Neutral Citation Number: **[2023] EWHC 3163 (KB)**

Case No: QB-2019-001102

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 08/12/2023

Before:

MR JUSTICE JAY

- -

Between:

MS JACQUELINE BEATTY **Claimant**

- and –

LEWISHAM AND GREENWICH NHS TRUST **Defendant**

- -
- -

Richard Furniss (instructed by **OH Parsons LLP**) for the **Claimant**
Anna Hughes (instructed by **Clyde & Co LLP**) for the **Defendant**

Hearing dates: 4th and 5th December 2023

- -

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.

This judgment was handed down remotely at 10:30am on 8th December 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MR JUSTICE JAY

MR JUSTICE JAY:

INTRODUCTION

1. In April 2016 Ms Jacqueline Beatty ("the Claimant") was an in-patient at the Queen Elizabeth Hospital, Greenwich ("the hospital") run by the Defendant. It is her case that a vascular surgeon, Mr Niall Aston, failed to diagnose an embolism. By the time this was diagnosed it was too late to save the Claimant's right leg, and in May a below-knee amputation was carried out at a different hospital.

2. This claim for clinical negligence focuses on just one event, namely Mr Aston's consultation and assessment on the ward on 13th April 2016. It is not now contended that the Defendant was negligent either before or after that date.

3. This was a relatively brief trial, with the evidence occupying just one day of court time. The relevant documents were quite limited in number. I heard oral evidence from Mr Aston and from two experts, Mr John Scurr (for the Claimant) and Mr Jonothan Earnshaw (for the Defendant).

4. This judgment will be divided into the following chapters:

   (1) Essential Factual Background (based on the medical notes).

   (2) The Evidence.

   (3) The Governing Legal Framework.

   (4) Discussion and Conclusions.

ESSENTIAL FACTUAL BACKGROUND

5. On 5th April 2016 the Claimant was admitted to the hospital following a fall. She was 46 years old and had no history of heart or vascular problems, notwithstanding a cryptic reference to a myocardial infarction in a GP summary which the parties are agreed is mistaken. In A & E it was noted that she had an extensive erythrodermic skin eruption which was painful and itchy. The Claimant was admitted under the care of the medical team. Their notes record that her rash followed a course of doxycycline and had worsened over the previous two days. Following initial blood tests the Claimant was started on intra-venous flucloxacillin and emollients. She was referred for a dermatology review and admitted to the ward under the care of a general consultant physician, Dr Tremble.

6. On 6th April it was noted that the blood cultures collected at admission had grown "gram positive cocci ? streptococcus". The impression was severe cellulitis. The microbiology department advised on a different antibiotic regime and that further imaging may be required to rule out deeper infection/necrotising fasciitis.

7. At 18:50 that day the Claimant was reviewed by Dr Shah, a SHO working at the hospital. He carried out a thorough examination and review, and noted in the records, "R middle + little toe have ? necrotic areas with exquisite tenderness on minimal palpation". There was a need to rule out "necrotising fasciitis ? trash foot of toes". The same doctor also noted that the orthopaedic team had reviewed the Claimant and had said that necrotising fasciitis was unlikely. At 19:55 Dr Shah carried out a handheld Doppler scan (a form of ultrasound which ascertains blood flow). This confirmed "biphasic signals in both posterior tibial and dorsalis pedis pulses bilaterally". Although a normal blood flow should produce triphasic signals, the limitations of the handheld Doppler are such that this scan could not be interpreted as providing evidence of abnormality.

8. At 21:50 or 23:50 (the handwriting is unclear) St Thomas' vascular team was contacted by Dr Hutton, the SHO working the night shift, to discuss the possibility that the Claimant had developed "trash foot", an embolic condition resulting from blockage of the small arteries of the foot by atherosclerotic debris. According to Dr Hutton's note of the advice they gave over the phone:

> "… if clinically trash foot to (1) treat with treatment dose dalteparin [a form of heparin], (2) vascular – duplex - imaging/vascular review mane [tomorrow]. Feels patient is unlikely to have this given lack of AF [atrial fibrillation] but worth treating if appears clinically."

By way of explanation, the Duplex is a more sophisticated Doppler scan which is carried out not with a handheld device but in the ultrasound/scanning department of the hospital. Its findings are more sensitive. It is common ground that the Claimant was administered dalteparin on a prophylactic basis.

9. On 7th April the microbiology department reported that blood cultures were positive for enterococcus faecalis and staphylococcus aureus. They advised that the Claimant's current antibiotics be stopped and that she be started on high dose intra-venous flucloxacillin.

