Neutral Citation Number: [2018] EWHC 1917 (QB)

Case No: HQ14C05155

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL
Handed down at Birmingham Civil Justice Centre

Date: 25/07/2018

Before:

MRS JUSTICE YIP DBE

- -

Between:

AMANDA JAYNE WELSH **Claimant**

- and –

WALSALL HEALTHCARE NHS TRUST **Defendant**

- -
- -

Mr Christopher Limb (instructed by **Pattinson & Brewer**) for the **Claimant**
Mr James Counsell QC (instructed by **Browne Jacobson**) for the **Defendant**

Hearing dates: 19, 20, 21, 25, 26 & 28 June

- -

Judgment Approved

Mrs Justice Yip:

1. This is a claim for clinical negligence relating to bariatric surgery undertaken at Walsall Manor Hospital on 3 January 2012.

2. The claimant, who was aged 40 at the date of surgery, was very overweight. She had a history of depression. She had hoped that gastric bypass surgery would mark a real turning point for her and bring about a significant improvement in her quality of life. Sadly, she developed serious complications which left her extremely unwell. She required an ileostomy and reversal of the bypass. She had to spend seven months in hospital. The experience was traumatic and, at the end of it, she was left without any of the hoped-for benefits. It is her case that there has been a lasting impact on her physical and psychological health, for which she should be compensated.

3. The claimant underwent open surgery under the care of Mr Mirza, a consultant bariatric and upper gastrointestinal surgeon. The Particulars of Claim raised issues as to the pre-operative assessment, consent and the choice of open rather than laparoscopic surgery. However, this aspect of the case was withdrawn at trial and so I need say no more about it.

4. Shortly after the surgery, an anastomotic leak occurred. This is a recognised complication of the procedure. It is agreed that its occurrence was not a result of

negligence. There is, however, an allegation of surgical negligence which is said to have played a part in subsequent events. The remaining allegations concern the detection and treatment of the leak and the claimant's post-operative care. The defendant admits a number of breaches of duty and accepts that the claimant has been caused some additional loss and damage. However, it is the defendant's case that the majority of her problems were caused by the leak itself, for which there is no liability.

5. The parties having cooperated to narrow the issues, I am now essentially invited to choose between two alternative scenarios. The claimant's primary case is that the leak should have been successfully repaired rendering the bypass a success. She would have recovered much more quickly and gone on to experience substantial weight loss leading to a significant improvement in her physical and mental health. The secondary case or middle ground is that the bypass would still have needed to be reversed but the claimant would not have required an ileostomy and there would have been fewer complications. The assertion then is that her condition would have been largely the same as pre-surgery. Within those two broad positions, there are some remaining issues to consider when looking at causation and quantum.

The initial surgery – 3 January 2012

6. Mr Fiennes, the expert in bariatric surgery instructed on behalf of the claimant, had prepared some helpful diagrams to which reference was made during the trial. I annex his Figure 1 which is a simple schematic representation of the gastric bypass procedure which the claimant underwent. The stomach is divided (using staples) into a very small pouch, which remains connected to the gullet, and the remaining bulk of the stomach into which food can no longer pass. The small bowel is then divided. One end is connected to the stomach pouch to restore a continuous food pathway. The other end is connected in a Y configuration further down the intestine. The alimentary limb so created was measured by Mr Mirza and recorded as being 150cm. The biliary limb was 100cm. The length of the common channel, which is the portion between the entero-enterostomy and the junction of the small bowel and colon, was not recorded in the operation note.

7. The length of the common channel should usually be not less than 300cm. It is generally considered that the total length of the adult human small bowel is around 600cm. Mr Mirza maintains that he would always measure the common channel in a patient with a BMI over 50 (as was the case here) and that he would not leave less than 300cm of common channel as this gives rise to a risk of nutritional deficiencies and other complications. He says that he followed his usual practice. However, it is the claimant's case that the common channel was left too short.

The post-operative period

8. The claimant's surgery had commenced at about 17.00 and she arrived in the recovery room at 19.45. There were no immediate concerns and she returned to the ward at 21.00. Her heart rate had risen by 04.00 on 4 January, although it remained within a normal range. Her observations were otherwise stable.

9. In their joint statement, the bariatric surgery experts agreed that there were progressive changes in the claimant's vital signs during 4-5 January. The changes on 4 January indicated careful monitoring was required but did not conclusively indicate a leak.

However, they agree that progressive deterioration during 5 January was clearly indicative of a leak. At 16.50 that day, results of blood tests showed a C-reactive protein level in excess of 300. This is significantly elevated and is a marker for an inflammatory response. The claimant was seen by Mr Mirza at 17.30 but no further investigations were arranged then.

10. The experts agreed in the joint statement that "on the strong balance of probabilities the leak had occurred by the evening of the 5th". They also agreed that no responsible bariatric surgeon would have failed to identify a probable leak by that evening. The claimant ought to have had a CT scan with oral contrast. My understanding of the expert evidence is that this would have led to further surgery soon after.

11. That did not occur. The claimant continued to deteriorate overnight into the morning of 6 January. She was seen by Mr Rao, a staff grade surgeon, at 09.07. Her temperature was 39 degrees and she was tachycardic. Her abdomen was distended and peritonitic. Mr Rao recognised that she required a laparotomy that day.

Surgery on 6 January 2012

12. Mr Mirza carried out the laparotomy at 10.00. He found a small anterior leak at the gastro-jejunal anastomosis. There was "murky fluid" in the midline wound with little contamination of the peritoneum. In evidence, Mr Mirza said that he found the tissue to be "friable" and therefore he did not attempt to suture it.

13. Mr Mirza inserted a Foley catheter into the wound with the aim of creating a controlled fistula. An issue as to the appropriateness of the catheter fell away at trial so that it no longer forms part of the claimant's case.

14. A feeding tube was placed into the common channel. Two drains were left close to the site of the leak. The abdominal wall could not be closed due to swelling of the small bowel and a sterile covering was used with a view to further surgery a few days later.

Surgery on 11 January 2012

15. Mr Mirza returned to close the abdomen on 11 January. At that time, he found that the anastomotic leak had disrupted further so that the disruption was greater than 60%. The Foley catheter was lying free.

16. Following discussion with another surgeon, Mr Mirza re-sutured the gastro-jejunal anastomosis and inserted a different type of catheter directly into the stomach pouch. There was no prospect of closing the abdomen. A VAC dressing was applied, and two further drains were inserted. The claimant was transferred to ITU for post-operative care.

CT scan 13 January 2012

17. The claimant's condition did not improve and on 13 January the pain was worse, and the abdomen was very distended. She underwent a CT scan which was reported not to show any significant concerns. In fact, there was generalised colonic dilatation and gas within the bowel wall.

18. The claimant continued to be very unwell. She later became agitated and required sedation and ventilation. There were further signs of sepsis.

19. A further scan was carried out five days later on 18 January 2012. This revealed acute changes in the right side of the colon which required further surgical exploration.

Surgery 18-19 January 2012

20. The claimant underwent further urgent surgery overnight under the care of Mr Mirza, assisted by colleagues. This was a lengthy procedure.

