Neutral Citation Number: [2011] EWHC 219 (QB)

Case No: 9RG01312

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18/02/2011

Before :

THE HON. MRS JUSTICE SWIFT DBE

- -

Between :

April Jane Dainton	**Claimant**
- and -	
Hazel Powell	**Defendant**

- -
- -

Mr Jack Ferro (instructed by **Rowberry Morris, Solicitors**) for the **Claimant**
Ms Katie Gollop (instructed by **Beachcroft LLP**) for the **Defendant**

Hearing dates: 23-24 November 2010

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Approved Judgment

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

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THE HON. MRS JUSTICE SWIFT DBE

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The Hon. Mrs Justice Swift DBE :

The claim

1. This is a clinical negligence claim brought by the claimant, April Jane Dainton, against the defendant, her former general practitioner (GP), Dr Hazel Powell. In August 1995, when the claimant was 7 years old, she was diagnosed as suffering from the condition which was then known as "congenital dislocation of the hip (CDH)" and is now more frequently referred to as "developmental dysplasia of the hip (DDH)" on the right side. For the purposes of this judgment, I shall use the term "CDH", which was current at the time of the relevant events. The claimant alleges that, in April 1988, when she was aged 9 weeks, the defendant negligently failed to identify the signs that she was or might be suffering from CDH and/or the defendant negligently failed to refer her to an orthopaedic specialist for diagnostic testing.

2. The claim was commenced in February 2009. Initially, a claim was also made against the Berkshire West Primary Care Trust, successors to the relevant District Health Authority which employed the Health Visitors who also had a role in monitoring the claimant during the first months of her life. It was alleged that the Health Visitors were negligent in failing to detect signs suggestive of CDH and/or failing to refer the claimant for an orthopaedic opinion. However, that claim was discontinued shortly before the trial of the action.

3. In her Defence, the defendant denied negligence, averring that, on the single occasion when she examined the claimant, she found her hips to be normal and it was thus reasonable not to refer the claimant to an orthopaedic specialist. On 7 December 2009, District Judge Darbyshire directed that there should be a preliminary trial of the issues of breach of duty and causation. A hearing of those issues took place before me on 23 and 24 November 2010. At the hearing, the claimant was represented by Mr Jack Ferro and Ms Katie Gollop represented the defendant.

4. At the time of the claimant's birth, Mrs Dainton was registered as a patient of the Pangbourne Medical Practice, Pangbourne, on the list of the defendant, who was a partner in the practice. Following the claimant's birth she too was registered on the defendant's list. Dr Matilda Oppenheimer was also a partner at the practice. She and the defendant both worked part-time and shared the job of a full-time partner. When one of them was off duty, the other would take over care of the patients on her list. The claimant and her mother ceased to be patients of the Pangbourne Medical Practice in August 1989, when the family moved out of the area.

The condition

5. The term CDH covers a spectrum of deformation of the hip joint which exists from the time of birth. It involves a delay in or failure of the development of the two elements of the hip joint, namely the acetabulum ("socket") of the pelvis or hip bone and the "ball" or head of the femur (thigh bone). The two elements develop co-dependently and if, for some reason, they are not in their normal anatomical relationship, both elements will fail to develop properly. The "cup" of the socket may remain too shallow and the "ball" of the head of the femur may not fill out into its proper hemispherical dimensions and may remain too flattened in shape. These abnormalities of morphological (i.e. shape) development are termed "dysplasia". If

they are not corrected, they will continue to develop abnormally and, when the child begins to walk and the hip is weight-bearing, further abnormal changes will occur and the condition will become more difficult to treat successfully. For this reason, it is essential that, if at all possible, CDH is detected and treated in the early months of a child's life, before the hip becomes weight-bearing.

6. Full dislocation of the hip (also referred to as the point when dislocation of the hip becomes "irreducible" or "established") occurs when the head of the femur becomes partly or completely displaced from the acetabulum. Sometimes, full dislocation is present at birth or from a time shortly thereafter. However, CDH often manifests itself first as instability of the hip, whereby a normally located hip is "dislocatable", i.e. it may be dislocated either partially (subluxation) or fully by gentle manipulation on the part of the examiner. It is believed that, in some cases, the instability resolves spontaneously, leaving no clinical signs, although symptoms and signs may become evident later in life. In other cases, the instability persists and eventually leads to full dislocation.

7. The earlier the diagnosis of CDH is made and treatment is given, the better the likely outcome.

Screening for CDH

8. Because of the importance of detecting any abnormality of the hip early in life, special physical examinations have been developed which can be carried out before a child begins to walk and which are designed to reveal the presence of signs suggestive of CDH. Any abnormality detected in the course of such an examination should result in a referral to an orthopaedic specialist for further investigation.

9. Frequently, abnormality of an infant's hip can be detected in the early part of his/her life by means of the so-called Ortolani/Barlow manoeuvre (also known as the Ortolani/Barlow test). The naked infant is positioned on his/her back with knees fully flexed and hips flexed to a right angle. The examiner gently manipulates each leg, then both legs together, in order to determine whether it is possible to move the head of the femur forwards into, or backwards out of, the acetabulum. A slight movement of the femoral head, often accompanied by an audible "clunk", suggests the presence of CDH.

10. The Ortolani/Barlow test is not a diagnostic test. It is used for screening purposes. Nor is it sensitive in that it will not detect all cases of CDH. An abnormal hip does not necessarily show consistently abnormal signs all the time.

11. At the same time as carrying out the Ortolani/Barlow test, the examiner should observe the range of abduction (outward movement) in flexion at each hip. The most important of the "classic signs" of full dislocation is limitation of abduction. If the hips are normal, there will usually be abduction to about 75 degrees. However, in the presence of dislocation, abduction will be limited.

12. Full dislocation of a hip gives rise to other "classic signs" which are caused by the displacement of the head of the femur upwards and the consequent shortening of the soft tissues around the hip joint. Above-knee shortening of the leg on the affected side (when compared with the other leg) will be evident on careful examination.

There may also be obvious asymmetry of the junction of the thighs to the trunk (as viewed from the front) and of the skin creases on the insides of the thighs. There may also be flattening of the buttock on the affected side. These signs will be less evident if there is dislocation affecting both hips.

The system of screening in the late 1980s

13. Guidance on screening for the detection of CDH for the use of health bodies, GP practices and hospital staff had been published by the relevant Government Department well before the 1980s. However, in 1986, revised guidance (known as the SMAC Guidance) was prepared by the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee for the Department for Health and Social Security (DHSS).

14. The SMAC Guidance estimated that there was evidence of hip instability at birth in 15-20 out of 1,000 live births. In a large proportion of cases where instability was detected, the signs of instability resolved in the first weeks of life without the need for any treatment. Approximately 10% of unstable hips would, however, persist and would develop the classic signs of full dislocation in infant life, whilst a further 10% were likely to show evidence of dysplasia and/or subluxation. The SMAC Guidance emphasised that it was impossible for the routine examination of a baby conducted shortly after birth (the neonatal examination) to detect every case of CDH and/or to identify those babies whose unstable hips would not recover spontaneously. Therefore, there must, it said, be a programme of continuing surveillance, at least until the child was seen to be walking normally. The SMAC Guidance stressed the need for all health professionals with a responsibility for newborn babies and young children to be aware of risk factors for, and alert to the signs suggestive of, CDH.

15. The SMAC Guidance described the Ortolani/Barlow test and the signs that a medical professional carrying out the test should look out for. The SMAC Guidance stated (paragraph 4.4):

> "It is important whenever an abnormality is suspected that the child is referred without delay to a consultant with experience in this condition, usually a paediatrician or an orthopaedic surgeon".

16. The SMAC Guidance recommended that infants should be screened for CDH at several different stages: within 24 hours of the infant's birth, at the time of his/her discharge from hospital, at 6 weeks of age, between 6 and 9 months of age, and between 15 and 21 months of age.

17. The SMAC Guidance placed on each District Health Authority the responsibility for formulating a policy for its own area. The policy was to set out who should be responsible for undertaking the screening at the various stages. The consequence of this was that practice varied from district to district. In some districts, hospital doctors would carry out the neonatal examination of the baby (including assessment of the hips), whilst midwives performed the assessment after a home birth. In other districts, midwives would carry out the neonatal examination, wherever the birth took place. In

some districts, GPs undertook both the 6-week and 6-9 month assessments. In others, Health Visitors carried out the 6-9 month assessments.