10. At 13:10 on 7th April the Claimant was seen by Dr Tremble. The clinical issues she identified included bacterial infection and widespread cellulitis. There was also a reference to "? trash foot". Dr Tremble's junior has written perfectly legible notes, the relevant parts of which contain the following:

> "Rt foot: 3rd toe digital ischaemic ? embolic phenomenon. Dusky discolouration 1st to 3rd toes rt foot. Difficult to palpate pulses bilaterally due to oedema … (no need for arterial doppler at present → unlikely to be able to tolerate)."

11. Dr Tremble's plan included the carrying out of an echocardiogram, arranging a vascular review, and continuing with the antibiotics.

12. At 17:50 on 7th April the Claimant was reviewed by Mr Hasanov, a member of the vascular team at registrar level. The Claimant was found to have swollen legs and a scaly skin. All peripheral pulses were present and her capillary refill was normal. Examination of the 3rd right toe revealed bluish discolouration of the distal phalanx. Dr

Hasanov diagnosed ischaemia of the right third toe. A possible deep vein thrombosis was considered. His plan was that an arterial and venous Doppler ultrasound test (i.e. a Duplex ultrasound) should be performed.

13. At 9:00 on 8th April the Claimant was examined by Mr El Gaddal, a consultant general and vascular surgeon. She was found to have a dusky third toe along with swelling and redness of the right foot. There was blanching of the toe on palpation which is evidence of some abnormality in blood flow. His plan was the same as Mr Hasanov's. At 09:45 the Claimant was seen by Dr Tremble and nothing had changed.

14. A Duplex ultrasound scan of both of the Claimant's lower limbs, from groin to toes, was performed that day and its findings were unremarkable; no abnormality was detected. In particular, triphasic waveforms were observed. An echocardiogram showed no infective endocarditis and no other abnormality.

15. At 11:30 on 9th April the Claimant was reviewed by an SHO. The diagnosis remained the same, "? ischaemic right foot". The Claimant complained that she felt "rubbish" and that her right leg felt heavy.

16. Later that day, although the time is not legible from the notes, the Claimant was seen by Dr Tremble. On that occasion the current issues included "vasculitic changes in right third toe". The Claimant reported a sudden onset of palpitation, chest wall pain and a fast heart rate. For this reason Dr Tremble included as an issue, "new AF". An appropriate drug was prescribed.

17. At 9:20 (the exact time is unclear from the notes) on 10th April the Claimant was seen by Dr Shah. On examination it was noted that the 3rd toe in the right foot appeared ischaemic. It "looks worse than last week". Overall, the right foot was shiny.

18. At 9:20 on 11th April the Claimant was seen by a general physician. On examination it was noted that the third toe on the right foot was "? Ischaemic" and that there was "significant overload". An urgent vascular review was requested.

19. The request for an urgent vascular review was communicated orally to Mr Aston. He saw the Claimant at 12:15 on 12th April. According to the notes, with abbreviations expanded:

> "Patient eating lunch. Legs covered. Dopplers unremarkable.
> Plan: will review tomorrow."

20. The clear inference is that Mr Aston had seen the notes. The experts in this case are agreed that it is "a pity" that Mr Aston did not examine the Claimant on this occasion, but in my opinion nothing turns on it.

21. Mr Aston returned at 14:30 on 13th April to review the Claimant. According to his notes, again with abbreviations expanded:

> "History reviewed. Scans reviewed.
>
> Previous smoker. Non diabetic.

> On examination, right toes warm. Superficial haemorrhagic vasculitis of sole of toes on right foot.
>
> Impression – vasculitic picture rather than embolic.
>
> Plan – no further vascular input."

22. The Claimant remained in hospital until 23rd April 2016 when she discharged herself. I have read the medical notes for the period 13th to 23rd April although little appears to turn on them. If anything, the Claimant's condition seems to have improved. I deduce that this was because her acute presenting condition, her cellulitis, was indeed resolving. There are continuing references in the notes to vasculitis, no doubt reflecting the clinical opinion of Mr Aston that this was the correct diagnosis.

23. One particular entry in the notes for this period merits further attention:

> "21/4/16
>
> 09:56
>
> O/E 3rd toe on right foot → ulcer appears cleaner and dark tissue has sloughed off."

24. I will be returning to this when addressing the expert evidence, but this note does not prove that the Claimant was suffering from ischaemia brought about by an embolic process.

25. The Claimant returned to the hospital on 26th April in a confused and very unwell condition. It is unnecessary to dwell on any of the detail because the experts are now agreed that it was too late to save the Claimant's leg. They are also agreed that the Claimant suffered a further embolus or thrombosis whose source was the lower or distal aorta. Further it is common ground between them that the Claimant was not suffering from vasculitis on 13th April (or, indeed, at any relevant stage) but from an embolic disease process originating in the distal aorta. The course of that disease process is not in issue and I will address it at the appropriate time.

