OUTER HOUSE, COURT OF SESSION

[2021] CSOH 130

A448/16

OPINION OF LORD UIST

in the cause

CAROLYN ALMOND-ROOTS

Pursuer

against

MUFTAH SALEM ELJAMEL

First Defender

and

NHS TAYSIDE

Second Defenders

Pursuer: Sutherland QC, T Brown; Thompsons
First Defender: Primrose QC, Watts; The Medical and Dental Defence Union of Scotland
Second Defenders: MacNeill QC, Dundas; NHS Scotland Central Legal Office

21 December 2021

[1] In this action of damages for personal injuries sustained as a result of clinical negligence I granted decree in terms of a joint minute agreed by all parties against the defenders for payment to the pursuer of the sum of £2,810,118 net of any liability that the defenders may have in terms of the Social Security (Recovery of Benefits) Act 1997, with interest thereon at the rate of 8% per annum from the date of decree until payment. I now require to decide the question of apportionment of damages between the two defenders under section 3(1) of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1940 ("the 1940 Act"), which provides

> "where in any action of damages in respect of loss or damage arising from any wrongful acts or negligent acts or omissions two or more persons are, in pursuance of the verdict of a jury or the judgment of a court found jointly and severally liable in damages or expenses, they shall be liable inter se to contribute to such damages or expenses in such proportions as the jury or the court, as the case may be, may deem just."

No evidence was led but the two defenders agreed the following facts by way of joint minute.

The agreed facts

[2] On 4 February 2013 the pursuer attended at the Accident and Emergency Department at Ninewells Hospital, Dundee. She arrived at 08.25. Her presenting complaint was noted to be "Right Leg Pain". She was triaged by Nurse Moira Clark at 08.57 and she was assigned a triage category of = 4. At 09.55 hours she was reviewed by Dr Amy Knighton, who was at that time a GP ST1 grade trainee doctor assigned to the Accident and Emergency Department. Dr Knighton noted that the pursuer was a 45 year old woman suffering from buttock numbness and right posterior thigh pain. Dr Knighton noted the following history from the pursuer (with explanation of her abbreviations being given in square brackets):

> "Increasing pain thru (sic) the night in R posterior thigh + altered sensation in R buttock. This has now spread to L buttock also. No pain in back but has had previous sciatica on R side which was not as severe and had assoc [associated] back pain. No history of trauma. Describes a pain in rectum and that 'wouldn't trust herself'' with regards to bowels – no incontinence as yet but feels an urge. No urinary symptoms. Has taken paracetamol/ibuprofen to little effect.
> PMHx [past medical history] Sciatica. DHx [drug history] nil NKDA [no known drug allergies]. SHx [social history] Independent; production operative."

[3] Dr Knighton carried out an examination of the pursuer. She made the following record of the examination in the pursuer's medical records (with explanation of her abbreviations being given in square brackets):

> "o/e [on examination] lower limbs – power/ sensation and tone N [normal] reflexes - patellar ↓ [reduced] ankles N [normal]. good ROM [range of movement] from back, back pain exacerbated on L lateral {illegible} anterior/ posterior {illegible}. Pain also exacerbated on SLR [straight leg raise]. Altered sensation over buttocks + perianally – R side > [greater than] left side. ↓ [reduced] anal tone – didn't feel she could squeeze my finger".

[4] ANP Weaver carried out a neurological examination of the pursuer's legs. She measured the pursuer's straight leg raise at 50 degrees and limited by pain on the right-hand side and 60 degrees with pain to the right side on straight leg raise to the left side. Tone was normal on both sides. Power was as follows:

Right side

Hip flexion 5/5

Hip extension 5/5

Knee Flexion 4/5

Knee extension 4/5

Ankle dorsiflexion 5/5

Ankle plantar flexion 5/5

Left side

Hip flexion 5/5

Hip extension 5/5

Knee flexion 5/5

Knee extension 5/5

Ankle dorsiflexion 5/5

Ankle plantar flexion 5/5.