21. The pouch-enterostomy was again found to be disrupted. The right hemi-colon was ischaemic with localised perforations. The gastric bypass was partially reversed. The anastomosis was disconnected, and the stomach pouch was re-joined to the rest of the stomach. A right hemicolectomy was undertaken, and an ileostomy was formed. The feeding tube was removed.

Post-operative period after 19 January 2012

22. The claimant was very unwell although she made steady progress. Concern was expressed about pressure areas and by 22 January the claimant had developed pressure sores.

23. On 24 January, bile leakage was noted. A fistula was noted on 26 January. A tracheostomy was performed on 31 January. Fistula leakage continued into February and a second fistula developed. Faecal material was noted in the VAC canister.

24. By 3 March 2012 the claimant was well enough to be discharged from the high dependency unit back to the ward. The volume of output from the fistulae was controlled. The claimant's time at Walsall was very distressing for her. She gave a graphic account of frequent leakage of blood and faecal matter.

25. On 4 April 2012, the claimant was transferred to the University Hospital of North Staffordshire in Stoke which was closer to home. She came under the care of Mrs Hall. She continued to have problems with the stoma bag leaking and soreness and excoriation of the wound around this. From Stoke, she was transferred to Bradwell Community Hospital, before finally being discharged home in August 2012. A further septic episode required a brief re-admission. The claimant remained low in mood.

Surgery at Stoke on 1 May 2013

26. Mrs Hall carried out surgery on 1 May 2013 to reverse the ileostomy and restore bowel continuity, completing the reversal of the gastric bypass.

27. At this time, the length of the common channel was measured by Mrs Hall as 70cm.

28. This surgery was successful. The initial post-operative recovery was uneventful, but the claimant developed acute pancreatitis on 10 May 2013. The claimant remained in hospital until 2 August 2013 and had a further brief re-admission after that.

Progress following discharge in August 2013

29. Recovery was again complicated with fistulae which did not heal until October 2013 and delayed healing of the wound until November 2013. Physically, the claimant made good progress thereafter. However, she regained the weight lost while she was hospitalised. She went on to develop fibromyalgia and chronic post-surgical pain.

30. In December 2013, the claimant was seen at the North Staffordshire Wellbeing Service. She was noted to be suffering from anxiety, low mood and problems associated with eating. She was said to be traumatised following surgery. Cognitive behavioural therapy was started on 5 February 2014. By 10 April 2014, there had been significant improvement and the claimant was discharged.

31. The claimant considers herself to be very restricted in what she can do. Her mobility has deteriorated and she now sleeps downstairs. She says that she hardly leaves the house. She has significant scarring to her abdomen. The pressure sores have left additional scarring to her neck, chin and heel. She has ongoing psychological problems.

32. In theory, the claimant could undergo further bariatric surgery but she would be at an increased risk of serious complications, including death. The defendant does not contend that she is being unreasonable in not wanting to run these risks.

Liability issues

33. The issues between the parties had narrowed to some extent by the end of the trial. By way of summary, the parties' final positions in relation to the pleaded allegations were as follows:

    i) Consent and pre-operative issues: These allegations were withdrawn by the claimant. Accordingly, it is admitted that she would have undergone the operations on 3.1.12 and 5.1.12 and would have had abdominal scarring and a longer than average period of recovery from bariatric surgery.

    ii) Surgical negligence on 3.1.12: The claimant alleges the common channel was left too short. This is denied. If I find that the common channel was too short, it is agreed that this did not cause or contribute to the initial leak. The extent to which it caused or contributed to subsequent problems remains to be determined. However, it was agreed during closing submissions that, in practical terms, this aspect of the case may not add materially to the impact of the failure to correctly interpret the CT scan on 13.1.12.

    iii) Delay in diagnosing the anastomotic leak: The defendant admits that the leak should have been detected earlier than it was. The experts agreed that it should have been identified by the evening of 5.1.12. There is an important issue between the parties as to whether the leak would then have been successfully repaired, leaving the claimant with the benefit of a gastric bypass and the expected significant weight loss.

    iv) Surgical negligence on 6.1.12: No allegations are maintained in relation to the appropriateness of the Foley catheter. The claimant does maintain that positioning of the feeding tube was negligent. The defendant denies this. The

causation issues in relation to this allegation are similar to those in ii) and, again, this aspect may not add materially to the breach on 13.1.12.

v) Failure to correctly interpret the scan on 13.1.12: The defendant admits breach of duty and that this resulted in a delay of 5 days before the claimant was operated on. In addition to the additional pain and suffering over those five days, the subsequent critical illness would have been curtailed. Although not the defendant's position when the case was opened to me, Mr Counsell QC conceded in his closing submissions (as set out in the table he provided to accompany them) that "Perforation and subsequent ileostomy (and later reversal of ileostomy in May 13) would have been avoided if action taken earlier". However, it is agreed that this breach did not cause the failure of the gastric bypass.

vi) Nursing breach: The defendant admits breach of duty in relation to the nursing care which caused her to develop pressure sores and has left her with scarring to her neck, chin and heel.

Relevant evidence

34. In determining these issues, I have had regard to the contents of the claimant's medical records; the factual evidence of Mr Mirza and the expert evidence of Mr Fiennes (called by the claimant) and Mr Beckingham (called by the defendant). The defendant's other witnesses of fact dealt with the consent issue which is no longer pursued. I had written evidence from experts in radiology and tissue viability. The defendant's admissions in relation to those aspects of the case meant that it was unnecessary to hear from those experts.

Joint statements

35. As I observed during the trial, the joint statements in this case were not as useful as they might have been. The difficulty was caused by the inability of the parties to agree a single agenda for the experts' consideration. This is not the first time that I have expressed concern about this and counsel confirmed that it is a problem that appears to be arising more frequently. When I enquired as to why that might be, Mr Counsell, having sought instructions, referred to the model directions for clinical negligence actions which provide for the claimant's solicitors and experts to prepare a draft agenda to be sent to the defendant's solicitors for comment and for the defendant to then agree the agenda or propose amendments within 21 days. Paragraph 13 of the model order says:

> "7 days thereafter all solicitors shall use their best endeavours to agree the Agenda. Points of disagreement should be on matters of real substance and not semantics or on matters the experts could resolve of their own accord at the discussion. In default of agreement, both versions shall be considered at the discussions. …"

36. It was suggested that the form of the model order encourages more than one agenda to be sent to the experts. I cannot agree with this. The standard direction makes it clear that the solicitors are required to do their best to agree a single agenda. In the vast

majority of cases, any disagreement ought to be capable of resolution through a bit of give and take. It may be appropriate to insert some additional questions into the draft at the defendant's request. It certainly should not become routine to provide two versions which, as here, travel over much of the same ground. That approach tests the patience of the experts (and frankly of the court); produces a lengthier joint statement; potentially increases costs and is simply not the best way to focus on the issues. I do not think that anything further needs to be said or done in this case. However, if this worrying trend continues, parties may find that courts begin considering costs consequences.

The length of the common channel

37. At the time of Mrs Hall's reconstruction surgery on 1 May 2013, the residual common channel was approximately 70cm in length. Mr Fiennes and Mr Beckingham agreed that ileostomy surgery might have accounted for an additional 20cm and that inflammation and fibrosis might have contracted the common channel by up to 30%, producing a total of 120cm. That left a discrepancy of 180cm against the standard 300cm that would usually be left.

