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Case No: HQ15CO2517

**IN THE HIGH COURT OF JUSTICE**
**QUEEN'S BENCH DIVISION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26 April 2017

**Before** :

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

**Between :**

**David John Smith** **Claimant**

**-and-**

**Barking Havering & Redbridge NHS Trust** **Defendant**

**Ms Rachel Vickers** (instructed by **Slater & Gordon (UK) LLP**) for the **Claimant**
**Ms Farrah Mauladad** (instructed by **Kennedys Law LLP**) for the **Defendant**

Hearing dates: 20-24 March 2017

# APPROVED JUDGMENT

I direct that pursuant to CPR PD 39A Paragraph 6.1 no official shorthand note or tape recording need be taken of this judgment and that copies of this version as handed down may be treated as authentic.

His Honour Judge Reddihough

**His Honour Judge Reddihough :**

1. This is a claim for damages for personal injury, loss and damage arising out of alleged negligent treatment of the claimant between August 2010 and March 2012 at Queen's Hospital, Romford, which is under the control and management of the defendant. The central allegation against the defendant is that there was a failure properly to treat or deal with a polyp in the claimant's sigmoid colon as a result of which it is asserted he suffered continuing bowel symptoms and had to undergo a resection operation in August 2012 involving the removal of the sigmoid colon and the upper third of the rectum. It is alleged that by reason of the continuing symptoms he suffered financial loss, and in particular loss of earnings, for which he claims, in addition to damages for pain and suffering.

2. It is necessary to consider the relevant history of the claimant's symptoms and treatment. He is now 60 years old and in the period in question his occupation was a self-employed sound engineer.

3. In July 2010 the claimant was referred to Queen's Hospital by his general practitioner as a case of suspected bowel cancer under the two week waiting scheme operated at the hospital. Under this scheme patients would be seen if possible within two weeks at the rectal bleed clinic which had the capacity to take the patient's history and undertake flexible sigmoidoscopy examinations. The claimant had a two year history of rectal bleeding on bowel opening and had begun to suffer increased bowel movements (three to four times a day) with loose stools. There was a familial history of bowel cancer, his father having died of that condition.

4. On 9th August 2010 the claimant was seen by Mr. Huang, a consultant colorectal surgeon at Queen's Hospital. Mr. Huang performed a flexible sigmoidoscopy on the claimant. He was unable to pass the flexible scope beyond 30 cm. of the sigmoid colon due to there being oedematous mucosa, which is an inflammation and swelling of the bowel wall. He identified a 1 cm. polyp 20 cm. along the sigmoid colon. He intended to remove the polyp by means of snaring it with a wire loop through which would be passed an electric current or diathermy. Unfortunately the diathermy equipment was not working at the time and so he was unable to do this.

5. Mr. Huang wrote to the claimant's G.P. on 10th August reporting his findings. He said: *"Flexible sigmoidoscopy was only possible to 30 cm. At this level the procedure was uncomfortable and there was oedematous mucosa in the sigmoid. I wonder if this represents diverticulitis. At the 20 cm. mark there was a 1 cm. polyp. I was unable to snare this today due to equipment failure. I have organised for him to have a colonoscopy and polypectomy and will keep you informed of his results."*

6. In the referral form for the colonoscopy Mr. Huang stated that the procedure required was colonoscopy and polypectomy. In the section of the form headed "Reason for request and results of previous endoscopies and X-rays", Mr. Huang entered "Rectal bleeding, change in bowel habit, loose stools. Flexible sigmoidoscopy to 30 cm. At 20 cm. polyp (not removed)." On his notes of the flexible sigmoidoscopy Mr. Huang had included a drawing showing the approximate position of the polyp which he had identified.

7. On 23rd August 2010 the claimant underwent a colonoscopy performed by Mr. Saharay, a consultant general surgeon at Queen's Hospital. Mr. Saharay was able to pass the instrument to the caecum and his findings were that there was diverticular disease in all of the sigmoid colon. He did not identify any polyp. The consent form for this procedure referred to colonoscopy but not polypectomy. Following this procedure Mr. Saharay referred the claimant back to Mr. Huang.

8. On 10th September 2010 Mr. Huang reviewed the claimant's notes. He noted that no abnormality had been detected in the colon and planned to take the claimant off the two week referral list, but to carry out a further flexible sigmoidoscopy in October/November.

9. On 14th September 2010 Mr. Huang wrote to the claimant as follows. *"I am writing to let you know that your recent colonoscopy examination confirms diverticulae in your colon. This is a completely benign condition which is akin to wear and tear and it can certainly explain some of your symptoms and findings. I enclose a leaflet regarding this condition. This is usually self limiting. I propose to have a look at your bowel again with a short telescope, also called a flexible sigmoidoscopy to see if things have settled."* Although there was no reference to a polyp in that letter it is clear that Mr. Huang knew that no polyp had been seen at the colonoscopy performed by Mr. Saharay. It appears that it was for this reason that he wished for a further flexible sigmoidoscopy to be performed on the claimant.

10. On 14th September 2010 Mr. Huang completed the request form for the further flexible sigmoidoscopy. In the section headed "Reason for request and results

of previous endoscopies and X-rays", he entered "Diverticulitis flexible sigmoidoscopy in August 2010. 1 cm. sigmoid polyp but not seen at colonoscopy. Re-scope to check."

11. The further flexible sigmoidoscopy was performed on 6th December 2010 by Mr. Reese, trainee endoscopist, under the supervision of Mr. Johnston, a consultant surgeon. On the report of the procedure it was stated that the quality of bowel preparation was satisfactory and that random biopsies were taken. Mild patchy inflammation in the distal sigmoid colon was noted.

12. The histology report dated 10th December 2010 in relation to the biopsies taken during the further flexible sigmoidoscopy indicated that there were no signs of active inflammation, dysplasia (abnormal cells) or malignancy. There were no signs of microscopic colitis.

13. It appears that Mr. Huang then reviewed the claimant's case and on 24th December 2010 he wrote to the claimant in the following terms: *"I am writing to let you know that your recent flexible sigmoidoscopy examination of your bowel did not reveal any abnormality. This is very reassuring. I hope that your symptoms have settled. I have not made any routine appointments to see you but would be most happy to do so if your doctor feels that it is necessary."* Again, in that letter Mr. Huang made no reference to the polyp which he had seen on his original flexible sigmoidoscopy. Thereafter, the claimant's bowel symptoms persisted. He was suffering increasing diarrhoea and had blood in his stools and developed abdominal pain. He therefore returned to his G.P. in October 2011. His G.P. referred him back to Mr. Huang, stating in his referral letter dated 19th October 2011 *"I would be grateful if you could review this*

*gentleman whom you last saw in December of last year. He had a sigmoidoscopy and a colonoscopy which confirmed diverticular disease. However his symptoms are persisting and he would like to be reviewed."*

14. In fact, he was not then seen by Mr. Huang but by Mr. Craddock, a specialist registrar at Queen's Hospital, on 16th January 2012 in Mr. Huang's clinic. The claimant reported to Mr. Craddock that his main problem was abdominal pain which had been going on for at least three months. In addition to this he had increased frequency of his bowels, up to six times per day, since the previous summer. He also had bright red rectal bleeding whenever he opened his bowels. Mr. Craddock reported these findings to the claimant's G.P. in a letter dated 17th January 2012 and stated, *"I wonder if this is all due to diverticulitis and I have arranged for a CT scan of the abdomen and pelvis ...."*

15. The CT scan of the claimant's abdomen and pelvis was undertaken on 8th February 2012. The report of the scan stated that a lot of diverticula were seen in the sigmoid and descending colon. There was also an impression of mild concentral wall thickening of the sigmoid colon in a length of 6.5 cm. The consultant radiologist suggested that further endoscopical investigation would be helpful. There was no reference to any polyp being seen on the CT scan report.