18. No contemporaneous documentation giving details of the screening regime being operated in Berkshire in 1988 is now available. However, two Health Visitors who practised from the Pangbourne Medical Practice in the late 1980s provided witness statements recording their recollection of the system in operation at the relevant time. The contents were not in issue and they did not give oral evidence.

19. Ms Sara Wise said that she qualified as a Health Visitor in 1987 and immediately started work in Pangbourne. She was based at the Pangbourne Medical Practice and had a close working relationship with the doctors who practised there. She said that part of the work of the Health Visitors was the undertaking of regular developmental reviews. They were trained to recognise what was "normal" for a child of a certain age and to spot features which might be abnormal and would require further investigation. Recognition of abnormalities which might indicate the presence of CDH formed part of a Health Visitor's training.

20. Ms Wise said that, in 1988, the system in Berkshire was for a series of reviews to be undertaken at various stages of the child's development. A midwife would carry out an examination of the child immediately after birth. The GP would conduct a developmental assessment at the age of 6 weeks. There would then be further assessments at 3 months and 8 months of age; those assessments would be carried out by a Health Visitor. Further reviews by a Health Visitor would take place when the child was aged 18 months, 2 ½ years and 3 ½ years. In addition, the Health Visitor would visit the child's family as and when necessary to give support and advice of a general nature and also in relation to any specific problems that might arise.

21. Ms Wise said that a physical examination of the hips (including the Ortolani/Barlow test) formed part of the 6-week developmental assessment carried out by the GP. Health Visitors would not carry out any such physical examination. However, when conducting their assessments, the Health Visitors would look out for any gross developmental abnormalities such as leg length discrepancy, asymmetrical skin folds, buttock flattening, abnormal gait or an unusual delay in walking. She said that she and her colleagues would rely heavily on any concerns reported by the parents and on their own impressions of the child's gait. If the Health Visitor became aware of any signs suggestive of an abnormality, she would inform the GP who would, if necessary, refer the child to a consultant. She said that she was aware of the possibility of CDH occurring although, during her own professional career, she had never encountered a child who required a referral on account of suspected CDH.

22. Ms Carol Porter qualified as a Health Visitor in 1988 and took over Ms Wise's post at the Pangbourne Medical Practice in January 1989. She confirmed Ms Wise's recollection of the system of child health surveillance in operation in Berkshire during the 1980s. She said that she had received training on the identification of abnormalities suggestive of CDH and had identified such abnormalities three times in her professional career. She confirmed that Health Visitors did not carry out physical examinations of a child's hips but were trained to look out for the abnormalities that might indicate the presence of CDH.

23. In 1988, routine screening for the presence of CDH did not include the use of radiology. Radiology was, however, used by consultants for the purpose of ascertaining whether a full or partial dislocation was present. Ultrasound scanning was not generally available in the 1980s, although evaluation of its use for screening purposes was being carried out in some centres. Ultrasound scanning is now used for screening purposes in some specialist centres with considerable success. It is effective in revealing deformity even in an apparently normal hip, thus enabling prompt treatment to be undertaken.

24. Mr Stephen Copeland, consultant orthopaedic surgeon, provided a witness statement dealing with his practice in the late 1980s. His evidence was not in dispute and he was not required to give oral evidence. In 1988, he was employed at the Royal Berkshire Hospital in Reading and was the orthopaedic specialist to whom infants with suspected CDH living in the Pangbourne area were referred.

25. Mr Copeland said that, had the claimant been referred to him, he would have carried out a clinical examination to ascertain whether there were any signs suggestive of CDH. The examination would have included the Ortolani/Barlow test, together with clinical observation of any limb or skin crease asymmetry and of limitation of abduction. If no abnormality was observed, the child would have been discharged without further follow-up. If there was any suspicion of CDH, the child would have been referred for an x-ray examination. If the x-ray examination was inconclusive or no diagnosis could be made at that stage, the child would be followed up at 12 months of age. If the x-ray examination had revealed the presence of CDH, it is likely that it would have been treated by means of traction to relocate the hip, followed by manipulation with splinting.

The system of screening from 1990

26. Documentation relating to the child health surveillance arrangements in force from the time of the new GP Contract in 1990 had been retained by the defendant and was available to the court. I was shown the Berkshire Family Practitioner Committee and East and West Berkshire District Health Authorities Joint Draft Programme for Pre-School Surveillance (the Berkshire Surveillance document) dated March 1990. It seems that the arrangements for child health surveillance in Berkshire remained much the same as had been the case before 1990. The onus for providing child surveillance arrangements passed to GPs and, after the introduction of the 1990 GP Contract, service payments were available to GPs for performing surveillance functions.

27. The Berkshire Surveillance document provided that an examination (to include a physical examination) should be carried out by "medical services" (a doctor or midwife) shortly after a baby's birth. The *aide memoire* which formed part of the Berkshire Surveillance document indicated that the examination should include the Ortolani/Barlow tests for CDH. There was then to be a review of the baby at 11 days old by a Health Visitor. The list of topics to be covered on that occasion did not include any reference to an examination of the hips, or indeed to a physical examination of any kind.

28. The Berkshire Surveillance document also provided for an examination of the baby by a doctor (usually the GP) at the age of 6-8 weeks. This was to include a physical

examination. The *aide memoire* for this examination required the GP to "check abduction and leg length".

29. The Berkshire Surveillance document stated that all subsequent checks of the child until the age of 39-42 months were to be carried out by a Health Visitor, rather than a doctor. None of those examinations included a physical examination. There was to be an assessment of the baby at the age of 8 months during which the *aide memoire* required the Health Visitor to ascertain whether the child was taking his/her weight on his/her feet and to ensure that he/she was standing symmetrically and that the buttock creases were even. At 18-24 months, the Health Visitor was required to check the child's gait. GPs who offered child health surveillance services were to be responsible for ensuring that all the examinations and developmental checks were carried out, whether by the GP himself/herself or by a Health Visitor.

30. In a joint draft Policy Statement for Community Child Health Services, also dated March 1990, the Berkshire Family Practitioner Committee and the East and West Berkshire District Health Authorities identified as one of the specific objectives for the Services to ensure that:

> "All cases of congenital dislocation of the hip will have been identified by three months of age".

The claimant

31. The claimant who is now aged 22 years, was born on 22 February 1988. She was the second child of Jane Caroline Dainton and Anthony Mark Dainton. Her birth was uncomplicated and she had none of the risk factors for CDH, e.g. breech delivery, birth by caesarean section, family history of CDH. Abnormal fusion (syndactyl) of the fingers of her left hand and the toes of her left foot was obvious from the day of her birth. Mrs Dainton and the claimant were discharged from hospital when the claimant was 2 days old. An immediate orthopaedic opinion was sought in relation to the claimant's left hand and foot. She was referred to a plastic surgeon. In November 1988, when she was 9 months old, she underwent an operation to separate the syndactyl on her left hand. The procedure involved a skin graft, using skin from the sole of her left foot. She had regular out-patient attendances at hospital thereafter and underwent a revision of the syndactyl of the left hand in 1993 and release of the syndactyl of the left foot in 1997.

32. The claimant was late in walking but, when she began to walk, her mother noticed nothing amiss. As the claimant got older, however, she began to limp and to walk with a "wobble". Mrs Dainton described her as "waddling like a duck". She said that her abnormal gait was initially attributed to continuing sensitivity at the site on the sole of her left foot from where the skin graft had been taken. The claimant had a number of other medical problems, in particular persistent enuresis and urinary infections. She started school, where she was teased about the appearance of her left foot.

33. Meanwhile, the claimant's walking got worse. In the summer of 1995, when the claimant was 7 years old, a friend of Mrs Dainton pointed out to her that the claimant's right leg appeared shorter than her left leg. At about the same time, the claimant began to complain of pain in her right leg and hip when she walked and was

limping. Mrs Dainton took her to her GP, Dr Swami, who referred her for an x-ray. The x-ray revealed an abnormality in the hip which was reported thus:

> "The right acetabulum is completely dysplastic and the femoral head is subluxed upwards. The appearances are developmental dysplasia of the hip. The left hip is normal."

