instructed on behalf of the claimant, gave evidence that had two essential components: orthopaedic management/consenting and then infection. I found Mr Donnachie to be an affable and engaging expert. I had no doubts at any point that he was being anything other than honest, and expressing his genuinely held professional conclusions. Very occasionally he did not answer the question posed directly or in the most succinct way. I put this down to his obvious enthusiasm to share his expertise rather than the evasion of the question.
98. On orthopaedic management and consenting, I found his evidence to be helpful and frank. Indeed, he gave evidence on oath that fundamentally and fatally undermined the claimant’s case in respect of Issue 4c. His evidence about Issue 1 and January 16 was also very candid and again resulted in significant forensic damage to the claimant’s case on this topic. It is a testament to his professionalism that he gave this evidence notwithstanding its impact on the case of the party that instructed him.
99. But where I found his evidence less persuasive was in respect of certain aspects of the infection persistence question (Issue 7). He professed to have expertise in the questions of microbiology and infection, having “liaised with microbiologists for 24 years” in the course of his orthopaedic practice and having encountered infection “very regularly”. Nevertheless, microbiology is not his prime specialism, being one of the collateral problems recurring from his surgical practice. That secondary focus was evident in his testimony around infection. I found that at times his evidence was inconsistent and not well thought through. This was all the more vivid when so rapidly contrasted with his more authoritative evidence about orthopaedics.
100. I found his answers on infection lacked authority, and were hesitant and unpersuasive when compared to, for example, Professor Robert Masterton, microbiology expert instructed on behalf of the defendant. To give but one example, he tried to say that Mrs Powell was on antibiotics and that may suppress the *Staphylococcus epidermidis*. But he failed to understand that the antibiotics administered were agreed to have no efficacy on this particular organism. This caused me to have a doubt about his reliability and expertise on these microbiology questions. He said that one of the factors against the June/defendant scenario was that “when the antibiotics stopped the wound got worse”. But since *Staphylococcus epidermidis* was not susceptible to the specific antibiotics administered, the cessation of antibiotics must be entirely irrelevant to the progress of any *Staphylococcus epidermidis* infection – a point he was ultimately forced to concede. In this respect, Mr Donnachie must be wrong.
101. I judged that it would have been better for him to adopt the course that Mr Sherman, defendant orthopaedic expert, chose: leave it to the microbiologists. Eventually, he did say that “I defer to microbiology experts”. I place little weight on Mr Donnachie’s contributions on microbiology.

102. I found that the evidence of Dr Rothburn, microbiology expert instructed on behalf of the claimant, far less impressive, consistent and complete than that of Professor Masterton. It struck me immediately as puzzling and unhelpful that Dr Rothburn expressed no preference for either the January or June scenario in his report. This was a critical issue. Yet his report was silent on this key question. Further, Question 13 of the Joint Statement was directed at precisely this. Dr Rothburn's observations effectively – and accurately – note that the negative samples in June did not exclude the presence of *Staphylococcus epidermidis* and the CRP could appear normal (not elevated) despite the organism's presence. Yet Dr Rothburn did not take the opportunity in the Joint Statement to challenge, query or doubt the factors mentioned by Professor Masterton or his analysis. Dr Rothburn also “deferred” to the orthopaedic experts about the existence of an infection: the clinical concerns of the surgical experts were “of paramount importance” (D4/385/Q13). However, he also conceded that they were irrelevant to the scenario choice (D4/110/2-15). As I have indicated, I was not impressed with the evidence of the orthopaedic expert Mr Donnachie instructed on behalf of the claimant in respect of infection, to whom, one supposes, Dr Rothburn would defer.
103. Overall, I accept the defendant's submission that in his report and the Joint Statement, Dr Rothburn's assistance to the court was confined to identifying factors there were not inconsistent with the scenarios. He did not weigh them. He deferred to the orthopaedic/surgical experts. This left the court in the position that the first time Dr Rothburn's opinion on the choice between the two scenarios was offered was in his oral evidence. When he did seek to justify his newly presented opinion, I found his answers unclear, far from straightforward and not coherent. An example was the resistance he put up to the proposition that it was unlikely that the infection would not have spread from the canals by October 2014. This should have been a simple concession to have made. It took unnecessarily repeated and prolonged questioning before he accepted what was always obvious (D4/98-101). At times he digressed rather than answering counsel's questions simply and directly. The court had to intervene and invite him to focus on the question and answer it. In the end, he accepted that the factors identified by Professor Masterton were consistent with the defendant's hypothesis.
104. By contrast Professor Masterton was at all times clear. He was consistent. He was prepared to make reasonable concessions, for example accepting the factors he had identified in the Joint Statement remained consistent with the claimant's (January) hypothesis. In his report, his answers in the Joint Statement and his evidence, he set out with great clarity and persuasiveness the factors he considered relevant and why. He gave his opinion about the relative likelihood of the competing scenarios and weighed them. This is what the court expects from an expert. Further, I find that Professor Masterton's overall conclusion about the choice between January/June to far better fit the balance of the evidence. He was an impressive, calm and authoritative witness.

