[redacted]

CLINICAL NEGLIGENCE

BETWEEN:

[redacted]

Claimant

-v-

[redacted]

Defendant

PRE-LITIGATION CLINICAL SCREENING REPORT – DISCLOSABLE ONLY TO THE CLAIMANT AND THEIR LEGAL ADVISERS

UROLOGY REPORT OF

MR KRISHNAN ANANTHARAMAKRISHNAN

Dated:	**16 July 2026**
Specialist Field:	**Consultant Urological Surgeon**
The Claimant:	[redacted]
Date of birth:	[redacted]
On the instructions of:	[redacted]

[redacted]

Introduction

On 13 December 2017, [redacted] [herein after addressed as RL] underwent ureteroscopy at [redacted], with insertion of a temporary left ureteric stent due for removal within 4–6 weeks. It was not removed as planned, causing ongoing abdominal/flank pain, recurrent UTIs, haematuria, purulent symptoms, and declining health. A CT scan on 11 March 2024 showed the stent remained in situ with left renal cortical atrophy, pelvicalyceal dilatation, and chronic obstruction; subsequent NHS investigations confirmed only about 14% left kidney function. The stent was removed on [redacted] followed by further infection, and b[redacted] the left kidney was non-functioning, requiring nephrostomy and planned left nephrectomy.

Instruction

I have been instructed b[redacted] to prepare a urological report on [redacted]

PURPOSE AND SCOPE OF THE REPORT

The claimant's legal team has instructed the preparation of an initial urological screening report. The objective is to review the clinical records of [redacted] to determine the viability of a clinical negligence claim. Specifically, this report assesses whether there was a potential **breach of duty** and **causation** related to a left-sided JJ ureteric stent that remained *in situ* for an excessive period, resulting in symptoms, deterioration in health, loss of kidney function, and the current recommendation for nephrectomy [loss of one kidney].

1. Whether the treatment provided fell below a reasonable standard of care (breach of duty);
2. Whether any such breach caused or materially contributed to the client's injuries (causation);
3. Whether the claim has reasonable prospects of success sufficient to proceed to full expert evidence.

Note: This report serves as a preliminary screening tool to assess case viability. It is confidential and is not formatted for submission to the court under Civil Procedure Rules (CPR) Part 35.

DOCUMENTATION REVIEWED

I have reviewed the core documents provided

1. [redacted]
2. [redacted]
3. Medical Chronology docs
4. Medical Chronology docsAttach13
5. NHS Additional Letters (1)
6. [redacted]

Missing Evidence Note:

1. The automated "Stent Registry" or logging database entry from the Trust has not yet been disclosed.
2. The full set of notes for perusal
3. Operating Notes
4. GP notes

CHRONOLOGY OF EVENTS

1. Index Procedure and Retained Stent

On [redacted] underwent left ureteroscopy [redacted] A temporary left ureteric stent was inserted and should have been removed within the planned post-operative period.

2. Prolonged Retention and Symptoms

The stent remained in situ for approximately six years. During that period, Mrs Lonning experienced persistent abdominal, flank and kidney-area back pain, recurrent urinary tract

infections, blood and pus in the urine, sleep disruption, and a gradual loss of independence and physical capacity.

The Consultation Report dated 25 June 2024 independently records severe abdominal and back pain for approximately seven years, daily pain without adequate intervention, and repeated use of antibiotics and painkillers.

3. Functional and Psychiatric Impact

The Consultation Report records a marked deterioration in day-to-day function and mental health. [redacted] was unable to exercise, take long walks, perform household chores, or sit without pain. She also suffered shooting pains, ongoing urinary symptoms, severe depression secondary to chronic pain, psychiatric consultation, and sleeping-tablet use.

This evidence supports chronic obstruction, recurrent infection, psychiatric injury, and sustained loss of independence.

4. Pre-Incident Baseline

Before the index procedure, [redacted] was physically active, attended the gym, walked normally, had no kidney history, had completed a master's degree in health and social care, and intended to pursue further employment. This establishes a clear baseline of independence and employability.

