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*Judgment: approved by the court for handing down (subject to editorial corrections)**	*Delivered:* **03/10/2024**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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KING'S BENCH DIVISION

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BETWEEN:

MARTINE NORNEY

Plaintiff

and

DR MICHAEL WATT

First Defendant

and

BELFAST HEALTH AND SOCIAL CARE TRUST

Second Defendant

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Mr Brian Fee KC with Ms Fiona Fee KC (instructed by O'Hare Solicitors) on behalf of the Plaintiff
Mr David Ringland KC with Mr Christopher Ringland (instructed by Carson McDowell LLP Solicitors) on behalf of the First Defendant
Mr Jonathan Park (instructed Directorate of Legal Services) on behalf of the Second Defendant

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COLTON J

Introduction

[1] The plaintiff, who was born in August 1981, is employed as a Finance Supervisor.

[2] By these proceedings she brings a civil claim against the defendants for what she says was grossly substandard medical treatment whilst under the care of Dr Michael Watt, a Consultant Neurologist.

[3] Sometime around October 2015, the plaintiff began to experience headaches, dizziness and nausea. She also complained of pins and needles in her right arm and sensitivity to light and sound. As a consequence, she was referred to the Neurology

Clinic at the Royal Victoria Hospital ("RVH") where she was seen by Dr Thomas Peukert, Consultant Neurologist, on 26 November 2015.

[4] Dr Peukert arranged an MRI scan of the brain to exclude any anatomical abnormality or a demyelinating disease. The scan was carried out on 21 December 2015 and was reported as normal.

[5] Dr Peukert diagnosed a cervicogenic headache (which is a headache originating in the upper part of the neck) in combination with migraine. He performed an occipital nerve block at the first consultation which gave her immediate relief and the success of which supported his diagnosis.

[6] The plaintiff's symptoms gradually returned, and she was referred back to Dr Peukert by her general practitioner who carried out further nerve blocks on 4 April 2016 and 15 June 2016. The relief provided by these blocks diminished on each occasion.

[7] The plaintiff decided to seek a private appointment which resulted in a consultation with the first defendant on 20 July 2016.

The plaintiff's evidence

The consultation on 20 July 2016

[8] The plaintiff gave evidence confirming the history set out above, which is not in dispute.

[9] As to the consultation with the first defendant on 20 July 2016 she recalled that she was asked questions about her symptoms. She reported that she had been suffering from neck pain particularly after she had been sitting at her desk all day. She had attended for physiotherapy, but this did not help. She described the headaches from which she suffered and in respect of which she was seeking treatment. Her evidence was that she told the first defendant if she lay down in a darkened room and fell asleep the symptoms improved. She said there was no immediate effect on lying down.

[10] Importantly, she was told by the first defendant that she had a hole in her spine, a leak. He told her that he would arrange to take blood from her arm. He would inject it into her back which would close the hole. (A blood patch). He told her that this would "cure the headaches."

[11] He told her that she was suffering from Spontaneous Intercranial Hypotension ("SIH") and that the fluid injected into her back would cure it. "It would take my headaches away."

[12] He told her that the blood patch would be performed under the National Health Service (NHS) rather than privately. She would subsequently receive notification of when to attend.

[13] There was no discussion about the risks associated with the procedure, the potential prospects for success or any alternative diagnosis. There was no suggestion of any further treatment such as an MRI scan before the blood patch would be performed. There was no indication that a review would take place. She was told that she "would be put in for a blood patch."

[14] After the consultation she was relieved. She felt that she would get a resolution of her symptoms from the blood patch.

Post 20 July 2016

[15] Whilst awaiting the date for the performance of the blood patch promised by the first defendant the plaintiff attended at the A and E Department of the RVH on 28 July 2016 where she was assessed by an SHO Dr Donnelly. He noted that "she tells me that she attended Dr Watt privately, who suggested that her problems could be caused by 'fluid leaking out of her spine', I presume she is referring to a CSF leak." Notwithstanding this, he went on to say that in his opinion her symptoms were not in keeping with low pressure headaches.

The epidural blood patch procedure – 21 November 2016

[16] The plaintiff's evidence was that she attended for the blood patch arranged by the first defendant at the RVH on 21 November 2016. She went there with her mother. She was called from a waiting area and shown into a small cubicle with her mother, where she was seen by the first defendant who was accompanied by a nurse. The plaintiff was wearing her normal clothes and was told to lie down prone on her front on a bed in the cubicle so that the first defendant could carry out the injection. He was in his everyday clothes; he was unmasked and in the plaintiff's recollection was not wearing gloves. She describes her clothes being moved aside at which point she felt the needle in her flesh. The first defendant said something along the lines of "we will just give this a wiggle and here will do."

[17] She experienced severe pain in her right leg during the procedure. She complained and asked the first defendant to stop, but he continued and said, "just a bit more." She describes the pain as excruciating, and she felt her right leg was going to burst. After further complaint the first defendant ended the procedure. He told her to stay prone for 5/10 minutes after which she should go on.

[18] She described how she lay still for a period. When she got up the first defendant and the nurse were already gone. She said she was very sore with pain in the back and in her right leg. She had to hobble out to the car. She was not provided

with any help or assistance. She was not given any leaflets or guidance about what might happen after the procedure. No appointment was made for a review.

The defendants' records of the interaction between the plaintiff and the first defendant

[19] The court has not heard any evidence from the first defendant or from any other person who was present on the two relevant occasions other than that of the plaintiff.

[20] The written records of what took place on those occasions prepared by the first defendant are woefully inadequate and substandard.

[21] On the date of the first examination the first defendant wrote to the plaintiff's general practitioner in the following terms:

> "One day in late November while sitting in work this 34-year-old woman felt as though the right side of her face had dropped and she lost feeling in her right arm. There was also severe pain in her right temple. She does a lot of training in the gym. Her neck has been tight for a good year or two particularly after she has been sitting at her desk all day. She is at her best in the morning. She has been going for massages and has also been for physiotherapy. She was last with the physios in the Royal in around September or October and she felt something in her neck after that and then her headaches started. The headaches build up through the day, it is always right sided and is exacerbated by training. She gets dizzy if she bends and stands up again. Her right arm is always sore and last week her back and two shoulders were sore. Her hearing can be a bit fuzzy in her right ear as though she is under water. Her right eye feels droopy a lot. She is tired and her concentration is not as good. Around Christmas she was quite clumsy. She finds that lying down helps her symptoms. She has attended Thomas Peukert at the Rapid Access Neurology Clinic in the Royal and he has performed several greater occipital nerve blocks which have been of some help. She has had a MRI scan of brain privately which did not show any significant abnormalities.
>
> I feel her symptoms are suggestive of spontaneous intercranial hypotension. I have arranged for her name to be added to the waiting list for a day case lumbar epidural blood patch in the Ambulatory Care Centre in the Royal and I have not arranged to review her here."

This letter reflects the handwritten notes prepared by the first defendant at the time. Importantly, Mr Ringland refers to the penultimate line in the note which reads "?S.I.H."