[5] ANP Weaver checked the pursuer's reflexes and found them to be normal. She examined the pursuer's sensation and recorded increased sensitivity in the S1 and S2

dermatomes on the right-hand side and increased sensitivity in the S1 dermatome on the left-hand side. She documented her treatment plan as follows:

> "not for urgent admission to neurosurgery. GP to optimise analgesia including pregabalin 75mg BD. Refer for neurosurgical consult through RMS [Records Management System]. MRI scan as outpatient organised by neurosurgery. GP to follow up also."

That note was revised after she spoke to the first defender and records her ultimate plan.

[6] ANP Weaver wanted to admit the pursuer to neurosurgery. She was not allowed to admit patients without first discussing them with a consultant. She went to speak to the first defender to discuss admission. She provided the first defender with the clinical history and details of her examination. She told him that the pursuer had undergone a rectal examination and was unable to squeeze the examining finger. The first defender told her that the pursuer did not have cauda equina syndrome and so was not for urgent admission. She therefore made a visible alteration in her handwritten note, writing "not for urgent admission" in place of the note that she had written before speaking to the first defender. She initiated arrangements for the pursuer to undergo an outpatient MRI scan. In her request she did not specify that the scan required to be done urgently. No follow-up in or by the Neurosurgery Department was arranged. It was noted that an outpatient MRI scan had been organised. The pursuer's GP was requested to optimise her analgesia and to start the pursuer on pregablin. The pursuer was to be referred to neurosurgery if appropriate. The pursuer was discharged home from the Accident and Emergency Department at Ninewells hospital by Dr Amy Knighton. She left the department at 12.27. She was given a prescription for co-codamol [a drug intended for pain relief containing paracetamol and codeine] on departure.

[7] The first defender was acting in the course of his employment as a consultant neurosurgeon with the second defenders on 4 February 2013. On that date ANP Weaver was acting in the course of her employment as an advanced nurse practitioner with the second defenders. The second defenders are vicariously liable for their acts and omissions on that occasion, along with the acts and omissions of their other employees.

[8] The MRI scan was undertaken at Ninewells Hospital on 20 February 2013. The second defenders' radiologist reported the scan as showing *inter alia* (a) between lumbar discs 3 and 4 a left paracentral disc protrusion which along with facet joint hypertrophy resulted in severe central canal and left lateral stenosis; (b) between lumbar discs 4 and 5 a very large central disc prolapse compressing the thecal sac and causing severe central canal stenosis. The radiologist noted that it appeared the pursuer had clinical cauda equina syndrome. No action was taken by the second defenders' employees in response to the scan report. The MRI scan should, in light of the pursuer's presentation at Ninewells Hospital on 4 February 2013, have been arranged on an urgent basis, to be undertaken within 48 hours. The second defenders' staff were negligent in not arranging an MRI scan within that period of time. Had an MRI scan been obtained within 48 hours of the pursuer's presentation at Ninewells Hospital on 4 February 2013 the result of the scan would have been the same as the result of the scan on 20 February 2013. Had an MRI scan been undertaken within 48 hours of the pursuer's presentation at Ninewells Hospital on 4 February 2013 the pursuer, because of the result of the scan, would have undergone spinal decompression surgery at Ninewells Hospital no later than 7 February 2013. Had spinal decompression surgery been undertaken at Ninewells Hospital no later than 7 February 2013, and had that surgery been undertaken with the skill and care of a neurosurgeon of ordinary competence exercising reasonable skill and care, the pursuer's radicular pain would have improved; bladder and

bowel function would have been normal; there would have been some impairment of perianal sensation in the long term with reduced sexual sensation; motor power would have been normal; there would have been no lower limb cramp; there would have been normal balance; and there would have been long-term reduced sensation in the S1 dermatomes and the right S2 dermatome, albeit of no functional significance. She would not have suffered complete cauda equina syndrome. Had the notional surgery not been undertaken by a surgeon of reasonable skill and care exercising reasonable skill and care the second defenders would have been vicariously liable therefor. If the pursuer had elected to undergo earlier surgery privately (i.e. not at Ninewells Hospital) and that surgery was not undertaken by a surgeon of reasonable skill and care exercising reasonable skill and care, the second defenders would not have been liable therefor.