16. It appears that there was a delay in the claimant or his G.P. receiving the report on the CT scan. The claimant was dissatisfied with Queen's Hospital and therefore asked his G.P. to transfer his care to St. Mark's Hospital, Harrow. His G.P. agreed and on 2nd April 2012 the claimant was seen by Miss Beaton at St. Mark's Hospital in the clinic of Professor Robin Phillips. Miss

Beaton noted that, according to the claimant, he had been experiencing intermittent lower abdominal pain which was colicky for the past two years. He was now opening his bowels up to seven times per day and there was still fresh blood mixed with the stool. The claimant told Miss Beaton that he had been investigated with three endoscopies and had been told that he possibly had polyps and diverticular disease. Miss Beaton also noted that the CT scan performed in February 2012 had shown a 6 cm. length of thickening in the sigmoid colon. Miss Beaton wrote to the claimant's G.P. on 3rd April 2012 setting out these findings and stating that she considered the claimant warranted a further colonoscopy so that it could be seen if he did have diverticular disease and a diverticular stricture.

17. The claimant underwent a colonoscopy at St. Mark's Hospital endoscopy unit on 14th June 2012. The endoscopists, Dr. Green and Dr. Suzuki, identified a polyp at 20 cm. The polyp was described in the endoscopy report as having a head approximately 1 cm. in diameter and looking mitotic. It had a very broad stalk about 2 cm. in length with overlying chicken skin mucosa. It was recorded that during the procedure the stalk of the polyp was injected and seemed to lift well, but when there was an attempt to remove the polyp with cautious snare diathermy the claimant felt sharp pain. The removal of the polyp was therefore not completed. It was considered that the polyp represented a T1 lesion but it was difficult to be accurate due to trauma through the area prolapsing.

18. The claimant was therefore referred for urgent staging CT scanning and a multidisciplinary team discussion.

19. On 19th June 2012 the staging CT scan was carried out and it was reported that on the scan marked diverticulosis was seen in the sigmoid colon and descending colon with bowel wall thickening in the mid sigmoid. The polyp was not visualised on the CT scan. The biopsies taken from the polyp on 14th June 2012, according to the histology report, revealed no invasive malignancy and stated that the features represented high grade dysplasia.

20. Despite the findings on histology, the doctors at St. Mark's were very suspicious that the polyp was cancerous. Dr. Suzuki said that, although histology showed high grade dysplasia, she remained extremely suspicious and referred to the fact that on the cautious snaring of the polyp during the colonoscopy the claimant experienced pain, which indicated cancerous infiltration of the polyp.

21. On 5th July 2012 the claimant was seen at St. Mark's Hospital by Mr Kennedy, a consultant surgeon, who said that he was sure that the polyp was cancerous. As a result it was recommended that the claimant should undergo a high anterior resection. The claimant underwent this operation on 8th August 2012. At the operation the sigmoid colon and upper third of the rectum were removed with a primary anastomosis.

22. The histology report following the operation indicated that the resected specimen consisted of 31 cm. of sigmoid colon and upper rectum. The lumen of the colon was narrowed and there was evidence of diverticular disease. The polyp measured 1.5 cm. and was described as "a tubular adenoma with low and high grade dysplasia … features of polyp torsion." There was, therefore, in fact, no evidence of malignancy in the polyp.

23. At the operation the claimant was provided with a loop ileostomy which was reversed on 26th September 2012. Following the surgery the claimant had accidentally pulled out his urinary catheter. After his discharge from hospital he began to suffer a loss of bladder sensation and these symptoms continued into 2014 but have now resolved. The overall result of the surgery was that the claimant no longer suffered from any of his previous bowel symptoms.

24. Some of the allegations of negligence alleged in the Particulars of Claim are no longer pursued. The allegations now relied upon can be summarised as follows. It is alleged that the claimant should not have been discharged in December 2010 and there should have been further endoscopic examinations and/or a CT colonogram so that the polyp could be identified and removed. It is further alleged that the claimant should have been advised in relation to the polyp and about whether his symptoms were referable to it, and of the risk of malignancy associated with it.

25. In the Defence, negligence is denied and it is averred that Mr. Huang acted appropriately in referring the claimant to have the colonoscopy and further flexible sigmoidoscopy. When the experienced consultants who carried out those procedures did not identify the polyp, it was reasonable for Mr. Huang to notify the claimant that he was suffering from diverticulitis rather than to concern himself further with the possibility of a polyp. It is said that the finding of diverticular disease in the sigmoid colon provided a satisfactory explanation for the claimant's symptoms. Thus it is denied that it was negligent for there to be no further endoscopic examination or a CT colonogram at Queen's Hospital and it is asserted that a responsible body of

surgeons would not have referred the claimant for such further examination following two endoscopic examinations which did not identify a polyp. It is further denied that it was negligent not to give the claimant further advice regarding the polyp.

26. So far as issues as to causation are concerned, it is the claimant's case that, had the claimant been advised properly about the polyp at Queen's Hospital, he would have required it to be removed. The claimant asserts that if further investigations had been carried out the polyp would have been identified and removed by snare or snare diathermy so that he would not have required the resection operation and the temporary ileostomy. It is further said that, had the polyp been removed in or around December 2010, he would then have suffered no or minimal bowel symptoms from his diverticulitis, which would have been managed conservatively.

27. The defendant asserts that, if there had been further investigations in 2010 or early 2011, the polyp would not have been identified or removed. Even if it had been so identified, it would not have been removed by snare diathermy as the claimant would have experienced pain on the attempt to remove it just as he did in June 2012. Therefore he would have required the resection operation in any event. The defendant further maintains that the polyp did not materially contribute to the claimant's bowel symptoms between 2010 and August 2012 and that those symptoms were attributable to his diverticulitis. It is said by the defendant that the symptoms from his diverticulitis became so bad that in any event he would have required the resection operation to arrest those symptoms.

28. The factual evidence on behalf of the claimant consisted of witness statements and oral evidence from the claimant, Mr. Roden and Mr. Langer. The evidence of the latter two witnesses was only in relation to the claimant's loss of earnings claim. On behalf of the defendant there was factual evidence from Mr. Huang and Mr. Saharay by way of witness statements and oral evidence. The expert evidence consisted of reports, joint statements and oral evidence from Mr. Raymond Delicata, a consultant surgeon with a specialist interest in colorectal surgery, instructed on behalf of the claimant, and Mr. Luke Meleagros, a consultant surgeon with a long experience in colorectal surgery, instructed on behalf of the defendant.

29. In his witness statement, the claimant confirmed the history as set out above. He confirmed that after the flexible sigmoidoscopy on 9th August 2010 Dr. Huang told him that he had found a polyp and wanted to snare it but that the equipment was not working. After the colonoscopy and further flexible sigmoidoscopy he was told that there was nothing there and that he simply had diverticulitis. He was advised to change his diet by a nurse.

30. The claimant then described how his bowel symptoms became worse thereafter until it was increasingly difficult for him to leave the house due to constant diarrhoea, blood in his stools and stomach cramps. He eventually went back to see his G.P. because of these symptoms in October 2011 when he was referred back to Queen's Hospital and underwent the CT scan in February 2012. Thereafter he asked to be transferred to St. Mark's Hospital and confirmed the treatment which he there received. He said that his bowel symptoms stopped after the operation in August 2012.

31. The claimant described how his bowel symptoms had eventually prevented him from working, as a result of which he lost his regular work as a sound engineer at London Zoo. He had been offered a job to install a new sound system at a club called Sophisticats, where a refit was to be carried out. He had known the owner of this club, Mr. Langer, for about thirty years. He was unable to take this job because of his bowel symptoms. He estimates he would have made a gross profit of about £70,000 from that job.

32. In his oral evidence, the claimant said that, following the second flexible sigmoidoscopy at Queen's Hospital, he was advised by a nurse that he would just have to live with his diverticulitis and was given some advice about diet. He accepted that he had first consulted solicitors in July 2012 after he was told by the doctors at St. Mark's that he had cancer and he therefore thought that Queen's Hospital had missed the cancer. He said he was told that he had a 99% chance that he had cancer, whereas, of course, it transpired that he did not have cancer. The claimant agreed that he had a two year history of blood in his stool by the time he was referred to Queen's Hospital in 2010. He claimed that he had not received the leaflet which was referred to in Mr. Huang's letter to him of 14th September 2010 but said that he did at some stage receive a leaflet about diverticulitis and diet.