THE EVIDENCE

Mr Niall Aston

26. Mr Aston BA, FRCS was appointed a Consultant General and Vascular Surgeon at the hospital in 1992. Since 2003 the hospital has only had an outpatient vascular service plus ward reviews of non-urgent cases in normal working hours. In 2016 that service was being provided by a team headed by Mr Aston and Mr El Gaddal.

27. Mr Aston's evidence was that he was not informed that the referral to him was urgent. Nothing really turns on that because any delay in his assessing the Claimant was not critical to the outcome. Mr Aston states that he would likely have been informed that this was a patient with bacteraemia and cellulitis who also had an issue with her foot requiring vascular input.

28. Mr Aston was aware from the hospital records that vascular imaging had showed that the Claimant's arteries were patent with triphasic waveforms present. By that he means that the Claimant's arteries from groin to toes in both limbs showed no significant abnormality.

29. According to his witness statement, which must have involved a degree of reconstruction of the salient events from the available contemporaneous records, the Claimant's feet were normal "save for some superficial haemorrhagic vasculitis of the sole of the right toes". It is agreed that this superficial bruising would have shown up as discolouration of the relevant area. In Mr Aston's opinion:

> "These appearances were somewhat difficult to interpret in circumstances where it had been 7 days since the lesions were first observed and there were no other rashes present."

30. Mr Aston added:

> "A diagnosis of emboli was considered … but excluded in circumstances where:-
>
> (a) there was no history of arterial disease.
>
> (b) vascular imaging had demonstrated normal blood flow through the arteries in the legs …;
>
> (c) the Claimant did not have atrial fibrillation and … an echocardiogram had been undertaken. This showed a normal left ventricular cavity. Thus, there was no evidence of source of embolism …
>
> (d) the skin abnormalities did not appear typical of arterial embolism but were more in keeping with vasculitis."

31. Mr Aston did not consider that a CT angiogram was necessary as:

> "… embolisation from the aorta at the age of 46 is very rare and there was normal arterial flow into both legs: any significant thrombus in the aorta would have reduced arterial flow into one or both legs."

32. In conclusion:

> "A diagnosis of vasculitis was therefore suspected. This was a diagnosis of exclusion and was consistent with the appearance of the Claimant's foot."

33. Under cross-examination Mr Aston explained that an embolus occurs where a fragment of clot or arterial wall detaches itself from the heart or a major artery and then travels through the circulatory system to a point where the size of the fragment matches the width of the vessel. A blockage or a restriction in blood flow then ensues. The external signs of embolism include discolouration of the skin as a result of ischaemia. Vasculitis,

on the other hand, entails an inflammatory process and can be a reaction to an infection. The Claimant had a severe bacterial infection which carried with it a risk of mortality. Bacteria get into the blood vessels and there is an inflammatory response. Mr Aston added that in the small vessels, including the small arteries, the appearance is similar to ischaemia. At another stage in his evidence he said that vasculitis includes an ischaemic element.

34. Mr Aston was taken through the medical records. He agreed that the general physicians were concerned about the Claimant's right foot, in particular her toes, and were clearly thinking in terms of a possible embolism. Mr Aston repeated the point that ischaemia may be a sign of vasculitis and it may signify an embolism: it is consistent with both.

35. Mr Aston's interpretation of the advice given orally from the vascular team at St Thomas' hospital was that the Claimant should be treated with anticoagulants as a precaution. That was what happened.

36. Mr Aston agreed with counsel that he had been called to assess the Claimant in order to rule out ischaemia caused by embolism. He agreed that embolism had been within the differential diagnosis. When pressed on the difference between his note recording the state of the Claimant's toes and the notes of others at the hospital, Mr Aston's answer was that the appearances had changed.

37. Mr Aston was asked whether he agreed with the expert joint opinion that the Claimant probably was suffering from an embolism on 13th April. Mr Aston's answers were somewhat equivocal in response to this question. At first, he was hesitant about agreeing with the expert consensus, pointing out that he could not identify the source of any embolism. Then he said that he was not sure that it was an embolism on 13th April although "in hindsight, it probably was". Later in his evidence Mr Aston said that even with hindsight this was more likely to have been vasculitis. Mr Aston added that his diagnosis of vasculitis was based in part on his inability to identify an embolic source. Vasculitis, he said, was a common association of severe infection.

