Neutral Citation Number: [2018] EWHC 1345 (QB)

Case No: HQ15C01195

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 05/06/2018

Before :

MASTER COOK

- -

Between :

Barry Frederick Hewes	**Claimant**
- and -	
(1) West Hertfordshire Hospitals NHS Trust	**Defendants**
(2) East of England Ambulance Service NHS Trust	
(3) Dr Pankaj Tanna	

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- -

Martyn McLeish (instructed by **Anthony Gold**) for the **Claimant**
Claire Toogood (instructed by **Medical Protection Society**) for the **3rd Defendant**

Hearing dates: 10 May 2018

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Approved Judgment

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

.....

MASTER COOK

Master Cook:

1. Cauda Equina Syndrome [CES] is a surgical emergency which will generally require immediate referral to hospital because if the compression of the cauda equina is not relieved promptly, permanent disability may result. The most common cause of CES is lumbar disc protrusion.

The factual background

2. The Claimant Mr Hewes had been experiencing lumbar back pain and left sided sciatica since May 2011 and had received treatment including on 22 February 2012 a caudal epidural for an L5/S1 postero-central protruding intervertebral disc which had been confirmed by earlier MRI scanning. The epidural did not fully relieve his symptoms. On 11 March 2012 he attended the Urgent Care Centre at Hemel Hempstead Hospital where he was given pain killers, advised to rest and to contact his regular GP if he experienced numbness.

3. On the morning of 12 March 2012 Mr Hewes experienced increased pain and numbness around his upper legs and groin. His wife telephoned the Urgent Care Centre at about 05.43 and reported her husband's symptoms. She was told that a GP would ring her back. At 6.02 Mr Hewes' wife rang for an ambulance and spoke to an operator of the Second Defendant, while she was on the phone the Third Defendant Dr Tana rang and spoke to Mr Hewes.

4. Dr Tanna's note of the call is as follows:

> "*Spoke to patient.* [previous] *OOH call reviewed*
>
> *Sciatica/herniated disc for 10 months. Epidural 3 weeks ago and no benefit*
>
> *Pain worse since yesterday*
>
> *LBP down left leg to calf* [Pins & Needles] *in left foot.*
>
> *No abdo pain, no urinary/bowels* [symptoms]
>
> *No numbness in perianal area*
>
> *Reports developed numbness under genitals/saddle area – in the past 1 hr and pain increasing ++*
>
> ?? *cauda equina. Advised to attend Watford A&E for urgent review*"

5. While Mr Hewes was speaking to Dr Tanna the Second Defendant's clinician called and agreed to phone back in 10 minutes. At 06.26 Mrs Hewes telephoned the Second Defendant again and was told to wait for a call from the clinician. At 06.32 the Second Defendant's clinician rang back and spoke to Mr Hewes who described his symptoms to the clinician. Mr Hewes was informed that an ambulance would be dispatched.

6. An ambulance arrived at Mr Hewes home at 07.21, he was assessed and at 07.38 was transported to Watford General Hospital arriving at 08.19. Mr Hewes was then assessed by an A&E Dr. The impression was "*worsening disc protrusion. Not cauda Equina"* and the plan was referral to the orthopaedic team for further scanning and pain control. Mr Hewes was accepted by orthopaedics at 10.40. At 11.59 an MRI scan was requested. The scan was carried out by 13.50 and the radiologist's report concluded; "*extruded disc at L5/S1 is leading to significant spinal canal narrowing and is compressing on the traversing roots at this level."*. At about 14.45 Mr Hewes was reviewed by the Registrar and as a result Mr Hewes' case was discussed with the National Hospital for Neurology and Neurosurgery at Queen's Square. At 18.20 Mr Hewes was booked for urgent surgery and transport to Queen's Square.

7. Mr Hewes was admitted to Queen's Square at 20.34 and was taken to theatre at 22.30 when decompression and discectomy was carried out. The surgery was uneventful; however, Mr Hewes is left with bladder, bowel and sexual dysfunction together with nerve pain in his left foot.

The Proceedings

8. On 5 March 2015 a claim form was issued by solicitors acting for Mr Hewes against all three Defendants. Particulars of Claim were served on 13 March 2017. In summary the Claimant's case was that he presented to each of the Defendants with incomplete CES [CESI] and that time to radiological confirmation and surgical decompression was of the essence. The case against the Second Defendant was that there was a failure to assess the Claimant as a "Green 2" emergency which would have warranted a response to his home within 30 minutes, that is by 06.32. The case against the Third Defendant was that having suspected CES he failed to refer the Claimant directly to the on call orthopaedic team at Watford General Hospital thereby by-passing A&E and avoiding delay caused by assessment and referral to the orthopaedic team. The case against the First Defendant is that having suspected CES there was a failure to carry out radiological investigations and manage the Claimant's symptoms within reasonable time. Defences were filed. The First and Third Defendants deny the claim in full and the Second Defendant admits there was a failure to assess the Claimant as "Green 2" but denies any causative effect.

9. A costs and case management hearing took place before me on 30 January 2019. I made an order for the trial of a preliminary issue on breach of duty and causation. Disclosure took place on 2 March 2018 and factual witness statements were exchanged on 27 April 2018. Expert reports are due to be exchanged by 3 July 2018. The trial of the preliminary issue has been listed for 6 days in a window commencing on 18 March 2019.