(d) Preliminary point: pleading “concession”

105. I deal first with a preliminary question. The claimant submits that by its pleadings the defendant has conceded the medical causation issue. This claim rests on the defendant's concession in the areas of agreement about the introduction of "the infection". The claimant contends that this is a concession that both *Staphylococcus epidermidis* and other infections were introduced after the November 2013 procedure. It is put in this way by the claimant (Cla/§6.3):

"The first agreement between the parties expressly accepts that "the infection" was in fact introduced at or soon after the November 2013 surgery. The pleaded case is not caveated to allege that "the infection" did not include the *Staphylococcus epidermidis* infection. It is submitted that this should be the starting point when considering medical causation and therefore the end point."

106. This cannot have been the defendant's case. If it was, it is mystifying why there was such prolonged and intense exploration of this issue with the microbiology experts at trial. At no point in the four days of hearings before me was this point mentioned by the claimant. If this were the true position, I would have expected the claimant to object to questioning of the microbiology experts on an issue that had been conceded. Indeed, why were these experts called? It was because this was still a live – hotly contested – issue. Confirmation, not that it is needed, comes from the opening skeleton argument dated 11 January 2023. At §18.d, it states that the defendant:

"Contentends that the DAIR procedure in fact eradicated the deep infection present in January 2014 (i.e. it achieved the same objective that the Claimant contends should have been achieved with a first stage procedure.) Accordingly, the cause of the problems with ongoing infection leading to the knee fusion and amputation operations was the fact that a new deep infection was introduced during the June 2014 operation. This was a risk with any surgery and was in fact more likely to occur with a second stage operation (which would have been required if a first stage procedure had been carried out). Accordingly, the claim should fail for lack of causation and/or because the new infection was outside the Defendant's scope of duty."

107. The claimant, when raising preliminary matters on the morning of the first trial day, never raised this issue. If this were a serious and credible point, it should have been. I reject the claimant's argument on this point.

(e) Factors for and against

108. I cannot accept Mr Davy's submission that the decision on medical causation "ultimately depends on which expert's balancing exercise the Court considers is the most persuasive" (Def/§26). We do not have trial by expert (*Liddell v Middleton* [1996] PIQR P3, per Stuart-Smith LJ). I do not judge the issue solely based on expert opinion. Rather, the task of the court is to identify and weigh all the relevant factors and then assess which scenario is more likely in the context of all the evidence, expert and non-expert. More precisely, I

reiterate that the claimant must prove that the January scenario is probably true. This was the approach endorsed by this court in *Barclays Bank PLC v Christie Owen & Davies Ltd.* [2016] EWHC 2351 (Ch) at [60]:

“To consider simply whether to prefer one expert over the other is not the correct approach. The Court should make a judgment as to the expert witnesses, the weight to be placed on different aspects of their evidence and the assistance to be derived from it, and then reach its own conclusion...”

