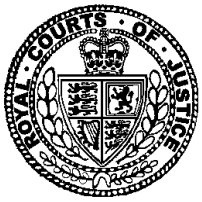

Neutral Citation Number: [2023] EWHC 2803 (KB)

Case No: QB-2021-000948

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 09/11/2023

Before :

His Honour Judge Freedman (Sitting as a Judge of the High Court)

- -

Between :

Mr Joe Ward	**Claimant**
- and -	
Oxford University Hospitals NHS Foundation Trust	**Defendant**

- -
- -

David Tyack KC (instructed by **Enable Law**) for the **Claimant**
Tim Found (instructed by **DAC Beachcroft LLP**) for the **Defendant**

Hearing dates: 24th and 25th October 2023

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 9 November 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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HIS HONOUR JUDGE FREEDMAN (SITTING AS A JUDGE OF THE HIGH COURT)

HHJ Freedman:

Introduction

1. This is a Clinical Negligence Claim arising out of an elective laparoscopic operation which was undertaken on 30 May 2017 at the Churchill Hospital in Oxford. In the course of the operation, the purpose of which was to remove a gastric band, the Claimant suffered a perforation of his stomach.

2. There is agreement between the medical experts – Mr Marcus Reddy instructed on behalf of the Claimant and Mr S. H. Rahman instructed on behalf of the Defendant – that it was not negligent to cause the perforation. It is also agreed that if the perforation, at the time of surgery, was of sufficient size to be seen then it was *Bolam* negligent for the surgeons not to detect the lesion during the course of the operation, and to repair it.

3. The issue, therefore, for the court to determine is within a very narrow compass, namely whether there was a culpable failure to identify and repair the perforation intra-operatively. This raises the question as to whether the perforation was of a sufficient size such that there would have been visible signs.

4. Put bluntly, on behalf of the Claimant, it is said that the perforation was *there to be seen.* On behalf of the Defendant it is argued that there were no visible signs of the lesion prior to the conclusion of the surgery.

5. Counsel have very helpfully agreed quantum in the sum of £150,000, in the event that breach of duty is established.

6. The Claimant was born on 25 March 1973. Accordingly at the time of the surgery, he was aged 44.

The Operation

7. The indication for this surgery was that the gastric band which had been fitted in 2011 was causing the Claimant significant abdominal problems. The removal of a gastric band is considered (at least by bariatric surgeons) to be a fairly routine procedure. The expectation was that the Claimant would be discharged the same day.

8. The laparoscopic surgery was performed by Ms Daniela Zanotti who, at the time, was a Senior Clinical Fellow in a training post. She is now a Consultant Upper GI and General Surgeon. The surgery was performed under the supervision of Mr Bruno Sgromo who is a Consultant Bariatric Surgeon. Whilst he was in theatre throughout the procedure, he was not surgically scrubbed. There was also present in theatre a surgical assistant, Dr Dickson.

9. The surgery lasted approximately 2 hours. It started at 8.30am and, according to the anaesthetic chart, it concluded at approximately 10.30am.

10. In accordance with standard practice, Ms Zanotti carried out the procedure relying on two screens, one in front and the other, either to her right or left. The camera was being held by Dr Dickson. The visualisation of the stomach, on the screen, was magnified to a factor of between six and ten.

11. The band had been placed around the gastric fundus. Removal of the band requires the removal of the sub-cutaneous reservoir which is used to inject water to inflate the band, as well as the tube which connects the band with the reservoir.

12. Of utmost significance in this case, the removal of the band also requires the dissection of scar tissue which had formed at the site of the band, known as the 'capsule'. Part of the capsule has to be removed before the band can be released. Ms Zanotti used diathermy which sends electric current through the tissues in order to dissect the capsule. Adhesions between the Claimant's stomach and liver were also dissected with diathermy. The same technique is used to release the band from the stomach and the band is then divided with scissors.

13. According to Ms Zanotti's witness statement, and confirmed in her oral evidence, there were no difficulties or complications in the course of this surgical procedure. She regarded it as straight forward and routine. Although Mr Sgromo did not give oral evidence, his witness statement (admitted under the Civil Evidence Act) also confirms there were no untoward events or complications during the course of the surgery.