38. Mr Beckingham suggested that such discrepancy might be accounted for by the further procedures the claimant underwent before Mrs Hall operated on her. However, there is no record within the claimant's notes of the subsequent removal of a further section of small bowel. Mr Fiennes indicated in his report that he had checked the records and could find nothing in any operation note or pathology report to support this. Further, Mr Mirza did not explain in his witness statement when and why a substantial piece of small bowel was removed. The experts noted in their joint statement that the wording of the operation note of 19 January 2012 was confusing. It referred to resecting the terminal ileum and transverse colon. However, the pathology report confirms that the specimen received consisted only of right hemi-colon.

39. Mr Mirza's evidence was that he measured the common channel and that he would not have left less than 300cm. In his witness statement he said that he could see from the operation note that greater than 300cm of common channel had been left in situ. However, in cross-examination he conceded that the note did not demonstrate this. He agreed that if a specific measurement is taken it ought to be recorded. He blamed his registrar for making an insufficient note although did acknowledge the note was his responsibility and that he had failed to check it properly.

40. In giving evidence in chief, Mr Mirza suggested that he had removed a large section of bowel during the operation on 18/19 January 2012. This did not appear in his witness statement. He accepted that he would usually send what he removed off to histology. Mr Limb put to him that he had only sent right hemi-colon to histology. He said that he had additionally removed a substantial part of the ileum but did not send that to histology as it did not appear diseased. He agreed that he should have recorded this in his note; that he should have sent the tissue to histology and that this was an important point that should have been included in his witness statement. Having heard his evidence, Mr Fiennes said that if Mr Mirza had done what he said on 18/19 January 2012 he would have expected the notes to at least record that a piece of matter was removed and to give some sort of estimate of length. He also said that it would be good practice to send it to histology. Mr Mirza went further than that, saying in re-examination that he would usually send all tissue that was removed to histology.

41. The experts cannot assist further on this issue and it is agreed that this is an issue of fact for me to determine on a balance of probabilities.

42. I regret that I found Mr Mirza to be a poor witness generally. He was not always clear or wholly convincing. At times, he appeared very uncomfortable in dealing with questions. On the issue of the common channel, I found his evidence to be particularly poor. Having weighed that evidence against the contemporaneous records, I do not accept that he removed a substantial section of small bowel on 18/19 January 2012. On the balance of probabilities, I find that he left the common channel too short at the time of the original surgery. I consider that the calculation of a length of 120cm in the joint statement represents a realistic estimate.

The position of the feeding tube

43. I must consider this issue in light of my finding as to the length of the common channel.

44. I note that, on the face of their joint statement, Mr Fiennes and Mr Beckingham appeared to be in agreement on the issue of the positioning of the feeding tube. However, Mr Beckingham resiled from the apparent agreement in the witness box.

45. The experts had agreed that placing the tube in the excluded stomach or in the proximal jejunum would have provided better nutrition for the claimant. The significance of this in the context of this case is that poor nutrition can contribute to problems with healing. The experts agreed that with better nutrition the claimant would have avoided some or all of the complications of pressure sores and ischaemia and perforation of the colon.

46. When asked whether there was a body of responsible bariatric surgeons who would have inserted a feeding tube as sited by Mr Mirza, the experts agreed "there could be a minority who would do this, but that the nutritional value of this approach does not withstand reason." On the face of it, that appeared to indicate a breach of duty, having regard to *Bolitho v City and Hackney health Authority* [1998] A.C. 232. However, in giving his oral evidence, Mr Beckingham initially said that he did not read the "second bit" before signing the joint statement, that is he suggested that putting the feeding tube in the common channel would be a minority practice but thought it was nevertheless logically justified. Later, he suggested that he himself would choose to put the feeding tube in the common channel because of the risk that other anastomoses might break down, provided that he thought that there was 300cm (or not less than 200cm) remaining.

47. I did not find Mr Beckingham's evidence on this issue impressive. The impression I had was that he had reached an agreement with Mr Fiennes following discussion but that he was going back on that at trial and perhaps compromising his neutrality to some extent. By contrast, I felt that Mr Fiennes gave his evidence in a careful, considered and measured way. In relation to this issue, he accepted that if the common channel had been of normal length and if the feeding tube was inserted 10cm from the top of the 300cm that would potentially provide sufficient opportunity for absorption. However, he continued to hold the opinion that it was irrational to place the feeding tube in the common channel. He said that there was no reason to think that there would be a problem with the anastomosis and the claimant would undoubtedly have had better nutrition had the feeding tube been placed elsewhere. I found what he said to be compelling.

48. Mr Beckingham's claim that he was in a minority that would put the feeding tube in the common channel depended on the common channel being of sufficient length to allow for adequate nutrition. It therefore appears that the fact that I have found that the common channel was too short resolves the issue as to the positioning of the feeding tube. Had it remained a live issue, I would have preferred Mr Fiennes' evidence and concluded that the agreement in the joint statement that putting the feeding tube in the common channel did not withstand reason was correct.

49. Accordingly, I find that the feeding tube was incorrectly positioned in the common channel and that such represents a further breach of duty.

50. The combined effect of the short common channel and the position of the feeding tube was that the claimant was not receiving a proper level of nutrition after her surgery.

Delay in diagnosing the anastomotic leak

51. The experts agreed that it was difficult to be precise as to when the initial leak or perforation had occurred. In their joint statement, they agreed that events on 4 January indicated the need for careful monitoring but did not conclusively indicate a leak. They noted changes in vital signs during the night of 4-5 January. Progressive deterioration on 5 January clearly indicated a leak but they said they could not be more specific than that.

52. They further agreed that "it is more probable than not that a contrast swallow during the afternoon of the 5th would have demonstrated a leak."

53. Mr Fiennes gave a very clear explanation of the process by which a leak develops. Indeed, Mr Beckingham commented upon the eloquence of his presentation and indicated that he agreed.

54. Mr Fiennes explained that the leak does not suddenly occur at a single point in time. It is the culmination of a process. Both experts described the beginning of that process as ischaemia, from which a leak will develop until it becomes a frank perforation. In cross-examination, Mr Beckingham said: "I believe perforation was complete sometime on the afternoon or evening of 5 January." Mr Fiennes acknowledged that the perforation had not occurred by the evening of 4 January. However, he considered that the process of a developing leak was in train by then. This fits with the agreement in the joint statement that "changes in vital signs were progressive from 4th to 5th, mirroring the fact that leak and perforation is a progressive process, not a point-in-time event."

55. The issue as to when the perforation occurred is an important one. It might have been identified more clearly at the start of the case. However, as other issues fell away, it was brought into focus.

56. The evidence of the two experts, taken together, was that the perforation occurred sometime on 5 January. I found Mr Fiennes' evidence that the CRP level 300 was indicative of significant egress of gastric juice into the peritoneal cavity to be well reasoned and compelling. The blood from which this result comes was drawn at 14.30 and was reported at 16.21 (see page 1873 of the medical records). The results were recorded in the claimant's notes by a Foundation Year 2 doctor at 16.50.

57. I therefore find as a fact that the perforation had occurred on 5 January at some time before 14.30 when the blood was taken.