109. None of this detracts from the obligation on the court to state what in the evidence of one expert is preferred to another on any particular point (*Flannery v Halifax Estate Agencies Ltd* [2000] 1 W.L.R. 377; *Simetra Global Assets Ltd v Ikon Finance Ltd* [2019] EWCA Civ 1413 at [38]–[47], per Males LJ). This is I will do.
110. Below I list the factors in favour of post-2013 procedure/pre-28 January 2014 infection introduction (January/claimant scenario). I need to say something about another technical term: CRP. This is an acronym for c-reactive protein. If there is inflammation in the body, your liver releases more CRP into the bloodstream. Inflammation is a way for the body to protect itself, such as a swelling around a cut. But this protein may be released into the body not just through physical injury but also infection. Thus as a marker, elevated levels of CRP may provide some information about infection. But there are important limits to what it can show. The crude CRP level cannot indicate what is causing the inflammation. Thus to make a more informed diagnosis, the CRP must be viewed along with other symptoms and data. With that introduction to CRP, I list the factors in favour of the January (claimant) scenario:
- (1) Mrs Powell reported pain in the knee post-operatively in November and December 2013 and that is consistent with *Staphylococcus epidermidis* infection (Dr Rothburn D4/73);
 - (2) The site from where the two specimens of *Staphylococcus epidermidis* were grown (left tibial and femoral canals) had not previously been sampled – so the infection may have been there and not tested;
 - (3) The antibiotics therapy administered between January and May 2014 would not have been effective against *Staphylococcus epidermidis* (this organism develops by local contiguous spread and is associated with biofilm formation - such organisms are typically highly resistant to antimicrobial agents);
 - (4) *Staphylococcus epidermidis* has a low virulence and is recognised to cause a low-grade infection;
 - (5) As such, it can infect the body without producing extensive local inflammation or systemic effects, in other words keeping a “low profile”;
 - (6) The CRP (C-reactive protein) inflammation markers can be normal even where there is a *Staphylococcus epidermidis* infection;

- (7) There were limited (“scanty” D4/112) pus cells in October, indicative of a limited inflammation response;
- (8) Thus (non-indicative) inflammatory markers and culture-negative findings cannot exclude infection as culture negative prosthetic infections are well recognised (B392-93);
- (9) The orthopaedic experts agree that CRP and white cell count are probably not good surrogate markers of active infection (see particularly Mr Donnachie);
- (10) Delayed-onset infections are often due to coagulate-negative *Staphylococci* and *Staphylococcus epidermis* is one of these;
- (11) If *Staphylococcus epidermidis* was introduced in June, that would be classified as an early onset infection at October 2014, and either *Staphylococcus aureus* or a gram-negative organism would be more common than *Staphylococcus epidermidis* as an early onset infection;
- (12) *Staphylococcus epidermidis* is the commonest cause of delayed onset infection (Dr Rothburn, D4/69/2-8);
- (13) Clinical records exist indicating ongoing infection and that the site did not heal well or completely:
 - a. 26 February, “some sloughy aspects”;
 - b. 12 March, the community nurse says the patient has a “high level of infection”;
 - c. 3 April, “the wound is not completely healed yet”;
 - d. 17 April, “ongoing infection”;
 - e. 24 April, “not completely dried up or healed”;
 - f. 8 May, “not completely dry”;
 - g. 15 May, “wound continues to heal”;
- (14) Mr Chauhan formed view that there was likely to be ongoing infection: 22 May review (2/3/208).
- (15) Mr Osborne the physiotherapist also formed that view:
 - a. On 29 May, Mr Osbourne records that Mrs Powell stated that she had some break outs in the last couple of weeks and “some oozing around the lower calf scarring” and “it does show that there is more infection going on”;
 - b. On 6 June, Mr Osbourne noted that Mrs Powell says “her symptoms are getting worse and it certainly look like this is the case”;
- (16) Absence of operative evidence of infection is “unsurprising” because a similar lack of operative findings was reported in January 2014 when there was a polymicrobial infection;