[9] The result of the MRI scan came to the attention of the pursuer's GP, Dr Dawn Dorward, on or about 1 March 2013. The GP telephoned the Neurosurgery Department at Ninewells Hospital on 1 March 2013 and reported her understanding that the MRI scan result showed cauda equina syndrome. She further advised that the pursuer was now seeking private medical care. She referred the pursuer to the first defender on 1 March 2013. The referral was sent to the BMI Fernbrae Hospital, Dundee, where the first defender had practising privileges. It was noted on the referral *inter alia* that:

> "the patient's symptoms are currently numbness in her right leg with back pain. She also has numbness in her right groin. She is now beginning to feel numb in her left leg. She has saddle paraesthesia, is able to pass urine normally and has been constipated due to the opiates she has been on but this is manageable with laxido. She has had no incontinence of stool or retention of urine".

[10] The first defender saw the pursuer in the outpatient department at the BMI Fernbrae Hospital, Dundee on 19 March 2013 at 18.00. That hospital is no longer in operation but was, at that time, a private hospital. The second defenders have no responsibility for the

acts and omissions of the first defender while he was providing private medical care to the pursuer at that hospital. The first defender wrote to the pursuer's GP, Dr Simone Killick, on 19 March 2013 advising *inter alia* that he had consulted with the pursuer at his outpatient clinic and he had discussed with her the possibility of undergoing a microdiscectomy. He noted that the pursuer had no urinary symptoms but that she did have root tension signs.

[11] The pursuer attended a pre-admission clinic at BMI Fernbrae Hospital on 5 April 2013. It was noted that she was experiencing constant pain in her lower back which was dulled by pain relief, that she was constipated and using laxido for constipation, that she had no genitourinary symptoms and no problems with micturition.

[12] Between 4 February 2013 and 16 April 2013 there was no major deterioration in the pursuer's neurological condition, which remained stable.

[13] The pursuer was admitted to the BMI Fernbrae Hospital on 16 April 2013 and there underwent a lumbar microdiscectomy which was performed by the first defender. During the operation it is likely that nerve root avulsion/stretching/division occurred. There may have been a leak of cerebrospinal fluid due to breach of the dura. All of the pursuer's new neurological deficits appeared during and after the operation on 16 April 2013.

[14] The surgery performed on the pursuer by the first defender on 16 April 2013 was undertaken negligently by him, as a result of which the pursuer suffered nerve root damage, all in the following respects:

(a) Fault. The first defender negligently performed only left unilateral small microdiscectomy-type fenestration with minimal undercutting of the facet joints at both lumbar disc space levels L3/4 and L4/5. A wider bilateral fenestration should have been undertaken by him at the level of lumbar disc space L4/5.

(b) Fault. The first defender negligently failed by his surgery to achieve effective decompression of the nerves and discectomy at either L3/4 or L4/5, thereby failing to achieve the purpose of the surgery. After the surgery (as demonstrated on MRI Scan on 19 April 2013) the nerve roots at those levels remained clumped with no cerebrospinal fluid around them. Their appearance remained essentially unchanged from that shown on the MRI scan taken on 20 February 2013.

(c) Injury. During the procedure nerve root injury in the form of avulsion and/or division and/or stretching occurred. In the absence of adequate surgical decompression of the nerves there would then be little or no space to accommodate post-operative swelling or haematoma resulting from the nerve root injury. As a result the pursuer post-operatively developed complete cauda equina syndrome. All of her new neurological deficits occurred during and after the operation of 16 April 2013.

