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Claim No. QB-2018-001602

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/06/2020

Before:

RICHARD HERMER QC
(SITTING AS A DEPUTY JUDGE OF THE HIGH COURT)

Between:

DARRELL STEWART JONES **Claimant**
- and -
MINISTRY OF DEFENCE **Defendant**

Simon Wheatley (instructed by **Russell-Cooke LLP**) for the **Claimant**
Russell Fortt (instructed by **The Government Legal Department**) for the **Defendant**

Hearing dates: 12-20 May 2020

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.

.....
RICHARD HERMER QC

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email, release to BAILII and publication on the Courts and Tribunals Judiciary website. The date and time for hand-down is deemed to be 10:00am on 22 June 2020.

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Richard Hermer QC:

A: SUMMARY

1. This clinical negligence case concerns the medical and financial consequences of a ten-month delay in the diagnosis of the Claimant's HIV status.
2. The Claimant received his diagnosis in September 2013. At that time, he was a serving soldier in the British Army and the Defendant was responsible for his medical care. The Defendant accepts the standard of that care fell below a reasonable level when, on 20 November 2012, a doctor failed to consider HIV as a possible cause for the Claimant's persistent medical complaints. It is accepted that had he done so the Claimant should have been sent for tests which would have resulted in the prompt diagnosis of HIV, and very shortly afterwards, commencement of treatment.
3. The Defendant accepts that it is liable to compensate the Claimant for the ill health he suffered during that ten month period and for a period of time thereafter when his weakened immune system meant he succumbed to pneumonia and then tonsillitis, both requiring brief hospitalisation. That concession is however the limit of what the Defendant accepts was caused by the negligent delay in diagnosis.
4. The dispute between the parties as to the consequences of the delay in diagnosis is very marked indeed. The Claimant's case, primarily based on the opinion of his medical expert Dr Ashley Croft, is that the ten month delay in diagnosis has had a profoundly detrimental impact on most aspects of his life. Dr Croft opines that whereas the Claimant could have expected to have recovered his health by now had he been diagnosed in November 2012, the impact of the delay is such that he remains markedly unwell, in particular suffering from severe fatigue. Perhaps most striking is Dr Croft's analysis of the impact of the delay on the Claimant's life expectancy. Dr Croft has a generally pessimistic view of life expectancy for those whose HIV is diagnosed late, but he is particularly gloomy about the Claimant's predicament. His evidence at trial was that the Claimant (who is now aged 38 years of age) will die within about ten years of now, whereas had he been diagnosed earlier he could have enjoyed an additional 12 years beyond that. In writing he had been even more pessimistic, opining that life expectancy could be as short as 6 years.
5. By contrast, the Defendant's primary expert, Professor Jonathan Ross, applies a far more optimistic analysis of both the Claimant's current health (in so far as it is directly related to HIV) and also life expectancy. His opinion is that although the Claimant was at grave risk of death at the time of diagnosis, the recovery of his immune system has been excellent and his HIV can no longer directly explain any ongoing health problems. As to life expectancy, his opinion is that the Claimant has now recovered to the point at which it can be considered that he will live as long as he would have done had he been diagnosed earlier. Professor Ross estimates the Claimant will live between five and seven years less than a non-HIV infected male in the general UK population. In other words, rather than living only for another 10 years as Dr Croft now predicts, Professor Ross considers the Claimant can expect to live another 36-38 years.
6. The difference in opinion between Dr Croft and Professor Ross explains in large measure the gulf between the parties on quantum. The Claimant, supported by the

evidence of Dr Croft and his expert psychiatrist, Dr Nabavi, claims that his ongoing fatigue (caused it is said by the delay in diagnosis), was the reason why he was discharged from the Army in 2015 and has subsequently been unable to obtain equally well remunerated employment. An Amended Schedule of Loss estimates past and future financial losses at just shy of £400,000. In addition, the Claimant's skeleton argument estimates general damages were at around £120,000.

7. As the Defendant does not consider itself liable for anything other than the short-term consequences of a ten month delay in diagnosis, which it submits does not include the reasons for discharge from the Army, its estimate of the value of the claim is correspondingly far lower. The latest iteration of the Defendant's Counter Schedule accepts responsibility solely for some limited gratuitous care provided to the Claimant by his wife which is given a value of just under £1,400. The Defendant's skeleton argument suggested that the appropriate figure for general damages was in the region of £10,000.
8. This in broad terms is a summary of the dispute before the Court from which it will be apparent that much will turn on whether the evidence of Dr Croft is to be preferred to that of Professor Ross, not least in respect of what are core issues impacting on quantum namely:
 - i) To what extent, if any, does the impact of the delay in diagnosis explain the Claimant's ongoing health problems, not least his fatigue?
 - ii) To what extent, if any, was the delay in diagnosis responsible for the Claimant's medical discharge?
 - iii) What, if at all, is the impact of the delay in diagnosis on the Claimant's life expectancy?
9. In addressing these and other relevant questions, it merits emphasising at the outset that when assessing the causal impact of the admitted negligence, it is important not to elide the impact that the underlying HIV would have had on health and employment prospects in any event (for which the Defendant is not liable to pay compensation), with that which has been caused by the delay (for which it is).
10. For the reasons given in detail in this judgment I have concluded that, at each turn, the analysis of Professor Ross is to be far preferred to Dr Croft. Taking into account all the relevant evidence, not just that of these two experts, I conclude that that the Claimant has not proved that the delay in diagnosis was responsible for his medical discharge from the Army. I also conclude that whilst the delay caused profound short-term suffering and also exposed him to a limited period of grave risk of death, his current condition and long-term prospects cannot be shown to be any different to how they would have been if he had been diagnosed earlier.

B: PROCEDURAL BACKGROUND

i. Procedural History

11. The claim was issued on 27 February 2017 (to protect limitation) and although the Particulars of Claim were formally served the following year on 24 June 2018, a draft

had already been provided as part of compliance with the applicable Pre-Action Protocol.

12. The Particulars of Claim identified three occasions on which it was said there was a negligent failure to test the Claimant for HIV, namely 10 November 2012, 20 November 2012 and 11 February 2013.
13. In a short Defence of 25 July 2018, the Defendant denied causally relevant negligence in respect of the two November medical appointments but admitted negligence in respect of the February 2013 appointment. The Defence essentially put the Claimant to proof of causation of loss flowing from the admitted seven month delay. An Amended Defence served in April 2019 set out a more strident and detailed case on causation. It positively averred that the medical discharge was unrelated to the admitted delay in diagnosis and it was denied that the Claimant suffered a reduction in life expectancy as a result of any delay. I note that in the period of time between the two iterations of the Defence, the Defendant had received at least two reports from Professor Ross, which may well explain the more robust particularisation of its pleaded case on causation.
14. On 9 April 2020, in the run up to trial and following a joint meeting of the experts, the Defendant admitted that it breached the duty of care owed to the Claimant on 20 November 2012. The letter from the Defendant's solicitors stated that the breach of duty "*... led to a delay in the diagnosis and treatment of the Claimant's HIV for a period of ten months.*"
15. In his opening skeleton argument, Mr Fortt, counsel for the Defendant, repeatedly referred to the consequences of the '*nine month delay*'. He clarified that position at the start of trial and made plain that the Defendant accepted that the Court and parties should proceed on the basis of a ten month delay.
16. In light of the further admission by the Defendant in respect of the 20 November 2012 consultation, the Claimant indicated that he would not pursue the allegation of negligence pleaded in respect of the appointment held just ten days earlier.
17. On 24 April 2020, the Claimant served an Amended Particulars of Claim. The purpose of the amendments was to add a claim for provisional damages, alternatively for periodical payments. These amendments were said to be necessary in light of the persisting disagreement between the experts on life expectancy. The Defendant did not oppose the granting of permission for the amendment but in a consequentially Re-Amended Defence, denied that either provisional damages or periodical payments were appropriate. In the event, during the course of his closing submissions, Mr Wheatley, counsel for the Claimant, indicated that he was no longer pursuing provisional damages.

ii. Witnesses

18. At trial I heard evidence from ten witnesses. I will list them briefly and in so far as relevant, give a more detailed description of their evidence later in this judgment.
 - i) The Claimant. In his written and oral evidence the Claimant vividly described his increasing ill-health from 2012 onwards, the horrifying impact of being

informed of his diagnosis, and how he has attempted to cope, not least with what he describes as ‘prostrating fatigue’. He was an impressive witness. He is intelligent and articulate albeit, as he acknowledged, has difficulty conveying his emotions. The Defendant rightly did not attempt to question his credibility.

- ii) Sarah Jones is the Claimant’s wife although they have been separated since November 2015. She served a short statement essentially confirming the relevant claim for gratuitous care that she provided. She was cross examined in some detail about the Claimant’s state of health over the relevant periods. She was also an impressive witness, clear in her recollection which was recounted without any hint of exaggeration.
 - iii) Lt Colonel (Dr) Ngozi Dufty is not only the Defendant’s Specialist Advisor for Sexual Disease and HIV, but one of the Claimant’s own treating physicians, in which capacity she co-authored a published paper that was critical of the care he received. The Defendant served a short witness statement from her which was primarily limited to a factual recitation of her clinical findings most relevant to the decision of others to discharge the Claimant from the Army. Although she was a witness of fact, Mr Wheatley (without objection from Mr Fortt) sought to cross examine Dr Dufty on matters that were plainly seeking to elicit expert opinion. I deal with this below.
 - iv) Colonel (Dr) Rowland Gill is an Occupational Medicine Consultant in the British Army. He was a member of the Medical Board that recommended that the Claimant be medically discharged albeit he did not attend that meeting in person but rather based his decision on a review of the relevant documentation.
 - v) Dr Ashley Croft is a Consultant Public Health Physician. As described above, he was the Claimant’s expert on the impact of the late diagnosis of HIV on his physical health.
 - vi) Dr S.B. Nabavi was the Consultant General Adult Psychiatrist called by the Claimant.
 - vii) Professor Jonathan Ross is the Professor of Sexual Health and HIV at University Hospital of Birmingham Foundation NHS Trust and was instructed by the Defendant.
 - viii) Dr Robert Kehoe was the Consultant Psychiatrist called by the Defendant.
 - ix) Mr Keith Carter was the Claimant’s employment expert.
 - x) Mr Bell-Walker was the Defendant’s employment expert.
19. Before turning to the substance of the evidence, I address two further procedural matters. Firstly, the fact that this trial was heard ‘remotely’ because of the limitations imposed by the COVID-19 Crisis, and secondly an application for anonymity, made without notice at the start of the trial.

iii. Covid-19

20. When this matter was first listed for trial few would have anticipated that the state of the world as it currently stands. Steps to reduce the risk of infection, not least through social distancing, have meant that Courts have not been able to operate in the normal way. When his claim was issued, the Claimant would have been entitled to expect that his metaphorical ‘day in court’ would include attendance at the Royal Courts of Justice where he would be able to give evidence in the presence of his family and legal team and also watch as experts and other witnesses took to the witness box. Members of the public and the press would also have had an expectation that they would have been entitled to enter the Courts and watch trials such as this.
21. This of course was not possible during lockdown but rather than adjourn the trial the parties were content for it to proceed by way of a remote hearing. The essential mechanics of the hearing were as follows:
 - i) The day before the hearing two short scoping exercises were conducted with the parties and their witnesses in order to ascertain which ‘video conferencing’ platform would be most suitable for trial. After testing both ‘Skype for Business’ and ‘Microsoft Teams’ a clear consensus was that Microsoft Teams appeared to be the most accessible and the most stable;
 - ii) At the outset of the hearing, I invited submissions on what accommodations should be made to take account of the fact that the hearing was being held remotely during a national ‘lockdown’ which might itself place added pressures on all participants. The parties sought (and I gave) breaks in between their respective questioning of witnesses in order to give and receive confidential instructions. I also agreed to permit a few additional uncontroversial questions in chief to the witnesses in order to take account of the unusual means of giving evidence;
 - iii) The Microsoft Teams platform permitted me to view all participants. As I explained to the parties, I ensured that my screen just showed either counsel (during submissions) or the witness and counsel asking the questions (during evidence). I had a large screen that was solely dedicated to the video conference (with the e-bundle on a separate screen). It enabled me to have a very clear view of a witness’ face although not of their body. I did not find that being unable to see a person’s body interfered with my assessment of their evidence. In large part this might be because this was not a case in which either party questioned the honesty or integrity of the other although even then, as has often been noted, reliance on body language as a guide to where truth lies can be notoriously unreliable and vulnerable to a range of biases. I also found that the format removed distractions from peripheral vision that can apply in a court room and intensified attention on the witness and what they were saying;
 - iv) The technology worked well throughout. The sound quality was generally excellent and when on the odd occasion a picture froze, or the sound clarity dropped, it was noticed by all and quickly remedied. The only exception to the smooth operation of the technology was in respect of one of the Defendant’s witnesses, Colonel Gill, who was unable to access any of the

video platforms because of MoD security restrictions. The parties consented to taking his evidence by way of a telephone conference, and, whilst not ideal, this sufficed in circumstances in which the evidence of the witness was not of central importance;

- v) The Daily Cause List published details of how public and press access could be gained to the trial. During the trial I received two requests for the media to be given access and one request from a member of the public. These were facilitated by sending them a 'Teams' invitation' by email.
22. Ultimately this format provided the opportunity for a fair trial because of the cooperation of the parties to ensure that it worked. The solicitors for the parties ensured that witnesses had the relevant electronic bundles and knew how to locate documents when asked to look at them during cross examination. They also ensured that witnesses were pre-warned about the need to take the oath with Bible or other Holy Book or affirm (in the absence of a Court Associate or Clerk) and were assiduous in ensuring that witnesses were available when required. The assistance and cooperation of counsel, Mr Wheatley and Mr Fortt, was invaluable and I record my gratitude to them.

iv. Application for Anonymity

23. One obvious shortfall in holding trials remotely is that it restricts access of the press and public. On the morning of the trial I received a request from the Press Association and one other journalist for access to the hearing. I informed the parties by email of the request and my intention to permit it on the basis that there were no applications before me for a private hearing or other relevant order limiting the open justice principle.
24. This email prompted a response on behalf of the Claimant not to give access to any reporter because he would be applying for an anonymity order. Mr Fortt, communicated that the Defendant did not object to the grant of the anonymity order. I indicated that I did not consider it appropriate to accede to the request to exclude the media from the hearing until such time as any relevant application had been heard and determined and that it should be dealt with at the outset of the hearing.
25. In the event, at the start of the hearing, having heard from Mr Wheatley and also representations from a representative of the Press Association, I decided to grant an interim reporting restriction for 24 hours in order to enable the Claimant to obtain some evidence to support his *ad hoc* application and for Mr Wheatley to be able to marshal his argument, not least by reference to the relevant authorities.
26. I heard argument from Mr Wheatley the following day. Notwithstanding the continued consent of the Defendant and the subsequent indication from the Press Association that they were not opposing anonymity, I refused to grant it. I have attached to this judgment a copy of the *ex tempore* judgment explaining why.