34. In September 1996, a consultant orthopaedic surgeon confirmed that the claimant had a dislocated right hip. In March 1997, she underwent surgery involving an open reduction, femoral osteotomy with shortening, and pelvic osteotomy. Intra-operative and post-operative x-rays showed that a satisfactory position had been achieved with no significant distortion of the pelvic brim. She had her leg in plaster for 9 weeks, and was then mobilised on crutches. Subsequently, she required removal of wires from the iliac crest and removal of the plate which had been placed in her right femur. She continued to limp slightly because of shortening (by about an inch) of the right leg. In 2001, she underwent further surgery to the hip to reduce the shortening of the right leg.

35. The claimant continues to complain of some discomfort in the right groin and thigh on occasion. There is still some shortening of the right leg and she wears a raise in the right shoe. She has some restriction in movement of the right hip. She is likely to develop further symptoms as a result of premature degenerative changes which will probably progress to the extent that a hip replacement will be necessary in her late 40s or early 50s, with subsequent revisions later in life. The claimant has developed a number of psychological and behavioural problems together with learning difficulties which her mother attributes to the problems with her hip.

Screening in the claimant's case

Examination in hospital

36. The hospital records show that, on the day of the claimant's birth, she underwent a routine neonatal examination at hospital. The record of the examination contains the following note:

> "Rt Hip √
>
> Lt Hip √ ".

The ticks signify that examination of the hips was considered to be normal. At the same time, the fusion of the fingers and toes of the claimant's left hand and foot was noted and an orthopaedic opinion sought.

37. There is no evidence in the hospital records of any examination of the claimant at the time of her discharge from hospital.

Examination by general practitioner

38. The defendant's evidence was that the usual system in her practice was for the GP with whom the baby's mother was registered was to make a first post-natal visit immediately after receiving the discharge letter from the hospital. However, the medical records contain no record of any such visit in the claimant's case. There was

a visit from the Health Visitor on 3 March 1988. It was not suggested that the post-natal visit, whether by the GP or the Health Visitor should have included any examination of the claimant's hips.

39. The claimant was first seen and examined at the Pangbourne Medical Practice by Dr Oppenheimer on 12 April 1988 when she was 7 weeks old. Subsequently, she was seen and examined by the defendant on 26 April 1988. These two examinations are central to this case and it is necessary to deal with them in detail.

Assessment by Dr Oppenheimer on 12 April 1988

40. The claimant's attendance on 12 April 1988 was for the purpose of the routine clinical assessment which the SMAC Guidance had recommended should be carried out at the age of about 6 weeks. Neither Dr Oppenheimer nor Mrs Dainton, who was present at the assessment, has any specific recollection of the occasion. Indeed, Mrs Dainton had no recollection of seeing any doctor at the Pangbourne Medical Practice other than the defendant. The factual evidence relating to the assessment is therefore confined to the note thereof made by Dr Oppenheimer in the claimant's GP records, coupled with her evidence about her usual practice at the time and what she would have meant by the words used in her note.

41. The note made by Dr Oppenheimer reads as follows:

> "7/40 *[this should be 7/52, i.e. 7 week]* check
>
> hips – rather stiff
>
> HS - *[heart sounds heard and normal]*
>
> Webbing digits *[this refers to the abnormal fusion of the fingers of the left hand]*
>
> Recheck hips 2/52 *[2 weeks]*. All imms *[immunisations]."*

42. Dr Oppenheimer made a witness statement for these proceedings and gave oral evidence before me. She said that, after qualifying as a doctor, she participated in the 2-year GP training scheme. She spent a year working at the Royal Berkshire Hospital: 6 months in general paediatrics and a further 3 months in both obstetrics and gynaecology. During her 3 months working in obstetrics, she had undertaken some examinations of newborn babies. She then spent a year at a Health Centre as a GP trainee. She joined the Pangbourne Medical Practice in 1985. Between 1985 and 1988, she had undertaken routine development assessments of 6 week old babies. After April 1988, Dr Oppenheimer remained at the Pangbourne Medical Practice and continues to practise there part-time.

43. Dr Oppenheimer said that it was clear from her note that she had carried out a physical examination of the claimant. Her examination would have included the Ortolani/Barlow test. She was cross-examined extensively on the meaning of her note that the claimant's hips were "rather stiff". She confirmed that the use of the word "stiff" in that context implied that she could not bring the claimant's legs out to the full range of abduction. She said that it was her practice to test for CDH as thoroughly as she could. However, there were occasions when this was not possible.

The baby might be resistant and/or uncooperative because of hunger or distress, making assessment of hip movement very difficult. She said that this was not an uncommon occurrence with young babies. She believed that it had been the case with the claimant. It was suggested to her that, if the claimant had been resistant and/or uncooperative, or if there had been some other problem with carrying out the examination, she would have included that information in her note of the assessment. Dr Oppenheimer replied that, at that time, it was her practice to make very short notes and she would not necessarily have recorded that type of information.

44. Dr Oppenheimer went on to say that, if there had been a limited range of abduction of one hip, she would have made a specific note of that. She had not done so. Instead, she had said that the hips (i.e. both hips) were "rather stiff". That meant that both hips had responded in the same way. She would not have referred to the "hips" being stiff if only one hip had been affected. She said that she would not have used the term "stiff" to mean that there was a restriction of movement suggestive of CDH. She had not noted any shortening of either leg or any asymmetrical skin creases. If she had done so, she would have noted the fact. She said that, if she had considered that any abnormality of the hips – or either of them - had been demonstrated, she would have immediately referred the claimant on to hospital for examination of the hips. She said that her threshold for referral to hospital was – and remains – very low.

45. Dr Oppenheimer was asked whether, when suggesting re-examination of the hips after a period of a fortnight, she might have had in mind the fact that, if there was an abnormality present, it would be more obvious after a further two weeks had elapsed. She said that that was not the case. By using the words "hips rather stiff", she would have meant that, while she had not identified any actual abnormality, she had been unable to satisfy herself that she had performed the Ortolani/Barlow test adequately and that she could pass the claimant's hips as normal. It was for that reason that she had advised that the claimant's hips should be re-examined in a fortnight's time.

Examination by the defendant on 26 April 1988

46. The claimant attended the Pangbourne Medical Practice for re-examination of her hips exactly two weeks after her assessment by Dr Oppenheimer. The claimant was then 9 weeks old. Neither the defendant nor Mrs Dainton, who was present at the examination, has any specific recollection of the occasion. The factual evidence relating to the examination therefore consists of the note thereof made by the defendant in the claimant's GP records, coupled with her evidence about her usual practice at the time and what she would have meant by the words used in her note, together with Mrs Dainton's evidence about the way she would deal with advice given by medical professionals.

47. The defendant's note of the examination reads:

> "Hips seem OK today.
>
> Check 9/12/12".

The last part of the note is not entirely clear (even the defendant had difficulty reading it) but it probably meant that the check referred to should be carried out in 9-12 months' time, i.e. when the claimant was aged between 11 and 14 months. It could

have meant that the further check should take place when the claimant was 9-12 months old. Either way, the note envisaged a further check taking place in several months' time.

48. The defendant made a witness statement for these proceedings and gave oral evidence. She said that she qualified as a doctor in 1972. She then spent 6 months as a senior house officer in paediatrics at Guy's Hospital, after which she spent a year as a neonatal registrar in Auckland, New Zealand. She held a 5-year research post at the John Radcliffe Hospital, Oxford, involving the developmental assessment of babies who had been born larger or smaller than would have been expected for their dates of delivery. She later underwent a year's GP training before starting work as a GP in 1985. She remained at the Pangbourne Medical Practice throughout her career as a GP and retired in September 2009. She said that she had been taught how to check hips and had done so quite frequently when working as a paediatric registrar.

49. The defendant said that, in April 1988, she was well aware that stiffness of the hips was a classic sign of CDH and that any suspicion of an abnormality of the hips should prompt an immediate referral to hospital. So far as she knew, the only information she would have had about the claimant's hips at the time of her examination would have been the note made by Dr Oppenheimer a fortnight earlier. She said that Dr Oppenheimer's note would not have suggested to her that Dr Oppenheimer had detected any abnormality on 12 April 1988. She knew that it was Dr Oppenheimer's practice, if she suspected any abnormality, to refer the child to hospital. Since Dr Oppenheimer had not done that, the defendant said that she would have assumed that Dr Oppenheimer had not managed to carry out a proper examination because the claimant had been crying or for some other reason.

