



Neutral Citation Number: [2021] EWHC 290 (QB)

Case No: QB-2017-003063

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

Royal Courts of Justice  
Strand, London, WC2A 2LL

Date: 9 February 2021

**Before :**

**HIS HONOUR JUDGE PLATTS**  
**(sitting as a Judge of the High Court)**

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**Between :**

**MRS AILEEN BRINT**  
**- and -**  
**BARKING, HAVERING AND REDBRIDGE**  
**UNIVERSITY HOSPITALS NHS TRUST**

**Claimant**

**Defendant**

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**Mr Conrad Hallin** (instructed by **Hodge, Jones and Allen**) for the **Claimant**  
**Miss Eloise Power** (instructed by **Hill Dickinson**) for the **Defendant**

Hearing dates: 9th to 20th November 2020  
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**Approved Judgment**

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....  
**HIS HONOUR JUDGE PLATTS**

*Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email and release to Bailii. The date for hand-down is deemed to be on 9th February 2020.*

### **His Honour Judge Platts:**

1. This claim arises from an extravasation injury following a CT scan with contrast carried out on the 29<sup>th</sup> December 2013 at the defendant's King George Hospital, which the claimant alleges has caused her significant disabling injury. Liability, causation and quantum are all in dispute. There is no issue that the claimant suffered an extravasation injury. However, there is considerable dispute as to events before, during and after the scan. On the eve of trial, the defendant notified the claimant that it intended to allege that she had been fundamentally dishonest in respect of the whole claim or at least a substantial part of it.
2. The evidence was heard remotely over video link over 10 days between 9<sup>th</sup> November and 20<sup>th</sup> November 2020 after which I received written closing submissions from both counsel. The delivery of this judgment has been delayed by an application made on the 7<sup>th</sup> January 2021 by the defendant to admit further evidence. I refused that application on the 20<sup>th</sup> January 2021. I give my reasons in an addendum at the end of this judgment.

### The claimant's case

3. At the time of the CT scan the claimant was 69 years old. On the 9<sup>th</sup> December 2013, she attended Dr Wickramaratne, a consultant rheumatologist, for routine blood tests and thyroid checks. Dr Wickramaratne noted a slight swelling on her neck and referred her for a full body CT scan. An appointment was made for the 29<sup>th</sup> December initially at the Queen's Hospital in Romford, but later changed to the King George Hospital. The radiographer who carried out the scan was Mrs Shell.
4. In her pleaded case, the claimant makes a number of allegations which I summarise as follows:
  - a) That the emergency department of the hospital was closed so that full support and resuscitation facilities were not available (this allegation was abandoned before trial);
  - b) That she was not warned of any material risk of a CT scan including the risk of extravasation injury;
  - c) That Mrs Shell injected a needle into her left thumb when the claimant had asked her not to do so;
  - d) That after the needle had been inserted into her left hand she complained of pain but Mrs Shell either failed to remove the needle or failed to ask her if she wanted it removed.
  - e) That Mrs Shell continued with the scan despite the claimant's continuing and repeated complaints of pain and ignored the claimant's requests that the scan be stopped and the cannula removed;
  - f) That she was not given appropriate care or treatment after the injury.
5. In the circumstances, the claimant's case is that the treatment was negligent and that to proceed with the scan without the claimant's consent amounted to an assault. She alleges that as a result she has developed Complex Regional Pain Syndrome, Post

Traumatic Stress Disorder and clinical depression causing her significant disability as a result of which she requires assistance with many aspects of daily living and single storey accommodation.

6. Much depends on whether or not I accept the claimant's evidence. The defendant accepts that if her account is accepted then liability will be established. However, it has attacked her reliability and credibility on almost every issue in the case. The claimant on the other hand argues that even if the defendant's evidence is preferred liability is established in any event.

#### The lay evidence

7. I have heard evidence from the claimant, her daughter Annemarie McGregor and her son Richard McGregor; the defendant has called evidence from Mrs Shell who carried out the scan, Mr Mahmoodi who says he was present, Mrs Wyness a healthcare assistant and Mr Salcedo, a charge nurse in the Accident and Emergency Department at the Hospital.
8. The claimant was an articulate lady who clearly still harbours considerable ill feeling against those who treated her on the 29<sup>th</sup> December 2013. Her evidence was clear and given calmly. She has been largely consistent in her account of what happened. She made immediate complaint, on the day of the incident, at the Accident and Emergency department to which she was taken, to a Mr Conteh at the radiology department before she left the hospital and later on that evening to her daughter. Further complaints were made in a letter of complaint to the trust on 11<sup>th</sup> January 2014, a further letter to Mr Cotter on 28<sup>th</sup> February 2014, and a further letter dated 10<sup>th</sup> March 2014. She has been largely consistent in her description of the development of her symptoms since.
9. However, for reasons which will become apparent throughout this judgment, I found her evidence on the whole to be unconvincing and unreliable. In short, her suggestion that she was fit, healthy and active before this incident is inconsistent with her extensive medical history and the fact that she had been in receipt of the highest rate of Disability Living Allowance (mobility component) since 1992; her evidence as to what happened at the hospital is in many respects at odds with the agreed expert evidence and in other respects is inherently improbable; and her description of the extent of her disability after the incident is brought into question not least by the evidence of the defendant's care expert. I will say more about these factors in the course of this judgment but my overall conclusion is that, despite her early complaints about what happened, I am unable to accept the claimant's account save to the extent that it is supported by other evidence which I do accept.
10. The claimant did not disclose that she was in receipt of Disability Living Allowance until she was seen by the defendant's care expert Mrs Savage. When she was asked about this she said that she had not thought that it was relevant to her case because it related to her longstanding back problem. Further, during her evidence, she suggested that she was not aware that her claim was for damages in excess of £1 million and that a large proportion of that related to claims for care and accommodation. However, she had signed her schedule of loss which particularised these claims with a statement of truth on the 7<sup>th</sup> May 2020. I find it improbable that she had signed the schedule without reading it, but if she did sign a statement of truth without reading the document to which it related, that says much about the general reliability of what she says.

11. Mrs Shell came across as a competent and caring radiographer. She is clearly upset and distressed by the allegations that the claimant has made against her. However, her evidence was not without its own difficulties. She has given a number of accounts of the incident for different purposes: a record made at the time of the scan; a statement for the internal investigation at the hospital; a statement in answer to a complaint made by the claimant to her professional body; and two statements for the purpose of these proceedings the last being a supplemental witness statement dated the 21<sup>st</sup> October 2020 containing important detail of the incident which she had never given before. The computer print-out of her note of the procedure and the evidence of her submission to her professional body were only produced during the course of the trial.
12. Mr Mahmoodi was the radiographer who assisted Mrs Shell. I am satisfied that he was present during the relevant scan. I reject entirely the claimant's firmly held recollection that the assisting radiologist was a white male called Nathan. The defendant's rota sheets confirm that Mr Mahmoodi was on duty (and that no-one called Nathan was) and it is wholly implausible that he would have given the evidence he did if he was not there. My impression of his evidence was that he was doing his best to assist the court but was relying heavily on his normal practice rather than his actual recollection. However, he did prepare a statement for the hospital's internal investigation on the 31<sup>st</sup> December 2013, only 2 days after the incident, in which he set out his recollection at that time. The fact that the claimant continues to insist that Mr Mahmoodi was not present is an example of the general unreliability of her recollection and evidence.
13. Mrs Wyness dealt with the claimant after the extravasation injury had occurred. In my judgment she was an impressive and compelling witness. She came across as a caring and dedicated nursing assistant and I have no hesitation in preferring her evidence to that of the claimant on the issue of how the claimant was cared for after the extravasation had occurred. The compelling nature of her evidence is another reason I find the claimant's recollection of those events to be unreliable.
14. Mr Salcedo had dealings with the claimant in the A&E department after the event. His evidence was compelling and supported by the contemporaneous medical records. Again, I have no hesitation in preferring his evidence to that of the claimant where they are in dispute.
15. Miss McGregor gave evidence as to the complaint made by her mother to her the evening after the incident occurred and to the effect of the incident on her mother. The fact that the claimant complained and the content of it was not challenged. However, I find that Miss McGregor tended to overstate the effects of the incident on her mother – for example her description that her mother's arm was swollen to three to four times its normal size on the evening of the incident is, in my judgment, not consistent with the photographs taken on the evening or other evidence as to the effects of the injury. Perhaps understandably, she has as, the defendant has put it, to a large extent "been drawn into her mother's world".
16. Mr McGregor was a convincing witness but, I find, his recollection is mistaken. His evidence goes to the timing of his mother's telephone call to him after the scan. His timing is inconsistent with the hospital notes and the evidence of Mr Salcedo. Mr Salcedo gave entirely convincing evidence which supported the times set out in the hospital records in particular that he gave analgesia to the claimant at 12.35 in

accordance with the prescription chart. This, again, is contrary to the claimant's evidence.

The Claimant's condition before the 29<sup>th</sup> December 2013.