5. Date of Knowledge: 11 March 2024

A CT abdomen/pelvis scan in [redacted] 11 March 2024 showed that the double-J stent remained present, with left renal cortical atrophy and pelvicalyceal dilatation. This appears to be the first date on which [redacted] became aware that the stent had not been removed, making it relevant to limitation.

6. NHS Confirmation of Renal Loss: [redacted]

NHS investigations confirmed severe renal impairment. A DMSA scan showed left kidney function at 14% and right kidney function at 86%. A clinic letter dated 14 May 2024 recorded chronic kidney disease and severe left renal impairment.

7. NHS Acknowledgement and Stent Removal

The Consultation Report dated 25 June 2024 records a seven-year pain history, chronic infection, psychiatric deterioration, functional restriction, and reference to an apology letter for the previous oversight. This is the first documented indication of NHS acknowledgment of error.

On 26 June 2024, hospital discharge records confirmed removal of a "retained ureteric stent". The records indicate that the stent had been present since 2018 and constitute formal NHS documentation of prolonged retention. A fit note was also issued confirming incapacity for work.

8. Post-Removal Complications and Further Treatment

Following removal, [redacted] experienced severe pain, fever, ambulance attendance, and the need for IV antibiotics after oral treatment failed.

In November–December 2024, she required emergency nephrostomy for an infected, obstructed kidney. Records described chronic hydronephrosis and a non-functioning left kidney, with an MDT decision to offer left nephrectomy.

9. Liability Summary

Breach

- Failure to ensure timely stent removal.
- Failure of the recall system.
- Failure to investigate persistent symptoms.
- Governance and system failure.

Causation

The retained stent caused or materially contributed to chronic obstruction, recurrent infection, renal scarring, atrophy, severe loss of renal function, nephrostomy, and the need for nephrectomy.

PRELIMINARY EXPERT OPINION

Issue 1: Breach of Duty

I have been asked to provide a preliminary opinion on whether the management of the left ureteric stent inserted on **13 December 2017** fell below a reasonable standard of care.

Legal test. Applying the *Bolam* principle, a breach of duty arises where the care provided falls below the standard expected of a reasonably competent body of urological practitioners.

Key Evidence

- A **left ureteric stent** was inserted following ureteroscopy. On the information provided, it was intended to be **temporary**, with removal planned within approximately **4–6 weeks**.
- There is no evidence that the stent was removed within the intended period.
- A urology letter dated **14 May 2024** reportedly records that the stent **should have been removed in 2018 but was not**.
- The stent was ultimately removed on **26 June 2024**. The discharge summary confirmed removal of a **retained ureteric stent**.
- The British Association of Urological Surgeons advises that standard JJ stents should not remain in place for longer than **3 to 6 months**, given the recognised risk of encrustation.
- Medical literature recognises ureteric stents as temporary devices. Prolonged dwell time increases the risks of **encrustation, infection, haematuria, pain and obstruction**.

Analysis

- Retention of a temporary ureteric stent for approximately **six years** would ordinarily represent a **serious departure from accepted urological practice**, unless there was unusual and clearly documented clinical justification.

- The likely explanations are failure to ensure timely removal, failure of the follow-up or recall system, or a combination of both.
- If the contemporaneous records confirm the stated facts, I will regard breach of duty as **likely to be established**. A final opinion should, however, await review of the complete medical records.

System failure. On the information available, the Hospital Trust appears to have failed to maintain a robust stent registry or tracking system and to arrange appropriate follow-up. That would suggest a systemic administrative failure falling below acceptable NHS safety standards.

Conclusion on Breach

- **In my opinion, there is a strong prima facie case of breach of duty.**

Issue 2: Causation

I have been asked to provide a preliminary opinion on whether any breach of duty caused, or materially contributed to, the client's injuries.

Legal Standard

For causation to be established, it must be proven on the balance of probabilities that the claimant's injuries would not have occurred *but for* the specific delay and negligence alleged.