(d) Differential outcome. Had the surgery been undertaken with the skill and care of a neurosurgeon of ordinary competence exercising reasonable skill and care the pursuer's radicular pain would have improved; bladder and bowel function would have been normal; there would have been some impairment of perianal sensation in the long term with reduced sexual sensation; motor power would have been normal; there would be no lower limb cramp; there would be normal balance; and there would have been long-term reduced sensation in the S1 dermatomes and the right S2 dermatome, albeit of no functional significance. She would not have suffered her complete cauda equina syndrome.

Post-operatively the pursuer's condition deteriorated while she remained a patient in BMI Fernbrae Hospital. At around 17.00 hours on 16 April 2013 she developed bladder and

bowel symptoms. She developed symptoms of numbness in both legs and in her groin. It was noted that the first defender was aware of her symptoms. By 20.00 hours she was still complaining of numbness to the legs and groin area. The first defender that day prescribed steroids and pregabalin for her. These are not standard medications for pain after spinal surgery but can be prescribed when nerve root damage has been caused and is likely to cause nerve pain. In the exercise of reasonable skill and care the first defender required to arrange investigation of these symptoms by means of emergency MRI scan of the pursuer's lumbar spine at around 17.00 hours on 16 April 2013.

[15] On 17 April 2013 at 07.00 hours it was noted that the pursuer had less numbness in her legs that morning but that numbness persisted in the pelvic area. She had passed urine. At 09.00 hours it was noted that she had paraesthesia at both gluteal areas and her groin, was feeling the desire to pass urine and had no feeling when opening her bowels. At 11.00 hours it was noted that she was again having trouble with numbness in her legs, trouble with bladder and bowel control and saddle anaesthesia. It was noted that the first defender was aware of these symptoms and was due to see her. At 13.00 hours she was noted to have numbness in her legs and groin. She was passing frequent small amounts of urine. She was reviewed by the first defender at 15.30 hours. It was noted that he would see her again the following morning. By 17.00 hours it was noted that she was very upset and incontinent of urine. By 19.30 hours there had been no change in numbness. She was catheterised at the suggestion of the first defender. At 23.00 hours it was noted that the catheter was draining well but that a pad and pants were in situ as she had little confidence in her bowels due to unawareness of any sensation. On 18 April 2013 it was noted that she remained anxious about her bowels moving. She had a feeling of fullness but was numb and had no sensation. She was reviewed by the first defender at or about 13.00 hours and it

was noted that she was to stay for one more night before being discharged with a catheter *in situ*. At 21.00 hours it was noted that, although she was comfortable, she continued to lack any sensation in her bowel.

[16] BMI Fernbrae Hospital did not have an MRI scanner and the necessary arrangements for a scan had to be made with Ninewells Hospital. On 19 April 2013 the pursuer was discharged by the first defender from BMI Fernbrae Hospital and underwent an MRI scan at Ninewells Hospital. The MRI scan showed the appearances at L3/4 and L4/5 to be essentially unchanged since the MRI scan of 20 February 2013, indicating that revision surgery was required. As a result the pursuer was admitted to the Neurosurgery Department at Ninewells Hospital, Dundee at 22.10 hours on 19 April 2013. She underwent lumbar disc revision surgery, which was performed by the first defender in his capacity as an employee of the second defenders, there on 20 April 2013.

[17] The first defender was negligent in failing to organise an emergency MRI scan and emergency revision surgery at around 17.00 hours on 16 April 2013. With revisional surgery on 16 April 2013 any immediate damage exhibited after surgery would not have improved but the pursuer would now have less bladder and bowel dysfunction than currently although it would not be completely normal.

[18] On 19 April 2013 the pursuer presented at Ninewells Hospital in order to undergo an MRI scan, but by that time her condition was irreversible. Following upon her scan she was clerked in as an emergency admission by the ward doctors at 22.10 hours. The presenting complaint was recorded as frequency/faecal incontinence/left leg numb. It was noted *inter alia* that she had frequency of urinary, faecal incontinence and perianal numbness. She was discharged home from Ninewells Hospital on 7 May 2013.