14. The operation note tends to confirm that, as far as the surgeons were concerned, there were no complications nor particular difficulties. The salient parts of the operation note read as follows:

"Findings: gastric band in place

Some adhesions to the liver

Nil else

Procedure: diathermy dissection of the bumper of the gastric band

Adhesions between the liver and stomach dissected

Band freed up completely – cut with scissors and removed

Some of the scar tissue/capsule removed with diathermy

Haemostasis on the liver

Tube of gastric band divided and port removed through 10mm port

Gastric band – tube complete".

15. Although not appreciated at the time, a perforation had been caused to the stomach at the gastric plication. Potentially this perforation could have been caused by cutting or by diathermy. In the end, both experts agreed that, on the balance of probabilities, it had been caused by diathermy at the time when the capsule was being dissected. According to Mr Rahman, the diathermic removal of the capsule is likely to have taken between 20 and 25 minutes. He postulated that the perforation was likely to have been caused during the early part of the dissection of the capsule. He suggested that it could take up to an hour to finish the operation after dissecting the capsule.

Post-Operative Course

16. Unsurprisingly, in the early aftermath of this kind of surgery, abdominal pain is to be expected. And so it was that this Claimant complained of what is described as *moderate* pain for two hours or so following the end of the operation. During this period, he was given intravenous fentanyl in 25mg doses.

17. By 12.10pm his pain was said to be 3 on a scale of 1-10. Ten minutes later, at 12.20pm it was recorded that he was not in pain and he was fit to go home. He was returned to the ward at 13.00, with his pain levels said to be *mild.*

18. During the very early afternoon, he was given something to eat and drink. This was in anticipation of him being collected by his wife at about 4pm.

19. In the event, by 16.15, it was noted that the Claimant was complaining of *severe* pain. He required repeated doses of fentanyl which were administered between 16.26 and 18.45. Some of the doses were 50mg. He was given a patient controlled analgesia pump (PCA).

20. At 16.30, the Claimant was reviewed by Dr Chong who noted that the severe abdominal pain had started 4 hours after surgery. There was a suspicion of a gastric perforation and the plan was to order a CT scan to investigate this. This scan was undertaken. At 17.50 the patient was reviewed by Mr Sgromo who considered that the scan did not appear to report any leakage. He advised that the formal report of the scan should be awaited but that there did not appear to be anything *sinister.*

21. When the scan was formally reported upon, it was noted that it did not show any obvious perforation. Accordingly, a 'wait and see' policy was adopted with the intention of taking the Claimant back to theatre in the event of any signs of deterioration.

22. At 18.50, the Claimant was reviewed by Ms Zanotti. She recorded that on the scale of 1-10, his pain was at 4. By this time, he had ceased fentanyl. Between 18.50 and 19.15, he had five 2mg doses of morphine intravenously. By 20.00 the Claimant was described as being *comfortable.*

23. There followed two further reviews by the specialist registrar, Mr Jones. At 20.30, Mr Jones noted that there was *no peritonism* although he was concerned about the possibility of a leak, having reviewed the scan.

24. At 22.15, Mr Jones noted that the scan had shown a subphrenic collection of gas locules/fluid but because he had been unable to tolerate the oral contrast, there was no definitive diagnosis. He described the Claimant as: '*currently looks well, slightly dry… no guarding'.*

25. At 23.44, the Claimant had 1000mg of paracetamol. No further analgesia was administered until 06.27 the following day, when he had another paracetamol tablet.

26. By 06.50, the Claimant was described as being distressed and in pain with tachycardia. The pain continued to worsen. At 07.15 Mr Jones noted that the Claimant was tender on examination '*with guarding upper abdomen'.* The impression was that there was a

perforation. The plan was for him to be reviewed by Mr Sgromo with a view to him being returned to theatre.

27. At or about 11.30 on 31 May, Mr Sgromo performed a re-look laparotomy. A perforation was found on the anterior of the stomach just above where the banding would have been located. Mr Sgromo measured the perforation as being 3 x 2 centimetres. There was evidence of peritonitis in all four quadrants. The perforation was resected.

28. Subsequent histology suggested that the perforation measured 18mm in diameter. However, it was agreed that, for a variety of reasons, the measurements at histology may not have been a true reflection of the size of the perforation when viewed by Mr Sgromo. At all events, for present purposes, it is accepted that this was a significant perforation measuring in the order of 3 x 2 centimetres.

