Neutral Citation Number: [2024] EWHC 2227 (KB)

Case No: KA-2023-00088

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 28/08/2024

Before :

MR JUSTICE JULIAN KNOWLES

- -

Between :

WAYNE ALLARD	**Claimant/ Respondent**
- and –	
GOVIA THAMESLINK RAILWAY LIMITED	**Defendant/ Appellant**

- -
- -

Caroline Allen (instructed by **Eversheld Sutherland (International) LLP**) for the **Defendant/Defendant**
Conor Kennedy (instructed by **Irwin Mitchell LLP**) for the **Claimant/Claimant**

Hearing dates: 13 December 2023

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Approved Judgment

This judgment was handed down remotely at 10:30 on 28 August 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Mr Justice Julian Knowles:

Introduction

1. This is an appeal with the permission of Sir Stephen Stewart granted on 19 September 2023. It arises out of a personal injury claim brought by the Claimant (C) (who is the Respondent to this appeal) against the Defendant (D) (which is the Appellant). The cause of action was negligence. For clarity, I shall refer to the Appellant as D and to the Respondent as C.

2. In brief, C claimed damages for injuries allegedly caused by him breathing in a noxious chemical whilst at work which the D should not have caused or permitted him to be able to use.

3. D appeals the order of Mr Recorder Cohen KC, dated 3 May 2023 made following a trial on causation and *quantum*. D admitted liability shortly before the trial.

4. In [2] of his order the judge ordered D to pay C £27,000 (plus interest) by way of general damages. In [6] he ordered C to file and serve an affidavit verifying his Schedule of Losses dated 21 April 2021, and in that affidavit to deal with any other earnings he had received in the period after 4 February 2020 from an employer called Elite or from any other employer.

5. D originally sought permission to appeal on five grounds, however permission was only granted on Grounds 4 and 5. The others are not now pursued.

6. The relevant subsisting grounds have been renumbered as Grounds 1 and 2. They are as follows:

    a. Ground 1: as to [2] of the order, the judge erred 'in the exercise of his discretion' and demonstrably failed to take into account evidence before the Court in that he awarded C the sum of £27,000 in respect of general damages (together with interest).

    b. Ground 2: as to [6], the judge erred in the exercise of his discretion in declining to assess special damages at trial, and in ordering C to file an affidavit verifying his Schedule of Loss and addressing loss of earnings from 4 February 2020 onwards (in respect of which no damages are sought).

7. In fact, as Sir Stephen Stewart pointed out in granting permission, and as I also pointed out, the judge did not 'exercise a discretion' in fixing damages; he reached a figure based upon his application of the relevant damages guidelines based upon his evaluative assessment of the evidence before him.

8. D sought permission to appeal against the judge's finding that its (by then) admitted negligence had caused the injury, but permission was refused, and so the appeal on Ground 1 is against *quantum* only.

9. Prior to consideration of the Defendant's appeal, it sought (and was granted) a stay of execution of the order of 3 May 2019 by an order of Sir Stephen Stewart dated 6 June 2023. The matter remains stayed pending the outcome of this appeal.

10. The nature of the issues on this appeal has required detailed consideration not just of the judgment below, but also a great deal of the evidence. This has taken time.

11. As well as my detailed notes, I have consulted audio recordings of the hearing in preparing this judgment.

Background

12. C pursued a personal injury claim against his former employer, D, Govia Thameslink Railway Limited, arising out of an incident at work on the night shift of 3/4 January 2017 when he was exposed for a period of approximately two hours (perhaps a little less) to fumes from a paint stripper containing dichloromethane (DCM or DME), a noxious chemical generally banned for use save in limited circumstances which are not relevant to these proceedings.

13. C had been tasked with removing paint from train axles using the paint stripper to allow them to be examined with ultra-sound equipment as part of safety checks, and became ill afterwards. As I have said, D accepted the C should not have been able to access a DCM based paint stripper.

14. Immediately after his exposure C suffered chest pains and was taken home by his supervisor in the middle of the night. Later that day (about 10-11 hours after the exposure) he attended hospital, and then later that day saw his GP.

15. C alleged that he suffered respiratory injury as a result of the exposure, in the form of permanent exacerbation of his pre-existing constitutional asthma.

16. The parties' respective cases were summarised by the judge as follows at [13]-[14] (the Defendant is GTR; the judge misnamed C as 'Mr Allardy'):

> "13. Mr Allardy's (*sic*) case is that this incident has caused permanent injury to his health by exacerbating his asthma as described by Dr John Collins, the medical expert called on his behalf. Dr Collin (*sic*) says that Mr Allardy must avoid contact either with DCM or other volatile fluids. Mr Allardy seeks both general damages and special damages for his loss of earnings and a *Smith v Manchester* award for damage to his prospects of employment.
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> 14. GTR's pleaded case was that it was neither in breach of duty nor was it negligent in relation to the incident which occurred. The case summary succinctly records GTR's contention that 'any exposure would have been minimal and regarded as de minimis.' GTR alleged that the task was carried out was well ventilated and that it would rely on a report by Socotec showing that the risk

> associated with DCM was 'considerably below the workplace exposure limit for the task … and the location he undertook it in.' GTR also alleged, relying on the evidence of Dr Charles Hind, that no injury of any kind was caused by the admitted incident which had occurred. Mr Allardy has merely continued to suffer from his pre-existing conditions of asthma, eczema and allergy. He has suffered no loss. A plea of contributory negligence on the part of Mr Allardy was also raised. Save for a non-admission, GTR has not pleaded to Mr Allardy's schedule of losses. Very late in the day, GTR's position has changed."

17. Under the heading, 'The issues for determination', the judge said at [18]:

> "18. The headline issues were whether the incident had caused injury and, if so, the nature of that injury and the quantification of the losses. Whether injury had been caused required determination of the nature and duration of the exposure to DCM in which it had been inhaled and what symptoms, if any Mr Allardy had suffered immediately in the incident."

18. Part of D's case is that neither when C attended hospital on 4 January 2017, nor when he saw his GP later that day, did he report the sort of symptoms which might have been expected in relation to asthma if, as he later maintained at trial, his pre-existing asthma had been exacerbated by exposure to DCM. He did not, for example, complain of shortness of breath. As I have said, he complained of chest pains, and thought he was having a heart attack.

19. The matter was listed for trial on two separate occasions and was twice adjourned. It eventually proceeded on 3 and 4 April 2023 before the Recorder. The last sentence of [14] in his judgment was a reference to the fact that breach of duty was conceded by D shortly before trial (on or around 31 March 2023), and so the trial hearing was concerned solely with causation and *quantum*.

20. C's original statement of value limited the claim to up to £3,000, with special damages pleaded at £234.95. No admission as to C's losses was made in D's Defence, and a Counter-schedule was served, putting him to proof.

21. An application was made by the Claimant thereafter to increase the value of the claim to £200,000. Permission was granted by DJ Lightman at an attended hearing on 15 October 2021, although the revised Schedule of Loss does not appear to have been served until some seven months later, in May 2022. This was substantial (in excess of £121,000).

22. By an order dated 15 May 2022 following a second attended hearing before DJ Lightman, C was granted permission to serve an updated witness statement by 7 October 2022. The order did not make provision for the service of an amended Counter-schedule by D.

23. By application dated 31 March 2023, shortly before trial, D sought permission to rely upon an amended Counter-schedule, in which nil offers were made in respect of each head of loss claimed by C.

24. The application was heard on the first morning of trial on 3 April 2023 before the Recorder; permission was refused; and a short *ex tempore* judgment handed down. The judge said this:

> "2. Today is the first day of the trial of a claim by the claimant for personal injuries suffered whilst at work, by inhaling fumes which are said by the claimant to have caused injury. The situation is this. The claim as originally issued, carried with it a schedule of loss identifying losses of £234.96. The claimant made a claim to damages not exceeding £3,000.
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> …
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> 4. The schedule for which permission was granted in 2021 is of an entirely different character. It details loss of earnings, which is spelt out in loss of pay for particular periods of time. It gives credit for payments received and it carries on to allege loss of pension contributions which it spells out, and details them properly. There is an interest calculation with it. There is also a claim for a *Smith and Manchester* award seeking compensation for disadvantage in the labour market. That was the state of affairs with no counter schedule specifically dealing with the individual heads beyond the statement of non-admission, which persisted.
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> 6. The counter schedule which was served by the defendant last week, really takes the matter very little further. It recites in its preamble that the defendant has denied breach of duty, has denied causation. It asserts the claimant is asthmatic, atopic, suffers from hay fever, eczema and it deals with his history. It mentions the medical reports which are not agreed. It is the defendant's case that the claimant did not suffer any injury following the alleged chemical exposure on 4 January 2017. I interject to say that when the draft counter schedule was served last week, breach of duty on the part of the defendant was denied, although this morning it is admitted that the defendant was in breach of duty, by the exposure of the claimant in the course of his employment to a chemical, which has dangers associated with it.
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> 7. Returning to the counter schedule it continues, 'Amount offered for general damages, nil", it then has the heading,

"Disadvantage on the labour market" it says causation is denied, the claimant has failed to serve evidence, amount offered nil. Past loss of earnings records the primary contention that the claimant's injuries are not related to the accident. The evidence of Dr Hinds is mentioned which sets out, "It would be reasonable to conclude that the claimant has not suffered from any injury due to the alleged chemical exposure.' The defendant repeats what is stated in the preamble on causation, the defendant offers nil. Loss of pension contribution, similarly, is a repetition of causation, and the defendant offers nil.