Submission for the first defender

[19] The submission for the first defender began by pointing out that the second defenders had elected not to take a plea of *novus actus interveniens*. It would have been open to them to seek to establish through pleadings and evidence that the actions of the first defender in April 2013 were such as to break the chain of causation between events in February 2013 and the harm ultimately sustained by the pursuer. It followed that they were held to be taken to accept that damages fell to be apportioned between them and the first defender. They had attempted to amend their pleadings in May 2021. The proposed Minute of Amendment introduced an argument to the effect that the wrongs of the first and second defenders were separate and distinct and thus that the pursuer's conclusion for joint and several liability was incompetent. The motion was refused by Lady Wise. There was concern on the part of the pursuer and the first defender that the second defenders were attempting to introduce a plea of *novus actus interveniens* via the back door. In refusing the motion to amend Lady Wise stated in terms that the pled position of the second defenders was one of apportionment of damages, and not of a break in the chain of causation.

[20] Section 3(1) of the 1940 Act gives the court a broad and unfettered discretion in relation to questions of apportionment. The court was required to do what it deemed just in the whole circumstances of a particular case. The authorities indicate that, in considering what would be a just outcome, the court should have regard to the moral blameworthiness of the wrongdoers and the causative potency of their respective acts or omissions. The exercise was a very fact-specific one, and the approach to apportionment will differ depending on the facts and circumstances of individual cases.

[21] The second defenders admitted that in failing to arrange for an urgent MRI scan to be performed within 48 hours of the pursuer's attendance on 4 February 2013 their staff

were negligent. They agreed that if the MRI scan had been performed, as it should have been, the result would have been that the pursuer would have undergone spinal decompression surgery at Ninewells Hospital no later than 7 February 2013. They admitted that had that surgery been undertaken by a neurosurgeon of ordinary competence acting with reasonable skill and care the pursuer would essentially have recovered without any of the long-term sequelae from which she now suffers. She was entitled to the benefit of the presumption that the surgery which ought to have taken place would have been performed competently: *Wright* v *Cambridge Medical Group (CA)* [2013] QB 312 at paragraph [75]. Had it been, the overwhelming majority of the pursuer's current problems would have been avoided. Accordingly, the agreed position was that the second defenders negligently failed in their management of the pursuer. Absent this failure, she would have been promptly diagnosed and operated on and would have been left with reduced pain, normal bladder and bowel function, no problems with cramp, no balance difficulties and no complete cauda equina syndrome. In addition, she would have been spared the additional pain and suffering which arose from her condition being left untreated between 7 February 2013 and her eventual surgery on 16 April 2013.

[22] Instead of undergoing the surgery in early February 2013, as she ought to have done, the pursuer underwent a routine MRI scan on 20 February 2013 and when the results were received she sought a private referral in the hope of securing earlier treatment (which by that point she ought already to have had). She thereby came to be a patient of Mr Eljamel at the BMI Fernbrae Hospital. After an outpatient consultation she elected to proceed with surgery which she underwent on 16 April 2013. The first defender accepted that the surgery which she underwent on 16 April 2013 was negligently performed by him and that had he performed the surgery to the correct standard the pursuer would not have suffered her

complete cauda equina syndrome and would have been left with comparatively minor deficits. It was also accepted that the first defender did not respond adequately to the pursuer's post-operative symptoms and should have organised an emergency MRI scan and emergency revision surgery after the pursuer's condition deteriorated at 17.00 hours on 16 April 2013. It was also agreed that this failure would not have avoided the immediate damage which was apparent after the surgery.