33. The claimant said that at the time of the investigations at Queen's Hospital he went on-line to look up diverticulitis and polyps. As a result of that he knew there was a risk of a polyp becoming malignant. He said that after the letter from Mr. Huang of 24th December 2010 he never went to anyone else about the polyp and never asked his G.P. to refer him back to Mr. Huang. Indeed, the

claimant had to accept that the G.P.'s records showed that he did not consult the G.P. between 24th December 2010 and October 2011, although his symptoms were becoming worse over that period. The claimant agreed that when he saw Mr. Craddock at Queen's Hospital in January 2012, he told him that his bowel movements had gone from four a day to six a day by the summer of 2011 and that he had had abdominal pain for three months. He said that by the time he saw Miss Beaton in April 2012 *"I had no control over my bowels - not literally incontinent but I had to be very careful."* He said he was going to the toilet some eight or nine times per day and would wake up in the night as well to go to the toilet.

34. The claimant said that his work had begun to be affected in mid 2011 and he thought he had lost the contract with London Zoo by the end of 2011 or the beginning of 2012. He was quite clear that he would have been awarded the Sophisticats job, as he had done large jobs like that before, although not since 2006. Although he had other medical problems, including osteoarthritis in his hand, he said they would not have affected his ability to work.

35. When he was re-examined, the claimant claimed that he thought his symptoms in December 2010 were due to the polyp and that the diverticulitis was "something to get on with". He said that he was concerned about the polyp but because he was in the hands of experts he did not ask anyone about it. When the second flexible sigmoidoscopy was being undertaken he did not hear the doctors discuss anything about the polyp. After that he claimed that he still thought he had the polyp but he never went back and asked about it. He only went back to his G.P. in October 2011 because of the worsening of his

symptoms. Although earlier in his evidence he had said that, from his on-line search in late 2010, he knew there was a risk of a polyp becoming malignant and had said that he thought his symptoms in December 2010 were due to the polyp, he asserted *"If I had been told there was a polyp and risk of cancer from it I would have been jumping up and down to get something done. If I thought that the polyp was causing any of my symptoms I would have got something done about it."*

36. Mr. Graham Roden confirmed in his witness statement that he had worked for the Zoological Society of London as head of estates until 2013. He confirmed that the claimant had regularly carried out work at London Zoo and spoke highly of him. He said that due to his symptoms his work and attendances had deteriorated to the point when he was given no further work at the zoo. In his brief oral evidence Mr. Roden said that the claimant had worked for some ten years at the zoo and in addition to his regular maintenance and other work he also on occasions tendered for projects, on some of which he was instructed.

37. Mr. Simon Langer's witness statement stated that he was a director of a company which owned the Sophisticats nightclub. He said he had known the claimant since the 1980's and he had done work for him in the past. He regarded the claimant as a good worker and so would regularly instruct him. He said that in around 2012 the Sophisticats club required a refit including a new sound system and lighting. This job was offered to the claimant but he had to decline it because of his ill health. He thought that about £150,000 to £200,000 had been spent in total on the refit but was unable to state how much of that would be attributable to the sound system. In his oral evidence he said

that he thought between £100,000 and £150,000 would have been paid to the sound and lights contractor.

38. Mr. Joseph Huang, consultant colorectal surgeon, in his two witness statements dated May 2016 and November 2016, gave a detailed account of the work which he undertook at Queen's Hospital and his treatment of the claimant. Mr. Huang had held the position of consultant colorectal surgeon at Queen's Hospital since 1st February 2006. He now sees about 2,000 new two week wait referrals each year, performing around 500 colonoscopy or flexible sigmoidoscopy procedures each year. He operates on between 80 and 100 major colectomy cases per year. In 2010 his practice was on a smaller scale than now. He gave a description of flexible sigmoidoscopy which examines the left side of the colon, and of colonoscopy, which looks at the whole of the large intestine. He described diverticular disease as a common condition in which pouches appear in the bowel, and diverticulitis where there is inflammation of the affected bowel giving rise to symptoms. He said that there is no conservative treatment which would prevent or get rid of diverticular disease, but a patient may elect to undergo surgery to remove those aspects of the bowel which are affected if the condition is affecting their lifestyle. He said that of the 80-100 major surgeries that he conducts in a year, he estimated that at least two-thirds are attributable to cancer and of the remaining third one half would be relative to diverticular disease.

39. Mr. Huang said in his statement that he had very little independent recollection of the claimant but that he was assisted by the entries in the contemporaneous medical records. He described the flexible sigmoidoscopy

which he performed on the claimant on 9th August 2010. He was unable to proceed past 30 cm. of the sigmoid colon, which is less than half of the distance he would normally have viewed. At that point the bowel wall was thickened due to oedematous mucosa. He did not push any further due to a risk of perforation. He considered that the claimant's presentation indicated diverticulitis and that his symptoms were consistent with that. In any event, the claimant required a colonoscopy so that the whole of his colon could be assessed.

40. Mr. Huang said that in conducting the flexible sigmoidoscopy he identified a polyp at 20 cm. along the sigmoid colon and he indicated on a diagram in the notes a rough indication of where the polyp was observed in the higher upper part of the rectum where it bends and turns a corner into the sigmoid colon. Mr. Huang confirmed in his second written statement that, although he would have intended to remove the polyp by diathermy, he was not able to attempt to do this due to failure of the equipment.

41. It was stated by Mr. Huang that he certainly did not think that the polyp was suspicious or cancerous. If it had been he would have queried cancer in his notes. If it were cancer the polyp would have looked different and would have had a change to its surface. If he had been suspicious that the polyp was cancerous he would have biopsied it rather than try to remove it. He said that in his experience it is highly unlikely that a 1 cm. polyp would have caused a change in bowel habit and so he would have been satisfied that the cause of the claimant's symptoms was diverticular disease and/or diverticulitis.

42. The claimant was then referred by Mr. Huang for a colonoscopy and polypectomy on the referral form referred to in the history set out above. After the colonoscopy Mr. Huang was provided with a copy of Mr. Saharay's report and he noted that diverticular disease was identified and affecting the whole of the sigmoid. He noted that no cancer had been detected in the colon. Mr. Huang said that he could recall that he was slightly surprised that the polyp had not been identified at the colonoscopy. Because he was confident he had seen a polyp on 9th August 2010, he wished for the sigmoid to be checked for a third time. He stated that it is possible to miss a polyp on endoscopy or that it is possible to believe that there is a polyp when there is not, as normal tissue can give the appearance of a polyp internally. He said that in general a polyp would be removed as it can turn cancerous after many months or years. He therefore completed the request form as referred to above for the repeat flexible sigmoidoscopy. He noted that that procedure was carried out by Mr. Reese under Mr. Johnston, the consultant colorectal surgeon, who was far more senior than Mr. Huang.

43. Mr. Huang accepted that in his letter to the claimant on 14th September 2010, notifying him of the results of the colonoscopy and the proposal to look at his bowels again with a further flexible sigmoidoscopy to see if his condition had settled, he did not mention that the primary purpose of the further examination was to consider the presence of a polyp. Mr. Huang said, *"I exercised my clinical judgment not to alarm the claimant when the indication was that his condition was benign diverticular disease."*

44. When the further flexible sigmoidoscopy did not identify a polyp Mr. Huang said that he felt that, as two senior colleagues had reviewed the same segment of bowel, he had probably been overcalling something that he had seen. The biopsies taken from the claimant's bowel confirmed there were no signs of active inflammation, dysplasia or malignancy. Therefore Mr. Huang considered that it was appropriate to put the claimant's symptoms down to his diverticular disease and diverticulitis. On the basis of the flexible sigmoidoscopies, the colonoscopy and biopsies, he did not consider that there was any justification for further investigation. He considered that as he had overcalled what he had seen it was not appropriate to put the claimant through an additional procedure. To do so would have raised the question of when investigations should have stopped when two more senior clinicians had already gone looking for and not identified the polyp. Mr. Huang said this was a clinical judgment which he was required to make.

45. He then wrote the letter to the claimant on 24th December 2010 in the terms referred to in the history set out previously.

