



Neutral Citation Number: [2023] EWHC 1290 (KB)

Case No: QB-2020-000913

IN THE HIGH COURT OF JUSTICE
KINGS BENCH DIVISION

Royal Courts of Justice
Strand
London
WC2A 2LL

Date: 30/05/2023

Before :

MRS JUSTICE HILL

Between :

ROSEMARY CHAPMAN

Claimant

- and -

**MID & SOUTH ESSEX
NHS FOUNDATION TRUST**

Defendant

Anna Beale (instructed by **Stewarts Law**) for the Claimant
Andrew Post KC (instructed by **Browne Jacobson LLP**) for the Defendant

Hearing dates: 20-25, 27-28 February 2023 and 7 March 2023
Further written submissions: 14 March 2023

Approved Judgment

This judgment was handed down remotely at 10.00 am on 30 May 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MRS JUSTICE HILL

Mrs Justice Hill:

Introduction

1. Rosemary Chapman, the Claimant, has a history of lower back pain caused by a severe grade 2/3 spondylolisthesis. On 20 March 2017 she was diagnosed with a different spinal problem, namely a prolapsed thoracic disc at the T11/12 level. She underwent surgery to remove that disc on 30 March 2017. By this claim she alleges that the Defendant was negligent in that there was a delay in diagnosing and treating the prolapse. Her case is that, as a result of the delay in treatment, the prolapse progressed and resulted in paraplegia.
2. The Claimant’s claim relates to two distinct periods of time: (i) her appointments with Dr Bopitiya, Consultant in the Department of Chronic Pain Management at Southend University Hospital, on 24 December 2009 and 30 September 2010; and (ii) her attendance at the Emergency Department at Basildon University Hospital on 9 March 2017, when she was assessed by an Emergency Nurse Practitioner (“ENP”), Becky Nice. A further claim against Dr Macaulay, the Claimant’s GP, arising out of his assessment of her on 13 March 2017, was withdrawn by the Claimant during the trial, which was listed for determination of liability issues only.
3. In determining the issues, I remind myself that, save in respect of contributory negligence, the Claimant bears the burden of proof.

The factual background

4. The Claimant has a long history of back-related pain which began following a fall on her patio in 1998. On 5 January 2001 an x-ray confirmed the presence of spondylolisthesis at the L5/S1 level. Spondylolisthesis is a degenerative back condition in which one of the vertebrae slips forward, causing pain. On 30 August 2001 the Claimant was seen by Mr Ker, Consultant Orthopaedic Surgeon. It was recorded that her leg pain was worse than her back pain. On 31 October 2001 she was referred by Mr Ker to Mr Targett, an Orthopaedic Spinal Surgeon. It was noted that “in view of her very severe symptoms she is prepared to contemplate surgery”. On 18 January 2002 a lumbar epidural was performed but it had little effect. On 26 February 2002, she was referred to the Royal National Orthopaedic Hospital (“RNOH”) for consideration of spinal fusion. The Claimant’s case is that a referral letter was sent but that an appointment was never arranged.
5. In January 2008, the Claimant was referred to the pain management service at Basildon Hospital. On 1 December 2008 she saw Dr May. Dr May noted a pain score of 66/70

for the extent of its interference with the Claimant's everyday life. He recorded that she "does not entertain the idea of surgery". On 2 January 2009, facet joint injections were attempted. On 27 March 2009 another lumbar epidural was administered. None of these treatments provided the Claimant with long-term relief, and she managed her pain with analgesics.

6. During 2009 the Claimant's pain medication regime was adjusted several times. She left her job as a cashier and has not worked since. On 28 April 2009 she saw Dr Salako, one of her GPs. The notes record that she had ongoing back pain; had had several injections but that none had helped; and that she had declined surgery. On 7 September 2009 the Department for Work and Pensions assessed the Claimant as capable of work. She was unhappy with this and on 6 October 2009, Dr Salako referred her to Dr Bopitiya at Southend Hospital for a second pain management opinion.
7. On 9 November 2009, the Claimant was assessed by the pain clinic nurse specialist at Southend Hospital, Sharon Brown. Nurse Brown recorded under the heading "Description of pain" that the Claimant had "Constant intense pain. Radiates into buttocks and both legs to feet. Beginning to radiate up back. Has shakes. If walks too far collapses. Has fallen down stairs ? leg gives way ?".
8. On 11 November 2009, the Claimant presented to her GP complaining of "abdominal pain for last 2 weeks in right hypochondrial region...traces it to a curry she had a few weeks ago...pain is colicky". She had slight tenderness in the right iliac fossa on examination and the GP's diagnosis was "? cholecystitis". She was referred for an ultrasound scan of her liver and gallbladder. On 3 December 2009 the scan was performed and showed normal organs and no stones, focal lesions or obvious evidence of cholecystitis. On 30 November 2009 the Claimant's GP completed a wheelchair assessment form for her.
9. On 24 December 2009, she was reviewed by Dr Bopitiya. His subsequent letter to her GP indicated that his examination of her had been limited because she was in a wheelchair. His treatment plan was as follows:

"...her type of pain has to be managed with a multi-disciplinary approach and she will need to see our psychologist for initial individual sessions and possibly at some stage receive physiotherapy input. In the longer term she may be suitable for the Pain Management programme. I have also explained that at this stage surgery or injections is not going to help her pain."
10. On 29 June 2010, the Claimant attended a clinical psychology clinic, but no assessment took place because the Claimant felt that psychological input could not help her symptoms. She was referred back to Dr Bopitiya.
11. On 30 September 2010 the Claimant saw Dr Bopitiya again. He did not examine her. His 4 November 2010 letter to her GP recorded his advice as follows:

"She will need to work with either the physiotherapist in terms of hydrotherapy and the Fitness Group to become more mobile and obtain a good quality of life and improve her ADL [Activities of Daily Living]

or see a surgeon to consider surgical options, which I have discussed in detail with her, however she is not keen on having surgery.”

12. Although the Claimant was due to see Dr Bopitiya after she underwent physiotherapy, no further appointments with him took place.
13. After November 2010 the Claimant had more limited medical attendances. On 7 February 2014 Dr Macaulay noted that she was “very upset the way [sic] she had been treated by psychiatrist and pain clinic, in connection with her back pain, and not prepared to attend for any referrals to any stakeholders anymore”.
14. In early 2017, the Claimant’s husband was injured in a car accident. At this time, she rarely left the house due to her pain, but she began to do so in order to visit him in hospital.
15. On 8 March 2017 the Claimant collapsed in the bathroom at home. She said her legs gave way. Her husband telephoned her GP and Dr Macaulay recorded that she had “collapsed in toilet with pain”. He advised her to attend the Accident and Emergency (“A&E”) department at hospital.
16. On 9 March 2017, the Claimant’s husband called an ambulance. Her case is that her legs had given way again when she tried to go to the toilet, she was in excruciating pain and had begun to have bladder accidents. At around 4 pm the ambulance attended. The ambulance staff recorded the following under “History/MOI”: “Ongoing back condition +++ onset pain in back. L5 [circled]. Pain +++ on movement. Pain in kidney region”. A further note on examination recorded “pt c/o pain in usual area on back & kidney area, worse on movement. Pt able to twist to side”. It was recorded that there had been no incontinence, there was no saddle anaesthesia and “BO + PU” [bowels open and passed urine].
17. At 5.08 pm the Claimant arrived at Basildon Hospital. She was triaged and then seen by ENP Nice at 7.05 pm. The Claimant’s case is that contrary to ENP Nice’s notes, she did not conduct the detailed examination that she had recorded; instead, ENP Nice explained that she was pregnant, and that as a result she could not fully examine the Claimant; that her examination was limited to asking the Claimant to move her own legs, and then moving the Claimant’s legs to see whether she could push back; and that ENP Nice incorrectly recorded that the Claimant was able to take steps, when she was not.
18. ENP Nice recorded her clinical impression as being “soft tissue inflammation” and “worsening of long-term condition”. Her plan was to send the Claimant home, with her GP “follow[ing] up for further management”. The consultation with ENP Nice concluded at 7.58 pm. The Claimant was taken home by ambulance, the notes recording “Transport booked for pt to go home as struggles in car.”
19. The Claimant’s recollection is that following the hospital attendance, she began experiencing pins and needles in her legs and problems with both her bowel and bladder.
20. At 9.54 am on 13 March 2017, the Claimant’s husband telephoned the GP surgery. Dr

Macaulay visited her at home. His note of the consultation reads:

“History: severe back pain, incapacitating, no recent fall or injury.
Examination: tender rt side back slr test 40 degrees.
Diagnosis: back and hip pain.
Plan: urgent mri scan back and pelvis.
Adv on medication and pain relieve [sic].”

21. At 12.36 pm on 15 March 2017, the Claimant’s husband rang the GP surgery again. The note records:

“History: husband called to say that wife cannot move the legs and have advised to call 999; asap.
Felt reluctant to do; and accepted.
Also told will fax the urgent referral for mri scan.
Plan: advised again to call 999 since cannot move the legs, to go to a/e.”
22. Following her experience at Basildon Hospital on 9 March 2017, the Claimant and her husband did not believe she would be taken seriously without the MRI scan for which Dr Macaulay had referred her, and that she would be left at the hospital for hours in pain for no reason. For that reason, she did not attend hospital on 15 March 2017.
23. On 17 March 2017, the Claimant was visited by an Occupational Therapist, Ms Tamsett. According to her notes the Claimant reported that when she went to hospital “she had some indep movement in her left leg but now has no movement in that leg and her bladder control has been affected”. There were further discussions about attending hospital, but the Claimant did not do so.
24. On 20 March 2017 there were discussions between Ms Tamsett and Dr Degun, a GP at Dr Macaulay’s practice, regarding the Claimant’s loss of functioning in her legs. There is a note from Dr Degun at 12.53 pm reading “spoke to ot loss of functioning of legs spoke to husband adv to call 999 will d/w wife adv to call asap”. Mr Chapman called an ambulance, which arrived at around 1.30 pm. The ambulance records note that the Claimant had double incontinence; an inability to mobilise; and numbness in both legs radiating into the abdomen. She was taken to Basildon Hospital, arriving at 2.41 pm.
25. At around 4 pm the Claimant was examined. It was recorded that she had no movement in her lower limbs at all. Further examinations similarly recorded no movement or 0/5 power in the lower limbs. A lumbar spine MRI was undertaken. This showed that, in addition to her existing L5/S1 spondylolisthesis, she had a T11/12 region paracentral disc protrusion. This was subsequently confirmed by a second MRI which fully visualised the thoracic area.
26. The Claimant was transferred to the Queen’s Hospital, Romford. On 30 March 2017 she underwent a left-sided thoracotomy and T11/12 discectomy. She has been left with T9 ASIA C incomplete paraplegia.

The legal framework

Breach of duty and causation issues

27. The legal test for determining whether a clinician has acted in breach of their duty to a patient was set out by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 at 587 thus: “[A doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men...Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.”
28. The *Bolam* test was modified to some extent in *Bolitho v City and Hackney Health Authority* [1998] AC 232 at 241-243, to the effect that the body of medical opinion relied upon by a doctor as supporting his/her practice must have a logical basis.
29. Mr Post KC argued that if I considered it difficult, due to the unreliability and inconsistency of the Claimant’s reports of her symptoms and history, to determine her true condition at any particular time, I should have regard to the principle set out in *Rhesa Shipping Co SA v Edmunds* [1985] 1 WLR 948 to this effect: “it is always open to a court, even after [a] prolonged inquiry with a mass of expert evidence...to conclude, at the end of the day, that the proximate cause of the...loss, even on a balance of probabilities, remains in doubt, with the consequence that the [Claimant has] failed to discharge the burden of proof which lay upon them.” This was recently applied in the clinical negligence context in *Roger Johnson v Andrew Williams* [2022] EWHC 1585.