58. In the joint statement, the experts agreed that no responsible bariatric surgeon would have failed to identify a probable leak by the evening of 5 January. In fact, it was not until 09.07 on 6 January that Mr Rao, conducting the morning ward round, identified the probable leak and the need for an urgent laparotomy, which took place at 10.00.

59. Mr Counsell sought to argue that the delay was a matter of a "few hours". In doing so, he appeared to take 23.30 as the starting point for the time at which the leak should have been identified. I cannot accept this. I do not believe 23.30 is a reasonable interpretation of the experts' description of the "evening of 5 January". The blood results, with the very elevated CRP level were noted in the claimant's records at 16.50. That should probably have prompted escalation to a more senior doctor. However, the claimant was, in any event, seen by Mr Mirza on his evening ward round at 17.30. I conclude that Mr Mirza ought to have identified the probable leak at this time and to have arranged urgent investigations and/or a laparotomy. Had he not proceeded immediately to laparotomy (as in fact happened the following morning), a scan would have revealed the leak and surgery would then have taken place.

60. There is no reason to think that surgery could not have taken place urgently on the evening of 5 January. I note that the surgery on 18 January started at 18.30 and continued into the early hours. The defendant called no evidence to suggest that the time of day at which the leak was identified would have had a significant bearing on how quickly the surgery took place. I conclude therefore that surgery would have taken place by 18.30 or certainly by no later than 19.30.

61. The relevant period of delay was therefore of the order of 15 hours.

Causation

62. In light of the above findings, I must consider causation on the basis that, but for the defendant's breach of duty, the claimant would have undergone surgery on the evening of 5 January and would have received an appropriate level of nutrition post-surgery.

63. The Defendant's position is that, even on the evening of 5 January, it would not have been possible to successfully repair the leak. Therefore, the claimant's gastric bypass surgery would not have been successful in any event.

64. In his report dated 1 July 2017, Mr Beckingham said that the earliest possible indication of a leak was on the late evening of 5 January / early hours of 6 January and that this would have led to the claimant returning to surgery "slightly earlier". He said that he did not believe that the difference of a "few hours" would have made any difference to the outcome.

65. Mr Fiennes' opinion, as expressed in his report dated 16 June 2017, was that the diagnosis of a leak or perforation should have been made no later than "the first half of" 5 January. On that basis, he opined that immediate remedial surgery would have led, on the balance of probabilities, to uncomplicated healing. The time at which surgery in fact took place was still within 48 hours of the first indications of a leak. Mr Mirza did not attempt to suture the perforation at the time. Mr Fiennes said about this

"48 hours or less after occurrence of the perforation primary repair would usually still be feasible, but I recognise Mr Mirza saw the findings and I did not." I note this is another example of him presenting his evidence in a balanced and measured way.

66. The issues between the experts appeared to have been narrowed by the joint statement. Mr Fiennes was prepared to push the time at which the leak should have been diagnosed back a little. It seems to me that this did not represent any fundamental change in his opinion but rather was a sensible concession, after discussion with Mr Beckingham, as to the latest time at which any responsible bariatric surgeon could have been expected to identify the leak.

67. The experts also agreed that "a leak of less than 24 hours duration would reasonably be sutured by a responsible bariatric surgeon" and that a policy of not attempting primary repair would be widely supported in the presence of a leak seeming to be more than 48 hours old.

68. They went on to agree that "the closer the operation is in time to the moment of frank perforation, the more probable it is that primary repair would have succeeded."

69. Mr Fiennes' oral evidence was consistent with what he had said previously and with the agreement reached in the joint statement. He told me that there was a "spectrum of outcomes". Generally, the longer the delay before operating the worse the outcome.

70. Mr Beckingham's evidence shifted quite considerably in the witness box. For the first time, he suggested that the leak would have had to be sutured within 24 hours of the original operation for the repair to be successful. Asked by Mr Limb about the agreement in the joint statement that a leak of less than 24 hours could usually be sutured, he confirmed that he had been talking about 24 hours from the perforation. He accepted that the suggestion that repair would have to take place within 24 hours of the original operation was not in his report or the joint statement but said that was his opinion. He became quite evasive. He then introduced further justification for his revised opinion, suggesting that the fact that "three days later" the staple line had broken down further suggested that it would inevitably have broken down whether stitched or drained. (I assume here he was referring to the findings on 11 January 2012.) Eventually, Mr Beckingham concluded that, on the balance of probabilities, repair was doomed to fail from the beginning. His explanation for not putting this in his report was simply "I did not think it through in that way." I am afraid I do not consider this to be a satisfactory explanation. This was not a case of oversight. Mr Beckingham's revised opinion was wholly inconsistent with the clear agreement in the joint statement that "the closer in time to the moment of frank perforation, the more probable it is that primary repair would have succeeded." I simply do not see how he could have signed a joint statement containing that agreement (recorded twice) if his true opinion was that in this case surgery at any time would not have successfully repaired the leak.

71. On this important issue, I unhesitatingly prefer the evidence of Mr Fiennes to that of Mr Beckingham.

72. Mr Mirza told me that he did not attempt suturing of the leak on 6 January as the surrounding tissue looked "friable". Mr Fiennes indicated that he was prepared to accept Mr Mirza's view. He had already fairly acknowledged that Mr Mirza had the advantage of having seen how the tissue actually looked. Both experts made the point

(which might be thought to be common sense) that the surgeon will always make an assessment of what is actually before him or her before deciding to proceed.

73. Mr Counsell contends that the window between the time of perforation and the operation on 6 January was still less than 24 hours. Despite that, Mr Mirza was unable to suture. That, he says, demonstrates that this was not a typical case. He draws further support for that proposition from the fact that there had been further substantial dehiscence by 11 January despite the insertion of a Foley catheter.

74. I do not accept that the fact that the perforation could not be sutured at 10.00 on 6 January leads to a conclusion that it could not have been sutured on the evening of 5 January. It is clear from both experts' evidence that it is difficult to fix the precise point in time at which the perforation occurred. This is not something which they would usually be required to consider in practice. Once a leak was identified, the surgeon would operate and respond to the findings when the abdomen was opened. Further, there is no cut-off point or line in the sand to demark when suturing can or cannot take place. The experts' agreement was only that a leak less than 24 hours old would usually be sutured and one more than 48 hours usually not.

75. In as much as what Mr Mirza found on 6 January evidences anything, it seems to me it is at least as likely to be evidence that the perforation had occurred more than 24 hours earlier. That would remain consistent with Mr Fiennes' evidence that it had not occurred by the evening of 4 January, but that egress of gastric juices had occurred by 14.30 on 5 January. Having heard both experts, I do not believe that it is possible to be more precise than that.

76. Mr Counsell relied upon the fact that the abdomen could not be closed after the operation on 6 January due to swelling from bowel oedema as further evidence that it would not have been possible to successfully repair the leak on 5 January. Again, I cannot accept this. It is plain that the claimant deteriorated significantly overnight. She was seen by Mr Mirza at 17.30 on 5 January, when her condition was such that he missed the indications of a leak. By 6 January, the claimant was plainly very unwell. Her abdomen was distended and peritonitic. It seems to me that this evidence in fact supports the experts' agreement that earlier intervention would have rendered successful repair more probable. I entirely accept the experts' agreed position in the joint statement that the closer in time to the frank perforation surgery occurs the more probable it is that primary repair will succeed.