Key Evidence

- [redacted] experienced persistent abdominal, flank and kidney-area back pain, recurrent urinary tract infections, haematuria, purulent urinary symptoms, sleep disruption, and a gradual loss of independence and physical capacity during the period in which the stent remained retained.
- The Consultation Report dated **25 June 2024** independently records severe abdominal and back pain for approximately seven years, daily pain without adequate intervention, and repeated use of antibiotics and painkillers.
- The retained stent became blocked and was associated with loss of kidney function, secondary urosepsis, and the subsequent need for invasive nephrectomy surgery.

Analysis

- A ureteric stent retained for over six years can become a nidus for mineral crystallisation and encrustation, with recognised risks of obstruction, recurrent infection and renal damage.
- On the information available, the chronology of pain, infection, urinary symptoms, obstruction and progressive renal impairment provides a clear and robust causal chain.
- Had the stent been removed at the planned six-week point, it is likely that the later blockage, deterioration in renal function, urosepsis and need for nephrectomy would have been avoided.

Conclusion on Causation

- **In my opinion, causation is strong. The available evidence supports the conclusion that the 72-month delay caused, or materially contributed to, the stent blockage, recurrent infection, loss of left renal function, secondary urosepsis and the subsequent need for nephrectomy.**

Key Evidence

- The client reports that, from 2018 onwards, she experienced persistent abdominal and flank pain, recurrent urinary tract infections, haematuria, purulent urinary symptoms, and progressive deterioration in health and function.
- On **11 March 2024**, a CT scan reportedly demonstrated that the stent remained *in situ* and showed **left renal cortical atrophy**, **pelvicalyceal dilatation**, and features consistent with **chronic obstruction**.
- Subsequent investigations in April/May 2024 reportedly showed left kidney function of approximately **14% on DMSA**, with chronic kidney disease noted.
- Later in 2024, the left kidney was described as **non-functioning**. Nephrostomy was undertaken, and nephrectomy was planned.
- Medical literature supports the proposition that forgotten or retained ureteric stents may cause **recurrent infection, pain, haematuria, chronic obstruction, renal impairment and, in severe cases, loss of renal function**.

Analysis

- The client's clinical course is **highly consistent** with the recognised complications of a retained ureteric stent.
- The combination of a prolonged retained foreign body, recurrent urinary infection, chronic pain, haematuria, imaging evidence of obstruction, and progressive loss of renal function provides a medically plausible causal chain.
- In my view, the failure to remove the stent in a timely manner is capable of having caused, or at least materially contributed to, the client's symptoms and deterioration of the left kidney.
- A full expert report should still consider possible alternative or contributing causes, including pre-existing stone disease, baseline renal impairment, or other renal pathology. On the facts presently available, however, those matters do not materially weaken the causal inference.

Conclusion on Causation

- **In my opinion, there is a strong argument that the breach caused, or materially contributed to, the client's injuries, including chronic pain, recurrent infection, chronic obstruction and irreversible loss of left renal function.**

Issue 3: Prospects of Success

I have been asked to provide a preliminary opinion on whether the claim has reasonable prospects of success sufficient to justify proceeding to full expert evidence.

Key Evidence

- The claim is supported by several important factual and clinical features.
- The left ureteric stent appears to have remained in place for a prolonged period.
- A urology letter reportedly acknowledges that the stent should have been removed in 2018.
- Objective CT and DMSA findings are consistent with chronic obstruction and severe left renal impairment.
- The discharge documentation records removal of a retained ureteric stent.

Analysis

- Claims involving retention of a ureteric stent for this duration are commonly capable of being supported by expert evidence because the alleged breach is straightforward and the mechanism of injury is well recognised.
- On the present information, the claim appears **more than arguable** and sufficiently strong to justify instructions to appropriate experts.
- A **consultant urologist** should address breach of duty and the standard of care.
- A **nephrologist** should address renal causation, prognosis and future risk.
- If required, a **radiologist** should review the imaging chronology.
- The principal limitation at this stage is the absence of the full contemporaneous medical records.