The approach to witness evidence

30. In *Gestmin SGPS SA v Credit Suisse (UK) Limited* [2013] EWHC 3560 at [15]-[22], Leggatt J (as he then was) made certain observations about the approach a court should take to the assessment of the reliability of witness evidence. These were to the effect that (i) an obvious difficulty which affects allegations and oral evidence based on recollection of events which occurred several years ago is the unreliability of human memory; (ii) memory is especially unreliable when it comes to recalling past beliefs; (iii) the process of civil litigation itself subjects the memories of witnesses to powerful biases; (iv) the best approach for a judge to adopt in the trial of a commercial case was, in his view, to “place little if any reliance at all on witnesses’ recollections of what was said in meetings and conversations, and to base factual findings on inferences drawn from the documentary evidence and known or probable facts”. He concluded that the value of oral testimony was:

“...largely...the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth.”

31. These principles were considered further in cases such as *Lachaux v Lachaux* [2017]

EWHC 385, *Carmarthenshire County Council v Y* [2017] EWFC 36 and *Kimathi & Ors v The Foreign & Commonwealth Office* [2018] EWHC 2066.

32. In *CXB v North West Anglia NHS Foundation Trust* [2019] EWHC 2053 (QB), HHJ Gore QC (sitting as a Deputy Judge of the High Court) considered these cases in the context of a clinical negligence claim involving a dispute as to the clinical record. He rejected the argument that the veracity and reliability of assertions contained in clinical notes and records should necessarily be preferred to contrary witness accounts. At [13], by reference to *Synclair v East Lancashire Hospital NHS Trust* [2015] EWCA (Civ) 1283, he summarised the question to be determined in such cases was:

“...whether, when the evidence is viewed as a whole, there is material that justifies the conclusion that the clinical record is unreliable or incorrect or whether, when the evidence is viewed as a whole, there is material that justifies the conclusion that the witness evidence to the contrary is unreliable or incorrect”.

He observed that the court was tasked with “...viewing the documentary and testamentary evidence forensically and not simply by subjective criteria such as demeanour of live witnesses”.

33. In *Ismail v Joyce* [2020] EWHC 3453(QB) Freedman J considered these cases in the context of another case where the medical records did not necessarily bear out what was recalled by the Claimant. At [29]-[32] and [38], he noted that (i) the inherent unreliability of memory means that it is fair and proper to test the accuracy of recollections of medical consultations against what is documented in the record; (ii) on the other hand, it does not necessarily follow that just because the complaint of a particular symptom does not feature in the record of a consultation, it was not, in fact, mentioned by the patient; (iii) it is human nature for a patient to not always give precisely the same account of his or her symptoms to every doctor who examines him or her; and (iv) just because in some instances, it is not possible to accept a witness’s evidence as to what happened or as to what was said, it does not mean that the totality of their evidence falls to be rejected.
34. Both *CXB* and the recent Court of Appeal decision in *Barrow v Merrett* [2022] EWCA Civ 1241 at [19]-[21] advocate caution in applying the guidance from *Gestmin*, a commercial dispute in which there was a significant “digital footprint”, wholesale to other types of case. At [97] in *Barrow* the Court noted that the judge had considered various “plausibility theories” which were “tests of the evidence by reference to its inherent probability” which *Gestamin* recognised were useful.

The Claimant’s witnesses

35. The Claimant has been in substantial pain for many years and is severely disabled. For these reasons she gave evidence by video link. There were some technical issues with the video link, as there were when Dr Simpson gave evidence remotely.
36. The Claimant gave evidence for 1.5 days. Her husband, Stephen Chapman, gave evidence for half a day. The Claimant’s son (Andrew) and daughter (Emma) also gave brief evidence, mainly related to the examination by ENP Nice.

37. It was clear to me that the Claimant and her husband both found giving evidence difficult and frustrating at times. Given the nature of the Claimant's claim they were both required to give evidence spanning over 20 years, from the initial onset of the Claimant's back problems. Inevitably their recollection of some events was imperfect.
38. Mr Post contended that the Claimant was an entirely unreliable historian. He highlighted a series of occasions when she had given different accounts to medical professionals over a short period of time. For example, she had given what he described as "strikingly discordant" versions of events over 20/21 March 2017. The differences related to both the extent to which she could move or feel her legs and when her symptoms started. While Ms Beale was correct to emphasise that by this point in time the Claimant was in a great deal of pain, these were not isolated examples. As will become clear under Issue (4), there were several occasions around 9 March 2017 when different medical professionals had elicited different histories from the Claimant. However, Dr Simpson provided some useful context about the reliability of the accounts patients often give clinicians from her own experience: in essence, she said that giving different accounts to different doctors is very commonplace; that histories can give different details but still present a consistent picture; and that a lack of consistency did not mean that the accounts were unreliable. These observations chime with those of Freedman J in *Ismail*: see [33] above.
39. A further example Mr Post gave was that the Claimant and her family had talked about a "loss of power" in her legs which must have meant that she could not move them at all. This was inconsistent with the case she was advancing on causation. However, Ms Beale correctly emphasised that it was important not to hold the Claimant to an unrealistically high standard and expect her to describe symptoms in the way someone medically qualified would: it was obvious from the surrounding evidence that the Claimant's "loss of power" meant an inability to weight-bear, not an inability to move at all.
40. I bore all these factors, and the legal principles set out at [30]-[34] above in approaching the Claimant's evidence and that of her family.
41. In fact, there was virtually no factual dispute underpinning the claim in relation to Dr Bopitiya. However, there were significant disputes between the Claimant and her family and ENP Nice about the latter's examination. I therefore return to the issue of the reliability of the Claimant's witness evidence under Issue (4) below.

The Defendant's witnesses

42. Dr Bopitiya and ENP Nice both gave evidence. As is often the case with medical professionals, neither had any independent recollection of their interactions with the Claimant.
43. An issue emerged during closing submissions as to whether I could take into account the witness statement from Dr Macaulay, the claim against him having been withdrawn by the Claimant before he gave his evidence. Further submissions were lodged on the issue. The Claimant did not seek to rely on his evidence, but the Defendant sought to rely on certain paragraphs of it.

44. As to the law, the parties agreed, by reference to CPR 32.5(5), 33.2 and 33.3, the White Book commentary thereon and *Abdulrida and others v Al Najjar and others* [2021] EWHC 398 (Ch) at [28]-[34], that (i) the statement was admissible notwithstanding the lack of a hearsay notice in respect of it; (ii) I retained a discretion to exclude it, for any appropriate reason, which could include a failure to comply with procedural requirements; and (iii) if the statement was admitted, its probative value was limited by the lack of cross-examination on it.
45. I considered it appropriate to admit those parts of Dr Macaulay's statement on which the Defendant sought to rely because (i) how the Claimant had presented to Dr Macaulay on 13 March 2017 was potentially relevant to her presentation to ENP Nice a few days before; and (ii) there was no prejudice to either party that would lead me to exclude it: all parties were aware of its content in preparing for trial and Ms Beale did not oppose me relying on it. I took into account that its contents had not been tested in cross-examination.

The expert evidence

46. The Claimant's pain management expert was Dr Simpson and the Defendant's was Dr Sanders. Both counsel sought to challenge the independence of these experts in the ways discussed under Issue (1) below.
47. The Claimant's nursing expert was Mr Paynter, and the Defendant's was Ms Brown. Their evidence was less contentious than the experts from other disciplines; the primary issues on the claim relating to ENP Nice being factual ones relating to the extent of her examination of the Claimant.
48. The Claimant's neurosurgery expert was Mr Radatz and the Defendant's was Mr Wilby. Mr Findlay had been instructed on behalf of Dr Macaulay and so he was not called to give evidence at trial. Both parties made reference to his written evidence in their closing submissions, albeit that it was recognised that it had not been tested in cross-examination.

The issues

49. The issues for determination are as follows:
- (1): In light of the Claimant's presentation and history, did Dr Bopitiya act in breach of duty in (i) failing to conduct a full neurological examination or order an MRI scan at the 2009 consultation; (ii) failing to take an adequate history or conduct an examination at the 2010 consultation; and (iii) on both occasions, giving her advice on surgery which was not within his remit?
- (2): If a scan had been ordered, would a surgeon have advised the Claimant to undergo surgery for the thoracic disc prolapse in 2009/10?
- (3): Would the Claimant have elected to undergo surgery for the thoracic disc prolapse if it had been offered in 2009/10?

(4): Did ENP Nice act in breach of duty in failing to undertake a proper neurological examination?

(5): What findings can properly be made as to the sequence of events and timescale for surgery after ENP Nice's examination in light of the Claimant's condition at that time?

(6): If surgery would have been performed at an earlier point than it actually was, does the evidence establish that the outcome of surgery would have left the Claimant materially less disabled than she presently is?

(7): Did the Claimant contribute to her injury by her conduct in refusing the advice of Dr Macaulay to call an ambulance and attend hospital on 15 March 2017?

Issue (1): In light of the Claimant's presentation and history, did Dr Bopitiya act in breach of duty in (i) failing to conduct a full neurological examination or order an MRI scan at the 2009 appointment; (ii) failing to take an adequate history or conduct an examination at the 2010 appointment; and (iii) on both occasions, giving her advice on surgery which was not within his remit?

(i): The 2009 appointment

50. Dr Simpson and Dr Sanders agreed that Dr Bopitiya's management plan of an initial referral of the Claimant to psychology services following her appointment with him on 24 December 2009 would be supported by most pain physicians if appropriate assessment and investigations had occurred and failed to identify a treatable pathology. The Claimant's case, based on Dr Simpson's evidence, was that Dr Bopitiya had not carried out "appropriate assessment and investigations" because he had not conducted a neurological examination encompassing, in particular, power, sensation and reflexes in the lower limbs; and/or ordered an updated MRI scan (the last one having taken place in 2001). On that basis, Ms Beale contended that Dr Bopitiya's plan to refer the Claimant to psychology services would not be supported by a reasonable body of medical opinion.
51. The context for the Claimant's case on this issue was the experts' agreement that (i) the role of a pain physician includes, where possible, establishing a diagnosis for the cause of a patient's pain after taking a history of the pain and symptoms (including the functional effects), physical examination and arranging/reviewing appropriate investigations; (ii) it is essential that a pain physician remains vigilant for new or changing pain and symptoms even in a chronic situation; and (iii) whilst it is important to minimise over-investigation and medicalisation in stable long-term pain conditions, a pain physician should be alive to significant changes in presentation that might indicate new pathology. When cross-examined by Ms Beale, Dr Sanders confirmed his agreement to all these propositions, specifically the need for pain physicians to remain "vigilant" for new or changing pain and symptoms, even in a chronic situation; and to be "alive" to significant changes in presentation that "might" indicate new pathology, whether or not the potential new pathology was a life-threatening condition or medical emergency.