The application

10. On 27 February 2018 solicitors acting on behalf of Dr Tanna issued an application seeking an order that the claim against their client be struck out pursuant to CPR 3.4(2) and in the alternative summary judgment pursuant to CPR 24.2(a)(i). The application was supported by the witness statement of Louise Morgan dated 27 February 2018.

11. By letter dated 28 March 2018 Ms Morgan wrote to the Claimant's solicitor and informed her that the application to strike out the claim would no longer be pursued.

12. On the 13 April 2018 Ms Morgan served a further witness statement in support of the application for summary judgment exhibiting an expert report prepared by Dr David Russell on behalf of Dr Tanna.

13. On 3 May 2018 Mr Hewes' solicitor served the statement of Ms Wedgwood in response to the Third Defendant's application. Exhibit "ALW 6" to Ms Wedgwood's statement was a letter dated 24 April 2018 from Dr Swale, the GP expert instructed on behalf of the Claimant, the relevant part of which stated:

> "I am a GP expert instructed by the Claimant in this case. I have been made aware that an application for summary judgment has been made on behalf of the Third Defendant. I have read the statements of case and I can confirm that, from my perspective as a GP I continue to remain supportive of the case set out in the Particulars of Claim and notwithstanding the Defences."

14. Before me neither party has sought an adjournment for the purpose of adducing further factual or expert evidence.

The Claim against the Third Defendant

15. Before proceeding further, it is helpful to set out in full the allegations of negligence made against Dr Tanna and Dr Tanna's response.

16. The allegation of breach of duty against Dr Tanna is set out at paragraph 3.3 of the particulars of claim;

> "3.3 The Third Defendant either suspected or should have suspected cauda Equina Syndrome [CES] having proper regard to the Claimant's symptoms as reported by him and recorded at par. 29 above. In those circumstances the Third Defendant should not only have advised the Claimant to attend WGH as soon as possible, but, following the end of his call with the Claimant at 06.12 he should have contacted WGH to ensure that an assessment by the orthopaedic team was expedited for the Claimant on his arrival at WGH, effectively bypassing A & E."

17. Factual Causation is pleaded at paragraph 4.1 of the particulars of claim:

> "4.1 The Claimant's case is that on the balance of probabilities, had it not been for the defendants' breach of duty, the Claimant's diagnosis of CESI would have been made much earlier and successful surgery would have avoided the permanent symptoms he now suffers as set out in section 5 below. The Claimant's case on factual causation is as follows:

> (i) had the Claimant been assessed as a Grade 2 emergency at 06.02, an ambulance should have arrived at the Claimant's home by 06.32;
>
> (ii) the Claimant would have concluded his phone call with the Third Defendant, and so soon after 06.12 the Third Defendant would have contacted WGH to arrange for the Claimant to be seen by the on call orthopaedic team on arrival;
>
> (iii) the ambulance would have left the Claimant's home at 06.49 and arrived at WHD at 07.30;
>
> (iv) assuming bypassing A & E the Claimant should have been seen by an orthopaedic registrar by 08.00;
>
> (v) examination of the Claimant should have been completed by around 08.30 with a working diagnosis of CESI and the plan should have included referral for an urgent MRI;
>
> (vi) the orthopaedic registrar should have contacted the on-call Consultant at 08.30;
>
> (vii) the MRI list should have been interrupted to accommodate the Claimant and the MRI should have been started by 09.18 and competed by 09.40;
>
> (viii) by 10.10 at the latest the MRI result should have been considered by the orthopaedic registrar or consultant, and the decision made either to transfer the Claimant to Queen's Square or to proceed to surgery at WGH;
>
> (ix) on the basis that the Claimant was transferred to Queen Square, the Claimant should have arrived at Queen Square by 11.26 and would have been prepped for surgery by 12.26;
>
> (x) during surgery disc fragments should have been excised within 30-60 minutes of 12.26 so between 12.56 and 13.26.
>
> 4.2 If surgery at WGH was possible, and transfer to Queen Square was not required, the Claimant would have been prepped for surgery by 11.10 and disc fragments excised by between 11.40 and 12.10."

18. Legal Causation is pleaded at paragraph 4.3 of the particulars of claim;

> "4.3 If the Claimant had undergone surgery on or before 15.00 on 12 March 2012 he would not have progressed to complete Cauda Equina Syndrome [CESR]. He would have retained voluntary bladder and bowel control. He would not have required ISC or Peristeen. His sexual function would be normal. He would have continued to suffer from some

> neuropathic pain in the saddle and genitals but his symptoms would have been better."