8. In my judgment, the counter schedule is one which wholly fails in the purpose which the court expects it to serve in personal injury litigation, certainly of this character where the claim is measured by quite significant sums. If I take the maximum level of £200,000 as demonstrating that, I treat that as a significant claim in which any employee has suffered loss in the course of his employment.

9. The purpose of schedules and counter schedules is to understand what happens if the court accepts the claimant's case that injury of some kind was caused by the exposure to the chemicals in question. In my judgment, this counter schedule serves no purpose whatsoever and I would for that reason alone, decline permission for it to be served at this stage. The counter schedule has completely failed to engage with what might be the claimant's losses if, which the defendant denies, injury of some kind was caused

10. There is more which affects the exercise of discretion which I must briefly note. No reason has been expressed to me about why this counter schedule or a counter schedule has not been served until later on. What is said is the defendant has been denied the opportunity to serve a counter schedule. In my judgment, that is entirely wrong.

11. Two hearings took place before District Judges, at which the defendant was, according to the orders made by the court, legally represented. Permission was granted to serve a new schedule, and on later stage an extension of time to serve it. If the defendant wished to serve a counter schedule, the appropriate response was to ask for permission which would readily have been granted by the court.

12. Courts struggle with the management of time and they depend upon efficient and normal approaches by parties to

> the conduct of the litigation. It is utterly unsatisfactory, in my judgment, for a counter schedule of any description to be served at this stage. The more so because that counter schedule actually failed to get to grips or deal with the losses in the schedule. For example, I take loss of earnings. This is an employer defendant of the claimant as its employee. It must know what were the earnings of the claimant during his employment and it is this which forms the basis of the calculation of loss during periods in which the defendant was unable to earn. Equally, pension contributions and the effect of the loss of those contributions is something of which the employer can be expected to have information of a kind which is better than can be expected of an employee. I would expect that to be dealt with properly in a counter schedule.
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> 13. It is not the sole reason for which I am refusing the permission to serve the schedule, but I would say that the basis on which I am asked to exercise discretion to permit it to come in late, is not one which has been satisfactorily made out. The principal reason is that the proposed counter schedule serves no useful purpose beyond the existed pleaded case of the defendant. I therefore reject the application."

25. Accordingly, C was required only to prove his loss and damage.

26. The trial concluded on 4 April 2023. On the final afternoon of the trial the Recorder indicated that he did not believe that he was going to be able to reach findings on *quantum* based upon the evidence before him, He suggested three options:

    a. that he accede to D's submission that there was no evidence supporting *quantum*; or

    b. that he assess *quantum* on the basis of the documents before him and on the basis that there was a verification of the schedule in the statement of case, or

    c. that that he say that he was unable to deal with special damages at that time.

27. Both counsel for C and counsel for D requested that the judge select option (b). Counsel for the D submitted that this would then (in effect) lead to option (a). Counsel for the C that if option (b) were held not to be possible, option (c) would be preferable.

28. Judgment was handed down on 3 May 2023. The judge held that causation had been established and awarded the sum of £27,000 in general damages. That award gives rise to Ground 1.

29. In relation to Ground 2, this arises in the following circumstances.

30. As I have said, the judge rejected the main submission of both counsel that he proceed to assess special damages on the evidence as it then stood, and permitted further evidence from C verifying the special damages claimed.

31. The relevant part of his judgment of 3 May 2023 was as follows:

> "83. With regard to special damages, I have already noted what I consider to be the defect in the evidence of Mr Allardy in that it does not, apart from the statement of truth, verify his schedule which it ought to have done even if the verification was relatively cursory. I have already noted the mere non-admission by GTR of the schedule when its case was actually there was no loss and nothing else. That non-admission is, in part at least, highly unfortunate because the response of GTR ought to have been to deal, so far as it could, with the schedule if, which it denied, its breach of duty and negligence had caused Mr Allardy's injuries. Unlike a case where a stranger's actions have caused losses, GTR was Mr Allardy's employer. It was in a position to admit or challenge what he said as to his earnings as well as the pension contributions allegedly lost. Very often, the employer will be better able to do this than the employee. The only head to which this does not apply is earnings for which credit has been given by an employer named Elite.
>
> 84. Both Mr Kennedy and Ms Allen make the same primary submission that I should proceed to make my assessment on the evidence as it stands. In Mr Kennedy's case, he says that the verification of the schedule by the statement of truth should be enough in the circumstances. His fall back position is that if I am against him in this regard, I should permit further evidence of a formal nature to verify the losses. In Ms Allen's case, she asks me to find that the evidence does not prove the special damages so that I should find no loss. She says it would be unjust and prejudicial to GTR to permit any further evidence, even of a purely formal kind.
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> 85. I do not find either Mr Kennedy's primary submission or Ms Allen's submission to be attractive. In my judgment, both submissions risk wholly unnecessary injustice which can be speedily and cheaply avoided. If I make an award in favour of Mr Allardy but he truly is unable to prove the losses in the schedule, the injustice would be to GTR. If I refuse to receive formal further evidence, the injustice would be to Mr Allardy because I am sure that there were financial losses which he has suffered.

86. In many cases, a submission of the kind addressed by Ms Allen might find some sympathy. A trial of liability and quantum ought to yield a final result. What is unusual is the difficulty caused by GTR having maintained its denial of breach of duty and negligence as well as asserting contributory negligence right to the eve of the trial. I have some sympathy of a limited kind in Mr Kennedy having believed that that special damages were accepted by GTR if the Court found that injury was caused. I have noted that even Ms Allen's skeleton argument dealt with special damages only briefly – in paragraph 11. Her skeleton did not take the proof point which I myself raised rather than asserting the losses were not attributable to the exposure or that the losses were short term with no special damage prior to 27 April 2018. I can well see why this confirmed Mr Kennedy's impression that the damages were admitted if I found as I have. I have also noted that Ms Allen did not seek to deal with any issue of quantum with Mr Allardy whilst he was in the witness box. The non admission would have entitled her to do this although it would not have entitled her to raise a positive case or to lead evidence.

87. I have decided to exercise my discretion to permit further formal proof from Mr Allardy as to his losses if, in the light of my findings, they cannot be agreed as to quantum, albeit that can be without prejudice to GTR's denial that any loss was caused. I will hear submissions when judgment is handed down as to when and how this proof should occur and the scope of any questioning which is proposed. If it is agreed that some course is appropriate such as an affidavit verifying the losses, I am likely to accept that course.

88. I have not yet dealt specifically with a *Smith v Manchester* award. My factual findings that Mr Allardy's prospects for employment have been affected by his injury suggest that such an award may be appropriate. However, I see no reason to decide that or its quantum until the formal proof is taken as I need to be open minded to the possibility that something may emerge which affects whether such an award is appropriate at all or its quantum. An example might be if Mr Allardy had found suitable and secure permanent employment in which the prospects of exposure to volatile solvents was avoided.

(5) Disposition

89. I find in favour of the Claimant and will award general damages in the sum of £27,000. I will exercise my

> discretion to allow further formal evidence verifying the special damages claimed. I will hear submission when this judgment is handed down in Court on how and when that will occur. I will also hear submissions on costs as well as any other application which the parties make."

32. The judge heard submissions on 3 May 2023. He ordered in [6] of his order dated 4 May 2023 that that formal evidence should take the form of:

> "… an affidavit verifying the schedule of losses dated 27 April and deal[ing] with any other earnings that the Claimant has received in the period after 4 February 2020 from the employer named Elite or from any other employer since that date".

33. This gives rise to Ground 2. Evidence was duly filed and served in April 2023. A single page affidavit from C dated 9 May 2023 was also filed and served.