C: RELEVANT BACKGROUND FACTS

i. HIV

27. In order to give context to the facts of the Claimant's own case it may be helpful to give a brief explanation of some relevant facts about HIV itself.
28. HIV stands for 'human immunodeficiency virus', which is a virus that infects humans and causes immune dysregulation. In its advanced stage it manifests itself as AIDS which stands for 'acquired immune deficiency'. To very many, HIV is seared in the memory because of the tragic impact that AIDS had on gay male communities and devastating toll it took (and still takes) in many developing nations, in particular those on the African continent. It can be transmitted through a number of routes but the most common route of sexual transmission is now through heterosexual intercourse – indeed misconceptions about the lack of impact on heterosexual men is one of the factors identified as a frequent cause of a failure to timeously diagnose the condition and in Dr Dufty's opinion, might explain why it took doctors so long to send the Claimant for a test.
29. The period of time which HIV can take before developing into AIDS can be considerable, and indeed it can incubate for around 15 years. On average the immune system begins to sustain damage about 7-9 years after infection caused by the HIV.
30. HIV attacks the immune system. In very simple terms the weaker the immune system the more vulnerable the body becomes to a range of opportunistic infections and cancers. The body enters what is known as a 'catabolic state' as it works exceptionally hard to fight infections whilst its immune system is weakened.
31. The standard measurement for assessing the functioning of the immune system is known as the CD4 count. CD4 cells are blood cells, or lymphocytes, which normally play a key role in combatting infection but are destroyed by HIV. A CD4 count is the measure of the number of circulating CD4 cells. There was some dispute between the experts as to what amount to a 'normal' CD4 count, and I make some limited findings on it later, but for the purposes of this general description it falls within a range of 350 – 1500 cells per mm³. Throughout this judgment I will refer to the CD4 level by simple unit. A patient presenting with a CD4 below 350 would be considered a late diagnosis.
32. An individual's CD4 count can vary day by day, for example, it is likely to be lower in any individual when they have a cold as their body is busy trying to fight infection. Clinicians treating HIV patients will therefore look at the trend in response to treatment (i.e. is the CD4 count going up or down over time) and also look to the percentage of CD4 cells in the white blood cells which, Dr Dufty explained, can provide a less fragile measure of trends. She considered that a percentage of between 25% and about 50% would be considered the normal range.
33. The other indicator of a patient's health and risks is what is known as the 'viral load' which is a measurement of the number of copies of HIV in a patient's plasma (the component of the blood which holds blood cells in suspension). The higher the viral load the greater the danger to the patient.

34. There have been hugely significant developments in the treatment of HIV over the past thirty years, by far the most effective of which has been the introduction of 'Antiretroviral Therapy' or ART. ART acts to restore the body's immune function, to reduce the level of HIV in the blood and to help regenerate cells and tissues. When a patient is treated successfully with ART then the effect is to increase the CD4 count and decrease the viral load to below the level of detection – disease progression has been halted. Once a patient has recovered an acceptable CD4 count then they are deemed to be 'immuno-reconstituted'. Some care needs to be adopted with this phrase as the individual will always remain infected with HIV. What the level of CD4 needs to be in order for a person to be considered immuno-reconstituted, and whether the Claimant has in fact reached this point, is very much a matter of dispute in this case.
35. The benefits of ART have been reflected in great improvements in both mortality and morbidity for those with HIV. Whereas prior to the introduction of ART death (from AIDS) would normally follow within 11 years, effective treatment has meant that in many cases life expectancy is becoming far closer to that of the general uninfected population.

ii. The Claimant Prior to Diagnosis

36. The Claimant was born on 1 October 1981. Having obtained good GCSE results, he entered the Army aged 16 and after basic training, trained as a telecommunications technician.
37. During the course of his career he was deployed overseas on numerous occasions including serving in the armed conflict in Iraq and as part of the peacekeeping force in Kosovo, Northern Ireland and Afghanistan.
38. Whilst on tour in Northern Ireland in November 2003 he developed symptoms of a very bad head cold. The medical experts are agreed that this probably marked the onset of HIV infection.
39. The Claimant's HIV then entered a latent phase for about nine years. During that period the Claimant enjoyed good fitness marked only by the development of shin splints in 2001, which resulted in 2007 in his 'downgrading', meaning that whilst he was still classed as employable in a combat zone he could no longer serve in a combat role.
40. He progressed through several ranks, from Apprentice to Signaller in May 1999, to Lance Corporal in 2000 and to Corporal in August 2001. In the intervening years the Claimant applied repeatedly for promotion to Sergeant. During the course of the Claimant's cross examination and that of the employment experts, the Court was taken to the documents generated from annual appraisals between 2005 and 2013. Typical of the recorded views of his superior officers was a comment from his 2011/12 appraisal which noted that he was dependable and diligent and:

"Cpl Jones is clearly a bright soldier who is well liked by his peers and has demonstrated a keen interest in developing those under him, thus showing his contributory nature and organisational skills."

41. Even after his diagnosis, when the Claimant was suffering from ill health, the comments remained positive:
- “He has had a successful career and should look forward to continuing this upon resumption of his duties. His powers of command, analysis and effectiveness are developing and he has a future potential as a Tp Sg” [Troop Sergeant – two ranks above Corporal]
42. In the course of cross examination, the Defendant suggested by reference to the appraisal documentation, that the Claimant’s career had essentially peaked in 2006 and that thereafter there had been a ‘dramatic downturn’ but I do not consider that is an accurate reflection of the records seen in their totality. It seems apparent that the Claimant maintained a positive attitude throughout his career, was hardworking and determined, demonstrated not least in his efforts to remain in the Army after his diagnosis when plainly very unwell.
43. One of the disputes between the parties at trial was whether or not the Claimant would have ever been promoted to Sergeant or whether he was destined to remain at his current rank for the remainder of his service. This was the subject of conflicting evidence from the employment experts. Mr Carter (for the Claimant) based his positive conclusions on the appraisal documentation and his long experience of assessing relevant military cases, including being regularly instructed by the Defendant. Mr Bell-Walker’s far less favourable estimate was based on the same documentation and also his many years of experience as a serving Officer in the British Army including sitting on multiple promotion Boards.
44. Of course, this dispute only really becomes relevant if the Claimant can demonstrate that, absent the Defendant’s negligence, he would have remained in the Army beyond the point at which he was in fact medically discharged – as I have already indicated, for the reasons explained in detail below, I do not consider that the Claimant has in fact proved that aspect of his case. Nevertheless, having considered the evidence I conclude that had the Claimant not become seriously fatigued to a degree incompatible with continued service, then he probably would have been promoted to the rank of Sergeant. I reach that conclusion having regard to the analysis of both employment experts but also an assessment of the contemporaneous documentation referred to above. Both experts sought to give their take on whether those documents should be read on their face as a reflection of a good candidate or as Mr Bell-Walker would have it, can be read as inferring a subtext that the Claimant was performing at sub-optimal levels. The documents are however almost all very positive and include clear recommendations for promotion from the officers under whom the Claimant served. Mr Carter’s report provided excerpts from the Defendant’s own published statistics showing that whilst the Claimant had remained a Corporal for longer that would have been expected in his cohort, in general over 60% of those at that rank progress to Sergeant. I conclude that, but for his fatigue and other associated problems, the Claimant would have been amongst them.

iii. The Onset of Ill-health

45. On 23 January 2012, the Claimant attended a medical appointment complaining of two weeks of flu like symptoms with sore throat and fever. As he had just returned

from assignment in Kenya his doctor suspected that he might have contracted malaria. Between then and the appointment of 20 November 2012 (the first occasion on which the Defendant admits the standard of care was not reasonable) the Claimant sought medical help on six further occasions with a list of complaints ranging from diarrhoea, to conjunctivitis, to oral thrush. It is likely that throughout this period he was already severely immunocompromised by reason of the HIV.

46. Between 20 November 2012 and his eventual diagnosis in early September 2013, the Claimant had a further multiple further medical appointments, complaining again of symptoms and signs of oral thrush, and conjunctivitis. By now his CD4 count, already very low, was continuing to fall to extremely dangerous levels.
47. The most common symptom during this period was severe diarrhoea. This became particularly acute when he and his wife took a delayed honeymoon to Mexico in April 2013. The Claimant was so ill that he was often unable to leave the hotel room. On his return he continued to suffer from severe episodic diarrhoea. Mrs Jones, who is a nurse specialising in palliative care, described her husband's condition during this period as so severe that he had to be helped onto the toilet and spent so much time on it that he was getting pressure sores. The couple were increasingly worried that the diarrhoea and associated weight loss might be signs of bowel cancer.

iv. Diagnosis

48. At the end of August 2013, in desperation at his ongoing symptoms, the Claimant attended the A&E department of the Royal United Hospital in Bath. Having taken a relevant history and examination he was advised by the medical staff to seek an HIV test. The test was taken when he attended his GP on 2 September 2013. The results were delivered to him a few days later and revealed that he was suffering from HIV. A further test taken the following week also confirmed this diagnosis.
49. At the date of this diagnosis the Claimant's CD4 count was 2. There is no dispute that this is a desperately low level that exposed the Claimant to a very real risk of death and a very real risk of serious medical complications. The Claimant was started on ART on 25 September 2013. At this time he was noted to be 14kg below his normal weight.
50. At the beginning of October 2013, the Claimant became very unwell. He collapsed and lost consciousness and was admitted to hospital. Tests showed that he was suffering from Pneumocystis Pneumonia (PCP). The Claimant was kept in hospital for nine days.
51. By the beginning of 2014 the Claimant was noted by his GP to making good physical progress (CD4 count of 53) but he suffered a setback when in mid-January 2013 he was hospitalised for three days with tonsillitis. Shortly after discharge, his GP noted that the Claimant complained of tiring easily.
52. In February 2014, the Claimant had his first appointment with Dr Dufty. The Claimant informed her that his CD4 count had risen from 2 to 53 and that he had had an undetectable viral load as of January 2014. In a letter to the medical centre at the Claimant's barracks Dr Dufty noted:

“Currently, I would not be able to support a grading other than MND [medically non-deployable] because he does not fulfil the criteria for a higher grading however I do expect that after 6–12 months on antiretroviral treatment he should be able to reach a point where I may be able to support an upgrading.”

53. Dr Dufty noted that her plan ‘ultimately’ would be to see the Claimant twice a year once he is stable on treatment and “*out of the danger zone*”.

v. Medical Discharge

54. The Claimant had been absent from work since his diagnosis but from late February onwards was making clear that he wished to return as soon as possible. On 26 February 2014 he was seen by a Dr Kate Horn. She noted that he was fully adherent to his antiretroviral therapy and now had a suppressed viral load. She noted that he was feeling physically much better and was keen to do some work rehabilitating so he could return to his usual level of physical fitness.

55. In March 2014 the Claimant was placed on a program known as GROW (gradual return to work) although this did not actually commence until the June to give him more time to prepare. By May 2014 it was noted that he had put on approximately 20 kg in weight over the previous 12 months and by the 10 June 2014 his CD4 count was up to 121.

56. The Claimant commenced the GROW program at the beginning of June 2014. His medical notes over this period do show that he was finding it very tiring and was struggling.

57. The Claimant saw Dr Dufty again on 22 September 2014. She noted it was taking some time to get back to fitness which she remarked was not surprising given his medical condition at the time of his diagnosis but that he was clearly very motivated to get back to the level at which he was operating before. She told him that he nevertheless needed to remain patient and realise that this is a slow gradual process but that “*eventually he will get there.*”

58. At around this time Dr Dufty began work with a colleague on an academic paper that, in an anonymised form, sought to highlight lessons to be learned from the Claimant’s experiences not least the failed opportunities to diagnose him earlier. The Claimant was given a draft of the paper and it was the first time that he appreciated that there had been a failure by the Defendant’s medical staff to diagnose him earlier.

59. The Claimant saw Dr Kate Horn again on 15 October 2014. She noted that his CD4 count continued to creep up (it was at 190) but that he was feeling very frustrated at what he saw as slow progress with his return to full fitness. She noted that he was still feeling very tired and unable to do a full day at work and a full exercise routine. Her notes record a discussion with the Claimant about the need for his CD4 count to rise above 200 before he could be considered fit to continue in the army. She noted:

“Darrell is beginning to consider the option of accepting a medical discharge but clearly this would be a major lifestyle change for him and his family.”

60. At a further review held in November 2014 where it was noted that he was still unable to proceed to full time working hours despite several attempts. The conclusion drawn in the record was that this “*leaves no alternative but to medically board and discharge him*”.
61. The Claimant was seen again by Dr Dufty on 15 December 2014. She noted that the Claimant:
- “... looked well today although he tells me that he has been very tired and suffering with fatigue. He has a one-year-old daughter who is very lively and does not sleep that well. Unfortunately he did not do very well with in his graduated return to work programme and did not make the progress that he had expected. He is therefore being put forward for a medical discharge. He is slowly coming to terms with this and will find out the results early next year.”
62. In light of the ongoing failure to be able to return to full time duties, the Claimant was placed before a Medical Board which convened on 13 February 2015. The nature of the Board, the evidence before it, the applicable framework governing its decision-making process and the result in the Claimant’s case, were the subject of the written and oral evidence of Colonel Gill.
63. As part of the process, the Claimant submitted a personal statement. The statement set out how his fatigue had meant he had been unable to complete the GROW course and the devastating impact of having to face up not just to his illness but the loss of his military career. The Claimant’s anger at the late diagnosis of his HIV, and his belief that it had caused the discharge, is clear from the terms of his statement, for example in one passage he stated:
- “... it is absolutely clear that had the defence medical services not ignored my symptoms and diagnosis me sooner, I would still be able to continue my service until my 22 year point in October 2021....I have never at any point stated that my illness is attributable to Service but I absolutely believe that the delay in diagnosis is attributable for my condition becoming worse, to such a point, in Oct 2013, that I was close to death.”
64. The Claimant was medically discharged on the recommendation of the Board and his last day of service was 17 August 2015.

vi. The Factual Reason for the Medical Discharge

65. There was a limited dispute between the parties as to the factual basis for the decision to discharge the Claimant.
66. The applicable criteria governing the Medical Board in March 2015 was a classification system for HIV soldiers that required amongst other things a CD4 count of over 200 and no significant co-morbidities.

67. Although the Claimant's most recent CD4 count at the time of discharge was just below 200 (191) it is clear on the evidence that the effective cause of the discharge was not the count but was the impact of his fatigue and the consequential failure to complete the GROW course. Dr Dufty's and Dr Gill's evidence, which I accept, is that had the Claimant been performing well with a count of 191, it is likely that he would not have been discharged. The core determinant of the Board's decision was his failure, through fatigue, to complete the GROW course.
68. At the outset of trial it was accepted on behalf of the Claimant that fatigue, rather than a low CD4 count, was the effective cause of discharge but during his closing submissions Mr Wheatley sought to develop an argument that, at least in part, an effective cause of the fatigue was the Claimant's increasing anxiety that he was unlikely to reach the 200 CD4 mark in time to save his career. I asked Mr Wheatley whether there was any express support for that proposition in the evidence of the claimant or indeed either of his medical experts. Mr Wheatley accepted that there was no such evidence and I do not consider that in those circumstances it is a finding open to the court.

vii. The Claimant's current state of HIV health

69. The Claimant complains that he has continued to suffer from very significant fatigue. There has however been a continued improvement in his CD4 levels and his viral load has remained at undetectable levels. The relevant CD4 results are set out below (the viral load being undetectable from 7 January 2014 onwards).

| Date | CD4 |
|----------|-----|
| 2.9.13 | 2 |
| 22.10.13 | 14 |
| 19.11.13 | 37 |
| 7.1.14 | 54 |
| 25.2.14 | 71 |
| 10.6.14 | 121 |
| 14.10.14 | 190 |
| 10.3.15 | 290 |
| 7.7.15 | 300 |
| 6.10.15 | 320 |
| 5.4.16 | 317 |
| 4.10.16 | 277 |
| 4.4.17 | 315 |
| 2.7.18 | 438 |
| 3.6.19 | 391 |

viii. Employment After Discharge

70. When the Claimant left the Army, he used some of his resettlement grant to take a course in fibre optics although it became clear that this was not something that interested him. He then secured a job in car sales but again this did not work out.