- (17) There had been an extended period of intravenous broad-spectrum antibiotics which increase the likelihood of culture negative findings;
 - (18) Late onset infection is consistent with implant surgery;
 - (19) The chances of introducing *Staphylococcus epidermidis* in a procedure like the June one, are “very low” (Dr Rothburn);
 - (20) Dr Rothburn’s opinion is that it is “highly likely” that the *Staphylococcus epidermidis* was in the canals in January and simply not tested (D4/67-68) and Mr Donnachie concluded Dr Rothburn’s opinion to be “the more appropriate one”.
111. Against this, the factors in favour of post-28 January (possible June) introduction (June/defendant scenario):
- (1) The chance of eradication by DAIR is less than 50 per cent, but that means that eradication occurs following DAIR in a number of cases;
 - (2) During the surgical procedure on 26 June 2014, no infection was observed by Mr Chauhan;
 - (3) The samples taken at the 26 June procedure showed no culture growth;
 - (4) Guidance is that antibiotics should be stopped two weeks before taking samples to reduce the risk of false negatives. Here the antibiotics were stopped on 15 May, well in advance of the sampling on 26 June;
 - (5) The *Staphylococcus epidermis* infection found following the October surgery was different to the infection found in January and had not been found before;
 - (6) Infection eradication is the most probable explanation for the positive clinical pathway of progress in Mrs Powell’s knee post-January;
 - (7) The observed inflammatory marker showed improvements consistent with the eradication of infection;
 - (8) On average, it is more like that you would find *Staphylococcus epidermidis* elsewhere other than the canals if it had been introduced into the body/wound longer than six months.
 - (9) Mr Donnachie accepted that the deterioration after stopping antibiotics cannot be linked to the presence of *Staphylococcus epidermidis* as this organism is not affected by the administered antibiotics;

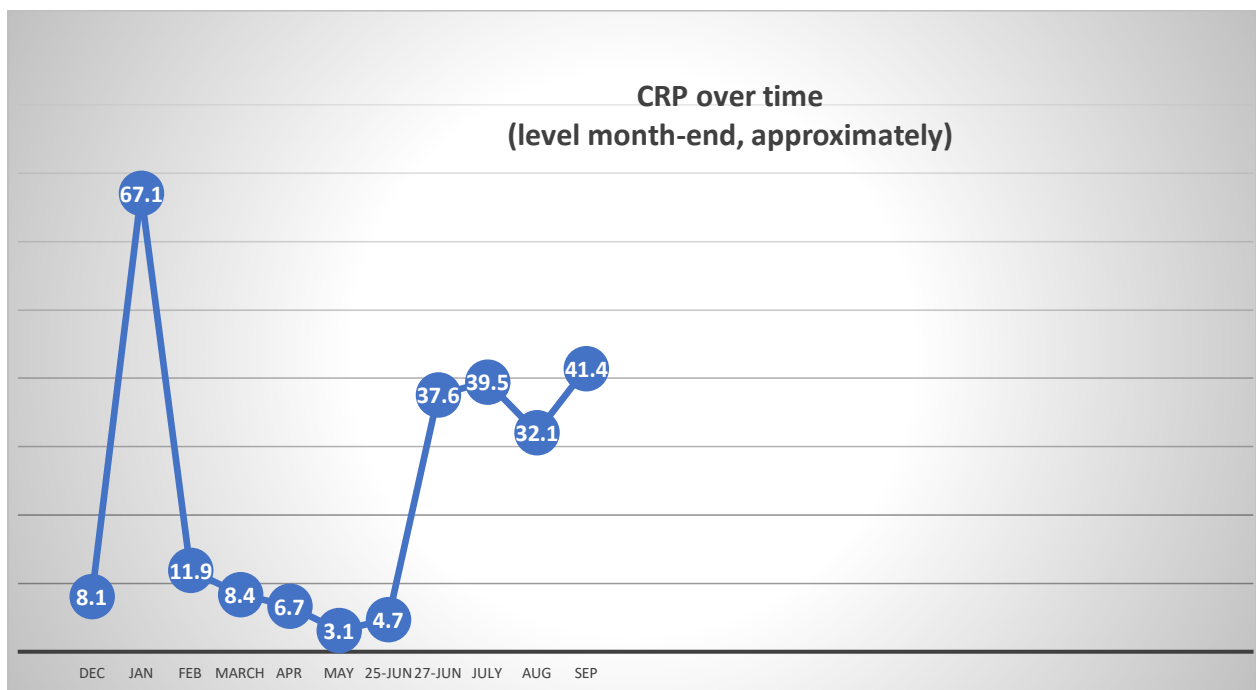
- (10) The chances of introducing *Staphylococcus epidermidis* during the June procedure are increased by Mrs Powell's diabetes and obesity and the fact she has had previous surgical procedures and infections;
- (11) Although the risks of an infection following the June procedure were lower than for a more extensive procedure, the risks of both are relatively low (5-8% versus less than 1%: Dr Rothburn, D4/135);
- (12) In 30 years as a microbiologist, Dr Rothburn had never encountered a patient with a knee joint presenting with the combination of early onset polymicrobial infection *and* late onset *Staphylococcus epidermidis* and there were no examples of this presentation in the literature (D4/169/4-19).
- (13) The elimination of an earlier infection followed by a new infection on subsequent surgical procedure is a "well recognised and reported sequence of events" (per Professor Masterton)