52. As to how those general principles applied to the facts of this case, Dr Sanders had referred in the joint statement to the “red flags” for cauda equina syndrome set out by the National Institute for Health and Care Excellence. He had also said that it would have been mandatory for Dr Bopitiya to conduct a neurological examination of the Claimant and order an MRI scan if there was evidence of “new neurological symptoms, significant trauma or significant changes in presentation not explained by known pathology”. At trial he adopted this broader formulation. He also referred to events he described as “neurological falls” and agreed that a significant change in the patient’s function would be relevant. The thrust of Dr Simpson’s evidence was that she agreed with these generic thresholds. The main dispute between the experts related to whether the information available to Dr Bopitiya at the 2009 appointment fell into any of these categories, such as to raise a suspicion of new pathology.
53. Dr Simpson was clear in her report, the joint statement and at trial that Dr Bopitiya failed to identify and act on evidence that might have indicated a new pathology, specifically: (i) the history of lower limb symptoms the Claimant had given Nurse Brown on 9 November 2009; (ii) the apparent deterioration in the Claimant’s functioning when Dr Bopitiya saw her, compared to when she had been seen by Dr May a year earlier; and (iii) the history of right hypochondrial/iliac fossa pain the Claimant had reported to her GP on 11 November 2009.

(a): The lower limb symptoms reported to Nurse Brown

54. When the Claimant saw Nurse Brown on 9 November 2009, the Nurse specifically noted “Has shakes. If walks too far collapses. Has fallen down stairs ? leg gives way?”. Dr Sanders agreed that it was important for Dr Bopitiya to take into account the history elicited by Nurse Brown, not least because she would have been able to spend significantly longer with the Claimant (at least 30 minutes and possibly longer because no physiotherapist had been present) compared to Dr Bopitiya’s approximately 15 minute appointment.
55. It was agreed that when Dr Bopitiya took his own history from the Claimant at the outset of the appointment, she did not volunteer the information she gave to Nurse Brown. However, that is not the end of the matter, because the experts and Dr Bopitiya himself agreed that he was required specifically to explore the symptoms given to Nurse Brown with the Claimant when taking the history, and there is no evidence that he did so: (i) the note of the appointment contains no reference to any question or answer relating to falls, leg giving way, shakes or lower limb weakness generally; (ii) he had no independent recollection of the appointment; and (iii) his first witness statement for these proceedings did not refer to these specific aspects of the history noted by Nurse Brown at all. For these reasons I find that Dr Bopitiya did not put specific questions about these issues to the Claimant, as it was agreed he should have done.
56. On that basis, all Dr Bopitiya had before him was the history from Nurse Brown. Dr Simpson was clear in her report that the history given to Nurse Brown, in particular the history of a fall, was a “red flag” that should have prompted Dr Bopitiya to conclude that further investigation was required. This should have been through a full musculoskeletal and neurological examination and ordering an updated MRI scan. Her opinion was that his failure to take these steps was not reasonable, particularly when he was being asked for a second pain medicine opinion.

57. Dr Simpson maintained her view when pressed by Mr Post to accept the Defendant's case that there was "no evidence before Dr Bopitiya of leg weakness". She was clear that there was such evidence: "...legs giving way was leg weakness". She was also clear as to the significance of this evidence: "...the description of legs giving way, shaking when walking, collapsing, falling are all indicative of the possibility of spinal cord or nerve compression."
58. Her evidence as to the significance of the report of leg weakness was supported by evidence from several other sources. Mr Wilby said he would have been "alarmed" if he had heard about the reports of weakness or inability to weight-bear. This is because such events can be evidence of cord compression impacting motor function; and the knee giving way specifically could be indicative of a thoracic problem. In his report he had said that a thoracic disc prolapse "usually" presents with "painless discoordination and weakness of the legs". Mr Radatz's opinion was that the information in Nurse Brown's assessment was evidence of an acute new symptomology. In his report he said that patients with thoracic disc problems may present with "weakness". More specifically, he was clear in the joint statement that the Claimant's existing pathology (her spondylolisthesis) would not explain a "whole leg giving way" and he was not challenged on this at trial.
59. Further, Dr Sanders accepted in cross-examination that (i) Dr May had not elicited any history of collapses or legs giving way; and (ii) a weakness or inability to weight-bear "could" be evidence of cord compression impacting motor function and "could" indicate a problem in the thoracic spine or indeed compression of the spinal cord at any level. Dr Bopitiya himself had included "evidence of cord compression impacting motor function – weakness, inability to weight bear" in his witness statement as one of the symptoms he would have expected someone to report if they had a thoracic spine problem.
60. Against that evidence, Dr Bopitiya said that that leg weakness "could be due to anything"; "pain itself can cause muscle dysregulation"; and "severe pain is one of the very common reasons for a weakness and give way". Dr Sanders said that it was common for patients to describe their pain in terms such as those used to Nurse Brown; and that a leg giving way could occur for a "multitude of reasons". His evidence was, effectively, that leg weakness could be consistent with what was already known about the Claimant but could also be consistent with a different pathology. At one point he suggested that the relevant question was whether the new information was "likely" to be linked to the existing pathology in the patient.
61. On that basis, the Defendant's position, as put to Dr Simpson, was that it was "commonplace in patients with severe chronic pain that they may suffer collapses and falls" and that such events are not necessarily neurological but can be caused by pain. She refused to accept this proposition, saying that such an approach involved a "risky assumption". She said it was a "risky inference to assume that it is just a pain thing without making further enquiries and investigating further".
62. In my judgment Dr Simpson's evidence on this issue was to be preferred. Her approach in this regard was more consistent with the agreed duty of a pain physician to be "vigilant" for new or changing pain and symptoms and "alive" to significant changes

in presentation that “might” indicate new pathology. This is especially so given that, as Dr Sanders accepted, the symptoms of spinal cord compression are potentially alarming because if they progress in a sudden manner the patient could be paralysed: as he said, this was the purpose of the list of cauda equina red flags. Further, as noted at [59] above, the unchallenged evidence of Mr Radatz was that the Claimant’s existing pathology would not explain a “whole leg giving way”. I accept Ms Beale’s contention that it was illogical for the Defendant to contend that just because the new symptoms might be attributed to the existing pathology, it was not necessary to investigate. Such an approach would not be consistent with the agreed role of a pain physician.

63. Dr Sanders’ concept of “neurological falls” was a little hard to follow. My sense of his evidence was in accordance with Ms Beale’s: that what he meant by this was a fall which might have a neurological cause. Mr Post contended that what Dr Sanders meant was a fall which, after the event, had been attributed to a neurological cause. However, as Ms Beale rightly highlighted, even this approach would require investigation and assessment, and Dr Bopitiya had not done these things.
64. Dr Bopitiya also said that he would not take one symptom such as leg weakness in isolation. He would look at the “overall picture” to see if there was any other evidence of nerve compression, such as pins and needles, numb feeling or bladder/bowel dysfunction, which often goes “hand-in-hand” with leg weakness. However, the effect of both Mr Wilby and Mr Radatz’s evidence was that a thoracic disc prolapse could lead to an adverse impact on motor function without there necessarily being an impact on sensory function.
65. Dr Sanders similarly said it was necessary to “look globally” at the situation. He described the “difficult balancing act” of pain medicine being the choice between undertaking “further investigations for symptoms that can be explained by pathology that you know about, because investigation is not necessarily a benign process”; or attributing those symptoms to “what you know”. While this may well represent an accurate general summary of the difficulties sometimes faced by pain physicians, the problem with its applicability here was that there was simply no contemporaneous evidence that Dr Bopitiya had carried out this sort of analysis at the time: on the contrary, the impression is that he had not identified the significance of the history reported to Nurse Brown at all; he did not refer to it in his notes in any way (even to discount it); he did not discuss it with the Claimant; he did not test it with a neurological examination and he did not order an MRI scan. I accept Dr Simpson’s evidence that by failing to do all these things, it was not safe to conclude that there was no new pathology present. He was not exercising the necessary need for vigilance.
66. Dr Sanders explained that there can be very good reasons not to order investigations, related to the need to avoid “medicalisation” of the patient and avoid counter-productive investigations that lead to heightened anxiety and distress without the prospect of remedial intervention, rather than helping the patient learn to manage their condition. Dr Simpson took a different view. She said that if the patient has new symptoms even if they have chronic pain, then they should have “the courtesy” of being investigated; and that patients with chronic pain conditions do not always suffer stress during investigations: she said they were often “relieved to be taken seriously and be investigated”. However, again, these differing generalised perspectives were of relatively little assistance, because there was no evidence that Dr Bopitiya had actively

considered ordering an MRI scan but then decided not to pursue it due to a concern about over-medicalising the Claimant. As an aside, I note that it was the absence of an MRI scan having been performed that led to the Claimant not attending hospital in March 2017. This suggests that she well understood the importance of such an investigation and would have welcomed it had Dr Bopitiya advised it.

67. As explained above, the thrust of Dr Simpson's evidence was that the report of a fall alone was a sufficient "red flag" to have required Dr Bopitiya to have investigated further. To the extent that it is necessary, I am satisfied that if Dr Bopitiya had specifically asked the Claimant about the issues raised in Nurse Brown's assessment, it is more likely than not that she would have confirmed them. I accept that the Claimant's witness statement in these proceedings did not refer to a history of her leg giving way or collapses before the Nurse Brown assessment; and that she accepted in cross-examination that the dramatic collapse in March 2017 was the first time this had occurred. However, she had plainly reported these clear and distinct events to Nurse Brown. As Ms Beale highlighted, they were prominent symptoms in the history taken by Nurse Brown and the appointment with Dr Bopitiya was only six weeks later. Further, some support for them can be drawn from the fact that a few months later, on 1 March 2010, the Claimant was described by her GP as "using walking stick, walked in ssttoped [sic], shaky, has lost weight".
68. Mr Post was highly critical of the manner in which Dr Simpson had given her evidence, submitting that she had been "anything but fair". He contended that she had inappropriately refused to accept during the joint expert process and cross-examination the "undeniable" proposition that the Claimant was not a consistent, accurate and reliable historian. I do not consider that this criticism was fair. As Ms Beale highlighted, this was an unusual question to see on an experts' agenda as such matters are primarily for the court. Further, when pressed in cross-examination, Dr Simpson expressed her views about the significance of inconsistencies in medical records (see [38] above) as she was invited to do. In my judgment her approach to this issue does not undermine her evidence in the manner Mr Post contended.
69. He also took issue with the manner in which she had answered certain questions on the agenda for the joint experts' meeting. These questions had specifically asked about symptoms of potential problems in the thoracic spine, the significance being that this would be suggestive of new pathology (the Claimant's existing back problems being in her lumbar spine). Dr Simpson had answered in general terms, referring to, for example, symptoms of a "widespread chronic pain condition" and "spinal cord problems". These answers were justified in that they reflected the central issue between the parties and thus the central issue for the court, namely whether there were any matters that required further investigation (whether related to the thoracic spine or not). While some greater specificity in her answers might have been more helpful, I do not consider that her approach to these questions showed she lacked independence.
70. There was one rather confusing element of Dr Simpson's evidence, in that during the joint statement process she had agreed that the history Dr Bopitiya had taken was reasonable. At the outset of her examination in chief she clarified that what she meant by this was that "the questions he asked were perfectly reasonable". She continued: "I did not mean that the assessment...dealt with all the matters". She was robustly cross-examined on this issue by Mr Post and at one point appeared to revert to the position in

the joint statement, leading him to submit that she had abandoned any attempt to suggest that the history taken was unreasonable. Looking at her evidence as a whole, I am satisfied that she remained critical of the history-taking by Dr Bopitiya. I note that (i) more than once, she drew a distinction between a pain history (which she accepted Dr Bopitiya had taken, and which was reasonable) and a broader “systemic” history which “isn’t about [pain]...it’s an enquiry about problems such as dizziness...shortness of breath, abdominal pains” and which would include “asking direct questions such as: do you have headaches? Are you generally well? Any chest problems?...Any urine problems? Any bowel problems?” (which she said he had unreasonably failed to take); (ii) when she was asked to accept that there was no basis for saying that Dr Bopitiya should have elicited a history of abdominal pain, she said that the Claimant “should have been asked” about those matters; and (iii) when pressed again about what she had said in the joint statement, she said “...the questions were reasonable, but I made it very clear in my report that the history wasn’t complete” and her final answer in this line of questioning was “It wasn’t unreasonable. The questions were very reasonable”.