[22] The letter was copied to Donna O'Hara, Secretary to Dr Michael Watt, Neurology Department, Royal Victoria Hospital.

[23] On the same date the first defendant wrote to Ms O'Hara in the following terms:

> "Dear Donna,
>
> I would be grateful if you could arrange for this girl's name to be added to the waiting list for a lumbar epidural patch. I have enclosed a copy of my letter to her GP."

[24] The history set out in this correspondence accords with the short-written note prepared by the first defendant at the time of the consultation.

[25] Neither of the defendants has produced any record whatsoever of the procedure on 21 November 2016. There can be no justification for this failure.

Can the plaintiff establish negligence against the first defendant in respect of the consultation on 20 July 2016?

[26] In answering this question the first issue is whether in fact the first defendant made a diagnosis of SIH on that date.

[27] After the case was opened by Ms Fee on behalf of the plaintiff, the first defendant made an application to amend his defence. The application was strongly opposed by both the plaintiff and the second defendant.

The amendment

[28] Where relevant the original defence served on behalf of the first defendant pleaded at para 7 as follows:

> "…
> (i) The plaintiff attended with the first defendant on 20 July 2016. The first defendant took a detailed history from the plaintiff and made a reasonable and appropriate diagnosis of spontaneous intracranial hypotension. …"

[29] At para 15(b) it is pleaded that:

> "the diagnosis of spontaneous intracranial hypotension was entirely reasonable."

[30] At para 15(g) it is pleaded that:

> "It is inconceivable that there was no communication between the first defendant and the plaintiff with regard to the diagnosis and treatment."

[31] At para 19 the following is pleaded:

> "The first defendant furthermore contends:
>
> …
>
> (b) as a result of the consultation on 20 July 2016, the plaintiff was reasonably diagnosed with spontaneous intracranial hypotension and was transferred to the second defendant for an epidural blood patch."

[32] Subsequently, at para 15 of the defence in which the first defendant denies certain allegations in the statement of claim the following is pleaded at sub-para (d):

> "(d) Denied. The first defendant puts the plaintiff on strict proof of same. In a patient with symptoms suggestive of spontaneous intracranial hypotension, even in the absence of confirmatory evidence or imaging, it is reasonable to undertake a blind epidural blood patch, primarily to treat the plaintiff's spontaneous intercranial hypotension, but it also acts as a diagnostic test as a response to such treatment would help to confirm the diagnosis. Therefore, it was appropriate to consider an epidural blood patch based on the information available on 20 July 2016."

[33] The first defendant sought to amend the defence to plead at para 7(i) that the first defendant made a "reasonable and appropriate diagnosis of symptoms <u>suggestive</u> of spontaneous intercranial hypotension." A similar application was made in respect of the plea at 15(b).

[34] In opposing the application, the plaintiff and the second defendant point to correspondence from the first defendant's solicitors confirming that the defence served on 21 July 2022 had been drafted on "the instructions" of the first defendant. It is clear from any fair reading of the original defence that it was carefully drafted and the court notes that it was settled by a highly experienced and respected senior

counsel. It was suggested in support of the amendment that the omission of the word "suggestive" was a mistake at the time the original defence was drafted.

[35] I confess that I have some difficulty with this suggestion. It was clear from para 15(d) referred to above that counsel was aware of the use of the word "suggestive" in the letter from the first defendant. The original pleading, as approved by the first defendant, could not be clearer in confirming a diagnosis was made. The court was also informed that the amendment was made on the instructions of the first defendant, but it is noted he gave no evidence at the trial.

[36] The amendment is significant. At trial there was a dispute between the parties as to whether in fact the first defendant had made a diagnosis on 20 July 2016. The first defendant's expert, Dr Ellis, Consultant Neurologist, relied on the letter of 20 July 2016 to argue that the first defendant had not made a diagnosis of SIH. This was a view he maintained in his oral evidence although he conceded that he had not had sight of the original defence notwithstanding that it had been drafted on the first defendant's instructions.

[37] After hearing arguments, I agreed to permit the amendment to ensure that all issues were properly before the court. I indicated, however, that the lateness of the amendment and the circumstances in which it was made were matters upon which the parties could comment.

Did the first defendant make a diagnosis on 20 July 2016?

[38] On this issue I have no doubt that the answer is "yes." I say so for the following reasons:

- The original defence drafted with the approval of the first defendant, by an experienced senior counsel, unequivocally accepts that he had made a diagnosis. In the defence he seeks to defend that diagnosis as "reasonable and appropriate."

- The plaintiff has given uncontradicted evidence, which I accept, that she was told without any qualification by the first defendant what her condition was and, importantly, that the treatment he was prescribing would "cure her."

- The actions of the first defendant subsequently supports the contention that a diagnosis had been made. When the plaintiff attended at hospital on 21 November 2016, he proceeded directly to perform the epidural blood patch without further review or discussion.

- At no stage in his notes or correspondence relating to 20 July 2016 examination, is there any suggestion of an alternative diagnosis.

- The first defendant did not arrange for a review appointment after he performed the blood patch. If the purpose of the procedure was to assist in diagnosis, then such a review would have been required.

- If the diagnosis was a "provisional" or "preliminary" one, one would have expected further investigations to see if an invasive procedure was needed.

[39] The first defendant relies on the expert evidence of Dr Ellis to support the suggestion that the first defendant had merely made a provisional or "not definite" diagnosis. In this regard, Dr Ellis relies on the use of the word "suggestive" and the question mark in the handwritten notes. In the court's view, in holding to this position, he ignores the uncontradicted evidence of the plaintiff. He does so in circumstances where he has no account from the first defendant as to what actually occurred on 20 July 2016. He has done so with apparent disregard for the original defence that was served on behalf of the first defendant on his instructions.

[40] I agree with the comment of Dr Patel, Consultant Neurologist, that it is not possible to be absolutely certain about diagnoses and doctors will often write in a language which considers their diagnosis as a differential.

[41] This is illustrated by the approach that Dr Ellis takes when referring to other medical notes and records in this case. For example, he describes Dr Peukert as "diagnosing" the plaintiff with migraine and cervicogenic headache. This is based on a letter from Dr Peukert dated 2 December 2015 in which he says "diagnosis: most likely a combination of migraine and cervicogenic headache, but Chiari malformation and demyelination to exclude" and "my feeling is that this headache is a combination of cervicogenic headache and migraine." Unlike the first defendant in his letter of 21 July 2016, Dr Peukert actually put forward alternative potential differential diagnoses.

[42] In short, I am satisfied that on 20 July 2016, the first defendant had made a diagnosis that the patient suffered from SIH and that arising from this diagnosis he had arranged for the plaintiff to attend for treatment based on that diagnosis, namely an epidural blood patch. As will be seen from the discussion below, the course had been set. This was a treatment plan, not a suggestion.

Was it negligent to diagnose the plaintiff as suffering from SIH on 20 July 2016?

[43] On this issue the plaintiff relied primarily on the expert evidence of Dr Patel (instructed by the plaintiff) and Dr Tyagi, Consultant Neurologist, (instructed on behalf of the second defendant). They gave evidence to the effect that there was no evidence of SIH based on the medical records or history, and no reasonable body of neurologists would have made this diagnosis.