17. The evidence as to the claimant's pre-scan condition is of relevance to two of the issues in the case: a) the extent to which the claimant is a reliable witness and b) the extent to which her current disability is caused by the scan as opposed to other, pre-existing issues.
18. To say that the claimant has had a significant medical history before this incident is an understatement. Her medical records extend to 12 lever arch files. She has complained of physical symptoms in many areas of her body over the years, some of which have been diagnosed with an organic cause yet many others not. The expert psychiatrists note in their joint statement that "she has experienced numerous physical symptoms in most body systems over many years and has been a regular attender at private and NHS clinics". When asked to give a summary of those entries in the claimant's medical history that indicate a presentation with physical symptoms which have not been fully explained they stated: "a comprehensive response to this question would be extremely lengthy".
19. In the light of the claimant's assertion that she was "fit healthy and active" before this procedure, a good deal of time in evidence was spent in going through her medical history. I do not propose to rehearse all of that in this judgment but will focus on her condition, as revealed by the medical records, in the three years before this incident. By way of background, however, I note that she underwent a spinal fusion for significant back pain in 1989 (the claimant accepted in evidence that the continuing back symptoms have been the basis for the claim for Disability Living Allowance); that she has been diagnosed as suffering from Raynaud's syndrome since 1994; and that she had auto-immune disorders including Sjogren's syndrome and suspected lupus; she has had a thyroidectomy and has been diagnosed as suffering from Hashimoto's disease, and she suffered with osteoarthritis (although in cross-examination she denied that she had ever been diagnosed with arthritis).
20. On 13<sup>th</sup> December 2010 she underwent a nerve root block injection using CT scan localisation at the Royal National Orthopaedic Hospital (RNOH). She had been complaining of significant low back pain before then. As will be seen, she complained about how that procedure was performed and has complained of significant symptoms following it. On 16<sup>th</sup> June 2011 she was seen by Dr Lucas, a consultant psychologist at the RNOH who recorded a complaint of pain throughout her lumbar spine, left leg and buttock with a subjective pain disability index of 70%. The claimant has significant concerns about her consultation with Dr Lucas suggesting that he acted like an opposing barrister towards her. However, there was no real issue taken with the nature of her complaints as recorded by him at the time. In particular, he records that the claimant had concerns about what happened during the procedure and her "significant anger" that she did not give informed consent, that she pleaded with the medical team to stop the injection felt ignored, that she was not supported or given advice, that she was left alone, and was offered no help (I shall come to the relevance of this later).

21. Due to the complaint of ongoing neuropathic pain the claimant was assessed by MRI scan but no cause for her continuing symptoms was identified. However, her complaints persisted:
- a) Following an appointment on the on the 30<sup>th</sup> November 2011 Dr Davies, a consultant rheumatologist, considered that her Sjogren's syndrome was in remission but that her Raynaud's syndrome "*remains problematic and will not probably improve*".
  - b) On 25<sup>th</sup> June 2012 she was seen at the RNOH by Dr Berman who wrote:  

“Although she has a history of low back pain, most of her current symptoms that are giving her most bother are the result of an L4 root block carried out at this hospital and she still has on-going bowel and bladder problems associated with this and really quite extensive weakness in the left lower limb.”
  - c) On 8<sup>th</sup> August 2012 an annual review of her connective tissue disease by Dr Wickramaratne recorded that her main complaint then was "*fatigue and tiredness*".
  - d) On the 12<sup>th</sup> September 2012 she was seen in the orthopaedic department with pain in her left shoulder following a fall in July 2012.
  - e) On the 9<sup>th</sup> October 2012 she was assessed by Dr Lingwood, consultant psychiatrist at the RNOH who wrote:  

“Mrs Brint presents with anger and significant upset following a traumatic nerve root block at this hospital in December 2010. The sense of humiliation she felt at the time of the procedure came across strongly during our appointment, as well as the injustice she feels has occurred since then...”

“reports severe ‘shooting, cramping, tiring and exhausting’ pain in her left lumbar and sacral region radiating around and down the front of her left leg. In addition, she describes the development of GI problems and urinary incontinence, insomnia and fatigue since the procedure.”

She adds “.. before the procedure she had back pain symptoms and occasional cramp in her foot but these were relatively mild compared to what she now experiences”.
  - f) On the 5<sup>th</sup> November 2012 she was seen in the Department of Pain at St Bartholomew's Hospital. The record reads:

“she has a longstanding history of low back pain which refers into her left leg in a radicular distribution.” Following the procedure at the RNOH “she subsequently had problems controlling her bowel and bladder functions as well as weakness of her left leg”. It is noted that “She currently takes Co-codamol up to 4 tablets a day and she very occasionally takes a short release morphine for the exacerbation of her pain”.

A referral was made for physiotherapy to her left shoulder and back.

- g) On the 21<sup>st</sup> November 2012 the claimant was put on the waiting list for a pain management programme having been assessed by a consultant in rehabilitation medicine. It is not clear from that letter what pain the claimant’s complaints were at that point.
- h) In January 2013 she was seen by Dr Wickramaratne who wrote:

“She had multiple complaints including polyarthralgia, fatigue, dry gritty eyes and generalised body itching. She also describes episodes of frontal headaches...”
- i) In February 2013 she was referred to a physiotherapist for treatment to her left shoulder and “*back pain and leg weakness*”.
- j) On the 3<sup>rd</sup> May 2013 she was diagnosed with “*Severe arthritis left DIP joint index finger... She tells me that her symptoms have now worsened and she would like to consider surgical treatment namely DIP joint fusion.*”
- k) On the 6<sup>th</sup> June 2013 she was seen in the department of Rheumatology at the King George hospital. The record reads “*this lady’s Raynaud’s have been bad and even as the weather has got warmer she has been struggling with it ...*” There is reference to continuing problems with her eyes and that she takes analgesics “*particularly if her lower back flares up*”.
- l) There is a letter dated 8<sup>th</sup> October 2013 which suggests that a video urodynamic assessment showed “*no obvious bladder dysfunction ....but there is a significant prolapse*”

22. It appears that around November 2013 the consequences of the nerve root injection in December 2010, including her abdominal pain, weakness in her leg and her psychological state, became more of a concern to her. On the 7<sup>th</sup> November 2013 (although she did not recall this when giving evidence) there is a record that she had consulted the psychiatric department of the RNOH requesting an appointment. On the 10<sup>th</sup> November she wrote a long letter to her MP voicing her grievance about what had happened in 2010 and her treatment thereafter. The letter concludes with the words “*I don’t feel I can cope any longer physically or emotionally*”. In mid-November 2013 the claimant telephoned a specialist nurse in bowel management who had treated her the

year before. The record notes: “*she is generally not coping and feels very “low”. She is experiencing left sided abdominal pain, most of the time.*” On the 19<sup>th</sup> November 2013 she was referred for a private opinion “*for further investigations as to the cause of her worsening abdominal pains...*”. On the 3<sup>rd</sup> of December 2013 the claimant attended the trauma clinic at Queen’s hospital complaining of her knee giving way and “*long term problems with cauda equina syndrome*”. An MRI scan was advised. Finally, on the 9<sup>th</sup> December 2013 she saw Dr Wickramaratne with neck pain and query a lump in her neck and cystocele with possible prolapse. It was this consultation that led to the referral for a CT scan.

23. I have gone through these records in some detail because, in my judgment, they show that the claimant was complaining of significant and disabling physical and psychological symptoms in the period before this CT scan. She had convinced herself that she had cauda equina syndrome (not confirmed by any investigation and, indeed, Dr Wilson agreed that it is unlikely that that she did suffer from cauda equina syndrome) and was suffering from back pain, abdominal pain, fatigue and low mood. That is to be contrasted with her assertion in evidence that she was “fit healthy and active”.
24. On any objective view she clearly was not fit and healthy. However, in so far as she considered herself to be “active” I am satisfied that, within the limitations of her various problems she was relatively active. I accept her evidence that she took part in yoga and swimming: these activities are not inconsistent with (and on occasions are recommended for) people with disability. There is reference to her doing these activities in her records. I accept that she walked as and when she could and that she tried to live as full a life as her problems would allow. Her evidence on these matters was credible and supported by her daughter who said of her that she “does a brilliant job in facing adversity” without wanting to place too much of a burden on her children. That evidence was given with conviction and had the ring of truth. Having seen and heard the claimant (albeit over video link) I accept that she considered herself to be active and, indeed that she was, in so far her symptoms would allow her to be.
25. Her description of herself as “fit” and “healthy” has to be considered in that context. To an extent I accept that in her own mind she did consider herself to be relatively fit and healthy given that she did maintain a level of activity. However, objectively she clearly was not fit and healthy and the fact that she sought to present herself as such is in my judgment misleading and is one of the reasons I find her evidence to be generally unreliable and inaccurate.
26. There is considerable dispute about what happened both before during and after the scan. It is convenient to deal with each phase separately.

#### Before the scan and the issue of consent

27. The agreed evidence of the expert radiologists Dr Wilson and Dr Hussain is that, although the risk of extravasation injury is small, a patient should be warned of the risk of this complication.
28. The claimant maintains that she was never warned of any risks associated with a CT scan let alone the risk of extravasation injury. She also says that she was never informed that a power pump would be used to administer the injection of the contrast. She says that she had to ask Mrs Shell if there were any side effects and was told there were



none. Although this does not form part of her pleaded case, her evidence was that if she had been warned of the risk of extravasation injury she would not have consented to the scan going ahead.