[23] Recent guidance on the approach which the court should take in determining a just outcome on the question of apportionment was provided in *Widdowson's Executrix* v *Liberty Insurance Limited* 2021 SLT 539. The first defender endorsed the approach taken by the court in that case and submitted that the same analysis should be applied in the present case. Mr Widdowson died as a result of injuries sustained in a road traffic accident. His next of kin sued the driver who had caused the accident (by driving at excessive speed, losing control and crossing the carriageway into the path of Mr Widdowson's oncoming vehicle). The insurers of the driver at fault served third party notices on both NHS Grampian and NHS Highland. Mr Widdowson had attended at Dr Gray's Hospital in Elgin (for which NHS Grampian were responsible) in the immediate aftermath of the collision. He was kept there overnight for observation and discharged the following day. After his return home his condition deteriorated and he was admitted to Raigmore Hospital in Inverness (for which NHS Highland was responsible) where his internal injury was diagnosed following a CT scan but where the treating surgeons elected to manage his presentation conservatively. He subsequently died. There were a number of similarities between *Widdowson* and the present case. If the first medical team had identified the internal injury which Mr Widdowson had sustained in the accident and treated it (as they should have done) when he was admitted to Dr Gray's Hospital the negligent treatment he received at Raigmore Hospital would never

have taken place as his condition would already have been dealt with by that point. The same analysis applied here. An appropriate response by the second defenders in February 2013 would have prevented the events of April 2013 from happening and avoided the harm the pursuer ultimately suffered.

[24] At paragraph [45] in *Widdowson* Lady Wise summarised the exercise which the court had to undertake when assessing the relative contributions that should be made by different defenders. It was agreed by counsel for all three defenders in that case that the correct approach was as set down by Hobhouse LJ in *Downs* v *Chappell* [1997] 1 WLR 426 at p445. At paragraph [46] Lady Wise made reference to the Supreme Court case of *Jackson* v *Murray* [2015] UKSC 5 in which there had been discussion of the concepts of relative blameworthiness and causal potency in assessing apportionment, although she drew a distinction between the exercise of deciding an apportionment of liability between defenders and the exercise of deciding what proportion of blame a pursuer ought to bear in respect of contributory negligence. At paragraph [47] she held that issues of relative blameworthiness and causal effect were essentially matters of fact, direct or inferred. It was a matter of agreement between the first defender and the second defenders in the present case that they were both responsible for negligent treatment of the pursuer.

[25] At paragraph [50] in *Widdowson* reference was made to the submission from the third defenders about the difference between acts and omissions. The second defenders in the present case were attempting to draw a distinction between negligent acts (making things worse) and negligent omissions (not making things better) and suggested that the former was of greater causal potency than the latter. In the context of the present litigation that analysis was flawed. It was an artificial distinction and had no place in the context of a clinical negligence claim where doctors can be held liable for both negligent acts and

negligent omissions. An omission in a clinical negligence claim could cause harm or even death just as much as a negligent act.

[26] The case of *Poole Borough Council* v *GN* [2020] AC 780 was referred to at paragraph [50] in *Widdowson.* That was not a case about apportionment of liability but about whether a duty of care arose out of the statutory powers and duties of the local authority under the Children Act 1989 to safeguard and promote the welfare of children. The Act provided duties and powers to enable the local authority to discharge those functions. The question was whether the local authority could be liable at common law for a breach of duty of care in relation to the performance of its functions under the Act. The passage from the case quoted in *Widdowson* referred to there being a distinction between acts and omissions because, in general, public bodies did not owe a duty to fail to confer benefits (not making things better). That distinction did not apply in circumstances where the public body had either created the source of the harm or, as in the present case, assumed responsibility to protect the claimant from harm. Thus, while there may be a distinction between acts and omissions for the purpose of deciding whether there can be legal liability in certain circumstances, that did not mean that omissions were always of less causal potency than negligent acts, particularly in the context of a clinical negligence claim. All such considerations were fact-specific.