34. Paragraphs 7 and 8 of the judge's order provided:

> "7.By 4pm on 24 May 2023 the Defendant must give notice by letter to the Claimant's solicitors which if any of the figures within the said schedule it disputes.
>
> 8. If the Defendant seeks to cross-examine the Claimant on his affidavit, it shall so indicate at the same time as giving notice in accordance with paragraph 7."

The experts' joint statement

35. The two experts prepared a joint statement dated 28 October 2022 on whether C had been injured by DCM as he claimed. The salient parts were as follows.

36. They agreed that the C was at the relevant time a forty-nine-year-old man whose parents originated in the Caribbean, and grew up in the UK. He indicated to Dr Hind that he had smoked ten – twelve cigarettes per day between the ages of twenty/twenty-five and approximately 2009. However, at the time of his assessments by his GP and in the local Chest Clinic in 2017, it was noted that he was a current smoker.

37. C described exposures to DCM during the course of his work on the night shift on4 January 2017, and a further exposure later the same year. Both doctors agreed that dichloromethane can result in irritation of the respiratory system.

38. Both doctors agreed with C's treating chest consultant, that this man is an asthmatic individual. In addition, he suffers from both hay fever and eczema. His history of asthma dates back to the 1990s

39. For the same, prior to events in 2017, C had been prescribed occasional steroid and bronchodilator inhaler therapies, and also required antibiotic (with on occasions, steroid tablet) therapy for respiratory tract infections with resultant exacerbation of his

underlying constitutional asthma. His asthma symptoms were also apparent when he was suffering from hay fever symptoms.

40. To both doctors, C gave a history of the development of worsening chest symptoms following exposure to DCM on the 4 January 2017, namely 'severe breathing difficulties', chest pain and palpitations. However, that account of both the nature and the timing of the development of those symptoms did not accord with the information contained within C's extensive contemporary medical records.

41. Thus, as regards chest pain, C first presented with this symptom to his GP prior to the incident on 4 January 2017. Namely, to his GP on 29 December 2016 ('bit of pain in lower left back – bottom of rib cage – first to press on it') and 30 December 2016 ('three day getting pain on the left side – pointed at it for me').

42. On 4 January 2017 C indicated to his GP 'four – five days' pain in side'. For the same C had attended the Casualty Department, and undergone a chest X-ray ('normal'). Indeed, he had been given a sick note by his General Practitioner for left flank pain from the 30 December 2016 – 13 January 2017. That sick note was continued from the 4 – 18 January 2017.

43. In Dr Collins' view that flank pain was caused by coughing.

44. In Dr Hind's view that flank/chest wall pain was most probably secondary to muscle strain from coughing, in turn secondary to a further lower respiratory tract infection as documented by his GP earlier in December 2016.

45. As to breathlessness, although C reported to both doctors that he developed shortness of breath following the incident on 4 January 2017, at the time of his assessment by his GP later the same day, it was noted 'not short of breath'. Furthermore, on examination his chest was clear.

46. In his medical report, Dr Collins concluded that exposure to DCM on the 4 January 2017, as a consequence of the irritant properties of the chemical in question would be included in the term occupation related asthma, meaning C as an asthmatic reacted adversely to some feature of his workplace. C's persistent coughing was an indication of his increased airway irritability from asthma. The airway irritability of asthma is fluctuant as demonstrated by the diurnal variation of peak flow with active asthma. The finding that his breath sounds were normal at times in the day is not unusual and evidenced by variability of peak flow.

47. Based on C's contemporary medical records, Dr Hind disagreed with that view. Had this been the case, in his view there would have been evidence of exacerbation of C's asthma at the time of his assessment by his GP on 4 January 2017. Instead, C specifically denied any shortness of breath, and no evidence of asthma (ie wheeze) was noted on examining his chest.

48. The likely consequences of exposure to an irritant are as described in the Reference 1, contained within Dr Hind's report. As indicated, the effect on the respiratory tract is immediate, and often associated with eye and nasal symptoms. C had experienced similar symptoms in the past from his hay fever (eye and nasal symptoms with

associated wheeze), and accordingly was well aware of this trigger for those symptoms. Yet, at the time of his assessment by his GP on the 4 January 2017, C did not recount such a history, as would have been anticipated, in Dr Hind's view, had he had significant exposures to a respiratory irritant.

49. Subsequent entries within his GP case records confirm the history of the development of chest symptoms prior to the incident reported on the 4 January 2017.

50. Thus, on the 18 January 2017, C indicated 'one-month cough' and 'chest wall pain with cough", on the 24 January 2017 'fed up, frustrated, diagnosed viral illness two months ago' and 'then developed left-sided lower rib pain. Sent for chest X-ray – normal", and on 17 February 2017 'left-sided chest wall pain – persistent', and 'unwell for ten weeks – on/off – missed work. Persistent cough".

51. Dr Collins' view is that while C's asthma had been active prior to the incident on 4 January, that did exclude the possibility that when examined by the GP that day his symptoms had resolved.

52. Dr Collins' view is that most of the clinical features of the C were not specific or exclusive to one condition.

53. Based on the above, in Dr Hind's view, C's contemporary GP case records do not support C's account of the timing of the onset of his chest symptoms in relation to the incident on the 4 January 2017. In his view the same were most probably precipitated by a further lower respiratory tract infection in December 2016. By virtue of the persistent cough for the same, he 'strained' his chest wall with resultant persistent pain, further aggravated by his persistent cough.

54. Dr Collins' view is that many of the symptoms of 'respiratory infections' are indistinguishable from those of asthma. Most 'respiratory infections' are presumptive diagnoses unsupported by laboratory confirmation since both conditions can share several clinical features.

55. C was symptomatic for a protracted period before the cited incident and continuing for some time afterwards.

56. Dr Hind's view is: that there was no suggestion from his contemporary medical records at the time that his symptoms had been precipitated by an event at work. Since early 2020, C has been off work because of his skin condition.

57. For the reasons indicated in his report, in Dr Collins' view, C has persistent asthma as a consequence of his previous exposures to DCM.

58. Based on the information provided, in Dr Hind's view the incident alleged by C in January 2017 has had no impact on the natural history of his atopic (allergic) asthma.

The judge's judgment on liability and *quantum*

59. At [27] the judge said:

> "27. In Mr Allardy's case, he has been much more deeply personally involved in the unfortunate events of that night from that night onwards. It is true that on the night in question he suffered an event which he found distressing and caused panic because he thought he was having a heart attack. I recognise the possibility that this may have affected his perception. Nonetheless, I have found him to be a good witness who gave very clear evidence I have not found him to be prone to exaggeration. I do not regard it as likely that any witness was trying to mislead me but caution is required as to the precise times and durations of the exposure."

60. At [49] the judge turned to the evidence about the symptoms immediately suffered by C after his exposure on 4 January 2017. He said:

> "49. Mr Allardy's evidence is that after stripping 4 axles and whilst still in the pit under the train, he thought he was having a heart attack. He was suffering from severe chest pain and, in his own words, he 'had difficulty catching my breath'. He stated in his witness statement that he felt 'scared and anxious'. In cross examination, he described his state as one of panic. He was permitted to leave his shift and was actually taken home by Mr Bourne, his supervisor. Once home, he 'continued to suffer with chest pains and breathing difficulties' and therefore attended an urgent care centre at Newham Hospital where he was taken by his wife and examined. Later he went to his GP and he was seen again in a hospital chest clinic before returning to work. He returned to work after being off sick nearly 5 weeks later.
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> 50. Mr Bourne saw Mr Allardy in the office as I have just described. According to his evidence, Mr Allardy was complaining of chest pain and that he could hardly move. His evidence was that he offered to take Mr Allardy to hospital but he insisted on being taken home. Mr Bourne himself took Mr Allardy home, a journey of about an hour, even at that time of the morning.
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> 51. Ms Allen on behalf of GTR challenges Mr Allardy's evidence in two respects:
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> 51.1. She submits he was not complaining of breathing difficulty. She asks me to reject this part of his evidence and accept Mr Bourne's recollection as a full account of what Mr Allardy reported.
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> 51.2. She asks me to also to find that Mr Allardy's evidence is much exaggerated as to what he was suffering

– it is perhaps right to point out that GTR's case remains that Mr Allardy suffered no harm whatsoever as a result of his de minimis exposure to DCM. She submits if he really thought that he was having a heart attack, it is incredible that he insisted on Mr Bourne taking him home rather than to hospital.

In support of these submissions, she draws attention to Mr Allardy's own evidence that he was panicked and scared from which she infers that he was confused and therefore unreliable in this part of his evidence. In contrast, Mr Bourne was a calm observer who was a good witness reporting accurately and fairly his recollection. She prays in aid the interpretation of Dr Hind, GTR's medical expert, that Mr Allardy was not complaining of breathing difficulties later on 4 January.