(f) Factor evaluation

112. I must next examine the overall picture and look at probabilities (*Re BR/In re B*). The probabilities pointing towards claimant scenario:
- The chance of *Staphylococcus epidermidis* being introduced in the type of procedure undergone in June were "very low" as a general proposition;
 - A low-grade infection is "predominantly acquired" (more likely to be acquired) during implant surgery (November 2013) rather than biopsy-type procedures (June 2014).
113. The probabilities pointing towards the defendant's scenario:
- It is highly unlikely that the *Staphylococcus epidermidis* would not have spread to the joint from the canals (Professor Masterton);
 - It is more likely that *Staphylococcus epidermidis* presents early rather than late;
 - *Staphylococcus epidermidis* is more likely to present with elevated CRP after 3 months, yet Mrs Powell's CRP falls from January until June;
 - In 30 years as a microbiologist, Dr Rothburn had never encountered a single previous case of early onset polymicrobial infection combined with late onset *Staphylococcus epidermidis* infection *and* there were no examples of it found in the literature.
114. I now evaluate the factors supporting the claimant's scenario. While there was pain post-operatively in November and December 2013, and it did recur from time to time in 2014, it did not persist or present regularly throughout 2014. When Mrs Powell experienced discomfort and swelling, she had typically walked excessively. It is true that the canals were not sampled in January 2014 and thus *Staphylococcus epidermidis* could have been present there, but against that is the high improbability of it not spreading in the subsequent period from February to October. It is true that *Staphylococcus epidermidis* has a low virulence and creates a low-grade infection, and CRP inflammation markers can

conceivably be normal where *Staphylococcus epidermidis* is present, but Dr Rothburn agreed it likely that such an organism would produce an elevated CRP level after 3 months if present – it did not. After 22 May 2014, there is no evidence of ongoing swelling or fever, and yet this is well after the 3 months post-introduction period when Dr Rothburn would expect to see elevated CRP levels (some indication of active infection). There were limited (“scanty”) pus cells in October, but this would be consistent with a low inflammation response following June introduction.

115. I accept that CRP level are not a highly reliable proxy for active infection. As Mr Donnachie put it in his evidence, “CRP is a marker, but I don’t think it’s a great marker”. However, what is likely to be of greater utility than a single reading or figure taken out of context is the overall trend in CRP over time. I stress that I do not find it determinative or anything near it, but nor do I find CRP totally irrelevant. It adds some limited information to the overall picture. The chart below takes the CRP levels from the data in the microbiology Joint Statement (B389-90) and the additional datum (December) provided by Mr Donnachie during his evidence.



The figure denotes mg/L. In the UK, levels of 8-10 (approx.) are considered elevated.