71. Overall, I found Ms Beale’s criticisms of the way in which Dr Sanders gave his evidence more persuasive. On more than one occasion, in both the joint report and cross-examination, he sought to explain Dr Bopitiya’s actions by reference to information that Dr Bopitiya would not have seen specifically, the Claimant’s GP records and her later witness statement. This wider information led Dr Sanders to have doubts as to whether the Claimant had indeed experienced the lower leg symptoms she described to Nurse Brown. I agree with Ms Beale’s suggestion that this appeared to have “polluted” his view: the central question was whether Dr Bopitiya had acted appropriately in response to those reported symptoms, including investigating them further, and he had not done so. There were also concerns about how Dr Sanders had answered some of the questions on the joint statement: as Ms Beale noted in opening her case, his answers were narrow in focus and only commented on the question of whether the symptoms relating to leg weakness indicated any new thoracic spine pathology. He had not engaged at that stage with Dr Simpson’s point that the information was indicative of a spinal cord problem in general, which in itself would be a new pathology for the Claimant.
72. For all these reasons, I prefer Dr Simpson’s evidence on this issue. I find that the lower leg symptoms reported to Nurse Brown required Dr Bopitiya to investigate further.

(b): The apparent deterioration in the Claimant’s functioning from 2008

73. Dr Simpson’s evidence was that Dr Bopitiya should also have identified the clear deterioration in the Claimant’s functioning when he saw her, compared with when she had been seen by Dr May a year earlier. The Claimant was still employed when she saw Dr May and had been able to sit comfortably in a chair for 10 minutes and walk normally during her appointment. However, by the time she saw Dr Bopitiya, she was no longer employed, described herself as “bed-bound” and attended in a wheelchair.
74. Based on Dr Sanders’ evidence, Mr Post took issue with whether there was such a deterioration. He highlighted that when the Claimant saw Dr May, she was already off work due to her health, she was using a wheelchair outside the home, and she indicated in her responses to the questionnaire that her pain was dramatically affecting every aspect of her life, scoring its impact on her enjoyment of life as “10/10” and writing in

the word “none”. Dr Sanders said that “fluctuation in function” in a patient such as the Claimant is unsurprising. Dr Bopitiya said that in his experience the use of a wheelchair did not “reflect any neuro compression with a weakness”: he saw a lot of patients who were in wheelchairs but without having “a significant deterioration in the spine pathology”.

75. In cross-examination, Dr Simpson accepted that she should have been clearer about the Claimant’s employment status at the time of the Dr May assessment but noted that she had “only just been signed off”. Overall, she maintained her view as to the Claimant’s deterioration in function: “I think it is a fair picture because when [the Claimant] saw Dr May she had been working up until a couple of months before then. She had hoped she was going back to work, was frightened of losing her job. Could sit comfortably for ten minutes. She walked into the consulting room. Her spine moved well and that was a very different picture to the picture with Dr Bopitiya. In addition, when she saw Dr May in 2008 she was profoundly depressed and that will have had an influence on her reporting and needs to be taken into account”.
76. Moreover, both Dr Bopitiya and Dr Sanders accepted that there had been a functional decline between the Dr May and Dr Bopitiya assessments, albeit emphasising that function changes over time with chronic pain, thereby asserting that the functional decline was not necessarily indicative of new pathology.
77. Mr Post submitted that there was an illogicality in Dr Simpson’s evidence on this issue because she accepted that it was reasonable for Dr May not to order a scan, and so she could not reasonably contend that Dr Bopitiya should have done it. I do not accept that Dr Simpson’s position was illogical: she had identified certain features which she considered evidenced a deterioration that justified her view that Dr Bopitiya should have taken a different step to Dr May. She also drew a clear distinction between Dr May’s assessment of the Claimant by comparison to Dr Bopitiya’s: “[Dr May] had performed...what I consider to be a more detailed examination. He had got her on the couch. He’d checked her limb movement, checked her sensation... That and her history reassured him that there was nothing new.”
78. I accept Dr Simpson’s evidence on this issue, for the reasons set out under section (a) above, and because her view that the deterioration in functionality might evidence new pathology, when taken together with the lower limb symptoms reported to Nurse Brown, was a logical one, which was consistent with the role of a pain physician.

(c): The right hypochondrial/iliac fossa pain reported to the Claimant’s GP

79. Dr Simpson’s view was that Dr Bopitiya should have taken a clear history of systemic problems, to include abdominal problems, especially as the Claimant had reported that she had nocturnal pain disturbing her sleep, which is a potential red flag for cancer.
80. Ms Beale contended that it was likely that if such an enquiry had been made, the Claimant would have given the history of the right hypochondrial/iliac fossa pain she reported to her GP on 11 November 2009, particularly as she had undergone an ultrasound scan in respect of this less than three weeks before the appointment with Dr Bopitiya. This was, on Mr Radatz’s evidence, a potential sign of pain spreading from the thoracic spine area. He had said in his report that “the unilateral radiation of pain

into the hypochondrium and iliac fossa” would not be explained by the Claimant’s spondylolisthesis.

81. I am not persuaded to the balance of probabilities standard that the Claimant would have disclosed the contents of the 11 November 2009 GP report. Although she told the GP she had had the pain for two weeks, she did not mention it to Nurse Brown on 9 November 2009. There is no evidence in the GP notes that this was a recurring or prominent issue for the Claimant at that time. She had attributed the pain herself to a curry and the scanning her GP ordered had not revealed any problems. The Claimant did not suggest that she volunteered any history of abdominal pain to Dr Bopitiya. When asked about it in cross-examination, she robustly said “No, never had any pain in the abdomen”. Accordingly, while it is possible that she would have raised this issue with Dr Bopitiya in the context of a systemic history, I am not satisfied that it is more likely than not that she would have done. In fairness, Ms Beale did not place great reliance on this aspect of Dr Simpson’s reasoning and neither did Dr Simpson: she said that “[m]issing the abdominal symptoms alone” was “not a huge issue”.

(d): Overall conclusions with respect to the 2009 appointment

82. Accordingly, I accept Dr Simpson’s clear and logical evidence that the lower leg symptoms reported to Nurse Brown and the deterioration in the Claimant’s function since the Dr May assessment mandated Dr Bopitiya to investigate further, so as to exclude new treatable pathology, and to do so by ordering an updated MRI scan and conducting a full neurological examination of the Claimant.
83. I also accept Dr Simpson’s evidence that Dr Bopitiya should have taken a systemic history, but I am not persuaded that this would have revealed the history of right hypochondrial/iliac fossa pain reported to the Claimant’s GP.
84. If Dr Bopitiya had ordered an updated MRI scan, this would have revealed the prolapse, as noted under Issue (2) below.
85. Dr Bopitiya suggested in his oral evidence that he might not have performed an examination because the Claimant was unable or unwilling to cooperate because of pain. There was no suggestion of this in his notes. The Claimant had been fully examined by Dr May; and would go on in March 2017 to be examined by several clinicians when she was in very severe pain. For those reasons, there is no basis for concluding that she would not have cooperated with an examination by Dr Bopitiya.
86. Ms Beale submitted that if Dr Bopitiya had conducted a full neurological examination of the Claimant, this would have led to a finding of new brisk or abnormal reflexes, which would have mandated referral for an MRI scan or neurological opinion, with a scan being the most likely outcome. However, I am not satisfied to the balance of probabilities standard that the Claimant’s reflexes on testing would in fact have been brisk or abnormal, for the reasons set out at [172] below. The neurosurgery evidence is similarly unclear as to whether if Dr Bopitiya had examined the Claimant’s spine more fully, the prolapse would have led to exquisite tenderness.
87. Accordingly, I conclude that Dr Bopitiya acted in breach of duty in failing to order an updated MRI scan or conduct a full neurological examination of the Claimant. To quote

the agreed expert evidence, these were “appropriate assessment and investigations” which were necessary before his treatment plan could be considered reasonable. However only the failure to order an MRI scan had any causative consequence.

(ii): The 2010 appointment

88. Ms Beale contended that by failing to take an adequate history from the Claimant and failing to examine her at the 2010 appointment, Dr Bopitiya failed to rectify and indeed compounded the negligent omissions in the 2009 appointment.
89. While Dr Sanders’ evidence at trial was that all reasonable pain physicians would at least have enquired as to the extent of a patient’s pain as a form of update at a follow-up appointment, neither Dr Bopitiya’s note of the appointment, nor his subsequent letter contain any reference to him seeking such an update. He had no independent recollection of the appointment, although he suggested at trial that there had been no change in her condition. I am satisfied to the balance of probabilities standard that he did not obtain any updated history from the Claimant. His note also records no examination of the Claimant during his appointment. I am satisfied that no such examination took place.
90. For the reasons discussed in section (i) above, I accept Dr Simpson’s evidence. On this issue, she said that in the absence of any reasonable neurological examination at the first appointment, and as it was now very clear that the Claimant felt she would not be assisted by psychological input, it was mandatory for Dr Bopitiya, in the light of the known history, to ensure that a neurological examination covering power, sensation and reflexes was carried out.
91. Accordingly, I conclude that Dr Bopitiya further breached his duty by failing to take an adequate history or conduct an examination at the 2010 appointment.

(iii): Advice on surgery

92. The experts agreed that detailed discussion of the benefits and burdens of spinal surgery including its potential risks is not a matter for pain physicians but for surgeons. Dr Sanders also agreed in cross examination that if a clinician is definitive about an intervention that falls outside their area that would go beyond their remit.
93. Ms Beale submitted that Dr Bopitiya exceeded his remit as a pain specialist and thus breached his duty of care by the definitive advice he gave the Claimant on surgery during the appointment on 24 December 2009. This was made clear from his notes (“Explained to patient that no surgery or injection will [sic] going to help”) and later letter (“I have also explained that at this stage surgery or injections is not going to help her pain”). She contended that he fell into the same error during the 30 September 2010 appointment: his later letter made clear that he had discussed surgical options with her “in detail”.
94. I agree that this advice was definitive in tone. I also accept Ms Beale’s submission that Dr Bopitiya’s evidence supported her case on breach of duty: he explained the detail of the discussions he had had with the Claimant about surgery and then sought, but struggled, to justify them. Dr Sanders accepted that Dr Bopitiya’s advice focused on

the burdens or risks of surgery rather than any benefits, which compounded the problem, as it meant he was only giving the Claimant one side of the story.

95. Accordingly, I find that Dr Bopitiya further breached his duty by giving the Claimant advice on surgery which was not within his remit.