46. At the trial Mr. Huang was cross-examined at some length. It was put to him that he had failed to advise the claimant about the polyp or mention it in his letter dated 24th December 2010. Mr. Huang again said that he thought he had "overcalled" the polyp because it was not seen on the two subsequent endoscopies. He said there was therefore no necessity to discuss it with the claimant as one does not go over non-findings. He said in his letter dated 24th December 2010 that no abnormality was found and there was no advice in the letter about the polyp because it had not been found on two occasions. In any

event he said when he had seen the polyp it appeared to him to be benign. He said that if he had seen that the polyp was on a stalk he would have recorded that. He said that it can sometimes happen that tissue is removed in the belief that it was a polyp but on histology it comes back as normal tissue.

47. Mr. Huang said that when the polyp was not seen on the colonoscopy his reaction was that the claimant needed to be looked at again in case he fell into the 2-5% where a polyp is missed. There was also the possibility that the polyp had resolved he said. Again, he referred to the fact that one can mistakenly identify a polyp where an area of the bowel is swollen and there is the appearance of a polyp, but when the inflammation settles the same surrounding area can settle as well.

48. Mr. Huang's view was that the 1 cm. polyp's contribution to the claimant's symptoms was minimal.

49. When Mr. Huang was questioned about what he meant by saying he had overcalled the polyp, he said that he was not saying he did not see it but it turned out that it was a polyp which did not need removing because it may have resolved. Again he emphasised that the polyp he saw had the appearance of a benign polyp. He agreed that he had not said to the claimant specifically that the polyp had resolved, but he said to him that there were no abnormalities. He conceded that the polyp could potentially be cancerous and the cause of the claimant's bleeding. However, he considered that it was highly unlikely that the polyp was the cause of the claimant's increased bowel movements and loose stools. He pointed out that the claimant's G.P. had never questioned the hospital about what had happened to the polyp.

50. Mr. Huang was pressed again in cross-examination about what he thought in relation to the fact he had seen the polyp in August 2010 but it was not seen in the subsequent two endoscopies. He said he concluded that there was no polyp in the sigmoid and that the possibility of it having been missed twice was very low. Therefore he did not think it should be investigated a further time. He would not have advised a CT colonogram because that has a higher miss rate than the last two investigations the claimant had undergone. He said it should not be overlooked that these endoscopies do carry risks including a risk of perforation. Thus he felt that there was no justification for a yet further endoscopy or CT colonogram.

51. It was put to Mr. Huang that he had discharged the claimant on 24th December 2010. There is an issue in the case as to whether or not the claimant was actually discharged on that date. Mr. Huang said he was careful not to use the word discharge in his letter of 24th December 2010. He said he was not closing the door to the claimant because he left it open for the claimant to return if his symptoms did not resolve. He had simply said to the claimant that he had not made any further routine appointments. Mr. Huang also pointed out that the claimant had been on the two week wait cancer pathway and that no cancer had been found, and so he would be discharged as there were no further tests pending.

52. Mr. Huang said that, if the claimant had come back to the clinic in early 2011 with ongoing symptoms, it would have been attributed to diverticular disease. Initially conservative measures would have been taken in relation to that, but if the patient's lifestyle is altered because of the symptoms then surgery would

be contemplated. He said that a patient such as the claimant going to the toilet seven times a day, soiling underwear and soiling the bed at night might be the type of symptoms which would lead to surgery.

53. It was rather suggested to Mr. Huang during cross-examination that he had been in a hurry to deal with the claimant's case when he wrote the letter on 24th December 2010. In answer to that, Mr. Huang pointed out that on the report of the further flexible sigmoidoscopy he had written a note for his secretary that he required the claimant's notes or letter. He said that he would not have written the letter of 24th December 2010 without perusing the claimant's notes and also the biopsy result.

54. There was some further cross-examination of Mr. Huang in relation to a letter which he had written to the legal services manager at Queen's Hospital following the claimant's letter of claim. He accepted that in that letter he had said he was unconvinced that the polyp he had seen would cause diarrhoea and increased bowel frequency, although it was likely to be the source of rectal bleeding. He accepted that he did not state in this letter that the polyp could have been inflammatory and have resolved. However he reiterated in that letter his view that the claimant's symptoms were caused by diverticular disease.

55. Mr. Saharay in his witness statement and oral evidence dealt with the colonoscopy which he performed on the claimant on 23rd August 2010. He had been appointed as a consultant surgeon at Queen's Hospital in 2000 with subspecialty interests in colorectal and endocrine surgery. He regularly performed endoscopies and undertook approximately 200 colonoscopies per

year. In his witness statement he described the colonoscopy procedure which involved viewing the whole of the colon from the anus to the caecum.

56. Mr. Saharay said that in the course of a colonoscopy, if a polyp was detected he would perform a polypectomy to excise it if possible. Mr. Saharay said he had no recollection of the claimant but was able to refer to the medical records. He stated that in the colonoscopy which he performed on the claimant he was able to pass the scope up to the caecum. He identified diverticular disease involving the whole of the sigmoid colon, which would have spanned from the rectum until approximately 40 cm. up into the colon. He noted that he did not find a sigmoid polyp in the course of the colonoscopy. He said if he had found a polyp he would have entered this on the findings section in the computer programme. He said that the purpose of the claimant's colonoscopy would have been the same irrespective of the previous identification of a polyp at the flexible sigmoidoscopy performed by Mr. Huang. He said that as a polyp had been identified at 20 cm. in that previous procedure, and because a referral for polypectomy had been made, he would have gone carefully around that area specifically to check for a polyp. He stated that the claimant had diverticular disease and oedematous mucosa can often be mistaken for a polyp.

57. In his oral evidence when he was cross-examined Mr. Saharay was adamant that prior to performing the colonoscopy on the claimant, he would have looked at the previous notes, the referral form and what the request was for. He maintained that he would have seen that Mr. Huang had requested a

colonoscopy and polypectomy. He said he would have explained to the claimant the purpose of the colonoscopy.

58. He said he would have seen Mr. Huang's clinical notes which referred to a polyp at 20 cm. It was also very likely he would have seen the letter to the G.P. regarding Mr. Huang's findings on 9th August 2010. So with these two documents as well as the referral form, he would have been very well aware of the viewing of a polyp by Mr. Huang. He said that in any event when undertaking a colonoscopy he would look carefully to see if there were any polyps. He said that as he did not find any polyp in the colonoscopy, it was not necessary for him to make a negative entry regarding that on his findings. He emphasised that he would have had a clear view during the colonoscopy because the rectum would have been insufflated in order to give a clear view. This would be particularly so when coming back from the caecum with the scope and the whole of the colon would be visualised. The whole procedure takes 20-30 minutes. He said he could miss a polyp because it was so small or because it was behind a fold in the bowel. There was also the possibility that what Mr. Huang had seen was not a polyp and was inflammatory mucosa. If a polyp is on a long stalk it can move away from the scope and not be seen. He regarded a 1 cm. polyp as small.

59. I next turn to the expert evidence in this case. In his report on breach of duty and causation of June 2016 Mr. Delicata set out the history of the claimant's symptoms and treatment as described above. Mr. Delicata made it clear that it was not negligent for the polyp to have been missed in the colonoscopy and the further flexible sigmoidoscopy at Queen's Hospital. He said that many

papers in the literature show that the miss rate for polyps is quite significant. By reference to a paper by Van Rijn & Others entitled "Polyp miss rate determined by tandem colonoscopy: A systematic review", he said that the actual pooled miss rate for polyps of any size is 22%. For polyps of the size found in the claimant's colon the miss rate is 2.1% but this goes up the smaller the polyp size. He said that the polyp which was eventually removed from the claimant's colon was pedunculated, that is having a stalk, and he said that such polyps notoriously tend to move away from the end of the endoscope making them sometimes very difficult to see.

