# CHAPMAN
# vs
# MID & SOUTH ESSEX NHS FOUNDATION TRUST

## MRS JUSTICE HILL

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**Introduction**

- Chapman, the Claimant, had a history of lower back pain caused by a severe grade 2/3 spondylolisthesis.

- On 20 March 2017, she was diagnosed with a different spinal problem, namely a prolapsed thoracic disc at the T11/12 level. She underwent surgery to remove that disc on 30 March 2017.

- By this claim, she alleges that the Defendant was negligent in that there was a delay in diagnosing and treating the prolapse. Her case is that, as a result of the delay in treatment, the prolapse progressed and resulted in paraplegia.

# The Experts

## Chapman (Claimant)

- Pain Expert – Dr S
- Neurosurgical Expert – Mr R

## Dr B (Defendant)

- Pain Expert – Dr S
- Neurosurgical Expert – Mr W

## Dr M GP (Defendant – Case Dropped)

- Neurosurgical Expert – Mr F

- **1 December 2008** she saw Dr M. “does not entertain the idea of surgery”. He performed facets and lumbar epidural.

- On **6 October 2009**, referred to Dr B for 2nd opinion.

- **9 November 2009**, Nurse B

  “Constant intense pain. Radiates into buttocks and both legs to feet. Beginning to radiate up back. Has shakes. If walks too far collapses. Has fallen down stairs ? leg gives way ?”.

- **11 November 2009,**

  Abdominal pain, 2 weeks right hypochondrial region, she traces it to a curry but investigations were performed for Gall Bladder- scan NAD.

- **24 December 2009,** Dr B, No Examination and comments in his letter below.

  - “*her type of pain has to be managed with a multi-disciplinary approach and she will need to see our psychologist for initial individual sessions and possibly at some stage receive physiotherapy input. In the longer term she may be suitable for the Pain Management programme****. I have also explained that at this stage surgery or injections is not going to help her pain*****.”**

- **Seen in Psychology** and referred back to Dr B
- **30 September 2010**, Saw Dr B, did not examine her and his letter said.

  "*She will need to work with either the physiotherapist in terms of hydrotherapy and the Fitness Group to become more mobile and obtain a good quality of life and improve her ADL [Activities of Daily Living] or* ***see a surgeon to consider surgical options, which I have discussed in detail with her, however she is not keen on having surgery***."
- Limited medical attendance but expressed dissatisfaction in **2014** regarding her Rx via pain clinic and psychiatrist to GP.
- **8 March 2017**, collapsed in the toilet with pain and "legs gave way" GP advised A&E attendance
- **9 March 2017** ambulance to A&E at Basildon and seen by ENP Nice who was pregnant and did not do a full examination.

- Symptoms worsened and seen by her GP on **13 March 2017**, examined and he suggested an urgent MRI scan.

- Did not go to A&E despite advice by GP, OT and Ambulance as felt would not be taken seriously till an MRI Scan was performed. (As recently had been to the A&E without any progress)

- **20 March 2017**, doubly incontinent and inability to mobilise, 4 pm Lumbar MRI and then thoracic MRI.

- **30 March 2017 She underwent a left-sided thoracotomy and T11/12 discectomy. She has been left with T9 incomplete paraplegia.**

- **The Judge preferred Mr R (Claimant) opinion.** According to him, the prolapse was symptomatic in **2009/10,** it was likely that the Claimant's pain had not persisted because it was, at that time, a soft disc prolapse (Presenting with leg giving way and abdominal pain).

- The disc had later **altered its position** within the spinal canal so that it was no longer causing nerve root impingement but continued to compress the spinal cord causing lower limb weakness and mobility difficulties.

- A thoracic disc prolapse can progress gradually over the years. In the Claimant's case, there had been a deterioration in her condition during 2009/10, and subsequently, she had **limited her activities** to a very significant degree, meaning that the irritation of the spinal cord had not progressed as it would in someone leading a more active life.

- The symptoms did then **progress in 2017** when the Claimant had to take on a more active role looking after her husband following his car accident.