29. During cross-examination Mrs Shell said that it was not her practice to inform a patient about the risk of extravasation because the risk was so small. In this sense, her practice appears to be contrary to what the experts considered to be necessary. However, the defendant's case is that the advice as to the risk of extravasation was given by Mr Mahmoodi. His evidence in chief was that it was his usual practice to give the warning. In cross examination he said that he was certain he did give the warning.
30. The claimant argues that the effect of the defendant's pleaded case is that there is an admission that no warning was given. The specific allegation of failure to warn of the risk of extravasation injury is pleaded at paragraph 22(b) of the Particulars of Claim. The pleaded defence to this allegation, at paragraph 52(b), of the Defence is:

“It is denied that there was a failure to take reasonable care to ensure that the Claimant was aware of the risk of extravasation injury. The radiography staff did not have the clinical skills, experience, qualification or knowledge of the Claimant's medical history in order to counsel her as to clinical risks and diagnostic benefits to her of a full body CT scan with contrast. It would have been inappropriate for them to do so:

It is denied that there was a specific duty on the radiography staff to warn of the risk of significant injury following extravasation of contrast media...”

31. At paragraph 11 of the Defence it is pleaded that:

“It is admitted that the risks and benefits of a full body CT scan with contrast were not discussed with the Claimant by Ms Shell or Mr Mahmoodi.”

32. The defendant submits that when these paragraphs are read together, the admission at paragraph 11 clearly relates to the clinical risks and diagnostic benefits of a full body CT scan (i.e. the information which would be provided by a doctor rather than a radiographer). However, this does not answer the point. Paragraph 52(b)(i) denies the existence of the duty to give the warning but does not deny the failure to give the warning.
33. However, I am not persuaded that this important issue should be resolved on a pleading point. There has been no application by the claimant for judgment on the admission pursuant to CPR 14; there has been no Pt 18 request to clarify the extent of the denial (if the claimant thought it ambiguous); and, in any event, I consider that the first sentence of paragraph 52(b) is a sufficiently broad denial of the allegation to permit the defendant to raise it as an issue at trial. In any event, and most importantly, I have heard all the relevant evidence on the issue, the claimant has not been taken by surprise by the evidence, and I consider that I should make my finding of fact based on that evidence.

34. Having taken all these factors into account, I find on the balance of probabilities that Mr Mahmoodi did warn the claimant of the risk of extravasation before the procedure was carried out. Although his recollection is probably significantly influenced by his usual practice there is no reason for me to conclude that he did not follow his usual practice on this occasion. During cross-examination he was certain that he had warned the claimant of the risk. It is of note that in his statement on the 31<sup>st</sup> December 2013 he wrote “after explaining the procedure any allergies and contra-indications were asked for and a more detailed explanation was given for the same”. This note written only 2 days after the procedure confirms that there was some significant discussion between him and the claimant in accordance with his usual practice. The claimant accepted that she had been alone with Mrs Shell’s assistant (whom she remembers as “Nathan”) and speaking to him for a few minutes before the scan started. Further, she made no complaint of the lack of warning of the risk of what had in fact occurred in her lengthy letter of complaint written on the 14<sup>th</sup> January 2014.
35. I therefore reject the claimant’s claim that she was not warned about the risk of extravasation injury. In so far as paragraph 22(b) of the Particulars of Claim alleges a failure to warn of any other risks, this has not been the focus of the claimant’s case at trial. However, taking into account the expert evidence as to what warning should be given and the evidence in particular of Mr Mahmoodi, I am satisfied on the balance of probability that the defendant did ensure that the claimant was aware of all material risks involved in the treatment in so far as it was under a duty to do so.
36. However, if I am wrong about that, I am nonetheless satisfied that if she had been warned she would have agreed to go ahead with the scan in any event. The risk of extravasation injury is low and the risk of serious complications from an extravasation injury are exceptionally low. The purpose of the scan was to investigate a possible cancer. I reject as highly unlikely the claimant’s assertion that she was not aware of the reason for the scan. She had been referred because of a suspicious lump in her neck and it is improbable that, even if she was not initially aware of its potential significance, she had not asked about it and been told. In her letter of complaint dated the 11<sup>th</sup> January 2014 she stated that she wanted the scan to be repeated as soon as possible – even after she had suffered an extravasation injury - “in view of the advised possible diagnoses”. On the 20<sup>th</sup> January 2014 her GP recorded that she had been told that she was a “high risk of cancer”. Further, Dr Wilson said that in his (significant) professional experience he had never had a patient decline a CT scan with contrast due to the risk of extravasation. Whilst I do not rely heavily on the claimant’s pleaded case, it is of note that at paragraph 24 of the Particulars of Claim the claimant does not allege that she would have declined the scan if she had been warned of the risk of extravasation.
37. There is an issue between the parties as to whether the claimant is entitled to succeed even if (as I have found) she would have agreed to have the scan after having been warned of the risk of extravasation. In view of my findings I do not need to resolve that difficult issue of law. There are strong arguments on both sides which I do not rehearse in this judgment. However, since it has been an issue in the case I will briefly set out my conclusion.
38. The claimant’s argument is based upon the decision of the majority of the House of Lords in *Chester v Afshar* [2005] 1 AC 134. Reliance is placed on the speech of Lord Hope at paragraph 87:

“To leave the patient who would find the decision difficult without a remedy, as the normal approach to causation would indicate, would render the duty useless in the cases where it may be needed most. This would discriminate against those who cannot honestly say that they would have declined the operation once and for all if they had been warned. I would find that result unacceptable. The function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content. It will have lost its ability to protect the patient and thus to fulfil the only purpose which brought it into existence. On policy grounds therefore I would hold that the test of causation is satisfied in this case. The injury was intimately involved with the duty to warn. The duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent. So I would hold that it can be regarded as having been caused, in the legal sense, by the breach of that duty.”

39. The defendant relies on more recent decisions of the Court of Appeal, in particular *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356, where Simon LJ said at paragraph 28:

“The crucial finding in *Chester v. Afshar* was that, if warned of the risk, the claimant would have deferred the operation. In contrast, in the present case, it was not the appellant’s case that she would not have had the operation, or would have deferred it or have gone to another surgeon”

40. In *Correia*, there is no evidence as to what the claimant would have done had she had the warning she ought to have had. However, I consider Simon LJ’s observation that the finding in *Chester* that the claimant would have decided to defer the operation was “crucial” is important. The present case is not a case, as Lord Hope put it, where “the patient would find the decision difficult”. Nor is it a case where she would have deferred the operation. I am confident that she would have agreed to proceed with the scan. I would therefore have concluded, had I had to decide it, that the present case can be distinguished on its facts from *Chester* and that the normal principles of causation should apply. I am fortified in this conclusion by the approach of the learned editors of Clerk & Lindell on Torts 23<sup>rd</sup> edition at paragraph 2-15. Had resolution of this issue been necessary for the determination of the case I would have expanded on my reasoning and addressed more closely the arguments of counsel for both sides. However, given my findings of fact it is not necessary for me to do so.

#### The scan

41. There is a stark divergence of evidence about what happened during the scan. The claimant’s account is that once she was correctly positioned in the scanning room Mrs Shell made a number of failed attempts to insert a cannula into the left elbow region. The claimant has been inconsistent as to how many attempts were made: her pleaded case is that there were “several”; her letter of complaint dated 11<sup>th</sup> January 2014

mentions only one; her letter of complaint dated the 10<sup>th</sup> February 2014 specifically says that there were two; her evidence at trial was that there were three, although maybe two attempts were into the same vein. She has always suggested that these attempts left her elbow area painful, bruised and bleeding. She insisted that no tourniquet was ever used.

42. The claimant's evidence is that after the failed attempt at the elbow, Mrs Shell then left the scanning room and, on her return she, the claimant, was sitting up and offered her right arm for the cannulation saying "at least I have two arms". She says that she specifically asked Mrs Shell not to put any needles in her hands due to her pre-existing condition of Raynaud's syndrome. Notwithstanding that, Mrs Shell ignored her and, without warning, began to insert the cannula needle into the base of her left thumb/end of her wrist on the back side of her hand. The claimant again asked her not to put any needles near her hands but this was again ignored. As the needle was inserted, the claimant says she felt a shooting pain up her arm like an electric shock causing her to call out in pain. This was also ignored by Mrs Shell who then, again without warning, started the scan. After the scan and pump started she alleges she called out at least five times asking for the scan to be stopped as she felt pain rapidly increasing and she felt her thumb, fingers and forearm swelling "as if they were going to explode". Mrs Shell responded by saying "not much longer" and "do not move". The claimant alleges that the scan lasted 31 minutes. She asked for the pump to be stopped and the cannula removed but her requests were ignored. When the scan was complete she says that her arm and hand had enormous swelling, were black and blue and her hand was in a fixed claw position.
43. A medical record made after she was taken to the A&E department by Mr Salcedo and timed at 2.00 p.m. records that the claimant then said that she had told the radiologists not to insert the cannula into her hands because of Raynaud's disease but that she was ignored. Before she left hospital, the claimant made a complaint which was recorded by Mr Conteh. Her complaint was broadly consistent with her current description of the incident although less detailed. Her belief at the time was "that the needle had not been correctly placed".
44. The claimant spoke to her daughter in America via Skype later that evening after she had returned home – about 10 to 12 hours after the procedure. The claimant's complaints were again broadly consistent with although less detailed than her current evidence. She then wrote two letters of complaint to the defendant hospital dated the 11<sup>th</sup> January 2014 and 10<sup>th</sup> February 2014. These letters, again, were broadly consistent with her evidence at trial. The timing and consistency of these complaints is relied on by her as supporting the veracity and accuracy of her account.
45. I have already commented that Mrs Shell's evidence is not without its difficulties given the way it has developed.
46. Her evidence in her witness statement (her evidence in chief) was that the claimant was assisted into the scanning room in wheelchair. This is disputed by the claimant but Mrs Shell was sure and I have no reason to doubt her evidence on this. She accepted that the claimant was anxious. She said that she explained the process of the scan and that she would have to place a needle in the vein. She recalls that the first attempt at cannulation in the elbow area failed because the vein collapsed. She said that the base of the wrist was used for the second cannulation as it appeared to have a more stable vein. She

describes that a tourniquet was applied to the left wrist (in cross examination she said, "I have never not used a tourniquet") and the area was cleaned with an antiseptic wipe. She told the claimant that there would be a scratch as she inserted the needle. She inserted the needle and then went to insert the cannula. It was at that point that the claimant became hostile saying something like "I have two arms you know". At this time, she says, the cannula was not connected to the pump. She said that the claimant did not request that the cannula be removed or re-sited.