52. I have considered these submissions with care. Unlike some other submissions which have been addressed by Ms Allen, they are developed from material which has some real basis so that careful evaluation is required both of the witnesses and other facts pointing to probability. My conclusion is that I accept the evidence of Mr Allardy as to the symptoms he was suffering in the immediate aftermath of the incident for reasons which I will now set out.

53. The important starting place is to recognise that Mr Allardy was giving first hand evidence as to the incident itself and also as to what he suffered. Mr Bourne's evidence is of what Mr Allardy told him when asking for permission to leave the shift and, to some degree, how Mr Allardy appeared to him. In relation to Mr Allardy, the question is whether I can accept his evidence as probable. In relation to Mr Bourne, the question which I asking is whether his evidence shows that Mr Allardy said something which was inconsistent with his evidence or, perhaps, that Mr Bourne observed something calling into question Mr Allardy's account.

54. I found Mr Allardy to be a good witness who truthfully reported his perception of what occurred on the night of 3/4 January. His evidence of the incident itself has actually been proven to be absolutely accurate (in contrast to Mr Bourne's witness statement) and that gives me confidence in the quality of his evidence. Although I am repeating myself, what I am really asking is whether there are reasons why I should not accept his account in relation to what he suffered.

> 55. Mr Allardy has lived with what occurred both in the weeks after the incident when he remained off work and ever since. There is no doubt he felt frustration and possibly anger as to the difficulty and delays in getting the truth out of GTR as to the chemical used. I am also sure that he was frustrated by what was undoubtedly the most unfortunate refusal by GTR until the start of this trial to accept its responsibility for what had occurred and, equally offensively, to attempt to blame him for the incident without any proper basis. Despite this frustration and anger which he was able to recognise himself, I have not detected any exaggeration or embellishment of his evidence as a result of it. Indeed, Mr Allardy's own evidence was that he was panicked and scared, possibly even somewhat confused in the wake of the incident. That recognition of his own state is something which may be a strength rather than a weakness in relation to a witness whose evidence in relation to the incident has been absolutely accurate. It does not necessarily detract from the accuracy of what Mr Allardy says were facts although it might bear on the rationality of his decision making. Nonetheless, I have noted Ms Allen's point and regard this as something to be weighed in deciding if I can accept his evidence. In that process, I need now to evaluate Mr Bourne's evidence and other pointers to probability.
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> 56. In Mr Bourne's case, I reiterate that I find that he did not set out to mislead me in his evidence. However, I have already found his evidence to be actually misleading in two aspects of important detail which I have explained. This does not provide me with confidence in the reliability of his evidence, particularly as to detail."

61. The judge then set out reasons for preferring C's evidence to that of Mr Bourne. He concluded at [60]:

> "60. I find as a fact that Mr Allardy at the time of the incident and when he saw Mr Bourne at about 02.51 was suffering severe chest pain and breathing difficulty. I do not find that Mr Bourne's account is inconsistent with this or that it undermines my confidence in Mr Allardy's evidence. I doubt whether a finding is actually necessary on whether Mr Allardy specifically said to Mr Bourne that he was suffering breathing difficulties but, although this is less clear than the evidence that he was actually suffering breathing difficulty, I would prefer Mr Allardy's evidence to that of Mr Bourne."

62. The judge said at [62]-[63] (italics as in original):

> "62. [Dr Collins] explains that DCM may cause an irritation to the airways and tissues of the lungs. He continued that in Mr Allardy's case *the inhalation of fumes from this volatile fluid, on the balance of probabilities, caused an irritant exacerbation of his asthma. Not by an allergic response, but rather by physical irritation of the bronchial mucosa. Which may be liked to provocation of dermatitis by abrasion with a fabric or other non-reactive material.* In fairly moderate terms, Dr Collins explained that for the foreseeable future, this may cause persistent symptoms from asthma which may be difficult to remedy. The conclusion was that the exposure had made the asthma much worse and more difficult to control and may affect Mr Allardy's employability. In his opinion, Mr Allardy must avoid inhalation not only of DCM fumes but also fluids and vapours unrelated to DCM may also cause his asthma to be worse. (I have noted that Nitromoors is avolatile solvent, albeit not containing DCM.)
>
> 63. After reviewing Mr Allardy in September 2022, Dr Collins' conclusion was similar but rather stronger in view of the fact that longer had passed. This conclusion noted that the asthma was improved at time of the examination and that there were normal breath sounds without wheezes. His opinion remained, however, that the increased activation of the asthma would persist indefinitely.
>
> …
>
> 68. Nothing emerged in the cross examination of Dr Collins which caused him to retract his conclusions or reasoning and nor did anything in his evidence provide me with cause for concern. I must now review the evidence of Dr Hinds which will enable me to decide whether Dr Collins' evidence has satisfied me of its conclusions."

63. In relation to Dr Hind's evidence the judge said this:

> "69. Dr Charles Hind is a Consultant Physician in General and Respiratory Medicine. He examined Mr Allardy on 1 September 2022. Like Dr Collins, Dr Hind has reviewed the medical records but, unlike him, he had reviewed the pleadings and also Mr Allardy's witness statement of 11 February 2021. Amongst the things which Dr Hinds will have therefore seen were GTR's assertions in its Defence that the area in which the stripping task was done was well ventilated and that the professional report of Socotec showed that the risk associated with DCM was well below

the workplace exposure limit for the task and location in which he undertook it. Dr Hinds recorded a second exposure working outside.

70. Dr Hinds's (*sic*) conclusions were that the symptoms alleged by Mr Allardy were not consistent with the medical records, particularly on 4 January 2017 which was the day of the incident. Specifically, he could not find anything which suggested that Mr Allardy might have suffered breathing difficulty. His view was that it was more likely that the symptoms of which Mr Allardy was complaining on 4 January 2017 were explained by a chest infection from which he had been suffering and from which there might have been a rib fracture caused by coughing which was not shown by x-ray. In his opinion, the incident had no impact on the natural history of Mr Allardy's atopic asthma. He also noted that Mr Allardy had been off work because of his skin condition.

71. If I accept Dr Hinds' (*sic*) evidence or if it causes me to doubt Dr Collins' evidence so that it does not satisfy me on the balance of probabilities, no injury or other consequence will have been caused by the incident. That was GTR's case.

72. Dr Hinds was in Court and listened to the evidence of fact which emerged as to the detail of the incident and with which I have already dealt. This did not affect his conclusion. I will say at once that I found this somewhat surprising. It was common ground between the two doctors that the duration of the exposure and the concentration of the vapour were highly influential to the probability of consequences. Yet, despite there being no dispute between the witnesses as to this, there was no re-evaluation by Dr Hinds of his conclusions. The reason became apparent within the first few minutes of cross examination: Dr Hinds readily accepted that integral to his reasoning was that he did not believe Mr Allardy as to the symptoms he had suffered. Although he said so with less clarity, the same is likely to be true as to Mr Allardy's account of the incident. In my judgment, it is entirely outside the remit of an expert to decide which witnesses of fact he believes or disbelieves.

73. Ms Allen has submitted to me that a medical expert can and should form a view as to whether he believes a Claimant. I do not accept this submission as put. Of course, it is entirely proper for a medical expert to say that the medical records are not consistent with what a person claims were his symptoms. However, in failing to

appreciate or deal with the possibility that the account of the symptoms provided by Mr Allardy might be true, Dr Hinds has deprived the Court of what evidence he might have been able to give if the Court accepted the truth of that account. What Dr Hinds does not begin to address or explain is the improbably absence of breathing symptoms caused by the exposure to and inhalation of a high concentration of DCM vapour in a confined and unventilated space over a period of 1-2 hours. Although this was not elicited in cross examination, the only likely explanation I can see is that he was persisting in thinking this was a minor and safe exposure to a low concentration in a well-ventilated space. Dr Hinds' report specifically notes the denial in the Defence that it was *denied that he was exposed to harmful level of* DCM.

74. In support of Dr Hinds theory, he has looked at and interpreted the medical records. I need to concentrate on 4 January 2017. Dr Hinds has drawn attention to two references:

74.1. The Urgent Care Centre's note recording *no difficulty in breathing*

74.2. The GP's note recording 'No SOB' [shortness of breath]. These, he interprets as inconsistent with Mr Allardy having reported that he suffered any breathing difficulty. Perhaps most extremely, Dr Hinds records *Mr Allardy specifically denied any shortness of breath.* He explained his reasoning to support this supposed specific denial that the GP would have asked the question *Are you short of breath* or something similar to which Mr Allardy would have replied *No.* I have added emphasis to reflect Dr Hinds actual words. My view is that this [is] exaggeration by Dr Hinds based on speculation. Shortage of breath can be diagnosed by observation and not merely based on questions and answers from a patient. He cannot safely have gone as far as saying that there was a specific denial by Mr Allardy.