77. I see some greater force in the argument that the further breakdown on the staple line by 11 January suggests that primary repair of the leak would not have been successful. However, the whole course would have been different if the claimant had been operated on and the leak sutured on 5 January. Mr Fiennes accepted that the findings on 11 January had to be considered but expressed the view that the delay in curtailing the process of inflammation made a contribution to the failure to heal. Further, I accept Mr Fiennes' evidence that inadequate nutrition in a septic patient would begin to play a part in relation to the healing process within days. Overall, I prefer Mr Fiennes' view that it is not reasonable to argue back from what happened in the absence of surgery on 5 January and to conclude that the perforation would not have been successfully repaired at that time.

78. Having considered all the evidence, I prefer Mr Fiennes' evidence where it differs from that of Mr Beckingham. Of course, there can be no certainty as to the outcome had a different course been taken. However, I conclude, on the balance of probabilities, that the leak would have been successfully repaired had the claimant been operated on during the evening of 5 January.

79. I accept the claimant would have been in hospital longer than would have been expected if the leak had not occurred and her recovery would have been slightly more prolonged. However, the difference would not have been more than a few weeks at most. The further surgery would have been avoided, as would the very protracted, stormy recovery thereafter. The claimant would not have needed an ileostomy. Crucially, her gastric bypass would not have been reversed. She would have experienced substantial weight loss. She would still have had the midline scar to her abdomen. She should not have experienced pressure sores and would not have the scarring associated with that. The claimant would reasonably have expected significant improvement in her physical condition compared to the pre-surgery position.

Psychiatric injury

80. I heard evidence from two consultant psychiatrists, Dr Beary called by the claimant and Dr Jackson by the defendant. I thought both gave their evidence well. It was clear that they had very different styles. The claimant had engaged better with Dr Beary than Dr Jackson. In part that may be because she regarded him as being on "her side". I suspect also that she preferred Dr Beary's manner.

81. It is agreed that the claimant had a long history of mental health problems. The experts agree she had pre-existing Recurrent Depressive Disorder but that she was apparently stable prior to the surgery. She was considered to be a good candidate for bariatric surgery. In the joint statement, Dr Beary expressed the view that she "would have enjoyed substantial benefit in terms of self-esteem at least had the bariatric surgery gone well and had that led to substantial and sustained weight reduction". Dr Jackson thought that her long history of psychiatric problems could not be seen simply as secondary to her obesity and that accordingly she would have continued to have psychological and psychiatric symptoms even had the surgery gone well. In cross-examination, Dr Jackson accepted that had the surgery been successful producing substantial weight loss some improvement could certainly have been expected. He said that, on the balance of probabilities, she would have experienced some improvement in her capacity to "get out and about and do things". However, he highlighted that she had always struggled with self-esteem.

82. The claimant appears to have opened up more to Dr Beary than she did with Dr Jackson. She told Dr Beary that she was waiting for the operation to change her life. She also said that by 2010 she had become somewhat reclusive, but she was also aware of "her biological clock ticking". It was clear from the claimant's evidence that she was distressed by not having had children. She told me that she thought that after the surgery she would meet "Mr Right" and start a family. She also referred to her niece as "the daughter I never had".

83. Predicting the likely course of the claimant's mental health had the bariatric surgery been successful is a difficult issue. It being accepted that the claimant cannot reasonably be expected to run the risks of going through further bariatric surgery, it is the sad fact

that she will never know how things would have turned out had the surgery worked. It is understandable that she feels her life would have been very different and that she has lost her dreams of finding a partner and having children. However, the available evidence does not suggest that successful surgery was likely to be the magic solution that she might have wished it to be.

84. I note that an entry in the claimant's IAPT notes dated 6 March 2014 refers to the "unhelpful cognitions" prompting her bariatric surgery: "If I could just be thin then I would be happy." I also note research from the United States, quoted in Dr Beary's report, which shows a disproportionately high suicide rate amongst patients who have undergone bariatric surgery. I consider that these pieces of evidence lend support to Dr Jackson's view, expressed in the witness box, that it is rare for patients to "head off into the sunset happily" following bariatric surgery.

85. It seems to me that common sense suggests that it would have been difficult for the claimant to have realised her dreams of having a family. Of course, I do not say it was impossible. However, she was aged 40 at the time of surgery. She would have taken some time to recover and to lose weight. Whether, and when, she would then have found a life partner who wished to have children is very uncertain. I have no specific evidence about her fertility (and do not consider such would have been appropriate) but it is known that fertility does continue to decline after age 40. On balance, I consider that the claimant was unlikely to have a family. From all that I have seen and heard, I consider that this would have been a major blow to her and that it would have counted against a major and sustained improvement in her mental health. Having said that, I do accept that substantial weight loss would have had some impact on her mood and well-being.

86. It seems to me that this conclusion is consistent with the evidence of both expert psychiatrists. In the joint statement, they agreed that the claimant would have continued to have episodes of depression even had the surgery gone well. The psychiatric evidence on both sides allows for some improvement but does not suggest this would have been a dramatic change. I accept Dr Beary's evidence that there would have been some real benefit in terms of self-esteem. However, I conclude that Dr Jackson was right when he said in cross-examination that the claimant's pre-existing vulnerabilities would have worked against a substantial and sustained change in her quality of life. In the end, while the experts may have presented a slightly different gloss, I did not feel they were too far apart in their views as to the prognosis had the surgery succeeded.

87. Having considered all the evidence, the findings I make as to the position had the surgery succeeded are as follows. The claimant would have experienced some improvement in her self-esteem and would have been likely to get out and about and do more. However, she would have continued to be vulnerable and to experience recurrent bouts of depression in response to life events. Overall, she is unlikely to have had a dramatic and sustained improvement in her mental health.

88. As matters turned out, not only did the claimant not gain the benefits that were to be expected but she suffered further trauma. Her recovery was extremely stormy. She experienced considerable additional pain and, at times, believed she was going to die. She gives a graphic account of her experiences in hospital, particularly frequent leakages of blood and faeces from the ileostomy. It is clear from her accounts to the

experts and in the witness box that her recollections of being covered in "blood and poo" continue to haunt her.

89. The experts agreed that the claimant suffered a further episode of depression, precipitated by the complicated and uncomfortable physical course she endured post-surgery. Dr Beary was of the view that this did not significantly improve until the ileostomy was reversed in May 2013. Dr Jackson found it hard to ascertain the extent to which the claimant was significantly worse after the surgery than before. In part at least, I believe this was because the claimant was less open in her consultation with him. However, he did accept that there had been an episode of depression related to the effects of the surgery. He thought it was difficult to estimate the length of that but that it was of the order of 3 to 6 months. I note that the IAPT records suggest that the claimant's self-esteem, depression and anxiety was 75% improved by April 2014 compared to when she started CBT treatment. On balance, I consider the evidence favours a rather more prolonged period of depression and anxiety than that suggested by Dr Jackson.

90. There was an apparent dispute between the psychiatric experts as to whether the claimant also suffered symptoms such as were sufficient to meet the diagnostic criteria for post-traumatic stress disorder (PTSD). That dispute appeared to narrow significantly during trial to the extent that counsel agreed that the precise diagnosis was perhaps of little real significance in the assessment of damages.