47. She said that she asked the claimant to keep still and the scan started. She warned the claimant that it might sting a bit due to the contrast. Mr Mahmoodi remained with the claimant for 30 seconds to ensure there was no problem with cannulation of the contrast. The scan then proceeded. Towards the end she saw that the claimant flex her wrist which is when the extravasation occurred. She said that after the scan the claimant's hand was swollen and that Mrs Wyness attended to assist in preparing a warm compress. She said that following the scan the claimant was hostile and rude.
48. In her supplemental witness statement, she provided additional details. She says that the claimant became verbally hostile after the successful second cannulation "when she sat bolt upright and said something along the lines of "I have two arms you know"" (this detail had already been mentioned in the short statement she had prepared for an internal investigation in January 2014.) However, she added, for the first time, that after this had happened she asked the claimant if she wanted to proceed and she said something like "I am here now, we might as well". She also added that it was normal practice to ask if there is any pain when flushing saline through the cannula. There is no reason for her to have departed from that practice on this occasion.
49. Mrs Shell's earlier descriptions were less detailed. On the day of the incident she recorded the scan on the scanning equipment in the following terms:

"patient was extremely difficult. Moved during scan causing 20ml of contrast to extravasate into wrist, warm compress applied where patient insisted that this would not help. Accused staff of being unable to do their job properly and said that I did not inform her regarding cannula (untrue), Patient then demanded painkillers and a doctor. Escorted to A&E where she continued to be difficult. LS"
50. A short time later she made a short statement for the hospital's internal investigation. (Although undated, I find that this was probably written in January 2014 as the defendant's response to the claimant's letter of complaint, dated 28<sup>th</sup> January 2014, refers to statements having been taken). In that statement she says that the claimant was "very anxious"; she describes the failure of the first attempt at cannulation and in relation to the second she says she warned the that there might be a sharp scratch. She applied a tourniquet and then:

"I advanced the cannula when the patient sat bolt upright and became hostile and shouted at me "I have two arms, you know!". The second attempt was successful and I asked the patient to keep still as the vein was delicate. The patient became even more agitated and we proceeded to scan her. The flowrate on the injector was lowered to 1.8mls/s to account for the small vein.

As the injection started, I warned the patient that it may sting as it goes in. The pressure was extremely low of the injector. The patient tensed up on the scanner and flexed her wrist (where the cannula was cited) causing an extravasation of approximately 20mls of contrast.

“Warm compress was applied to the patient’s wrist where she continued to be hostile and was rude to other staff members.”

51. Her response to the complaint made by the claimant to the Health and Care Professions Council dated 2<sup>nd</sup> March 2015 was disclosed during the trial after it was suggested by Mrs Shell during cross examination that she had previously said in this statement that she had asked the claimant if she wanted to proceed and that the claimant had replied “I might as well now I’m here”. It is clear she did not make that allegation in this statement. However, in her other responses are broadly consistent with her evidence at trial.
52. During cross examination these earlier descriptions of the incident were put to her. She accepted for the first time in her evidence that the claimant had mentioned her Raynaud’s condition after the first cannulation had failed (although in her reply to the HCPC she had said that the claimant mentioned this after the second cannulation had been successful). She said that Raynaud’s is not a contraindication for cannulation but that in any event the injection was not to the hand but, rather, was to the anatomical snuffbox which she demonstrated in evidence. She agreed that the insertion of cannula can cause pain. She said that before the dye was inserted a saline solution was flushed through. She accepted that if a patient complains of pain at that stage then the needle can be removed. She said that the claimant commented “I have two arms you know” after the arm had been successfully cannulated but before the cannula had been secured. She said that after that she asked the claimant to lie down and stay still. She said that she was supporting the cannula while the claimant lay back down. She confirmed that she asked the claimant about her comfort level and if she wanted to proceed. The claimant agreed. She said that if the claimant had told her that she had a pain shooting up the arm it would have meant a nerve had been hit and she would have removed the cannula immediately. She described the claimant as being quite abrupt and rude, questioning her and Mr Mahmoodi’s professionalism.
53. I have to decide which of these conflicting accounts is more likely to be correct. I take into account the relative consistency of the claimant’s account and the way in which Mrs Shell’s evidence has developed during the course of the litigation. However, my firm conclusion is that, where there is a difference, I prefer Mrs Shell’s account to that of the claimant. This is for a number of reasons:
  - a) There are aspects of the agreed expert evidence which do not lie easily with the claimant’s account:
    - i) The radiologists agree that it would be either very difficult (Dr Wilson) or impossible (Dr Hussein) to attempt to perform a venepuncture without a tourniquet. Mrs Shell is adamant that she

did use one. I reject the claimant's evidence that there was no tourniquet used.

- ii) The scan resulted in good images being obtained. The radiologists agree that this suggests strongly that the claimant remained still during the scanning.
  - iii) The experts also agree that whenever the vocal cords, oropharynx, and diaphragm were visible during the scan there was no movement to indicate vocalisation, agitation or movement. These factors are more likely to be consistent with the claimant co-operating with the procedure at that stage rather than her being in severe pain, shouting out at least five times and requesting that the procedure stop.
  - iv) The experts agree that the extravasation probably occurred towards the end of the scan and probably consisted of only 20 ml of contrast. This is contrary to the claimant's belief that the needle was wrongly positioned at the outset and inconsistent with her evidence that the swelling started when the contrast began to be pumped into her vein. It also suggests that any pain due to the extravasation itself probably only occurred towards the end of the procedure and not before.
  - v) The plastic surgeons agree that extravasation is unlikely to have caused the hand to become black and blue or in a fixed claw position while in the scanning room or that her skin split as a result of the swelling as the claimant alleges.
- b) In my judgment it is highly unlikely that the claimant was unaware that there was going to be an injection at the base of her thumb as she alleges. In order to carry out the procedure I accept that Mrs Shell would have wiped the area with an anti-septic and applied a tourniquet before inserting the needle. These actions alone would have indicated to the claimant that that area was going to be injected.
  - c) The claimant's account is of a total and alarming disregard for the comfort and well-being of the patient. Having seen and heard her give evidence I find it highly unlikely that Mrs Shell would have acted in such a way.
  - d) In all material respects Mrs Shell's evidence is supported by the evidence of Mr Mahmoodi. I reject entirely any suggestion that he has adjusted his evidence in order to support Mrs Shell or the defendant. The claimant's evidence that he was not there is just not credible.
  - e) For reasons given elsewhere in this judgment I find the claimant generally to be an unreliable witness on several other issues in any event. That impression is reinforced by my concerns about her evidence as to what happened during this procedure (and afterwards – to which I will come).

- f) Whilst the way in which Mrs Shell's evidence has evolved is of concern, in general, it has the ring of truth. Although she did not mention the claimant "sitting bolt upright" in her witness statement for trial it was not a recent fabrication. It had been mentioned by her in her first statement for the internal inquiry and is likely to be true. Similarly, although she did not mention that the claimant had mentioned her Raynaud's within the litigation until cross examination, she had mentioned it in 2015 in the response to the HCPC complaint. These are examples that although Mrs Shell may have given matters of detail late it does not necessarily mean that they are not to be accepted.
- g) In my judgment, her description of the claimant becoming "even more agitated" in her statement for the internal inquiry (which is relied on heavily on behalf of the claimant) has to be read in the context in which it was written. It was not a statement written for litigation purposes nor could it reasonably have been anticipated that it would be subject to close forensic analysis some seven years later. It was a short statement intending to describe the whole event. It was not intended to be used as the basis for litigation nor was it intended to be an accurate statement of the sequence of events. It was a general description of the claimant's demeanour during the scan. The reality is that the claimant was calm at the time that scan was performed as evidenced by the fact that good images were obtained. She became more agitated after the scan and I find that that is probably what Mrs Shell was referring to.