Issue (2): If a scan had been ordered, would a surgeon have advised the Claimant to undergo surgery for the thoracic disc prolapse in 2009/10?

96. Mr Radatz and Mr Wilby agreed that the Claimant's disc prolapse was present in 2009 and would have been identified on an MRI scan, including a scan of the lumbar spine, if Dr Bopitiya had ordered it on or after 24 December 2009. However, whether surgery would have been offered to the Claimant depended on whether the disc was symptomatic in 2009. If it was, the Defendant conceded that the Claimant would have been offered surgery. If it was not, surgery was unlikely: Mr Radatz said that in those circumstances disc surveillance would be the normal recommendation and surgery would be very unusual.
97. Mr Radatz gave consistent evidence that the disc was symptomatic in 2009. He relied on (i) the symptoms recorded by Nurse Brown on 9 November 2009, including falling downstairs and give-way weakness, which were indicative of thoracic disc prolapse; and (ii) the 11 November 2009 GP record of right hypochondrial pain, tenderness in the right iliac fossa and "colicky" pain (ie. intermittent and spasmodic pain, mimicking cholecystitis). He said the matters at (ii) were well-recognised, albeit unusual, presentations of disc prolapse at the T11 level. In these circumstances, the abdominal pain is caused because the T11/12 disc nerve root innervates the kidney, the urethra, part of the colon and the duodenum. While such pain could also be caused by an upset stomach, this did not appear likely here as the Claimant had not reported diarrhoea and vomiting, which would usually accompany an upset stomach; and her GP seemed to think that there was something else occurring as he referred her for an urgent abdominal ultrasound.
98. Mr Radatz's evidence as to the progression of the disc was as follows. Although the prolapse was symptomatic in 2009/10, it was likely that the Claimant's pain had not persisted because it was, at that time, a soft disc prolapse. The disc had later altered its position within the spinal canal so that it was no longer causing nerve root impingement but continued to compress the spinal cord causing lower limb weakness and mobility difficulties. A limitation of cord function, arising from a thoracic disc prolapse, can progress gradually over years. In the Claimant's case, there had been a deterioration in her condition during 2009/10, and subsequently, she had limited her activities to a very significant degree, meaning that the irritation of the spinal cord had not progressed as it would in someone leading a more active life. The symptoms did then progress in 2017 when the Claimant had to take on a more active role looking after her husband following his car accident.
99. Mr Post took issue with his reliance on the Claimant's abdominal pain. He argued that in light of his concession that there no was nerve root impingement in 2009 or 2017, and no suggestion that it had developed in between those two dates, it could not be suggested that the Claimant was suffering any pain symptoms referable to the disc. However, as Ms Beale pointed out, it was not suggested by Mr Radatz that the

abdominal pain had persisted throughout the period: rather, it was relied on by him to pinpoint when the prolapse occurred. He had also relied on the give-way weakness to reach that conclusion.

100. Mr Post challenged Mr Radatz's reliance on the Claimant's alleged increasing mobility issues and decline in function after 2009. He submitted that the Claimant had never given evidence of leg weakness; that in 2008 the Claimant's husband and son were already doing chores for her; and that as late as spring 2017, she was able to walk to Basildon Hospital with one stick. On balance I conclude that there was a sound basis from the totality of the Claimant's medical notes from 2009-March 2017 for Mr Radatz's view that, overall, she had experienced a deterioration in mobility and function. There was some evidence of give-way weakness in the form of the Nurse Brown assessment in 2009. She had gone from being able to work and walk normally without a stick in 2008 to being unable to work or walk without a stick in 2017 (and, indeed, was already being described in March 2010 by her GP as walking in a "sttoped [sic], shaky" fashion). In any event, as Ms Beale rightly contended, deterioration in the Claimant's case was unlikely to be precisely linear given that she was also disabled by pain.
101. Mr Post was also critical of the manner in which Mr Radatz gave his evidence. He submitted that (i) he had said in answer to question 5 of the joint statement that the Claimant's "upper back pain" was due to the thoracic disc prolapse, but there was no evidence that she had suffered this; (ii) when summarising the 11 November 2009 GP appointment in his chronology, he purported to transcribe the notes but omitted the likely explanation for the pain in the form of the words "traces it to a curry she had few weeks ago"; (iii) in his report he omitted the key evidence as to the appearance of the disc on MRI scanning on 21 March 2017; (iv) he claimed to have assessed the imaging, but nowhere set out his conclusions on it; (v) he had failed to refer to the Brief Pain Inventory completed ahead of the Claimant's assessment with Dr May, which was important evidence as to her baseline functioning in 2008; and (vi) his oral evidence about the thoracic pain was unimpressive, ranging from a "typical" sign of a thoracic disc prolapse" to "an unusual...[but] well-recognised pathology" to a "rare pathology".
102. I accept Ms Beale's submissions that these criticisms do not fundamentally undermine Mr Radatz's evidence. Adopting the same numbering: (i) it was not clear that this an error (as Ms Beale contended that the Claimant had reported upper back pain to the ambulance crew in March 2017), but if it was, it did not detract from Mr Radatz's principal points that the prolapse was causing hypochondrial/iliac fossa pain and then mobility decline, as explained in the remainder of his answer to question 5; (ii) Mr Radatz provided an explanation for not mentioning the curry issue, which was that having reviewed the records he did not consider the pain was attributable to a gastrointestinal upset and explained why; (iii) was a semantic point; (iv) Mr Radatz's answers, read fully, made clear that he had reviewed the scans; (v) he clearly was well aware of the Claimant's function at the time of the Dr May assessment and had carefully considered whether it had deteriorated thereafter by reference to her use of walking sticks, a wheelchair; and (vi) during the trial he moderated but did not fundamentally change his evidence as to the thoracic pain.
103. I found that there were greater difficulties with Mr Wilby's evidence on this issue. His

position by the end of the trial was that the disc was present in 2009/10 but was asymptomatic. However, as Ms Beale highlighted, this involved a significant shift in his evidence. In his report, he had used the fact that the disc was symptomatic as the basis for his conclusion that the prolapse was in existence in 2009. He had noted the references to give-way weakness in the medical notes at that time. He opined that as soon as calcified thoracic discs start to cause symptoms; they are fully developed. Mr Wilby then resiled from this position during the joint statement process, agreeing with Mr Findlay that the Claimant's thoracic disc prolapse only became symptomatic in March 2017, without explaining why (despite the instruction in the agenda that experts should explain any changes in their views).

104. It was only during his evidence in chief that he provided his rationale for his change of view. He said that his conclusion that the disc was present in 2009/10 was, in fact, based on its appearance as a "really calcified longstanding disc" that had blended with the dura (the lining of the spinal nerves). His view now was that the disc was present, but not symptomatic, in 2009/10. This was because he had been reminded of the fact that once patients start to deteriorate, they generally carry on deteriorating, typically over a period of around two years. On that basis, the Claimant would have been paraplegic by 2011 anyway, and she was not. Logically, therefore, the prolapse must have been asymptomatic in 2009. In cross-examination, Mr Wilby indicated that his change of view had come about as a result of discussions with Mr Findlay, but this issue does not appear in Mr Findlay's report; and Mr Wilby had not given this explanation in the joint statement.
105. Ms Beale contended that Mr Wilby's new evidence was illogical. In the absence of an MRI scan from 2009/10, the only clear way of knowing whether it was present or not was that it was symptomatic. There was force in this point: as Mr Radatz explained, the calcification and penetration of the dura only indicated that the disc had been there for a long time but did not provide an indication of when the prolapse occurred.
106. I also accept her submission that Mr Wilby's generalised assertion in respect of a normal timeframe for deterioration was unconvincing. He cited no literature in support of this proposition. It also appeared inconsistent with his original report, where he had suggested that progression may occur over a long period of time: he said that a thoracic disc presents usually with painless discoordination and weakness of the legs which ultimately, if untreated, can result in "gradual decrease in power and function of the lower limbs and the possibility of bladder and bowel incontinence".
107. Mr Wilby in fact made several concessions with respect to Mr Radatz's evidence. He accepted that pain originating at T11 could come to the level of the belly button and thus could possibly be described as hypochondrium pain; and that the right inguinal region is near to the right iliac fossa, where the GP found tenderness on 11 November 2009. He agreed that it was possible for colicky pain to be a presentation of disc prolapse at this level. He agreed that it was "entirely possible" for a thoracic disc prolapse to progress in the way described by Mr Radatz (albeit that he thought it highly unlikely). He also agreed that there was likely to be more wear and tear on the disc/cord in more active than less active people.
108. Ms Beale also pointed to an occasion when Mr Wilby had been willing to stray outside of his areas of field of expertise. He had asserted in the joint statement that the

Claimant's history of seizures was due to "non-organic pathology". However, he had been forced to accept in cross-examination that this was misleading as he is not an expert in neurology or functional neurological disorders and no neurologist or epilepsy doctor had found the Claimant's seizures to be non-organic.

109. Mr Wilby was clear that he did not often see soft discs in the thoracic spine in his clinical practice. Accordingly, the fact that he appeared to perform more surgeries per year than Mr Radatz did not take matters much further.
110. Put simply, Ms Beale's case was that the Claimant had, in late 2009, reported new signs and symptoms consistent with a thoracic disc prolapse (falls and give-way weakness in the legs and right hypochondrium/iliac fossa pain), in circumstances where the experts agree that she did in fact have a large such prolapse. On that basis, it was more likely than not that those symptoms arose from that thoracic disc prolapse. Thereafter, Mr Radatz had provided a clear and logical basis for the nature of the progression of the disc in the Claimant's case, bearing in mind the evidence of her variation in function, namely that it was slower to progress in her than it would have been in a more active person: see [98] above. I accept this analysis. For the reasons set out above I prefer Mr Radatz's evidence to that of Mr Wilby on this issue.
111. Accordingly, I find that the disc was symptomatic, and a surgeon would have advised the Claimant to undergo surgery for the thoracic disc prolapse in 2009/10. The answer to Issue (2) is therefore "Yes".

Issue (3): Would the Claimant have elected to undergo surgery for the thoracic disc prolapse if it had been offered in 2009/10?

112. The Claimant was clearly very reluctant to undergo surgery for her L5/S1 spondylolisthesis. In her oral evidence, she said that she was "scared to death" at the thought of having surgery and of hospitals in general; that she did not want to go in one; and that she would "fight" the suggestion that she did. Moreover, it is clear, as Mr Post rightly contended, that the Claimant was unwilling to have this surgery despite being "grossly disabled" by the spondylolisthesis when she saw Drs May and Bopitiya and knowing that the purpose of the surgery was to help with the very severe pain she was suffering in her legs and back.
113. Notwithstanding this, the Claimant's evidence was that if she had been advised that the thoracic disc prolapse could result in paralysis, she would have undergone the surgery recommended: "...they would have told me that the spinal damage if I didn't have it and then I could end up paralysed, so obviously I would have had the surgery".
114. Mr Post contended that it was clear the Claimant did not wish to undergo surgery for her severely disabling lower back and leg pain; and so, she would not have opted for surgery to address the much less significant problems caused by the thoracic disc. He invited me to reject her evidence on this issue.
115. In approaching this question, I am very mindful of the guidance in *Smith v Barking, Havering and Brentwood HA* [1994] 5 Med LR 285 to which Mr Post referred, emphasising the need to treat with caution assertions made at trial as to what a Claimant would have done. I also take into account the very firm views the Claimant expressed

against the idea of surgery for the spondylolisthesis as noted in the preceding paragraph. However, on balance, I accept the Claimant's evidence as to the option of surgery for the thoracic disc prolapse for the following reasons.