91. In the end, Dr Jackson was happy to accept that the claimant suffered some new symptoms due to a post-traumatic stress reaction, albeit he maintained that the full diagnostic criteria for PTSD were not met. Dr Beary acknowledged that many psychiatrists would not have diagnosed PTSD. He frankly admitted that when he prepared his report, following his assessment in March 2016, he was probably pushing the boundaries in making a diagnosis of PTSD. He explained that he just felt the claimant was very severely ill. He was aware though that there was a lack of evidence of avoidance. Subsequently, he felt such evidence was supplied by the claimant's unwillingness to discuss things with Dr Jackson. Dr Beary suggests that she displays avoidant behaviour unless she has established a high degree of trust with the person she is relating to. This may also be demonstrated by her unwillingness to engage in trauma work as planned by the IAPT service.

92. I conclude that this a borderline case so far as the diagnosis of PTSD is concerned and that Dr Beary is in a minority of psychiatrists who would make a formal diagnosis of that condition. However, there is no doubt that the claimant suffered post-traumatic symptoms which differed from her previous mental health problems and which are attributable to the defendant's negligence.

93. Dr Beary and Dr Jackson agreed that the claimant might benefit from CBT after the end of the legal process. It emerged during the trial that she has been undergoing EMDR (eye movement desensitisation and reprocessing) treatment and that this has been going well. The experts regarded that as a positive development. The evidence of both experts at trial was that the long-term prognosis is likely to be much the same as it was before the surgery. The claimant will continue to suffer recurrent bouts of depression and anxiety in response to life events.

94. I therefore assess damages on the basis that the claimant has suffered a psychiatric injury of moderate severity, including a significant episode of depression and anxiety and symptoms of PTSD. She made a substantial improvement after the ileostomy was reversed and further improved with CBT in early 2014. However, some psychological symptoms attributable to the surgery persist even now six-and-a-half years on. With treatment, they are likely to settle to the pre-surgery position. The claimant's long-term prognosis is not very different to that had the surgery been successful, save that she will not enjoy the benefits in self-esteem that significant weight loss would have produced. Although she would have enjoyed some improvement in self-esteem, the impact on her mental health is unlikely to have been as dramatic as she would have hoped.

Fibromyalgia and chronic pain

95. Following her surgery, the claimant has suffered significant pain in her abdominal area and more widespread pain, together with fatigue and problems with memory and concentration. Fibromyalgia has been diagnosed. I had reports from Professor Sameh Eldabe and Dr Nicholas Padfield, consultants in pain medicine. The large measure of agreement they reached in their joint statement meant that it was unnecessary for them to be called to give evidence at trial.

96. The pain experts agreed that the claimant is suffering from fibromyalgia and chronic post-surgical pain. They agreed that the development of fibromyalgia was not a direct result of the surgery. Each expert took a slightly different view as to causation, but they agreed following discussion that:

> "she may on balance have developed a picture of fibromyalgia later on in life absent the negligent surgery. However, had this occurred its effect would not have stopped her working and would have caused her a great deal less in terms of symptoms and psychological adverse impact. … the adverse events surrounding the alleged negligent surgery and its aftermath have materially amplified the impact of the fibromyalgia and caused it to be a much more significant problem than it would have been, had the surgery never taken place."

97. Professor Eldabe and Dr Padfield advised that the prognosis would be very poor without treatment. They advised that the claimant required some form of CBT. Further, they agreed that the claimant was most likely to benefit from a 'buddy', who would be a suitably experienced practitioner, undertaking one-on-one therapy on a domiciliary basis three times a week over a six-month period. Thereafter, they thought the claimant may then be able to benefit from a pain management programme in a group situation. However, they recognised that the claimant may never get to a psychological status that would permit such engagement. Even with treatment, the claimant will continue to experience the physical sensation of pain, but treatment is likely to impact on how the pain affects her daily life.

98. The pain consultants agreed that, if the claimant is able to engage with the recommended treatment, her sense of social isolation should improve, allowing her to be more connected with her community and environment. That may result in some improvement in physical functioning such that she could consider returning to a part-time desk job. In turn that would have a positive impact on her self-esteem, financial

situation and social connection. It is clear from the joint statement that there is considerable uncertainty as to the claimant's capacity to engage with treatment. However, I regard the fact that she is engaging positively with EMDR as a positive development.

Quantum

99. The parties indicated that they had been able to reach a large measure of agreement as to damages, subject to my findings in relation to breach and causation. I shall therefore deal only with those heads identified to me as raising issues requiring determination by me, namely:

i) General Damages for pain, suffering and loss of amenity

ii) Past and future loss of earnings

iii) Aspects of the claim for care

iv) Bathroom adaptations

v) Psychological therapy

Pain, suffering and loss of amenity

100. I have regard to all the matters set out above. The claimant is to be compensated on the basis that she underwent three surgical procedures that would not have been required but for the defendant's negligence. She was critically ill for 7 to 8 weeks and in hospital for about 7 months. Her recovery was very stormy and unpleasant as detailed above. She suffered significant pain and the psychiatric injury I have detailed. She is also to be compensated for the pressure sores she developed on her neck, chin and heel. These have left scarring. I note that the claimant is conscious of her scars. That to her face was not readily visible to me when she gave evidence, but it is fair to observe that this does not represent normal conversational distance. The claimant has regained her weight. She is morbidly obese. She is very unlikely to attempt bariatric surgery again. Her life expectancy is reduced. The claimant's functional capacity is limited by shortness of breath and pain. She uses a stick to mobilise at home; requires a wheelchair to access the community and has been sleeping downstairs as she cannot properly negotiate stairs. She has pain throughout her body. There are significant digestive problems, including heartburn and diarrhoea. The claimant requires assistance with normal daily living activities. I was impressed with the evidence of her sister, who is plainly doing a lot for her and who told me that the claimant was not "swinging the lead at all". Had she thought the claimant was capable of more than she was doing, she would give her some "tough love". The impression I had was that the claimant is really quite disabled currently.

101. But for the defendant's negligence, the claimant is likely to have lost a significant amount of weight and her physical health and mobility would have been substantially better. Based on the pain consultant's agreement, I find she is likely to have developed fibromyalgia at some stage but at a less disabling level. Psychologically, she would have been better although she would have continued to have recurrent bouts of anxiety and depression.

102. I consider that the claimant is likely to experience some improvement in her psychological condition and her ability to cope with pain with treatment following the conclusion of the litigation. While she will remain physically disabled, an improved outlook will have a positive impact on her quality of life.

103. Counsel referred to various categories within the Judicial College Guidelines, including the brackets for bowel injuries and psychiatric injury. Mr Counsell submitted that the appropriate figure for pain, suffering and loss of amenity was £90,000. Mr Limb contended for £150,000.

104. I have carefully considered the Judicial College Guidelines. I have looked not only at those sections to which counsel referred but also at other categories of injury, producing restriction in mobility, pain and psychological distress. Ultimately, my assessment depends to a large measure on experience of other personal injury claims and attempting to fit the claimant's overall level of disability and suffering into a broad scale of awards for multiple and complex injuries. Taking account of the 10% uplift which applies in this case, I have concluded that an appropriate award for pain, suffering and loss of amenity is £100,000. I trust that the parties will agree the interest to be added to that.