71. During his period of depression referred to above, the Claimant had a few months off work before he completed his HGV licence and then took up employment with a driving agency albeit his work is primarily for one company.
72. It was suggested to the Claimant in cross examination (by reference to reportage in the Defendant's employment expert report) that he had always intended to become a driver on leaving the Army. The Claimant dismissed this suggestion, making plain that this was far from his idealised post Army career. His response to this line of questioning came across as genuine and I accept that had he not suffered from the poor health described by all four medical experts, he would have found himself in more rewarding employment in civilian life.

D: CAUSATION – THE IMPACT OF THE LATE DIAGNOSIS

73. As summarised at the outset of this judgment, there is a very marked difference of opinion between Dr Croft and Professor Ross on the impact that the delay in diagnosis of HIV has had on the Claimant, beyond their agreement that it is responsible for a short-term period of acute ill health and exposure to a significant, but time limited, risk of death. A key dispute, certainly in respect of quantum, is the cause of the Claimant's fatigue which led to his medical discharge. Another key dispute is the impact, if any, that late diagnosis has had on the Claimant's life expectancy. The unlocking of these disputes in turn reveals a range of further disagreements between the experts, including even what one might have expected to be uncontroversial issues such as the applicable framework for classifying the stages of HIV.

i. Dr Croft's analysis

74. Dr Croft is a Consultant public health physician and medical epidemiologist. The headings of his reports state that he is an expert in infectious diseases, public health, travel and tropical medicine. In addition to acting as an expert witness in litigation he is a post postdoctoral Research Fellow at the University of Portsmouth. A review of his curriculum vitae shows that he has published a number of research papers and research letters as well as contributing to chapters in medical textbooks. None of those papers, nor any identified presentations at scientific conferences etc, are addressed to HIV or to sexual health. A key interest appears to be the treatment of malaria. Dr Croft's present role as a public health physician means he does not currently treat patients. He had some very limited previous experience with HIV, both in a previous capacity as a GP and as a trainee doctor in the early 1980s. He also provided some advice to the Army on protocols connected to HIV such as reducing risk of infection (but not its treatment) albeit during the time he served the Defendant's policy was to immediately discharge those diagnosed with HIV. He also drew attention to a tropical medicine training course, completed in 2002, which included two weeks or so observing local doctors on ward rounds in The Gambia where there was a very high incidence of HIV and a week of lectures on the subject back in London.
75. Dr Croft was plainly not an expert on HIV in the sense that he was able to provide an opinion borne of expertise garnered from specialised academic, research or clinical experience of the subject. This puts him at some disadvantage to Professor Ross who is undoubtedly an expert in HIV but that obviously does not mean that the Court can simply reject his evidence. Dr Croft's expertise stem from his capacity as a Consultant in public health and in addition one with a particular interest in infectious

diseases. In addition, as both parties accept, in determining the disputed issues it is entirely legitimate that experts consider the relevant medical literature, which as a Public Health Physician, Dr Croft is qualified to opine on. Whether that expert opinion is well founded is another matter.

76. A summary of Dr Croft's position on the core issues, derived from his three reports, the two memoranda of his meetings with Professor Ross, and his oral evidence is:
- i) The delay in diagnosis meant that the Claimant was so severely immuno-compromised by the time treatment started he will never achieve immuno-reconstitution;
 - ii) This is in large part because he was at 'Stage 3' HIV in November 2012 when he should have been diagnosed but had deteriorated to 'Stage 4' by September 2012. The references to 'stages' are to the system of classification that the World Health Organisation (WHO) applies to chart the progress and status of HIV;
 - iii) The Claimant's current CD4 show that he has not in fact reconstituted because he has not reached a CD4 of over 500. This represents the 'sunny uplands' and the threshold by which immuno-reconstitution is established. The Claimant will not now reach this threshold but would have done had he been diagnosed earlier;
 - iv) His ongoing fatigue and much of his continuing ill-health is a direct cause of his current poor HIV status demonstrated by a CD4 count below 500;
 - v) His gloomy life expectancy is caused by the late diagnosis.
77. As to points (i) to (iv), Dr Croft has been consistent that the delay in diagnosis has had a profoundly detrimental impact. He has explained his reasoning in large measure by the impact of the failure to diagnose the Claimant when his HIV was only at 'Stage 3' on the WHO classifications – the rapid move to 'Stage 4' has had long-term, permanent damage including the persistent fatigue. In his first condition and prognosis report, dated 10 June 2018, he opined:
- “Had HIV testing been carried out in late November 2012, this would've tested positive and Mr Jones would have been quickly started on antiretroviral therapy and would (more likely than not) have responded very well to this therapy; he would not have progressed rapidly to Stage 4 disease, as in fact he did, as he would have had 12–18 years of continued life with the last three years of his life being unproductive.... Mr Jones could also have continued to serve in the army, with well-controlled HIV disease, for approximately 10 years after November 2012.”
78. In a causation report dated 6 November 2018 Dr Croft develops this opinion and concludes:

“During the winter of 2012–2013 Mr Jones progressed to ‘Stage 3 disease’ (i.e. mildly symptomatic HIV disease, manifesting as opportunistic infections notably, recurring oral candidiasis)... The opportunity to diagnose Mr Jones’s HIV infection was missed at this time, by his treating physician; it should not have been missed – and if the diagnosis had been made, his long-term prognosis and his life expectancy and his subsequent health generally would all have been very much better than it is now the case.”

79. In his third report of September 2019 he stated:

“Mr Jones’ profound fatigue, which persists to the present, was a direct consequence of his late HIV diagnosis [see Annex A¹]. Had he been diagnosed in a timely fashion (he wasn’t), he would not have developed severe, intractable fatigue.”

80. In his evidence, Dr Croft explained that the Claimant’s most recent CD4 count of 391 (3 June 2019) represents mild HIV disease and that tiredness is a ‘classical symptom’ of it.

81. Dr Croft was in stark disagreement with Professor Ross as to whether the Claimant was ‘clinically well’. In his November 2018 report he stated:

“Prof Ross’s assertion that Mr Jones will remain ‘clinically well’ is at odds with what is known of the natural history of end-stage HIV disease which has been diagnosed at a point when the CD4 count is already very low (and was extraordinarily low, in Mr Jones’s case). Mr Jones has had recurring infections, and severe fatigability, since starting HIV treatment and leaving the Army; I cannot see that this equates to him being “clinically well” as Prof Jones [sic] asserts.”

82. Although Dr Croft has consistently stated in his reports that the Claimant has not immuno-reconstituted, he sought to clarify one aspect of his reasoning during his evidence. The memoranda of his meeting with Professor Ross recorded that he (Dr Croft) had opined that a normal CD4 range in a healthy individual would be between 400 to 1400. The Claimant reached this level by July 2018, although dropping just under it the following year. In evidence Dr Croft stated that he was now of the opinion that a CD4 count of below 500 would be classified as abnormal. It demonstrates, in his opinion, that the Claimant had not immuno-reconstituted and provides an explanation for his ongoing fatigue and other health problems.

83. The basis for this clarification was said to be that when reading the trial bundle he studied one of the published papers relied upon by the Defendant, in which the WHO give the CD4 range in the non-HIV populations as between 500 and 1500. He now considered this to represent the ‘gold standard’ for measuring immuno-reconstitution and in turn the assessment of whether symptoms such as fatigue could continue to be

¹ Annex A is a single sheet document produced by JAMA (Journal of American Medical Association) for patient information entitled “HIV Infection: The Basics”. I consider this document later in the judgment.

ascribed to HIV. Dr Croft opined that had treatment begun in November 2012 the Claimant would have been immuno-reconstituted by about November 2014 because he would have reached the threshold of CD4 500 a figure which he described as marking the thresholds of the ‘sunny uplands’.

84. In respect of life expectancy, Dr Croft has again been consistent that the late diagnosis has had a very marked effect albeit in the course of the litigation he has become slightly more optimistic. The lowest estimate he gave in his report of 8 years (6 years from now) was revised upwards to about 10 years. He was careful to make plain that there is no exact science to the prediction of life expectancy and in his report, of September 2019 he concluded:

“It is in my view not tenable to argue (as seems to be the Defendant’s case) that Mr Jones has achieved immune reconstitution (he hasn’t) and therefore has near normal life expectancy. In fact Mr Jones’ quality of life is very poor. His life expectancy has been very significantly shortened – to under 10 years from today, in my professional opinion.”

85. The essential stepping-stones of Dr Croft’s analysis of the Claimant’s life expectancy appeared to be:

- i) Life expectancy for those infected with HIV is markedly lower than average life expectancy notwithstanding the introduction of ART;
- ii) The later the diagnosis the worse the impact on life expectancy;
- iii) Accordingly, an estimate of life expectancy can be reached by significantly marking down the Claimant’s life expectancy beyond that for HIV infected men generally because his CD4 count was so very low on diagnosis.

86. In evidence, Dr Croft explained that the foundations for this staged process were two scientific papers. The first by *Marcus et al* and the second by *May et al*, both of which I consider in a little detail below. He considered that these provided a baseline demonstrating that in general a lower life expectancy results from a late diagnosis of HIV, from which he makes further deductions in light of the exceptionally low CD4 count that the Claimant had on actual diagnosis.

ii. Professor Ross’s Analysis

87. Professor Ross is a Consultant Physician and Professor of Sexual Health at the University Hospital Birmingham. His full CV runs to 51 pages and reveals his undoubted expertise in sexual health and HIV. He is the author of over 30 review/editorials and 90 original papers on HIV and sexual health. He has been the principal investigator in over 60 trials investigating sexually transmitted infections and HIV over the past 20 years and is Vice-President of the British Association for Sexual Health and HIV.

88. Professor Ross provided 3 written reports together with his opinion recorded in the two memoranda of his meetings with Dr Croft.
89. Professor Ross's opinion is that the delay in diagnosis is responsible for the medical problems that the Claimant suffered from between November 2012 and some months after his actual diagnosis. Thereafter, Professor Ross considers that the Claimant responded very well to treatment and accordingly his ongoing problems cannot be attributed to his HIV.
90. There were two main strands to Professor Ross's analysis as to the lack of causal impact between the delay in diagnosis and ongoing health problems:
- i) At the time of the negligent failure to diagnose, the Claimant was already severely immuno-compromised. Using data from two published studies, Professor Ross calculated his likely CD4 count in November 2012 as being approximately CD4 54².
 - ii) The Claimant's response to treatment has been excellent and his HIV can no longer directly explain his on-going health problems, including fatigue.
91. In terms of ascribing the link between ill-health and HIV, Professor Ross was clear that it was not particularly relevant to look at the CD4 starting point (once a person had moved out of a danger zone) but rather to assess how they are responding to treatment, what the trajectory/trend of the CD4 count is and whether the viral load has moved to essentially undetectable levels. He expanded on these points in evidence. Asked whether the Army's use of CD4 200 as a threshold showed that up until that point a person was at risk of serious infection he stated:

“... there is a continuous process here. It's not a single cut-off point. I would certainly accept above 200 people are very likely indeed to be very well. Probably before that. Certainly by 200 the immune system is in pretty good shape by that point with regard to risk of ongoing infection, complications of the HIV.”

Later in evidence he stated:

“In reality, from a clinical point of view, your prognosis and your risk of death, infections, complications of HIV, are very low indeed, as long as one goes up about 100 to 200, and importantly, most importantly, the viral load remained undetectable at less than 40, ie you're controlling the virus, the virus replication has been stopped, essentially, by the drugs and the immune cells are slowly recovering, but it's the control of the virus itself that's the important thing here. So immune reconstitution occurs as soon as you start therapy. There's no

² The studies were May et al *CD4 T cell count decreases by ethnicity among untreated patients with HIV infection in South Africa and Switzerland* J Infect Dis 200(11): p1729-35; and UK Health Protection Agency *Longitudinal analysis of the trajectories of CD4 cell counts*.

cut-off above which you say that's reconstituted, that's not reconstituted. But certainly achieving a count above 200 is certainly good enough to have a very low risk indeed of any complications of your HIV. Take the tablets, viral load below 40, you will do fine."

92. Flowing from this opinion was Professor Ross's view that the Claimant's ongoing fatigue could not be explained directly by the HIV beyond a period of approximately twelve months after treatment began. He accepted that it was a likely explanation for the fatigue for some months until the treatment began to raise CD4 levels and reduce the viral load but this was time limited. In both writing and in oral evidence he stated that fatigue could well be explained by CD4 levels of 54 (likely level in November 2012) and 2 (September 2013) but not once it picked up.
93. As the fatigue was the reason for the Claimant's discharge, he was understandably asked repeatedly about it in cross examination. He maintained his view that the direct relationship between fatigue and HIV was time-limited. He stated:
- "... as I indicated earlier, the level of immune-recovery above probably around even 200 but certainly by 300, plus viral load, I think fatigue is unlikely to be linked to the HIV.... ..
- ... it should be quite a big improvement [in fatigue] in a few months as the viral load comes down to undetectable, and then maybe a year or so I would expect very little effect to be caused by the HIV itself and the CD4 count here is not central to that, it's not the major factor, the core HIV is the important factor."
94. Professor Ross was asked to calculate when the Claimant would have achieved a CD4 count of around 200 had he been started on ART 10 months earlier than in fact was the case. He opined that it would have been around September 2013, i.e. the point at which he was actually diagnosed. He was clear and consistent that the delay in getting to that threshold has not of itself however, caused any long-term impact on the Claimant nor does it explain his ongoing fatigue. In evidence he ultimately reached the point where he concluded that he would expect recovery from fatigue related to HIV within 6 to 12 months of commencing treatment, with gradual improvement before then once treatment started to take effect.
95. As to life expectancy, Professor Ross's analytical approach was to identify the general life expectancy for HIV patients and to adjust for the personal characteristics of the Claimant drawn from variables in the studies themselves and his own clinical experience.
96. Professor Ross relied on two main studies. The first by *Gueler et al*³ based on Swiss data and the second by *Lohse et al*⁴ based on a Danish cohort. These studies calculated overall life expectancy for HIV infected individuals compared to the non-infected population to be 8-12 years shorter. Noting that late diagnosis can be a poor

³ *Life Expectancy in HIV-positive persons in Switzerland: matched comparison with general population*. AIDS 2017 31(3): p.427-436

⁴ *Survival of persons with and without HIV infection in Denmark, 1995-2005* Ann Intern Med, 2007. 146(2) p.87-95

prognostic indicator, Professor Ross identified a number of more positive indicators that would be expected to improve the Claimant's life expectancy including the fact that he has responded well to treatment, has no history of drug use, smoking or other co-morbidities. Taking all these factors into account, and stressing that it is impossible to be precise, Professor Ross arrived at a figure that HIV would shorten the Claimant's life by about 5-7 years less compared to had he not contracted HIV.