Ms Zanotti

29. It is obviously important to have regard to Ms Zanotti's training and experience at the time when she undertook this procedure. She had spent five years in Italy as a trainee Doctor doing a variety of surgical procedures under supervision. Prior to this operation, she had been working in the UK for three years undertaking multiple procedures including upper GI surgery. In her UK training, she had done 57 laparoscopic surgeries prior to this procedure, some of which were abdominal. As at the date of this operation, she had always operated under supervision, apart from surgery involving inguinal hernias. She said that she was familiar with the surgical technique for the removal of adhesions. This operation was only the second time that she had assisted in the removal of a gastric band.

30. As to the supervision provided to her by Mr Sgromo, she said that he was guiding her throughout. Whilst he was not scrubbed up, he was focusing on the camera and on what she was doing.

31. Her recollection was that this operation was not a difficult procedure. She described *everything* as being *very clear* on the two screens. She believes that she looked at one or other of the screens throughout the operation. She accepted that, from time to time, she might have spoken to the anaesthetist or the scrub nurse for the purposes of explaining what she intended to do next. She said that when talking to a colleague, she might have briefly ceased operating or she might have continued with the operation. If the latter, she was adamant that she continued to look at the screen.

32. She said that she was not particularly concerned about the risk of perforation in this operation. On the other hand, she was adamant that if there had been any perforation causing a leakage of gastric content, this would have been observed by her. She stood by what she stated at paragraph 8 of her witness statement:

> "…*Mr Sgromo and myself visually inspected the area of the stomach in which the dissection took place and checked for any damage prior to closure. There was no leakage of gastric content at the time when laparoscopic ports were removed.*"

33. Ms Zanotti also assisted with the re-look laparotomy. However, perhaps a little surprisingly, she had no recollection of this second procedure.

Mr Sgromo

34. As indicated above, the court did not have the benefit of oral evidence from Mr Sgromo. He was out of the country, on holiday. This clash with the Trial had occurred due to an administrative error. Attempts at arranging a video-link proved to be futile. Accordingly, his evidence was before the court by virtue of a Civil Evidence Act notice. This notice was served only a few days before trial.

35. Whilst Mr Tyack KC did not object to the hearsay notice and, therefore, the admission of Mr Sgromo's witness statement into evidence, he does place reliance upon sections 2 and 4 of the Civil Evidence Act. In essence, he submits that very little, if any, weight should be given to the non-agreed parts of Mr Sgromo's witness statement given that it was not accepted that Mr Sgromo could not have attended the trial and that, furthermore, the Hearsay notice was served very late.

36. Manifestly, the fact that Mr Sgromo's evidence has not been tested in cross-examination does adversely affect the weight which is to be given to his evidence. It must also be borne in mind that not only was Mr Sgromo not himself performing the operation but he was not scrubbed which, at least, potentially, may have had the consequence of him being less involved in the procedure, albeit that he was present in theatre.

37. At all events, I make it plain, at this stage, that the evidence of Mr Sgromo must be treated with some caution and circumspection. In short, and whilst it would not be appropriate to ignore what he says in his witness statement, the weight to be attached to it is necessarily limited.

38. In terms of his experience and expertise, it is worthy of note that Mr Sgromo was appointed as the Clinical Lead for the Oxford Bariatric Unit at Oxford University's hospitals between 2009 and 2015. Currently, he is the Clinical Lead for the Upper GI Unit. Since 2009, he has performed over 700 bariatric procedures. Candidly, Mr Sgromo accepts that he has no recollection of the original operation although he does recall the events which ensued because of the Claimant's complicated recovery. He accepts therefore that he is entirely reliant upon the operation note and his usual practice in making any comments about the operation itself. At paragraph 16 of his witness statement, he says:

> "*My usual practice when ending surgery and closing up is to check for bleeding and any evidence of bowel content leaking and, in this case this was done by Ms Zanotti under my supervision. There is no record of any leak being present, which indicates we did not see any perforation on visual inspection. A perforation would have been identified by the presence of bleeding, or evidence of stomach content leaking, and if a perforation had been discovered it would have been essential to repair it immediately*."