50. The defendant said that she approached her examination of the claimant on 26 April 1988 afresh. It was her practice to carry out such examinations fastidiously. She was aware of the difficulties associated with the Ortolani/Barlow test and always adopted a high level of suspicion. She described in detail how she carried out the test. She said that she would test the range of abduction of each hip separately and then again with both hips together. She would expect to see abduction of 75 degrees on both sides. She said that she would not regard anything less as normal.

51. The defendant was asked about the comment in her note that the claimant's hips were OK "today". It was put to her that the note suggested that she had accepted that there had been some abnormality at the time of Dr Oppenheimer's examination. She said that was not the case. She would have assumed, because Dr Oppenheimer had not referred the claimant to a specialist, that there was no abnormality. The defendant was also asked about that part of her note which appeared to suggest that there should be a further check of the hips in 9-12 months' time. She was unable to explain why she should have advised a further check of the hips at that stage. She said that her note cannot have meant that she had any reservations about the results of her examination or the fact that the hips were normal. If she had had any suspicion at all that the claimant's hip(s) was/were abnormal, she would have referred her to a specialist immediately. She agreed that, if there had been any question that one or both of the claimant's hips might be abnormal, it would be unacceptable to wait for 9-12 months before carrying out a further check.

52. In her witness statement, the defendant said that the check she had advised should be undertaken in 9-12 months' time was not a check of the claimant's hips. She believed that her intention had been "a general interest in tracking [the claimant's] development, particularly in the light of the history of syndactyl". In her oral evidence, the defendant suggested that "Check 9/12/12" might have referred to some other problem affecting the claimant that had been raised on 26 April 1988. She agreed that, if that had been the case, one would have expected the additional problem to be referred to in her note, but said that this did not always happen. She suggested that the claimant's mother might have had some anxiety and that the suggestion of a check in 9-12 months' time might have been in the nature of a "safety net".

53. The defendant was asked about her knowledge of the system of monitoring children's hips which was in operation in Berkshire during the 1980s. She said that she could not remember if she had known exactly what the system was. In particular, she could not remember whether she was aware that the surveillance carried out by Health Visitors would not include any physical examination of the hips. From 1990 onwards, she was aware of the system being operated locally and she knew that Health Visitors did not conduct physical examinations, although they would carry out visual checks. She knew that Health Visitors were taught to look out for discrepancies in leg length since, on occasion, a child had been referred to her by a Health Visitor for that reason.

54. The defendant said that the Pangbourne Medical Practice had no facilities for issuing patients with an appointment several months ahead. The doctors would rely on the patient or the patient's parent to make the appointment nearer the time. Thus, the usual practice would have been for her to tell Mrs Dainton that a check would be required and to advise her to make an appointment for the claimant at the appropriate time.

55. Mrs Dainton made four statements in connection with these proceedings. In her fourth statement, she described herself as a concerned and competent mother. She said that, whenever she was told by a doctor that she should make or attend an appointment for one of her children, she would do so. She pointed out that, having been told by Dr Oppenheimer (as she must have been) that the claimant's hips should be re-checked in a fortnight's time, she made an appointment and attended the surgery with the claimant for that purpose.

56. Having seen the note made by the defendant on 26 April 1988, Mrs Dainton said that she did not recall ever having been told that there was anything wrong with the claimant's hips. She said that, if she had been told, she would have remembered. If she had been told by the defendant that the claimant needed a further check in 9-12 months' time, she would have made an appointment at the appropriate time and kept it. Mrs Dainton said that, if it had been possible to make an appointment so far in advance, she would have made the appointment for the further check "then and there", whilst she was at the surgery. If that had not been possible, she would have written a reminder to herself in the health record book she had been supplied with after the claimant's birth.

Contact with the Pangbourne Medical Practice after April 1988

57. The claimant's GP records show only one further consultation with a GP at the Pangbourne Medical Practice between 26 April 1988 and the date in August 1989

when the family moved house and transferred to a new GP practice. That consultation was on 27 September 1988, when Dr Michael Powell (the defendant's husband and also a partner in the Pangbourne Medical Practice) made a domiciliary visit to the claimant's home in the early hours of the morning. The note of the consultation recorded that the claimant was coughing, crying and slightly wheezy. The note concluded (at the bottom of a page) with the words "review mane *[tomorrow]*". There are no further records of attendances at the Pangbourne Medical Practice. In particular, there is no record (as one would expect) of a consultation the day after the domiciliary visit or, indeed, of any attendance at the surgery over the period of 11 months before the claimant and her family left the Pangbourne Medical Practice.

58. Those two factors are surprising and raise the possibility that there was originally another page of notes made whilst the claimant was a patient at the Pangbourne Medical Practice which has now been lost. The records from that period were kept in manuscript form as was usual in the 1980s and were not transferred onto computer by the new GP practice. I was assured that, when the GP records came to be examined for the purposes of this case, no further notes for 1988/1989 were found. The case has therefore proceeded on the basis that, after 27 September 1988, there were no further consultations with the doctors at the Pangbourne Medical Practice and that, in particular, the claimant did not attend for a further check, as the defendant had apparently intended when she wrote her note on 26 April 1988.

Assessment by the Health Visitors

59. Ms Wise had no specific recollection of the claimant. Her notes revealed that she had visited the claimant several times during her first weeks at home. On 25 May 2008, she performed the routine 3-month check. She had no concerns about the claimant's development at that stage. The only concern reported by her parents related to the fusion of her toes and fingers, for which she had been referred to hospital.

60. Ms Wise's notes showed that she carried out the 6-month review on 22 August 1988. Again, the notes reveal no concerns. Ms Wise recorded that she had seen the claimant performing a number of age-appropriate activities, including weight bearing. Her parents reported that she had achieved other "milestone" activities. The claimant was due to undergo hand surgery shortly.

61. Ms Wise's notes record that she conducted the 8-month assessment on 16 November 1988. On that occasion she had some concerns about the claimant's development. She noted that the claimant did not sit unsupported and was not able to look for a fallen toy. She also recorded concerns about the claimant's reactions and in relation to aspects of her language development. Ms Wise said that she would not have made a specific examination of the hips during the assessment but would have been generally alert to any abnormal observations. Because of her concerns, she arranged to review the claimant's sitting and weight bearing in a month's time. Although her notes do not record that any such review was carried out, she is adamant that she would have reviewed the claimant informally at a visit which is recorded as having taken place on 28 November 1988. Her notes do not mention any concerns on that date which, Ms Wise said, indicated that there appeared to be no ongoing problems with the claimant's development at that time. Ms Wise had no further contact with the claimant after 28 November 1988.

62. Ms Porter had no recollection of the claimant and relied on her notes for information about any contact she might have had with her. The notes record that Ms Porter carried out a developmental assessment of the claimant on 19 August 1989. During that assessment, she observed the claimant stooping, squatting and starting to climb. She recorded that the claimant had attained the milestones appropriate for her age in those and other activities. Ms Porter noted that the claimant had not reached the expected milestones for walking unsupported or walking upstairs. Ms Porter observed her walking whilst holding onto furniture and a toddler truck. She was told that the claimant had walked across the room. The claimant's mother suggested that the claimant was "lazy" about walking. Ms Porter recommended that the claimant's walking ability should be monitored. She also recommended monitoring of the claimant's speech patterns since she had noticed that her speech was not clear. She advised that her development should be reviewed when she attained the age of 2 years.

63. The 2-year review took place after the claimant and her family had transferred to a new GP practice. The notes of that review reveal that the only remaining concern at that time related to the claimant's speech for which she was subsequently referred to a speech therapist. It does not appear that there were any concerns about her walking at that stage.

Expert evidence on breach of duty

64. The expert evidence on breach of duty came from Dr Simon Holmes, for the claimant, and Dr Gavin Young, for the defendant. They each prepared a Report, together with some additional written material, for these proceedings. In addition, following a telephone discussion on 18 November 2010, they provided a Joint Statement setting out the areas of agreement between them and the areas of disagreement. They both gave oral evidence.

The claimant's evidence

65. Dr Holmes has 16 years' experience as a full-time GP in a practice in Twickenham. In the course of his professional life, he has had experience of the assessment, diagnosis and management of hip abnormalities, including CDH. He is now Chief Medical Director of Doctors Direct. He continues to work part-time in NHS general medical practice and also works part-time in private general medical practice.