[27] In any event both instances of negligence, the negligence in February 2013 on the part of the second defenders to arrange a scan and to operate, and the negligent execution of the operation in April 2013, were properly characterised as omissions. The failure of the first defender at the BMI Fernbrae Hospital was a failure to carry out the operation with the requisite degree of skill and care. The pursuer in article 8 of condescendence characterised the acts of negligence which occurred during the operation on 16 April 2013 as failings, in

that the first defender "failed to decompress the disc at L4/5" and pleaded that "this failure was the reason that the pursuer suffered from cauda equina syndrome post-operatively and now has permanent symptoms." In *Widdowson* a distinction was drawn between acts and omissions because those responsible for the latter bore much less share of the blame and the positive act of the car driver was "by far the more culpable" (paras [60] and [61]). When the first defender carried out the operation in this case he did not cause the disc prolapse: what he did was to fail to perform the operation correctly to alleviate the prolapse and avoid the cauda equina syndrome.

[28] The second defenders' approach to the question of causation in this case was erroneous. They sought to argue that they should be entitled to a 0% apportionment on the basis that the failure to scan the pursuer and carry out an urgent operation, which should have happened had the scan been done, did not cause the pursuer any loss or damage. This could not possibly be correct. First, it disregarded their sole responsibility for the pain and suffering the purser endured between February 2013 when she should have been successfully operated on by the second defenders and April 2013 when she eventually sought private surgery from the first defender. Secondly, it was a matter of agreement that had the first act of negligence not occurred (a failure to scan and thereafter arrange for an urgent operation) the pursuer would have been treated and she would not have undergone the subsequent negligently performed operation. In these circumstances it was clear that the first act of negligence had a part to play in the occurrence of the second, and had a causative effect. To put matters in the traditional language of causation, "but for" the first act the second would not have occurred. The second defenders should therefore clearly be liable to some extent.

[29] A similar approach to the causative effect of a first tort, even in the absence as a defendant of the hospital which committed the second tort, was taken by the Court of Appeal in *Wright* v *Cambridge Medical Group (a Partnership)* [2013] QB 312. Elias LJ at p336, paragraph [89] summarised the facts as follows:

> "To summarise the essential features in a nutshell, the claimant ought to have been referred by her doctor on the Wednesday; in fact, she was referred on the Friday evening. Had appropriate steps been taken by the hospital at that time, the permanent damage to the hip would have been avoided. However, she was not given the appropriate antibiotics and by the Sunday it was probably too late. Accordingly, by the time the consultant saw the patient on the Monday, nothing could be done to prevent the permanent injury."

The defendants contended that they could not be held liable for the permanent damage caused by the failure of the hospital to identify the "super infection" and that their liability was limited to the loss suffered by the delay in referral (para [29]). Lord Neuberger analysed why the defendants' argument that they could not be liable for the effects of the subsequent wrong committed by the hospital was wrong as follows:

> "**29** The defendants' case under this head is that their duty as the claimant's general practitioners was to refer her to a hospital to enable her condition to be properly treated. They accept that they should be liable for having failed to refer the claimant when they should have done, but they contend that they complied with their duty by referring her on 17 April, which was well in time to have her hip condition remedied: it was only because of the hospital's negligence after 17 April that the condition was not remedied. In other words, the argument is that the defendants' breach of duty was in having referred the claimant to the hospital later than they should have done, but not too late to be treated, and that, as a result, the damages she should recover from the defendants should be for the loss she suffered from having been referred later than she should have been, not for having been referred too late for her condition to have been remedied.
>
> **30** It seems to me that this argument raises two questions. The first is whether, on a fair view of the facts, the defendants' negligence was a cause of, or, to put it another way, significantly contributed to, the claimant's permanent injury. The second question is whether that injury was, to use the traditional expression, too remote, or, to put it in more modern terms, whether that injury fell outside the scope of the defendants' duty. I shall consider these two questions in turn, although I think that the reasoning on the first question also has a part to play when discussing the second.