[44] In support of her opinion Dr Patel stated that there were no clear low-pressure features and the symptoms of slight improvement when lying down was in her view typical of migraines. With low pressure headaches, there should be a clear worsening

within five minutes of standing up and then gradual worsening, with complete remission within minutes of lying down. This was not the history presented by the plaintiff.

[45] On behalf of the second defendant Dr Tyagi referred the court to the diagnostic criteria for SIH which had been published prior to 2016, namely the Scheivink 2008 criteria and ICHD-2 published in 2004.

[46] The ICHD-2 criteria are as follows:

A. Diffuse and/or dull headaches that worsen within 15 minutes of either sitting or standing, with at least one of the following and fulfilling criteria D -

(i) Neck stiffness.

(ii) Tinnitus.

(iii) Hypacusia.

(iv) Photophobia.

(v) Nausea.

B. At least one of the following –

(i) Evidence of low CSF pressure on MRI.

(ii) Evidence of CSF leakage on conventional CT myelography or cisternography.

(iii) CSF opening pressure < 60mm H_2O in sitting position.

C. No history of dural puncture or other cause of CS fistula.

D. Headaches resolved within 72 hours after epidural blood patching.

[47] The 2008 Scheivink criteria are as follows:

Criterion A

A demonstration of a spinal CSF leak; or

if criterion A not met:

Criterion B

Cranial MR imaging changes of intercranial hypotension and the presence of at least one of the following:

1. low opening pressure (< 6mm H_2O),

2. spinal meningeal diverticulum, and

3. improvement of symptoms after epidural blood patching;

or if criterion A and B are not met,

Criterion C

The presence of all of the following or at least 2 of the following if typical orthostatic headaches are present:

1. low opening pressure (< 6mm H_2O),

2. spinal meningeal diverticulum,

3. improvement of symptoms after epidural blood patching.

[48] The criteria for the diagnosis of SIH changed in 2018 when ICHD-3 was published. This removed criterion D of ICHD-2 namely that headaches resolve within 72 hours after epidural blood patching.

[49] There was some suggestion on behalf of the first defendant at the trial that a possible purpose of the epidural blood patch carried out in November 2016 was a possible diagnostic test. In light of the court's findings set out above para [38] above, this was not the case here.

[50] There is no evidence that the first defendant worked his way through the criteria described above, nor does it appear that he did so from his notes.

[51] Plainly, the symptoms described by the plaintiff did not meet these criteria. There was no indication of a leak or loss of pressure on earlier MRI. There had been no evidence of the plaintiff's headaches becoming worse after 15 minutes in a sitting or standing response. The headache was not dull or diffuse but one-sided and had not responded to nerve blocks in the past.

[52] Dr Ellis places emphasis on the first defendant's comment that "she finds that lying down helped her symptoms." However, I accept the evidence of Dr Tyagi and Dr Patel that this a common response from a patient suffering migraine headache and it does not distinguish it as being SIH.

[53] The evidence of Dr Tyagi and Dr Patel on this issue was supported by Dr Peukert.

[54] The plaintiff also points to the opinion of Dr Donnelly referred to at para [15] above when he asserted that the plaintiff's "history is not in keeping with a low-pressure headache in any way."

[55] All of the experts agree that a definite diagnosis should not have been made on 20 July 2016. In light of the court's factual findings on this issue, the first defendant's diagnosis, as the court finds it, was negligent and not within an acceptable body of medical practice at that time. This negligent diagnosis was compounded by other actions of the first defendant, these can be summarised as follows:

(a) ***Failure to conduct a neurological examination***

[56] The plaintiff's uncontradicted evidence was that the first defendant did not perform a neurological examination. There are no notes indicating that he did. It is common case between all the experts in the case that a neurological examination ought to have been performed. Such examinations were carried out when Dr Peukert and Dr McCluskey saw the plaintiff as a patient. Dr Peukert told the court that it was important to record negative as well as positive findings as reference points to return to following future examinations. Dr Peukert's evidence, which I accept, was that a neural examination sets a vital baseline for patient diagnosis, care and treatment. Failure to conduct a neural examination falls below what is required of a consultant neurologist. Obviously, the failure to record any examination would also fall below the required standard.

(b) ***Failure to obtain informed consent.***

[57] The plaintiff's evidence was that the first defendant did not explain what the advantages and disadvantages of the blood patch procedure were. He did not warn her that there was a 50% chance of the procedure being unsuccessful. She was not warned of any risks associated with the procedure, of which there are many. He did not discuss the possibility of other less invasive procedures such as an MRI with contrast. She was not given any information leaflet or further information to consider while she awaited the procedure. Dr Ellis identified the risks as:

(i) Immediate pain.
(ii) Low back pain.
(iii) Radicular pain and dysfunction.
(iv) Danger of dural puncture.
(v) Risk of intradural blood.
(vi) Rebound high pressure.
(vii) Risk of failure.

[58] There is a dispute as to when would be the appropriate time to seek consent in respect of the proposed procedure. Dr Bricker, Consultant Anaesthetist, retained by the plaintiff, gave evidence that it is important to commence the consent process at an early stage so that the plaintiff would have time to reflect and make an informed decision. His evidence was that clinicians had developed a practice against seeking consent immediately before a procedure. Dr Patel also supported Dr Bricker on this issue. She did not say that final consent should have been obtained on 20 July, but the plaintiff should have been informed of the procedure, the potential 50% success rate, the risks and give her time to consider her options. Her evidence was that "if you've got time, and it is not an emergency, you approach the subject, they may need time and then another appointment to discuss further, to manage expectations."

[59] The duty on a doctor to gain informed consent from a patient is well-established by the Supreme Court in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, per Lords Reed and Kerr:

> "An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."

[60] Mr Park on behalf of the second defendant referred the court to the useful passage from Green J in the case of *Thefaut v Johnston* [2017] EWHC 497 at para 78:

> "It is also accepted that the brief discussion between Mr Johnston and Mrs Thefaut on 17th May 2012 immediately prior to surgery was not, by itself, sufficient to warn Mrs Thefaut of the risks and benefits. I would make one general observation about this. It is routine for a surgeon immediately prior to surgery to see the patient and to ensure that they remain wedded to the procedure. But this is neither the place nor the occasion for a surgeon for the first time to explain to a patient undergoing elective surgery the relevant risks and benefits. At this point, on the very cusp of the procedure itself, the surgeon is likely to be under considerable pressure of time (to see all

> patients on the list and get to surgery) and the patient is psychologically committed to going ahead. There is a mutual momentum towards surgery which is hard to halt. There is no 'adequate time and space' for a sensible dialogue to occur and for free choice to be exercised."

[61] In light of the court's finding that the first defendant was committed to a course of treatment at the time of the diagnosis on 20 July 2016, it is clear that there has been a complete failure to have any proper dialogue with the plaintiff as to the wisdom of going ahead with the procedure. Quite simply there was no attempt whatsoever to take proper informed consent from the plaintiff.