39. In relation to his findings during the second procedure, at paragraph 31 he says:

> "*the operation note for the second procedure recalls that the perforation I identified measured 3 x 2 centimetres. This is not a small perforation and a perforation of this size, and in this location, could not have been missed during the first procedure. The removal of the gastric band had been carried out laparoscopically, and therefore the images of the procedure were being magnified and displayed on a television monitor in the theatre for us to see. An intra-operative perforation like this would have been visible to anyone who could see the monitor and could not have been missed prior to closing.*"

Expert Evidence

40. It is not necessary to rehearse the CVs of Mr Reddy and Mr Rahman. It is sufficient to note that both surgeons have very wide and extensive experience in bariatric surgery, both primary and revisionary. There can be no doubt but that they were both extremely well qualified to give evidence in this case.

41. I should also make it clear that I formed a very favourable view of both experts. It seemed to me that both were doing their level best to assist the court. They both gave their evidence in a careful and measured way, without any suggestion of lack of partiality or objectivity.

42. Moreover, unsurprisingly, given the narrowness of the issue which falls to be determined, there was a very large measure of agreement between the experts. The salient points upon which they agreed can be summarised as follows:

    i) The damage to the abdominal wall was probably caused by diathermy when removing part of the capsule.

    ii) To cause such damage in these circumstances does not signify a lack of skill or care.

    iii) The peritonitis which was subsequently found at the re-look laparotomy was caused by the leak of fluid from the Claimant's stomach into the peritoneal cavity through the gastric perforation.

    iv) The position of the perforation on the anterior gastric wall would have made it readily visible to surgeons, if its measurements were as found by Mr Sgromo at the re-do operation. Indeed, Mr Rahman did not appear to disagree with Mr Reddy that even if the defect had been half the size that it was found to be at the re-do operation, it would have been visible.

    v) If the perforation had been detected and repaired intra-operatively, the complications of sepsis and peritonitis (and the problems attendant upon those conditions) would have been avoided.

43. Where the experts parted company was in relation to whether the perforation was *there to be seen* at the time of the original surgery. Mr Reddy, for his part, was unwilling to

accept that over the course of 24 hours, a very small non-leaking perforation had grown and expanded into a 2 x 3cm perforation. Whilst he accepted that it may have expanded, to some extent, over the course of the day, following the first operation, due to the effect of the gastric juices, he considered that it must still have been readily visible on the monitor when the surgery was being undertaken. He postulates that there would have been, at the very least, some bubbles created by gastric fluid mixing with gases. Although he was unable to say with certainly what leakage would have occurred, he thought it likely that there would have been some yellow/green fluid and white frothy bile.

44. In relation to the Claimant's post-operative clinical course, Mr Reddy considered that it was broadly consistent with an evolving sepsis/peritonitis. Whilst he acknowledged that there was a period during the early afternoon, post-operatively, when the Claimant appeared to be clinically quite well, he attributed this to the large doses of opiates, the IV fluids and the fact that the Claimant was a relatively young man. Mr Reddy considered that these factors enabled the Claimant to compensate. He took a similar view about the apparent period of stability and absence of pain overnight: the Claimant's improvement was attributable to the analgesia and intravenous fluids.

45. Mr Rahman considered that it was perfectly conceivable that, whilst there had been a perforation at the time of the procedure, because it was relatively small and because the stomach was comparatively empty (the Claimant had been on nil by mouth prior to the operation), there may not have been any signs, in the form of leakage or fluid or bubbles, before the stomach was closed up. He explained the growth in size of the perforation over the period of 24 hours on the basis that a localised collection of gastric juices would have a corrosive effect causing ischemia and necrosis. In his opinion, this evolving process may well have been responsible for extending substantially the size of the perforation so that by approximately 6am on 31st May, there was a significant leakage of fluid from a much larger perforation causing the peritonitis.

46. As to the post-operative clinical course, Mr Rahman considered that this did not support the presence of a significant perforation on the 30th May. It was his view that if there had been a sizable perforation in the hours after surgery, there would have been a significant leak of fluid; and peritonitis would have been established at that time.