66. Dr Holmes said that it was important to recognise that the Ortolani/Barlow test was a screening test with a "pass" or "fail" outcome, not a definitive diagnostic test. If the Ortolani/Barlow test revealed any abnormality, this constituted a "failure" and the baby should be referred to an appropriate specialist for further assessment and diagnostic investigations to be undertaken. All competent GPs would be aware that the threshold of suspicion for referral should be very low, having regard to the serious consequences of a failure promptly to diagnose and treat CDH.

67. In relation to Dr Oppenheimer's assessment on 12 April 1988, Dr Holmes said that, in evidence, Dr Oppenheimer had confirmed that the use of the word "stiff" in her note in that context implied that she had not been able to achieve a full range of abduction. Dr Holmes said that Dr Oppenheimer's note clearly suggested that she had observed an abnormality when she examined the claimant. He said that, if that was so, the

claimant had failed the screening test and should have been referred to an appropriate specialist immediately.

68. Dr Holmes referred to Dr Oppenheimer's evidence that her note indicated – not that she had found any abnormality in the claimant's hips – but that she had been unable to examine them properly. He acknowledged that the claimant might have been distressed and/or resistant while being examined. However, he did not accept that it would not have been possible to complete the examination. He said that, in 30 years of practice, he had never been in that position. The examiner had to persevere gently and repeat the manoeuvre until he/she could be satisfied that he/she had obtained the full range of abduction and flexion. If that was done, the baby would eventually relax or stop resisting. Dr Holmes said that, in any event, if there had been real problems with carrying out the examination, one would have expected that fact to appear in Dr Oppenheimer's record of the examination.

69. Dr Holmes said that, having observed an abnormality, or possible abnormality, of one or both hips (as Dr Oppenheimer's note indicated she had done), a large proportion of competent GPs would have referred the claimant immediately to an appropriate specialist. He said that there was a body of competent opinion that might have thought it acceptable to arrange for the hips to be re-checked after a short time. He therefore concluded that Dr Oppenheimer's care of the claimant had "just about reached an acceptable standard" provided that the abnormality that she observed was relatively minor and/or present only fleetingly. However, the fact that an abnormality or possible abnormality had been observed at the time of the first examination should, he said, have put the doctor who carried out the second examination on high alert for the existence of a possible problem.

70. In connection with the defendant's examination of the claimant's hips on 26 April 1988, Dr Holmes said that the note made by the defendant indicated that she had found no stiffness or other abnormality on that occasion. He commented that the note was inadequate in that it did not indicate what tests had been carried out. Moreover, the use of the word "seemed" did not indicate that the defendant was certain that the hips were normal. Dr Holmes stated that the defendant should have asked the claimant's mother to bring the claimant for another check within a short time (2-3 weeks), in order to see whether the examination findings remained normal or whether the abnormality could be elicited on a subsequent occasion. This was necessary because of the fact that stability of the hip can vary according to the position of the femoral head. Dr Holmes observed that all competent GPs would be aware that CDH could cause a hip to be correctly located at some times and dislocated at others. Even if the defendant had found nothing abnormal on 26 April 1988, that did not alter the fact that an abnormal finding had apparently been made on 12 April 1988. It did not mean that there was no underlying abnormality present. Indeed, the defendant's reference to the claimant's hips seeming "OK today" suggested that the defendant was aware that the results of her examination differed from those observed by Dr Oppenheimer. He said that the advice apparently given in the defendant's note, to the effect that the claimant's hips should be checked again in 9-12 months, was wholly inadequate and fell below an acceptable standard of practice. He said that no competent GP would have given such advice.

71. Dr Holmes said that if, a third examination had revealed no abnormality, it would have been acceptable for the defendant to have arranged to review the claimant at the

age of 8 months, whilst advising the claimant's mother to bring the claimant back immediately if any abnormalities suggestive of CDH (which the defendant should have described to Mrs Dainton) became apparent. An alternative course which the defendant should have considered on 26 April 1988 was, he said, to refer the claimant immediately to an orthopaedic specialist. Many competent GPs would, he said, have taken the view that that was the safest option in the light of the apparently abnormal results of the first screening test.

72. Dr Holmes said that it was possible that, at the time of the examination on 12 April 1988, one or both of the claimant's hips were dislocatable and was/were actually dislocated at the time of Dr Oppenheimer's examination. By 26 April 1988, the hip(s) could have become relocated and thus apparently normal at the time of the defendant's examination.

The defendant's evidence

73. Dr Young has been a partner in a general medical practice in Temple Sowerby, Cumbria, since 1976. In addition he has for many years acted as an examiner for the prestigious Fellowship examination of the Royal College of General Practitioners.

74. In relation to Dr Oppenheimer's examination on 12 April 1988 and her note that the claimant's hips were "rather stiff", Dr Young said that he could imagine a case where a baby's hips were globally stiff (as opposed to having a limitation of abduction) and therefore difficult to assess fully. That might happen if the baby was very upset and tense. It would not constitute a "failed" Ortolani/Barlow test. If, on the other hand, the hips were generally mobile but there was a limitation of abduction, that would be a failed test.

75. Dr Young said that he agreed with Dr Holmes' evidence about the need to persevere with the examination if the baby was resistant. He said that he had never personally had to abort an examination of a baby's hips because of the baby's tension and resistance. However he said that he believed that doctors varied in their willingness to continue with an examination in the face of resistance. Dr Oppenheimer's evidence had been that she felt unable to carry out the examination fully; she did not feel that there had been a failure of the screening test. Dr Young said that, if that was so, it was reasonable for her to advise that the claimant's hips should be re-checked in two weeks' time. If she had suspected that there was any abnormality, she should have referred the claimant for an orthopaedic opinion immediately. He observed that it was well known that the Ortolani/Barlow test was not a very sensitive screening device and that it failed to pick up all cases of abnormality. Accordingly, if there was any doubt as to whether an abnormality was present, the child should be referred.

76. As to the defendant's examination of the claimant on 26 April 1988, Dr Young said that, since she found no abnormality on that occasion, there was no need to bring the claimant back for a further examination of the hips or to refer her to an orthopaedic specialist. He accepted the defendant's explanation in her witness statement that the reference to a check in 9-12 months' time related, not to the claimant's hips, but to a general interest in checking the claimant's development and/or syndactyl. He said that, if the defendant had had continuing concerns about the claimant's hips, it would have been "utterly inappropriate" to advise a review months later.

The expert evidence on causation

77. Expert evidence relating to causation was given by Mr David Jones, consultant orthopaedic surgeon, for the claimant, and by Professor Nicholas Clarke, consultant orthopaedic surgeon, for the defendant. Mr Jones provided a Report and additional letter and Professor Clarke provided a Report and Supplementary Report. In addition, following a discussion on 11 November 2010, they provided a Joint Statement setting out the areas of agreement between them and the areas of disagreement. They both gave oral evidence, Mr Jones by video link.

78. Mr Jones has been a consultant in trauma and orthopaedics for over 31 years. He is currently senior consultant orthopaedic surgeon at Great Ormond Street Hospital and a senior lecturer at the Institute of Child Health in London. He has extensive experience of CDH.

79. Professor Clarke has been a consultant in trauma and orthopaedics, specialising in paediatric orthopaedics, since 1986. He did part of his training in the USA and is the only UK member of the Paediatric Orthopaedic Society of North America. In 1986, he was acting as an adviser to the DHSS when the SMAC Guidance was published. He has for many years been a pioneer of the use of ultrasound in the diagnosis of CDH. He is based at the Southampton University Hospitals Trust where he sees 60-80 babies a week for screening and diagnosis and operates regularly.

80. The causation experts agreed that it was not possible to say what proportion of cases of CDH were detected at each of the various stages in a child's life. Professor Clarke said that it was known from a surveillance study carried out by the Medical Research Council, reported in an article in the Lancet Vol 351 April 18 1998 entitled, "Surgery for congenital dislocation of the hip in the UK as a measure of outcome of screening", that the majority of children in the UK who required surgery for CDH had not been detected by the clinical screening programme. The study showed that, in 222 cases out of 318 cases of children who had undergone a first operative procedure for CDH, the condition had not been detected by the routine screening programme. Professor Clarke said that that the findings of the study reflected his own experience, which was that there was still a "steady stream" of cases of CDH which presented after the age of 18 months up to the age of 6 or 7 years.