60. Mr. Delicata considered that the diagnosis of diverticulitis made at Queen's Hospital was appropriate. He said that treatment for such disease differs upon the degree of symptoms or the presence of complications. In the absence of complications, treatment largely consists, he said, of conservative measures in the main being the intake of a high fibre diet. He said that more invasive treatment such as surgery is usually reserved for those patients whose quality of life is very poor because of the severity of the symptoms, or the fact that they have to be admitted to hospital on more than one occasion in a specified period of time. He thought that the giving to the claimant of a leaflet about diverticular disease and advice about his diet from a nurse was all that was needed to be done in relation to that disease at the end of 2010. However, he said the claimant should not have been told that he should just live with his condition and should have been advised that, if his symptoms became worse, he would need antibiotics or further investigation. Mr. Delicata noted that, on 24th December 2010, Mr. Huang discharged the claimant, although he also said he would be happy to see him again if his doctor felt it was necessary. It

was the opinion of Mr. Delicata that Mr. Huang should not have discharged the claimant at that time. He said that in the first flexible sigmoidoscopy Mr. Huang had actually seen the polyp and was so sure that it was there that he was going to remove it and did not do so only because of equipment failure. In his opinion Mr. Huang should either have repeated the colonoscopy or should have requested a CT colonogram. He said the polyp detection rate of CT colonography is very similar to that of colonoscopy. In his view a CT colonogram would on the balance of probabilities have confirmed the presence of a polyp. It was further his opinion that, had the polyp been excised when Mr. Huang first saw it, the claimant would not subsequently have required an operation with the fear that he could have cancer as well as the attendant complications of surgery. He said that the decision not to pursue excision of the polyp exposed the claimant to the real risk of cancer development and, had it not been removed by the anterior resection at St. Mark's Hospital, it is almost certain that it would have turned malignant subsequently.

61. It was accepted by Mr. Delicata that it was possible that the symptoms which the claimant suffered from were not necessarily all due to the polyp, and even if the polyp had been excised he would still have had some diarrhoea secondary to the diverticular disease. He said that the diverticular disease was not very severe on CT and histologically and so in his opinion removal of the polyp endoscopically in 2010 would have, on the balance of probabilities, resulted in a considerable improvement in his symptoms such as the diarrhoea but not necessarily all of the pain.

62. It was the overall conclusion of Mr. Delicata that there was a breach of duty of care when Mr. Huang discharged the claimant in 2010 because he had seen the polyp and was so sure that it was there that he would have removed it had it not been for the equipment failure. It was further his opinion that Mr. Huang should either have requested a further endoscopic examination or at least should have asked for a CT colonogram which, on the balance of probabilities, would have shown the presence of the polyp so that this also amounted to a breach of duty of care. If the polyp had been identified and snared in 2010, it was his opinion that the subsequent surgery would more likely than not have been avoided.

63. The report from Mr. Meleagros on behalf of the defendant dated 17th August 2016 also set out the relevant history. It was Mr. Meleagros's opinion that at Queen's Hospital in 2010 the claimant's bowel symptoms were fully investigated with two flexible sigmoidoscopies and a colonoscopy. The finding of diverticular disease in the sigmoid colon with evidence of inflammation provided a satisfactory explanation for the claimant's symptoms. Like Mr. Delicata, he said that it is well recognised that colonoscopy and flexible sigmoidoscopy may not detect polyps in a small minority of cases. Thus in his opinion there was no evidence of substandard care in the polyp not being detected at Queen's Hospital subsequent to August 2010. He disagreed that a CT colonogram or repeat colonoscopy should have been carried out. His view was that a CT colonogram is not as sensitive in the detection of small colorectal polyps compared to endoscopy. Mr. Meleagros also noted that the CT scan on 8th February 2012 did not demonstrate the polyp, and nor did the CT scan at St. Mark's Hospital on 19th June 2012. In the opinion of Mr.

Meleagros, a CT scan soon after December 2010 would have failed to demonstrate the polyp and the findings would have been identical to those of the scans performed in February 2012 and June 2012.

64. Mr. Meleagros said that endoscopic examination of the colon by flexible sigmoidoscopy or colonoscopy is regarded as the "gold standard" investigation of the colon with the highest detection rate for malignancy and polyps. In the present case two of the three endoscopic examinations at Queen's Hospital did not demonstrate the polyp. Mr. Meleagros said that in his opinion a responsible body of surgeons would not have referred the claimant for a fourth endoscopic examination in the light of the two negative examinations. He said there is no evidence to support the claimant's allegation that a third follow-up colonoscopy or flexible sigmoidoscopy would have confirmed the presence of the polyp, on the balance of probabilities. That would then mean that the claimant would allege that endoscopic examinations should have been performed repeatedly until the polyp could be identified. He said such repeat examinations are not undertaken by a responsible body of surgeons if two endoscopic examinations prove negative. Whilst with repeated examinations the polyp would probably eventually have been noted, there is no evidence to support the allegation that a third follow-up colonoscopy rather than a fourth or fifth would have identified the polyp. He noted that when the polyp was eventually identified at St. Mark's Hospital, the polyp tended to prolapse, thus rendering its detection and treatment difficult.

65. Mr. Meleagros said that the resection operation which the claimant underwent in 2012 was because the claimant had experienced pain on attempted snare

diathermy of the polyp which suggested there might be malignant infiltration of the wall of the bowel beyond the stalk of the polyp. Because the dimensions of the polyp were similar to what Mr. Huang saw in August 2010, Mr. Meleagros said that it is almost certain that the same difficulty with snare excision of the polyp would have been encountered in August 2010 if this had been attempted. Thus it would have required removal by surgery in 2010, or whenever the polyp was found thereafter.

66. It was the firm view of Mr. Meleagros that the claimant's bowel symptoms between August 2010 and August 2012 were not due to the presence of the polyp but to extensive and complicated diverticular disease. Thus if the polyp alone had been removed by snare polypectomy sometime between August and December 2010, the claimant's symptoms of severe diarrhoea would have continued unchanged. The surgery which the claimant underwent in August 2012 included removal of the sigmoid colon affected with diverticular disease. The claimant's symptoms improved following the surgery which had removed the diverticular disease. The presence of diverticular disease in the sigmoid colon was completely unrelated to the polyp.

67. In his report Mr. Meleagros accepted that diverticular disease is not usually treated by resectional surgery unless there are complications or chronic severe symptoms which significantly impact on the patient's quality of life. He said that it appeared that the claimant suffered with such symptoms in the form of chronic diarrhoea and passage of blood in the stool. If the diverticular disease alone was to be treated surgically, the decision to undertake an operation would have depended on the nature of the claimant's symptoms and their

severity. He considered that eventually the claimant would have been advised to undergo surgical resection of the sigmoid diverticular segment in order to treat his symptoms. Therefore the surgery would have been required in any event to treat the symptoms of diverticular disease rather than the polyp itself.

68. Towards the end of his report Mr. Meleagros repeated that in his opinion the claimant's symptoms could be explained entirely by the presence of diverticular disease. He said small polyps, and even large polyps, do not cause abdominal pain or frequent loose stools. Polyps can cause bleeding but diverticular disease causes bleeding as well. Therefore he considered that all of the claimant's symptoms could be explained by the presence of the diverticular disease, especially as this was extensive and had caused complications, namely swelling of the bowel lining mucosa and thickening of the wall of the bowel extending over 6 cm. He referred to the findings regarding the marked diverticulosis in the CT scan of 30th June 2012 and the histology report on the resected colon. Because the claimant's symptoms were due to complicated diverticular disease, he would not have avoided surgery because surgical resection of the diseased sigmoid colon would have been mandated.

69. The two experts in two joint reports dated 3rd March 2017 provided lengthy responses to a series of questions posed on behalf of the claimant and the defendant respectively. Whilst I have considered all of the views set out by the experts in their answers in the joint reports, I do not propose to set out all the details of them as some addressed matters which do not go to the main issues in the case, and because they largely maintained the opinions which they had

expressed in their respective reports. However, it is appropriate to highlight some of their answers.