47. He considered that the periods of apparent clinical stability in the afternoon and night of the 30th May militated against the proposition that there was, at that time, a significant leak of fluid. Otherwise, he said that there would have been clear signs of peritonitis. Although, the Claimant became unwell during the afternoon of the 30th, Mr Rahman explained this on the basis that he had something to eat which would stir up gastric juices thereby irritating the perforation. The improvement thereafter was not consistent with a significant leakage of fluid causing peritonitis. Mr Rahman also noted the absence of signs of a systemic inflammatory response such as pyrexia, tachycardia and altered respiratory rate. He also attached weight to the fact that at 22.15 there was no abdominal guarding, in contrast with the position at 07.15 when the Claimant was found to be tender *with guarding upper abdomen*. In short, he considered that the clinical picture did not fit with a significant perforation at the time of surgery.

Claimant's Submissions

48. In answer to the question as to how an obvious lesion could have been missed by both Ms Zanotti and Mr Sgromo, Mr Tyack KC makes the obvious, but valid and important, point that mistakes do and can occur, even in the hands of experienced and expert operators. In relation to Mr Sgromo, whilst stressing that little weight should be attached to his statement, Mr Tyack KC submits that there are good reasons to conclude that his perception of the risks associated with this procedure was of too low an order such that mistakes were made. In support of this submission, he points out that Mr Sgromo entrusted the procedure to Ms Zanotti when she lacked sufficient experience. Mr Tyack KC relies upon the observations of Mr Reddy to the effect that he himself would have expected a doctor of Ms Zanotti's level of experience to observe such a procedure being undertaken before being permitted to do it herself, and only then, under close supervision. Mr Tyack KC submits that it was a big leap from assisting in the removal of one gastric band to performing the operation by herself, with only hands off supervision. Mr Tyack KC also relies upon the fact that Mr Sgromo was surgically unscrubbed thereby suggesting that he did not consider that this operation carried much risk.

49. Mr Tyack KC submits also that Ms Zanotti failed to appreciate the level of risk entailed in this procedure. Had she done so, he argues that the error would have been avoided. He points out that she described the operation as being straight forward whereas that was not the opinion of Mr Reddy. He submits that she failed to appreciate the technical difficulties inherent in the dissection of the capsule and the risk of damage to surrounding tissues. Additionally, he points out that there was greater scope for error on the part of Ms Zanotti because of her lack of experience in doing this kind of operation and because of the lack of hands on supervision.

50. Generally, Mr Tyack KC submits that there was ample scope for errors to be made. He says that given the piecemeal nature of this operation and the fact that the surgeon is moving between different tasks, it would not have been surprising if, at various times, Ms Zanotti became distracted. There would have been natural and necessary interruptions when she spoke to colleagues or changed instruments; and this could have resulted in her failing properly to observe what was happening on the screen. In short, Mr Tyack KC submits that there was a significant risk, at various times, that Ms Zanotti may have lost focus and this, coupled with her relative inexperience and lack of hands on supervision resulted in the lesion not being detected.

51. Mr Tyack KC also places some reliance on the fact that Ms Zanotti had no recollection at all of the second procedure, to the extent that she did not even know the size of lesion. She only became aware of the size of lesion in the course of the litigation. Mr Tyack KC submits that this implies she rather dissociated herself from the life-threatening event, underlining the point that she did not appreciate the scope for error and that a lesion could go undetected if proper care was not taken.

52. Additionally, of course, Mr Tyack KC places heavy reliance on the expert opinion of Mr Reddy. Whilst, inevitably, it is not possible to re-construct precisely the course which a perforation of the abdominal wall might take over a period of 24 hours, Mr Tyack KC argues that considerable weight should be attached to the opinion expressed by Mr Reddy because of his clinical experience. He urges the court to accept Mr Reddy's view that it is not plausible to contend that the perforation expanded in the way contended for by Mr Rahman. Mr Tyack KC invites the court to accept the view of Mr Reddy that a full thickness perforation which occurred at the time of surgery would not

have expanded from being invisible to becoming dramatically visible in the space of 24 hours.

53. Furthermore, Mr Tyack KC submits that there was some shift in Mr Rahman's opinion in that in his report, he suggested that the perforation may not have been readily visible *'due to the adhesion and also due to the lack of extrusion of gastric fluid due to the fold'.* In oral evidence, Mr Rahman made no reference to the fold of the stomach, or indeed, the adhesions concealing the fluid but rather he said that the lesion must have been so small that it could not have been seen; and that there was nothing leaking from the perforation.