Conclusion on Prospects

- **In my opinion, the claim has reasonable, and likely good, prospects of success and should proceed to full expert evidence.**

Assumptions

- This preliminary opinion proceeds on the following assumptions:
- The stent inserted on **13 December 2017** was intended to be temporary.
- Removal was intended within approximately **4–6 weeks**.
- There is no evidence of earlier removal.
- The urology letter of **14 May 2024** is accurate.
- The imaging and renal function findings summarised above are accurate.

Limitations

- This is a **screening opinion only** and not a full expert report.
- It is based on the factual summary provided and not on review of the complete medical records.
- The opinion is limited by the absence of key records, including:
- the operative report;
- discharge and follow-up records;

- appointment and recall documentation;
- microbiology and GP records;
- baseline renal function and pre-2017 imaging;
- any evidence of patient non-attendance or alternative causation.
- Final conclusions should be reserved until the full records have been reviewed by the relevant experts.

Overall Conclusion

- In summary:
- **Issue 1 — Breach:** likely established.
- **Issue 2 — Causation:** strong and medically plausible.
- **Issue 3 — Prospects:** reasonable to good, and sufficient to proceed to full expert evidence.

6. Case Strengths, Weaknesses and Recommended Next Steps

Case Strengths

- **Clear chronology of delay:** A stent intended for removal after approximately six weeks appears to have remained in place for around 72 months, which strongly supports the allegation of substandard care.
- **Objective radiological evidence:** CT imaging confirms that the stent remained visible *in situ*.
- **Documented renal impairment:** DMSA isotope scanning demonstrates significant loss of left renal function.
- **Consistent clinical picture:** The reported symptoms, imaging findings and subsequent renal deterioration are consistent with the recognised complications of prolonged stent retention.

Case Weaknesses and Issues Requiring Clarification

- **Possible contributory negligence:** The Defendant may argue that the claimant failed to attend scheduled appointments, although the current records appear to show that no removal appointment was generated or offered.

- **Quantification of renal damage:** The precise degree of long-term renal functional loss may require further specialist nuclear medicine evidence, including a MAG3 scan if clinically appropriate.
- **Baseline renal function:** Pre-existing renal function at the time of the original stone management requires clarification through review of blood tests, imaging and any available pre-incident records.
- **Patient responsibility:** The Defendant may argue that the claimant ought to have sought further medical review or followed up on ongoing symptoms. This issue should be assessed against the discharge advice, follow-up arrangements and the claimant's understanding of the care plan.
- **Discharge and follow-up plan:** Any discharge summary or plan referring to ureteroscopy or further intervention should be reviewed to determine whether it gave the claimant clear information about the need for stent removal and future follow-up.

Recommended Next Steps

1. **Proceed with the claim:** On the information currently available, the case appears to have strong prospects on both liability and causation, subject to review of the complete records.
2. **Request specific disclosure:** Seek disclosure from the Defendant Trust of all relevant phone logs, appointment-booking records, recall-system data and internal stent registry entries to determine whether any removal appointment was generated, offered or missed.
3. **Commission full expert evidence:** Instruct a urological expert witness to prepare a formal CPR Part 35 liability and causation report based on the complete medical records.
4. **Obtain renal function evidence:** Consider arranging specialist renal imaging, including MAG3 assessment if clinically appropriate, to quantify long-term damage to the left kidney for the purposes of prognosis and quantum.

Sources

- The following literature informed this preliminary opinion:

- EAU Guidelines on Urolithiasis.
- Tomer N, Garden E, et al. Ureteral Stent Encrustation: Epidemiology, Pathophysiology, Management and Current Technology.
- Beysens M, Tailly T. Ureteral stents in urolithiasis .
- Thangavelu M, Abdallah MY, et al. Management of encrusted ureteral stents: Two center experience

The writer

1. I am Mr Krishnan Anantharamakrishnan, and I serve as a consultant urological surgeon at The Sherwood Forest Hospital NHS Foundation Trust, located in Mansfield, Nottinghamshire.

Special Interests

2. I have developed a particular interest in several areas within urology, including both benign and cancerous prostate conditions, female urology, neurourology, urodynamics and reconstruction, lower urinary tract dysfunction, urinary stone disease, andrology, and paediatric urology.