Loss of earnings

105. The claimant was not working at the time she underwent surgery. She had last been in paid employment in 2004. Prior to that, she had worked in an administrative role in the NHS for around 13 years. She repeatedly made reference to that employment in the course of her evidence and it appears she considered it valuable work. Her case is that she left that work to take up a counselling course. However, her grandmother had a stroke and she gave up the course to help care for her. After her grandmother's death in 2003, she got a civil service job, which she told me she loved. However, she left after a matter of months due to problems with a colleague and has not since returned to remunerative work. She explained that her mother had suffered heart failure after an operation and she had been caring for her. I note this was around 2008. Her claim is put on the basis that she would have returned to administrative or secretarial work a year after the surgery and that she would have been continuously employed thereafter.

106. The claimant told Dr Jackson that she had not worked since 2004 because of her nerves and her physical health problems. Mr Counsell pointed to a significant number of entries in her GP records relating to unrelated physical problems. Neither the contemporaneous records nor the claimant's evidence suggest that a return to work was a particular motivation in her seeking bariatric surgery. From all I have read and heard, it seems that family is very important to the claimant. In her statement she said:

> "I imagined that if I had surgery I would lose weight and everything else would fall into place. I imagined I would meet someone and get married and have children."

107. I have concluded that this was probably unlikely. I am not persuaded that the claimant was then likely to switch her focus fairly quickly on a return to employment. By then, she would have been away from the employment market for many years. She plainly enjoyed doing things for her family, she told me that she loved cleaning and feeling useful in that way. To some extent, I believe the claimant has subconsciously rewritten the narrative as far as her employment history is concerned. Her claim to have been

out of employment because she was doing equivalent work as a carer did not stand up when the chronology was scrutinised.

108. I certainly consider that there are far too many imponderables to adopt a multiplicand/multiplier approach to past and future loss of earnings. I have considered whether a more broad-brush approach such as in *Blamire v South Cumbria Health Authority* [1993] 1 P.I.Q.R. Q1 might be justified on the evidence before me. However, *Blamire* makes it clear that the legal burden of proving the likely pattern of future earnings following injury compared to the uninjured position remains on the claimant throughout. Mr Limb says, "there was no reason to think she should not have gone back to work." However, it is for the claimant to prove, on a balance of probabilities, that she would have returned to paid work. On the basis of all the evidence before me, I am afraid she has simply not established that. She had been out of remunerative employment for a very long time; she was (and would have remained) psychologically vulnerable and her motivation for the weight loss surgery was the desire to start a family rather than a return to paid employment. In the circumstances, I do not allow her claim for loss of earnings (both past and future).

Disputed aspects of the care claim

109. The defendant disputes that the claimant is entitled to recover damages on behalf of her relatives for time spent visiting her in hospital and monitoring her home. I am asked to decide as a matter of principle whether such matters properly fall within her claim for gratuitous care and services. I am not asked to calculate the sums that would be recoverable if so.

110. As a result of substantial agreement reached between the parties during the course of the trial, I did not hear evidence from the care experts. However, I have considered their written reports and the joint statement. I am not required to descend into the detail.

111. I was addressed fairly briefly on this aspect of the case. Mr Counsell referred to *Huntley v Simmonds* [2009] EWHC 405 (QB) in which a claim for the time spent by relatives visiting the claimant in hospital was disallowed. In that case reference was made to *Havenhand v Jeffrey* [1997] EWCA Civ 1076 (unreported) which was approved in *Evans v Pontypridd Roofing* [2001] EWCA Civ 1657. In *Havenhand*, Beldam LJ accepted that no allowance could be made for:

> "normal hospital visits arising from family affection and not [made] for the purpose of providing services which the hospital did not provide."

112. The observations in *Havenhand* were also considered by Langstaff J in *Warrilow v Norfolk and Norwich Hospitals NHS Trust* [2006] EWHC 801 (QB). I respectfully agree with and endorse his approach (at paragraphs 157 to 160). Langstaff J rejected the notion that a principle that "companionship cannot amount to care" could be deduced from the case of *Havenhand.* He went on to say [159]:

> "So far as Havenhand is concerned, the issue is whether the visit by relatives is an aid to the claimant's recovery, rather than facilitating ordinary social contact which would have occurred in any event. In the case of an old lady, as was the claimant in

> Havenhand, one can envisage relatives going to see her anyway. They would be doing no more by going to hospital than they might be doing anyway by going to her home. The fact that, in the brief reasoning which the judgment provides, some of the hospital visit was regarded as suitably remunerated, does not suggest that as a matter of principle it was being determined that companionship is not recoverable, if it would not otherwise be provided, if it is reasonably necessary for psychological or psychiatric stability, and if it is provided by a relative who would not otherwise have done any similar act. Where a person is, for instance, in danger of harming herself, or in danger of slipping into a deeper and chronic depression, the fact of companionship may be importantly therapeutic, and an essential part of care. Care is not only physical labour : time has its cost, and if time is devoted which would not otherwise be, and which meets the reasonable needs of an injured party, it deserves recompense. "

113. Here, I note that both care experts considered that the family had provided emotional and practical assistance during their daily visits. Ms Harris (the defendant's expert) noted that the claimant's parents had liaised with medical and nursing staff and brought food in for her. I note that the claimant did not always receive optimum nursing care in hospital, as evidenced by her pressure sores. Her sister provides evidence that after the claimant's move from ITU a nurse had said "she is not in ITU with one to one care now, tell her to stop demanding attention". The claimant was an emotionally vulnerable person, with a history of reacting badly to difficult life events. It seems to me that she did have a real need for care and support from her family which went beyond normal visits arising from family affection.

114. I do accept that the claimant was accustomed to spending a lot of time with her family. No doubt, some of the time spent in hospital would have been normal family chat, particularly as the claimant improved. However, her parents were put to the very real inconvenience of travelling to visit the claimant. The claimant said in her statement that this was very stressful for them. Before her surgery, generally the claimant would go to visit her parents.

115. It seems to me that a fair assessment of the care provided to the claimant in the form of emotional and practical support while she was in hospital would be represented by an average of 14 hours per week, to include travel time. That reflects the fact that, some of the time spent together in hospital would amount to normal family interaction. No doubt this varied from day to day. However, I believe 14 hours per week represents a reasonable allowance, looking at the family circumstances before her surgery and the assessment of the care experts as to the support being provided afterwards. I accept Ms Harris's suggestion that this claim should be allowed from 1 March 2012 to take account of care that would have been provided anyway. In so far as that start date may be a little generous to the defendant, I believe that the outcome is fair when viewed in the round.

116. In addition, I accept that the claimant is entitled to claim an additional one hour per week for the service provided to her in monitoring her home. As I understand it, this includes checking that her home was secure and that no problems had arisen, and collecting post. I consider it perfectly reasonable that a householder would wish regular

checks to be made on their home while they were away from it. I cannot see any particular distinction in principle between that and services such as cleaning a home, dog-walking, gardening and such like that are routinely allowed. The care experts joint statement suggests that there may have been a factual issue as to whether the claimant's home was unoccupied or whether her sister was living there in any event. However, I was not addressed on any factual issue. Assuming, as a matter of fact, that the house would otherwise have been unoccupied while the claimant was recovering in hospital or at her parents' address, I see no objection to her recovering an hour per week for the monitoring of her home.