54. Generally, Mr Tyack KC submits that, whilst very surprising that it was not seen, nevertheless, this perforation would have been readily visible at the time of the operation and, the failure to identify and repair it was due to the lack of care on behalf of the surgeons.

Defendant's Submissions

55. Understandably, Mr Found relies principally upon the evidence of Ms Zanotti who was the only person in a position to say what was seen or what was not seen. He describes her as having the hallmarks of a careful, cautious and caring surgeon. He submits, if there were frothing bubbles and green fluid to be seen on the monitor, any reasonably competent surgeon would not have failed to see it. Mr Found adopts the observation of Mr Reddy that even a member of the public would have picked up the bubbles and leakage of fluid. That being so, he submits that the Court is driven to conclude that the perforation was not readily visible at the time of the operation.

56. Although recognising that Mr Sgromo's evidence has not been tested in cross examination, Mr Found does place reliance upon the fact that he did not see any lesion. Whilst Mr Sgromo may not have been surgically scrubbed, he was present in theatre. Mr Found submits that the chances of Mr Sgromo not looking at the screen in the hour between the injury being caused and closure of the abdomen are very slim. Moreover, he says that if Mr Sgromo had any reason to suppose that there had been a perforation, he would not have put in place expectant management; he would have immediately moved to a re-do operation.

57. Mr Found acknowledges that there is no literature to support the positions taken by either of the two experts. But he does emphasise that Mr Reddy has no scientific basis for asserting that the perforation would have only grown a small amount over the period of 24 hours. Furthermore, he argues that Mr Reddy is not able to explain the relative periods of 'tranquillity' during the earlier afternoon and overnight, if there had been significant leakage of fluid into the peritoneal cavity. He says that these two periods when the Claimant was clinically well are consistent with a small perforation and a very minor, localised leakage.

58. In summary, Mr Found submits that whilst the perforation was very regrettable and the failure to repair it intraoperatively was unfortunate, the Claimant has failed to demonstrate, on the balance of probabilities, that there was any want of care on the part of the operating surgeons.

Discussion

59. It would be tempting but, in my judgment, impermissible to start from the premise that the fact that neither surgeon saw this lesion before closing up the stomach is a good indication that it was not there to be seen. As Mr Tyack KC says in his opening skeleton, that is a circular argument.

60. On the other hand, the fact that the perforation was not picked up by either surgeon in circumstances where it is said by all the witnesses in the case (expert and lay) that it would have been very obvious is highly material and cannot be ignored in the overall evaluation of the case. The point has been made several times that if the perforation was 2cm x 3cm or, even half that size, it would have been readily visible and there would have been signs such as bubbles and leakage of green fluid. If Ms Zanotti, Ms Sgromo and Mr Rahman are correct, the lesion was so small as not to be visible and there was no leakage of fluid. If Mr Reddy is correct, although there to be seen, for whatever reason both surgeons failed to note and repair the lesion.

61. It seems to me that Mr Found is correct in his submission that the starting point should be the evidence of Ms Zanotti. I agree with his assessment of Ms Zanotti: she impressed me as a careful and measured witness who answered questions in a straightforward manner. Of course, the way in which a doctor presents in court may not shed any light on their competence as a surgeon. However, there is no material before the court which tends to call into question her competence and expertise. Whilst it is true that she lacked experience in performing this type of procedure, I accept her evidence that she felt well able to carry out the operation with the help and supervision of Mr Sgromo. She was well used to doing laparoscopic surgery and some of these operations had involved the dissection of adhesions and capsules. At all events, it seems to me that I should proceed on the basis that, in the normal course of events, Ms Zanotti was sufficiently trained and had the requisite competence and expertise to have identified any visible damage to the abdominal wall. I acknowledge, of course, Mr Tyack KC's point that mistakes do occur, even in the hands of skilled operators.

62. The other factual witness is of course Mr Sgromo. I have already made it clear that limited weight can be attached to what he says about the matter. But clear it is, he was present in theatre and he did not observe any complication of any kind. He makes it plain that the anterior aspect would have been visible during the whole of the procedure and would have clearly been seen before the stomach was closed.