116. First, the Claimant's reluctance to have surgery for her spondylolisthesis needs to be seen in its full context. Although she had been referred for an appointment at the RNOH for consideration of spinal fusion in 2002, there is no record of such an appointment, and she did not recollect going to the RNOH before 2017. The Claimant had therefore never been fully advised about the option of surgery for her spondylolisthesis by the appropriate experts. Further, she had been told by her treating doctors that spondylolisthesis was a "painful nuisance and something I would have to live with"; one had suggested to her that it might not improve matters; and she had heard about other patients who found they were in more pain after fusion surgery. In 2009, she was advised in definitive terms by Dr Bopitiya that no surgery was going to help her pain.
117. Second, she frankly accepted that she was reluctant to undergo surgery for her spondylolisthesis but made clear that the prospect of surgery for the thoracic disc prolapse was different. Her evidence on this issue was clear, consistent, and credible.
118. Third, the reason for the distinction drawn by the Claimant had a logical basis. It related to the fact that the underlying purpose of the two types of surgery varied. The surgery for the thoracic disc prolapse was intended to reduce the risk of the Claimant being paralysed. As Mr Radatz explained, in circumstances where the prolapse was already symptomatic, the Claimant would have had to have been advised that, in the absence of surgery, "she is at high risk of trauma causing further cord damage immediately with a loss of function or total or permanent paralysis and double incontinence". Mr Wilby said that such surgery "stops you getting worse 90% of the time". There was also the possibility of improvement: Mr Wilby accepted in cross-examination that on average patients increase by one grade of neurological function. That would have been the basis on which the Claimant made the decision about surgery.
119. Fourth, the Claimant had been clear that retaining some mobility was key for her. In further addressing the issue of surgery for her spondylolisthesis, she said "I decided I'd wait till I was up to a point where I couldn't bear it any more... I wanted to leave it... to the last possible moment". She referred to the fact that she was still able to walk at this point. She said that it was only if she "faced the prospect of not being able to walk at all" that she would have considered surgery. That was effectively what she would have been told if she had been advised about surgery for the thoracic disc prolapse: see the reference in Mr Radatz's evidence to "total or permanent paralysis" at [118] above.
120. Fifth, the Claimant's evidence about what she would have done if offered surgery in 2009/10 is consistent with her evidence to the effect that she would have attended hospital in March 2017 if she had been told that otherwise she could be paralysed and that this explained why she had not attended hospital. She said that being told about being "potentially paralysed" would have "frightened the life out of me. I wanted to be mobile".
121. Sixth, it is consistent with the fact that she did elect to undergo a thoracotomy, which the experts agreed is major surgery and involved significant risks, in March 2017. This supports the suggestion that she would have agreed to this surgery in 2009/10, albeit

that Mr Radatz's evidence was that there might have been a less intrusive option available at that point, on the basis that the disc would have been soft and not calcified in 2009/10.

122. I therefore find, on the balance of probabilities, that the Claimant would have undergone surgery for her thoracic disc prolapse in 2009/10 if this had been offered. I answer Issue (3): "Yes".

Issue (4): Did ENP Nice act in breach of duty in failing to undertake a proper neurological examination?

123. The Claimant's case, in summary, was that ENP Nice's note did not accurately record the history she took and the examination she carried out; but that even if the note was accurate, the assessment ENP Nice carried out would not be supported by a responsible body of ENPs in certain respects.

(i): ENP Nice's pregnancy and the impact on her work duties

124. The Claimant's evidence and that of her husband and son was that ENP Nice told them that she was 6/7 months pregnant and gave an indication that this would limit her ability to examine the Claimant; and that she then proceeded to carry out a much more limited examination than that recorded in her note. ENP Nice denied mentioning her pregnancy and said she carried out all the elements of the examination recorded in her note, and others.
125. ENP Nice was, in fact, nearly 7 months pregnant at the time of the examination. Her pregnancy had, in fact, limited her working practices: a risk assessment disclosed by the Defendant late in the pre-trial process made clear that as well as not undertaking limb manipulations, she was advised not to carry out activities which included "repeated strenuous movements such as bending, stretching, twisting or lifting", and to adjust patient assessments to accommodate this. The assessment also noted that she had expressed concerns about bending to assess limbs and had been advised to either ask the patient to lift their own limb high or to have a stool available to assess limbs. ENP Nice's witness statement was to the effect that she worked "normally". However, she corrected this in evidence in chief to explain that there were two things she could not do at all (manipulation of Colles fractures and shoulder dislocations) but that her other working practices, including those used for assessing limbs, had been modified.
126. The Claimant's position that ENP Nice was pregnant and that this impacted on the examination was made clear long before any disclosure in these proceedings setting out the matters referred to in the preceding paragraph. ENP Nice confirmed in her oral evidence that she would not have told the family in any other context that she was 6/7 months pregnant; and Stephen Chapman said that prior to ENP Nice's comment, he had not appreciated she was pregnant.
127. I agree with Ms Beale that if ENP Nice had not mentioned her pregnancy, it would be a surprising coincidence for the Claimant and her family to have guessed that she was pregnant, how far along she was, and that this impacted on her work. It therefore appears likely that something was said about ENP Nice's pregnancy and the impact this had on her work during the consultation.

(ii): General observations about the plausibility and reliability of each party's case

128. In assessing the wider allegations of the Claimant and her family as to the nature of the examination ENP Nice carried out, I have found it helpful to consider the various “plausibility theories” proposed by counsel, in accordance with *Gestmin* and *Barrow* (see [30] and [34] above).
129. Mr Post contended that it was highly improbable that any nurse, let alone one as professional as ENP Nice, would refuse to examine a patient, especially one presenting with a history of a serious deterioration in her condition; would fail, if for some reason they could not conduct the examination, to refer the patient on to a colleague; and would instead fabricate a series of findings in relation to an examination they had not performed. A nurse would have nothing to gain from behaving in that way. In fact, they would have a lot to lose, in that they would be likely to face very serious professional consequences. He drew support from the evidence of Claimant’s nursing expert, Mr Paynter, to the effect that a refusal to examine a patient in the face of a highly alarming history would be “outlandish”; a refusal to ensure examination by a doctor instead would be “nonsensical”; and recording an antalgic gait in a patient who could not, in fact, walk would be “extraordinary...nonsensical and incomprehensible”. I found all of these factors persuasive.
130. The Claimant’s case with respect to some parts of ENP Nice’s note was, effectively, that she had conducted a more limited examination due to her pregnancy and then fabricated her notes to conceal that fact. I did not consider this logical. All the available evidence suggested that her employers were, quite rightly and in accordance with their legal obligations, seeking to protect her during her pregnancy; and working with her to ensure she could carry out her responsibilities safely, modifying them as appropriate. It was not therefore clear to me why she would have anything to fear by operating within those limits and seeking help as needed.
131. Ms Beale suggested that the most likely explanation for ENP Nice making an untrue note of the Claimant taking steps was that she considered the Claimant was dramatising her condition and that she was in fact capable of taking steps. I struggled to accept this for the reasons set out at [149]-[150] below.
132. On the other side of the general “plausibility” balance, Mr Post suggested that the Claimant’s husband, son and daughter, who all gave evidence about some aspects of the examination conducted by ENP Nice, might be giving inaccurate evidence due to family loyalty to the Claimant. He contended that all of the family’s evidence might be inaccurate due to their obvious collective dissatisfaction with Basildon Hospital leading them to recall events there in a negative light and/or a process of combined recollection of dramatic events with, as they see it, disastrous consequences. Taken together with the general difficulties with memory highlighted in *Gestmin*, I found these factors persuasive potential general explanations for the discrepancy between the competing accounts.
133. For all these reasons, my overall starting-point was that ENP Nice’s account of the examination was more plausible, and thus more likely to be accurate, than the account of the Claimant and her family.

134. I was fortified in this view by some wider concerns about the reliability of the evidence from the Claimant. Her witness statement was shown to be wrong in parts: for example, she had said no surgeons or doctors had discussed surgical options with her other than Dr Bopitiya and one other, but had to acknowledge in cross-examination a series of such conversations. Her amended List of Documents asserted that she had thrown away all the paperwork relating to her benefits, but then some was located at her home while she was giving evidence and she referred to other such material which she had sent to her solicitors, but which appeared to have got lost in the post.
135. There were also some broader concerns about Stephen Chapman's evidence. Under cross-examination he accepted that Dr Macaulay had advised him to take the Claimant to hospital on 13 March 2017. Ms Beale optimistically sought to characterise this as a concession that illustrated his desire to assist the court even when the same would not help his wife's case. However, in reality, it was an entire reversal of the relevant part of his witness statement, on which the claim against Dr Macaulay had largely been based and which was discontinued shortly after he gave his evidence. The two complaint letters he had written to Basildon Hospital shortly after the Claimant's examination by ENP Nice were also inconsistent with the claim advanced at trial, principally in the suggestion made therein that ENP Nice had said she could not touch the Claimant at all, whereas at trial it was accepted that she had conducted some form of examination, albeit one that was said to be inadequate.
136. I turn now to the specific issues raised in the evidence and submissions.

(iii): The history taken by ENP Nice

137. Ms Beale invited me to reject ENP Nice's evidence as to the history she had taken from the Claimant in three respects.
138. First, she submitted that ENP Nice's evidence that a history of a sudden loss of power/control in the legs was not given to her by the Claimant was out of kilter with the accounts the family members gave to other clinicians around this time. She referred to (i) Mr Chapman's description to Dr Macaulay on 8 March 2017 of her "collapse" in the toilet; and (ii) the transcript of his 999 call, referring repeatedly to "collapse", a fall to the floor, shaking legs and legs giving way underneath her. She contended that the Claimant's collapses on 8 and 9 March 2017 were the key reasons for her attending hospital; such that it is inconceivable that neither she nor her family would have mentioned them to ENP Nice, as they all gave evidence they did. This was especially so given that she was not a regular visitor to hospital and was generally mistrustful about hospital treatment, such that something out of the ordinary must have happened that led her to attending hospital on this day.
139. However, as Mr Post highlighted, there was contemporaneous evidence going the other way, in that (i) on the face of the records of the ambulance staff, the Claimant had given no history of a sudden loss of power/control in the legs had been reported to them; and (ii) the same was true of the hospital triage notes, which record "pt known to have a bad back, recent few weeks increased pain to lower back". These documents, completed by different medical professionals, mean that I cannot be satisfied that it is more likely than not that the Claimant reported this history to ENP Nice.