Professional Approach

3. Throughout my career, I have utilised my teamwork skills to not only enhance my own expertise but also to support the professional growth of colleagues. This collaborative approach has enabled us to introduce innovative procedures and undertake research projects within my specialist fields.

Qualifications and Experience

4. Further information regarding my qualifications and experience can be found in **Appendix One.**

Signature

Mr Krishnan ANANTHARAMAKRISHNAN, MBBS, MS, FRCS, MSc [Urol], FRCS [Urol], FEBU, Pg. Dip [Clin. Ed.], Pg. Cert Human Factors and Patient Safety

Consultant Urological Surgeon

Dated: 11th May 2026

Appendix 1 – Biographical section

Mr Krishnan Anantharamakrishnan is a consultant urological surgeon and trained expert witness with Inspire Medilaw. He is enrolled at the University of Strathclyde for an accredited expert witness certificate for medical professionals. He provides expert opinion for both claimants and defendants in clinical negligence and personal injury cases.

Clinical negligence cases handled include:

- Circumcision
- Vasectomy and vasectomy reversals
- Scrotal surgery
- JJ stents
- Iatrogenic injuries
- Artificial urinary sphincters
- Penile operations, including treatment for cancers
- Andrology, including Peyronie's disease
- Infertility issues
- Urethral injury caused by catheters and surgery
- Vesico-vaginal fistula
- Ureteric or bladder injury resulting from hysterectomy or caesarean section
- Bladder distension injuries
- Urogynaecological injuries

Information Pertaining to the Expert Witness and Medico-Legal Opinion

Summary of Urological Expertise

1. Renal Stones

Mr Anantharamakrishnan has worked extensively as a urological specialist, performing both open and endoscopic procedures on the kidneys and ureters. His main focus has been on stone disease, and he has conducted basic science research on stone diseases in Manchester.

2. Scrotogenital Day Surgery

He possesses considerable experience in urological day surgery, with a particular emphasis on minimally invasive techniques. Most scrotogenital procedures, such as circumcision, vasectomy, vasectomy reversal, removal of epididymal cysts, varicocoeles, and testicle removal, are performed as day cases.

3. Gynaecological Injury to the Urinary Tract

With over two decades of experience, Mr Anantharamakrishnan has managed major surgical complications following gynaecological surgery, including perforated bladder, fistulae, ureteric damage, and bladder distention. He gained significant expertise at the trauma centre in QMC Nottingham.

4. Management of Neuro-Urology – Cauda Equina

He is experienced in managing urological complications associated with spinal cord injuries and has expertise in the diagnosis, treatment, and evaluation of Cauda Equina Syndromes.

5. Prostate Conditions

Mr Anantharamakrishnan is thoroughly conversant with the operative management of benign prostate disease, including transurethral resection (TUR), as well as the management and diagnosis of prostate cancer.

6. Pain Syndromes

In the last decade, he has developed a keen interest in urological pain syndromes, such as painful bladder syndrome, urethral syndrome, prostatitis, pelvic pain of urological origin, and chronic testicular pain.

7. Malignant Disease of Kidney and Bladder

He has been responsible for clinical governance at Kingsmill Hospital and regularly presents urological cancer cases at weekly multidisciplinary team meetings. His surgical experience in renal and bladder cancer is extensive, gained through years of work at Sherwood Forest Hospital Trust.

8. Andrology and Male Health

He currently practises as an andrologist, specialising in erectile dysfunction, Peyronie's disease (penile curvature), penile implants (no longer performed), and other complex male health issues. Andrologists typically manage specialised conditions, including:

- Male Infertility: Investigating low sperm count, azoospermia, and performing surgical sperm retrieval or vasectomy reversals.
- Sexual Dysfunction: Treating erectile dysfunction, premature ejaculation, and low testosterone (hypogonadism).
- Penile Conditions: Correcting Peyronie's disease, phimosis, and performing penile reconstruction or implant procedures.
- Testicular Health: Managing varicoceles, hydroceles, undescended testicles, and testicular cancer.
- Surgical Procedures: Performing vasectomies, circumcisions, and gender affirmation surgeries.