97. Two points are noteworthy about this analysis.
- i) Firstly, in the case of the Claimant, Professor Ross is of the view that the late diagnosis will have no impact on life expectancy beyond the general reduction caused by virtue of HIV infection itself. He accepted that studies showed that life expectancy for those diagnosed late could be shorter than those diagnosed more timeously. In his view these results were readily explainable by the fact that many diagnosed late would either die or respond poorly to treatment with a knock-on deflationary impact on the statistics for all categorised as having a late diagnosis. However, once a person had escaped from this period of acute risk and responded well to treatment they achieved the same projected outcome as a person who had been diagnosed earlier;
 - ii) Professor Ross's analysis is not simply based on the data but on his clinical experience. As explained further below, clinical experience is a relevant tool for the assessment of the core medical issues dividing the parties.

iii. Discussion

98. I conclude, without any hesitation, that the analysis of Professor Ross is to be preferred to that of Dr Croft.
99. My reasons broadly fall into two categories which are the reflection of each other, in that I prefer (i) the cogency of Professor Ross's analysis backed up by the epidemiology, his research experience in HIV and a lifetime of highly germane clinical experience and (ii) I was unimpressed with what I consider to be the lack of cogency, consistency and rigour in the opinions expressed by Dr Croft.
100. As stated, there is no doubt that Professor Ross is an eminent expert in the field. Equally in my view there is no doubt that his clinical experience, borne from decades of treating patients with HIV, is a relevant and powerful tool for assisting in the assessment of the core issues in this case, namely whether the Claimant's HIV is a cause of ongoing health problems (most importantly fatigue) and also his likely life expectancy. Importantly, Professor Ross's evidence is not based solely on clinical judgment, indeed he relies as a starting point for the assessment of life expectancy on the epidemiology, but he made plain, and I accept, that clinical judgment also has a part to play in the assessment of core issues such as the cause of ongoing fatigue and life expectancy. As he stated in cross examination:

“In taking an evidential approach, you of course look for studies showing what would happen in real life and see if you can get data from those to use. I've done that, the data is limited but I've used it. There is no study telling us a man of Mr Jones' age, with a count of two, responding in a particular

way, how long he will live for. The data doesn't exist for that, and therefore we have to fall back on my expert opinion. I've dealt with patients with HIV for 30 years. I've seen plenty of patients with a CD4 count of two for 20 or 30 years who have recovered. So my experience and based on the literature available, my estimate is five to seven years reduction..."

101. Dr Croft, in cross examination, recognised that clinical experience was a matter that could be relevant in making conclusions in this claim. Later in his evidence however, in the context of how patients with a low CD4 count respond to treatment he asserted that 'experience can be a dangerous thing' and said of experts applying clinical experience:

"Well, they could speak from their experience if they had a very large caseload of people who had had extremely low CD 4 counts, but sometime experience is not necessarily valuable. By chance you can have had a particularly unfortunate set of patients who have all died, whereas somebody else could have had a case of patients who all survived."

102. In the abstract and as a matter of generality, Dr Croft's evidence on this point may be right. As Dr Croft's answer, albeit only by implication, recognises, it can have no relevance to Professor Ross. It is not disputed that over the past 30 years Professor Ross has had a large case load of patients with an extremely low CD4 count and is also applying knowledge gained from a lifetime of high-level academic research into HIV. His views cannot possibly be said to be skewed by clinical experience limited to only a small caseload of particularly unfortunate, or particularly fortunate, patients.
103. As set out above, Professor Ross provided evidenced explanations based on his clinical experience and also in large measure by reference to the limited peer reviewed literature in leading journals. Professor Ross presented as one would expect from an eminent expert in his field. He was measured and careful in his answers to questions. At no stage did he give the impression that he was arguing for a particular party but rather gave straight and consistent answers.
104. In light of the power of his evidence, one would need to have at least an equally powerful and cogent expert case from the Claimant's side in order to persuade the Court that Professor Ross' conclusions on the various issues could be safely ignored or qualified.
105. Dr Croft was not however an impressive witness. I conclude that his analysis on all the core disputed questions is flawed, unreliable and cannot be preferred to that of Professor Ross, for the following reasons:
106. **Firstly**, Dr Croft displayed a marked lack of familiarity with basic aspects of HIV and its treatment. This judgment highlights a number of occasions on which this became apparent, but the starting point was his very use of the WHO system of classification for the staging of HIV, rather than the criteria set by the Centre for Disease Control (CDC).

107. The classification, or staging, of the CD4 level is important not least because it forms a key component of Dr Croft's opinion that the late diagnosis has had a very material impact on the Claimant. He opined that the Claimant was permitted, by the negligent failure to diagnose HIV, to slide from 'Stage 3' in November 2012 to 'Stage 4' by September 2013, and this had profoundly detrimental consequences for his health and life expectancy.
108. It is however difficult to understand why Dr Croft was using the WHO classifications. As Professor Ross explained, and I accept, it is not one used at all by HIV practitioners in the UK, or the United States nor indeed any high-income nations. The UK, in common with many other high-income countries, applies the categorisation used by the US Centre for Disease Control (CDC), which relies on CD4 readings to rate the stage of HIV from A to C (C being the most severe).
109. The WHO system was developed to permit the classification of HIV in countries that do not have widespread access to testing of CD4 levels – it is one based not on objective results of blood tests but rather the categorisation of a range of signs and symptoms to assist doctors working in less developed healthcare systems without access to testing facilities. It makes sense that absent access to blood sampling, treating doctors and public health officials would want to rely upon a system that permitted classification by reference to relevant signs and symptoms on physical examination. As Professor Ross explained, there would be no reason at all why anyone would use the WHO system to assess the Claimant when we have his CD4 tests. All clinicians assessing the Claimant would use a classification system based on CD4 levels, namely that provided by the Centre for Disease Control.
110. This is recognised in the WHO standards themselves. The relevant document is "*WHO Case Definitions of HIV for Surveillance and Revised Clinical Staging and Immunological Classification of HIV-Related Disease in Adults and Children*" (2007). It notes that AIDS case reporting in middle and low income countries has been incomplete and of variable accuracy and this problem has been exacerbated by weak health information systems and the lack of diagnostic capacity. It also notes that countries should apply their own national case definitions and develop their own testing algorithms for diagnostic and surveillance purposes. It states that "*WHO provides a simplified HIV case definition designed for reporting and surveillance.*"
111. There is nothing in Dr Croft's reports that explains the reason why he departed from the standard system of HIV classification, indeed an uninformed reader would be forgiven for believing that terms such as 'Stage 3' or 'Stage 4' were the accepted terminology. The issue of classification was addressed at the expert meeting held with Professor Ross in December 2019 and Dr Croft stated that "*there are two commonly-used staging systems*" – in so far as this was seeking to describe the classification in the healthcare system in the country in which the Claimant lives, this is plainly incorrect.
112. Had it been the case that Dr Croft considered that the application of the WHO categories would give some particular insight into the Claimant's plight that could not be derived from the standard CDC classification then one would have expected some explanation of this in his reports, both identifying that he was adopting a different classification to the norm and why it provided greater or additional insights. No such qualifications or explanations were provided. I consider that Dr Croft's almost

exclusive reliance on the WHO classifications and his belief that they enjoy parity in the UK with those of the CDC reflects a lack of familiarity with the subject matter that does little to instil faith in the quality of the rest of his analysis.

113. **Secondly**, and more importantly, Dr Croft has in any event misapplied the WHO classification system in a manner that fundamentally undermines core aspects of his wider analysis.
114. This is because in applying the WHO categories, he failed to have regard to the Claimant's CD4 counts, which as Professor Ross explained need (where available) to be factored into the WHO criteria themselves. The WHO recognises that late stage HIV (AIDS) should (where available) be classified by reference to CD4 levels and not exclusively symptoms/signs. The guidance states that:

“The immune status of a child or adult living with HIV can be assessed by measuring the absolute number or percentage of CD4+ cells. And this is regarded as the standard way to assess and characterize the severity of HIV related immunodeficiency”.

A Table in the WHO document defines the criteria for diagnosis of 'severe HIV' as being a CD4 count of less than 200 in an adult. Severe HIV is classified as 'Stage 4' under the WHO criteria.

115. Although no CD4 measurement was taken from the Claimant in November 2012 both experts (now) accept that it can readily be estimated. Dr Croft belatedly accepted that it would have been around 40, even lower than the 54 estimated by Professor Ross. This means that under the WHO criteria, the Claimant would have been properly classified as having already been well within Stage 4 rather than Stage 3 by November 2012 and probably for some time before that.
116. Dr Croft only accepted that the Claimant's likely CD4 count was around 40 in November 2012, when he had his first joint meeting with Professor Ross. Having done so it might have been thought that Dr Croft would have wished to review his reliance on the WHO staging before coming to give evidence. He did not. In fact, in his answers recorded in the memoranda of the meeting with Professor Ross, Dr Croft went further. He not only maintained that the Claimant was only in 'Stage 3' when his diagnosis was missed but that, applying the CDC criteria, he would have been 'Category B' on the CDC scale in November 2012 not 'Category C'.
117. Professor Ross made plain, by reference to the CDC published criteria, that any individual with a CD4 count below 200 would be classified as 'Category C'. When it was put to Dr Croft in cross examination that his classification was unsustainable in light of the CDC's published criteria he answered that he would only '*potentially*' agree. I found the reason he gave for qualifying his answer troubling. He stated that the qualification as to his agreement was because he had not in fact considered the CDC published categories notwithstanding that Professor Ross had referenced them in his report and he himself had used them to classify the Claimant in the joint meeting. It thus appears that although Dr Croft stated that in November 2012 that the Claimant was at CDC Category B, he did so without actually checking the CDC criteria, and was still unfamiliar with them when he came to give his evidence. This show not

only a lack of rigour in the formulation of Dr Croft's opinion but (again) a lack of familiarity with the subject matter.

118. In cross examination, Dr Croft bowed to the inevitable. He accepted that, contrary to that which he had expressed in writing, the Claimant was probably in both CDC Category C and WHO 'Stage 4' long before November 2012. Although he did not accept the Defendant's contention that the threshold (200) was probably crossed in 2010 he did accept it would have been reached by March 2011, about 20 months before the failure to diagnose in November 2012. Had Dr Croft properly considered the impact of his own assessment of a CD4 count of 40 in November 2012 then these are views he should have appreciated long before stepping into the witness box.
119. In circumstances in which so much of Dr Croft's analysis was pinned to his view that real damage was done because the delay in diagnosis deprived the Claimant of an opportunity to be treated whilst still only Stage 3 or Category B, his ultimate concession, and his failure to properly analyse this point earlier does little to instil faith in the solidity of the remainder of his analysis.
120. **Thirdly**, having belatedly accepted that had the Claimant been diagnosed earlier in November 2012, his CD4 count would still have been very low, I found Dr Croft's continuing justification for why late diagnosis nevertheless made a significant difference to anything other than short-term suffering, unconvincing.
121. Dr Croft, having accepted in cross examination that his earlier classification of the stage of the HIV in November 2012 was probably misplaced, nevertheless went on to state:

“... but we're still left with the situation that there was a delay in a diagnosis and the CD4 count, okay was perhaps lower than I'd originally made allowance for and it became still lower and then still lower and then still lower again. That's really the whole point and during that 11 months of continuing worsening, irrespective of what is happening with the symptoms, with every further missed opportunity the ultimate outcome was going to be worse and the life expectancy was being shortened. So I think we're perhaps getting a little caught up on whether it's the symptoms that are the important factor.

The important factor is just the delay and the immeasurable and dramatic worsening that was occurring in the CD4 count, which was, if you like, the pivot of Mr Jones' ability to function with an immune system that would protect him in this life.”

122. Professor Ross, building on his expertise as a researcher and clinician in the field applied a markedly different analysis. He opined that in a patient responding well to ART, with increasing CD4 levels and a non-detectable viral load, one would not expect to see a patient suffering directly from fatigue after approximately 12 months and that such a patient will return to the same track as they would have done had treatment started earlier. This applies irrespective of the CD4 count on

commencement of treatment – once the patient with a very low count is out of the danger zone, they follow the same track as other HIV patients.

123. Dr Croft’s analysis was premised on a repeated assertion that the later the start of treatment (and thus the lower the CD4 level) the worse the outcome for the patient, which he considered applied to fatigue. Had the Claimant been treated earlier then his prognosis would have been better and the fatigue accordingly either resolved or less significant. This was obviously not an opinion (in contrast to Professor Ross) based on clinical experience of observing differing outcomes in patients with different CD4 levels, and it is therefore important to look carefully at what Dr Croft relied upon to justify his continuing belief that late diagnosis continues to explain the Claimant’s poor health.
124. Dr Croft relied on two published documents to support his conclusion. The first is what he described as a ‘*short paper*’ by ‘*Stevens et al*’ published in the Journal of the American Medical Association (JAMA), which he described as “*the number two medical journal in the world. It’s very prestigious.*” The second document is an academic paper co-authored by Dr Dufty which drew on her own treatment of the Claimant.
125. JAMA is indeed one of the world’s leading medical research journals and I took it from his repeated references to its high standing that Dr Croft was seeking to elevate the importance of what he described as the “short paper”. The document relied upon is not however an academic paper let alone the type of peer reviewed study that JAMA reputation is founded upon. Rather, it is a one-page document on the “*JAMA patient page*” entitled “HIV Infection: The Basics.” It is designed to help members of the public understand the basics about HIV. It is written in the plain language of the layperson as one would expect of a public health pamphlet, for example explaining how HIV is transmitted and how it can be prevented in highly practicable terms such as “*If you inject drugs, seek treatment and do not ever share needles with others*”. In medical publication terms it is the antithesis of a peer reviewed study.
126. In any event the document does not support the proposition that a delay in diagnosis leads to worse long-term outcomes in terms of fatigue.
127. The particular lines relied on by Dr Croft in the patient page are a comment that:

“Symptoms tend to increase in severity and number the longer the virus is in the body if the individual remains untreated. Symptoms may include.... Persistent tiredness....”
128. To rely upon this passage as providing authoritative support for the proposition that a delay in diagnosis results in a worse outcome, once a patient has responded to treatment, including for tiredness, misconstrues what it is saying (which is no more than the longer you leave a symptom the worse it gets) and wrongly elevates a public health pamphlet into the status of a peer reviewed article. To describe it as Dr Croft did as a “*paper by Stevens et al*”, emphasising the prestigious standing of JAMA is to seek to give an impression of its status neither its single author (Stevens), nor the association, could possibly have intended.

129. That this is one of the key ‘papers’ relied upon by Dr Croft does nothing strengthen the robustness of his conclusions. His attempts to elevate its importance do little to instil confidence in his analysis of the epidemiology generally.
130. Dr Croft also misinterpreted Dr Dufty’s article which can certainly be described as a ‘paper’. He sought to rely both in his reports and in evidence on the paper’s findings that a delay in diagnosis results in worse outcomes. The paper does indeed stress the importance of early diagnosis and notes in respect of the Claimant that the delay “... *put this soldier at risk of potentially irreversible complications of advanced HIV infection.*” At the time the paper was written (about a year post diagnosis) the Claimant was still immunocompromised, as it notes:
- “His CD4 count remains below 200 cells/mm³ and may not ever fully recover. It is likely he will be unable to remain within the Army because he remains immunocompromised and he struggles with symptoms as a direct consequence of the late diagnosis.”
131. When Dr Dufty came to give her evidence, she was cross examined on the contents of the paper and it was suggested to her (consistently with Dr Croft’s views) that the paper supported the proposition that the late diagnosis has led to long-term problems for the Claimant, including fatigue. Dr Dufty disagreed. She contended that the late diagnosis put the Claimant at grave risk of death and exposed him to risks of opportunistic infections but only whilst he remains severely immunocompromised. Since she wrote the paper he has responded very well to treatment and can be deemed to be immuno-reconstituted. Whereas she was previously concerned that he would not recover his CD4 levels sufficiently, or even worse that he might die, that is no longer the case. The expressions about worse outcomes for those diagnosed late reflect the fact that some of these patients will either die or will have worse outcomes because they do not respond well to ART. Once a patient has responded well to ART, with a consistent rise in CD4 levels and drop in viral load, the outcome for morbidity and mortality is essentially the same as if they had been diagnosed earlier. This explanation is entirely consistent with that of Professor Ross, namely that the late diagnosis exposed the Claimant to a short-term period of significant risk but because he has responded so well to treatment, from an HIV perspective he can be considered healthy.
132. Dr Croft indicated that he had read Dr Dufty’s evidence but maintained that in so far as she considered the Claimant had now immuno-reconstituted, she was wrong and maintained that her paper supported his views. For the reasons given, I disagree.
133. **Fourthly**, I found Dr Croft’s ‘11th hour conversion’ to a CD4 of 500 as marking the threshold for a ‘normal range’, unconvincing and his explanations for it revealing a lack of independence of thinking.