75. The are other points as to why I am doubtful as to Dr Hinds' theory:

75.1. Both doctors agree that shortage of breath or even wheezing is likely to reduce or abate over time as well as the fact that asthma is episodic so that between attacks there may not be symptoms. Approximately 11 hours had elapsed after Mr Allardy's exposure to DCM. There is a significant possibility that some of his symptoms had reduced significantly or even abated. Such reduction or

abatement is different from the effect which had occurred according to Dr Collins on the mucous membranes of the airways.

75.2. Once again context is important in understanding what both the Urgent Care Centre and the GP were and were not considering in what was an urgent appointment. They were not dealing with an incident of inhalation of a toxic chemical – Mr Allardy did not know that he had inhaled DCM and GTR remained in denial of this for at least 6 more months. I have described this already as diagnosing blind to the facts. That blindness made the recent history of chest infection the obvious thing to be considering. Nonetheless, Mr Allardy was referred to a chest clinic suggesting that breathing issues were in mind. Also, whether it was the Urgent Care Centre or the Chest Clinic who were enquiring as to a COSHH statement itself suggests that they were considering possible causes of symptoms other than the recent chest infection.

Expert Evidence - Finding

76. I have contrasted the evidence of the two experts and I prefer that of Dr Collins which I find conservative, clear and persuasive in reaching a moderate conclusion on the facts. I regret that I find the problems with Dr Hinds evidence do not give me confidence in his expert opinion which, in any event, does not help me in relation to the incident and symptoms I have found.

77. I therefore accept Dr Collins' evidence and find that injury was caused as he describes."

64. The judge's judgment on *quantum* began at [78] of his judgment. He said:

"78. With regard to general damages, Mr Kennedy [for C] submits that I should find that the injury fits within the following guideline [ie, the Judicial College's Guideline]:

'(b) Chronic asthma causing breathing difficulties, the need to use an inhaler from time to time, and restriction of employment prospects, with uncertain prognosis.

£26,290 to £43,010'

79. Ms Allen [for D] submits that if I find there was some irritation/exacerbation of the existing asthma, it was for a very short period for which she says that the appropriate award is £2,200-£5,320. Of course, this submission does

> not reflect my factual findings and acceptance of Dr Collins' evidence that this is a permanent injury which will affect employment prospects and will cause breathing difficulties from time to time.
>
> 80. In considering the appropriate bracket, I have noted the age of Mr Allardy at the time of the incident as 43 so that restriction to his working will be for a long period, albeit that some employment might be found which avoids contact with irritants. Thus it is not likely that Mr Allardy will work again as an engineer.
>
> 81. I have also borne in mind that the immediately lower bracket of Mild asthma-like symptoms affecting working or social life with the likelihood of substantial recovery with a few years of the exposure to the cause leads to an award in the bracket £19,200 to £26,290. In this case, Mr Allardy always suffered from asthma so that it is the worsening must be considered. The character of the asthma has moved from a common disease managed by medication to one which is more difficult to control with common therapies, will be permanent and has the effect that Mr Allardy cannot be expected to do any job which exposes him to volatile solvents of any kind, as did his job as a railway engineer. If this was the bracket which I adopted, I would select the top of this bracket which is little different from the bottom of the bracket suggested by Mr Kennedy.
>
> 82. I will accept the bracket submitted by Mr Kennedy and I find that Mr Allardy is at the bottom end of that bracket. I award £27,000 for the injury."

65. The final part of the judgment, which I quoted earlier, dealt with the issue of further evidence from C in support of his special damages claim.

Grounds of appeal

66. In relation to Ground 1, the Defendant submitted as follows.

67. Ms Allen said the judge had failed to take into account evidence that was before him when awarding C £27,000 general damages plus interest. Whilst Ms Allen accepted that an appellate court generally takes a restrictive approach to appeals on *quantum* (see eg *Santos v Eaton Square Garage Ltd* [2007] EWCA Civ 225, [2]), she said this was an appropriate case for this court to intervene because the judge had gone wrong on a matter of principle and/or had reached a conclusion which was plainly erroneous because he had misapprehended the facts.

68. She said that the judge correctly had identified the basis upon general damages had to be assessed at [81] of his judgment, namely that, 'In this case Mr Allard has always

suffered from asthma so that it is the worsening that must be considered.' No issue was taken with this. As Ms Allen made clear, D now accepted that there had been *some* worsening of C's asthma as a result of his DCM exposure. However, she said that it had been nowhere near as severe so as to justify the judge's *quantum* figure under the Guidelines.

69. D therefore challenged this evidential conclusion by the judge as being plainly erroneous and unsupported by the evidence:

> "81. … The character of the asthma has moved from a common disease managed by medication to one which is more difficult to control with common therapies, will be permanent and has the effect that Mr Allard cannot be expected to do any job which exposes him to volatile solvents of any kind …"

70. Ms Allen said this assessment of C asthma was incorrect because:

    a. there was no evidence before the judge to substantiate the assertion that the C's asthma had become more difficult to control with common therapies and/or that it was not being well managed by medication: in fact, the opposite was the case;

    b. C's asthma was constitutional in origin and permanent in any event; and

    c. it was conceded by Dr Collins that he had no evidence as to the C's susceptibility to volatile compounds, save for DCM.

71. On behalf of C, Mr Kennedy submitted that I was being asked to substitute my own view for that of the judge who heard the evidence and that, as I was an appellate court, I was not in a position to do that. Like Ms Allen, he also said the judge's decision on *quantum* had been one of 'discretion' which I should not interfere with. I have already referred to this not wholly accurate characterisation of the judge's decision.

72. He said there had been ample evidence of long term deterioration in C's asthma, based on C's own evidence, which had not been challenged in cross-examination. He said the focus of the cross-examination had been on his symptoms immediately post-exposure on 4 January 2017, and whether he had suffered breathing difficulties. This had been 'high-risk strategy' which had failed because the judge accepted C's evidence.

73. Also, he said that the judge had been entitled to reach the conclusions that he did based on Dr Collins' report and his evidence.

74. Mr Kennedy said that the key passage of cross-examination of Dr Collins relied on by D in connection with Ground 1 (set out below), which it said to show he agreed that C's asthma had gone back to pre-exposure level, when read properly and in context, showed that what Dr Collins had been saying was that there had been an improvement since C's 4 January 2017 exposure, rather than an improvement back to his pre-exposure condition.

75. Overall, Mr Kennedy said the judge was entitled to find as he did.

76. On Ground 2, Ms Allen submitted as follows. She said the judge had erred in declining: (a) to determine special damages and whether a *Smith v Manchester* award should be made (and the *quantum* of the same) at trial on 4 April 2023 and, following a further hearing on 3 May 2023; and (b) in ordering the Claimant to file an affidavit 'verifying the schedule of losses dated 27 April 2021 and … deal[ing]…with any other earnings he has received in the period after 4 February 2020 from the employer named Elite or from any other employer since that date'.

77. A *Smith v Manchester* award is an award of general damages representing between about three months' and five years' net earnings to reflect the contingent future risk that a claimant will find him/herself on the open labour market for longer between jobs if the range of available jobs is reduced by his/her injury. As such, it is a claim for a contingent future loss of earnings: see the eponymous case at: [1974] EWCA Civ 6, and the more recent case of *Palmer v Seferif Mantas and Liverpool Victoria Insurance Co. Ltd* [2022] EWHC 90 (QB).

78. Stripped to its essentials, D's submission was that it was for C to prove his losses in whatever form he chose; he did so; by serving his Schedule of Loss verified by a statement of truth and the judge should have decided the matter on that basis. A statement of truth was sufficient verification of truth. He should not have allowed C a further opportunity to adduce evidence to improve his case. Ms Allen said orally (and perfectly politely) that the judge had rejected the agreed position of counsel and 'gone on a frolic of his own'. He should have just determined damages at the time in the interests of proportionality as much as anything.

79. C had not claimed damages for loss of earnings for the period after 4 February 2020, and any evidence concerning loss of earnings from that point onwards would be pertinent only to a *Smith v Manchester* award.

80. On behalf of C, Mr Kennedy submitted in outline that what the judge did in permitting further evidence on damages was a case management decision taken in the exercise of his discretion. The judge carefully considered both sides' positions and gave detailed reasons for ruling as he did. I should therefore not interfere with his case management decision.