63. I turn next to the Claimant's post operative course and the experts' interpretation of what was the likely chain of events during the 24 hours or so before the second operation. Mr Reddy maintains that the signs and symptoms exhibited by the Claimant in the post operative period were consistent with a leaking perforation leading to frank peritonitis in the early hours of the 31st May. It does seem to be me, however, that if there was significant leakage of fluid into the peritoneal cavity from the time when the Claimant left theatre, it is very surprising that the Claimant was apparently well enough to be discharged during the afternoon (albeit this did not happen) and then, after a period of becoming acutely unwell, he was relatively comfortable overnight, not requiring any analgesia.

64. Mr Reddy postulates that the Claimant was compensating by virtue of the large doses of analgesia received coupled with the intravenous fluids; and he was still a relatively young man. But, to my mind, this theory lacks plausibility.

65. I say that because I accept Mr Rahman's evidence that once leakage has occurred, it is probable that the patient will follow an unremitting course of being unwell, with deterioration over time. It is improbable that there would have been periods when he appeared to be well, if there was gastric fluid leaking out from the perforation into the peritoneal cavity. In my view, there is a force in Mr Rahman's observation that the absence of signs of a systemic inflammatory response would tend to suggest that there was no substantial leakage of fluid into the peritoneal cavity until approximately 5am or 6am the following morning. To put it another way, I am satisfied that if the perforation at the time of surgery had been of a size to permit significant leakage of fluid into the peritoneal cavity, on balance, signs of a systemic inflammatory response would have been evident during the hours following the operation.

66. Before reaching a final conclusion, I need to make reference to the apparent inconsistency between Mr Rahman's oral and written evidence in so far as, in his report, he appeared to be saying that the extrusion of gastric fluid would not have been visible *due to the fold*. Mr Tyack KC says that this contradicts what he said in his oral evidence to the effect that there would have been no gastric fluid. However, as I re-read paragraph 7.1.6 of his report, it seems to me that it is somewhat ambiguous: he makes specific reference *to the lack of extrusion of gastric fluid*. Thus, he does appear to be saying that there would not have been visible gastric fluid. In essence, that observation accords with his oral evidence. I am prepared to accept that closer scrutiny of the medical records caused Mr Rahman to develop somewhat his theory as to what occurred during the procedure and thereafter.

67. Ultimately, the court has to choose between two competing theories. What the experts postulate can only be *theories* since they are seeking to reconstruct a course of events which, in normal circumstances, does not occur. There is, therefore, necessarily a degree of speculation involved. There is no literature that can be relied upon to support the views expressed by either of the experts. In the circumstances, this is not surprising.

68. Overall, on the balance of probabilities, I am persuaded that the theory advanced by Mr Rahman is more logical, and therefore, more plausible than the position adopted by Mr Reddy. I repeat that there would not appear to be any satisfactory explanation for the Claimant's 'wellness' during the two periods which have been identified unless it be the case that the significant leakage started at a later time. That being the likely scenario, there is no convincing evidence that there would have been signs of leakage at the time of the operation.

69. I return to what I stated at paragraphs 59 and 60 of this judgment. The fact that no leakage or other signs of perforation were observed by the two surgeons is not determinative of this case. On the other hand, plainly, it has significant evidential value. Mr Reddy said many times that the leakage would have been *unmissable*. Mr Rahman agreed. Both surgeons were very clear that had there been an interoperative perforation of a significant size, it would have been visible to anyone who could see the monitor.

70. I add this: if there had been but a brief window of opportunity to observe any damage intraoperatively then the fact that the surgeons did not see the damage may carry less weight. However, on the evidence, it seems probable that the perforation occurred no later than at a midpoint during the procedure. Given that this part of the stomach would have been visible on the monitor throughout the procedure, it seems to me inherently improbable that evidence of perforation would have been missed, if it was there to be

seen. In short, the number of opportunities to pick up the damage over a period of, perhaps, 1 hour renders the Claimant's claim even more difficult to accept.

Conclusion

71. In conclusion, and of course, whilst having every sympathy for the Claimant, I find that there was not a negligent failure to identify and repair this perforation intraoperatively on the basis that I am not satisfied that there was visible evidence of the damage.

72. It follows that judgment must be entered in favour of the defendant. I assume that counsel will be able to agree an Order.