19. Dr Tanna's response to the allegation of breach of duty is set out at paragraphs 11 to 13 of the Defence;

> "11. It is clear from the notes and the transcript of the call that the Third Defendant considered cauda equina syndrome was a possible diagnosis. He recorded "*?? Caudia Equina"* in his notes, and advised the Claimant in straightforward and practical terms of the risk that nerves can be pinched which affect bladder bowel and genital function.
>
> 12. The advice given by the Third Defendant was in accordance with a responsible body of medical practitioners. The Third Defendant advised the Claimant to attend his nearest A & E department.
>
> 13. It is denied that it was mandatory for the Third Defendant to contact Watford General Hospital to ensure that an assessment by an orthopaedic team was expedited for the Claimant on his arrival there, in order to bypass A & E:
>
> a) The Third Defendant had not examined the Claimant and therefore could not give the hospital any further details than those which the claimant had given him and which the Claimant would reasonably tell the hospital on arrival there.
>
> b) The Claimant did not complain of bladder and bowel symptoms nor of numbness in the perianal area. The only symptoms of which the Claimant complained which prompted the advice to attend A & E was numbness in the genital area.
>
> c) It was reasonable for the Claimant to be examined by a clinician before referral to the orthopaedic department. In order to save time, it was reasonable for the Third Defendant to advise the Accident and Emergency department in order to be examined by a doctor there, rather than attend the Urgent Care Centre.
>
> d) The Third Defendant's actions were in accordance with a responsible body of medical opinion."

20. Dr Tanna's response to the Claimants case on causation is set out at paragraphs 14 to 18 of the Defence;

> "No Causation
>
> 14. It is not admitted that the orthopaedic department at Watford General hospital would have agreed to see the Claimant without any assessment by a general practitioner or

> accident and emergency practitioner, based only on a complaint of numbness in the genital area and no symptoms of bladder and bowel disturbance or perianal numbness. The Claimant is put to strict proof of his claim that the Claimant would have been seen by an orthopaedic registrar by 08.00.
>
> 15. The Claimant's proposed timeframe in paragraph 4.1 of the Particulars of Claim is unrealistic and is denied by the Third Defendant. Even if, which, is denied, the Claimant had been admitted to directly to the orthopaedic department, the Claimant would have been assessed at about 08.45 -09.00, after the night shift/day shift handover. This was approximately an hour earlier than the orthopaedic assessment which in fact took place.
>
> 16. Even on the Claimant's case, it is alleged that the Claimant would have been assessed by the orthopaedic department only two hours earlier than in fact took place.
>
> 17. It is denied that any act or omission on the part of the Third Defendant caused any injury, loss or damage to the Claimant.
>
> 18. On the balance of probabilities, the delay of an hour (alternatively two hours) which is allegedly attributable to the Third Defendant was not causative of any injury."

The applicable legal principles

21. The principles governing summary judgment are well known and not in dispute. I was referred to the helpful summary given by Hamblin LJ in *Global Asset Capital Inc v Aabar Block SARL and others* [2017] 4 WLR 163 at para 27;

> "27. It was common ground that for the purpose of the present case the applicable principles concerning strike out and summary judgment may be conveniently summarised as follows.
>
> (1) The court must consider whether the case of the respondent to the application has a realistic as opposed to fanciful prospect of success – in this context, a realistic claim is one that carries some degree of conviction and is more than "merely arguable".
>
> (2) The court must not conduct a "mini-trial" and should avoid being drawn into an attempt to resolve conflicts of fact which are normally resolved by the trial process.
>
> (3) If the application gives rise to a short point of law or construction then, if the court is satisfied that it has before it all the evidence necessary for the proper determination of the question and that the parties have had an adequate opportunity

> to address it in argument, it should "grasp the nettle and decide it".
>
> See *Easy Air Limited v Opal Telecom Limited* [2009] EWHC 339 (Ch) at [15]: *Arcadia Group Brands Ltd & Ors v Visa Inc* [2014] EWHC 3561 at [19]; *Tesco Stores Ltd v Mastercard Incorporated* [2015] EWHC 1145 (Ch) at [9]-[10]:

22. In the *Tesco* case Asplin J stated that in reaching its conclusion, the Court must take into account not only the evidence actually placed before it on the application for summary judgment, but the evidence that can reasonably be expected to be available at trial, she referred to *Royal Brompton Hospital NHS Trust v. Hammond (No. 5)* [2001] EWCA Civ 550 at [19].

23. It is common ground that the relevant legal test to be applied in relation to the Third Defendant's treatment of the Claimant is that set out in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 and *Bolitho v City of Hackney Health Authority* [1998] AC 332.

24. In directing the jury in the *Bolam* case, McNair J said as follows at page 587:

> "I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art… 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."

25. In *Bolitho*, the House of Lords emphasised that McNair J had said that the practice in question had to be accepted as proper by a responsible body of medical men. Elsewhere in his judgment he had said that it must be regarded as acceptable by a reasonable body of opinion. Lord Browne-Wilkinson, who gave the leading speech, commented as follows at page 241:

> "The use of these adjectives – responsible, reasonable and acceptable – all show that the Court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or acceptable, will need to be satisfied that, informing their views, the experts have directed their minds to the question of comparative risks and benefits and reached a defensible conclusion on that matter."

26. Later, at page 243, he continued:

> "In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are

> questions of assessment of the relative risks and the benefits of adopting particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinion. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.
>
> I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only when a judge can be satisfied that the body of expert opinion cannot logically be supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed."

