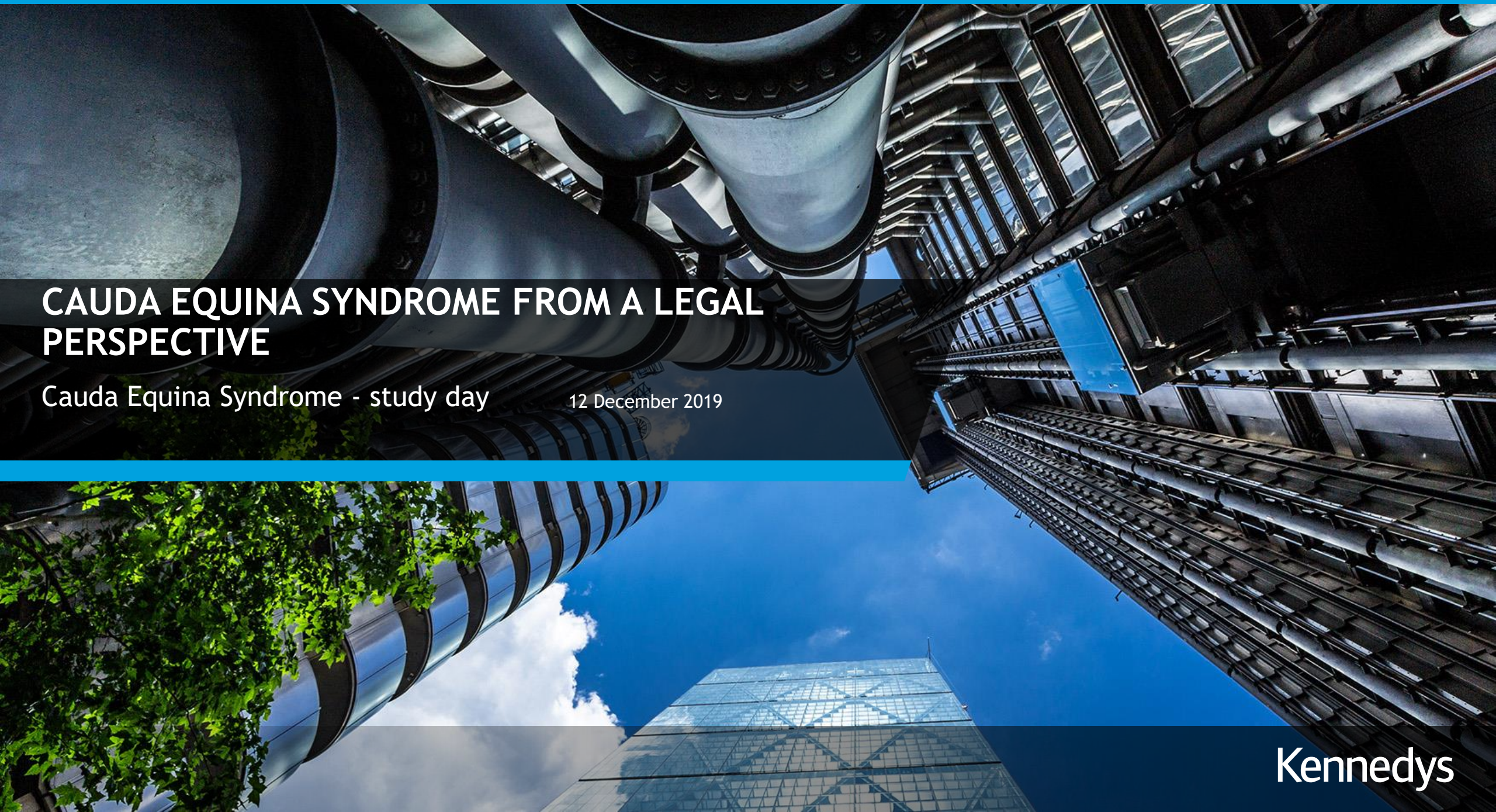

CAUDA EQUINA SYNDROME FROM A LEGAL PERSPECTIVE

Cauda Equina Syndrome - study day

12 December 2019

Kennedys

Introduction

- CES; rare condition with high medico-legal profile as catastrophic clinical outcome and significant claim value.
- Occurs following large central lumber disc herniation or prolapse. Early decompression removes mechanical factors which cause neurological damage.
- When presented with CES, medical assessment on when neurological investigations are required (breach of duty) and whether such investigations and treatment would improve the clinical outcome (causation).
- Incidence per population between 1 in 33,000 or 1 in 100,000 [2007 Slovenia study; CES from disc prolapse 1 in 1.8 million]. Healthcare practitioners rarely see genuine CES.