9. Urinary Incontinence

Mr Anantharamakrishnan is highly experienced in the management of urinary incontinence, including continent treatments, urinary incontinence therapy, Botox bladder injections, and artificial urinary sphincter operations (no longer performed) and procedures for genuine stress incontinence. His expertise encompasses colposuspension and mesh-based treatments (previously performed).

10. General Urological Conditions

In addition to the above, he is well versed in general urological conditions, such as prostatitis, urinary tract infections in women, loin pain haematuria syndrome, and investigations for visible haematuria.

Scholarships and Awards

- European Urological Scholarship Programme (EUSP) – Clinical Scholar, 2008
- Royal College of Physicians and Surgeons – College Travelling Fellowship, 2008
- 24th World Congress of Endourology, Cleveland, Ohio: Poster presentation on transition zone biopsies was selected and highlighted at the congress.
- Achieved second highest mark in the in-service FEBU exam, March 2005
- Best poster presentation award, 16th EAU Congress, Geneva, April 2001
- Distinction in the first-year course assessment of the MSc in Urology, June 2000

Appendix 2 – Expert's Declaration for use in Civil Cases in England & Wales

I, Mr Krishnan Anathararmakrishnan, DECLARE THAT:

1. I understand that my duty in providing written reports and giving evidence is to help the Court, and that this duty overrides any obligation to the party by whom I am engaged or the person who has paid or is liable to pay me. I confirm that I have complied and will continue to comply with my duty.
2. I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case.
3. I know of no conflict of interest of any kind, other than any which I have disclosed in my report.
4. I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.
5. I will advise the party by whom I am instructed if, between the date of my report and the trial, there is any change in circumstances which affect my answers to points 3 and 4 above.
6. I have shown the sources of all information I have used.

7. I have exercised reasonable care and skill in order to be accurate and complete in preparing this report.

8. I have endeavoured to include in my report those matters, of which I have knowledge or of which I have been made aware, that might adversely affect the validity of my opinion. I have clearly stated any qualifications to my opinion.

9. I have not, without forming an independent view, included or excluded anything which has been suggested to me by others, including my instructing lawyers.

10. I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report requires any correction or qualification.

11. I understand that;

    1. My report will form the evidence to be given under oath or affirmation;

    2. questions may be put to me in writing for the purposes of clarifying my report and that my answers shall be treated as part of my report and covered by my statement of truth;

    3. the court may at any stage direct a discussion to take place between experts for the purpose of identifying and discussing the expert issues in the proceedings, where possible reaching an agreed opinion on those issues and identifying what action, if any, may be taken to resolve any of the outstanding issues between the parties;

    4. the court may direct that following a discussion between the experts that a statement should be prepared showing those issues which are agreed, and those issues which are not agreed, together with a summary of the reasons for disagreeing;

    5. I may be required to attend court to be cross-examined on my report by a cross-examiner assisted by an expert;

6. I am likely to be the subject of public adverse criticism by the judge if the Court concludes that I have not taken reasonable care in trying to meet the standards set out above.

12. I have read Part 35 of the Civil Procedure Rules, the accompanying practice direction and the Guidance for the instruction of experts in civil claims and I have complied with their requirements.

13. I am aware of the practice direction on pre-action conduct. I have acted in accordance with the Code of Practice for Experts and/or code of conduct for experts of my discipline, namely Urology.

Appendix 3 – Statement of conflict of interests

I confirm that I have no conflict of interest of any kind, other than any which I have already set out in this report. I do not consider that any interest which I have disclosed affects my suitability to give expert evidence on any issue on which I have given evidence and I will advise the party by whom I am instructed if, between the date of this report and the trial, there is any change in circumstances which affects this statement.

Appendix 4 – Statement of awareness

I confirm that I am aware of the requirements of CPR Part 35, Practice Direction 35, and the Guidance for the Instruction of Experts in Civil Claims (2014)

Appendix 5 – Statement of truth

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.