81. Mr Jones agreed that it was not possible to give an exact answer in statistical terms. However, based on research he had carried out in the 1970s, he calculated that perhaps 50% of cases of CDH might be diagnosed within 6 weeks of birth, with another 30-40% during infancy and before the child began to walk. The remainder would be detected only after the child had started walking, usually between the ages of 12 and 24 months.

82. As to the time of onset of the claimant's CDH, Mr Jones said that his experience suggested that, in the majority of cases where dislocation was going to occur, full dislocation had become established by the age of 6-8 weeks. Once dislocation had become established in a child without other complications, there was likely to be limitation of abduction. He said that, on a balance of probabilities, the dislocation of the claimant's right hip would have become established at or shortly after birth and that there would have been limitation of abduction after that time.

83. Professor Clarke's view was that there would have been some instability of the claimant's hip at birth with full dislocation occurring at some point after that. He was unable to say when that would have been in the claimant's case. However, his evidence was that the likelihood was that full, irreducible dislocation would not have developed by April 1988. He said that the textbooks suggested that this might not happen until the age of 5-6 months. He acknowledged that, in a few cases, full dislocation may occur within the first few weeks. However, those would, he said, be bad cases and easily detectible.

84. Mr Jones said that he was not critical of the fact that no abnormality of the claimant's hips had been detected at the neonatal examination. The Ortolani/Barlow test sometimes produces negative results even when an abnormality of the hip is present. It was well known that a significant proportion of CDH cases are missed at the neonatal examination stage.

85. Mr Jones agreed with Professor Clarke that, at the time of the examinations by Dr Oppenheimer and the defendant, the Ortolani/Barlow test for instability may well have been negative. He considered that this was because the dislocation would have been becoming established at that time. It was probable that there would have been limitation of abduction such as would have alerted a competent examiner to the possible presence of CDH. He said that limitation of abduction could be present in a child as young as the claimant was at that time. He considered that the "stiffness" observed by Dr Oppenheimer was in fact limitation of abduction. He said that stiffness in an otherwise normal child would usually relate to abduction. It was possible for there to be such limitation in a child who was fretful and unable to co-operate. In a healthy relaxed child, one would expect a normal range of movement.

86. Professor Clarke was unable satisfactorily to explain the word "stiffness", noted by Dr Oppenheimer at the time of her examination on 12 April 1988. He accepted that there may have been limitation of abduction indicative of CDH at the time, although he observed that limitation of abduction would generally be considered a failure of movement, rather than "stiffness". He said that the "classic" signs of CDH – including limitation of abduction – were not usually evident until much later in the child's life, generally after the age of 9 months. He said that these "classic signs" usually became evident only after the dislocation had become established. He explained that limitation of abduction of the hip occurred because of contraction of the adductor muscles located in the thigh. The contraction was caused by the movement of the "ball" of the femur upwards and backwards. The contraction happens progressively, not overnight. He said that, if there was limitation of abduction present at the time of Dr Oppenheimer's examination, it would have been slight. However, once present, it would not come and go. It would progress.

87. Mr Jones considered that, at the time of the examinations by Dr Oppenheimer and the defendant, there would also have been other signs of asymmetry such as creasing or shortening which would have been evident, if not to a GP, at least to an experienced orthopaedic surgeon such as himself. He accepted that Dr Oppenheimer and the defendant said that they had not seen those features. Nevertheless, he considered that they would have been present.

88. Professor Clarke was asked about the significance of the fact that the claimant's left hip appeared relatively normal on both x-ray and ultrasound examination. He said that

it was not possible to say whether it had been normal at the time of the examination by Dr Oppenheimer. He said that results of ultrasound examinations in Austria had shown that, where one hip is abnormal, the opposite hip is usually not completely normal either, although any abnormality in it may be very minor and may not give rise to clinical signs.

89. As to the likely course of events had the claimant been referred to an orthopaedic specialist at the age of 9 weeks, i.e. after her examination by the defendant, Professor Clarke said that, even if the clinical findings had been normal at that stage, it was possible that an x-ray examination would have been undertaken. However, x-rays of children of that age were, he said, difficult to interpret and CDH may well not have been diagnosed even then.

90. Mr Jones disagreed. He said that he was using x-ray examination successfully in 1988. His experience was that, at the age of 2-3 months, a dislocation of the hip would usually be apparent on x-ray examination. At the least, there would be enough evidence to arouse suspicion so that a repeat x-ray examination would be conducted later.

91. The causation experts were asked about the prognosis in the claimant's case if she had been referred to an orthopaedic specialist in April 1988 and if an x-ray examination had revealed the presence of dysplasia or dislocation. Professor Clarke considered that the claimant would probably have been treated by keeping the femoral head in the correct (reduced) position and the hips abducted, for 8 weeks or so by means of a fixed abduction splint or harness. On a balance of probabilities, the treatment would have been successful and the hip would have been likely to develop normally thereafter.

92. Mr Jones said that different surgeons had different approaches to the treatment of CDH. However, he considered that the claimant would probably have been treated by closed reduction, followed by immobilisation in plaster and then a splint for 3 months. He said that, although a minority of cases cannot be successfully treated by these means, the likelihood is that a successful reduction would have been achieved and that the claimant would have been unlikely to have any disability until middle age. He said that, at that stage, it was probable that she would have developed degenerative changes necessitating a hip replacement in her late 50s or 60s with no requirement for a revision of the replacement thereafter.

93. Mr Jones said that, if CDH is diagnosed after a child begins to walk, it is likely that open reduction of the dislocation will be necessary, usually with a re-alignment osteotomy of the femur or pelvis to help stabilise the reduction. In the majority of cases, this treatment is successful and the condition will cause no further problems until much later in life. At that stage, there is the likelihood of degenerative changes developing, with the need for a hip replacement when the patient is in his/her 40s or 50s. In these circumstances, no subsequent revision is likely to be required. He said that, in a case such as the claimant's, where CDH was diagnosed late and where more complex surgery was required, the onset of degenerative changes, and the need for a hip replacement, were likely to arise earlier, probably in the patient's late 40s, with a revision operation being necessary subsequently.

The parties' cases

The claimant's case

94. For the claimant, Mr Ferro submitted that the central question was: what was found by Dr Oppenheimer on 12 April 1988 and by the defendant on 26 April 1988. He argued that it was clear from Dr Oppenheimer's note of her examination that she had found limitation of abduction, a classic sign of full dislocation of the hip. If she had been unable properly to examine the claimant by reason of her distress or for some other reason that would have been noted. Mr Ferro said that Mr Jones' evidence had been that, in most cases where full dislocation develops, the dislocation is established by the age of 6-8 weeks. He argued that the MRC survey, on which Professor Clarke had relied, failed to take account of those cases in which no operative treatment was required, i.e. in which CDH was detected very early in life. If they were taken into account, the proportion of CDH cases identified by means of the clinical screening programme might well be very much higher. He pointed out that, in any event, Professor Clarke had conceded that it was possible for full dislocation and consequent limitation of abduction to be present at 6-8 weeks, albeit not – according to him – the usual pattern. Mr Ferro also referred to the SMAC Guidance which referred to the "classic signs" of dislocation being "increasingly common" after the first 6 weeks of life.

95. Mr Ferro said that it was clear that Dr Oppenheimer had detected some abnormality which, in her view, necessitated a second examination. That second examination should, he said, have been approached with a high level of suspicion. He said that the claimant did not accept that the defendant's clinical findings were or should have been entirely normal. If it were right that Dr Oppenheimer had found some limitation of abduction, the claimant's hip cannot have been normal. Even if the defendant believed that it was, that did not mean that no abnormality existed. It was clear from Dr Oppenheimer's note that her examination had revealed an abnormality and the defendant's note that the claimant's hips "seemed" OK "today" carried the clear implication that she believed her findings were different from those of Dr Oppenheimer. In those circumstances, the proper course was to re-examine within a short time. He said that the defendant appeared to have had doubts about the results of her examination which caused her to advise that the hips should be checked in 9-12 months' time. That was plainly inappropriate.