- What is negligence in the clinical context for CES claims
- What damages are sought in clinical and CES claims
- Case studies

Types of CES claims

- Primary care – delay in arranging CES investigations from GPs, physiotherapists, chiropractors, osteopaths etc
- Acute care – delay in neurological investigations and surgery in Hospital once referred
- Inadequate surgery to relieve neurological symptoms (post-operative observations)

What is Clinical Negligence?

- In order to establish clinical negligence, the Claimant (patient) will have to prove the following:-
  - The healthcare provider owed a **duty of care**;
  - The healthcare provider was in **breach of that duty**;
  - As a result of that breach, a loss/injury has been suffered **(causation)**.
- If one of these factors is not proved, the claim will fail.

(i) Duty of Care

- Where there is sufficient proximity or “neighbourhood” between the Claimant and the Defendant; in the Defendant’s reasonable contemplation, carelessness on her/his part might cause damage to the Claimant (*Anns v Merton London Borough [1978]*).

- There is a clear duty of care between a healthcare provider and their patient.

(ii) Breach of Duty

- The healthcare provider is required to provide “reasonable care”.
- The standard of “reasonable care” based upon medical judgment.
- Bolam test; Healthcare provider treating a patient in accordance with **approved medical practice**, even if followed by a minority of the profession, cannot be found negligent.
  (*Bolam v Friern Hospital Management Committee 1957*)

- The healthcare practitioner must however follow a **reasonable and reputable** body of medical opinion:-

  Bolitho v City and Hackney Health Authority (1998) Lord Browne-Wilkinson stated that:

  "*The Court has to be satisfied that the exponents of the body of medical opinion relied upon can demonstrate that such opinion has a **logical** basis*".

(iii) Causation

- The Claimant must be able to prove that the healthcare provider's negligence (i.e. breach of duty) caused their injury/loss.

- The Defendant's breach of duty must as a "matter of fact" have caused the damage on the balance of probabilities i.e. *Barnett v Chelsea & Kensington Hospital Management Committee (1969)*:-

- Three night watchman attended the Defendant's hospital complaining of vomiting after drinking tea.

- The nurse on duty consulted a doctor by telephone; go home and consult their doctors, if their condition persisted. Later that day, one of the watchmen died of arsenic poisoning.

- Hospital in breach of duty of care but not causative; Even if the Deceased had been treated, on the balance of probabilities, it would not have been possible to save his life.

Whether decompression surgery when patient presents with CES Retention – too late.

Damages in Clinical Negligence

Principles of Compensation

- Compensation is to put the Claimant back into the position they would have been if the injury had not occurred (so far as it possible in monetary terms). Considers Claimant's life before and after injury.

- Damages to meet **reasonable** requirements or needs arising from injuries.

(i) General Damages

Pain & Suffering and Loss of Amenity

- General damages are designed to compensate the Claimant for mental and physical suffering attributable to the injury;

- Loss of faculty or pleasure in life over and above the pain and suffering of the injury;

- The Judicial College Guidelines (15th Edition): Quantify injuries in broad terms:
  - Quadriplegic: £304,000 - £379,000
  - Very severe brain damage: £265,000-£379,000
  - Unnecessary operation with scarring - £8,110
  - Minor injuries with recovery in seven days; £650

- CES general damages for severe back injury with incomplete paralysis and significantly impaired bladder, bowel and sexual function; £85,500-£151,000

(ii) Special Damages including for CES claims

- Losses caused by negligence and capable of precise quantification including:
  - Loss of earnings
  - Care - nursing services rendered to the Claimant (future care)
  - Medical expenses - including the cost of private medical treatment