(c) ***Failure to consider alternative approaches***

[62] Linked to the issue as to whether the first defendant had made a definitive diagnosis in July 2016 is the issue of alternative approaches. Dr Patel said, if the diagnosis was a provisional diagnosis the clinician should consider alternative investigations before carrying out an invasive procedure.

[63] Both Dr Patel and Dr Tyagi said that such investigation should have included an MRI of the brain and spine with contrast, given that the previous one was without contrast. Such a procedure is non-invasive and does not carry the same level of risks as performing a blood patch. All the experts agreed they would have performed an MRI scan with contrast. The only difference was that Dr Ellis indicated that whilst he would have carried out such a scan as part of his own practice in 2016 some neurologists would not.

[64] Ultimately, this issue is not determinative of the allegations of negligence made against the first defendant in relation to the 20 July 2016 consultation. However, I prefer the evidence of Dr Patel and Dr Tyagi on this point.

Was the blood patch procedure carried out within an acceptable body of medical practice?

[65] The only evidence about what occurred during the procedure comes from the plaintiff. There are no notes or records in relation to the procedure. I accept the plaintiff's account of what happened. It is trite to say that the conduct of the first defendant was appalling. This would be clear to any lay person.

[66] In terms of expert evidence on this issue the evidence of Dr Bricker is the most significant in the court's view. He is the only expert from whom the court heard who actually performs this procedure. It is not something normally carried out by neurologists. As Dr Patel confirmed "We have never done that procedure. Never trained on it. It's not part of our experience."

[67] The litany of unacceptable behaviour is outlined in Dr Bricker's report. I summarise these as follows:

(a) There was no reassessment of the plaintiff.

(b) There was no, or any informed consent, obtained.

(c) There was no proper pre-procedure preparation. She remained dressed in her outdoor clothes. This would have made it more difficult to isolate and clean the site of injection with antiseptic solution. She should have been dressed in a hospital gown that allowed ready access to the site of the epidural injection.

(d) The cubicle as described by the plaintiff was an inappropriate area for the performance of an invasive procedure which requires sufficient space to establish two separate sterile fields. It should also have contained resuscitation equipment.

(e) At the very minimum the first defendant should have worn gloves and a mask, dressed in surgical scrubs and be bare below the elbows. The fact that he was otherwise attired in the words of Dr Bricker "represents wholly substandard practice." As he points out this practice risks introducing infection with the formation of an epidural abscess which is a potentially disastrous complication.

(f) The position of the plaintiff during the procedure was substandard. Dr Bricker described the appropriate technique which involves raising the lumbar spine with some form of substantial pillow under the abdomen and then tilting the table into a moderate jack-knife position. The epidural space is identified by using what has been described as the "hanging drop" method. Placing the plaintiff in a prone position has significant disadvantages.

(g) I accept the plaintiff's evidence that the first defendant persisted beyond the plaintiff's complaint of pain and discomfort. I accept that he told her, "a bit more", albeit he did stop finally when she found the procedure intolerable. This is important. As Dr Bricker explained "My view is it is not something you should persist with because of risk of compressive nerve damage. Stop the procedure. You can come back another week, try another space."

(h) The post procedure management was substandard. I accept Dr Bricker's evidence that ideally the patient should remain recumbent for at least one or two hours post procedure. There was no post procedure observation, review or information about follow-up care or what the plaintiff should do in the event of any delayed complications.

Documentation

[68] Dr Bricker explained an epidural blood patch is an invasive procedure with significant risks. Accordingly, a complete record should be dated, timed and signed and would include the following information:

- The names of the practitioners, epiduralist and venesectioner (if applicable).
- Patient position.
- Sterilisation solution (ideally with confirmation that it was allowed to dry).
- Confirmation of separation of sterilising solution and epidural equipment.
- Confirmation of aseptic venesection.
- Local anaesthetic for skin infiltration: drug, concentration and volume.
- The veritable level of injections.
- The type and gauge of needle that was used.
- The technique used for identifying the epidural space.
- The depth at which the space was identified.
- The volume of injected blood.
- Any immediate side effects or none as appropriate.
- Post-procedure instructions.

In particular the lack of any information about the volume of blood inserted or where exactly it was inserted is of significance in the context of the plaintiff's complaint of nerve damage.

As indicated (para [25]) above there can be no justification for the failure to produce any record whatsoever of the procedure on 21 November 2016.

First defendant's expert evidence

[69] In contesting the plaintiff's claim the first defendant primarily relied on the expert evidence of Dr Simon Ellis. He is an eminent and experienced Consultant Neurologist. He has a background in lecturing in neurology for higher medical training. He has been a Consultant Neurologist in the University Hospital of North Staffordshire since 1994.

[70] In relation to the specific issue of SIH his evidence was that there was ongoing debate about the appropriate criteria for diagnosing this condition.

[71] He referred the court to a paper published in January 2023 entitled "Multidisciplinary Consensus Guideline on the Diagnosis and Management of Spontaneous Intracranial Hypotension."

[72] It was prepared after consultations from experts in neurology, neuroradiology, anaesthetics, neurosurgery and patient representatives, including Dr Ellis.

[73] The purpose of the paper was to create a multidisciplinary consensus clinical guideline for best practice in the diagnosis, investigation and management of

spontaneous intracranial hypotension due to cerebrospinal fluid leak based on current evidence and consensus from a multidisciplinary specialist interest group.

[74] Self-evidently that paper was not available in 2016. The paper indicated in relation to criteria that:

> "SIH should be considered in any patient presenting with orthostatic headache (other than following iatrogenic dural puncture or major trauma):
>
> > 'end of the day' or `second half of the day' headache with improvement of the headache on lying flat (as defined below); thunderclap headache which is followed by orthostatic headache; and new daily persistent headache with an initial orthostatic quality. The presentation of associated symptoms (see table 3) should increase the suspicion of SIH.
>
> We recommend a working definition of orthostatic headache as a headache which meets the following criteria:
>
> - Absent or only mild (1-3/10 on verbal rating scale (VRS)) on waking or after prolonged lying flat.
> - The onset of headache occurs within 2 hours of becoming upright.
> - After lying flat, the headache should have a `good' improvement in severity (>50% on VRS) within 2 hours).
> - The timing of headache onset and offset is consistent."

[75] Differential diagnoses of SIH which should be considered included postural tachycardia syndrome (PoTS), orthostatic hypotension, cervicogenic headaches and migraine.

[76] In answer to the question "what first-line investigation(s) should be performed in patients with suspected SIH?" the paper says:

> "Ideally, MRI of the brain with intravenous contrast and an MRI whole spine should be performed as first-line investigations. If not possible to achieve both at the same

> time, MRI of the brain with contrast should be performed as the first-line investigation."

[77] His evidence in relation to the alleged negligence on 20 July 2016, turns on the court's conclusions in relation to whether the first defendant's diagnosis was merely a provisional one. As is apparent from the analysis above the court has concluded that on the facts of this case the first defendant had made a diagnosis that the plaintiff was suffering from SIH and had put in train a treatment plan for that condition. The court finds as a fact that the intended performance of the epidural blood patch was not to be used as a diagnostic tool as is abundantly clear from the failure by the first defendant to arrange for a review after the procedure was performed. Furthermore, that this was a confirmed diagnosis with an intended treatment plan is apparent from the uncontradicted evidence of the plaintiff.