116. The picture that emerges when one charts the CRP levels is consistent with an infection present in January following introduction at or after the November revision. That (polymicrobial) infection is then treated with antibiotics and eradicated. CRP levels remain low until June. On the day before the June procedure on 26 June, CRP is 4.7. The day after, on 27 June, it jumps to 37.6. If a further infection (this time *Staphylococcus epidermidis*) were introduced

then, the consistent elevation in CRP until the October procedure would also reflect that. This would be early onset *Staphylococcus epidermidis*, but this organism is more likely to present as early onset, so early onset fits its typical profile. I emphasise that this is evidence of consistency and cannot be dispositive. The limited value provided by CRP levels comes from the fact that *Staphylococcus epidermidis* can exist without a necessary rise in CRP. However, Dr Rothburn did accept that after 3 months he would expect the CRP to rise. Thus, we may expect to see elevated CRP in February/March/April if *Staphylococcus epidermidis* had been introduced into Mrs Powell's knee by 28 January 2014. The chart shows that CRP falls away rapidly after January and remains relatively low until the June procedure. Of course, the rise in CRP after the June surgical intervention may be attributable to swelling post-operatively. However, if that is the explanation, the swelling does not fall away as it did after the January procedures. This is one factor that makes this explanation less likely. The elevated levels post-June procedure are consistent with a contribution from post-operative swelling plus an early onset June-introduced *Staphylococcus epidermidis* infection. I remind myself that it is for the claimant to prove that the rival January scenario is probably true.

117. The problems that Mrs Powell experienced with her wound in April and May were located at the lower calf site and unlikely to be connected to *Staphylococcus epidermidis* infection in the canals. This is the context in which Mr Donnachie's comments about the wound "worsening" after the termination of antibiotic therapy should be seen. The "views" of Mr Osbourne and Mr Chauhan prior to the June procedure about "infection" provide only limited support for the January scenario. This is because when Mr Chauhan gave evidence, he explained his comment about 22 May. He said not being "surprised" was not the same as concluding a joint infection was likely. It was something he needed to eliminate with the further tests he ordered. I accept that evidence. These constitute two different indexes of suspicion or certainty. As to Mr Osbourne, he is a physiotherapist, an important profession, but he is not a microbiologist or orthopaedic surgeon. On 28 May, Mr Osbourne noted that Mrs Powell's CRP was "slightly high" (D2/209). Mr Chauhan stated that this is not suggestive of an infection because the CRP was "within normal range". As to Mr Osbourne's letter of 6 June, while it is correct that he noted concern about infection, this was not about a joint (knee) infection. The heading of the letter is clear: "Diagnosis: Ongoing infected left calf for further review". When Mr Chauhan had seen Mrs Powell on 22 May, there was no evidence of any tracking between the left calf where the infection was suspected and the knee. Thus, Mr Chauhan felt that the break-out on the calf had nothing to do with the knee joint.
118. While late onset infection is consistent with implant surgery and *Staphylococcus epidermidis* is the commonest form of late onset infection, against this must be placed the fact that this organism is more likely to present as an early onset infection. Dr Rothburn assesses the typical chances of introducing *Staphylococcus epidermidis* with the June biopsy-like procedure as low. However, against this, for a patient with the specific characteristics of Mrs Powell, that risk increased due to her (1) diabetes; (2) obesity; (3) previous infections; (4) having undergone previous surgical procedures.

119. The claimant relies on an answer given by Professor Masterton in cross-examination (D4/164-65):

“even taking everything else out of the equation because it is finely balanced, is it not more likely that this was a delayed low grade infection that had been there all the way through, rather than an early infection that Mrs Powell was just so unfortunate enough to get in June 2014 with a biopsy procedure.”

120. This is said by Ms Knight to be a “critical” concession (Cla/§6.5). It was not. The citation provided by counsel in the claimant’s skeleton was incomplete. It needs to be seen in the context of what was said before and after. I provide the fuller excerpt:

“MS KNIGHT: I just want to clarify, Professor: early infection, it would be more likely that you would find either *Staph aureus* or a gram-negative on sampling, than it would be that you would find *Staph epidermidis*.

PROFESSOR MASTERTON: Yes.

Q: And with a delayed onset, or low-grade infection, it would be more likely that you would find *Staph epidermidis* than finding *Staph aureus* or something else.

A: Yes.

Q Can I just put it to you that for reason alone, even taking everything else out of the equation because it is finely balanced, is it not more likely that this was a delayed low-grade infection that had been there all the way through, rather than an early infection that Mrs Powell was just so unfortunate enough to get in June 2014 with a biopsy procedure.