54. An interesting feature of the claimant's complaint is its similarity to her reaction to the nerve root block injection using CT scan localisation at the RNOH in December 2010. On the 10<sup>th</sup> November 2013 (only 7 weeks before this CT scan) she wrote a long letter to her MP voicing her grievance about what had happened in 2010 and her treatment thereafter. Her description bears marked similarities to what she says happened during this procedure. She wrote:

"The procedure could have been stopped as at the very onset of the procedure my left leg started twitching violently and I immediately cried out in severe pain fully expecting the needle to be withdrawn as it was clear that the needle had hit the nerve. It was like an electric shock from from (sic) my spine all the way down my left leg. Despite my distress and calling out several times and my leg twitching violently, there was clear visible (sic) and verbal warnings given to the radiologist, but she carried on regardless, pushing the needle in further despite all the evidence that the needle was directly in the nerve. I fully expected the needle to be withdrawn immediately and the procedure stopped .....I was totally ignored .... It felt like my leg was being pumped up and the muscles were tearing at the same time"... " The radiologist and 2 staff members, all unknown to me at the time as they did not speak to me before, during my ordeal or after, other than I vaguely (sic) heard in a mumbling voice what sounded like "you can go now" as the room fell silent. I could not move had no way of contacting



anyone for help and was left face down on a scanner bed not knowing if I would ever walk again.”

55. The similarity between what she alleges happened on the 29<sup>th</sup> December 2013 and her complaint made only 7 weeks earlier about what had happened in 2010 is striking: the description that she felt an immediate pain like an electric shock when the needle was inserted; the allegation that there were clear warnings to the radiologist to stop; the allegation that the pain got worse as the needle was inserted; the description that it felt like the limb was being pumped up; the allegation that her complaints were ignored; and the allegation that afterwards she was left alone without any help. These are all common complaints arising out of two separate incidents. In my judgment it is unlikely that the claimant would have suffered such similar experiences from two entirely independent injections. The fact that she felt driven to write to her MP in November 2013 about an incident nearly three years earlier clearly indicates that she was still dwelling on those events, and that they were still dominant in her mind when she underwent this scan.
56. In the circumstances, I cannot discount the possibility that she somehow in her own mind has conflated the two events. There is no doubt that the claimant was anxious before this procedure, that she was concerned about her Raynaud’s, that the scan did not go smoothly in that the first attempt at cannulation failed and the procedure resulted in an extravasation injury, that she was distressed and hostile afterwards, and that she was eager to complain. When she did make her complaints the incident of December 2010 (as she remembered it) was still very much on her mind. As will be seen when I deal with issues of causation, the claimant has a complicated psychological profile and a combination of all of these factors may well account for some of the detail which she has ascribed to this incident and which, for reasons I have given, I have rejected.
57. I therefore find on the balance of probabilities:
- a) Mr Mahmoodi was present as he says.
  - b) The claimant was assisted into the scanning room in a wheelchair as described by Mrs Shell.
  - c) There was one failed attempt at cannulation (in the left elbow). I reject the claimant’s evidence that there were three attempts. Mrs Shell said, and I accept, that it would be unusual to have three attempts at cannulation.
  - d) I accept that Mrs Shell used a tourniquet for venepuncture and cannulation. Her evidence is supported by the expert evidence. I reject the claimant’s evidence that a tourniquet was not used.
  - e) I accept that after the failed attempt at cannulation in the left elbow the claimant informed Mrs Shell that she had Raynaud’s syndrome. I do not accept the claimant’s evidence that she expressly told Mrs Shell not to inject her hand or wrist. I accept Mrs Shell’s evidence that she did not believe that Raynaud’s was a contra-indication to continuing and that, in any event, the injection was away from any site that would be affected by Raynaud’s. In so far as Mrs Shell had suggested in her statement to

the HCPC that she was told of Raynaud's after the second cannulation, I find that she was probably mistaken about that. I accept her evidence as given at trial.

- f) I am satisfied that Mrs Shell put the needle in the area of the left "anatomical snuffbox". It is highly unlikely that this was done without the claimant's knowledge and consent. I am satisfied that Mrs Shell probably wiped the area with antiseptic before inserting the needle which would certainly have put the claimant on notice that she was going to inject that part of her wrist. As I have said, I find that a tourniquet was applied. I reject the claimant's suggestion that she either failed to give or withdrew her consent to the injection.
- g) I reject the claimant's evidence that she felt an immediate pain like an electric shock when the needle was inserted. In my judgment that is unlikely. It is not a common occurrence. If it had occurred the reaction would have been extreme and I am satisfied that both Mrs Shell and Mr Mahmoodi would undoubtedly have been aware of it and would have remembered it. The allegation is so similar to that made about the 2010 procedure that it is improbable that both are correct. The claimant accepted that she did not withdraw her arm upon insertion of the needle as she is likely to have done had she felt such pain. I therefore reject the suggestion that a nerve was touched when the needle was inserted. I find it more probable that this allegation of the claimant has its roots in her recollection of her experience at RNOH in 2010.
- h) After inserting the needle, Mrs Shell inserted the cannula. A blue paediatric cannula was used.
- i) I accept that the claimant probably did feel some discomfort and that she reacted by sitting bolt upright and saying words to the effect of: "*I have two arms you know*". I am satisfied on the balance of probabilities that this occurred after the cannula was inserted – but before the cannula was secured. I find that this reaction was probably due to her general anxiety, a response to a combination of there having been a failed attempt at cannulation in the elbow, the concerns she had already expressed about her Raynaud's syndrome and the discomfort she then felt. I find that this was the only time the claimant made reference to the fact that the cannulation could have been in her right arm. It was made as a comment not a request and was made after the cannula had been sited (but not secured) in the left arm.
- j) In my judgment this did not amount to or even approach the withdrawing of consent. She was calmed and re-assured by Mrs Shell.
- k) I find that Mrs Shell's first response was to ensure that the cannula was secured. She asked the claimant to keep still and lie down. When the claimant lay down, Mrs Shell asked her whether there was any pain, what the problem was and whether she wanted to carry on and the claimant replied to the effect of "*I might as well as I'm here*". I reject the claimant's evidence that she asked for the scan to be stopped. I am

satisfied that by her actions and words the claimant indicated that she was content to proceed.

- l) I am satisfied that the claimant wanted the scan completed. There was a suspicion of a potentially cancerous lesion in her neck and she was concerned to have it investigated.
- m) I find that Mrs Shell then flushed saline through the cannula to check that it was properly sited. The claimant did not complain of any pain and indicated that she wanted to carry on with the scan (as confirmed both by Mr Mahmoodi and by Mrs Shell).
- n) Mrs Shell started the pump and proceeded to the scan. Before the scan started Mr Mahmoodi stayed with the claimant for about 30 seconds to ensure that everything was in order. It was. The claimant was not in pain and was not in a state of agitation when the pump and scan began. As confirmed by the expert evidence, the Claimant lay still for the majority of the scan and did not call out.
- o) Towards the end of the scan the claimant flexed her wrist. It was probably as a result of that that a quantity (probably under 20 ml) of contrast extravasated.
- p) In so far as Mrs Shell has spoken of the agitation and hostility of the claimant in her various accounts, I am entirely satisfied that any such agitation and hostility before the scan was not such as to indicate that the claimant did not want the scan to proceed but was consistent with the claimant's anxiety and concerns generally. Further, any agitation and hostility after the scan had been completed was as a result of her realisation that she had suffered an injury to the left arm as a result of it.

58. Dr Wilson and Dr Hussein agreed that if there was no evidence of severe pain or distress and if performing the scan was in the best interests of the patient to continue with it would not have been outside the range of reasonable radiological management. Dr Wilson accepted during evidence that there are strong clinical reasons to continue with a scan in particular when a patient is being investigated for a potentially serious condition such as a cancerous lesion. He accepted that if a patient complains of pain or discomfort it was a matter of clinical judgment, taking all things into account, whether or not to continue. In the circumstances I am far from persuaded that Mrs Shell departed from a standard of care to be expected of a reasonably competent radiographer when dealing with the difficulties which arose from the claimant's presentation.

59. For the above reasons, and on the facts as I have found, the claimant has not persuaded me that there has been any breach of duty on the part of the defendant when performing the scan.

#### Aftercare

60. The pleaded allegations are that the claimant was left alone in a dark cold room for a significant period without any appropriate care or treatment, that hot water was poured

onto her swollen arm and that her arm was not elevated or she was not provided with a cold compress. These allegations were significantly elaborated on in her evidence.