140. Second, Ms Beale contended that ENP Nice failed to elicit during the history-taking that the Claimant's pain had suddenly worsened the previous day and was different in nature and location.
141. There was a conflict in the contemporaneous documentation: while the ambulance staff recorded that the Claimant had had an onset of back pain on the previous day and that she had pain in the kidney area (which was a new location), the triage notes do not refer to these matters. Accordingly, they offer limited support for Ms Beale's contention.
142. The family's consistent evidence was that the Claimant had told ENP Nice that her pain was "like a bear clawing at the inside of her ribcage". It was agreed by Ms Brown that as the kidneys are situated at the lower end of the ribs, complaints of ribcage pain are potentially consistent with pain in the kidney region. However the evidence from the Claimant and her family on this issue was, in my judgment, problematic. This very graphic description did not feature in Mr Chapman's initial complaint, the letter of claim or the Particulars of Claim. The Claimant's evidence was that she used this phrase to both the ambulance staff and ENP Nice. Mr Paynter accepted that, had this "descriptive and concerning" phrase been reported as alleged, it would have been "very unusual" for a medical professional not to record it. There is no mention of this phrase in the notes from either the ambulance staff or ENP Nice. On balance, I do not consider it likely that this phrase was used.
143. In any event, I am satisfied that ENP Nice examined the Claimant's kidney area for the reasons given at [178]-[180] below.
144. Third, Ms Beale argued that ENP Nice had failed to record the Claimant's explanation that she was experiencing bladder urgency in the form of difficulty holding on when she felt the urge to urinate. Again the documentary evidence from both before and after the examination by ENP Nice does not support the proposition that the Claimant was likely to have reported this: (i) the ambulance staff notes record the Claimant denying difficulties with her bladder; (ii) the handover/streaming note records "NO urinary incontinence"; and (iii) Dr Macaulay's witness evidence was that he specifically asked the Claimant about urinary difficulties when he saw her a few days later on 13 March 2017 and would have noted any concerns, which he did not (albeit that I appreciate his evidence was not tested at trial).
145. For all these reasons I find that ENP Nice's note accurately records the history she took from the Claimant and there was no breach of duty in this regard.

(iv): The examination conducted by ENP Nice

(a): The Claimant's ability to take steps

146. The most fundamental dispute between the parties in relation to Issue (4), and indeed in the whole trial, was as to ENP Nice's evidence that the Claimant had been able to take steps during the assessment and that she had an antalgic gait when doing so. ENP Nice accepted at trial that by taking steps, she meant taking a couple of steps without crutches.

147. The consistent evidence of the Claimant and her husband and children, maintained under cross-examination, was that she could not walk at all, even on crutches. Ms Beale drew support from the contemporaneous documents, namely: (i) Dr Macaulay's 8 March 2017 note that the Claimant had collapsed in the toilet; and (ii) Mr Chapman's description during the 9 March 2017 999 call of how her legs "gave way" underneath her.
148. I have found this issue a finely balanced one. Ultimately, I have concluded that I cannot accept the evidence of the Claimant and her family.
149. I have given careful consideration to Ms Beale's contention that the most likely explanation for ENP Nice making an untrue note was that she considered the Claimant was dramatising her condition and that she was capable of taking steps. She contended that this was supported by the tone of ENP Nice's note and discharge summary and the fact that she did not give "safety netting" advice, which suggested she wished to pass the "problem" of the Claimant back to her GP rather than have her return to hospital.
150. However, ENP Nice's note had already made clear that she had doubts about the accuracy of what the Claimant was saying to her: after recording that the Claimant had an "antalgic gait" and was "PWB" (Partially Weight Bearing), she specifically noted "States can't walk but taking steps for assessment". She was not concealing that she thought the Claimant was dramatising her condition. On that basis, if the Claimant's account was correct, ENP Nice could just as easily have written something to the effect that the Claimant had not been able to walk during the assessment, but that she doubted that this was an accurate representation of her functionality. She could have taken such a course without visiting upon herself the very significant professional risk she would run by positively asserting that the Claimant could take steps when she could not.
151. Further, I did not consider it realistic to "read in" to the lack of written safety netting advice the disparaging or dismissive attitude towards the Claimant contended for by Ms Beale. I accept ENP Nice's evidence that she "definitely" gave this advice orally: it was part of her routine with every patient to advise them to return if symptoms worsen or change.
152. In addition, one part of Mr Chapman's second complaint letter dating back to August 2017 said that his wife "just about managed" to take a step, albeit with the crutches, when asked to do so by ENP Nice.
153. I have also had regard to the greater plausibility of ENP Nice's account on the nature of the examination and my wider concerns about the evidence of the Claimant and her husband, as set out at [129]-[136] above.
154. For all these reasons I prefer ENP Nice's account of the Claimant's ability to take steps and find that her note in this respect was accurate.

(b): Assessment of power

155. ENP Nice recorded 4/5 power bilaterally in hip flexion and extension, knee flexion and extension, ankle dorsiflexion and plantar flexion and toe flexion.

156. Ms Beale relied on the family's evidence that ENP Nice conducted a very limited assessment of power: simply moving or bending her right leg and asking her to push it back down (the Claimant's account) and/or testing whether she could push her legs back against resistance, with ENP Nice's hands on her toes (Stephen and Andrew Chapman's account, with the latter detail only coming from Stephen Chapman). It is notable that their accounts were not entirely consistent on this issue.
157. She calculated that all of the results noted by ENP Nice would have required her to carry out 14 separate assessments, which ENP Nice accepted. She contended that ENP Nice simply could not have done this without bending, stretching and lifting, which were contrary to her pregnancy risk assessment. Ms Beale contended that ENP Nice had identified that the Claimant had some ability to push back against resistance and so justified a score of 4/5 power; and had then wrongly applied this score to all the lower limb myotomes (groups of muscles), even though it did not properly assess any myotome. She suggested that had a proper assessment of power been undertaken, ENP Nice would have identified a differential in power between the Claimant's two legs, as Dr Macaulay had done when he saw her on 13 March 2017.
158. The pregnancy risk assessment advised against "repeated strenuous" bending, stretching and lifting, and it does not appear that these assessments of power would have required that. The evidence that Dr Macaulay identified a differential in power on 13 March 2017 is unclear: he simply said in his witness statement that he decided not to assess her left leg given the level of pain she was in when he raised her right leg, and he was not cross-examined about this. Accordingly, this does not evidence that ENP Nice's assessment was deficient in the manner alleged by Ms Beale. For these reasons, and for those set out at [128]-[135] above, I prefer ENP Nice's evidence as to the assessment of power she carried out and do not accept that she fabricated her notes in this way.

(c): Saddle sensation

159. ENP Nice recorded that the Claimant had no saddle anaesthesia (i.e., reduced sensation in the area that would be in contact with a saddle if sitting on one). It is agreed that she elicited this by asking the Claimant a question about this, as the ambulance crew had done.
160. Ms Beale contended that ENP Nice failed to go further and carry out the mandatory physical examination of the saddle area, on the basis that (i) the Claimant's clothing remained on (and Ms Brown agreed that it would be necessary to remove her trousers and underwear from around the anal and perianal area to do so); and (ii) the Claimant's son remained in the room at the relevant time (which the Claimant said she would not have permitted and which ENP Nice agreed would not have been appropriate). Further, the experts' position that there was no need to perform a per rectum examination was premised on their being no findings of altered sensation. Ms Beale rightly highlighted that if the sensation had not been tested, this was not a safe conclusion.
161. However, ENP Nice's evidence in her witness statement was clear that she had carried out this examination: she said that she "felt from the pelvis down" and felt "around the anal area". When it was put to her that she had missed out this part of the examination and satisfied herself with the Claimant's answer to her question on the issue, she was

adamant that this was not the case: “No way”. She was also clear that she could “work around” the Claimant’s clothing. She appeared to suggest that if someone was wearing thin pyjamas she could feel the groin through them. I also refer to the reasons set out at [128]-[135] above for finding her account more plausible. For these reasons I accept ENP Nice’s evidence that she did conduct this assessment.

(d): Deep tendon and plantar reflexes

162. ENP Nice’s note records no assessment of deep tendon or plantar reflexes, which was agreed by the nursing experts to have been a mandatory part of the examination.
163. Her evidence was that she did assess the Claimant’s reflexes, as although she could not specifically recall doing so, this was “so ingrained as part of my routine that there is no way it would have been missed out”; it was an “integral part” of her examination; and “any abnormality would have been noted”. She said she took a systematic approach to her examinations such that she would not have moved on from the part concerning reflexes until she had completed it; and she had simply failed to record the results due to human error and working in a busy A&E department. She maintained her position under robust cross-examination on the issue.
164. Mr Post drew support from Mr Paynter’s evidence to the effect that ENPs have a set routine which they work their way through; and that the pressured nature of work in emergency departments means that incomplete note taking does happen from time to time.
165. He also relied on the fact that Stephen Chapman accepted in cross-examination that he could recall seeing ENP Nice checking the deep tendon reflexes, by using a hammer or something similar. Ms Beale argued that the manner in which this answer was given suggested that it was at least possible that he was answering as he did as he simply wanted the cross-examination to end and/or to avoid criticism; and he did resile a little from it in re-examination. It is right that there was one occasion when I felt the need to intervene as Mr Chapman appeared to agree to a proposition that he did not understand, but this was not such an occasion. This was his sworn evidence; and as Mr Post highlighted, he had been willing and able to deny other propositions put to him robustly and would not easily have made concessions in respect of Basildon Hospital towards which he plainly had a negative attitude.
166. Ms Beale submitted that based on the notes alone, it is just as likely that ENP Nice forgot to carry out the reflex testing as it is that she forgot to make a note of the assessment. That is correct, but at the risk of stating the obvious, equal possibilities do not suffice in this context: for the Claimant to succeed on this issue, I need to be satisfied that her case is more likely than not.
167. She drew additional support for the proposition that ENP Nice had not tested the reflexes from Mr Paynter’s evidence as to the various ways in which such reflexes are tested. She contended that the first one he described - lifting the knee of a supine patient into a relaxed position, supporting it in the clinician’s elbow and then giving it a sharp tap with the hammer – was one that ENP Nice would not have done given the advice to her to avoid lifting.

168. However, again, it does not appear that this sort of examination would require “repeated strenuous...lifting” which is what the pregnancy risk assessment advised against. Mr Paynter accepted Mr Post’s proposition that both this and the second method he described avoided the need for any “significant lifting”. ENP Nice also described how the testing could be done while avoiding bending: the trolley could be brought up and the clinician could put their hands under the patient’s thighs and knees in a relaxed position and then use the tendon hammer to perform the test.
169. Mr Paynter explained that there is a second way to test reflexes which avoids any lifting or twisting by seating the patient on the end of the bed with their legs dangling independently. Ms Beale contended that there was no evidence from either ENP Nice or the Chapman family that this had occurred and that it was unlikely that the Claimant would have been able to sit independently in view of her limited mobility and significant pain. However, the ambulance crew had noted that she was “able to sit from lying without assistance or +++ pain”. It therefore appears possible, albeit unlikely, that this was the method used.
170. Ms Beale also pointed to ENP Nice’s agreement that the Claimant’s legs would have had to be bare for the reflexes to be tested and the family’s evidence was that she did not remove her pyjama trousers. However, ENP Nice’s evidence was that she generally could “work around” the Claimant’s loose-fitting clothes to get to the area she was looking for, and I accept her evidence in this regard.
171. Ms Beale contended that the results of reflex testing on 9 March 2017 would have been an abnormal upgoing plantar response; and that it is even less likely that ENP Nice would have failed to record the results in her note, had she carried out such testing, not least because such a result would have required a referral to senior clinician.
172. Mr Wilby explained that once neuronal damage is taking place, brisk reflexes and abnormal plantar responses develop. However as to when, precisely, this occurred in the Claimant’s case remained unclear, not least because (i): Mr Radatz said that it was possible for someone with mild myelopathy to have upgoing plantars, not that this would necessarily be the case; and (ii) the Claimant’s plantars were still downgoing on her admission to Basildon Hospital on 20 March 2017 (albeit Mr Radatz suspected that that was incorrect). This evidence was insufficiently clear to merit a finding that on examination on 9 March 2017 the Claimant’s reflexes would have been abnormal.
173. Further, in a sense, this argument was a little circular: if the results were normal, this would arguably make ENP Nice’s failure to record the facts of the tests easier to understand.
174. Finally, Ms Beale relied on the fact that neither the Defendant’s response to the letter of claim nor the Defence positively asserted that reflex testing was carried out; indeed, the Defence appeared to accept that reflex testing was one of the “handful of particular investigations referred to by the Claimant” which were not carried out as they were “not indicated”. However, these pleading points were of limited assistance: ENP Nice said she did not recall seeing the Defence and in any event the Defendant’s case had clearly moved on by the time of trial, with ENP Nice’s evidence that she did carry out the reflex testing.