A: **If you look at that issue alone, yes.”**

(emphasis provided)

121. Professor Masterton was making it plain that what is important is the combinations of factors. That must be correct. Isolating one factor out of context is the precisely the erroneous approach (*Re U, Re B; A County Council v A Mother and others*)
122. Numerically, I have identified significantly more factors in favour of January rather than June (20-13). However, it would be wrong in principle for the court to mechanistically count up the factors for and against. The answer lies in their intrinsic nature and quality. I weigh them in light of the expert evidence in the context of all the evidence and sense-check my provisional conclusion against the whole of the relevant evidence. Having done so, I judge that the factors pointing to the defendant’s scenario are more compelling than those supporting the claimant’s. That is because I cannot understand how the infection, if present by 28 January 2014, had failed to spread *at all* from the canals in the many

months following. Professor Masterton is undoubtedly right: this lack of spreading is highly unlikely. There has been no convincing or credible explanation about how this highly unlikely event occurred on the January scenario. There is little persuasive argument to set against this point and Dr Rothburn has conceded that it is unlikely not have to have spread beyond the canals. However, should the organism have been introduced in June, it is more probable that it had not spread beyond the canals by October. Therefore, the lack of spreading much more closely supports the defendant's hypothesis than the claimant's.

123. But this factor must not be seen in isolation. To my mind, it is telling that in a patient with a knee joint, Dr Rothburn had *never* encountered the combination of presentations pressed for the claimant – early polymicrobial/late *Staphylococcus epidermidis*. I judge this materially supportive of June scenario. That hypothesis is further bolstered by such combined presentation not being found in the authoritative medical literature. If it were there, I have little doubt that either Dr Rothburn or Professor Masterton would have brought it to the court's attention. The June scenario is further supported by the inherent nature of this infection - *Staphylococcus epidermidis* more usually presents early (more consistent with June). There is further, albeit limited, support from the CRP levels, which fall after January, indicating the eradication of infection and is more consistent with the defendant's scenario.
124. Thus, we have a constellation of factors that point in the same direction and away from the claimant's hypothesis. I find that while the factors relied upon by the claimant are consistent with *Staphylococcus epidermidis* infection by end of January 2014, they do not come close to proving – as the claimant must – that the June/claimant scenario is probably true. For example, the force of the general (I emphasise *general*) very low likelihood of *Staphylococcus epidermidis* introduction by June-type procedure is diminished by the particular characteristics of Mrs Powell, that increase the likelihood that this particular patient with her history and traits could have been infected with *Staphylococcus epidermidis* in June 2014. We are not dealing with the trends in the general population, but traits of a specific patient. Further, it is well recognised that an earlier infection or infections (here polymicrobial) could be eradicated and then followed by a further (and different, here *Staphylococcus epidermidis*) infection in a subsequent procedure. I find that this is likely to be what happened here. As such, I cannot accept Dr Rothburn's conclusion that it is "highly likely" that the infection was present in the canals in January and simply not found. I far prefer the evidence of Professor Masterton. He was unquestionably the more impressive and authoritative witness. He concluded that the defendant's (June introduction) hypothesis is significantly more likely than the claimant's (D4/171/9). I agree. I find that the defendant's scenario is probably true.

(g) Conclusion Issue 7

125. Therefore, I find that (1) Mrs Powell has not proved the post-2013 (January) hypothesis is probably true; (2) the June hypothesis is more likely and probably true.
126. This provides a second and separate basis for the failure of the claimant's action.

§X. Overall conclusion

127. I indicated that the viability of this claim rested on two condition precedents, and both had to be met. It was essential that the claimant prove to the requisite civil standard both Issue 6 and 7. Having reviewed the wide canvass of the evidence and examined the arguments of parties, my conclusions are as follows:

- **Issue 6:** the claimant has failed to prove that she would have chosen first stage procedure if properly informed and advised as at 28 January 2014;
- **Issue 7:** the claimant has failed to prove that *Staphylococcus epidermidis* was present as at 28 January 2014.

128. Yet, and at the same time, the court has found that Mr Chauhan was in breach of his duty of care to Mrs Powell. I must say something about that.