96. Mr Ferro submitted that, if I were to find that there had been limitation of abduction at the time of the examinations by Dr Oppenheimer and the defendant and that the claimant should have been referred to an orthopaedic specialist (probably Mr Copeland) at or about that time, the likelihood was that he would have detected some clinical abnormality and sent her for x-ray examination. That would, he argued, probably have revealed the dislocation. If it had not, the likelihood was that the claimant would have been kept under surveillance until the possibility of CDH could be excluded. In that event, CDH would have been diagnosed significantly earlier than was in fact the case and the outcome for the claimant would have been a great deal better.

The defendant's case

97. For the defendant, Ms Gollop submitted that the key issue was what the defendant found on 26 April 1988. The evidence of what Dr Oppenheimer observed a fortnight earlier shed no light on what was in the defendant's mind on 26 April 1988. She said that, since neither Dr Oppenheimer nor the defendant had any actual recollection of their examinations of the claimant, their evidence as to their usual practice at the time was of particular importance. They had said that it was their usual practice, if they had any suspicion of a hip abnormality, to refer the child for a specialist orthopaedic opinion. The defendant's evidence was that she was aware of Dr Oppenheimer's practice and that it was for that reason that she did not suspect that Dr Oppenheimer had found any abnormality of the claimant's hips on 12 April 1988. She had been adamant that, if she had had any concerns about the claimant's hips, she would not have advised a further examination several months in the future. Ms Gollop submitted that it was most unlikely that both doctors had failed to follow their usual practice on this occasion. She submitted that I should find that there had been no breach of duty.

98. As to causation, Ms Gollop invited me to find that there would have been no limitation of abduction or visual signs of asymmetry in April or May 1988. She submitted that Professor Clarke's evidence on this point was to be preferred to that of Mr Jones. She said that Mr Jones' evidence was inconsistent with the findings of the MRC study. If clinical signs of CDH were generally evident at such a young age, the proportion of cases which went undetected during the screening programme would be much smaller than that identified by the study. In any event, the claimant had been seen by Ms Wise, as well as by the defendant. She had noticed no signs of asymmetry of the claimant's legs.

99. Ms Gollop argued that it was clear from the defendant's note and her evidence that there was no limitation of abduction present at the time of the defendant's examination on 26 April 1988. Given the mechanism which causes limitation of abduction, it was not possible for limitation of abduction to have been present on 12 April 1988 but absent a fortnight later. Consequently, the stiffness observed by Dr Oppenheimer must have occurred as a result of something other than limitation of abduction. Moreover, Dr Oppenheimer had noted that both hips were stiff. There was no evidence of any problem with the left hip which could have caused muscle contracture. This supported the argument that there had been no limitation of abduction on 12 April 1988.

100. Ms Gollop submitted that, even if the defendant had re-examined the claimant a short time after 26 April 1988, or referred her to Mr Copeland, the outcome would in all probability have been the same. There was no reason to believe that any clinical abnormality would have been found. That being the case, Mr Copeland would not have carried out an x-ray examination and no further steps would have been taken to keep the claimant under review.

Discussion and conclusions

101. It is clear from the SMAC Guidance published in 1986 that the importance of detecting CDH as soon as possible – preferably in the first three months of life – should have been well recognised in 1988. GPs who were involved in the process of screening infants for signs of CDH should have been aware of the signs to look out

for and the importance of initiating investigations if they had any suspicion that CDH might be present.

102. It is clear also that, even when CDH is present, it can be difficult to detect in the early weeks of life. At that stage, there may be instability of the hip. That instability may not be evident when carrying out the Ortolani/Barlow test. Where full dislocation is present, the results of the test may well be negative. In many cases, the classic signs of dislocation may, as Professor Clarke suggested, not yet have developed. It is for these reasons that, despite the fact that there has for many years been a programme for clinically examining all infants for the presence of CDH, the condition is still being diagnosed in children who have started to walk or have been walking for some time.

103. Since the claimant was subsequently diagnosed as having a full dislocation of the right hip, it is clear that the hip must have been abnormal from the time of her birth. Some instability of the hip (or full dislocation) must have been present from the first. That instability (or dislocation) was not detected at the time of the neonatal examination carried out in hospital. The evidence suggests that this is not an uncommon occurrence, even when the examination is competently carried out.

104. It follows therefore that there must have been some abnormality of the hip at the time the claimant was examined by both Dr Oppenheimer and the defendant. That fact alone does not, of course, mean that their failure to detect the possible presence of CDH automatically constituted a breach of duty. It is common ground between the experts that, even in the presence of CDH, the results of the Ortolani/Barlow test may be negative without any fault on the part of the examiner. However, the fact that it is known that some abnormality of the hip was present assumes considerable significance when considering Dr Oppenheimer's findings on 12 April 1988.

105. Dr Oppenheimer noted that the claimant's hips were "rather stiff". Although she had no recollection of the examination, her explanation for those words was that the claimant's distress, lack of cooperation and/or resistance must have been such that she had to abort the examination without being able to satisfy herself that the claimant had full movement of the hips. I am unable to accept that explanation. First, the evidence of the two GP experts was that they had never had to abort an examination in similar circumstances. Whilst it is not impossible that Dr Oppenheimer, who was relatively junior and perhaps lacking in confidence at the time, might have done so, the evidence suggests that it is unlikely. Moreover, if she had had to abort the examination for any reason, I am quite satisfied that she would have made that clear in her note. It would have been important to do so, not only as an *aide memoire* and record for herself, but also in order to inform the defendant, who was responsible for her patients in her absence and who might be (and in fact was) required to carry out the further examination of the hips a fortnight later. The words "hips - rather stiff" strongly suggest that Dr Oppenheimer was recording the results of an examination carried out. They certainly do not imply that no proper examination was possible.

106. If Dr Oppenheimer did complete her examination and find that the claimant's hips were "rather stiff", what conclusion can be drawn from that? The most obvious explanation is that what she in fact observed was limitation of abduction, a classic sign of dislocation of the hip. Indeed, if tension and resistance on the part of the claimant are excluded, the experts were able to offer no other explanation for a finding of "stiffness" in an otherwise normal child. I am satisfied that if there had

been any obvious reason for the finding of stiffness – such as resistance on the part of the claimant – that would have been noted by Dr Oppenheimer. I find that the "stiffness" she observed resulted from the fact that the right hip was by that time fully dislocated causing limitation of abduction. Whilst the views of Mr Jones and Professor Clarke differ as to the proportion of cases where full dislocation occurs as early as 7 weeks (the claimant's age at the time of Dr Oppenheimer's examination), it is quite clear that dislocation and consequent limitation of abduction can in some cases occur very early in life. I find that that is what happened in the claimant's case. Since the dislocation was already established at the time of Dr Oppenheimer's examination, it is not surprising that the Ortolani/Barlow test was negative. It may be, as Professor Clarke suggested, that the limitation of abduction at that stage was slight only. Nevertheless, it is clear that it was sufficient to attract Dr Oppenheimer's notice.

107. In finding that Dr Oppenheimer observed limitation of abduction on 12 April 1988, I do not overlook the fact that she referred to stiffness of the "hips", whereas it is clear that there was no dislocation present in the left hip and, indeed, the left hip has subsequently been found to be normal. On any view – and whatever she was describing – Dr Oppenheimer's note was brief and unspecific. She did not note what tests she had performed, any negative results found or the extent of any stiffness she observed. This may have reflected the usual practice of doctors when making notes in the 1980s. It may have been the product of her own personal practice and/or her relative inexperience at the time. The note contained one obvious mistake: the claimant's age was noted as "7/40", rather than "7/52". I consider it probable that the reference to "hips" constituted another error. Either Dr Oppenheimer was unable to – or did not - differentiate accurately whether the stiffness she observed was present in one hip or both, or she used the word "hips" in a sloppy fashion when noting her findings.

108. Dr Oppenheimer advised a re-check of the hips a fortnight after 12 April 1988. The timing of the re-check provides further support for my finding that she had not had to abort her examination of the claimant's hips on 12 April 1988 without achieving any result. If that had been the case, there would have been no need to wait a fortnight before attempting the examination again. Given my finding that she observed limitation of abduction on 12 April 1988, it is not clear why she did not refer the claimant to an orthopaedic specialist at that stage. It may be that, because the limitation was slight, she was uncertain and wanted to be confident that her observation had been correct before making a referral. I find that she advised that a period of 2 weeks should elapse before the re-check because she was aware that, with the passage of time, any abnormality was likely to become more evident.