61. I do not intend to rehearse the totality of her evidence. However, she made serious allegations about the way both Mrs Shell and Mrs Wyness treated her after the event. She suggested that when Mrs Shell realised what had happened she was “in a panic”, grabbed the cannula with all the connections threw them to the floor. She reached across the bed grabbing her “slumped” left arm so hard that she “simply broke down crying loudly due to the severe pain”. She says that her arm was wrenched above her. She was pushed from the bed so that she fell into the wheelchair hurting her spine. She said that Mrs Shell then tied the blanket around her neck so that she felt unable to breathe. She alleges that Mrs Wyness poured a jug of hot water over her left arm. She says she repeatedly asked to see a doctor but was refused.
62. She then claims that she was taken to an unstaffed area and left in total darkness, alone, freezing cold, in total isolation and in severe pain for several hours. During cross examination she said she had problems breathing and she felt that she might never see her family again. She alleges that either Mrs Wyness or Mrs Shell “crept in silently” and pushed her further out of sight into a passageway to the toilets. “I can only assume that this was to ensure that I was not seen or found”.
63. She then describes how she was then taken to the nurse’s station at, she thinks, at about 2.00 pm. She had to wait about another hour before she was given pain killers. She made a phone call to her son at about 14.30 and finally saw a doctor at 16.30. She describes her arm at that stage as “still hanging by my side, enormous in size, black and blue in colour with clearly no circulation or sensation in the hand and the fingers were clenched”.
64. I reject her evidence on this issue. There are a number of reasons for doing so:
  - a) I am satisfied that her account of the passage of time (which she insisted was accurate during her evidence) is wholly wrong. The defendant’s witnesses’ recollection about the timing is supported by the medical records. The scan records show that the scan was completed by 11.52. The A&E department records show that she was registered there at 12.15 and triaged at 12.29. The drug chart shows that analgesia was prescribed at 12.35. The clinical notes record that she was reviewed at 12.40 when there is reference to her making her telephone call to her son. The note includes “patient not happy -states offered no analgesia and left waiting for 1 ½ hours... after CT scan...” I note that even at that early stage she seems to have held an entirely unrealistic view of what had in fact occurred. She was then reviewed at 13.20, saw Mr Salcedo at 14.00 and then a doctor Dr Rashid whose note is untimed. The suggestion that all these records have inaccurate timings is nothing more than fanciful. I reject entirely that suggestion that she was left alone, in the dark, untreated and uncared for, for hours after the scan.
  - b) As she left the hospital she made a complaint that was recorded on an incident report completed by a Mr Conteh. In so far as this report relates to events after the scan it reads:

“the patient was put in a wheelchair and brought out to the nurse’s station for the arm to be looked at. An attempt was made by the radiology support worker to treat the swelling with “hot water” before being taken to A&E. The patient requested to see a doctor at which point she was wheeled over to A&E for further help. In A&E at KGH, left hand was placed in an ice pack, anti-inflammatory drug and painkiller (co-codamol) were used for treatment. Left hand placed in a sling and patient was told to go home. The patient felt she was being ‘fobbed off’ by the nurses in A&E. She wanted to be seen by a doctor but the male nurse insisted that he was just as good in dealing with her problem. Patient waited and eventually saw a doctor”.

There is no mention of her being left alone and cold for hours in a dark room without treatment. Rather, in so far as this part of the incident is concerned the record is largely consistent with the defendant’s evidence, the reference to hot water probably being to the warm compress which, it is accepted, was applied to the swollen arm.

- c) Her description of the immediate effects of the extravasation does not accord with the other evidence. Mrs Shell, Mr Mahmoodi and Mrs Wyness described a slight swelling as a result of the extravasation. Mr Salcedo has recorded on examination swelling to the hand and fingers (not whole arm), bruising to proximal third of the forearm; sensation and perfusion are marked with a tick; and there was a full range of movement in wrist and finger joints. Dr Rashid noted “Neurology intact; able to do a full range of movement in left hand fingers and wrist.”. This evidence (which I accept) is at significant variance to the claimant’s evidence. Her description of description of her hand and arm at that stage was that her arm was “hanging by my side, enormous in size, black and blue in colour with clearly no circulation or sensation in the hand and the fingers”. She maintained that hand was “in a fixed claw position”. She maintained that the doctor did not do any examination of the arm. I reject her evidence on all these points and accept that of the defendant’s witnesses.
- d) Whilst by no means determinative, it is relevant that the expert radiologists have agreed that the account of events given by the claimant after the incident is unlikely to have occurred. I share that view. I find that her allegations are inherently unlikely, all the more so having seen and heard Mrs Shell, Mrs Wyness and Mr Salcedo give evidence.
- e) Importantly, I found Mrs Shell’s, Mrs Wyness’ and Mr Salcedo’s evidence as to these events to be impressive and compelling. I accept their evidence in all respects where it differs from that of the claimant. Mrs Shell and Mrs Wyness in particular were vehement in their denials of the claimants’ allegations such that Mrs Shell commented that they were “outlandish” and Mrs Wyness commented they were “absolutely absurd”. They both accepted that the claimant was complaining of pain, demanding to see a doctor and, in the words of Mrs Shell, was hostile aggressive and rude. However, they maintained, and I accept, that they

dealt with her in a proper and professional manner, dealing with the extravasation entirely appropriately and speedily.

65. With regard to the evidence of Mr McGregor regarding the timing of his mother's telephone call to him from the hospital, I find that he is honest but mistaken in his recollection. The hospital record at 12.40 makes reference to the call at that time. It is unlikely that the call was made later.
66. For the above reasons I reject the claimant's evidence on this part of the case. It follows that I reject any allegations of negligence in relation to her care after the extravasation injury occurred. Further, I record that I take into account her total lack of credibility on this issue when assessing the overall reliability of her evidence.

### Conclusion on liability

67. In the circumstances the claimant has failed to satisfy me that there was any breach of duty on the part of the defendant in relation to any aspect of the CT scan on the 29<sup>th</sup> December 2013. The claim therefore fails on the issue of liability.

### Causation

68. In view of my finding on liability it is not necessary for me to deal with causation. However, I propose to do so, perhaps more briefly than I would otherwise have, because it has formed a significant part of the evidence and argument, it is of importance to the parties, and it is potentially relevant to the allegation of fundamental dishonesty now raised by the defendant.
69. The issues that fall for determination are whether the claimant has a disability in fact or whether she is feigning symptoms; and, if she has a disability, whether any of that disability has been caused by the events surrounding the CT scan or whether they have any other, independent, cause.
70. There is no dispute that an extravasation injury involving 20 ml of contrast dye would normally have no long-term effect. Mr McArthur, consultant plastic surgeon instructed by the defendant said that small volumes of contrast extravasation such as in this case normally only provoke a mild inflammatory response involving a mild degree of swelling, some redness of the overlying skin and associated discomfort which normally fully resolves within 48 hours. The claimant's case is that it has a profoundly worse effect on her.
71. There is disagreement between the experts on the nature, degree and causes of the claimant's condition. I have heard evidence from Dr Jenner and Dr Pither, consultants in pain medicine, and from Professor Morgan and Dr Carnwath consultants in psychiatry. The one thing they do agree on is that this is an extremely complex case both in relation to the claimant's presentation before and after this incident. A good deal of their evidence has focussed on the proper diagnosis of any disability she has. The diagnostic label is of some assistance to me in determining the issues that I have to decide but I remind myself that (subject to liability) the claimant is entitled to damages if she has a genuine disability caused by the events surrounding the CT scan whatever its cause be it CRPS or psychiatric.

Is there a genuine disability?

72. As I have observed, the claimant had confirmed diagnoses of Raynaud's syndrome, Sjogren's syndrome, Hashimoto's disease and osteoarthritis well before 2013. These conditions had caused her problems from time to time over the years. She had also presented to doctors with symptoms which were extensively investigated and yet no organic cause could be found. The most recent and striking example was her complaint of cauda equina syndrome after the nerve root injection in December 2010 at RNOH. From the records to which I have referred earlier in this judgment I find that in the three years thereafter she probably was significantly disabled from continuing back pain, pain and weakness in her left leg, osteoarthritis in her left index finger, abdominal pain, bowel and bladder symptoms and fatigue.
73. After this incident the claimant has reported symptoms, initially in her left upper limb but later more widespread, to many different clinicians and at a number of different hospitals. The first significant recorded complaint was to Dr De Silva (a neurologist) on the 20<sup>th</sup> February 2014 when she described symptoms of impaired function in the arm and allodynia with exacerbation of her Raynaud's. She has been relatively consistent and persistent with her complaints since that time. She was referred to the pain clinic in October 2014 at which time Dr De Silva suggested that CRPS was "highly likely". Since then she has been investigated for, diagnosed with and treated for CRPS by a multiplicity of clinicians. In December 2015 she was referred to Dr Padfield, a consultant pain specialist, who both experts acknowledged was a renowned leader in the field of pain medicine. As a result, she underwent treatment by way of spinal cord stimulation, a treatment that is invasive, expensive, not without risks and not offered lightly. In general terms, I accept that her complaints have been largely consistent over time.
74. In so far as the claimant has been observed showing more function in her arm and hand than she has admitted, I find that her level of function is probably variable, and that when stating her symptoms to her treating clinicians she often states them as at their worst. Although she has described her left arm as "paralysed" from time to time, I do not believe that she has been deliberately withholding her true level of function from her treating clinicians or from the experts who have examined her for the litigation.
75. I accept the evidence of the defendant's care expert Mrs Savage, that during her assessment on the 6<sup>th</sup> August 2019 she saw the claimant use her left arm and hand to sort through some papers and when making a cup of tea. The claimant denied that this occurred but I have no reason to doubt the accuracy of Mrs Savage's observation as an expert witness giving evidence of her assessment.
76. I also of note that on the 12<sup>th</sup> August 2019, only 6 days later, the claimant was seen by Dr Janet Carter a consultant in old age psychiatry who noted that "*she spoke at length about her complex medical symptoms reporting pain all over her body, paralysis in her left arm although she was able to move it freely in the interview*". The claimant's use of the word paralysis may be her way of describing her disability but the observation of Dr Carter suggests that it is an inaccurate description although the extent of movement is not clear. The video taken by Dr Pither on the 8<sup>th</sup> April 2019 is also inconsistent with the description of "paralysis" but does demonstrate significant impairment of function.