38. Mr Aston was asked about the episode of atrial fibrillation. He said that the echocardiogram showed no evidence of infection or of any embolism in the heart. That answer was correct insofar as it went, although the echocardiogram was carried out before the Claimant was complaining of palpitations. Nothing turns on this, however, because there is no evidence that these complaints continued or were still being made on 13th April.

39. It was put to Mr Aston that the experts were in agreement that on 13th April the disease process was micro-embolic and that the source was not the Claimant's heart. Mr Aston's answer was that (a) micro-emboli are not visible on a Duplex scan, and (b) 80% of emboli come from the heart and mainly from atrial fibrillation. Mr Aston referred to what appears to have been a meta-analysis published in 2017 which supported a figure of 86%. Given that this paper both post-dated the events with which I am concerned and was not disclosed to the court, I say no more about it. However, I am able to accept Mr Aston's clinical judgment that emboli emanating from an artery below the heart are rare. He also said that if the problem were in the aorta (and not visible on the Duplex scan), one would still expect to see changes on the scan, particularly in the groin. Initially, Mr Aston did not accept the proposition that the normal echocardiogram was

irrelevant if the source of the embolus was the aorta. Later he agreed that this scan would not pick up an embolus lower down the aortic vessel.

40. It was put to Mr Aston in direct terms that in order to exclude embolism it was essential to carry out a CT angiogram. His answer was as follows:

> "A CT angiogram was not mandatory. The chances of embolism from anywhere else were very small. Most likely this was an infection. Vasculitis was related to the infection. I diagnosed vasculitis as the diagnosis of exclusion."

41. Mr Aston was then asked whether he should have ordered a tissue biopsy to exclude vasculitis. His answer was it was for Dr Tremble to decide whether such a procedure was necessary, and that he discussed the issue with her. This is the first time Mr Aston made that suggestion. There is nothing in the notes or in the correspondence clearly to suggest this, and I reject that part of Mr Aston's evidence. I think that his memory is playing tricks with him.

42. I asked Mr Aston whether a CT angiogram should have been carried out because the consequences of this being an embolism were potentially catastrophic. Mr Aston's answer to that question was that it is not realistic to carry out tests to exclude everything.

Mr John Scurr

43. Mr John Scurr BSc, FRCS has had a very distinguished career in the NHS, private practice and latterly working for the CQC in public service. He retired from full-time NHS practice in 2006 and then worked part-time until 2014.

44. Initially, Mr Scurr was of the opinion that the hospital's management of the Claimant's deteriorating condition was unacceptable in relation to the period 26th April to early May 2016. He has changed his mind on that issue following discussions with Mr Earnshaw. Taken in isolation, I do not consider that this change of mind should be seen as a point against him. However, the point does not exist in isolation.

45. In his report dated 22nd October 2021, Mr Scurr expressed the following opinions:

> "e. Given her past history of myocardial infarction the probability of having underlying arterial disease was high and similarly, a pulmonary embolism would mandate exclusion of a thrombotic process.
>
> …
>
> h. I appreciate this lady had a number of other medical problems but essentially the problem she had related to the blood supply in her right foot.
>
> i. I note that there are several references to requiring vascular assessment but it is unclear whether this ever took place.

> j. A vascular assessment would have included a proper examination by a vascular surgeon including Duplex ultrasound imaging probably followed by angiography."

46. And then under the rubric, "Conclusion":

> "This lady presented with small necrotic changes of her toes, suggestive of embolisation. I do not think she was adequately investigated and a precise cause for the embolisation was not accounted for."

47. In the Joint Experts' Statement, Mr Scurr expressed the following opinions, either in agreement with Mr Earnshaw or on his own account:

> "9. We agreed that Mr Aston thought this was a vasculitic picture rather than embolic.
>
> …
>
> 12. We agreed Mr Aston probably did do an appropriate examination, but there were problems with the interpretation of his findings (see below).
>
> 13. Q. Mr Aston's impression was that the Claimant's symptoms were vasculitic in nature rather than embolic. Would this condition [it should say, diagnosis] be supported by a reasonable body of vascular surgeons practising in April 2016?
>
> A. Not acceptable.
>
> 14. Q. The recommendation was that no further vascular input was required. To the extent not covered above, please set out whether it was mandatory for Mr Aston to arrange any further investigations, including further Duplex ultrasound and CT angiogram.
>
> A. Was mandatory."