[78] Dr Ellis' evidence was that SIH was a possible diagnosis worthy of consideration was based on the plaintiff's account that lying down helps her headaches and they tended to occur at the end of the day.

[79] It seems to the court that looking at the relevant criteria which existed in 2016 that none of the criteria set out there were met. In this regard the court accepts the evidence of Drs Patel and Tyagi that there was no evidence of SIH based on the medical records and history and no reasonable body of neurologists would have made this diagnosis.

[80] As to whether the first defendant carried out a neurological examination on 20 July 2016 (which all the experts agree should have been performed) Dr Ellis in his report indicates that:

> "There is no recorded neurological examination, though my understanding is that when Dr Watt saw a new patient he would undertake a neurological examination, but only record abnormal findings." (My underlining).

[81] Regrettably, the report does not indicate the basis for this "understanding." Understandably, this was a matter of concern raised by Mr Fee. In the course of the hearing the first defendant provided further discovery which indicated that the basis of that understanding was a letter of instruction from the first defendant's solicitors dated 16 March 2022 which contained the following:

> "Comments on the plaintiff's private treatment
>
> The standard new appointment in the UIC was 30 minutes. Review appointments were 15 minutes in duration. Dr Watt's customary practice was to review a patient's

> electronic care record (giving access to all health service correspondence) prior to an initial attendance.
>
> It was Dr Watt's customary practice to perform a full neurological examination during a patient's first private appointment. Dr Watt's customary practice was not to tend to record any negative findings. Dr Watt elicited a significant amount of clinical information from simply observing patients during the interview, as to how they move, how they talked and when they walked down the corridor when they were leaving (without them being aware) as well as any changes in them."

[82] The court has not seen any statement from the first defendant. He did not give evidence at the trial. This is despite the fact that he approved an amended defence shortly after the case was opened.

[83] The uncontradicted evidence of the plaintiff together with the absence of any record of a neurological examination leads the court to conclude that no such examination took place.

[84] In relation to the performance of the blood patch procedure, there seems little dispute that the plaintiff received an appalling standard of care.

[85] In addressing this standard of care it might be said that Dr Ellis takes an unduly favourable approach in respect of the first defendant.

[86] Thus, when referring to the absence of any records in relation to the procedure carried out on 21 November 2016 he says that:

> "I therefore think it is most likely that such a note has been misplaced."

[87] In relation to whether it was appropriate for the first defendant to carry out this procedure he states:

> "Given my understanding is that Dr Watt had frequently undertaken such procedures previously he would be the necessary person present to undertake the blood patch as he had the skill and experience."

[88] The basis of this "understanding" is unclear.

[89] In relation to the failure to secure written or verbal consent he says:

> "I think it highly unlikely there would not have been a discussion about the procedure and therefore verbal consent would have been obtained."

[90] In similar vein he says that he thinks it is "unlikely" anyone with experience of spontaneous intracranial hypotension would state that a blind lumbar blood patch could be guaranteed to cure the symptoms.

[91] In relation to the clothing worn by the first defendant at the relevant time he thinks it is "highly unlikely" that he would not have worn some protective clothing, particularly gloves. Finally, whilst accepting that he has seen no documentary evidence that would allow him to comment on the plaintiff's assertion that she was not provided with information in relation to follow-up care he says that:

> "It seems highly likely Dr Watt would have provided some advice as to what to do following a blood patch, with the advice to contact his secretary if there are any problems."

[92] All of these comments should be seen in the context that when cross-examined by Mr Fee on behalf of the plaintiff Dr Ellis confirmed that he had provided advice in relation to 30 claims alleging negligence against the first defendant.

[93] He further accepted he was aware as a result of publicity concerning the first defendant in 2017/2018 that the first defendant had been restricted from practice. He was aware that he had been found guilty by a tribunal of medical practitioners of various failings including by way of example failure to take adequate histories and carry out clinical examinations of patients, persistent and repeated failure to make correct diagnoses, inappropriate prescription of drugs with toxic side effects, use of inappropriate criteria for SIH leading to patients receiving unnecessary invasive treatment (epidural blood patches), missing significant clinical signs, poor medical treatment and performing interventions that resulted in life altering and/or life limiting consequences, failure to consider involving specialist colleagues in the management of complex patients and failure to discuss the risks and benefits of treatment of patients to allow them to come to informed decisions and to obtain informed consent.

[94] With this knowledge it seems to the court that this should have influenced the opinions expressed by Dr Ellis in his expert report. I consider that this should have tempered his acceptance of what he was told about the first defendant's "normal practice" and expressing views about what would have been likely or unlikely when assessing the allegations made by the plaintiff.

[95] I have no hesitation in determining that the patch procedure was carried out in a wholly substandard way. The plaintiff clearly establishes negligence in respect thereof.

Causative responsibility between the first and second defendants

[96] It will be apparent from the facts of the case that the first defendant was involved in the care of the plaintiff, firstly in his private capacity on 20 July 2016 and, secondly, in his capacity as an employee of the second defendant on 21 November 2016.

[97] The first defendant's fundamental argument is that when the plaintiff was referred to the care of the second defendant she became its complete responsibility. Mr Ringland submits that everything that happened or should have happened thereafter has no connection with the first defendant in his private capacity.

[98] In support of this argument he points to a handbook published by the Health Service in Northern Ireland in 2007 entitled "Management of Private Practice in Health Service Hospitals in Northern Ireland."

[99] In particular, paras 24-28 deal with "Access to Health Service Facilities and Change of Status."

[100] The relevant paragraphs provide:

> "24. A change of status from private to Health Service must be accompanied by an assessment, by the appropriate consultant, of the patient's clinical priority for treatment as a Health Service patient.
>
> 25. It is important that any private patient who wishes to become a Health Service patient should gain no advantage over other Health Service patients by so doing. This accords with the agreed key principles (see paragraph 14).
>
> 26. Private patients reverting to Health Service status must therefore take the place appropriate to their clinical priority on the waiting list for hospital admission or for diagnostic procedures or for further in-patient or other treatment, as appropriate. This rule must be applied, for example, to private patients who see a consultant privately for an initial consultation – whether in the consultant's private consulting rooms, in the hospital or elsewhere – and who subsequently decide to become Health Service patients, and Trusts will need to be able to identify such patients for monitoring purposes.
>
> 27. It is therefore important that the process of changing patient status is effectively controlled and

> documented as an assurance that the delivery of service is equitable as intended in the key principles at paragraph 14.
>
> 28. A patient seen privately in rooms who then becomes a Health Service patient joins the waiting list at the same point as if his consultation had taken place as a Health Service patient."

[101] The key principles referred to in para 14 relate to HSC consultants and HSC employing organisations working in partnership, to prevent conflicts of interest and to ensure that the provision of services for private patients should not prejudice the interests of HSC patients or disrupt HSC services.