- Cost of accommodation / adaptations to accommodation (necessary)
- Cost of medication and prescriptions (new drugs)
- Cost of transport arising out of the Claimant's injury (cost of replacement vehicle)
- Cost of therapy; occupational therapy/ physiotherapy
- Equipment

CES case studies

A v B

- Attended GP; history of chronic back pain several years – bilateral lower limb numbness and incontinence of urine
- Suspected CES; Immediate referral to Hospital for MRI – **urgent**
- Hospital Dr noted 200ml of retained urine but not arrange urgent MRI despite foot drop
- MRI 2 days after hospital attendance. Reported on day 3. Patient only then referred to neurosurgical team with CES
- Surgery 2 days later but continued to suffer bladder and bowel incontinence and foot drop - time taken to operate - Cauda Equina was irreversible
- Delay around 5 days for the surgery; should have been within 24-48 hours- Liability established; Claim value to be determined.

Learning points

- Documentation for full history and in the context of new examination – red flags to be recorded
- Bladder scan recorded pre-operatively and followed up
- Same day MRI for suspected CES and surgery expedited. This could have avoided sphincter damage and foot drop.

E v C

- History of lower back pain after injury at work for a national rail provider. Acute presentation to GP but no neurological deficit only right leg numbness; referred for physiotherapy.
- First physiotherapy appointment indicated disc protrusion and nerve pain. Suitable for community physiotherapy. Advised on CES.
- 5 days later reviewed by another physiotherapist; intermittent neurological deficit down both legs, numbness in the genital area when standing and an apparent involuntary bowel movement. Advised on CES but reassured by previous physiotherapist.
- Further physiotherapy over 5 months – no improvement.

E v C continued

- Low back pain spasm at home and collapsed 5 months after physiotherapy commenced. Admitted to Hospital and MRI – large central disc prolapse (L4/L5) with severe CES (CES R). Surgery but loss of neurological function.
- Lack of investigations prior to the Claimant's collapse with continuing intermittent neurological symptoms (CES I)
- Potential defence that an initial referral unlikely resulted in surgery to prevent CES, as not significant protrusion
- Settled £1.75 million plus costs

E v C continued

Settlement based on:

- General damages - £120,000
- Past and future care - £800,000
- Past and future loss of earnings - £500,000
- Past and future travel – £20,000
- Accommodation - £250,000
- Therapy - £50,000
- Miscellaneous expenses - £20,000

Learning points

- Record presentation in full and explore all CES symptoms/checklist at all presentations
- Early clinical investigations even if CES unclear. Allow the Hospital/clinicians to consider symptoms and presentation separately

S v PA

The Claimant injured back in RTA whilst working as taxi driver

- MRI revealed normal appearance with degenerative disc L3/4 and L4 protrusion
- 1 year later altered sensation in right leg with neurological deterioration. Attended Trust A&E. Placed on waiting list for spinal decompression
- Developed dropped foot and bowel problem. MRI showed large disc protrusion L4/5 and progression. NOT CES.
- 6 months later operation to decompress L4/5 and L3/4; intra-operative dural tear and protrusion

S v PA

- Post-operatively numb from the knees down in both legs. Ongoing weakness and loss of bowel and bladder control noted. Day 4 symptoms suggestive of Cauda Equina Syndrome and MRI. Day 7 – Consultant review and exploration procedure for further decompression but left with significant loss of function.
- Liability for the first operation (not removing L4/5 disc bulge adequately and reducing protrusion from dural tear) and lack of investigations in a timely fashion evidence of post-operatively.
- Settled for £1.6m plus costs

General damages for Loss of mobility, bowel and bladder incontinence: £115,000

Past and future care: £500,000

Loss of earnings: £250,000

Accommodation: £600,000

Therapy: £60,000

Past and future transport: £40,000

Miscellaneous expenses: £30,000

- Offset with contribution claim on RTA

Learning points

- Post operative observations and CES awareness
- Consultant led investigations
- Ensure accurate medical records

Conclusion

1. Importance of keeping accurate records and documents

2. Consider early investigations if in doubt

3. Importance of communication with the patient on their condition and possible red flags with the appropriate provision of information.

Questions


@KennedysLaw


linkedin.com/company/Kennedys


facebook.com/KennedysTrainees

kennedyslaw.com

Kennedys