Discussion

Ground 1

81. I bear in mind, as was common ground, that I cannot overturn the judge's conclusion finding on *quantum* absent some error of principle or something in his reasoning which is plainly erroneous. In particular, I cannot intervene simply because I might have made a different award had I been trying the case. This following passage from *Santos* is pertinent:

> "2. Before turning to the circumstances of the case it is appropriate to state and keep in mind the approach of this court to quantum appeals. It has long been established that we do not interfere with an award unless satisfied that the

> judge acted on some wrong principle of law, misapprehended the facts or that the amount awarded was wholly erroneous. It is not sufficient that the members of this court would have awarded a different sum if they had been sitting as the court of first instance -- see *Flint v Lovell* [1935] 1 QB 354, *Owen v Sykes* [1936] 1 QB 192. If anything, the current approach is less rather than more interventionist. Thus, in *Ashdown v Michael* (unreported) [98/0516/2] Buxton LJ stated that:
>
> > "It should only be in exceptional cases … where this court should be asked to consider interfering."
>
> For my part, I would add that in this context it is pertinent to have regard both to the sums of money involved and the cost of appellant litigation and to ensure that the one is not disproportionate to the other."

82. Furthermore, the judge's assessment of *quantum* followed from his findings of fact after a trial. Appellate courts have been repeatedly warned by cases at the highest level not to interfere with findings of fact by trial judges, unless compelled to do so. This applies not only to findings of primary fact, but also to the evaluation of those facts and to inferences to be drawn from them: see eg *Fage UK Limited and another v Chabani Limited and another* [2014] EWCA Civ 5, [114]. Similar *dicta* can be found in many cases such as *Henderson v Foxworth Investments Limited* [2014] 1 WLR 2600 and *Grizzley Business Limited v Stena Drilling Limited* [2017] EWCA Civ 94, [39]-[40]. In the former case at [67], Lord Reed gave examples of the limited circumstances when such interference by an appellate court was justified, namely when a critical finding of fact had no basis in the evidence, or was based on a demonstrable misunderstanding of, or failure to consider, relevant evidence. I was also referred to *In re B (A Child) (Care Proceedings: Threshold Criteria)* [2013] 1 WLR 1911, [52]-[53], where Lord Neuberger of Abbotsbury PSC said:

> "52. There is no question of this court interfering with, or indeed being asked to interfere with, the findings of primary fact made by the judge Bearing in mind that it is a second appeal tribunal, the Supreme Court is virtually never even asked to reconsider findings of primary fact made by the trial judge. The Court of Appeal, as a first appeal tribunal, will only rarely even contemplate reversing a trial judge's findings of primary fact.
>
> 53 As Baroness Hale JSC and Lord Kerr of Tonaghmore JSC explain in paras 200 and 108 respectively, this is traditionally and rightly explained by reference to good sense, namely that the trial judge has the benefit of assessing the witnesses and actually hearing and considering their evidence as it emerges. Consequently, where a trial judge has reached a conclusion on the primary facts, it is only in a rare case, such as where that

> conclusion was one (i) which there was no evidence to support, (ii) which was based on a misunderstanding of the evidence, or (iii) which no reasonable judge could have reached, that an appellate tribunal will interfere with it. This can also be justified on grounds of policy (parties should put forward their best case on the facts at trial and not regard the potential to appeal as a second chance), cost (appeals on fact can be expensive), delay (appeals on fact often take a long time to get on), and practicality (in many cases, it is very hard to ascertain the facts with confidence, so a second, different, opinion is no more likely to be right than the first)."

83. All of this I bear firmly in mind.

84. The first and most important issue, is whether the judge was right to conclude (at [81] of his judgment) that C's asthma had moved from 'a common disease managed by medication to one which is more difficult to control with common therapies will be permanent and has the effect that Mr Allardy cannot be expected to do any job which exposes him to volatile solvents of any kind, as did his job as a railway engineer'.

85. As I have said, this was Dr Collins' opinion, which the judge accepted. Ms Allen attacked this paragraph in particular.

86. The focus of Ground 1 was upon the judge's treatment of the expert evidence. However, it seems to me, having carefully read and re-read the judge's judgment, that an equally important issue was that he accepted C's evidence about his symptoms and the worsening of his asthma later in 2017 following the incident on 4 January 2017.

87. C's witness statement of 11 February 2021 said, in summary, that on the night of 4 January 2017 he started to suffer with significant chest pains and had difficulty in catching his breath; he thought he was having a heart attack; and felt scared and anxious and was taken home. He continued to suffer with chest pain and breathing difficulties and attended hospital. He had many hospital and GP appointments because he felt increasingly unwell and had flu like symptoms and a dry cough and felt very weak. In August 2017 his chest problems significantly worsened. He said he continued to be under review for his debilitating symptoms.

88. In cross-examination he was asked about when he reported to his supervisor Mr Bourne:

> "Q. And you did not mention breathing problems at that stage at all, did you?
>
> A. When? Yes, I did. I couldn't breathe. I told him I was having palpitations and I had difficulty breathing. I actually thought I was having a heart attack."
>
> …

Q. What I am going to suggest to you is that in fact, your recollection of what took place is not accurate. You did not think you were having a heart attack. You felt that you were in pain, but you were not experiencing shortness of breath –

A. No, that –

…

Q. – and you did not believe you were having a heart attack, because if you had, then you would have asked to go to the hospital.

A. That's incorrect.

…

A … I went to the hospital.

Q. Did you drive yourself?

A. No, my wife drove me to the hospital. Because I went into the house with palpitations, couldn't breathe. She took me back into the car, dropped me to the hospital, the hospital kept me overnight. They thought at first I had a cracked rib. They were doing x-rays for a cracked rib and all this, different things, why I'm having breathing problems. And then they couldn't find any breakage or anything like that, so they asked me to go to my doctors, they're signed a referral and my doctor referred me to a chest specialist."

89. Towards the end of cross-examination he was asked about the GP's record of 4 January 2017 which recorded 'No SOB':

"Q. Again, Mr Allard, there is a specific history no shortness of breath. Would you accept that that is accurate?

A. No, that's not true. I was fine up until we started using this chemical. So like I said, we was using a chemical since the late 2016. So when these new trains came in and their axels had to be stripped. They can't run the trains, they can't do these tests on them, and they all come fully powder coated. So when I actually become really ill was because I was under that train for much longer than that. I explained to you, they used to flood the train out with guys, ten to fifteen of us or more, and we would be in and out much more quicker."

90. Mr Kennedy is therefore correct in his submission that whilst there was a challenge to C's evidence about his symptoms immediately following his exposure, there was no challenge to C's evidence about the worsening of his symptoms or the other matters in his witness statement.

91. So far as C's evidence is concerned, the judge was entitled to reach the findings that he did in relation to it. He saw and heard C give evidence and found him to be a reliable witness. He rejected the specific challenge that C had not had breathing problems on 4 January 2017 following his exposure to DCM, and found that he had. In line with the principles I set out earlier, I cannot properly interfere with these findings.

92. It is clear that the judge's acceptance of C's evidence affected his assessment of the expert witnesses' evidence. One of his criticisms of Dr Hind's evidence was that he had not dealt with the possibility that the account of the symptoms provided by C might be true.

93. Turning to Dr Collins' first report, dated 11 March 2020, reviewed C's medical records. He concluded at [3.6]-[3.8] that on the balance of probabilities, C's exposure to DCM had caused an irritant exacerbation of his asthma by physical irritation of the mucosa; when the severity of asthma is increased by any mechanism it may leave the individual with persistently active airway irritability presenting as wheezing, coughing and breathlessness; such a reaction on the balance of probabilities had been induced in C; for the foreseeable future this may have caused C to have persistent symptoms from his asthma which may be difficult to remedy.

94. Dr Collins saw C in September 2022 and produced an updated report, dated 5 October 2022. This contained a review of the then recent medical records:

> "1.50 For this revised report a further A4 file of clinical records of the Claimant to 2020 [this obviously should read 'from 2020', given the analysis which follows deals with the records from 2020] was available for review. During the additional period the health records were dominated by his skin problems, his non-alcoholic steatorrhea (fatty liver) and type 2 diabetes.
>
> 1.51 Reviews of the Claimant's asthma during that period show that it was well controlled without further exacerbations or the need for increase or revision of his treatment."

95. Dr Collins' account of what C told him was as follows:

> "3.2 When asked about his health the Claimant said the most difficult thing for him was his very extensive dermatitis. Of his breathing, he reported that it is much improved, he does have to use an inhaler but not more than once a month. He still feels physical limitations and has not returned to work. He has been unemployed for two

years. When again asked about his breathing, the Claimant replied 'still as it was before', but he agreed he was no longer struggling for breath. His sleep is occasionally broken by wheezing, but less frequently than once a week. He is able to walk unlimited distances at a steady pace.