27. Lord Browne-Wilkinson's reference to the quotation from Lord Scarman was to the case of *Maynard v West Midlands Regional Health Authority 919840 1 WLR 634 at 638E*:

> "A case which is based on an allegation that a fully considered decision of two consultants in the field of their specialist skill was negligent clearly presents certain difficulties of proof. It is not enough to show that there is a body of competent professional opinion which considers that theirs was a wrong decision, if there also exists a body of professional opinion equally competent, which supports the decision as reasonable in the circumstances. It is not enough to show that subsequent events show the operation never need have been performed, if at the time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper. I do not think the words of Lord President Clyde in *Hunter v Hanley* 155 SLT 213, 217 can be bettered
>
> > "in the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men … The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure that no doctor of ordinary skill would be guilty of if acting with ordinary care …"

The parties' submissions

28. On behalf of the Third Defendant Miss Toogood submitted that the allegation that Dr Tanna was negligent because "he should have contacted WGH to ensure that an assessment by the orthopaedic team was expedited for the Claimant on his arrival at WGH effectively bypassing A&E" has no real prospect of success in the sense that it is not realistic and is not better than merely arguable.

29. Miss Toogood places reliance on the report of Dr David Russell dated April 2018 and exhibited to Ms Morgan's second witness statement. It is his opinion that Dr Tanna's actions in advising Mr Hewes to attend the Accident and Emergency Department were in accordance with a responsible body of general practitioners and does not consider that it was mandatory for him to telephone the orthopaedic department at WGH.

30. Miss Toogood drew my attention to three particular matters relied upon by Dr Russell to support his opinion. Firstly, the telephone conversation occurred soon after 6 am and it would probably have been a difficult and time-consuming process to try to locate an appropriate person to speak to at the Hospital, if anybody was available. Secondly, the Third Defendant had not conducted an examination (as the consultation was by way of telephone) and therefore could not make a definite diagnosis and thirdly, it was reasonable to rely on the Accident and Emergency Department to conduct an assessment of the Claimant's condition and decide the plan, including onward referral to the appropriate department (which may have been neurosurgery rather than orthopaedics).

31. Miss Toogood pointed out that unusually in a case of this kind there was no dispute of fact regarding the consultation between Dr Tanna and Mr Hewes, she referred to the transcript which is reproduced in Dr Russell's report. She pointed out that the Court should be able to accept that the purpose of an Accident and Emergency Department was to admit emergencies.

32. Miss Toogood submitted that Dr Russell's opinion that the Dr Tanna acted reasonably is clearly capable of being logically supported for the reasons set out in his report, in particular she drew my attention to the fact that Dr Russell notes, although all competent GPs should be aware that a patient presenting with possible cauda equina syndrome should be seen urgently within secondary care, this does not have the same urgency as a patient who presents with a possible myocardial infarction or collapses, which would mandate a blue flashing light ambulance. Being seen within a few hours is reasonable.

33. Miss Toogood therefore submits that the Claimant has no real prospect of succeeding in his claim unless he can show that the opinion of Dr Russell is not capable of withstanding logical analysis. For the reasons given in ***Bolitho*** and ***Maynard*** above, it matters not that a different expert holds a different view if a body of professional opinion supports the Third Defendant's actions as reasonable. She submits that the Third Defendant has submitted credible evidence in support of his application for summary judgment and that the Claimant is therefore subject to an evidential burden to prove some real prospect of success or some other reason for trial. Therefore, the fact that Dr Swale states in his letter of 24 April that he remains supportive of the case does not assist the Claimant in demonstrating that he has a realistic prospect of

success as he gives no reasons why Dr Russell's differing view is illogical. In other words the Claimant's case lacks any credibility.

34. Miss Toogood then moved to the issue of factual causation. She started with the basic proposition that Mr Hewes must also prove that the alleged breach of duty by Dr Tanna was causative of his loss. She submitted that there is no realistic prospect of establishing that the Claimant would or should have bypassed A & E following a telephone call from Dr Tanna to the orthopaedic department.

35. Miss Toogood then referred to the pleadings and pointed out that the Defence of the First and Second Defendants avers at paragraph 6:

> "it was reasonable that in the first instance the Claimant was seen by Emergency Department staff before being referred to the Orthopaedic Surgery team"

She then pointed out that the Claimant did not take issue with this averment in his Reply.

36. At paragraph 15(c) of the Defence of the First and Second Defendants, it is pleaded:

> "The Claimant would not have bypassed the Emergency Department as averred. It is noted that the Claimant has not sought to aver that the actions of the Emergency Department were unreasonable nor is it alleged that it was inappropriate for care to have been initially afforded within the Emergency Department."

The Reply states:

> "The Claimant does not allege that the First Defendant was negligent in agreeing to treat him at A & E. Treatment by a non-specialist at A & E necessitated referral to specialist orthopaedics, thereby causing delay. Whether or not treatment at A & E was negligent, the Claimant would have been referred by A & E to orthopaedics for assessment in any event, so any breach of duty at A & E would not have caused the Claimant any loss"

She therefore submits that it is clear that the Claimant does not allege that it was negligent for care to have been initially afforded within the Emergency Department.

37. Miss Toogood also invited the court to have regard to the witness statements which have now been exchanged and which will be available to the trial judge. In particular she referred to the witness statement of Mr Langdon, Consultant Orthopaedic Spinal Surgeon at Watford General Hospital, who states at paragraph 12 of his witness statement:

> "In the event a GP has called to speak to someone in the orthopaedic department and I had received this call I would have told the GP to send the Claimant to A & E for assessment.