117. The claimant also seeks to recover damages for the loss of the services she provided to her parents and her niece prior to her surgery. The defendant contends that the claimant's situation is far removed from that in *Lowe v Guise* [2002] 2 Q.B. 1369, where the claimant had accepted an obligation to provide care for his disabled brother with whom he lived. In that case, the care went beyond the help provided out of normal family ties and affection. The claimant had lost something of real value in losing the ability to meet his brother's clear need for care.

118. On the basis of the evidence I heard, I do not accept that the claimant is entitled to recover damages in respect of services provided to her parents and niece. I take into account that she enjoyed doing things with and for her niece and helping her parents. Her inability to do those things after her surgery represents a real loss of amenity for her, which I have taken into account in assessing general damages. However, I do not accept that the help the claimant was providing before the surgery crossed into the territory of recoverable loss envisaged in *Lowe v Guise*. Without belittling what the claimant did at the time of her surgery, I do not believe this represents a real identified need for services rather than the normal give and take of family life. I would therefore disallow this aspect of the claim.

119. The final issue concerning the future care claim is the assessment of the multiplier. The parties agree that the whole life multiplier is 36.43. The claimant contends that is the appropriate multiplier for the future care claim. The defendant suggests I should allow a multiplier of only 24.2. That figure would be the appropriate multiplier to age 70. The defendant puts this forward on the basis of arguing that the claimant's need for care would have increased as she got older in any event. It is not contended that any needs attributable to the defendant's negligence will cut off suddenly and completely at age 70. Rather, it is said that this represents a pragmatic solution that takes a number of factors into account. Those factors include the normal impact of ageing; the claimant's pre-existing psychological problems (which Dr Jackson suggested were likely to worsen over time); the likelihood of her suffering fibromyalgia in any event (albeit less severely) and the prospect that there may well be some improvement in physical function with the benefit of the recommended equipment and treatment. Mr Counsell submitted that everything could be taken into the round by selecting the multiplier he contended for.

120. I do not accept the contention, based on Dr Jackson's evidence, that the claimant's needs due to her psychological condition would have worsened over time. With the exception of that point, I do consider that the defendant has identified factors which should properly be taken into account in assessing the appropriate multiplier.

121. The advent of the Ogden Tables brought a far more mathematical approach to the calculation of future losses. There is, in my view, a risk sometimes of falling into the trap of believing that the selection of multipliers must be a precise scientific exercise. That cannot always be so. Sometimes, a more pragmatic approach is called for to do justice between the parties. In my judgment, the factors identified by the defendant can, and should, be reflected by some adjustment to the multiplier for future care.

122. The correct starting point, in my view, is the full Ogden life multiplier. I consider that the reduction contended for by the defendant by reference to the multiplier to age 70 is too great. That is particularly so in the context of a negative discount rate. It would effectively discount the future care claim by one-third. That, in my judgment, is too great a discount on the facts of the case.

123. I conclude that an appropriate multiplier for future care, taking all the above into account is 30. That does not represent a particular cut-off age, nor does it involve a precisely calculated discount. It is a round number, falling roughly between the parties' respective positions, which seems to me to best do justice. It allows for the pre-existing problems; the likelihood of fibromyalgia developing; the impact of ageing and the prospect of there being some improvement in function with the purchase of equipment and further therapy.

124. I note that I have not been told the extent of the agreement between the parties as to the multiplicand(s) to be adopted in relation to future care. I hope that it will be possible for them to agree the basis upon which the multiplier is to be applied in any calculations. The matters to which I have had regard in selecting the multiplier are those which Mr Counsell invited me to take into account. I have not looked at other issues which might impact upon the multiplicand.

Bathroom adaptations

125. This claim is a relatively modest one, which I shall deal with fairly briefly. In her schedule of loss, the claimant claimed £5,200 in respect of "bathroom adaptations and non-slip flooring in the bathroom and kitchen". This was not supported by evidence until an invoice dated March 2015 was produced during trial, after the claimant had given evidence. There is no evidence to explain how the work done was required by reason of the defendant's negligence. The defendant's counter-schedule dated December 2017 put the claimant on notice that she was required to produce documentary evidence in support of this claim and to explain what works had been done.

126. The claimant therefore had the opportunity to properly vouch her claim for bathroom adaptations. I am not satisfied that the invoice she has belatedly produced without any further explanation establishes that the works were properly attributable to the defendant's negligence. Accordingly, I disallow this head.

Psychological therapy

127. The final head that was identified for my consideration is the claim for psychological therapy.

128. The claimant seeks £7,800 for the cost of the 'buddy' programme recommended in the pain experts' joint statement and £36,000 for the pain management programme that would follow if the outcome of the initial treatment is sufficiently good to allow her to engage in group-work.

129. Mr Counsell complains that the claimant has not provided updated records since 2016. The defendant had been unaware until she was in the witness box that she was undergoing EMDR treatment. It had not been possible to explore that properly to see whether it would throw light on how the claimant might respond to further psychological treatment. Further, the pain consultants joint statement came very late leaving little time to clarify the position about future treatment. Overall, he said that it was too early to say whether the claimant was likely to undergo the recommended treatment.

130. Mr Counsell properly acknowledged that the need for the buddy programme might have been made out on the evidence presented at trial. The psychiatrists had welcomed the news of the EMDR but did not suggest that would replace the need for the treatment recommended by the pain experts. Although Dr Beary was cross-examined about the benefits of the claimant getting out of her home to access treatment, I did not think anything I heard from the psychiatrists detracted from the sensible recommendation for a tailored one-to-one programme such as recommended in the pain consultants' joint statement. I allow the cost of that programme in the sum of £7,800.

131. The position is less straightforward in relation to the cost of the pain management programme. The experts' evidence suggests that the question of whether the claimant will move on to the pain management programme is finely balanced. It might be said therefore that the claimant has not proved, on the balance of probabilities, that she will incur those costs. However, Mr Counsell acknowledged (sensibly and properly, in my view) that I might allow a percentage of the cost on the basis of the chance that it may be incurred.

132. I believe this is a reasonable approach to this head of loss. Usually, a future expense will be allowed in full if it will probably be incurred and not at all if it will probably not. However, my experience is that it is not uncommon for uncertainty as to whether future treatment will take place to be met by an allowance of less than the full cost. The aim is to do justice between the parties. The evidence suggests that the chance of the claimant undergoing the programme or not is about evens. In the circumstances, it seems to me that the fairest solution is to allow for half the cost of the programme. I acknowledge that if she does require it, she will face a shortfall which will have to be met from other heads of claim. If she does not undertake the programme, she will have a windfall. The potential injustice to each party is equally balanced and the risk of a greater injustice is avoided. I will therefore allow the sum of £18,000 in respect of the pain management programme.

Disposal

133. I hope that the above deals with all disputed matters sufficiently to allow the parties to calculate the appropriate judgment sum and to agree an order reflecting my judgment. In the event that there are any outstanding matters for me to deal with, I would invite the parties to clearly identify the issues and their proposals for resolution.

Figure 1:

Figure 1: Schematic Construction of Gastric Bypass Roux-en-Y (not to scale)