175. For all these reasons I prefer ENP Nice's evidence on this issue. I find that she did conduct the reflex testing but simply failed to record it.

(e): The back examination

176. I accept ENP Nice's evidence that she was able to work around the Claimant's dressing gown so as to fully examine her back. Mr Post conceded that ENP Nice had failed to identify what was described in the RNOH referral as an "obvious deformity" in the mid-lower lumbar spine caused by spondylolisthesis. However, this did not lead the experts to criticise the totality of her assessment as unreasonable.

(f): The kidney area

177. Mr Paynter and Ms Brown agreed that no responsible body of ENPs would have omitted a full exploration and investigation of the kidney area.

178. Although ENP Nice's notes do not record her conducting an examination of the kidney area, her evidence was that she had felt "around the kidney area", apparently as part of her spine examination. Ms Beale relied on Ms Brown's evidence that palpation of the spine would mean feeling over the vertebrae up and down the spine for any inconsistencies or pain, widening out at the bottom in the area of the lumbar spine and the sacroiliac joint, rather than in the kidney area; whereas palpation of the kidney area would normally be done of the back as part of the abdominal examination (going around to the rear). She contended that there was no indication in ENP Nice's evidence that she had done this on examining the Claimant's abdomen.

179. I accept ENP Nice's evidence that she did examine the Claimant's kidney area. Even if she did so in a technically incorrect fashion, neither expert suggested that this vitiated her overall examination. Further, the net result of Mr Paynter's evidence was that even if kidney pain had been identified, this would only have led to a urine test and on the facts of this case such a test "wouldn't have taken things any further at all".

(g): The straight leg raise test ("SLR")

180. ENP Nice's notes record a positive SLR, indicated by a tick. The Claimant's husband and son said that ENP Nice performed this test by asking the Claimant to raise her own legs. ENP Nice agreed that this was what she had done. The experts explained that the test is normally performed passively with the clinician lifting the leg and that the result is generally recorded as the number of degrees at which pain was reproduced. Ms Brown therefore agreed that ENP Nice's note in relation to the SLR was not technically correct.

181. However, ENP Nice carrying out the SLR in the way described was consistent with what she had been advised to do due to her pregnancy: the risk assessment advised her to avoid lifting and rather than bending to assess limbs to ask the patient to lift their own limb. Further, this issue did not lead the experts to depart from their view expressed in the joint statement that the totality of ENP Nice's assessment was a reasonable one.

Conclusion on Issue (4)

182. For all these reasons I conclude that ENP Nice did not act in breach of duty and the answer to Issue (4) is “No”.

Issue (5): What findings can properly be made as to the sequence of events and timescale for surgery after ENP Nice’s examination in light of the Claimant’s condition at that time?

183. Mr Findlay and Mr Radatz agreed that by the time the Claimant attended hospital on 9 March 2017 she had “some mild weakness”, showing early signs of myelopathy, but that she was not yet paraplegic.

184. Ms Beale submitted that absent a breach of duty by ENP Nice on 9 March 2017, the signs of myelopathy would have been elicited, resulting in a referral to a senior clinician, a specialist orthopaedic in-patient team and an MRI scan, revealing the prolapsed disc. The experts agreed that surgery would then have taken place within 24–48 hours. This proposed chain of events was consistent with what actually happened after 20 March 2017.

185. Mr Post conceded that if the Claimant’s condition at the time of her examination by ENP Nice on 9 March 2017 was as she said it was, with no power at all in her legs, then it was obviously serious. On the basis of that serious presentation, he accepted that surgery would have taken place promptly.

186. I accept the likely sequence of events set out at [184] above.

187. ENP Nice’s assessment of the Claimant took place after 7 pm in the evening of 9 March 2017. Therefore, allowing for the various other steps in the chronology referred to at [184] above, it seems likely that the very earliest the Claimant would have had surgery would have been 11 March 2017.

188. Accordingly had I upheld the Claimant’s claim in relation to ENP Nice based on the entirety of the Claimant’s account, I would have found that surgery would have taken place at some point on 11 March 2017 or shortly thereafter.

Issue (6): If surgery would have been performed at an earlier point than it actually was, does the evidence establish that the outcome of surgery would have left the Claimant materially less disabled than she presently is?

189. The neurology experts agreed in the joint statement that surgery at a point when the Claimant had only mild (grade 4/5) weakness would have resulted in the Claimant having a full neurological recovery, with normal bladder, bowel, and sexual function. Pain and disability arising from her spondylolisthesis would have persisted. Further, they agreed that surgery once she was paraplegic (with no motor function in her legs) would have made no difference to the outcome.

190. On the basis of my answers to Issues (1) and (3), the Claimant would have had surgery at some point in 2009/10, more likely 2010. She only had mild (grade 4/5) weakness at that point, and so would have made a full neurological recovery of the sort described at [189] above.

191. If the claim in relation to EPN Nice had succeeded, I would have found that she would have had surgery on or shortly after 11 March 2017: see [188] above.
192. Ms Beale submitted that the Claimant continued to have power in her legs until 15 March 2017: that was the first date on which a loss of power/movement in both lower limbs was recorded in the contemporaneous documentation, in her GP records. This chronology was supported by the Chapman family's evidence to the effect that the "loss of power" in her legs on 8 and 9 March 2017 meant an inability to weight-bear, not an inability to move the legs completely; and wider evidence such as the occupational therapist's 17 March 2017 note, to the effect that when the Claimant went to hospital (on 9 March 2017), she had "some indep movement in her left leg but now has no movement in that leg and her bladder control has been affected".
193. As to what was happening between 9 and 15 March 2017, although the Claimant herself could not recall the specifics, when Dr Macaulay saw her on 13 March 2017, he said the Claimant could move her legs independently but with difficulty due to pain. I accept that evidence. On that basis, as per the experts' joint statement, there had been "no major deterioration" by that stage. Mr Findlay's view was that she developed the paraplegia "probably around 15...March 2017". This fits with Ms Beale's analysis of the factual evidence as set out above.
194. For these reasons I find that provided surgery took place between 11 and 15 March 2017, as appears likely on the time estimates given by the experts, the Claimant would have made a full neurological recovery.

Issue (7): Did the Claimant contribute to her injury by her conduct in refusing the advice of Dr Macaulay to call an ambulance and attend hospital on 15 March 2017?

195. The Defendant alleged contributory negligence by the Claimant in failing to call an ambulance or attend A&E on 15 March 2017, despite advice to that effect.
196. In considering this allegation I remind myself that the Defendant bears the burden of proof; and of the observations of Yip J in *Dalton v Southend University Hospital NHS Foundation Trust* [2019] EWHC 832 (QB) at [33], to which Ms Beale referred, to the effect that the circumstances in which a finding of contributory negligence can properly be made in a clinical negligence claim will be rare.
197. Ms Beale identified the relevant questions as (i) whether there was fault on the part of the Claimant; (ii) whether this was causative of damage; and (iii) if so, to what extent it be just and equitable to reduce damages.
198. There is no basis for a finding of contributory negligence in respect of the claim in relation to the Claimant's claim against Dr Bopitiya. The effect of my findings on Issue (1)-(3) and (6) is that the Claimant would have undergone surgery at some point in 2010 from which she would have made a full neurological recovery as described therein. Accordingly, the deterioration in her condition and the issue of her attending hospital on 13 March 2017 would simply not have arisen.
199. Even if the Claimant had not undergone surgery in 2010, she and her GP would have known that she had a large thoracic disc prolapse which was likely to produce the very

symptoms she was experiencing on progression in early March 2017. In those circumstances, I accept Ms Beale's submission that it is highly unlikely that the Claimant would have rejected the advice to go to hospital. On that basis the Defendant cannot show the requisite level of fault by the Claimant.

200. Had the claim in relation to ENP Nice succeeded on the basis of the evidence of the Claimant and her family, there is a good argument that it would have been understandable for her and her husband to conclude that attending the same hospital again without the results of an MRI scan would only lead to a lengthy wait at hospital for no real purpose. Again, therefore, the Defendant would have been unlikely to be able to show fault by the Claimant in not attending hospital on 15 March 2017.
201. More persuasively, though, I have accepted the factual and neurosurgical evidence, summarised at [192]-[193] above, to the effect that by 15 March 2017 the Claimant had developed paraplegia. In accordance with the neurology evidence noted at [189] above, intervention on or after that date would have made no difference to the outcome. As such any fault by the Claimant as alleged by the Defendant was not causative of damage.
202. The final argument Ms Beale advanced against a finding of contributory negligence was that there was no reliable evidence that on 15 March 2017 the Claimant was given advice from Dr Macaulay to attend hospital which complied the GMC Consent Guidance, paragraph 5. Dr Macaulay's written evidence was that he did provide warnings of the medical implications of not attending hospital including of damage to the spinal cord. As his evidence was not tested in cross-examination, I do not consider I can make fair findings on this disputed issue.
203. However, the Defendant's case on contributory negligence would still have failed for the reasons given at [200]-[201] above.

Conclusions

204. Dr Bopitiya acted in breach of duty in failing to order an updated MRI scan or conduct a full neurological examination of the Claimant. He also acted in breach of duty in failing to take an adequate history or conduct an examination at the 2010 consultation and by exceeding his remit and giving the Claimant advice on surgery: see [50]-[95] above.
205. The disc prolapse was symptomatic in 2009/10, such that the Claimant would have been offered surgery for it at that point: [96]-[111].
206. The Claimant would have elected to undergo this surgery: [112]-[122].
207. Had this occurred, the Claimant would have made a full neurological recovery, whilst pain and disability arising from her spondylolisthesis would have persisted: [189]-[190].
208. The Claimant's claim in relation to Dr Bopitiya is therefore upheld.
209. ENP Nice did not act in breach of duty on 9 March 2017 in failing to undertake a proper

neurological examination: [123]-[182].

210. The Claimant's claim in relation to ENP Nice is therefore dismissed.
211. Had I upheld the Claimant's claim in relation to ENP Nice I would have found that that surgery would have taken place on 11 March 2017 or shortly thereafter. Provided surgery took place between 11 and 15 March 2017, as appears likely on the time estimates given by the experts, the Claimant would have made the same recovery as described at [207] above: [183]-[188] and [191]-[194].
212. I have made no finding of contributory negligence on the Claimant's claim in relation to Dr Bopitiya and would not have done so had I upheld the claim in relation to ENP Nice: [195]-[203].
213. Directions will now be needed for the determination of quantum issues.
214. I reiterate my thanks to both counsel for their considerable assistance with this complex case, in particular for their commendably comprehensive yet focused submissions.