> This is because the Claimant would not have had a proper clinical assessment as I understand the GP's assessment was only done over the phone. It would have been premature for the Orthopaedic team to admit the Claimant at this time without the benefit of a physical assessment by a clinician."

She submits the Claimant has disclosed no evidence to contradict this position and there is therefore no realistic prospect of the Claimant proving that he would have bypassed the Emergency Department following a telephone call from the Third Defendant, particularly in circumstances where the Third Defendant had not examined the Claimant.

38. Miss Toogood went on to submit that the Claimant had not established a case on causation against the Third Defendant as to how bypassing the Emergency Department would have avoided his injury. She pointed to the Claimant's case that bypassing the Emergency Department would have led to assessment by an orthopaedic registrar at approximately 08.00 hours, 2 hours and 40 minutes earlier than the assessment by Dr Kirkby and made the point that surgery would have had to have taken place 8 hours and 30 minutes earlier than in fact occurred for injury to have been avoided.

39. Miss Toogood finished her submissions by reminding the Court that the power to grant summary judgment was part of its powers of active case management. She submitted that it was reasonable for the Third Defendant to consider its position following the close of pleadings and the Case Management Conference on 30 January 2018. As the application for summary judgment was not listed to be heard until 11 May 2018, the parties have complied with the Court's directions, giving disclosure and exchanging witness statements. The Third Defendant then took the decision to disclose its expert GP evidence early to support the application. However, there will still be a significant saving in costs if the Third Defendant's application is successful, as the costs of the Claimant's GP expert, the Third Defendant's neurosurgical evidence relating to causation, the joint GP discussions and the Third Defendant's trial costs will all be avoided. She urged the Court to give effect to the overriding objective and to *"grasp the nettle"* and enter summary judgment for the Third Defendant.

40. On behalf of the Claimant Mr McLeish submitted that this was a highly unusual application in the context of a clinical negligence case. The argument between the parties on breach of duty is not an unusual one. The Claimant argues that the actions of the GP failed to conform to the standard of a reasonable practitioner, Dr Tanna's case is that his actions were in accordance with a reasonable body of medical practitioners. It is unclear why the particular facts of this case would justify him having summary judgment in this particular case when such reasoning would apply to all cases in which breach of duty and the application of the *Bolam/Bolitho* principles were in issue.

41. Mr McLeish submitted that it would be inappropriate for D3 to have summary judgment when both parties have permission to rely upon the evidence of GP expert witnesses. It is envisaged that both experts will participate in a joint discussion and give evidence at trial if necessary. Given the procedural steps which the Third Defendant agreed at the CCMC, the application for summary judgment is at best

premature. In reality, however, the Third Defendant is saying that the Claimant's case on breach of duty cannot succeed: this is simply unarguable for the very simple reason that the Third Defendant has not yet seen the evidence upon which the Claimant relies in support of his case.

42. Mr McLeish submitted that the views set out in Dr Russell's report are contrary to the Claimant's pleaded case, and the Claimant is entitled to cross-examine him at trial with a view to establishing that his opinion is wrong. Ms Wedgwood sets out some of the grounds for challenging Dr Russell's report at paragraph 26 of her witness statement;

> "26. Even if the court were to find that D1's on-call orthopaedic team would not have accepted a direct referral from D3, it is C's case that such a decision would have been unreasonable and/or illogical having regard to the totality of evidence including the following:
>
> a) D1's orthopaedic department's "policy for admissions" [document 8 of the first exhibit "LGM1] expressly confirms that direct GP referral is a recognised method of admission to WGH.
>
> b) D3's own expert opinion (I refer to Dr Russell's report marked LGM2) acknowledges CES is a surgical emergency requiring "specialist" assessment and that a reasonable course of action open to a GP is to telephone the hospital and advise them that a CES patient will be attending.
>
> c) In the leading case on CES, *Oakes v Neininger and Others* [2008] EWHC 548 (QB), a GP referred Mr Oakes, who had CES, directly to the orthopaedic SHO at Bolton Hospital. [see paragraph 4 of the judgment].
>
> d) There is considerable open source medical literature that advocates direct referral by a GP to a "specialist" (i.e. Either the neurosurgical or orthopaedic departments) for urgent admission. For example, I refer to the Medical Defence Union Article entitled "*Delay in diagnosis of cauda equina syndrome"* dated 1 January 2002 marked "ALW7" and the NICE Clinical Knowledge Summary (CKS) marked "ALW8".
>
> e) C has supportive expert evidence from an independent orthopaedic surgeon supporting C's case on this point I refer to the letter from Mr Thorpe marked "ALW9".

These matters he submits are sufficient to discharge any evidential burden that the Claimant may have to demonstrate some real prospects of success.