[102] Mr Ringland argues that the requirement to carry out an assessment outlined in para 24 of the Handbook means that the nature and extent of the patient's problem will have to be fully assessed anew with whatever investigations are necessary.

[103] Mr Park, on behalf of the second defendant, argues that the purpose of paras 24 and onwards, is to ensure that someone who was previously a private patient obtains no advantage in terms of priority for treatment, particularly when read with the key principles set out in para 14.

[104] I consider that there is considerable force in Mr Park's submission, but it is not the key to the resolution of this issue.

[105] The weight of the medical evidence from Dr Peukert, Dr Patel and Dr Ellis, is that a review by the Health Service doctor is required, although this was not the experience of Dr Tyagi in relation to his hospital in Glasgow. It seems clear to the court that a review would be necessary before carrying an invasive procedure such as an epidural blood patch, not least because of the passage of time between the referral date and the date upon which the epidural was to be performed.

[106] The fact that the first defendant was the clinician who treated the plaintiff on 21 November 2016 is not necessarily significant as continuity of care is something which is preferable in these circumstances, as confirmed by the experts who give evidence.

[107] In light of the court's findings there can be no dispute that the second defendant is vicariously liable for the conduct of the first defendant on 21 November 2016. The issue to be determined as between the first and second defendants is whether the negligence found by the court in respect of the first defendant acting in a private capacity is in any way causative of the plaintiff's injuries.

[108] As in most aspects of the law, context is key. The answer to this question must lie within the facts of the case.

[109] The thrust of the submissions made on behalf of both the plaintiff and the second defendant is that it is artificial to suggest that the first defendant's responsibility acting in his private capacity ended when he referred the matter to the health service.

[110] On the facts of this case, I am satisfied that a decision to carry out the epidural blood patch was made on 20 July 2016. The treatment plan was in place. The first defendant arranged the transfer of the plaintiff's care to himself in his capacity as an employee of the second defendant. There was no review. He was the only consultant neurologist carrying out this procedure. When the plaintiff attended with the first defendant on 21 November 2016, he proceeded directly to carry out the treatment plan decided on 20 July 2016, based on his negligent misdiagnosis. The course was set on 20 July 2016. In those circumstances, I consider that the causative potency of the negligence of the first defendant on 20 July 2016 to the plaintiff's injuries sustained on 21 November 2016 is strong and compelling.

[111] I do not consider that the court's findings on these facts could have significant ramifications for the transfer of patients between the private sector and the health service here.

[112] It cannot always be the case, as a matter of principle, that the act of transferring a patient from private to health service care should automatically end any established negligence on behalf of the same clinician acting in a private capacity before the transfer. The court must look at the facts of the case and the contribution, if any, the initial negligence has contributed to the harm suffered by the patient. Subsequent negligence on behalf of the health service does not automatically vitiate any negligence on behalf of the clinician acting in his private capacity prior to referral.

[113] The court's factual findings are entirely consistent with the case law in relation to causation and do not support the first defendant's argument that the transfer of the plaintiff to the second defendant constituted a *novus actus interveniens*.

The law on novus actus interveniens

[114] Mr Fee refers the court to relevant principles summarised in Clerk and Lindsell [24th ed] [2-111] which outlines the four issues that need to be addressed on this question:

> "(i) Was the intervening conduct of a third party such as to render the original wrongdoing merely a part of the history of events?

(ii) Was a third party's conduct either deliberate or wholly unreasonable?

(iii) Was the intervention foreseeable?

(iv) Is the conduct of a third party wholly independent of the defendant, ie does the defendant owe the claimant any responsibility for the conduct of that intervening third party.

In practice, in most cases of novus actus more than one of the above issues will have to be considered together."

[115] Preceding these issues Clerk and Lindsell at 2-107 explain:

> "Whatever its form the novus actus must constitute an event of such impact that it "obliterates" the wrongdoing of the defendant."

[116] Further, at 2-108 the authors say:

> "If the defendant was under a duty to prevent the very intervention that occurred, he cannot complain that that intervention broke the causal link, since that would render the duty ineffective."

[117] The performance of the epidural blood patch was the implementation of the treatment plan directed by the first defendant on 20 July 2016. It flowed naturally from his actions on that date. He referred the plaintiff to his own blood patch treatment list, knowing that he was not a consultant anaesthetist, who invariably performs those procedures. I agree with Mr Fee's submissions that the first defendant cannot rely on his own negligent performance of the blood patch, whilst employed by the second defendant, as a novus actus interveniens sufficient to "obliterate" or eclipse his own original wrongdoing.

[118] I adopt the comments of Laws LJ in *Rahman's case* [2021] QB 351, para [28] referred to in *Wright v Cambridge Medical Group* [2003] QB 312 when he said that:

> "Every tortfeasor should compensate the injured claimant in respect of that loss and damage for which he should justly be held responsible."

[119] The decision in *Wright* is of some assistance on this issue. Para [32] of the judgment provides:

> "… In many cases where there are successive acts of negligence by different parties, both parties can be held responsible for the damage which ensues, so that the issue is not which of them is liable, but how liability is to be apportioned between them. The mere fact that, if the second party had not been negligent, the damage which subsequently ensued would not have occurred, by no means automatically exonerates the first party's negligence from being causative of that damage."

[120] At para [36] the court said:

> "36. In the present case, I consider that the defendants' negligence was a causative factor of the claimant's permanent injury. In other words, as in *Rahman's case* [2001] QB 351, para 34, I have concluded that the negligence of the defendants and the failings of the Hospital had 'a synergistic interaction, in that each tends to make the other worse', and accordingly it seems appropriate to proceed on the basis that both were causative of the damage suffered by the claimant."

[121] Ultimately the court is engaged in an evaluative exercise based on all the circumstances. Applying the law to the facts established in this case, I am satisfied that when acting in his private capacity the first defendant's actions had a causative effect on the plaintiff's injuries. That causative effect has not been obliterated by the subsequent negligence of the first defendant when acting on behalf of the second defendant. This is not a case where "the causative potency in relation to the neurological harm suffered was nil" as found by the court in *CAR v Eljamel & NHS Tayside* [2022] CSIH 34, when considering alleged negligence against one of two defendants. Ultimately as per Dr Patel, "the entire pathway followed by Dr Watt" was below the appropriate standard. That pathway cannot be dissected so as to eliminate the first defendant's negligence at the outset.

[122] In light of the court's findings, I am satisfied that the plaintiff has established liability against both defendants on a joint and several basis.

[123] As to apportionment between the first and second defendants, issues having been joined between them, there is no exact science on which to base this assessment. It could be said that the root cause of the plaintiff's injuries was the negligent misdiagnosis of the first defendant acting in his private capacity. The epidural blood patch procedure flowed inevitably from that decision. That said there clearly was a failure on behalf of the second defendant to ensure proper governance (including a lack of review and failure to obtain informed consent) in respect of the first defendant's actions. Furthermore, the negligent performance of the blood patch was

the immediate cause of the harm to the plaintiff, albeit some of that harm would have been caused even if carried out in a proper manner.

[124] Taking all these factors into consideration it seems to the court that the just and fair apportionment between the defendants is a 50/50 split.