48. The experts were agreed that the diagnosis of vasculitis was not correct, and that:

> "[Q.16] the optimal investigation would have been a CT angiogram of the entire aorta, which would probably have led to the correct diagnosis with a clot visualised in the lower aorta [and, per Q17, to successful treatment]"

49. Mr Scurr said under cross-examination that he saw no difference for these purposes between NHS and private practice. His reason for withdrawing the allegation of sub-standard practice in relation to the period after 26th April was that it made no difference to the outcome, although he then went on to say that his department would have done more. He added that he has now taken a kinder view of the practice in what he described as this District General Hospital in respect of the later period.

50. Mr Scurr accepted that there was no evidence in the records of a previous history of myocardial infarction or pulmonary embolism. He said first of all that this was not relevant to his opinion. Eventually he agreed that if one were to remove these conditions from the equation "it does help but it does not exclude the possibility that she was at risk of a thrombotic event". By "it does help" I take Mr Scurr to accept, as must be obvious, that without a relevant past history the risk was lower.

51. Mr Scurr was pressed by counsel to justify para (i) of his "Opinion" (§45 above). He eventually accepted that the Claimant was reviewed by the vascular team on three separate occasions: that is to say, by Mr Hasanov, Mr El Gaddal and Mr Aston. Mr Scurr's point was that the Claimant was not properly assessed and/or that she was assessed "after a fashion".

52. Mr Scurr was taken to a previous case where he was subjected to judicial criticism for making mistakes and failing to justify his conclusions by providing reasons: *Kennett v East Kent Hospitals NHS Foundation Trust*, Canterbury County Court, 31st July 2018. Mr Scurr's explanation was that the judge failed to understand the evidence.

53. It was pointed out to Mr Scurr that he had criticised Mr Aston without taking the latter's witness statement into account. His explanation was that he prepared his report before seeing Mr Aston's statement and then, having read it, saw no reason to alter his opinion.

54. It was put to Mr Scurr that at no stage before giving oral evidence had he explained why no reasonable vascular surgeon could have diagnosed vasculitis rather than an embolism, and why it was mandatory to carry out a CT angiogram. Indeed, on one reading of his answer to Q.16 posed in the agenda for the joint experts' meeting, Mr Scurr fell short of saying that a CT angiogram was mandatory. Mr Scurr's answer was that Mr Aston should have recognised the limitations in Duplex scanning and have proceeded directly to the next step. The tests that had been performed "did not give them the answer", he said. In order to exclude embolus it was necessary to do more. He then added that the diagnosis of vasculitis could and should have been proved. Mr Aston was not entitled to rule out embolism on the basis of the information he had.

55. It was then put to Mr Scurr that there was a range of opinion on this issue, and that Mr Aston's reasoning process was not illogical. Mr Scurr totally disagreed and added that it was illogical not to consider all the factors. Mr Scurr denied that resource limitations might be relevant. He accepted that he should have done more in the reports than merely to assert that no reasonable body of vascular surgeons would have supported Mr Aston's practice. He then added this:

> "Most people would have said that it was embolic. It was embolic."

Mr Jonothan Earnshaw

56. Mr Jonothan Earnshaw MBBS, FRCS worked as a Consultant Vascular Surgeon within the Gloucestershire NHS Trust until his recent retirement. In his report dated 13th September 2021 he expressed the following opinions:

> "40. Mr Aston did not make the diagnosis of distal embolisation on 13th April 2016, but thought [the Claimant] had vasculitis.

> This was reasonable, since he had seen the results of the Doppler examination from 7th April 2016, and the Duplex scan from 8th April 2016, which did not suggest arterial disease. Reassured by these negative findings, no further tests were done, which in my opinion, was reasonable. There was no indication to arrange further investigation at this stage, and in particular CT angiography was not indicated.
>
> 41. If the diagnosis of digital embolisation had been considered a realistic possibility by Mr Aston in the presence of the negative tests obtained already, it would be mandatory to arrange investigations to seek the cause, i.e. the origin of the emboli. The investigation of choice would be CT angiography to look for a source of emboli within the aorta itself."

57. It was Mr Earnshaw rather than Mr Scurr who first clearly explained that if an embolism had been diagnosed on, say, 13th April 2013 appropriate treatment thereafter would have saved the Claimant's lower leg.

58. Mr Earnshaw's answer to Q.13 in the Joint Experts' agenda (see §47 above) was as follows:

> "Mr Aston explains that he concluded the findings were not embolic because the Claimant did not have AF, had a normal echocardiogram, normal Dopplers of the pedal vessels, and a normal Duplex scan of the arteries of the lower leg. He found the skin abnormalities "did not appear typical of arterial embolism but were more in keeping with vasculitis.". In my opinion this conclusion would be supported by a reasonable body of vascular surgeons."

It followed from the above that it was not mandatory for Mr Aston to arrange CT angiography.