43. Mr McLeish submitted that if the Claimant has a real prospect of successfully challenging Dr Russell's conclusion then it would be wrong to dismiss the case summarily. He referred me to the comments of Neuberger J. (as he then was) at

paragraphs 32-33 of *Layland v Fairview New Homes Plc* [2002] EWHC 1350 (CH). These comments were made in the context of a single joint expert's valuation report which was averse to the respondent in a summary judgment application:

> "32. One starts with the fact that the Court, plainly rightly bearing in mind the comparatively small size and the nature of the claim, exercised its jurisdiction, without any apparent objection from the parties, to order a report from a single expert. Although the nature of the valuation exercise, and the evidence involved, may mean that such a report will often not be conclusive, it seems to me that Mr Russ's report was, as the Judge found, careful, reasoned and detailed. It arrived at a clear conclusion, which received apparent support from the facts and evidence upon which it rests. Unless it is wrong, it must mean that the claimants fail, at least so far as their claim is based on diminution in value. In order for the claimants to resist their claim being dismissed under CPR Part 24 , it was therefore necessary for them to establish that they have a real prospect of successfully challenging Mr Russ's conclusion.
>
> 33. In my judgment, if the claimants cross this hurdle, then it would be wrong to dismiss their claim summarily. The fact the single expert's view is adverse to the claimants, on whom the burden of establishing a diminution rests, cannot mean that they are effectively bound by his conclusion. Provided there is a prospect of the expert, through cross-examination, or the court, through submissions, being persuaded to a different conclusion, the claim cannot be dismissed on the basis of the expert's view.
>
> CPR Part 24, in light of its terms and because of the fundamental right of a citizen to have recourse to the court, does not enable a Judge to dismiss a claim merely because it is for a small sum, looks weak and is being pursued unattractively or ineptly. These are factors which can, indeed often should, be taken into account when the court is managing the case, but they cannot, at any rate on their own, directly justify dismissing a claim."

44. Mr McLeish submitted that to demonstrate the Claimant has no prospects of success the Third Defendant has to do more than show it is probable that the Claimant will lose, but that the claim has "*no real prospect of succeeding*". This is a very high threshold to reach: "*The criterion which the judge has to apply under CPR Pt 24 is not one of probability; it is absence of reality*", as per Lord Hobhouse of Woodburgh in *Three Rivers DC v Bank of England* (no 3) [2003] 2 AC 1 at para 158 G.

45. Mr McLeish responded to Miss Toogood's submissions on causation in the following way. He submitted that the question of whether or not the Claimant would have bypassed A & E is a matter of fact, or hypothetical fact, is to be determined by the trial judge. The Claimant's case and the First Defendant's case are subject to proof and there is an issue of fact between the parties. In these circumstances the Third Defendant simply cannot say that the Claimant cannot succeed on this part of his case:

witness evidence was exchanged on 27 April 2018 after the application for summary judgment was made and expert evidence is still to be exchanged. The court should judge the case on the facts found at trial rather than hypothetical facts advanced on an application for summary judgment, see *Hughes v Colin Richards & Co* [2004] EWCA Civ 266 per Peter Gibson LJ at paragraphs 22 and 30

Discussion and conclusions

46. I am bound to say that my initial reaction to the Third Defendant's application was sceptical. I perceived considerable merit in McLeish's submission that the summary judgment application was premature, in circumstances where the Claimant's expert evidence was yet to be served. However, on reflection, my initial reaction does not do justice to Miss Toogood's submissions. It is necessary to first isolate the question which the trial judge will have to resolve in relation to Dr Tana's breach of duty.

47. Dr Tanna does not stand accused of failing to include CES as part of his working diagnosis. It is beyond doubt common ground that he actually suspected CES, as is clearly stated in his note of the telephone consultation with Mr Hewes. It is also important to note that the basis of his suspicion, as confirmed by the transcript, was the reported numbness in Mr Hewes' leg and genital area.

48. In order to establish that Dr Tanna's actions amounted to a breach of duty Mr Hewes would have to prove that in referring him to the Accident and Emergency Department at Watford General Hospital Dr Tanna failed to act in accordance with a responsible body of general practitioners. Or to put the question the other way around, that no responsible body of general practitioners would have referred Mr Hewes to the Accident and Emergency Department of Watford General Hospital.

49. At paragraph 5.15 of his expert report Dr Russell identifies four possible courses of action that Dr Tanna could have taken:

> "He could have arranged to see the Claimant in an urgent face to face consultation, and taken a more detailed history and examination, and then arrange for the Claimant to be assessed urgently within secondary care by either contacting the accident and emergency department or appropriate secondary care specialist (be that a neurosurgeon, spinal specialist or orthopaedic surgeon).
>
> He could have told the Claimant to attend the nearest accident and emergency department with MRI scanning facilities urgently, and contact that department himself, giving the Claimant's details and advising them that on the basis of his telephone conversation he might be presenting with possible cauda equina syndrome.
>
> He could have told the Claimant to attend the nearest accident and emergency department with MRI scanning facilities urgently, and contact that department himself, giving the Claimant's details and advising them that on the basis of his telephone conversation he might be presenting with possible

> cauda equina syndrome. He could then have arranged the ambulance transport himself.
>
> He could have told the Claimant to attend the nearest accident and emergency department with MRI scanning facilities with no further action taken."

In his opinion any of the above actions would be in keeping with some responsible bodies of competent general practitioners. I would also note contrary to Mr McLeish's submission that Dr Russell's second course of action is that which the Claimant contends should have occurred. Dr Russell is saying that there is a range of responsible opinion on this issue, and in my judgment, he has given sound reasons (summarised at paragraph 30 above) to support that opinion.