134. As referred to earlier, in the first joint memoranda of December 2019, Dr Croft had stated that the normal CD4 range in a healthy body was between 400 to 1400. The Claimant reached that level, and has remained close to it, since July 2018⁵.
135. Dr Croft first indicated his change in view on the CD4 threshold in a healthy population during his cross examination. He explained that he had taken the opportunity to review the trial bundles and had read the WHO paper relied upon by the Defendant, which referred to a threshold in the healthy population as being CD4 500-1500 rather than the 400 he had previously identified. It might be thought surprising that Dr Croft had not considered this WHO paper beforehand as it is the source for the staging criteria (i.e. Stages 1-4) that he had based much of his written analysis upon, but in any event he explained at trial that he now considered the WHO criteria of 500-1500 to represent the ‘gold standard’.
136. In his oral evidence, Dr Croft placed very considerable significance on the WHO figure of CD4 500. A count of CD4 500 was not simply the beginning of the range in healthy individuals but it importantly, he said, marked the point at which an individual has achieved full immuno-reconstitution. He stated that had the Claimant attained this figure (which he believes he would have done with earlier intervention) then he would have reached the ‘*sunny uplands*’ and could have been considered to be reconstituted. He stated, for example, that “*if his CD4 reading rose above 500 he would not have immunodeficiency and so therefore it’s not likely to have tiredness to the same degree.*” He also stated, in respect of the change from his previous opinion that the threshold was 400:

“... since then I think I’ve considered the gold standard figure, the slightly authoritative figure is different to that, and its 500 to 1500, and I think that explains a lot about this case, that explains why Mr Jones is still unwell, he still unwell, he’s still fatigued, because he’s got HIV associated immunosuppression.”

137. Professor Ross was having none of this. In answer to a question from me he stated:

“... it’s a very artificial distinction, as I mentioned, I think the cut-off for what normal CD4 count is is not very relevant with regards to your risk of future illness and when you are in therapy the viral load is less than 40. However, normal will change in different laboratories. Laboratories use different kits to measure CD4 counts, they have different ranges, the average is around 400 to 500, at my lab it’s 350 to 450. It varies. WHO has given a figure not to be used in this way, however, it’s merely a guide to what we think is normal.”

⁵ In the joint memorandum, Professor Ross marked his agreement with that range although in evidence he was clear that different institutions applied different ranges (his own hospital has 350 as a threshold, Dr Dufty told the Court that her laboratory applies a threshold of 300). Professor Ross also explained that the ‘normal’ range in healthy adults is not of itself a key indicator of health in a person infected with HIV, let alone the threshold at which they could be deemed to be immuno-reconstituted. A far more reliable indicator was to see how they responded to treatment and so long as the response was good, the CD4 recovery steady and the viral load undetectable, then these were the best indicators of HIV related health.

138. Dr Croft appeared to be suggesting in his oral evidence that the WHO was not simply the ‘gold standard’ but thereby the only standard that regard should be had to. When it was suggested to him that there is a broad range of opinion (an example given was the evidence from Dr Dufty that her laboratory uses a figure of 300,) Dr Croft robustly disagreed:

“No, there isn’t a broad range of opinion. There’s an authoritative ruling from the WHO as to what constitutes a normal range. Now, it may be that in individual practice clinicians will be inclined to blur the margins a bit and they may do that for their own encouragement or to encourage their patients. But I would have thought, Mr Fortt, that that is the gold standard definition, the WHO definition for the normal range in adults and adolescents for a CD4 count and textbooks may say something else, but that’s because they perhaps have a different focus. So I think it would be helpful to stick with what’s on page 794 of the bundle and 795” [the WHO document]

139. As Dr Croft’s was so clear in his oral evidence that (i) 500 was in fact the applicable standard and that importantly (ii) it marked the point at which someone could be understood to be effectively healthy, it is reasonable to carefully examine this final iteration of his opinion.
140. It is clear to me that the WHO was not seeking to set any particular standard in its paper, let alone could it be described, as it was by Dr Croft, as some form of ‘pronouncement’ or “an authoritative ruling”. It is simply a single sentence in the 46 page document produced in 2007 which states, as part of general description of immune status in adults that “*The normal absolute CD4 count in adolescents and adults ranges from 500 to 1500 cells per mm³ of blood*”. The paragraph in which it is contained, then goes on to deal with decreasing CD4 counts in HIV individuals and makes no further reference to the CD4 range in the healthy population. None of the sentence, paragraph or document can be read as setting down (expressly or by implication), a universal definition, ruling, or pronouncement as to what the range of CD4 counts is in the non-HIV infected population. It equally does not suggest that if an HIV patient reaches an CD4 count of 500 then that is the point at which they are clinically deemed to have recovered.
141. Dr Croft stated in cross examination that his previous opinion, that the threshold was 400-1400, was based on the fact that this was the standard set out in medical textbooks. Asked to explain the difference between the textbooks and the WHO his answer was:

“... I can see now why it is that textbooks are really aimed at clinicians will say that – they will say normal range is 400, and that’s partly because clinicians in the field want to be optimists, they want to motivate their patients to take the drugs and so they will introduce just a bit of a fudge factor by saying 400 is kind of getting on for normal, so let’s call it 400 to 1400 as a normal range and that also incorporates this consideration of

the fact that a given reading might fluctuate from one area to the next.”

142. I found this to be a bewildering answer. It suggested that medical textbooks deliberately provided doctors with false information about the range of CD4 in the healthy population in order to encourage them to give inaccurate advice to HIV patients that they were making progress. In order to make good such a dramatic assertion one would have expected to see some form of substantiation in evidence, for example reference from a credible source that there was an acknowledged pattern in medical textbooks of giving inaccurate data to clinicians in order to nudge them into providing encouraging advice to patients. Unsurprisingly there was none.
143. One might also have expected a bit more caution or humility from Dr Croft before dismissing the notion that the different ranges referred to in textbooks, and the practice of experts such as Dr Dufty, should be so summarily disregarded. Such caution might have been thought warranted in circumstances in which it appeared he himself was blissfully unaware of the ‘gold standard’ until shortly before he stepped into the witness box. I am forced to the conclusion that Dr Croft’s stance, in particular his explanation for the ranges found in textbooks, was no more than an unedifying attempt to find any argument, however ill-informed, to justify his position. It was certainly not the result of informed, considered or well researched analysis.
144. It was not the only example of Dr Croft’s paucity of reasoning when seeking to explain away evidence that on its face appeared inconsistent with his opinion. It was put to him that, contrary to his own view that the Claimant responded poorly to ART, his treating doctors, including Dr Dufty, contemporaneously recorded the opposite. He was taken to a letter Dr Dufty wrote to the Claimant’s GP in February 2014 where she noted that CD4 had started to go up, his viral load had gone down to undetectable levels, that he was fully adherent to treatment and that these “*were all good prognostic indicators*”.
145. When asked whether or not Dr Dufty’s entries were evidence that the Claimant was responding well to treatment, Dr Croft told the Court that she had sent the letter to the GP knowing that the Claimant would read it and:
- “... what the clinician wants to do is to get the patient enthusiastic about their course of treatment and about the drugs so one can see there’s a certain amount of Pollyannaishness about this letter, that presenting a rosier picture, I suspect than Colonel Dufty really had in her mind, and it’s with good clinical reason.”
146. Dr Croft was suggesting that the treating Consultant was providing inaccurate information to the GP in order not to discourage the patient. None of this was put to Dr Dufty. One would have thought it reasonable to assume that a treating clinician would consider it important to communicate an accurate picture to a GP and that the latter would need to know whether their patient was, or was not, responding well to treatment. In my assessment, Dr Croft in these answers and others was clutching at straws in attempts to seek to justify his position. That is confirmed in my view by the fact that Dr Dufty’s assessment that the Claimant was responding well to treatment, is reflected by an objective reading of her notes and findings including the fact that he

continued to see his CD4 levels rise and he continued to maintain his non-detectable viral load. It was also the view of Professor Ross who has long experience of observing responses to treatment in HIV patients.

147. I far prefer the analysis of Professor Ross. The assessment of whether HIV is a likely cause of ill-health is not undertaken by asking whether or not s/he has reached a CD4 of 500 nor indeed by primary reference to the CD4 range in the general population. It is by assessing whether a patient is responding well to treatment, has a good trend in CD4 count that is above 200 and is maintaining an undetectable viral load.
148. **Fifthly**, I found Dr Croft's explanation for his highly pessimistic views on life expectancy to be very unconvincing indeed.
149. The analytical framework that he employed shared some characteristics with that of Professor Ross in that both started with a figure for general life expectancy for HIV males drawn from the literature and then modified that number to take account of the Claimant's individual characteristics.
150. In evidence, Dr Croft stated that his initial very pessimistic estimate of as little as 6 years until death, which has now moved up to about 10 years, relied on two papers (i) *Narrowing the Gap Expectancy between HIV-Infected and HIV Unaffected Individuals With Access to Health Care* by Marcus et al⁶ and (ii) *Impact of late diagnosis and treatment on life expectancy in people with HIV-1: UK Collaborative HIV Cohort (UK CHIC) Study* authored by May et al⁷. However, on even cursory examination, these papers did not justify his low estimate of life expectancy and his analysis of the *May* paper in particular, betrayed a basic misreading of the study.
151. The *Marcus* paper notes a dramatic increase in lifespans for those diagnosed with HIV since the introduction of ART. The reasons why life expectancy has not reached 'normal levels' are noted to include the heightened risk associated with the social demographics of many suffering from HIV and the high prevalence of other risk factors such as drug use, hepatitis etc that lead to co-morbidities and affect survival – indeed one study cited in this paper noted that now HIV-infected men lose more life years through smoking than HIV infection itself. The study did not consider directly the impact of late diagnosis but rather concluded that the gap in life expectancy for HIV infected individuals is now about 8 years even for those who start treatment with high CD4 levels of above 500. It noted disparities on the basis of race and lifestyle most particularly drug abuse and smoking.
152. The *Marcus* study does not, without more, support Dr Croft's argument that the Claimant's life expectancy will dramatically fall. Its conclusion is that (albeit in those who start treatment early) general life expectancy without other risk factors is about 8 years less than average. Dr Croft's analysis is that as the Claimant was diagnosed late one must 'knock off' decades more.
153. In order to justify a drop in life expectancy of approaching 30 years, Dr Croft relied upon a second study which did seek to differentiate outcomes according to CD4 levels at the time of commencement of treatment. That was the study by *May et al*.

⁶ *J Acquir Immune Defic Syndrome* 2016

⁷ *BMJ* 2011

154. This study focused on life expectancy of those whose were diagnosed late, which was defined as having a CD4 count of less than 200 at the start of ART. The cohort studied was comprised of those who started treatment between 1 January 1996 and 31 December 2008 (the paper was published in 2011) and I consider that Professor Ross was right to note that some considerable caution needs to be exercised over the results because life expectancy has significantly increased over this period because of increased drug efficacy.
155. In the course of his evidence, Dr Croft was taken to this study and asked to explain how he utilised it to extrapolate his low estimate of life expectancy. He took the Court to a passage in which the authors discussed their results and sought to explain how it demonstrated a greatly reduced life expectancy for those diagnosed with a CD4 below 200. Dr Croft explained how the authors showed that life expectancy reduced markedly by 10 years with every drop of 100 CD4 before the commencement of treatment supporting, in his view a reduction of about 38 years in the Claimant's life expectancy. It became apparent however that Dr Croft had very materially misread the passage. In fact, as became clear when he was shown the authors illustration of this part of their discussion ('Figure 2') their results in fact suggest that a 30 year old man who started ART therapy between 2000-8 with a CD4 count of below 200 could expect to live a further 30 years. This was a drop in life expectancy of some twenty years, more than the later *Marcus* paper showed but still far off the figures that Dr Croft estimated and indeed had wrongly stated this paper supported. Dr Croft's misreading of the paper, which he himself identified as one of two foundation stones of his analysis of life expectancy (and the only one looking at different outcomes dependent on the CD4 level at the start of treatment) undermines the credibility of his opinion.
156. Dr Croft explained that the papers provided a form of launchpad from which he could base a more nuanced life expectancy based on individual factors relevant to the Claimant. Key to his more nuanced calculation was, in his opinion, the very low CD4 count on diagnosis. He said (correctly) that predicting life expectancy is not an exact science and that his initial estimate of 6-9 years included a certain amount of guesswork. What he could not adequately explain was how he could apply the figures in the two papers that he identified and articulate a reason why he thought that the Claimant's likely life expectancy was so dramatically worse. He was repeatedly asked to provide a reasoned basis for his conclusion which self-evidently cannot be explained by the two studies alone, but in my view wholly failed to provide a cogent, reasoned basis. He pointed to the unhappy condition of the Claimant, what he considered (wrongly in my view) to be the poor response to treatment, the fact that his CD4 remained below the WHO 'norm' of 500 (see above) and placed some reliance (again wrongly in my view) on Dr Dufty's view in her paper that the Claimant's prognosis was uncertain.
157. Dr Croft's analysis does not stand comparison with that of Professor Ross on this issue. Professor Ross relies upon a correct reading of the two studies that he identified as relevant (see below) and applies a bespoke analysis to the Claimant based on the absence of presenting risk factors (he is compliant with his medication, has no relevant co-morbidities, and a non-smoker) and he brings to this issue a lifetime of research and clinical practice.