59. When cross-examined, Mr Earnshaw agreed that acute ischaemia caused by emobilisation is usually limb-threatening. He accepted that it was necessary to build up the full picture from a consideration of all the available evidence. Mr Earnshaw stated that a clinical judgment is based on a constellation of different things and not just one factor.

60. He then said:

> "The problem is that with vasculitis/emboli the end result is the same: dead tissue. Vasculitis, either septic or inflammatory, causes damage to the external lining of blood vessels. I don't agree that this looked more like emboli. Emboli often presents in multiple toes and in both feet. The end result is much the same. There was purple discolouration, healing, scabs and then they fell off. The blood supply to the foot was still intact [here, Mr Earnshaw was dealing with the medical record dated 21st April 2016, §23 above]. There was a more major embolus later on. [I

> did not take a verbatim note, and I may have added the occasional word to put what Mr Earnshaw said in neater form]"

61. Later in his evidence Mr Earnshaw added that a significant embolus would show up in some way on the Duplex scan, whereas here there was nothing. He accepted that some vascular surgeons confronted with this clinical picture would have sought CT angiography but said that others would not. "We are taught to be rational", he said. By that I took Mr Earnshaw to mean that resources in the NHS are not infinite.

62. Mr Earnshaw accepted that ischaemic findings seen on one day do not disappear by the next.

63. Mr Earnshaw did not accept that Mr Aston was being asked to exclude a diagnosis of embolisation. He was being asked to consider the possibility of embolisation and then make a diagnosis based on the whole picture. Given the overall presentation, this was more likely to be vasculitis. Normally, one diagnoses vasculitis using an ANCA blood test. The results of such a test were noted in the records after 26th April (they were of course negative), but it is not clear when they were ordered.

64. In answer to my question Mr Earnshaw said that Mr Aston's diagnosis should not have been regarded as definitive for all purposes going forward. If the clinical picture changed, it would need to be reconsidered.

65. I asked Mr Earnshaw to consider para 41 of his Opinion (see §56 above). He agreed that para 41 should read: "had or should have been considered". He did not accept that Mr Aston should have considered embolisation as a realistic possibility. He repeated the constellation of factors relevant to the present case, including Mr Aston's findings on examination.

THE GOVERNING LEGAL FRAMEWORK

66. The classic *Bolam* test requires little explication or elucidation. The leading cases may be taken as read.

67. In a situation such as the present, the fact that Mr Earnshaw has expressed the view that a reasonable body of medical opinion would support Mr Aston's clinical judgment as reasonable in all the circumstances does not mean that I must perforce conclude that the Claimant's case fails. It is not my role to prefer one responsible body of medical opinion over another, but it is my duty to decide (a) whether Mr Earnshaw is right in saying this, and (connectedly) (b) whether Mr Aston, and for that matter Mr Earnshaw, have provided an adequate logical support for their relevant reasoning process as part of the formation of the clinical judgment in the first instance and the expert opinion in the second.

68. It follows, I think, that were I to conclude that a reasonable and responsible body of medical opinion would support Mr Aston's practice but that it was illogical, then I must reject Mr Earnshaw's expert advice to the court. That was the conclusion of the Court of Appeal in *ARB v IVF Hammersmith Ltd* [2018] EWCA Civ 2803; [2020] QB 93, at para 59.

69. Although I do not think that NHS resources are relevant to this case, because there is no evidence to suggest that CT angiography is expensive or time-consuming, it is well established that doctors are not required to undertake all conceivable tests in order to rule out realistic possibilities. In *Bolam* itself, McNair observed that:

> "A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work." ([1957] 1 WLR 583, at 594).

DISCUSSION AND CONCLUSIONS

70. In his closing submissions to me, Mr Richard Furniss for the Claimant accepted that I might be concerned about certain aspects of Mr Scurr's evidence. He may not have put it quite that way. Counsel's encapsulation of what Mr Scurr was saying was that no one in their right mind would have failed to order a CT angiogram given the presenting features of this patient. Mr Furniss submitted that in order to find for the Claimant I would have to make two findings: first, that Mr Aston was not entitled to rule out embolisation completely and diagnose vasculitis; and, secondly, that to rule out an embolism a CT angiography was mandatory. Put in these terms, it may be seen that Mr Furniss' two questions are interconnected.

71. Mr Furniss submitted that all the evidence shows that other doctors in the hospital, including Mr El Gaddal, a vascular surgeon, were concerned as to the possibility that the Claimant's ischaemic presentation had an embolic source. Even if one were to proceed on the basis of a 14% metric (derived from the 2017 meta-analysis), the risk or the index of suspicion was sufficiently high to demand that the next diagnostic step be taken.