Assessment of damages

[125] There are a number of elements to the plaintiff's claim.

Unnecessary procedure

[126] The first relates to the fact that she was subjected to a wholly unnecessary procedure. That in itself entitles her to compensation. This was an invasive procedure and one which was carried out in an appalling fashion.

[127] Even properly performed, in addition to the invasive nature of the procedure, it involves a degree of discomfort for a patient. In this case the plaintiff suffered above and beyond what would normally have been expected in respect of such a procedure. I accept her evidence that it was a distressing, painful and unpleasant experience.

[128] I assess damages in respect of this aspect of the claim at £15,000.

Headaches

[129] The plaintiff's evidence was that as a result of the negligent performance of this procedure she suffers from ongoing headaches and right leg pain.

[130] On this issue, leaving aside for the moment her account, the plaintiff relies on the expert report from Dr Bricker.

[131] In relation to her complaints of headaches, in his written report he says as follows:

> "On 29 November 2016, Ms Norney attended the Accident & Emergency Department at the RVH complaining of a headache which was worse since the blood patch was performed. This headache was not postural and had none of the characteristics of a post-dural puncture headache. However, the injection of blood or fluid into the epidural space can increase the pressure within the skull (the intercranial pressure) by compressing the fluid containing dural sheath which is in continuity with the fluid inside the skull. This increase in pressure may have been enough to have triggered a deterioration in her symptoms and this would have been made more likely had a large volume

> been injected rapidly. The absence of any documentation makes it difficult to draw a definitive conclusion in this regard."

[132] I have no difficulty in accepting that the plaintiff suffered from severe headaches after this procedure. I accept her evidence on this issue.

[133] Her evidence in this regard is strongly supported by the medical notes and records. These confirm that she had been trying to contact the first defendant in the immediate aftermath of the procedure because of headaches. The GP note records:

> "… still having severe headaches, does not feel injection has really helped. Keeps having to leave work because of headaches and states pain keeps getting worse. REQ to speak to GP re pain management for over weekend – I have tried contacting neurology today but cannot get any secretaries."

[134] The note records that the plaintiff complained of "… worsening continuous headaches with nausea and neck stiffness..." He noted that the attendance was four days after the blood patch procedure.

[135] There clearly was no improvement in her symptoms over the weekend and she attended at the A&E Department of the RVH on Monday 29 November 2016. The notes indicate that she continued to complain of headaches (although the notes are difficult to read).

[136] The plaintiff's complaints about headaches must be seen in the context that she was already suffering from chronic headaches prior to the procedure. Indeed, the procedure was performed with a view to resolving those headaches.

[137] The court's conclusion on the issue of headaches is that the plaintiff suffered a short-term worsening of her headaches.

[138] I consider the plaintiff is entitled to modest compensation for this injury and I propose to award her £5,000.

Psychiatric injury

[139] The court received medical reports from Dr Mangan, Consultant Psychiatrist, on behalf of the plaintiff and from Dr Armstrong, Consultant Psychiatrist, on behalf of the second defendant.

[140] Dr Mangan saw the plaintiff on 23 February 2021. He diagnosed mixed anxiety and depressive disorder/adjustment disorder. She told Dr Mangan that she had problems with anxiety 6-7 years ago with problems of insomnia at that time.

[141] Dr Mangan had access to the plaintiff's medical notes and records which confirmed anxiety after a road traffic accident in December 2011. There was a record of an anxiety state after a burglary to her house on 10 February 2016, in respect of which she was prescribed some antidepressants. There were also reports of stress arising from her daytime job in finance at that time. She was reviewed on 7 April 2016. She reported some improvement but still had some emotional symptoms.

[142] In her evidence she was challenged about the extent of disclosure of her medical history. I do not consider that she has been in any way disingenuous on this issue.

[143] In any event, Dr Mangan, an experienced Consultant Psychiatrist, was fully sighted of the plaintiff's detailed medical notes and records.

[144] In his opinion she suffered an exacerbation of her mixed anxiety and depressive order following the blood patch procedure in November 2016. Symptoms included sleep disturbance, inability to relax, tiredness, irritability, reduced confidence and weight gain due to inactivity.

[145] She also was anxious at the time of the neurological patient review which identified the issues concerning the treatment of patients by the first defendant. She suffered a further deterioration in her mental health at this time which Dr Mangan has described as an adjustment disorder.

[146] In light of her ongoing complaints at that time, Dr Mangan indicated the plaintiff would benefit from cognitive behavioural therapy. His opinion was that with the appropriate psychological treatment there should be a significant resolution in her symptoms within the following 12 months.

[147] Dr Armstrong saw the plaintiff on 11 August 2023 by which stage her symptoms had resolved.

[148] At that time her main psychiatric issue related to her fertility. She told Dr Armstrong that she and her partner would like to have children at some point but was advised not to by the first defendant "until he got me fixed." Unfortunately, as a result of her partner's diagnosis with oesophageal cancer, plans have had to be put on hold.

[149] At the time of his examination, Dr Armstrong concluded that there was no evidence of an acute mental disorder.

[150] He recognised that the plaintiff does suffer from stress in her life and that this comes from several sources. He describes that her reactions to the failed neurological intervention are commensurate with how one would expect someone to react to such a situation, but he says it did not constitute an adjustment disorder.

[151] He points to the lack of any note in the medical records in relation to psychiatric issues. Ultimately, he does not deny the impact medical problems have had on the plaintiff's life. He says that there has been a psychological impact, particularly in relation to fertility considerations, but it is not possible to separate the impact of the first defendant's actions from multiple other factors.

[152] Notwithstanding this he does suggest that upon conclusion of this legal process the plaintiff should consider counselling to help her move on from these events.

[153] I have had the benefit of hearing the plaintiff give evidence, during which time she was cross-examined on the medical issues. I am satisfied that Dr Mangan's diagnosis is the correct one. I consider that her symptoms were at their most intense in the six months after the procedure, diminishing thereafter. Residual symptoms are minimal and would not be sufficient to constitute a recognised psychiatric condition.

[154] I consider the appropriate range for damages in respect of the psychiatric injury lies between £10,000 and £15,000.

Pain in the right leg

[155] The plaintiff's case is that since the procedure she has suffered from ongoing pain in her right leg. That pain has had a significant impact on her lifestyle, in particular, her attendance at a gym. This loss of amenity is regarded as very significant by the plaintiff. She explains how in her twenties she engaged in a regular exercise programme to deal with her weight. As a result, she became very interested in fitness programmes and became an enthusiast for gym-based exercise. She undertook coaching courses and obtained qualifications in box-fit coaching, circuits coaching and kettle-bell coaching. She had set up a part-time business with her then partner. She rented premises and led classes in these exercises.

[156] She has not been able to continue this since the blood patch, but the plaintiff has accepted the break-up of the relationship with her partner was the major reason for discontinuance of her business. Nonetheless, she has been unable to enjoy and participate in gym-based activity.