3.3 On examination the Claimant had extensive dermatitis of his scalp and hands. His pulse was 109 bpm regular with normal heart sounds. His chest expansion was normal and there were normal breath sounds audible throughout his lungs without any wheezes."

96. Dr Collins' key conclusions in his report were:

"4. Opinion

4.1 The Claimant was first diagnosed with asthma in 1992 which was difficult to control requiring changes in his medication.

4.2 The Claimant had frequent exacerbations of asthma provoked by a variety of causes needing frequent changes in his treatment.

4.3 In June 2015 he had a raised blood eosinophil count of 0.6 10*9/L (normal < 0.5). Studies have shown that 35 to 40% of people with asthma have raised blood eosinophil levels may be allergic to environmental antigens (e.g.: house dust mite, pollens) which can cause increased reactivity of their asthma.

4.4 The clinical records of the Claimant did not show that allergic factors caused problems with control of his asthma.

4.5. In July 2017 the Claimant was reviewed by GPs Dr Sikka and then Dr Koneru and for the first time the role of his work were considered as possible causes for his breathing difficulties.

4.6. It was then that a possible connection was considered with a paint stripper containing DME (dichloromethane) he was using at work was affecting his asthma.

4.7. This compound has been shown to be a potent cause of inflammation of the lungs, skin, liver, and other organs.

4.8 In his work the Claimant was not provided with protective masks or satisfactory ventilation at work when using recognised hazards such as DME.

4.9 The Claimant's exposure to DME caused irritation and inflammation of his respiratory tract and a deterioration of his asthma, by physical (chemical) irritation of the tissues of his lungs, particularly airways

4.10. When the severity of asthma is increased by any mechanism, it can cause persistent inflammation of airways causing wheezing, cough, breathlessness, and resistance to treatment.

4.11 On the balance of probabilities exacerbation of the Claimant's asthma was caused by inhalation of fumes from DME.

4.12. For the foreseeable future the Claimant may have persistent asthma which may be difficult to control with standard inhaled medications.

4.13. The Claimant must avoid further exposure to DME or other volatile fluids.

4.14. This susceptibility to react to volatile compounds may impact on his employability on the open market.

…

5. Conclusion

5.1 The increased activity of his asthma has persisted and is more difficult to control with standard inhaled therapies.

5.2. This type of asthma is referred to as work-associated asthma. On the basis that the Claimant was asthmatic before known to be asthmatic before his exposure to DME (*sic*).

5.3 To date DME is not listed by the HSE (Health and Safety Executive) as a cause of occupational diseases

5.4 The term Occupational asthma implies that asthma is caused *de novo* through factors at work

5.5. For the future the Claimant must avoid inhalation of fumes of DME and other volatile compounds.

5.6. Thus he may react to fluids and vapours, unrelated to DME, making his asthma more difficult to treat.

> 5.7. The increased activation of his asthma, on the balance of probabilities, will persist indefinitely.
>
> 5.8. This may impact on his employability on the open market."

97. The passage of cross-examination principally relied upon by D on Ground 1 which it said undermined the judge's central conclusions was this:

> "MS ALLEN: But, Dr Collins, may I ask, you have referred to the increased activation, is that increased activation upon exposure to volatile compounds, or increased activation generally speaking?
>
> A. It's true of increased activation generally.
>
> Q. Because what we have from the claimant recounted to you is that he said in fact his breathing difficulties became very much better, are greatly improved.
>
> A. Correct.
>
> Q. And on the face of it, that would not appear to be consistent with increased activation, would it? That would appear to be consistent with decreased activation in fact.
>
> A. Yes.
>
> Q. So in fact, what the claimant reports to you is decreased activation of his asthmatic symptoms.
>
> A. Yes.
>
> Q. And what I understand you to be saying is that he continues to be vulnerable to exposure to volatile compounds --
>
> A. Which can provoke his asthma.
>
> Q. Which can provoke his asthma. But it will be fair to say, wouldn't it, that as an asthmatic individual prior to exposure he would have been vulnerable to irritation by volatile compounds in any event.
>
> A. Yes.
>
> Q. And in fact, what there isn't is any evidence of increased vulnerability, he was vulnerable before, he remains vulnerable, but that is due to his constitutional asthma.

A. Yes."

98. I accept that this passage, read alone, could be read as meaning that Dr Collins was saying that C's asthma had returned to pre-exposure levels. However, it has to be read in context. That context is in particular: (a) the exchange which immediately preceded it; and (b) Dr Collins' conclusions in his reports, which he did not retract.

99. The extract I have quoted came immediately after this passage (my italics):

> "MS ALLEN: I'm looking now a page 355 paragraph 4.12 where you say:
>
> 'For the foreseeable future the claimant may have persistent asthma which may be difficult to control with standard inhaled medications.'
>
> Now, at the time you saw him it wasn't difficult to control with standard inhaled medications.
>
> A. No.
>
> Q. And you mentioned he must avoid further exposure to DMC, but of course it's not a substance that anybody should be exposed to without appropriate protective equipment, you would accept?
>
> A. Yes.
>
> Q. Now, would it be fair to say that you have no evidence as to the claimant's susceptibility to react to volatile compounds, other than (inaudible).
>
> A. No, I don't.
>
> Q. And in respect of the claimant's chronic skin condition, it's accepted I think by you and Dr Hind in the joint report that that's unrelated to his exposure.
>
> A. Yes. But I'm not a dermatologist.
>
> Q. At paragraph 5.7 you refer to increased activation of his asthma, but in fact as at the time you saw him there was no increased activation, nor was that (inaudible).
>
> A. No.
>
> Q. And you refer to his liver condition, paragraph --

MR RECORDER COHEN: Just one moment, I am just trying to digest the question and answer. Were you asking, Ms Allen, on 5.7 whether on the day he was seen his asthma was at an increased level, or were you asking a question about whether his asthma was at a generally increased level? I have not really understood the question and answer and I do not want it to just slip by. Doctor, do you understand the point I ask counsel to clarify?

A. Yes.

MR RECORDER COHEN: So in paragraph 5.7 you say it increased activation of his asthma, on the balance of probabilities will persist indefinitely?

A. The reactivity, yes.

MR RECORDER COHEN: So you are not talking about what was happening on the day that you saw him, rather than the generality to the increase?

A. (inaudible).

MR RECORDER COHEN: Ms Allen, I think you were actually directing the witness to a rather different subject of how was he on the day.

MS ALLEN: But your evidence, Dr Collins, following clarification is that there was no increased activation generally.

A. Yes, (inaudible).

Q. As an asthmatic individual, prior to --

MR RECORDER COHEN: I am sorry, I am not sure whether you are at crossed purposes, were you saying that generally there was no increased activation, or generally there was increased activation?

A. I am saying from what he reported that he was having increased activation, or susceptibility.

MR RECORDER COHEN: Ms Allen, you may not have -

MS ALLEN: That was not what I understood Dr Collins to have said.

MR RECORDER COHEN: Again, I appreciated that the yes which started with that question digressed somewhat

> from what was said afterwards, and I was not sure that I understood that what you probably thought was right, which was why I asked him immediately to clarify. *I think what he has said, Doctor, I think what you said is that there was an increased level of activation in the asthma, although on the day you saw him it was not at that increased level.*
>
> *A. Correct*."

100. Although it is apparent that there was a degree of 'cross-purposes', and the inaudible nature of some of the responses does not help understanding, I consider it to be sufficiently clear that what Dr Collins was saying was that although C was better at the time he saw him (in September 2022) that he had at points before, generally his asthma had become worse overall since that event – in other words there had been increased activation of it. The questions and answers which followed, which D relies upon and which I set out above, have to be read in that context.

101. Reading the transcript, it is clear the judge was appropriately interventionist and quick to clarify matters of evidence. I therefore have to accept that he understood the evidence. The judge was therefore entitled to find as he did in [81] of his judgment.

102. In respect of difficulty of control with inhaler treatments and susceptibility, these were matters upon which the judge was entitled to rely upon Dr Collins' expertise of treating patients with asthma like C's. He was looking to the future and giving his professional opinion based upon his knowledge and experience as to likely future prognosis notwithstanding the improvements he noted. It is not right to say, as D does, that there was 'no evidence' to support the judge's findings. Dr Collins gave that evidence. The judge was therefore entitled to conclude based upon this evidence (which was based in turn on C's evidence about his disease which, as I have said, the judge accepted) that notwithstanding C's asthma had been well-controlled as he described and accepted in the recent past, nonetheless, looking to the future, C's disease would be more likely to difficult to control with inhaler therapies (and I note from the history there had been one instance of him being prescribed tablets), and that he had an increased susceptibility to volatile compounds because of the effects of his exposure on 4 January 2017.