50. In my judgment Dr Tanna has adduced logical and credible evidence from an appropriately qualified expert and this evidence is sufficient to raise the evidential burden requiring the Claimant to prove some real prospect of success or some other reason for a trial. This approach is confirmed by the note in the White Book at 24.2.5:

> "If the applicant for summary judgment adduces credible evidence in support of their application, the respondent becomes subject to an evidential burden of proving some real prospect of success or some other reason for a trial. The standard of proof required of the respondent is not high. It suffices merely to rebut the applicant's statement of belief. The language of r.24.2 ("no real prospect … no other reason …") indicates that, in determining the question, the court must apply a negative test. The respondent's case must carry some degree of conviction: the court is not required to accept without analysis everything said by a party in his statements before the court (ED&F Man Liquid Products Ltd v Patel [2003] EWCA Civ 472; [2003] C.P. Rep. 51 at [10]). In evaluating the prospects of success of a claim or defence judges are not required to abandon their critical faculties (Calland v Financial Conduct Authority [2015] EWCA Civ 192 at [29])."

51. It is therefore necessary to examine the material and arguments deployed by Mr McLeish with a view to determining whether Mr Hewes' prospects of success against the Third Defendant at trial are realistic as opposed to fanciful. Whatever my decision on this issue the case will proceed against the Ambulance Trust and the Health Trust.

52. Firstly, Mr McLeish pointed to the fact that the Claimant's expert evidence has not yet been served. I am asked to infer that this evidence, when served, will support the contention that that no responsible body of general practitioners would have referred Mr Hewes to the Accident and Emergency Department of Watford General Hospital. I readily accept that if there is a real as opposed to fanciful possibility the Claimant's expert evidence would support such a contention then the Claimant has satisfied the evidential burden. It is no part of my function to make a ruling on the relative merits of the respective expert's positions on an application for summary judgment, to do so would be to ignore the established case law warning against the conducting of mini

trials. That does not mean that the mere assertion that a supportive expert's report will be served will suffice.

53. While the Claimant has not yet served his final expert's report he has had ample time to obtain his expert's view on the central question in this case. Dr Tanna's Defence served on 18 July 2018 made it very clear that he was asserting his actions were in accordance with a responsible body of medical opinion. In these circumstances I am bound to say that I find Dr Swale's letter of 24th April 2018 far from satisfactory, as it entirely fails to identify and address this central issue in the case. It has the hall mark of being drafted by the Claimant's solicitor, given its striking similarity to the letter from Mr Thorpe, the Claimant's expert spinal surgeon. If Dr Swale's evidence is to the effect that no responsible GP would have referred Mr Hewes to the Accident and Emergency Department of Watford Hospital it would have been very easy for him to say so and to give brief reasons for expressing that view. If Dr Swale was unable to address the issue in the time available, the Claimant could have sought an adjournment of the summary judgment application. As I have already observed no such application has been made. This is a striking omission, and in the circumstances, I cannot simply accept that the Claimant's "supportive" expert evidence when served will raise a realistic *Bolitho* issue.

54. I must therefore consider the remaining matters put forward by McLeish by which he sought to persuade me that there was a realistic prospect of satisfying the trial judge that Dr Russell's opinion was or might be wrong with a critical eye.

55. The first matter was the First Defendant's "policy for admissions" document. The first point to note about this document is that it contemplates admission to the Department of Orthopaedics via Out Patients or following direct referral from their GP. The aim of the policy is clearly set out:

> "1. To provide a safe environment for patients whose neurological condition has the potential to deteriorate between admission and the delivery of appropriate surgical care (with particular regard to cases of acute cauda equina syndrome).
>
> 2. To ensure that, when patents are admitted, they are investigated expeditiously, their pain requirement are managed optimally) including early surgery when necessary and where possible they are mobilised and discharged from hospital without unnecessary delays.
>
> 3. To ensure an appropriate degree of record keeping, communication and delegation of responsibility between junior and senior staff."

56. I can find nothing in this policy which could realistically be deployed to undermine Dr Russell's opinion. To the extent that the document contemplates direct admission to the Orthopaedic Department in some circumstances, it is entirely consistent with Dr Russell's opinion.

57. The Second matter is Dr Russell's own opinion that CES is a surgical emergency requiring "specialist" assessment and that it would be a reasonable course of action

open to a GP to telephone the hospital and advise them a CES patient will be attending. This must be read in the light of Dr Russell's reasons for approving the course taken by Dr Tana. As I have pointed out Dr Russell's evidence is that there were a range of responsible courses open to Dr Tanna.

58. The third matter is reliance on the facts in the case of *Oakes v Neininger and Others* [2008] EWHC 548 (QB) where a GP made a direct referral to a specialist orthopaedic senior house officer. I do not think it is helpful to rely on the facts of other cases. The GP in question was not a defendant and the court was not considering that GP's conduct. The relevant part of the judgment is contained in the first four paragraphs:

> "1. Stephen Oakes, the Claimant, and his wife, Elizabeth, moved house in April 2001 to The Birches, Rigby Lane, Bradshaw, Bolton. He had suffered from back pain for some years as well as an unrelated urinary problem. Following a holiday in Italy, with increasing back pain, he visited his former GP, Dr Neininger (the First Defendant) on 14 July 2001 at about 10.30 to 11 a.m., who considered that he was still suffering from back pain or strain and prescribed anti-inflammatory and pain killer drugs.
>
> 2. Following a weekend of further pain, Mr Oakes had a very disturbed night on the 15th July. He got out of bed at about 2 am, and had difficulty in urinating (but did so). Later, Mrs Oakes telephoned the GP out of hours call out service and explained the problem but, being unable to secure a GP to come out, the first ambulance crew was called ("the 1st Call-Out"); they arrived at 4.46 a.m. The crew believed that sciatica could well have been the problem and advised Mr Oakes that calling a GP would be the best course for pain relief purposes. The crew facilitated a GP to visit.
>
> 3. Dr Brown (the Fourth Defendant) was the GP who arrived at 6.32 a.m. to visit Mr Oakes. He also considered that there was a sciatica problem and he provided painkiller and tranquiliser drugs. A second ambulance crew was called out ("the 2nd Call-Out") and arrived at 9.30 a.m. The crew did not recommend that Mr Oakes go to hospital.
>
> 4. Mr Oakes fell asleep at about 11.30, doubtless exhausted and with the various drugs making him drowsy. At some stage, he became incontinent between about 11.30 and 2.30. He had a hot bath but was not able to urinate until he later lost bladder control as he made his way downstairs. He lay down on the floor downstairs. By about 4.30 p.m. he started to feel comfortable and felt no pain. Mrs Oakes had earlier gone out to register him at a local medical practice and arranged a home visit by a Dr Benjamin. She arrived at about 6.30 p.m. and, following an examination, formed the view that Mr Oakes had developed neurological symptoms which required urgent specialist attention. She referred him to a specialist

> (orthopaedic) Senior House Officer at Bolton Hospital who saw him at 9.25 p.m. that evening. He formed the view that Mr Oakes was suffering from "Cauda Equina Syndrome" ("CES") and recommended an immediate transfer to the nearby Hope Hospital which had a specialist neurosurgical unit."

59. On any view this is a wholly unrealistic comparison. By 6.30 am Mr Oakes' neurological symptoms were much further advanced, having progressed through incontinence to loss of bladder control and the GP actually conducted a physical examination before making a referral.

60. The fourth matter is the open source literature referred to by Ms Wedgwood at paragraph 26 of her witness statement. I have carefully considered all of this material particularly the NICE Clinical knowledge survey. I can find no material which would contraindicate a referral to A & E in a case of suspected cauda equina syndrome and which could be used as a basis to attack Dr Russell's opinion.

61. The last matter was the existence of supportive evidence from an orthopaedic surgeon. I have already referred briefly to Mr Thorpe's letter dated 25 April. This letter suffers from the same shortcomings as Dr Swale's. It does not begin to set out a reasoned criticism of Dr Russell's opinion that Dr Tanna acted in accordance with a responsible body of medical opinion.

62. Lastly, there was some dispute between the parties as to whether I could take into account the fact that an A & E department is an appropriate place to refer an emergency, this was prompted by the comment at paragraph 12 of Mis Toogood's skeleton argument:

> "12. The purpose of an Emergency Department is to admit emergencies. There is no realistic prospect of demonstrating that it was unreasonable for the Claimant to be advised to attend the Emergency Department and that it was mandatory for him to bypass the Emergency Department."

Mr McLeish did not really take issue with the principle that an A & E department was an appropriate place to refer an emergency. In my view he was right to do so and the statement is consistent with the literature referred to paragraph 60 above; it is just part of the background to this case.

63. In my judgment and having applied my critical faculties, the above issues whether taken individually or cumulatively do not raise realistic or credible grounds to undermine the opinion of Dr Russell.

64. In the circumstances I have concluded, not without some initial hesitation, that the Third Defendant has satisfied me that the Claimant has no reasonable prospect of success, the Third Defendant having adduced credible evidence that he acted in accordance with a responsible body of medical opinion and the Claimant having failed to persuade me that he has a realistic as opposed to fanciful chance of proving that he did not at trial.

65. I am not satisfied there is any other compelling reason this issue should go to trial, indeed without this issue the trial judge will be able to focus on the actions of Ambulance Trust and Health Trust without the unnecessary distraction of the allegations against Dr Tanna. This will have the added benefit of streamlining the trial and saving costs.

66. That is sufficient to dispose of the application for summary judgment and it is not strictly necessary for me to consider the parties submissions on factual causation. However, if this matter were to go further, it is right that I briefly state my conclusion on this issue.

67. Miss Toogood's submissions had a great deal of force. Paragraph 12 of the witness statement of Mr Langdon, who was the on call orthopaedic consultant at Watford General Hospital on 12 March 2012, states clearly that he would have required any GP to refer the patient to Accident and Emergency in circumstances where there had been no physical examination of the patient. However, it would seem that he was not on duty at the time it is alleged the telephone call should have been made and was only available on the ward from about 09.00.

68. Dr Kirby, who was an FY1 doctor, was the on call doctor who was on duty on the morning it was alleged the telephone call should have been made. Her witness statement is silent both as to her actual hours of work and as to what she would have done if such a telephone had been made.

69. In the circumstances, given the admissions policy document to which I have previously referred, giving rise to the possibility of direct admission to the Orthopaedic department, there is a potential issue of fact which could be resolved in the Claimant's favour. I think it unlikely it would be resolved in the Claimant's favour given Mr Langdon's evidence, however I am unable to say there is no realistic chance of success on this issue. In the circumstances I would not have granted summary judgment on the issue of factual causation.