[157] This was perhaps the most difficult aspect of the case to assess. The experts disagreed on the extent of any injury suffered by the plaintiff to her right leg. Dr Ellis took the view that the plaintiff did not come to any harm. Dr Tyagi took the view that she did not suffer from any long-term harm. Dr Patel was of the view that she suffered worsened right arm pain and weakness, dropping things after the blood patch but she was not aware of any long-term harm.

[158] Mr Fee points out, however, that these opinions were based on the medical records and were subject to the plaintiff's evidence.

[159] On this issue the plaintiff relies on the opinion of Dr Bricker.

[160] In his written report Dr Bricker opines:

> "12.7 The pain in the front of her right leg dates from the performance of the blood patch and is likely to be due to irritation or damage to one or more of the lumbar nerve roots which supply sensation to that area (L1, L2 and L3). Given the strong temporal association, it is my opinion that the persistent pain is a direct consequence of the epidural blood patch. Nerve damage by compression is a recognised complication of the procedure (about which Ms Norney was not warned) which is why it is important to inject blood slowly into the epidural space and to stop at the first sign of discomfort. Dr Watt did not so."

[161] Importantly, he excludes issues relating to MRI scans of the plaintiff which reported minor posterior disc bulges at C5, C6 and C7 as being in any way causative of the plaintiff's problems in the lower limb.

[162] In his oral evidence, Dr Bricker stood over his written opinion and indicated that the risk of nerve damage to a patient's leg arose from how the procedure is performed, including the volume of blood injected, where it was injected and with what force. His evidence was that this was "a narrow space, if a large volume of blood is injected potentially under force, this runs the risk of compression damage." His opinion was that the damage was "likely caused by volume of blood, under undue pressure, when warning signs were there, and she asked him to stop."

[163] Dr Bricker's opinion was challenged on the basis that nerve damage by compression was not a recognised complication of the procedure.

[164] It will be seen, however, that the words "neural damage" do appear in the complications list set out in para 4.2 of his report.

[165] It will be noted that Dr Bricker reached his conclusion based on, inter alia, "the strong temporal association" between the procedure and the plaintiff's symptoms. This was a significant issue at the trial. However, in my view, the records do support a temporal association. When she attended at the hospital on the Monday after the procedure, it is recorded that "she is suffering from pain down her right arm and leg at the weekend."

[166] The defendants say that the use of the words "at the weekend" suggest that it was only then that the symptoms developed.

[167] The court is wary of an over reliance on the use of medical notes and records to attack the plaintiff's credibility. The plaintiff's evidence was that she was suffering

from pain in her right leg immediately after the procedure. That pain has to be seen in the context of multiple complaints being made by her. Clearly, given the background here, the focus was always on the fact that she was suffering from headaches. In my view, the fact that the pain was present "at the weekend" does not undermine the plaintiff's evidence on this issue.

[168] Dr Bricker accepted that if the plaintiff's main complaint was headache, then it is not surprising that she continued to focus on it when attending medical practitioners after the procedure. The worsening of those headaches would be her primary focus.

[169] In terms of pain to the right leg, his evidence was that any excruciating pain she suffered at or about the time, was due to the pressure she experienced but that any long-term consequences arise from damage to the nerves. His opinion was that there would typically be an acute period followed by a dull period.

[170] After cross-examination by both the first and second defendants, Dr Bricker stood over his opinion that the ongoing aspects of the plaintiff's leg pain were due to a nerve injury caused at the time of the negligent procedure in November 2016. He accepted that this was based on a temporal relationship between the procedure and the onset of the symptoms.

[171] Both defendants were critical of the fact that despite extensive medical notes and records, the first reference to a complaint to the GP (as opposed to the A&E) about the leg was almost a year after the incident. Dr Bricker's opinion on this was as before, namely that:

> "I think this is explicable in the way patients present to GPs. They present with a primary problem. With more than one, there is no time or capacity. I assume it was not excruciating, the plaintiff's discomfort was secondary to all her other issues."

[172] Mr Ringland specifically drew the court's attention to attendance notes from the plaintiff's solicitor on 14 November 2018:

> "Following this procedure my leg was very painful for a couple of days but gradually returned to normality (ie as whatever was normal for me). It had no effect on my complaints, and everything was just as bad."

[173] In describing her ongoing right leg pain, the following was recorded:

> "The physiotherapist links the pain in the groin to my lower back. An MRI apparently shows bulging discs, but I am not sure whether the pain down the right leg comes

> from this or whether it is a direct result of the epidural blood patch. I should say that I used to have periods of sciatica before the blood patch was done."

[174] It will be noted from the analysis above that Dr Bricker expressly excludes the bulging discs as being causative of the plaintiff's complaints in relation to her right leg.

[175] On a further attendance note dated 9 December 2020, the following is recorded:

> "The initial pain was very painful for a couple of days, but after that I had a tightness which started to move into my right hip and the pain, if I was sitting too long, and the pain moved down the right leg and into my calf which is very tight. What I would describe, and I still have in my calf, is like a continuous pulse going all the time and then from time to time I would impulsive jerks in my leg which are more prevalent at night-time."

[176] It was also recorded that "I do a lot of exercise in the gym, and I have constant tightness at the bottom of my back and in my leg if I do any work at all."

[177] This was only a few weeks after the blood patch. I do not consider the fact that she was doing some exercise in the gym at that time as being in any way inconsistent with her evidence that she is no longer able to carry out such exercises.

[178] There is no doubt from the medical notes and records that the plaintiff suffers from multiple complaints, and these can be difficult to disentangle in terms of the extent to which they might be related to the blood patch procedure.

[179] I do not consider that the plaintiff has been guilty of exaggeration or fabrication of symptomology.

[180] My assessment is that she is someone who genuinely suffers from many ailments and has desperately sought treatment for these. Unfortunately given her experiences she has lost confidence in, and is frustrated with, the medical profession. She has found the sequelae to the blood patch procedure and the consequences of the medical reviews in relation to the first defendant and the litigation process difficult and stressful.

[181] The relevant notes and records relate to the primary issues about which she was complaining when seen and, in my view, it would be unfair to the plaintiff to suggest that she has been exaggerating or fabricating her symptoms.

[182] What the court must do, is to try to make a fair assessment and judgment of the extent to which the plaintiff has suffered pain in her right leg as a result of the blood

patch procedure based on her evidence, the evidence of the experts and the medical notes and records.

[183] Based on all of that, I conclude that the plaintiff has sustained an injury to her right leg. That was initially very painful and has remained as a dull ache ever since. That ache has to be seen in the context of the multiple conditions from which she undoubtedly suffers.

[184] I do not consider that the ongoing issues in her right leg are the primary cause of her disability or her loss of amenity.

[185] I consider that the range for damages for this aspect of the plaintiff's claim is between £15,000 and £20,000.

Other medical issues

[186] The experts have excluded any relationship between the plaintiff's complaints pertaining to the right side of her face and right shoulder to the performance of the blood patch.

Conclusion

[187] I therefore award the plaintiff £50,000 damages, which reflects a mid-range figure for the psychiatric injury and the injury to the right leg. Judgment shall be entered for this amount against both defendants. I determine that the liability as between the defendants is 50% against the first defendant and 50% against the second defendant.