158. **Sixthly**, I was deeply unimpressed by Dr Croft's attempts to critique the studies relied upon by Professor Ross in his report.
159. As noted above, Professor Ross relied in his assessment of life expectancy on findings in two studies, one by *Gueler et al* and the other by *Lohse et al*. Professor Ross noted that they showed that with successful ART patients were enjoying life expectancies not far off that of the general population. He identified and explained the contents and significance of these studies in his first report. He also explained why their data was more relevant to the Claimant than those relied upon by Dr Croft.
160. In Dr Croft's second report he addressed these studies. As they were important to Professor Ross' analysis one might have expected a detailed response from Dr Croft and a thorough epidemiological critique. In fact, the studies were dismissed by Dr Croft, in the space of a sentence, on a rather dramatic basis:
- “the two papers that Prof Jones [sic] encloses that might seem to support his thesis (his second and third enclosures) were both sponsored by drug companies, and hence too are prone to commercial bias”
161. That was the total of his analysis. There was no attempt to explain how funding bias might have actually impacted on the integrity of either paper, let alone any wider critique of their methodology. That was bad enough but worse was the fact that the accusations were simply wrong.
162. As Professor Ross noted in his second report, *Gueler* was not funded by a drug company but by the Swiss National Science Foundation which has clear policies to ensure scientific integrity. The study was peer reviewed and published in a high-ranking medical journal. *Lohse et al* was also not funded by a drug company but rather the Danish AIDS Foundation. It too was peer reviewed and published in a high-ranking medical journal. Professor Ross explained that some authors in both studies received funding from drug companies for other unrelated work but that this was common for high quality researchers and was declared appropriately and transparently. All this is apparent from the face of the articles themselves, which contain specific sections identifying the funders and also potential conflicts of interests. Had Dr Croft read the articles carefully this should have been obvious to him.
163. Rather than backtracking, or seeking to substantiate his critique, Dr Croft dug in, moderating only to the extent required by the indisputable facts, to record in the expert memorandum that because some of the authors had openly declared in the papers that they financial links (his phrase) to drug companies it “*seriously undermine the paper's credibility.*” Had Dr Croft's critique been part of a more comprehensive analysis on the impact of industry funding on biases in academic papers, supported by evidence, then it would have been an issue that the Court would have had to grapple with. As it is, all that Dr Croft's position on these highly relevant papers amounts to is an unevidenced, unexplained and inaccurate, assertion. It reflects in my opinion a ‘shoot from the hip’ approach to the evidence that I have not found helpful when seeking to understand the complexities of the Claimant's case.

164. It was not unfortunately the only example of a somewhat cavalier approach to important evidence. One more example suffices. In his second report, Dr Croft critiqued Professor Ross' calculation of the likely CD4 level in November 2012. As noted above, Professor Ross had based his calculations on two studies one from the UK Health Protection Agency and the other by May et al showing an average decline of CD4 63 per annum in an HIV patient who was not being treated with ART. In his second report Dr Croft was dismissive of this whole approach:

“I do not consider that Prof Jones [sic] retrospective calculations as to Mr Jones's likely CD4 count at various timepoints are helpful (or indeed valid, given the observed and very wide biological variation in individual patient responses to infection with HIV); the calculations are based on one study only (May 2009) which looked almost exclusively at non-white patients. Mr Jones if [sic] of course “Caucasian”.”

165. Two things are noteworthy about this trenchant criticism of Professor Ross. Firstly, as Professor Ross pointed out he relied on two studies not just one. In the UK study, which was consistent with the other study by *May et al*, 80% of the cohort was comprised of Caucasians – entirely negating Dr Croft's criticisms. Secondly, by the time of the expert memoranda, Dr Croft himself was quite prepared to estimate CD4 levels at November 2012 and indeed provided a figure below that given by Professor Ross.

166. It will be evident from all that I have set out that I found Professor Ross to be authoritative and fair. His analysis was cogent, clear and corroborated by both the epidemiology and his very significant clinical expertise. It will also be apparent from the foregoing analysis that I took a very different view of the evidence of Dr Croft.

Dr Dufty

167. As described earlier, Dr Dufty was called by the Defendant as a witness of fact. Her involvement in the Claimant's case reflects her dual role as the senior military officer advising the Defendant on HIV and also as one of the Claimant's treating doctors in her capacity as a Consultant Physician in Sexual Health and HIV Medicine at University Hospital Birmingham (the same institution as Professor Ross).

168. Although her witness statement merely set out factual details of her examinations of the Claimant, Mr Wheatley chose to cross-examine her, in considerable detail, on matters that sought her expert opinion. Her evidence was, in so far as it overlapped with that of Professor Ross, consistent with it, not least her view that the Claimant had (from an HIV perspective) recovered well. She was also asked by Mr Wheatley about the paper that she had co-authored and provided a good explanation as to why it could not be relied upon to support the view that late diagnosis in a patient who subsequently responded well to treatment would have a worse outcome than a person diagnosed earlier.

169. I found Dr Dufty to be a very impressive witness. She is clearly an expert in her field and an enthusiastic proponent of the importance of early detection of HIV for both civilians and military personnel alike. She is of course a serving officer in the British Army but there was not (nor could there credibly have been) any suggestion that the

contents or tone of her evidence was a reflection of anything but her independence of thinking. She was robust in her criticism of the Defendant's doctors for failing to diagnose the Claimant earlier. I make plain that the conclusions I have reached are precisely the same that I would confidently have made even if Dr Dufty had not been asked to express her opinions but they have been a source of affirmation.

iv. Summary of Conclusions on Core Medical Issues

170. In light of my assessment of the evidence of Dr Croft and Professor Ross, I conclude as follows:

- i) As a result of the late diagnosis the Claimant suffered many months of distressing and debilitating symptoms including two admissions to hospital in the period immediately after treatment began;
- ii) By a time before his medical discharge from the Army (indeed from around October 2014 at the latest) HIV ceases to be a probable cause for his ongoing fatigue. I accept the evidence of Professor Ross that one would have expected to see early improvement in fatigue as the treatment started to have effect and that it would cease to have any direct causal role after about 6 months to a year. The fact that the Claimant showed no improvement in fatigue suggests that the virus itself was not the main driving cause from at least the autumn of 2014 onwards.
- iii) Subject to consideration of the psychological impact of HIV and the delay in diagnosis on the Claimant (see below) there is no adequate basis to conclude that an earlier diagnosis would have made any difference to the persistent and significant fatigue that the Claimant still suffers from – I accept the evidence of Professor Ross that one has to look elsewhere for answers.
- iv) Therefore, by the time that the Claimant was assessed by the Medical Board in February 2015 (which in effect, on the evidence, was the last opportunity to demonstrate recovery or at least promising improvement) HIV was no longer the direct cause of his fatigue and thus his dismissal. Had HIV been the effective cause of on-going fatigue even in the months prior to that date (covering for example some of the time on the GROW course) then one would have expected to have seen improvement as his CD4 count increased and he maintained an undetectable viral load.
- v) The late diagnosis has had no effect on the Claimant's life expectancy. The very alarming figures advanced by Dr Croft are unsustainable and far more probable is the assessment of Professor Ross.

E: OTHER POSSIBLE CAUSES OF FATIGUE

i. Overview

171. At the outset of the trial one might have been forgiven for concluding that the only explanation for the Claimant's fatigue, at least the only one advanced on his behalf, was that it was directly caused by the impact of the virus on his body. There was very little suggestion at all of reliance on alternative explanations for the fatigue, either at

the time of his discharge, or its ongoing persistence. Both the Particulars of Claim and the later amended version, contained a section setting out a case in causation solely based on an assertion that the Claimant's ongoing problems were caused by his unresolved HIV status. The only medical report referred to in this section of the pleadings was that of Dr Croft. The reference to the psychiatric report of Dr Nabavi was in respect of a claim for a discrete psychiatric injury said to be caused by the negligent delay in diagnosis.

172. The pleaded case was reflected in the evidence served. Dr Croft gave no other explanation for the Claimant's fatigue apart from the direct impact of HIV. This is how the claim was put in both the Claimant's skeleton argument and opening oral submissions.
173. Nor was a psychiatric explanation for fatigue, and its relationship to the delay in diagnosis, a feature, certainly not a prominent feature, of the reports of Dr Nabavi. In his first report Dr Nabavi concluded that the Claimant has been suffering with a depression since about 2011. He listed a long list of symptoms that he ascribed to the depression and which in turn he considered had been caused by the late diagnosis. These included low mood, agitation and irritability. Although Dr Nabavi identified fluctuating sleep as a sign of the Claimant's depression, there is no discussion at all in his first report of the causes, from a psychiatric perspective, of the fatigue that has been such a feature of the Claimant's life since at least 2013. Fatigue was considered in his second report although again there was no analysis beyond a sentence describing that the Claimant continued suffering from clinical symptoms of depression which include fatigue.
174. Furthermore, no consideration of any psychiatric explanation for ongoing fatigue was addressed at the meeting held between Dr Nabavi and Dr Kehoe. The clear impression is that prior to trial the focus of the Claimant on the question of the cause of the fatigue really only centred on whether it was physically caused by the virus, or not.
175. By the time of closing submissions, the Claimant was placing considerably more weight on a psychiatric cause for the continuing fatigue. The evidential basis for these submissions were answers given by both psychiatrists in their cross-examinations. Although the primary submission remained (per Dr Croft) that the virus itself explained the fatigue, considerable reliance was placed by Mr Wheatley in closing on his alternative case in causation based on the oral evidence of Dr Nabavi.
176. The strengths and weaknesses of the arguments built on that evidence need to be examined on their own merits and there was no objection in principle by the Defendant to the Claimant's attempts to develop arguments in this way so late in the day. I do observe however that it is a somewhat unsatisfactory foundation on which to build a case on one of the principal issues at trial. That is because the parties, experts and Court were deprived of the benefits that, by design, spring from expert opinion being carefully set out and explained in written reports. Nor did we have the insights that can result from experts responding in writing to the competing views of each other, nor the products of their thinking at joint meetings. It would be too crude to say that simply because the Claimant's arguments were developed late in the day that they must therefore be inherently weak, as I have said there was no objection raised by the Defendant per se, and they will have to be examined on their merits.

Nevertheless, it is often the case that arguments developed on a more *ad hoc* basis lack a degree of clarity and consistency. The prejudice that may flow from this inures against the party seeking to rely on such evidence, all the more so when that party bears the burden of proof.

ii. The Claimant's Case

177. To be fair to Dr Nabavi, who may well not have been asked to provide a detailed analysis of the cause of fatigue in his reports, the foundations of his subsequent analysis can be identified in his consistently held opinion that prior to his discharge the Claimant was suffering from depression. Dr Nabavi has also been consistent in his view that this depression was materially caused by the late diagnosis. Although his report considered that the depression began in around 2011, in evidence he preferred 2013 as the likely starting point.

178. Dr Nabavi interviewed the Claimant once in December 2016 (his first report is dated 22 June 2018). He took a full and careful history. He carried out a test known as HADS which assists in the assessment of whether a person has been suffering from depression. He concluded that the Claimant developed symptoms of a major depression since experiencing a deterioration in his health and receiving his diagnosis. Dr Nabavi considered that had he been diagnosed earlier he would probably have suffered only from an Adjustment Disorder rather than a Major Depressive Disorder. Dr Nabavi stated:

“... in my opinion, on the balance of probabilities, at the material time since 2013, the severity of his psychiatric injuries and the degree to which it has affected his functioning and state of mind is more profound than would be explained by a diagnosis of adjustment disorder....

....

In my opinion, on the balance of probabilities, I believe that had he been diagnosed correctly on 20 November 2012... he would have suffered at worst, an ‘adjustment disorder’, as the course and prognosis of his HIV infection would have been different.”

179. During the course of his cross-examination, Dr Nabavi set out the reasons why he considered that the Depression, and thus the fatigue, was caused by the delay in the diagnosis. I set out a lengthy excerpt from an uncorrected transcript because it captures almost the totality of Dr Nabavi's analysis on the impact of the delay in diagnosis on the fatigue.

“Q. Are you able to say that the fatigue that you say may be attributable to depression would or would not have occurred but for the further delay in diagnosis?”

A. It is multifactorial and it is extremely difficult to actually just make any comment regarding your question. But what I'd actually like to say is that of course we've got all these contributory factors and this sort of marked deterioration in his

physical status in the course of 2012. But, again, we have to give different weight with regard to the sort of impact and contribution to the onset of the depressive disorder. For instance, if we suffer from some physical sort of problems, or adversities, but then they kind of actually just recovered or treated properly within a few days or few weeks, we might not kind of actually go through a depressive disorder, forming then depressive symptoms, they might actually go through the Adjustment Disorder for a few weeks or a few months and then to fully recover.

Q. Yes, but we do know in his case that he was feeling noticeably unwell from January 2012, so that, even when the delay in diagnosis that we're concerned with from November 2012 kicks in, he's already been substantially unwell for a period of some 11 months. Yes?

A. Yes. He was substantially unwell, physically.

Q. Well, and that was a period in which he experienced marked distressed. I think you eventually accepted that's the likely period. Yes?

A. Yes, but I'm repeating myself just to say that, because it is quite important, that they've got different weights with regard to their contribution to the onset of depressive disorder. We can't actually put them on the same place having some sort of physical problems and then having a diagnosis of HIV and then later on a feeling or thinking, because this, as I said, for the respected court to look into, but that, having the delayed diagnosis of HIV. So they've got different sorts of psychology, they've got different impact with regard to the onset of the depressive disorder.

Q. Does that mean therefore mean that it's difficult to say, given it is so multifactorial, that the period of delay from November 12 to December 13 itself was the tipping point that tipped him in a depression and fatigue rather than all the other factors potentially also have tipped him into the depression and fatigue?

...

A. The form -- I'm actually just -- what I'm trying to say is that delayed diagnosis is a very significant matter and, again, it is quite important to consider that people -- we get more kind of actually affected if we know that the injury that we have received or we have -- is actually the cause problem to us, is hand made rather than being something naturally. So say, for example, if there wasn't any sort of delayed diagnosis, of course Mr Jones was feeling quite -- sort of going through the

Adjustment Disorder and may or may not entering the depressive disorder phase. But when you come to this conclusion that it was delayed, it was human error or mistake, then that would have actually had more effect with regard to the psychiatric illnesses. That's why we can see patients who are raped, for instance, they're more kind of having -- or having more severe symptoms of PTS or depression in compared to people who suffered through the earthquake or something like that.

MR FORTT: But can I put this proposition to you, that, whilst that may be a factor in your assessment in bringing about depression, but you also equally can't rule out the other issues causing him depression, can you?

A. Can you explain your question for me?

Q. Yes, the long period of ill health that he'd already had through HIV, which you said was causing him significant distress in 2012, had he been diagnosed then with HIV, having had a long period of physical or challenging physical ill health, you don't suggest that that means he wouldn't have suffered depression, do you?

A. I don't know. The main reason is because I'm not an expert with regard to the treatment of HIV and the course of HIV, because then it depends whether he, as a result of the delayed diagnosis, he actually just had more severe, more advanced symptoms of HIV and then that per se could have adverse effects on his mental state. So if we actually think about 2012 and having these physical problems and then having the diagnosis of HIV and having treatment, appropriate treatment, for that, probably he wouldn't have gone through that period of diarrhoea that had kind of experienced later on in the course of 2013, in July/August sort of time, and then later on in 2013 he had quite a significant sort of pneumonia, which you usually see in HIV. So these two, they were quite significant sort of illnesses that he experienced, without knowing why he's having these sort of symptoms, especially diarrhoea, and then as a result he had significant sort of weight loss and all can be kind of major contributing factors with regard to his diagnosis of depressive disorder."

180. I took the evidence of Dr Nabavi on this point to be advancing an argument, albeit carefully caveated and with some diffidence, that the ill-health that the Claimant suffered from during the period of the 10 months before diagnosis was a major factor in the development of a depression, which remained largely unresolved, and that this explains the persistence of fatigue in so far as the direct impact of the virus does not. Had there not been a delay then the Claimant may only have suffered a short-term Adjustment Disorder rather than a more profound Depression with associated fatigue.