129. Mr Chauhan failed to inform or advise Mrs Powell about reasonable alternative treatments prior to the procedure on 28 January 2014. Further, he breached his duty of care by not informing her of the material difference in the chances of infection eradication between first stage procedure and DAIR. He holds himself out, with some justice, as a knee specialist. Knee surgery has been his sole practice for over 15 years. In that time, he has performed hundreds of operations on the knees of countless members of the public. As he puts it himself:

“We perform over 150 revision procedures a year and I personally perform over 30 per year.” (B52/§3)

130. I have no doubt that Mr Chauhan has given many, many patients great relief from pain and has improved their mobility and capacity to enjoy life. None of this should be forgotten. Equally, the court cannot generalise from a sample size of one. It is not fair to Mr Chauhan to extrapolate from his treatment of Mrs Powell to other patients. That said, I have found that his care towards Mrs Powell was in the respects I have identified deficient and negligent. He showed a less than meticulous approach to consenting Mrs Powell. This meant that as at 28 January 2014, she was deprived of at least considering and discussing first stage procedure with her orthopaedic surgeon, a surgical treatment that the *majority* of surgeons would have advised her to undergo, carrying with it the effective certainty of eliminating infection deep in her knee joint. She was also deprived of discussing her orthopaedic surgeon’s advice about the relative merits of procedures with her family, as I find she undoubtedly would have done. All of this, I am bound to say, is deeply regrettable. We live in an age of informed patient consent, not as a mere technicality, or a laborious box-ticking exercise, but as a genuine commitment to and recognition of the autonomy and self-determination of patients - a stark reminder that it is their life and their body.

131. Nevertheless, I have found that even if Mr Chauhan had complied with his duty of care, it would not have made any difference to the outcome in this case, and the very sad loss of Mrs Powell’s left leg. Tragically, the *Staphylococcus epidermidis* that was (likely to have been) introduced into her body after 28 January 2014, would have resulted in the amputation of her leg even if Mr

Chauhan had informed and advised her as she was entitled him to have done. I suspect that a lot of learning and reflection has followed from what happened to Anne Powell. Anyone hearing what occurred is bound to have great sympathy for her. But sympathy is different from the finding of facts. The facts do not change with the winds of sympathy and deep concern. As Lady Hale said of fact-finding in *In re B* [2008] UKSC at [31]:

“The task is a difficult one. It must be performed without prejudice and preconceived ideas. But it is the task which we are paid to perform to the best of our ability.”

132. That is what I have tried to do. Yet this case unmistakably underscores the importance of patient autonomy. Professor Ronald Dworkin put it this way (*Life's Dominion: An Argument about Abortion and Euthanasia*, London: Vintage Books, 1993):

“Recognizing an individual right of autonomy makes self-creation possible. It allows each of us to be responsible for shaping our lives according to our own coherent or incoherent - but, in any case, distinctive – personality. It allows us to lead our lives rather than be led along them, so that each of us can be, to the extent a scheme of rights can make this possible, what we have made of ourselves.” (p.224)

133. That said, Lord Bingham concluded in *Chester* at [9] that:

“The patient’s right to be appropriately warned is an important right, which few doctors in the current legal and social climate would consciously or deliberately violate. *I do not for my part think that the law should seek to reinforce that right by providing for the payment of potentially very large damages by a defendant whose violation of that right is not shown to have worsened the physical condition of the claimant.*”

(emphasis provided)

134. That is the position here. Having said this, I am acutely aware that the agreed sum of damages would have made Mrs Powell’s life and that of those who care for her so diligently markedly easier. But the legal basis for awarding them is not there. However, I emphasise that nothing said here must in any way be taken to diminish or underestimate the gross pain and loss that Mrs Powell, a perfectly respectable wife, mother and member of our community, has suffered. She formed a strong impression on me as a stoical, courageous and entirely affable person, who bears her terrible loss with fortitude. Her life has been tough and she has persevered with what is admirable tenacity.

§XI. Disposal

135. This claim must fail and is dismissed.
136. I will receive submissions about costs and consequential directions and direct parties to agree an order to reflect the judgment of the court.

137. That is my judgment.