72. Ms Anna Hughes for the Defendant was critical of Mr Scurr's evidence in a number of respects. She submitted that even if I were to accept that some doctors in Mr Aston's position would have ordered a CT angiogram, I should still accept Mr Earnshaw's evidence that a reasonable body of medical opinion would hold otherwise.

73. My point of departure is to identify the key issue in this case: was it mandatory for Mr Aston to have ordered CT angiography of the Claimant's aorta on 13th April 2016?

74. If the answer to that question were to be achieved by my giving a straightforward preference for the opinion of one expert over another, this case would be simple.

75. I regret to say that Mr Scurr was not a satisfactory witness. He was combative in answering some of Ms Hughes' perfectly fair and reasonable questions, and betrayed at several points in his evidence a degree of partisanship which came close to advocacy. For example, when pressed on the *Kennett* decision, Mr Scurr said that it was "one of the few cases I was involved in we didn't win". Further, there are mistakes in Mr Scurr's reports. I do not accept Mr Furniss' attempt to save sub-para (i) of the Opinion section of Mr Scurr's main report (see §45 above). Putting aside Mr Aston's examination of 13th April, both El Gaddal and Mr Hasanov carried out proper vascular assessments of the Claimant. Further, the answer to Q.4 in the joint expert agenda mistakes Mr Aston for Mr El Gaddal. Mistakes such as these should not be made in expert reports.

76. More importantly, nowhere in Mr Scurr's main report do we see any attempt to identify the key issue in this case or to supply any reasoning directed to the conclusion that the standard of care was inadequate. The closest we come to it is sub-para (j) but that does not go far enough. To say that a proper assessment would probably require angiography is not a solid platform for a conclusion that this test was mandatory. We see the same looseness of language in Mr Scurr's assent in the joint statement to the proposition that "the optimal investigation would have been a CT angiogram". The adjective "optimal" is not a synonym for "mandatory".

77. But perhaps Mr Scurr's most egregious shortcoming was to reach an opinion in his main report without properly analysing Mr Aston's witness statement. What we learned in cross-examination is that he wrote his report before reading that statement but did not sign it off until he had done so. There was nothing in it to cause him to change his mind. On any view, Mr Aston's witness statement was not addressed and it contained substantial food for thought.

78. Mr Scurr's answers to Qs. 13 and 14 in the joint agenda were unacceptably terse. An expert is required under the CPR to set out the reasoning for his conclusions. This obligation exists even if the reasons seem blindingly obvious to the maker of the opinion.

79. It was only in cross-examination that Mr Scurr began to develop a reasoned argument to support the proposition that CT angiography was mandatory. However, it seems to me that he veered somewhat between two lines of thought. According to the first line, CT angiography was required because without it an embolism would not have been diagnosed. That is correct insofar as it goes, but it begs the question and/or proves too much. On this argument, CT angiography would always be required even if its presence was not a realistic possibility. According to the second line of argument, CT angiography was necessary in this case because the Claimant's presenting signs looked embolic rather than vasculitic. Clearly, there is greater logical force in this argument, but in my view Mr Scurr has still failed to address the right question. In a nutshell, he has failed to address whether no reasonable body of medical opinion would support Mr Aston's clinical judgment. Furthermore, I heard nothing from Mr Scurr which addressed the evidence of Mr Aston, repeated in slightly different language by Mr Earnshaw, that a diagnosis of ischaemia – without more – does not distinguish between an embolic process on the one hand and a vasculitic process on the other.

80. In rejecting Mr Scurr's first line of thought, I should make it clear that I am also rejecting the notion that Mr Aston's task was to exclude an embolic disease process. Here, I accept that Mr Furniss has more material to work with. Mr Aston accepted in cross-examination that he was called in to rule out ischaemia caused by embolism. It could well be said that his contemporaneous notes do not state that embolism had been ruled out. The "impression" was of vasculitis, although that needs to be read in conjunction with the "plan" of no further vascular input. The final resting point of Mr Aston's evidence was that vasculitis was the diagnosis "of exclusion".

81. My overall assessment of Mr Aston is that he is a thoughtful, careful clinician who did not rush to judgment in the Claimant's case. Under the forensic spotlight his thoughts were not always expressed with the precision a lawyer would like to hear, but the exercise of clinical judgment has an important intuitive and experiential component. My analysis, in line with Mr Earnshaw's evidence, is that it was not Mr Aston's duty

definitively to rule anything out. His duty was to examine and assess the Claimant, and to express a clinical opinion. That opinion would include a diagnosis and a plan, the latter depending on the former. In an ideal world, and no doubt in many clinical situations, a doctor *will* be able to conclude that the diagnosis is certainly X rather than Y; but in the real world that degree of sureness will often not be possible.