77. Against this background, and on the totality of the evidence, I am satisfied that the claimant has and has had a genuine disability. The consistency and the persistence of her complaints over many years together with the fact that they appear to have been accepted as suitable for investigation and treatment by so many different clinicians strongly supports the conclusion that she is not feigning. It would appear that all those who have treated her have accepted her complaints at face value and have not questioned her veracity. Despite my conclusions about her lack of reliability generally, I did not consider her evidence about her current symptoms to be incredible. Whilst I have some reservations about the true extent of her disability I am satisfied that she probably is significantly disabled.

### Chronic Regional Pain Syndrome

78. There is a difference of opinion between Dr Jenner and Dr Pither as to whether or not the claimant has CRPS. If she does not have CRPS there is also a difference of opinion between Professor Morgan and Dr Carnwath as to whether or not she has a somatoform disorder (a psychiatric disorder which can give rise to genuine physical disability without organic cause) or a factitious disorder (a psychiatric disorder which causes the claimant to deliberately feign symptoms but without a malingering motive). Professor Morgan and Dr Carnwath also disagree as to whether or not she has PTSD. All the experts acknowledge that the making of an accurate diagnosis is extremely difficult in this case and it seems to me clear that there is often a considerable overlap between CRPS and psychiatric or psychological conditions.
79. I reject Dr Carnwath's opinion that the claimant has a factitious disorder. Although I accept that he advanced this argument with reluctance and after careful consideration, it was a conclusion reached only shortly before trial. It was not a consideration in his first or supplementary reports and was first advanced in the joint statement dated 17<sup>th</sup> September 2020. However, even in that joint statement he says: "the extent of the physical symptomology and multiple presentations suggest somatisation disorder". In his first report he had specifically stated that "I do not consider it probable that the claimant is being untruthful.....". In my judgment he has not given any satisfactory explanation as to why he has moved from that view. He agreed that it was an uncommon diagnosis (Professor Morgan referred to it as being "as rare as a black swan"). Further it is not a diagnosis that has been considered by any of the clinicians who have been involved in the claimant's care over the years.
80. The differential diagnoses therefore appear to be between CRPS and a somatoform disorder. In advancing her case that she has CRPS the claimant relies on the opinion of Dr Jenner together with the fact that she has been investigated for, diagnosed with and treated for CRPS by a multiplicity of clinicians since 2013 as set out above. The defendant relies on the opinion of Dr Pither. I found Dr Jenner to be a more impressive and helpful witness than Pither. Dr Jenner was measured, prepared to make concessions (as discussed below) and was clearly willing to assist the court. From the outset Dr Pither was dismissive of the claimant as an historian, a position that appeared to colour all his evidence. He was strident in his views, on occasions argumentative during cross-examination and dismissive of the opinions and conclusions of many treating clinicians. When initially reporting he had not made reference to the relevant Budapest Criteria for the diagnosis of CRPS and, in my judgment, was unduly dismissive of the claimant's disability as shown on the video of her which he took during the course of his examination.



81. There are a number of factors which argue against a diagnosis of CRPS. It is of note that Dr Jenner's initial opinion was that the cause of the CRPS was multifactorial including a traumatic insertion of the cannula causing extreme pain; extreme pain on injection of the contrast dye; the extravasation injury, multiple attempts at cannulation; thermal injury from hot water and compression. However, on my findings of fact, only one of those actually occurred, namely the extravasation injury involving 20 ml of contrast. There is no doubt that this led to some pain and swelling in the left hand and forearm but there was not the "extreme pain" that Dr Jenner initially relied on.
82. Further, Dr Jenner accepted that there were features of the evidence which tended not to support the diagnosis of CRPS. In particular:
- a) The fact that the claimant did not complain of pain in her left arm during visits to clinicians in January 2014 was surprising in his opinion (although she did complain of symptoms in her left arm after the incident to her GP on the 3<sup>rd</sup> February 2014 and I have already mentioned the view expressed by Dr De Silva on 24<sup>th</sup> February 2014.)
  - b) According to the records the claimant has had injections into the left arm on no less than 12 occasions since 2013 including a cannula in her left hand in August 2016 and various blood tests blood test and influenza vaccinations. Dr Jenner agreed that it is unlikely that a patient suffering with frank CRPS would accept injections into the affected arm. At trial only one of these was put to him (a blood test on the 17<sup>th</sup> March 2016) and he rather unconvincingly sought to argue that the record might be incorrect but I reject that. There are two separate records of the use of a cannula in the left hand in August 2016; and, in any event, it is unlikely that all the records relied on by the defendant are wrong.
  - c) Dr Jenner acknowledged that a patient with true CRPS affecting her left arm is unlikely to have made specific complaints of discrete conditions within that arm. On the 11<sup>th</sup> September 2015 the claimant complained of painful arthritis in her left index finger and on the 25<sup>th</sup> May 2016 she attended her GP with "pain in left hand for weeks getting worse". I acknowledge that both records acknowledge that the claimant has a diagnosis of CRPS or something similar but, as Dr Jenner said, "if you have CRPS you are oblivious to anything else".
  - d) I accept that the claimant has demonstrated movement in and use of her left arm which argues against the diagnosis as discussed above.
83. On the other hand, the claimant has presented with not only symptoms of CRPS but also with signs which are consistent with the diagnosis of CRPS. These include discoloration in particular of the left hand, (on the 21<sup>st</sup> August 2014 Dr Wickramaratne noted that she thought this discoloration was not related to Raynaud's); differences in temperature (noted in November 2014 and subsequently), muscle wasting in the affected limb (noted by Dr Wickramaratne in January 2015). In addition, there is noted evidence of brittle nails. Dr Pither argues that all of these signs could have other causes which he describes, but in my judgment the fact that they all occur in the same affected limb, are consistent with other signs and symptoms of CRPS and all develop within a relatively short period of time makes it less likely they have independent causes.

84. The impression I gain from the expert evidence is that CRPS is a poorly understood condition. Its aetiology is uncertain and it is likely that there is a huge range in the way that different patients present. Its onset can be insidious, its progress unpredictable and it is difficult to treat. There is clearly a large overlap between CRPS and psychological / psychiatric factors. Dr Jenner conceded that a differential diagnosis could be a somatoform disorder or somatic symptom disorder. The experts did not discount the possibility that CRPS and a somatoform disorder might both be present. This was initially raised by Dr Carnwath in his first report and Professor Morgan accepted that there may have been some somatoform tendencies before December 2013.
85. This is a complex and difficult issue. On the totality of the evidence, I am persuaded that the claimant probably does suffer from a degree of CRPS but with significant psychological overlay which probably includes a somatic element. In so far as there is an element of CRPS, I rely on the relative consistency of the reported symptoms and signs, the fact that the condition has been accepted by various treating clinicians since 2014, and my preference for the opinion of Dr Jenner over Dr Pither. In finding that there is probably some a significant psychological component to her presentation I rely on the pre – incident medical history and the fact that she has a long history of presenting with complaints that have no obvious organic cause. It is likely that there was an element of somatisation before December 2013 and it is likely in my judgment that that has become a component of her presentation after December 2013.

#### Post Traumatic Stress Disorder

86. There is no dispute that the claimant has developed clinical depression and has significant feelings of grievance about the index event. She has presented to clinicians with symptoms consistent with PTSD including nightmares, flashbacks and tearfully reliving the events as she perceived them to be. There are a number of references in her medical records to such complaints although these all appear to be since 2015 (the first one relied on by the claimant in closing is in a letter dated February 2015). She has been treated twice with cognitive behavioural therapy, the second time with some success.
87. The difficulty with the diagnosis is that, on my finding of fact, the claimant did not in fact suffer the trauma she says she did. Without evidence of sufficient trauma, the diagnosis has less validity. However, Professor Morgan and Dr Carnwath agreed that it is the perception of the patient as to the risk to which she was exposed which is important. The claimant clearly thought from an early stage that the needle had been wrongly sited and that the contrast dye had been pumped into her arm so that it was swollen to three to four times its size. She was wrong about that as a matter of fact – her perception was very different from the reality. However, it was that perception that was the content of her complaints made at the time. In the context of her complex psychological profile that perception quickly grew in the hours and days thereafter so that they were recorded in the various accounts she later gave. On balance, therefore I accept the diagnosis of PTSD.
88. However, I am not persuaded that a formal diagnosis of PTSD matters for these purposes. Relying on the extensive records I am satisfied that the claimant has developed the symptoms of which she reports and that these are probably a form of PTSD. They are associated with a depressive disorder on which the experts agree. In general terms I preferred Professor Morgan's evidence on this point.

Is her condition caused by the extravasation injury?