He also opined that the depression was then exacerbated by learning that there had been a failure to diagnose him earlier.

iii. The Defendant's Case

181. Although the Claimant had not developed an alternative explanation for fatigue prior to trial, Professor Ross had flagged some potential candidates. In his first report, he recommended that a psychiatrist consider the relative importance of the delay in diagnosis on the Claimant's mental health compared to the adjustment that comes in any event with living with HIV. He also noted that the anxiety and fatigue are known side effects of ART and referenced a product information document showing the incidence as being in 1-10% of patients. In his second report he thought that HIV was unlikely to be a major contributor to fatigue but noted that the explanation might lie in the fact that he had been diagnosed with a recurrent depressive disorder. This was a view he maintained at the first meeting held with Dr Croft where he stated again that HIV could explain initial fatigue at the time of diagnosis but not once he had started to respond well to treatment. He noted:

“... fatigue can be caused by multiple physical and psychological factors and the with the subsequent control of his HIV infection and associated immune recovery it is unlikely that HIV remains a major contributing factor. Other relevant factors include recurrent depressive disorder and ART side effects, both of which can cause fatigue.”

182. Professor Ross was not cross examined on the impact of ART medication on fatigue notwithstanding that he had raised the issue on at least two occasions – nor did Dr Croft proffer a counter analysis, although at one stage he did try to suggest that a delay in diagnosis might have meant that the Claimant was put on more harmful medication, another unevidenced and ill-informed assertion that was authoritatively dismissed by Professor Ross.
183. Dr Kehoe's report did not address the extent to which fatigue had been caused by the delay in diagnosis. In contrast to Dr Nabavi he did not consider that the Claimant suffered from a Major Depressive Disorder in 2013/14 although in common with his counterpart he did agree that he developed one in 2015 after discharge from the Army. Dr Kehoe did not consider that the delay in diagnosis has had any material impact on the Claimant's mental health. He stated:

“If he had been diagnosed at an earlier stage, I understand that he would probably not have experienced the more severe episode of illness (as experienced in late 2013). At whichever stage he was diagnosed as HIV positive, it is likely that he would have experienced a period of emotional distress. This appears to have been the situation in September 2013 when he was diagnosed as HIV-positive. There are references in his medical records to ‘emotional distress’. This could be interpreted as amounting to an adjustment disorder but based upon the history as provided by Mr Jones and upon review of his medical records, I consider it likely that he had a period of

emotional distress (not a psychiatric disorder), as would expected in such a circumstance.”

184. Dr Kehoe’s conclusions as to the Claimant’s condition in around 2013 were in large measure based upon a reading of the contemporaneous medical notes but also a discussion with him as to his recollection of the emotional impact at the time. This was of course an interview conducted many years later but the Claimant did appear able to recall his feelings at the time, for example:

“Mr Jones emphasised that he didn’t get preoccupied with who he had caught the HIV from but rather he focussed positively on being treated. He had the attitude that he needed to “soldier on”. He also however recognises that whilst this can be a positive approach, a degree of denial can also be problematic.”

iv. Discussion and conclusions

185. I am not satisfied on the balance of probabilities that the Claimant suffered from a Major Depressive Episode prior to the onset of the depression that both experts agree started in 2015 after his discharge. Furthermore, whether or not stemming from a diagnosable psychiatric condition, I am not satisfied on the balance of probabilities that the Claimant’s fatigue, even if shown to stem from his mental health can be shown to have been caused by the delay in diagnosis. There are three principal stepping stones in the reasoning leading to these conclusions.
186. **Firstly**, I consider that there is a real possibility that the Claimant’s persisting fatigue has been caused by his medication. This is a potential alternative cause for fatigue flagged up by Professor Ross since his first report of August 2018. Mr Wheatley argued that the data about the risks of fatigue are no more than would be expected in any disclaimer about the risks of all forms of medication and that no real reliance can be placed on them. I disagree. This is not a case of a vague reference to an unspecified or very low risk. Rather this is a Professor of HIV Medicine identifying a recognised phenomena arising from a commonly used medication and highlighting it as a potential cause. The level of risk is not insignificant (1-10%) but the Claimant elected not to address the issue either in evidence or detailed cross examination. It is right to make the point that at no stage do the records reveal that any consideration has been given by the Claimant’s treating physicians to his ART being the cause of his fatigue, but in light of (a) the known link between the medication and fatigue, (b) the fact that fatigue has remained after the virus no longer explains a direct cause of fatigue and (c) the opinion of Professor Ross, I consider that it represents a realistic explanation, which the Claimant (who of course bears the burden of proof) has been unable to satisfactorily discount.
187. As stated above, there is no evidence that had the Claimant been diagnosed earlier he would have been put on different medication, nor that the timing of the commencement of the medication could of itself explain the reaction to it.
188. It is not necessary to reach a firm conclusion the point which would have been difficult in any event given the relatively scant material on the issue before me, and the lack of detailed examination of the issue in evidence. This is because, in any event, I conclude that the Claimant has failed to prove that the delay in diagnosis has

caused psychiatric symptoms that explain the ongoing fatigue. This takes me to the next step in my reasoning.

189. **Secondly**, even if the medication does not explain the persistent fatigue, I do not consider that the Claimant did in fact sustain a Major Depressive Disorder before 2015. In essence this is because I prefer the opinion of Dr Kehoe on this point to that of Dr Nabavi.
190. Dr Kehoe's analysis of the Claimant's state of mind in 2012-13 is based on two sources to which he applied his experience and expertise. The first source is the medical records which do not reflect significant complaints or signs of depression during the period (indeed some documents, for example the Claimant's own letter to the Medical Board, eschew any significant psychological impact). The second source is the account he took from the Claimant himself in which he appears to downplay any significant mental health problems during the period. The accuracy of Dr Kehoe's reportage of the Claimant's account was challenged to a certain degree in cross examination but I consider that it should be treated as accurate.
191. The difficulty with Dr Nabavi's analysis is not just (as he accepts) the absence of supporting evidence in the contemporaneous medical notes but that his report does not contain (in contrast to that of Dr Kehoe) any record of a detailed discussion with the Claimant about emotions in 2012/3 from which his conclusions can be calibrated and tested. Dr Nabavi is certainly entitled to nevertheless bring his professional judgment to bear on the issue. He is also right to note that care has to be exercised with medical records because they can mask the fact that many people suffering with depression are reluctant to talk about it even to medical practitioners. I accept that the Claimant may well fall into this category, indeed as Mrs Jones said in her evidence, at a time when his health was particularly bad they had a black joke that the phrase "*I'll be fine*" would be engraved on his headstone. Nevertheless, whilst an absence of contemporaneous relevant complaint does not negate the existence of a serious depression it does create difficulty in proving a case – all the more so, when as here, some records and reportage point the other way.
192. In the context of a retrospective assessment of the Claimant's medical health, conducted some years after the event, in light of the history given to Dr Kehoe and the contents of the relevant medical records, I am not prepared to accept on the balance of probabilities that Dr Nabavi's evidence should be preferred to that of Dr Kehoe.
193. **Thirdly**, even if I were to have concluded that he was suffering from a Major Depressive Disorder during 2013-2015, or as Dr Kehoe accepts, periods of low mood, then it would not be possible to find, on the balance of probabilities, that the effective cause of the fatigue was the delayed diagnosis as opposed to the eventual diagnosis itself, the inevitable consequences of that diagnosis and other life events.
194. The causes of any diagnosable depression like general stress and anxiety would have been multifactorial, and Dr Nabavi acknowledged that picking these factors apart is a difficult exercise. There is no doubt that the shock of receiving a diagnosis of HIV would have been profound, as would the knowledge of the reality of living with the misperceptions of others about the disease and the fact that treatment would be required for life. All of these would have been highly distressing factors irrespective of when the Claimant would have been diagnosed. In addition, even if diagnosed

earlier in November 2012, the Claimant would have been told he had a perilous CD4 count and that he faced a period of acute risk to his health and that his prognosis would be uncertain until it could be established whether or not he was responding well to treatment. All of these no doubt would contribute to low mood and I am unable on the evidence to conclude that the delay in diagnosis, and the consequences for the Claimant's health can be identified as the effective cause of a psychological reaction (be it depression or low mood) that has in turn caused the persistent fatigue.

195. Accordingly, I am not satisfied that the Claimant has established his secondary case on causation namely that the persistent fatigue can be explained by a psychiatric or psychological reaction to the consequences of the delay in diagnosis.
196. It follows from this that I conclude that the Claimant has not established that his fatigue (which was the effective cause of his discharge from the Army) was caused by the delay in diagnosis as rather than the consequences that would have flowed in any event from his HIV status.
197. None of this is to diminish the real suffering that the Claimant endured as a consequence of the failure to diagnose him in November 2012, nor to underestimate the great anger he felt in 2014 when he was alerted to this failure by Dr Dufty, it is simply a conclusion that these failures cannot be shown, to the requisite standard, to be the cause of his persistent fatigue.

v. Depression in 2015

198. Both Dr Nabavi and Dr Kehoe agree that the Claimant suffered a depressive episode in 2015 to 2016 albeit the former considers that this was part of a continuum since at least 2015. In the memorandum of their joint meeting they stated:

“If Mr Jones, in the absence of any negligence, had still experienced these other life stressors (the marital breakdown; an ongoing diagnosis of HIV, the necessity to leave the army and adjust to civilian life) then he would likely have experienced a depressive episode even in the absence of any alleged clinical negligence.

199. The onset of the depressive episode followed discharge from a life in Army that the Claimant relished. He understandably found a return to civilian life difficult, no doubt all the more so because of his fatigue. I have found however that the reason for his discharge, whilst related to his HIV, was not the delay in diagnosis. Furthermore, there is no real suggestion in the evidence that the cause of the Claimant's marital breakdown was caused by the diagnosis of HIV let alone the late diagnosis. The only suggestion to the contrary is a bold, unevicenced, assertion to that effect by Dr Croft. I am therefore unable to conclude that the delay in diagnosis caused the depression in 2015 to 2016 or any time thereafter.

F: QUANTUM

200. In light of my conclusions that the delay in diagnosis was not responsible for the Claimant's discharge from the Army and (fortunately) that it has had no long-term

adverse impacts on his health, the quantum of this claim is obviously far less than claimed.

201. There is no dispute that the Claimant is entitled to an award of general damages to compensate for the pain, suffering and loss of amenity endured not simply during the 10 months in which he was wrongly left with undiagnosed HIV but the months following, in which his weakened immune system led to two incidences of hospitalisation.
202. The Defendant suggests that these periods were not as traumatic as painted by the Claimant, pointing for example, to the fact that he was able to play a game of football. I disagree. I accept the evidence as to the intensity of his suffering in this period, which was eloquently amplified by the insights provided by Mrs Jones in her evidence.
203. It is clear that for many months leading up to his eventual diagnosis the Claimant was in a dreadful state. In particular the intensity of the diarrhoea, as described not least by Mrs Jones, was having a major impact on his life. The level of suffering and distress was such that the Claimant and his wife thought he might have bowel cancer. It was so bad that, fed up with further appointments at the GP, they went to an A&E department.
204. The two subsequent admissions to hospital for the PCP and the tonsillitis were also caused by the admitted negligence. The first admission was shortly after he had been diagnosed with HIV, he had lost a huge amount of weight and his collapse led to 9 days of hospitalisation. The second attributable period of hospitalisation was for 3 days, just after the birth of his daughter, and was for tonsillitis that the Claimant, not a man inclined to exaggeration, described as the worst pain he had ever experienced.
205. There is very little guidance in the Judicial College Guidelines (JCG) that can be readily applied to this case. Mr Wheatley helpfully supplied the Court with a chapter in *Kemp & Kemp on Damages* that has a separate section on awards for cases of missed diagnosis but nothing within it was of application to this case because the consequences were generally more severe or of an entirely different nature. What is being compensated is not the fact of a misdiagnosis itself but rather the consequences of it in terms of pain, suffering and loss of amenity.
206. Absent a discrete category in the JCG, or in any reported cases for the same condition then it is appropriate to look for comparators. The focus in the search for relevant comparators is not the description of the relevant condition but rather an overlap in similarity in the pain, suffering and loss of amenity caused. It seems to me that some assistance, on that basis, can be drawn from the category quantifying illness to the digestive system, not least because diarrhoea was such a prominent and distressing feature of the Claimant's presentation in the months running up to September 2013.
207. The JCG provide the following bracket showing figures with and without the 10% uplift:

(b) Illness/Damage Resulting from Non-traumatic Injury, e.g. Food Poisoning

There will be a marked distinction between those, comparatively rare, cases having a

long-standing or even permanent effect on quality of life and those in which the only continuing symptoms may be allergy to specific foods and the attendant risk of short-term illness.

| | | |
|--|---|---|
| (i) Severe toxicosis causing serious acute pain, vomiting, diarrhoea, and fever, requiring hospital admission for some days or weeks and some continuing incontinence, haemorrhoids, and irritable bowel syndrome, having a significant impact on ability to work and enjoyment of life. | £32,780 to £44,790 | £36,060 to £49,270 |
|--|---|---|

| | | |
|---|------------------------------------|------------------------------------|
| (ii) Serious but short-lived food poisoning, diarrhoea, and vomiting diminishing over two to four weeks with some remaining discomfort and disturbance of bowel function and impact on sex life and enjoyment of food over a few years. Any such symptoms having these consequences and lasting for longer, even indefinitely, are likely to merit an award between the top of this bracket and the bottom of the bracket in (i) above. | £8,140 to £16,380 | £8,950 to £18,020 |
|---|------------------------------------|------------------------------------|

| | | |
|---|-----------------------------------|-----------------------------------|
| (iii) Food poisoning causing significant discomfort, stomach cramps, alteration of bowel function and fatigue. Hospital admission for some days with symptoms lasting for a few weeks but complete recovery within a year or two. | £3,370 to £8,140 | £3,710 to £8,950 |
|---|-----------------------------------|-----------------------------------|

| | | |
|--|---------------------------------|---------------------------------|
| (iv) Varying degrees of disabling pain, cramps, and diarrhoea continuing for some days or weeks. | £780 to £3,370 | £860 to £3,710 |
|--|---------------------------------|---------------------------------|

208. In this case the period of attributability is approximately over a year which on one view would place it sub-category (iii) above. That would though be a very significant underappreciation of the Claimant's plight during this period. This includes not simply prolonged and repeated bouts of severe diarrhoea over a number of months but the two subsequent hospitalisations, the first after a collapse that led to 9 days admission to hospital.

209. In my opinion the appropriate level of general damages is £20,000 plus interest.

210. On the basis of my conclusions on causation, the only element of the Schedule of Loss that can be attributed to the delay in diagnosis is the gratuitous care provided by Mrs Jones.

211. On the basis of the findings made above, I consider that the Claimant is entitled to recover reasonable care costs but only those attributable to the delay in diagnosis. I consider that this period runs until mid November 2014 by which he would have

recuperated from the tonsillitis, the impact of his earlier pneumonia and his CD4 would have exceeded 200 with a non-detectable viral load – in other words the point at which it was no longer probable that his problems could be ascribed to delay in diagnosis. Although the Claimant would have been diagnosed very late with HIV in any event, there is no evidence to suggest that had treatment commenced then he would have suffered the same stormy period and required care – indeed I understood the Defendant, on the basis of the views of Dr Dufty and Professor Ross to concede as much.

212. The Defendant sought to suggest that the figures claimed for care were unrealistically high. I disagree. On the basis of the evidence given by Mrs Jones as to the level and intensity of the care provided, I consider that they are fully justified and I allow them in full.
213. The level and nature of this award means that it is not appropriate to make any order for periodical payments.
214. On the basis of these findings, I would invite counsel to agree the sums together with interest to be provided in the form of a draft Order.