70. Both experts were agreed that there is no literature dealing with the question of what proportion of polyps which have been previously identified at sigmoidoscopy are missed at colonoscopy. The Van Rijn paper gives a miss rate of about 2% for polyps that are 1 cm. or greater. However, that paper assesses polyp miss rates determined by tandem colonoscopy. That is a method in which two same-day colonoscopies are performed with each patient. The miss rate is expressed as the number of polyps detected only during the second colonoscopy relative to the number of polyps found during both examinations. Mr. Delicata considered that, on the basis of that paper, the proportion of polyps detected at one endoscopic examination but then missed at a subsequent endoscopic examination is on the balance of probability also around 2%. Mr. Meleagros referred to the NHS publication on bowel cancer screening from 2011 which states there is a recognised rate of missed adenomas at colonoscopy of 6% where they are greater than 1 cm. in diameter and 27% where they are smaller than ½ cm. Thus Mr. Meleagros said the claimant's polyp could have been missed at any one endoscopic examination. The 2% non concordance rate referred to by Mr. Delicata meant, according to Mr. Meleagros, that the probability of Mr. Saharay not noticing the polyp which Mr. Huang stated he had seen was 2%, and the probability of the further flexible sigmoidoscopy obtaining findings different from the colonoscopy was 2%.

71. The experts discussed the likelihood of a polyp becoming cancerous. By reference to literature Mr. Delicata said that actuarial analysis revealed that the cumulative risk of diagnosis of cancer at the polyp site at 5, 10 and 20 years was 2.5%, 8% and 24%, respectively. Mr. Meleagros's view was that the risk of the claimant's polyp becoming cancerous was approximately 1-2% at 5 years from the time of diagnosis of the polyp, assuming it was benign at that time.

72. In connection with the cause of the claimant's bleeding, diarrhoea and abdominal pain, Mr. Delicata referred to the findings at St. Mark's Hospital that the polyp was prolapsing and its surface was traumatised and there appeared to have been torsion of it. Thus, Mr. Delicata argued that trauma to the surface of the polyp would have caused bleeding and an exudative reaction causing diarrhoea. He also said that the prolapse of the polyp would have caused episodes of intussusception of the colon which, together with the torsion, would have caused pain. As I understand it, intussusception is a condition in which part of the intestine folds into another section of intestine. Mr. Meleagros said that prolapse is normal in pedunculated (with a stalk) polyps and this does not cause pain. He further said that torsion of such polyps does not cause pain because there are no nerve endings within a polyp or in the mucosa of the colon. He also said that there was no evidence of any intussusception of the colon as speculated by Mr. Delicata. This was not noted at any of the endoscopies or the CT scans. Mr. Meleagros also considered that the notion that trauma to the surface of the polyp was responsible for bleeding and an exudative reaction causing diarrhoea was unfounded speculation. He said that small 1 cm. tubular adenomas do not cause such symptoms. He said it

was not possible that a 1 cm. polyp would have caused such a degree of exudation as to result in seven episodes of diarrhoea and loose stool a day. He reiterated his opinion that all or virtually all of the claimant's symptoms were attributable to diverticular disease.

73. At the trial both experts were questioned at considerable length. Mr. Delicata, in considering whether Mr. Huang might reasonably have thought that the polyp which he had seen had resolved because it had been an inflammatory polyp, or for some other reason, stated that inflammatory polyps are extremely rare if it is an isolated polyp. He also said that he had never seen a tubular adenoma which resolved spontaneously. He conceded that it was possible that an inflammatory polyp might disappear on its own. He also agreed that oedematous mucosa can sometimes have the appearance of a polyp.

74. Mr. Delicata was unable to say the degree of dysplasia of the polyp in 2010, but conceded he should not have stated in his report that it would have been only low grade, but should have said mainly low grade.

75. It was accepted by Mr. Delicata in cross-examination that all of the claimant's symptoms could have been the symptoms of diverticular disease. He was not prepared to accept that there had been an increase in the claimant's diverticular disease between 2010 and 2012. However, he then accepted that the CT scan on 19th June 2012 did show progression of the diverticular disease since the previous CT scan. He sought to say that the histology of the removed section of bowel, because it referred to focal evidence of diverticular disease at the proximal margins, indicated that the disease was not general. However, he accepted that the reference to representative sections from the longitudinal

resection margins showing congested and oedematous large bowel mucosa could be indicative of diverticular disease.

76. When pressed, Mr. Delicata accepted that the claimant's bowel problems were increasing in that stool frequency had become six times a day from the summer of 2011, were seven times a day when he saw Miss Beaton in April 2012, and were eight to nine times a day and once or twice at night by July 2012. He accepted that that may be partly related to diverticular disease but said it could also be related to the polyp. He repeated his views about the prolapsing and torsion of the polyp giving rise to symptoms, to which I have already referred.

77. Mr. Delicata was referred to the chapter entitled Polypoid Disease in the standard text "Surgery of the anus rectum and colon" (Keighley & Williams). It was there stated that the symptoms and signs of adenomatous polyps depend to some extent on their size, number, site and degree of villous component. It was further stated that bleeding from a polyp is usually relatively small. So far as the production of diarrhoea and passage of mucus was concerned, larger polyps are more prone to produce these symptoms particularly if situated in the rectum and are villous in nature. Abdominal colic only rarely occurs due to colocolonic intussusception.

78. Mr. Delicata then made some important concessions in cross-examination. He accepted that, if the claimant's polyp was causing bleeding every day, he would have expected ulceration of it and there was no evidence of that. He therefore conceded that on a balance of probabilities the bleeding was caused by the claimant's diverticular disease, but at the time of his operation. When

further pressed, he accepted that over the whole period from 2008 on the balance of probabilities the majority of the claimant's bleeding was due to diverticular disease. He conceded that any contribution to bleeding by the polyp was not more than minimal.

79. So far as diarrhoea being caused by the polyp was concerned, he reiterated his previously expressed view that this resulted from intussusception. He accepted that the textbook, referred to above, made no mention of intussusception in connection with diarrhoea resulting from a polyp. In the face of that he said, "I have to accept in the claimant's case that intussusception from the polyp was not a cause of his diarrhoea." Mr. Delicata went on to accept that in 2012 it was more likely than not that the diverticular disease caused the claimant's abdominal pain.

80. Despite the concessions which he had made, Mr. Delicata still maintained that, if the polyp had been removed in 2010/11, the claimant's symptoms from diverticular disease would have settled. However, he was unable to say on the balance of probabilities the extent to which the polyp or the diverticular disease caused the claimant's symptoms.

81. Mr. Delicata agreed that, in considering a breach of duty by Mr. Huang, one had to look at it from his position in 2010. He said that, as to whether Mr. Huang should have caused further investigations to be carried out, it depended on how positive he was that he had seen a polyp. Mr. Delicata pointed out that Mr. Huang was so sure of it that he would have proceeded to removing the polyp had the equipment been working. He then stated: "If it had been me I would have gone on until I found the polyp." This is to be contrasted with an

answer he gave in one of the joint reports, where he said that after the further flexible sigmoidoscopy the claimant should have had a CT colonogram, but if that did not show anything then the clinicians would have had to conclude that the cause of the claimant's symptoms was due to diverticular disease and treatment would have then been directed towards that. In his evidence Mr. Delicata continued by saying that no reasonable body of surgeons would have done what Mr. Huang did when they were sure they had seen a polyp. However, he then said: "If after the further endoscopies Mr. Huang was not sure that he had seen the polyp I accept a reasonable body of surgeons would have taken the same course as him."

82. With regard to the question of whether or not the claimant may have been in the minority of patients with diverticular disease who required surgery to deal with it, Mr. Delicata agreed that, if the patient is suffering from symptoms which are so disabling that he cannot work and cannot manage his symptoms, surgery would be the option after careful consideration. He thought that if the claimant only had diverticular disease and no polyp, and had developed the symptoms which he did with their effect on his way of life, he would have been offered surgery.

83. In what was a lengthy re-examination of Mr. Delicata, he sought to go back on some of the concessions which he had made in cross-examination. He now sought to say again that Mr. Huang should have gone on looking for the polyp until it was found. Despite what he had conceded about intussusception, he reverted back to saying that he thought the large majority of the claimant's symptoms in 2010 were due to intussusception. He sought to revert back to his

opinion that the majority of the claimant's symptoms were caused by the polyp.

84. Although he said that conservative treatment in his opinion would have reduced many of the symptoms of diverticular disease, he was unable to say that that would have taken away completely the need for surgery, and that, if the claimant's symptoms did not improve, then he may have had to have surgery.