109. There was no evidence of any discussion between the defendant and Dr Oppenheimer about the claimant prior to the defendant's examination of her on 26 April 1988. The defendant's evidence was that she would not have understood from Dr Oppenheimer's note that Dr Oppenheimer had detected any abnormality on 12 April 1988. She knew that it was Dr Oppenheimer's practice, if she suspected any abnormality, to refer the child to a specialist. Since Dr Oppenheimer had not done that, the defendant said that she would have assumed that Dr Oppenheimer had not managed to carry out a proper examination and that it was for that reason that a re-check of the hips had been advised.

110. I am unable to accept that evidence. No-one reading Dr Oppenheimer's note could have inferred from the observation "hips – rather stiff" that she had been unable to complete the examination. The only sensible inference to be drawn from the fact that she had recorded stiffness of the hips and had thought it necessary for the claimant's hips to be re-examined in a fortnight's time was that she suspected – but was perhaps not confident – that there may be some abnormality present. I am satisfied that the defendant understood that to be the case and that it was for that reason that she noted that the claimant's hips "seemed" OK "today", thus drawing a comparison between her examination and that of Dr Oppenheimer.

111. The note made by the defendant at the time of her examination was, like that of Dr Oppenheimer, brief and unspecific. Her evidence was that she would have carried out the Ortolani/Barlow test. Given that I have found that the claimant had by that time developed a full dislocation of the right hip, it is likely that the test would have been negative. There would, however, have been limitation of abduction present. The evidence was that such limitation, once present, does not come and go, but is progressive. Thus, it is likely that the limitation would have been more marked than at the time of Dr Oppenheimer's examination. Why it was not observed by the defendant is impossible to say. It may be that, having achieved a normal Ortolani/Barlow test, as she may well have done, she did not adequately test for limitation of abduction. The limitation may have been relatively minor and she may have missed it. But what is clear is that the limitation of abduction which had been observed by Dr Oppenheimer and had been sufficient for her to describe as "stiffness" must have been present and the defendant failed to observe it.

112. In my view, the most likely explanation for these events is that, in April 1988, the defendant – and probably Dr Oppenheimer also – was not as well informed about CDH as she later became. Her note of 26 April 1988 contains a clear indication that this was the case. Having noted that the claimant's hips "seemed" to be "OK today", she went on to note "check 9/12/12". Her evidence was that the check in 9-12 months' time cannot have related to the claimant's hips but must have been directed at some other aspect of her health and/or development. I found that explanation wholly unconvincing. The rest of the note relates solely to the claimant's hips. There is no reason whatever to believe that the further check related to any other issue. If it had done, the purpose of the check would plainly have been noted. If it had not, there was an obvious risk that, during the following months, the defendant would forget the intended purpose of the check. I have no doubt at all that what the defendant was advising was that there should be a further check of the claimant's hips in 9-12 months' time (or, possibly, at the age of 9-12 months). In doing so, she was, I find, recognising that an abnormality had been suspected by Dr Oppenheimer but not confirmed by the defendant, and was seeking to ensure that the possibility of an abnormality was followed up in the future.

113. The experts agreed that it would have been wholly inappropriate to advise a check so many months later. If any residual concern remained, the claimant should either have been referred to an orthopaedic specialist immediately or re-examined within 2-3 weeks. The fact that the defendant, as I have found, considered it appropriate to delay for several months before re-checking the hips demonstrates that she had an inadequate grasp of the nature of CDH and/or the way in which it was likely to develop and of the importance of diagnosing and treating it at the earliest possible

opportunity. That being the case, it is perhaps not surprising that she failed to observe limitation of abduction which was present and should have been evident to her as it had been to Dr Oppenheimer. I realise that the defendant had, on the face of it, more experience in assessing young babies than the average GP starting in practice. But the fact that she had been carrying out assessments for some time does not of course mean that she had been doing so satisfactorily.

114. The evidence of the claimant's mother was that she was not told that there was any concern about the claimant's hips and was not advised by the defendant to return for a further check in 9-12 months' time. I do not accept that evidence as accurate. Mrs Dainton must have been aware that the purpose of the appointment with the defendant on 26 April 1988 was for the claimant's hips to be checked again. It may well be that Dr Oppenheimer said nothing to alarm her and suggested that such re-examination was a normal process. Similarly, when the defendant advised her – as I am quite satisfied she would have done – that the claimant's hips should be re-checked in 9-12 months' time, she would no doubt have done so in a manner calculated to reassure. It was clear when Mrs Dainton gave her evidence that she had a poor recollection of the events of 1988, as exemplified by the fact that she did not remember ever having seen any GP at the Pangbourne Medical Practice other than the defendant.

115. It is surprising that the claimant's dislocation was not diagnosed until she was aged 7 years. On any view, it must have become established well before that time. Any abnormalities that were present must have been overlooked by the Health Visitor and medical professionals who saw her during the period after the defendant's examination. The only indication in the records of any observed abnormality was Ms Wise's concern about the claimant's failure to walk unsupported, a concern which seems to have been allayed shortly afterwards. It is impossible to say why her dislocation was not picked up earlier. It may be that the Health Visitors, like the GPs, were not at that time as conversant with the signs of CDH as they later became. The claimant's syndactyl, and the ongoing treatment she was receiving for it, may have distracted attention from any possible problem with her hips. As she got older, the problems - both physical and psychological - from which she was suffering must also have confused the picture. Even her mother did not notice the discrepancy in the length of the claimant's legs until it was pointed out to her by a third party. The claimant's abnormal gait seems to have been attributed - for a time at least – to the skin graft taken from the sole of her foot and/or the syndactyl of her feet. Whatever the reason, it does not alter my conclusion that the dislocation was present from a very early stage.

116. In rejecting the explanations for their notes and actions given in evidence by Dr Oppenheimer and the defendant, I do not suggest that they were deliberately intending to mislead me in any way. They have been placed in the unenviable position of being asked to explain their actions 20 years or so later, with the minimum of assistance from the contemporaneous documents. There is no reason to suppose that, in other respects, they were not careful and competent practitioners. They gave that impression when giving their evidence. I have little doubt that they subsequently became knowledgeable about CDH (probably after 1990, when the arrangements for child surveillance were transferred to GPs) and that, as they said, they had a low threshold for referring suspected cases of CDH to an orthopaedic specialist. However, I consider that, when reviewing their notes of what occurred in April 1988 with the

benefit of the experience and knowledge they later acquired, they had difficulty in accepting that they did not have the relevant understanding of CDH at that time and that they acted as they did. It is for that reason, I find, that they persuaded themselves that there must have been circumstances not apparent from their notes which caused them to act in that way.

117. In all the circumstances, I conclude that the defendant should have detected the presence of limitation of abduction at the time of her examination and should have referred the claimant to an orthopaedic specialist immediately after 26 April 1988. At the very least, she should have required the claimant's mother to bring her to the surgery for a third examination in a further 2-3 weeks' time. I find that her failure to take either of these courses constituted a breach of duty on her part. Since the limitation of abduction would have been present, and indeed is likely to have progressed further by the time a third examination (whether by the defendant or one of her partners) took place, I find that, if that third examination had been carried out competently, the abnormality would have been recognised and the claimant would or should have been referred to an orthopaedic specialist at that stage.

118. If the claimant had been referred to Mr Copeland in April or May 1988, the limitation of abduction would have been present and would, I am satisfied, have caused him to order an x-ray examination of the claimant's right hip. Whilst it is possible that the results of that x-ray examination would, as Professor Clarke suggested, have been equivocal, I accept the evidence of Mr Jones that the presence of limitation of abduction, coupled with the results of the x-ray examination, would on a balance of probabilities have led to a diagnosis of CDH and the institution of treatment at that stage. Even if the condition had not been immediately diagnosed, the overwhelming likelihood in my view is that it would have been monitored and detected and treated well before the claimant began to walk, thereby resulting in a significantly better prognosis than the current one.

119. I find that the likely means of treatment would have been, as Mr Jones suggested, by way of closed reduction, followed by immobilisation in plaster and then a splint for 3 months. On a balance of probabilities, the treatment would have been successful in ensuring that the claimant suffered no disability until well into middle age. There would, however, have been a likelihood of degenerative changes occurring and leading to a hip replacement in her late 50s or 60s.

120. I therefore give judgment for the claimant against the defendant on the issues of breach of duty and causation, with damages to be assessed. The parties should seek directions in relation to the preparation and hearing of the issue of quantum.