## Points raised by the Defendant's Pain Expert

The claimant was not a **consistent and reliable historian** (witness statement, reported symptoms to clinicians)

"commonplace in patients with severe chronic pain that they may suffer collapses and falls" and that such events are not necessarily neurological but can be caused by pain.

Leg weakness "could be due to anything"; "**pain itself can cause muscle dysregulation**"; and "severe pain is one of the very common reasons for a weakness and give way".

There was **no evidence of nerve compression**, such as pins and needles, numb feeling or bladder/bowel dysfunction, which often goes "hand-in-hand" with leg weakness. However, Spinal Expert evidence was that a thoracic disc prolapse could lead to an adverse impact on motor function without there necessarily being an impact on sensory function.

The "**difficult balancing act**" of pain medicine being the choice between undertaking "further investigations for symptoms that can be explained by pathology that you know about, because investigation is not necessarily a benign process"; or attributing those symptoms to "what you know".- No E/O of this analysis in the records.

Avoid "**medicalisation**" of the patient as counter-productive. Functional decline was not necessarily indicative of new pathology

**Claimants Expert Points**

- “risky inference to assume that it is just a pain thing without making further enquiries and investigating further”.

- The pain physician should be “**vigilant**” for new or changing pain symptoms and be “**alive**” to significant changes in presentation that “might” indicate new pathology.

- The thrust of Dr S’s evidence was that the report of a **fall alone was a sufficient “red flag”** to have required Dr B to investigate further.

- Dr B should also have identified the clear **deterioration** in the Claimant’s functioning when he saw her, compared with when she had been seen by **Dr M** a year earlier.

**Mrs Justice Hill's Conclusions**

1. Dr B acted in breach of duty in failing to order an updated MRI scan or conduct a full neurological examination of the Claimant. He also acted in breach of duty in failing to take an adequate history or conduct an examination at the 2010 consultation and by exceeding his remit and giving the Claimant advice on surgery.
2. The disc prolapse was symptomatic in 2009/10, such that the Claimant would have been offered surgery for it at that point.
3. The Claimant would have elected to undergo this surgery: Had this occurred, the Claimant would have made a full neurological recovery, whilst pain and disability arising from her spondylolisthesis would have persisted.
4. The Claimant's claim in relation to Dr B is therefore upheld.
5. ENP Nice did not act in breach of duty on 9 March 2017 in failing to undertake a proper neurological examination. The Claimant's claim in relation to ENP Nice is therefore dismissed.

- **My Opinion / Observations**
- With hindsight, Dr B should have picked on the “red flag” in the nurse’s letter, an MRI scan ordered, with a referral to the spinal surgeon in 2010. He should have acted in his remit and not advised on Surgery.
- Pre-existing lumbar problems and thoracic discs requiring surgery are rare. (**Incidence?**)
- Most pts say that their **symptoms are worse**, but do we examine all wheelchair-bound patients or refer them for an MRI scan? Especially if the patient says that they **do not want surgery** and has known lumbar spine pathology.
- The appointment with Nurse B was greater than **30 minutes** and the appointment with Dr B was for 15 minutes.
- According to the judge, **Defendant Spine Expert** “resiled” and made “several concessions” to his opinion regarding the thoracic disc in the JS. The Judge accepted the Claimant’s Spinal Expert opinion. (Mr **F?**)
- Dx 20 March 2017 but surgery was on 30 March 2017. Why the delay in a doubly incontinent patient?
- ENP Nice got away
- Contributory negligence by the Claimant? **(Claim Amount** £685,000**)**

- **Learning Points for a Pain Consultant**

- Examine if Wheelchair-bound- esp if symptoms have changed and document the absence of red flag signs. If you cannot examine then document why the patient was not examined?

- At **review note** any change in symptoms and document re-examination.

- Do not opine on whether a pain patient requires **Surgery** or not as this is not in the remit of a pain consultant. If unsure refer or take 2nd opinion or discuss at the MDT if available.

- Low threshold for an MRI scan if symptoms/signs (Controversial)

- Look for any ”red flags” embedded in the nurses’/pharmacists' letters.

- When a patient is seeking a 2nd opinion- be critical rather than follow the previous opinion.