103. Overall, I agree with this paragraph from C's Skeleton Argument:

> "11. The questions put to Dr Collins in cross examination at the bottom of page [207] ask whether the Claimant would have been vulnerable to exposure to volatile compounds pre-exposure, i.e. by virtue of his constitutional asthma, but it was open to the judge to conclude from the totality of the written evidence, and from the expert's oral evidence, that the Claimant was more vulnerable to exposure to volatile substances such that he could no longer work as an engineer post-exposure to the index banned chemical."

104. I turn to the judge's quantification of general damages and his application of the Judicial College's *Guidelines for the Assessment of General Damages in Personal Injury Cases* (16th Edn). I set this out earlier. This was not a straightforward exercise because this was a case of exacerbation of an existing condition, rather than negligence which caused an asthma-inducing injury to an hitherto non-asthmatic person. That was a key point.

105. Application of the Guidelines required an exercise of judgment based upon the judge's factual findings. Given the judge's findings as to the extent of C's exacerbated illness, which I have upheld, I do not consider that his application of the Guidelines was so obviously erroneous that I should intervene.

106. It is clear the judge was alive to the central issue that C had pre-existing asthma, and that what he was concerned with was how much worse that asthma had become as a result of D's negligence. He indicated as much in this exchange with Mr Kennedy in closing submissions:

> "MR KENNEDY: It is chronic asthma actually, yes, it is ongoing. Yes, it is chronic. It does cause breathing difficulties. The inhaler is from time to time and it does restrict his employment prospects. Now, I hear what my learned friend says about being an aggravation of constitutional asthma, and I say if your Honour is moved by that, perhaps it could be moved to the bottom of that bracket. But certainly this is the starting point.
>
> MR RECORDER COHEN: Her submissions I think are persuasive that if one actually looks at this gentleman, he was a chronic asthma sufferer. What I am trying to measure as I understand the damages calculation is how that chronic asthma was made worse by the episode in question. The fact he was and has always been an asthma sufferer is not something for which compensation is payable, it is what has happened to make it worse. That is what I am looking at, and I hope that is the substance of Ms Allen's submission which I am trying to make sure I understand your response of.
>
> MR KENNEDY: Well my reading of this conclusion of Dr Collins is that paragraph 4.12, for the foreseeable future he may have persistent asthma which may be difficult to control, it will affect his employment opportunities, his employability on the open market. And the only sensible interpretation to put on that is that Dr Collins is saying as a result of this work-related asthma … I mean, Dr Collins does not say anywhere in this report that this incident has not affected the claimant in any way --

> MR RECORDER COHEN: What he says in 4.11 is on the balance of probabilities, exacerbation the claimant's asthma was caused by inhalation of fumes.
>
> MR KENNEDY: Yes, so there is an exacerbation."

107. The judge had well in mind Ms Allen's submission that the bracket should be much lower, but rejected it for the reasons that he gave. Before me, Ms Allen accepted that conclusion. However, she said the judge had still gone wrong. However, she submitted that the appropriate bracket was in the 'Lung Disease' section of the Guidelines, namely Section B of Chapter 6. Ms Allen submitted that because this was an exacerbation of an existing, the proper bracket should have been Chapter 6(B)(f) ('Some slight breathlessness with no effect on working life and the likelihood of substantial and permanent recovery within a few years of the exposure to the cause *or the aggravation of an existing condition*') which has a range of £10,640 - £20,800. She said the categories considered by the judge were for *de novo* cases of asthma and so not applicable in this case. She suggested an award of £12,000.

108. I well understand Ms Allen's submission, but overall I do not think the judge was in error in using the bespoke part of Chapter 6 which deals with asthma. The introduction to Section B reads (my emphasis):

> "Most of the reported cases are of asbestos-related disease (as to which see (C) below) *but, save for asthma (which is also dealt with separately in (D) below)*, the brackets set out are intended to encompass all other lung disease cases irrespective of causation, e.g. silicosis and pneumoconiosis."

109. Asthma is a different disease to things such as silicosis and pneumoconiosis. No doubt that is one of the reasons why they are dealt with separately Overall, I consider the judge was entitled on his findings of fact to conclude that C's injury justified an award towards the bottom of the bracket £26,290 to £43,010 in Chapter 6 (D)(b) of the Guidelines ('Chronic asthma causing breathing difficulties, the need to use an inhaler from time to time, and restriction of employment prospects, with uncertain prognosis'), (or at the top of the bracket £19,200 to £26,290 in Chapter 6 D(c) ('Bronchitis and wheezing, affecting working or social life with the likelihood of substantial recovery within a few years of the exposure to the cause') (there being little difference between the two points the judge identified). Such an application of the Guidelines yields a figure around £27,000.

110. As I have said, Section D is the bespoke section of Chapter 6 which deals with asthma specifically. And the judge, also as I said, had the exacerbation point well in mind. He did not precisely set out his working, but no doubt that is why he selected the particular figure he did, based upon Mr Kennedy's submission to him. A *de novo* case would have resulted in a higher award within the bracket the judge took. The fact that he went to the bottom of the bracket he applied reflects, I conclude, his acknowledgement that this was an exacerbation case.

111. I return to the point that I am not concerned with a re-assessment of what damages I would have awarded had I been the trial judge. I have concluded that the judge's decision was not vitiated by the sort of error which would allow me to intervene. I therefore reject D's Ground 1.

112. In relation to Ground 2, it seems to me that the judge was faced with a difficult and unusual situation (which Mr Kennedy accepted) in how he managed C's special damages claim, for the reasons he explained. In considering what the judge did, I bear in mind the decisions that have emphasised the importance of supporting first-instance judges who make robust but fair case-management decisions: see eg *Re TG (A Child)* [2013] EWCA Civ 5, [24]-[38].

113. There were points that could be made both ways, and the judge carefully dealt with them. That said, I think there is merit in Ms Allen's submission that the judge was wrong in considering that something more than a statement of truth was required to verify C's Statement of Loss. As she said, the Schedule of Loss was accompanied by a signed statement of truth by C in accordance with CPR r 22.1 and the Practice Direction thereto. The veracity of the statement of truth was not challenged at any time by D and there were no defects in its form: the wording used within was identical to that set out at CPR PD 22, [2.1]. There was accordingly no need for a further affidavit and no defect in verification to be remedied. Mr Kennedy agreed.

114. On the other hand, I think the real nub of D's complaint under Ground 2 was the opportunity the judge gave to C to adduce further evidence in support of his case. This was the core of the judge's reasoning in [85] of his judgment (set out earlier).

115. After careful consideration I have decided that in making this order the judge was doing his best as he saw it to do justice to both sides, for the reasons he gave. I accept that point made by D that it was for C to prove his damages claim and if his evidence was inadequate, then he might have had to bear the consequences. On the other hand, the judge was plainly critical of aspects of how D had presented this part of its claim. During the hearing on 3 May 2023 the judge said:

> "We have been through a trial on this. We have been through a trial with an opportunity to cross-examine and, to my recollection, not a single question was asked about any of this. You see, it may be that although I am critical that the claimant's evidence did not tackle this head on, I am very critical also of the defendant's approach, the silence on it."

116. I do not think the judge erred in the exercise of his case management discretion in relation to the order he made in [6] of his post-trial order (or in [7] and [8]) allowing further evidence in a way that would allow me to intervene. Ms Allen made a point that C's stance on special damages and lack of evidence in support might have affected her client's stance on Part 36 offers. I do not know whether there were or are any, but as Mr Kennedy said, if this is a good point, it can still be taken into account at the suitable time. Mr Kennedy made clear that C is not claiming for loss of earnings beyond what is pleaded (save as relevant to a *Smith v Manchester* award). He said the order the judge made was fairly limited and proportionate and I agree. Overall, I

consider what the judge did in the fairly novel situation in which he found himself falls within [112] of Lord Kerr's judgment in *Re B*:

> "112 Where what is under review by an appellate court is a decision based on the exercise of discretion, provided the decision-maker has not failed to take into account relevant matters and has not had regard to irrelevant factors and has not reached a decision that is plainly irrational, the review by an appellate court is at its most benign. Truly, in that instance, an appellate court which disagrees with the challenged decision of the judge will be constrained to say, even though we would have reached a different conclusion, we cannot interfere."

117. I therefore reject Ground 2.

Conclusion

118. It follows that this appeal is dismissed.