89. It is for the claimant to persuade me that her condition is as a result of the extravasation injury she suffered on the 29<sup>th</sup> December 2013. I am satisfied that the incident caused an initial problem in her left arm beyond that normally expected from an extravasation. Although there is no recorded complaint during her visits to her general practitioner on the 3<sup>rd</sup> January 2014 and 20<sup>th</sup> January 2014 (her complaints then were of pain to her neck and her concern that she said she had been told that “she is a high risk of cancer”), she did complain in February 2014 and has been consistent in her complaints about her left arm since then. It is clear from the records that her condition has become more widespread and disabling over time.
90. The complaints of pain in her lower limbs and right arm came later. On the 2<sup>nd</sup> December 2015 the claimant was referred to Dr Padfield. The referral letter states that she has left arm and shoulder CRPS, cauda equina from 2010, and “feet going blue and constantly paining her and cramping and limiting her mobility for the last 10-11 months”. It goes on to confirm that she also has had abdominal pain “for about a year”. So far as I am aware, this referral letter is the first reference in her records that she was complaining of symptoms in her feet. It is also an indication that she was still troubled by what she believed to be cauda equina symptoms and abdominal pain at that time. Dr Padfield described her condition as “a nasty complex regional pain syndrome which not only causes considerable loss of function of her left forearm and is also apparently spreading into the left lower limb”. It is not clear to what extent if at all Dr Padfield was aware of her previous medical history. Later, in June 2017 there is reference in the GP notes to both arms being affected.
91. Dr Pither said (and I do not think Dr Jenner took issue with this) that the spread of CRPS to other parts of the body, whilst recognised, is unusual. In my judgment it would be more likely if there was no other explanation for the symptoms in those other areas of the body.
92. However, before 2013 the claimant had made complaint of significant symptoms in all the areas now affected. She had confirmed diagnoses of Raynaud’s and osteoarthritis affecting her left upper limb which had troubled her intermittently in the past (the Raynaud’s was on occasions controlled by treatment). Both conditions troubled her after this incident. I have already recorded that on the 11<sup>th</sup> September 2015 she was complaining of painful arthritis in her left index finger and on the 25<sup>th</sup> May 2016 she attended her GP with “pain in left hand for weeks getting worse”. These entries suggest that at about the time she was developing pain in her legs she was also experiencing symptoms consistent with these pre-existing established pathologies affecting her left arm.
93. She also had a significant history of leg pain and weakness before 2013 in particular in her left lower limb. It was those symptoms which apparently contributed to her decision to undergo a nerve root injection in 2010. Following that procedure, she continued to have problems complaining of extensive weakness in the left lower limb (25<sup>th</sup> June 2012) pain in her left leg (October 2012); and her knee giving way (December 2012). The cause of these symptoms has never been identified.
94. In addition, I am satisfied that overlying her physical pathology there is an element of somatisation before 2013 and, probably afterwards.

95. Looking at the totality of the evidence I am left far from satisfied that her current symptoms and level of disability are caused by the extravasation injury to her left upper limb in December 2013. On the balance of probabilities, the disability in her legs was probably caused by or related to her pre-existing leg problems combined with an element of somatisation. I am not satisfied that there is any causal connection between the CT scan and these symptoms. Further, whilst I accept that the extravasation caused more than usual symptoms in her left arm, I find on the balance of probability that the disability as she now has in her left arm would have developed in any event, again as a result of the pre-existing conditions with an element of somatisation. For the same reasons she has not persuaded me that any symptoms she now has in her right upper limb are caused by the events of 29<sup>th</sup> December 2013.
96. For how long the effects of the extravasation injury lasted is extremely difficult. However, doing the best I can I would accept symptoms in the left arm alone until a period around the middle of 2016 when she began to complain specifically of pain in her left hand. Thereafter, she has not persuaded me that her symptoms can be related to what happened in December 2013.
97. In view of these findings I do not propose to consider issues of quantum unless I am invited to.

#### Fundamental Dishonesty

98. In view of my finding on liability, the issue of fundamental dishonesty does not arise in the context of section 57 of the Criminal Justice and Courts Act 2015. However, I deal with it because it is an important and serious allegation raised against the claimant and in the event that the defendant seeks to rely on CPR Part 44.16(1) on the issue of costs.
99. The defendant first informed the claimant that it intended to advance a positive case that she had been fundamentally dishonest on the eve of trial. The basis for the allegation became clear during cross examination and is repeated in closing submissions. The defendant relies on the claimant's "incredible or unreliable" version of the events at the time of the scan; her "failure to give a satisfactory account of her benefits claim" and / or her "failure to give a satisfactory account of her long-standing multiple prior health conditions in her witness statement and to the experts instructed in her case." I have already found that her evidence about the events at the time of the scan and about her prior health condition was unreliable and that her evidence about the benefits claim was unsatisfactory.
100. I am reminded of the test of dishonesty as set out by the Supreme Court in *Ivey v Genting Casinos Limited* [2017] UKSC 67 [Lord Hughes, para 74]:

“When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established,

the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.”

101. Having considered the totality of the evidence, including her evidence given over one and a half days in cross examination, I am satisfied that, despite the overall unreliability of her evidence, she genuinely believes that the case she advances is true and I am not persuaded that she has been dishonest. The following factors are in my judgment relevant:

- a) The allegation first came extremely late in the litigation. It is not a case when the spectre of dishonesty arose during the live evidence. The defendant knew the claimant’s account of the scan and her view of her prior condition when her witness statement was served. It knew that the claimant had made a claim for benefits claim when it was disclosed to Mrs Savage in 2019. The lateness of the positive averment, in my judgment, suggests that it was not considered to be an appropriate allegation to be made until the start of trial. I have not seen anything which justifies the change of approach.
- b) Until Dr Carnwath raised the possibility of factitious disorder, none of the experts in the case and none of the claimant’s treating clinicians had accused her of being dishonest in her presentation. I reject Dr Carnwath’s opinion for the reasons I have given.
- c) I reject any suggestion that the claimant has been motivated by the prospect of financial gain. It has not been suggested by any of the expert witnesses and, indeed, Dr Carnwath agreed in evidence that she did not appear to be motivated by money or financial reward. That accords with my impression of her as a witness.
- d) The claimant made prompt and consistent complaints about her treatment on the 29<sup>th</sup> December 2013. It is highly unlikely that she invented those complaints within such a short period of time and remained so consistent about them thereafter if they were pure invention. Her account has striking similarity to the events at the RNOH in 2010 and I have commented that I find it probable that she has somehow conflated the two events in her own mind. I am sure she genuinely believes that what she says happened in fact happened.
- e) I have dealt with her pre-2013 condition. She has been unreliable in her evidence but for the reasons I have given I accept that her description of herself as being “fit healthy and active” accords with her perception of the effect of the conditions on her within the limitations of her health.
- f) Her failure to be fully frank from the outset about her receipt of Disability Living Allowance is of more concern. However, again, I accept her evidence that she thought it irrelevant because it related to her back problem about which she was not making a direct claim. Further, it

is relevant that she has never actively denied receiving the benefit and indeed volunteered that she had received it to the defendant's care expert.

- g) It is perhaps telling that the highest the defendant puts the allegation in closing is her "failure to give a satisfactory account" of her benefits claim and her health conditions. Failing to give a satisfactory account is very different from giving a false account.
- h) In my judgment her evidence has to be viewed against the background of her psychological profile which has been discussed at length by the psychiatric experts.
- i) Finally, and importantly, my impression of her as a witness whom I heard and observed (albeit over video-link) during extensive cross examination when all these matters were put to her was that she was not a dishonest person. She has a genuine and significant disability which she firmly believes has been caused by the events of the 29<sup>th</sup> December 2013.

102. This has been an extremely complex case. However, when I stand back and look at the totality of the evidence I am far from persuaded that the claimant has deliberately made up events that did not occur or that she has deliberately told lies about her condition in order to advance her claim. Applying the two-stage test, I am satisfied that the claimant genuinely believed in the truth of the evidence that she gave and that, applying the standards of ordinary decent people I find as a fact that although her evidence was wholly unreliable in the sense that I do not accept it, she has not been dishonest. I therefore reject the allegation of fundamental dishonesty.

### **ADDENDUM**

Reasons for dismissing the defendant's application dated the 7<sup>th</sup> January 2021.

1. It is only in exceptional circumstances and where the interests of justice require it that further evidence should be admitted after the parties have closed their cases and made closing submissions and while the court was considering its judgment.
2. The defendant was aware in August 2019 that the claimant was in receipt of benefits. No request for disclosure of DWP records was made until June 2020. The defendant could and should have pursued the absence of the complete DWP records earlier and/or applied to adjourn the trial if it wanted to rely on the records at trial.
3. Given that the court was considering its decision, the application, if it were to be made, should have been made promptly. The defendant received the records before the 4<sup>th</sup>

December 2020 when they were disclosed to the claimant. The application was not made until the 7<sup>th</sup> January. There is no explanation for that delay.

4. Although I have not read them, the records appear to be of limited relevance. During trial I was taken extensively through the claimant's medical records. I am told that the DWP records relate to the period 1989 to 1995. It is difficult to see how they might have a significant bearing on my decision as to what happened in 2013 or the claimant's credibility or reliability in 2020. The claimant accepted in evidence that she was in receipt of benefits. What she may or may not have said about that 25 years ago is unlikely to be of great help.
5. The consequences of admitting the records would be unfair to the claimant and disproportionate. Unfair to the claimant because she would have to be re-called to give evidence in order to comment on them. On any view of the evidence, she is psychologically vulnerable and has already been cross-examined for 1½ days. It would be unfair to require her to attend for further cross-examination on matters that happened over 25 years ago. Disproportionate in that it would result in further costs including input from four expert witness, another day's hearing, further submissions and further time for judicial consideration.
6. I reserve costs since I had had not submissions from the defendant. To assist the parties, my preliminary view is that the defendant should pay the claimant's costs of this unsuccessful application.