82. Mr Aston's "diagnosis of exclusion" should not therefore be interpreted as the expression of a clinical judgment to the effect that this definitely was not embolic. Mr Aston was saying something less definitive. How exactly Mr Aston's diagnosis should be interpreted is a topic which I will need to consider in a moment.

83. Before doing so, I must address Mr Earnshaw's evidence. In my judgment, he was a measured and careful witness who made concessions where appropriate and answered questions both directly and without emotion. In virtually all respects, his evidence was compelling and could immediately be accepted.

84. The one potential Achilles' heel in Mr Earnshaw's evidence concerns para 41 of his report (see §56 above). Mr Earnshaw accepted that the critical clause should read:

> "If the diagnosis of digital embolisation had **or should have** been considered a realistic possibility by Mr Aston in the presence of the negative tests obtained already, it would be mandatory …" [with necessary words added]

Mr Earnshaw told me that with the notional insertion of these words he would adhere to his conclusion that a reasonable body of medical opinion would support Mr Aston's practice on this occasion. He relied in part on Mr Aston's note of what he saw on examination.

85. In my judgment, this reformulated wording contains the correct legal test. Here, the position is of course being examined at the conclusion of Mr Aston's assessment rather than at the outset. Given the potential seriousness of digital embolisation as well as the uncertainties, I would hold that although it could not be incumbent on Mr Aston to exclude it altogether, it was his duty to ask himself the question whether it was a realistic possibility. If the answer were in the affirmative, it is clear that he would then have to proceed to the next stage, namely CT angiography.

86. I should deal at this stage with Mr Aston's note. What he apparently saw was "superficial haemorrhagic vasculitis". That is consistent with the findings of others that this was bluish discolouration. The word "superficial" may be more debatable, and it might have been better to write "ischaemia" in place of "vasculitis", being a more neutral term. However, at the end of the day I think that we are playing with words. The end-point of both embolism and vasculitis is ischaemia, and to the trained naked eye the patient's skin looks discoloured. I cannot accept that Mr Aston wrote down other than what he saw, and the notion that he ought to have seen, or interpreted, something different is not plausible.

87. Mr Aston did not use the language of "realistic possibility" in his witness statement and oral evidence. However, in answer to a question put to him in cross-examination (see §80 above), Mr Aston said that the chances of this being embolic were "very small" and that this was "most likely" an infection, and by implication vasculitic. Mr Aston's

oral evidence did not differ materially from his witness statement (see §31), although it may be that at that stage he was assessing the risks *ex ante*. I have set out Mr Earnshaw's evidence directed to the presenting features of the Claimant's case (in the Joint statement, see §58 above), as well as his answer in cross-examination (see §63 above) directed to the nature of Mr Aston's task. My reading of Mr Earnshaw's evidence taken as a whole is that a reasonable body of medical opinion would support Mr Aston's assessment that digital embolisation could in practical terms be excluded because the chances of it being that were sufficiently low.

88. Mr Furniss did not cross-examine Mr Aston or Mr Earnshaw explicitly on the basis that a realistic possibility of this being embolic could not be excluded. Instead, he chose to take the higher ground – that embolism could not be logically excluded without CT angiography. It was only when, at the very end of his evidence, I asked Mr Earnshaw a question about para 41 of his main report that the issue acquired the significance that I believe it warrants. It follows that if I were to find for the Claimant I would be doing so on an alternative case not explicitly supported by Mr Furniss and not prefigured by the Claimant's expert. That would be deeply unsatisfactory.

89. In my judgment, a common-sense and non-legalistic approach to the evidence of Mr Aston is required. He lives in the world of clinical judgments rather than fine linguistic and legal distinctions. My overall interpretation of his evidence is that he concluded that this was unlikely to be embolic and/or that the chances of this being embolic were very low. He has explained why: the relative youth of the Claimant; the unremarkable scans; the absence of AF (at the material time); and a presentation of ischaemic signs which were more consistent with vasculitis, against the backdrop of serious infection. Statistical and/or epidemiological factors also support him, as does the absence of a relevant medical history. The Claimant's smoking will not have helped, but that factor was expressly noted. These matters have all been considered by Mr Earnshaw, but not by Mr Scurr. I accept Mr Earnshaw's oral evidence, in answer to my question, that Mr Aston's diagnostic conclusions may be interpreted as excluding a realistic possibility of digital embolisation, and that a reasonable body of medical opinion would agree.

90. It follows that this claim must be dismissed.