85. At the start of his oral evidence, Mr. Meleagros gave a long exposition by reference to the images taken at the further flexible sigmoidoscopy as to why, in his view, Mr. Reese and Mr. Johnston were specifically looking for the polyp to which Mr. Huang had made reference. At some length he also said it was his opinion that Mr. Huang, in the two week clinic, which many hospitals do not have, had gone beyond what most surgeons would have done. It was his view that after the negative colonoscopy many surgeons would not have referred the claimant for any further endoscopy, as opposed to what Mr. Huang did. He said following the further flexible sigmoidoscopy, no responsible body of surgeons would have carried out further investigations. If a CT colonogram had in fact been carried out then it is likely it would have failed to pick up the polyp.

86. Mr. Meleagros then compared the risk of a polyp having been missed with the risk of death or serious repercussions which could arise from the performance of a colonoscopy. He concluded that the risk of missing a polyp which could become cancerous was lower than the risk of dying in a colonoscopy. For that

reason, too, he was of the view that Mr. Huang's conduct complied with that of a responsible body of surgeons.

87. When he was cross-examined, it was suggested to him that the images taken at the further flexible sigmoidoscopy did not show that the surgeons were specifically looking for the polyp at the 20 cm. level and that the images were taken in the rectum. Mr. Meleagros said he disagreed 100% with that suggestion and gave reasons for that. He said that the polyp may have been missed because it was hidden behind a fold or there could be other acceptable reasons why a polyp may not be seen.

88. When questioned about the miss rates in relation to polyps, Mr. Meleagros said that a doctor doing an endoscopy does not have such statistics in mind but he acts according to what is acceptable practice. Mr. Meleagros considered that the letters written by Mr. Huang to the claimant or his G.P. were appropriate and he said that as initially Mr. Huang had mentioned the polyp it was open to the claimant or his G.P. to ask further questions about it.

89. When it was put to Mr. Meleagros that, if the claimant had been put on conservative treatment for diverticulitis in 2011, it would have improved his symptoms and prevented any increase in his symptoms, he strongly disagreed. He accepted that he very rarely operated on patients with diverticular disease, but said that with some patients with symptoms like the claimant's you do have to go to surgery. He thought that the claimant was in that small cohort of patients who do require surgery. He said that the fact that, at St. Mark's at the time of the resection surgery, no reference was made to the diverticular disease was of no significance because they were concentrating on a polyp

which they thought was cancerous, although in fact it was not. He reiterated his view that the histology of the resected section was consistent with the CT scans and the development of complicated diverticular disease. Although the claimant may not have had surgery but for the polyp at that stage, within a year or two in any event he would have required surgery because of his symptoms from the diverticular disease.

90. Regarding what Mr. Delicata had said in relation to intussusception and that it could be temporary, Mr. Meleagros said that that theory was "for the birds" and did not stand up to scrutiny. If pain was caused by intussusception then the claimant would only have felt it during defecation. In no way would intussusception produce mucus and diarrhoea.

91. Having set out the relevant evidence in this case in considerable detail, I can state the law which applies relatively briefly. In general terms the proper approach to the standard of care required of a doctor remains as set out in Bolam -v- Friern Hospital Management Committee [1957] 1 WLR 582 and Maynard -v- West Midlands Regional Health Authority [1984] 1 WLR 634. As stated in those cases, the standard of care of a doctor is to be assessed by reference to the ordinary skill of a doctor in the relevant field. The doctor is not negligent if he acts in accordance with the practice accepted at the time by a responsible body of medical opinion, even though other doctors may adopt a different practice. As was stated by Lord Scarman in Maynard at Page 638: *"Differences of opinion and practice exist and will always exist in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A Court may prefer one body of opinion*

*to the other: but that is no basis for a conclusion of negligence."* At Page 639 he stated*: "....In the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another."*

92. There is a possible adjustment to the approach in the Bolam and Maynard cases as arises from Bolitho (deceased) -v- City & Hackney Health Authority [1988] AC 232, where the House of Lords held that the court may reject the standard set by a body of medical opinion if it does not stand up to analysis, was illogical or was unreasonable in the light of the state of medical knowledge at the time.

93. Bearing in mind those legal principles, I shall now set out my findings based on my assessment of all of the evidence in the case and having regard to the helpful written and oral submissions of Counsel.

94. I have no doubt that the claimant was a truthful witness, doing his best to give accurate evidence about the period in question. However, he was, as I have already mentioned, somewhat inconsistent in his evidence as to what he would have done if he had been told that the polyp could not be found on the further endoscopies and as to the risk of a polyp becoming cancerous. He said if this had been the case he would have asked for something to be done about the polyp. However, he had conceded that when mention was first made of a polyp and diverticulitis, he had gone on-line and obtained information about them and that he knew from that that there was a risk of a polyp becoming malignant. Despite that, of course, he raised no questions with his G.P. or Mr.

Huang about the polyp, or indeed did not go back to his G.P. until October 2011.

95. So far as Mr. Huang and Mr. Saharay are concerned, I found them to be clear and careful witnesses, giving their evidence in a considered manner and wishing to give an accurate account of their involvement in the claimant's treatment.

96. The two expert witnesses are both very experienced but in general terms I found both the written and oral evidence of Mr. Meleagros more compelling and persuasive. I have referred to a number of concessions which Mr. Delicata made when cross-examined and his attempts to go back on such concessions in re-examination. It was suggested on behalf of the claimant that Mr. Meleagros had not been sufficiently objective in his evidence and had acted as an advocate for his views rather than as an independent expert. It was also suggested that he misused facts to support his arguments and was totally inflexible. Whilst it is true that some of his answers were lengthy, I do not accept that Mr. Meleagros was acting as an advocate or in any way sought to mislead the Court. He was simply at pains to make clear his views and the reasons for them in an understandable and emphatic manner.

97. The first question which arises is whether or not as alleged there was negligence on the part of Mr. Huang in not causing a CT colonogram or further investigations to be carried out after the second flexible sigmoidoscopy had not detected the polyp. I entirely reject any suggestion that Mr. Saharay and Messrs. Reese and Johnston were not particularly looking for a polyp during their respective endoscopies. I find that they saw the referral

information from Mr. Huang and each was well aware of the fact that Mr. Huang thought he had seen a polyp in his flexible sigmoidoscopy but had been unable to remove it. I reject any suggestion that Mr. Saharay carried out his colonoscopy without reference to the claimant's notes and the referral document. I further find that there was absolutely no necessity for Mr. Saharay or Mr. Reese and Mr. Johnston actually to record a negative finding of not having found a polyp. It is clear that one of the important objectives of their endoscopies was to find polyps and remove them if possible. They would have been all the more focused on that by reason of the fact that they were aware that Mr. Huang thought he had seen a polyp. The fact that they made no record of finding a polyp gives rise to the clearest of inferences that they did not find a polyp. That was the obvious inference which Mr. Huang himself drew when writing to the claimant on 24th December 2010. Insofar as it was suggested that when he wrote that letter Mr. Huang had forgotten about the polyp and did not refer to the claimant's medical notes, I completely reject that suggestion.

98. In my judgment it was reasonable for Mr. Huang, in the light of the fact that his senior and more experienced colleagues had not identified a polyp at the colonoscopy and further flexible sigmoidoscopy, to conclude that he had "over called" the polyp and that he may have been mistaken as to it being a polyp or it may have resolved. Whilst Mr. Delicata emphasised that Mr. Huang was so sure that he had seen a polyp that he would have proceeded to remove it if the equipment was working, I find that subsequently by 24th December 2010 Mr. Huang was not sure that he had seen a polyp.

99. In any event, in my judgment Mr. Huang was not in breach of duty in failing to carry out any further investigations to seek to find the polyp. His actions have to be viewed as to the position at the time, not in hindsight, knowing that the polyp was subsequently found by the doctors at St. Mark's Hospital. I find, as was the opinion of Mr. Meleagros, that Mr. Huang acted in accordance with a responsible body of doctors in not carrying out any further investigations. Mr. Huang was careful to require a second check by way of the further flexible sigmoidoscopy and I find that some responsible doctors, as Mr. Meleagros stated, would not even have gone to that extent once the colonoscopy had not found a polyp. It may very well be that some responsible doctors, and in particular Mr. Delicata, would have carried out further investigations, but, on the basis of the law to be applied, that does not make Mr. Huang negligent when another responsible body of doctors would have done exactly as he did.