Appendix

Ex Tempore Ruling on Anonymity

1. I am going to give a short summary of my decision at the outset so that the parties, and in particular Mr Jones, are not kept in suspense as I set out my reasoning. I fully accept that disclosure of Mr Jones identity will be a source of real anxiety to him and I do not doubt the veracity of anything he says about it. I nevertheless decline to make the order sought. This is because an anonymity order, infringing as it does the principle of open justice, is a form of order that can only be justified in exceptional circumstances and I do not consider that they are met here.
2. I will now set out my reasons for reaching this decision.
3. Yesterday morning, shortly before the commencement of the trial, I informed the parties by email that I had just received a request from a journalist from the Press Association (PA), seeking access to the 'Microsoft Team's' platform in order to watch the trial. I stated that as no application had been made for any part of the trial to be in private, nor for any form of order seeking anonymity, I would facilitate access. Mr Wheatley emailed in reply to ask me not to grant the journalist access to the platform and indicated that he intended to apply for an order that his client be granted anonymity. In response, I informed the parties that I would deal with this matter at the outset of the hearing at which the journalists would be entitled to be present and make representations.
4. No formal application was lodged and no discrete supporting evidence was provided but at the start of the trial yesterday I heard short submissions from Mr Wheatley and also representations from Ms Kershaw a journalist from the PA. Mr Fortt, on behalf of the Defendant, indicated that there was no objection to the making of an order. I mean no criticism of Mr Wheatley when I observe that the very late timing of the application meant that he was unable to fully develop the submissions necessary to justify the making of an order, not least he did not really possess an adequate evidential basis for submissions on the impact that publicity might have on the Claimant.
5. Faced with an unformulated application of this nature I determined yesterday that the appropriate way forward was to make an interim order, applying 'balance of convenience' principles and granted anonymity to the Claimant effectively for 24 hours until a properly founded application could be made.
6. Pursuant to that Order, the Claimant's advisers this morning served on the Court, Defendant and Press Association a skeleton argument, draft order and a further witness statement from Mr Jones dealing specifically with this application.
7. Mr Fortt maintains his client's stance that there is no objection to the order and earlier this morning an email from Ms Kershaw communicated that the PA did not oppose the application.
8. As I made plain yesterday, applications for anonymity under CPR 39.2(4) should be made early on in litigation (generally at the outset) and absent exceptional reasons should not await the commencement of a trial. Late applications prejudice the parties,

the media and the good administration of justice. They prejudice the party on whose behalf a late application is made not least because it increases the likelihood that their identity might already have been placed in the public domain. In this case, for example, the pleadings would have been available to public inspection for some time together with previous orders of the Court and indeed this case was listed without objection on the daily cause list published on the Court Service website. A late application also unacceptably prejudices the representatives of the media who are given little, or no, opportunity to seek to challenge an application and ensure that their voice is properly taken into consideration before any principles of open justice are potentially infringed. It also puts the court in a difficult position as it is capable of depriving it of the time necessary for proper consideration of what are important applications.

9. Mr Wheatley quite properly accepted that this application should have been made earlier and was at pains to point out that the fault for this lies with not with the Claimant himself, who he says has always made clear that he wanted his identity protected, but with his advisers who did not make an appropriate application.
10. Although I have deprecated the lateness of the application, I do not think that this in itself is a factor for refusing it. The Claimant's advisers have accepted that the fault for delay lies with them and, in any event, if there is material that demonstrates that publication of his identity would cause harm to the Claimant, or otherwise interfere with his legal rights, then I do not think that procedural breaches should inevitably provide an obstacle to reaching the right result on the legal and factual merits.
11. I turn then to the application.
12. The Claimant is a private man who has kept his HIV status secret from much of his social circle and his employers. He is understandably concerned about the impact that disclosure might have on his relationships with people and his employment. Yesterday I gave permission for the Claimant to rely upon a supplemental statement dated 24 April 2020 in the substantive proceedings. This gives some outline, by inference, of the Claimant's concerns were his identity to become more widely known. See in particular paragraphs 4 and 5. At §18 of that statement he describes how he has not been following up on medical appointments because he wishes to avoid difficult conversations with his boss about why he needs time off from work. This is expanded upon in much more detail in the further statement that I received from the Claimant this morning in which he describes the concerns that he has about the impact that disclosure of his identity would have and the fear and trepidation he felt when he learned that a reporter would be present when he gave evidence.

The relevant legal principles.

13. Any discussion of anonymity orders starts with the reiteration of the importance of the principle of open justice and the concomitant need to be satisfied that any departure from it is fully justified and in accordance with legal principle. The importance of these principles and the need to carefully balance the requirement to secure open justice with any conflicting rights of the individual are stressed in a large number of cases, from at least *Scott v Scott* [1913] AC 417 onwards, of which reference to only a few suffice for current purposes.

14. A useful starting point is Lord Rodger's analysis of 'what's in a name' in *Guardian News v Media Limited* [2010] UKSC 1 at §63

"What's in a name? "A lot", the press would answer. This is because stories about particular individuals are simply much more attractive to readers than stories about unidentified people. It is just human nature. And this is why, of course, even when reporting major disasters, journalists usually look for a story about how particular individuals are affected. Writing stories which capture the attention of readers is a matter of reporting technique, and the European Court holds that article 10 protects not only the substance of ideas and information but also the form in which they are conveyed: *News Verlags GmbH & Co KG v Austria* (2000) 31 EHRR 246, 256, para 39, quoted at para 35 above. More succinctly, Lord Hoffmann observed in *Campbell v MGN Ltd* [2004] 2 AC 457, 474, para 59, "judges are not newspaper editors." See also Lord Hope of Craighead in *In re British Broadcasting Corp'n* [2009] 3 WLR 142, 152, para 25. This is not just a matter of deference to editorial independence. The judges are recognising that editors know best how to present material in a way that will interest the readers of their particular publication and so help them to absorb the information. A requirement to report it in some austere, abstract form, devoid of much of its human interest, could well mean that the report would not be read and the information would not be passed on. Ultimately, such an approach could threaten the viability of newspapers and magazines, which can only inform the public if they attract enough readers and make enough money to survive."

15. The import of the underlying governing principle, that of open justice, was reiterated by the Supreme Court in *R(C) v Secretary of State for Justice* [2016] UKSC 2, where at §1 Lady Hale said:

"The principle of open justice is one of the most precious in our law. It is there to reassure the public and the parties that our courts are indeed doing justice according to law. In fact, there are two aspects to this principle. The first is that justice should be done in open court, so that the people interested in the case, the wider public and the media can know what is going on. The court should not hear and take into account evidence and arguments that they have not heard or seen. The second is that the names of the people whose cases are being decided, and others involved in the hearing, should be public knowledge."
[Emphasis added]

16. The importance of the identity of parties being in the public domain was stressed by Moore-Bick LJ in *JX MX v Dartford & Gravesham NHS Trust* [2015] EWCA Civ 96, where at §17 he said:

"The identities of the parties are an integral part of civil proceedings and the principle of open justice requires that they

be available to anyone who may wish to attend the proceedings or who wishes to provide or receive a report of them. Inevitably, therefore, any order which prevents or restricts publication of a party's name or other information which may enable him to be identified involves a derogation from the principle of open justice and the right to freedom of expression. Whenever the court is asked to make an order of that kind, therefore, it is necessary to consider carefully whether a derogation of any kind is strictly necessary, and if so what is the minimum required for that purpose. The approach is the same whether the question be viewed through the lens of the common law or that of the [European Convention on Human Rights](#), in particular article 6, 8 and 10.”

17. These and other relevant authorities were considered by Males J (as he then was) in *Armes v Nottinghamshire CC* [2016] EWHC 2864 where he identified six summary point (§28):

“I would summarise the position as it emerges from these authorities, so far as relevant to the present case, as follows:

- a. The court has power to make an order for the anonymity of a witness, but only if it is “necessary” to do so in order to protect the interests of the witness. Nothing less than this will do. Some of the cases emphasise this by saying that anonymity must be “strictly necessary”.
- b. Although other “interests” may sometimes be in play, often the interests which may need to be protected are a witness's rights under [Article 8](#) to respect for his or her private or family life. That is the position here.
- c. In such a case the first question to be determined is whether identification of the witness would interfere with his or her rights under [Article 8](#). This will only be the case if the consequences of identification reach a certain level of seriousness (or as Lord Neuberger put it in *JIH*, if the facts and circumstances of the case are “sufficiently strong”). Depending on the subject matter of the case and the nature of the evidence, giving evidence as a witness may be embarrassing or sometimes even humiliating, but this will not generally be enough to justify an order for anonymity by reference to [Article 8](#). Something more is required, although in view of the wide range of circumstances in which [Article 8](#) can apply, I doubt whether that something is susceptible of precise definition.
- d. If identification would interfere with the witness's right to respect for his or her private or family life, it is necessary to consider (in the terms of [Article 8.2](#)) whether that interference “is necessary in a democratic society ... for the

protection of the rights and freedoms of others”. The rights and freedoms of others which will generally require consideration are (or at least include) the right to freedom of expression, including the vital freedom of the press to report court proceedings held in public, under Article 10. A balance therefore needs to be struck.

e. In striking that balance, the question has been described as whether there is a sufficient public interest in identification of the witness to justify the interference with the witness's Article 8 rights. Considered in isolation that way of posing the question may suggest that once any material interference with Article 8 rights has been identified, there is a presumption in favour of anonymity unless there is a strong public interest in identification. However, when this formulation of the question is viewed in the full context of the cases discussed above, it is apparent that this is not so. I would make three points. One is that the general rule remains the principle of open justice. The second is that what matters is not merely the fact of interference with Article 8 rights but rather the severity or otherwise of the consequences for the witness of being identified. The more severe those consequences, the more likely it is that anonymity will be ordered and vice versa. The third is that the weight to be given to an interference with freedom of expression must depend on the extent to which the issues raised by the litigation involve matters of real public interest. The greater the public interest (as distinct from the separate question whether the identity of the witness is likely to be of interest to the public), the more likely it is that anonymity will be refused.

f. All these points need to be taken into account. Inevitably, therefore, striking the necessary balance requires close attention to the facts of the particular case.”

18. Although each case will turn on its own facts, these general principles were applied by Martin Spencer J in the context of a clinical negligence claim *Zeromska-Smith v United Lincolnshire Hospitals NHS Trust* [2019] EWHC 552, in which the court refused to make an anonymity order notwithstanding the highly personal nature of the subject matter of the claim which required dissection of intimate details of the claimant's private and family life including her relationship with her two young children.
19. One further reference to authority is the difference that the capacity of the person seeking anonymity can make – a court might more readily grant it to a witness whose attendance is voluntary rather than a party who has elected to get involved in litigation – a point made by Lord Woolf in *R v Legal Aid Board, ex p Kaim Todner* [1999] QB 996 at paragraph 8:

“A distinction can also be made depending on whether what is being sought is anonymity for a plaintiff, a defendant or a third party. It is not unreasonable to regard the person who initiates the proceedings as having accepted the normal incidence of the public nature of court proceedings. If you are a defendant you may have an interest equal to that of the plaintiff in the outcome of the proceedings but you have not chosen to initiate court proceedings which are normally conducted in public. A witness who has no interest in the proceedings has the strongest claim to be protected by the court if he or she will be prejudiced by publicity, since the courts and parties may depend on their co-operation. In general, however, parties and witnesses have to accept the embarrassment and damage to their reputation and the possible consequential loss which can be inherent in being involved in litigation. The protection to which they are entitled is normally provided by a judgment delivered in public which will refute unfounded allegations. Any other approach would result in wholly unacceptable inroads on the general rule.”

20. I am satisfied on the evidence that has now been submitted that publication of the Claimant’s identity would affect his legal interests not least his right to privacy protected by Article 8 of Schedule 1 to the HRA.
21. I also accept that this is not a case in which the identity of the Claimant is critical to a public understanding of the issues in the case, the trial of which will be proceeding in any event without any further restrictions on the open justice principles other than those inherent in remote hearings. This is also not a claim, in contrast with some of the reported cases, in which the claimant is a famous person, or one of notoriety in which there is an inherent public interest in their identity being known.
22. I am not however satisfied that the impact that publication of his identity might have on the Claimant is sufficient to justify the exceptional order sought. Whether the relevant test is formulated through the prism of Article 8 (in shorthand, is the interference with his rights in accordance with law, necessary for the protection of the rights and freedoms of others, and proportionate) or a more binary common law balancing of a litigant’s personal rights with the public interest in maintaining open justice, the result is the same and I conclude that the grounds for granting an anonymity order cannot be made out because it is not necessary.
23. I reach this conclusion for three related reasons.
24. **First**, whilst I have accepted that publication might adversely affect the Claimant’s rights (on the basis that I accept his evidence about his real and genuine concerns about the impact of further disclosure on his private life), and without wishing to belittle them in any way – these are not at the level of gravity that Courts have generally found necessary to depart from the open justice principle. This is not a case, for example, where the impact of disclosure might have a profound impact on the safety of a witness or where there is evidence that it would have a profound

impact on mental health. The agreed evidence of the psychiatrists in this case is that whilst the Claimant has suffered psychologically as a result of contracting HIV (the precise cause, duration and severity of which is a matter of dispute), his illness has not been very severe and he is no longer classified as suffering from any diagnosable condition. This is not a case therefore where the evidence suggests that the disclosure will cause actual physical or psychiatric harm.

25. **Second**, whilst I do not doubt that HIV regrettably still carries with it some social stigma, it is less widespread and less intense than would have been the case a generation ago, reflecting no doubt advances in treatment and also positive changes in societal attitudes. I remind myself that mere embarrassment or humiliation is not of itself a ground to grant an application albeit I accept this case goes somewhat beyond that. Many clinical negligence claims will involve the disclosure of very personal information and/or concern conditions that a litigant would understandably wish to keep from not simply the public but their friends, family and employers.
26. Mr Wheatley argues that disclosing the names of claimants in claims such as these would act as a deterrent to victims of medical accidents having fair access to a Court. If this submission was borne out of reliable statistical evidence that potential litigants in clinical negligence claims were not pursuing otherwise valid cases because their identities might become public, then one could envisage an argument that the public interest in open justice might not generally require the names of parties to be routinely disclosed in clinical negligence cases. Even if such a change were considered necessary or desirable (on which I express no view) then I do not consider that the current state of the law permits a first instance judge to develop it in the face of the clear principles and guidance set out in established authority.
27. **Third** is the fact that the Claimant's name and the fact he is bringing this claim is already in the public domain. It is on court papers available for public inspection at Court and this case has been listed without objection on the Daily Cause List published on the Judiciary website. I accept that may not yet have been reported in the media but particular care needs to be exercised, and particularly compelling reasons identified, before seeking to effectively retrace steps and retrospectively seek anonymity;
28. Thus, whilst disclosure of his identity will impact upon his private life, within the meaning of Article 8, it is not at a level that provides a sufficiently robust ballast against the competing interest of ensuring open justice. These principles are no less important during the Covid crisis when there is no effective public access to the courts and the need for the media to freely report proceedings is arguably all the greater.
29. I do not consider the Defendant's consent to the application to be particularly relevant let alone determinative. As the authorities have made plain, the consent of the parties does not diminish the obligation of the Court to carefully scrutinise any application whose effect would be to diminish the principles of open justice. As Sir Christopher Staughton said *Ex parte P., The Times, 31 March 1998* : "*When both sides agreed that information should be kept from the public that was when the court had to be most vigilant.*"

30. Similarly, although I take into account that the PA did not object to the making of an order it does not relieve Court of responsibility. The PA is just one, albeit representative, media organisation but the ultimate guardian of the public interest in protecting open justice is the Court.
31. For these reasons I dismiss the application.