100. I further find that on a balance of probabilities, even if a CT colonogram had been carried out after the second flexible sigmoidoscopy, the polyp would not have been identified. Although in that instance Mr. Delicata sought to say in his evidence that he would have gone on and on investigating until he found the polyp, he had said in the joint statement that, if the CT colonogram was negative regarding polyps, the claimant then would have had to be treated simply for diverticulitis.

101. In reaching these conclusions, that Mr. Huang was not negligent in not carrying out further investigations, I have borne very much in mind the expert evidence about the miss rates for polyps which are clearly low, even though

there is no research regarding the miss rate for a polyp found on a flexible sigmoidoscopy and not found on later endoscopies. I have also had regard to the fact that Mr. Delicata in cross-examination conceded that if, after the further endoscopies, Mr. Huang was not sure that he had seen the polyp, a reasonable body of surgeons would have taken the same course as him. As I have indicated, my finding is that that was indeed the state of mind of Mr. Huang. Additionally, in my judgment Mr Huang was reassured by the fact that no active inflammation, dysplasia or malignancy or sign of microscopic colitis was found at the histology of the biopsies taken at the further flexible sigmoidoscopy.

102. Having found that Mr. Huang was not negligent in failing to carry out further investigations, I next turn to the allegation that he failed to give the claimant appropriate advice and information before discharging him in December 2010. There was considerable dispute as to whether Mr. Huang had actually discharged the claimant at that time. In the end, this may be a question of semantics. It is certainly true that, in his letter of 24th December 2010, Mr. Huang, having stated that the further flexible sigmoidoscopy did not reveal any abnormality, said that he had not made any routine appointments to see the claimant again. In one sense this might be regarded as discharging the patient. However, Mr. Huang then went on to say that he would be most happy to make a further appointment if the claimant's G.P. thought it was necessary. That letter was copied to the claimant's G.P. Thus the door was very much being left open to the claimant to return to Mr. Huang if his symptoms did not settle.

103. It is suggested that, in his letter dated 14th September 2010, Mr. Huang should have made some mention of the polyp and that it had not been found on the colonoscopy and that is why the further flexible sigmoidoscopy was going to be performed, rather than saying that that was going to be done "to see if things have settled". In my judgment, while some doctors may have mentioned the polyp at that stage, I consider that it was not negligent to have failed to have done so and that it was a reasonable clinical decision not to wish to alarm the patient unduly. Once Mr. Huang was of the view that he had overcalled the polyp, in my judgment it was not necessary for him to have given advice to the claimant about the fact that polyps could become malignant. In any event, I reject the claimant's evidence where he stated that, if he had been given such advice, he would have immediately taken action to have the polyp found and something done about it. He had already conceded that he had discovered by his research online that there was a risk of a polyp becoming malignant. He, and indeed his G.P., was well aware that Mr. Huang thought he had seen a polyp in August 2010. It was open to the claimant and his G.P. in the light of that knowledge to have queried further with Mr. Huang or the doctors at Queen's Hospital as to what the position was about the polyp. In fact, neither did that and the claimant did not ever return to his G.P. between December 2010 and October 2011 despite the persistence and worsening of his symptoms. Thus, even if, contrary to my finding, Mr. Huang was negligent in the advice and information he gave to the claimant, it would not have been causative of any injury or loss.

104. If I am wrong in finding that Mr. Huang was not negligent and that on the carrying out of further investigations the polyp would have been found, I

nevertheless find that on a balance of probabilities the polyp could not have been removed by snare or snare diathermy. I accept the opinion of Mr. Meleagros that on a balance of probabilities the same would have occurred in 2010 or 2011 as occurred in 2012, when at St. Mark's they attempted to remove the polyp during the colonoscopy. Because the claimant reacted with pain the attempt was discontinued because it was feared that that may indicate cancerous infiltration of the polyp and bowel wall. Thus, even if the polyp had been discovered on further investigations after December 2010 at Queen's Hospital, the claimant would have required the resection operation to remove the polyp for the same reasons that occurred at St. Mark's Hospital.

105. Next, I consider the question of what the situation would have been if I am mistaken in finding that Mr. Huang was not negligent and that the polyp would have been found and removed by snare diathermy in 2010/2011. This raises the question of the cause of the claimant's symptoms between 2010 and August 2012. I find Mr. Meleagros's opinion that all or virtually all of the claimant's symptoms during that period were attributable to diverticular disease very compelling. It is clear that by 2010 the claimant had a two year history of rectal bleeding and a change in bowel frequency. I also find that from 2010 through to 2012 his symptoms markedly worsened. I find, as stated by Mr. Meleagros, that the worsening of the claimant's symptoms coincided with the development of his diverticular disease, in particular as seen on the relevant CT scans. By the time of the CT scan of 30th June 2012 there was marked diverticulosis in the sigmoid colon and descending colon with bowel wall thickening in the mid sigmoid. This was also borne out by the histology following the resection operation. On the other hand, there was no change in

size or in pathological type or in dysplasia grade of the polyp between August 2010 and June 2012.

106. I also consider that the literature and text book entries to which I was referred regarding this question very much support a finding that the claimant's symptoms were due to diverticulitis and not to the polyp. I was not at all persuaded by the views of Mr. Delicata regarding the claimant's rectal bleeding, diarrhoea and abdominal pain being caused or largely caused by the polyp. His theory about intussusception being causative in this regard I find to have little merit.

107. It is therefore my very firm conclusion that all or virtually all of the claimant's symptoms from 2010 to August 2012 were caused by diverticulitis and that the polyp made no or no significant contribution to those symptoms. I am strengthened in reaching this conclusion by the concessions which Mr. Delicata made in cross-examination. He conceded that on a balance of probabilities over the whole of that period the majority of the rectal bleeding was due to the diverticular disease, and that any contribution to the bleeding by the polyp was not more than minimal. He also ended up accepting that intussusception from the polyp was not the cause of the claimant's diarrhoea. He conceded that in 2012 it was more likely than not that the diverticular disease caused the claimant's abdominal pain. I was not impressed by his attempts to go back on these concessions in re-examination.

108. Finally, I find that the claimant was in that minority of patients who, by reason of diverticular disease, would have required the resection operation irrespective of the presence of the polyp. The experts agreed that it is in a

minority of cases where a patient's symptoms from diverticulitis are so bad that surgery is required. It will often depend on the degree to which the patient's way of life has been affected. As described by the claimant in his evidence, he had come to a situation where he had had to cease work, he was afraid to leave the house because of the bowel frequency and he was having to empty his bowels seven to nine times per day. This clearly had a dreadful effect on his way of life and in my judgment surgery would have been necessary to remove that part of his bowel affected by the diverticular disease. It is noteworthy, in my judgment, that after he underwent the resection operation at St. Mark's which did remove that section of bowel as well as the polyp, his symptoms largely ceased. Mr. Delicata in his evidence accepted that if the claimant had had only the diverticular disease and had developed the symptoms which he did with its effect on his way of life, he would have been offered surgery.

109. It will be clear from the foregoing that the claimant's claim must fail because he has not established negligence against the defendant. Furthermore, as I have found, even if he had established negligence as alleged, his claim would fail because he would not have proved that such negligence was causative of his symptoms and of any loss or damage. By reason of his diverticular disease, he would have had to cease work in any event at the time when he did and would have suffered the same losses. In those circumstances, it is not strictly necessary for me to address the question of the quantum of the claimant's claim. However, for the sake of completeness, I say that, in brief and general terms, had the claimant succeeded in negligence and causation, on a broad brush approach I would have accepted he had incurred some loss of earnings

including a possible loss from the nightclub contract and awarded a global sum of £40,000. So far as general damages for pain and suffering are concerned, bearing in mind the Judicial College Guidelines and the cases to which I was referred, I would have awarded £20,000.

110. Of course, one has sympathy for the claimant's unfortunate experience due to his bowel condition, but for the reasons I have indicated his claim must fail and there will be judgment for the defendant.