> **31** So far as causation is concerned, although it may very well have been that, had it been a party, the hospital would have been held to be more to blame than the defendants, I would reject the contention that the defendants' admitted negligence did not contribute to the claimant's permanent injury. The defendants' case to the contrary, as summarised in para 29 above, has obvious attraction. However, it should be examined critically, because of the obvious point that, where there are successive tortfeasors, it cannot be right that each can avoid liability by blaming the other.
> **32** Accordingly, where there are successive tortfeasors, the contention that the causative potency of the negligence of the first is destroyed by the subsequent negligence of the second depends very much on the facts of the particular case. 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. As Lord Denning MR said in *Lloyds Bank Ltd v Budd* [1982] RTR 80, 83 'the doctrine of last opportunity is gone forever'."

In the present case the causative potency of the initial act of negligence committed by the first defender while in the employment of the second defenders cannot be said to have been eclipsed by his negligence at the BMI Fernbrae Hospital. Had the pursuer had an MRI scan and then been referred for an operation in February she would have been left with little in the way of permanent *sequelae* and would still have been able to lead a normal life. Instead the scan was delayed and when it did come it was followed by the negligent operation. Accordingly, the failure to scan and to operate at an earlier stage and the negligent operation were both causative of the damage to the pursuer. Had the negligence of the first defender not occurred while he was acting in the course of his employment with the second defenders there would have been no subsequent operation. As in *Wright* there was a presumption that, had the pursuer been referred earlier, she would have received competent and appropriate treatment.

[30] There was a further reason why the court should not accept the proposition that the second defenders' liability should be apportioned at nil. The 1940 Act allowed the court to apportion liability between joint wrongdoers according to the proportions which it deemed just. If only the second defenders had been sued, and an attempt had been made to hold the first defender liable for all of the loss occasioned by the pursuer as a result of the initial failure to refer for an MRI scan he could not have argued that he should not be found liable in respect of his negligent omission on 4 February 2013 on the basis that, even if he had not committed that breach the damage would have occurred anyway because he would have committed the subsequent breach of duty while acting as a private consultant at the BMI Fernbrae Hospital. Such a possibility was explicitly rejected by Lord Browne-Wilkinson in *Bolitho* v *City & Hackney Health Authority* [1998] AC 232 at p240 and in *Wright*

Lord Neuberger affirmed what he described as the "generally accepted proposition" and sought to explain its basis at paragraphs 56 to 58 and 61. That being so, it was not just that in a situation where the second defenders have been convened in the action they can argue that they should have no responsibility for the damage suffered by the pursuer and that the first defender's acts while in their employment should be viewed as of no causal significance. This was particularly so because in this case, unlike that of *Wright*, both acts of negligence were, very unusually, committed by the same surgeon. It would not be "just and equitable" to allow the second defenders to escape liability for the first wrong committed by the first defender on the basis that he then went on to commit a further wrong in his private practice. He should not be allowed to profit from his earlier wrongdoing in this manner.

[31] Furthermore, to allow the second defenders to escape liability in the circumstances of this case would, as Lord Neuberger put it at paragraph 46 of *Wright* "involve resurrecting the discredited last opportunity doctrine". As he mentioned at paragraph 32, 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. The attempt by the second defenders to rely on cases such as *Brian Warwicker Partnership Plc* v *HOK International Limited* [2005] EWCA Civ 962, Arden LJ at paragraphs 42 and 45 and *McEwan* v *Lothian Buses plc* 2006 SCLR 592 at paragraphs 32-34 was not helpful. The ratio of these cases is that non-causative factors count for little in the assessment of apportionment. That reasoning did not apply in the present case because there was significant causal potency in the first act of negligence by the first defender, namely, the failure to carry out an urgent scan which would have resulted in the performance of an operation which would have allowed the pursuer to live what would have been, to all intents and purposes, a normal life.

[32] Moreover, there was a significant element of moral blameworthiness attached to the failings of the first defender on the morning of 4 February 2013 when he refused to admit the pursuer or send her for an urgent scan. That morning the pursuer was seen at Ninewells Hospital by a junior doctor, Dr Knighton, who felt it necessary to discuss her condition with a senior colleague, Dr Tonge. There was then a recognition that the pursuer's presenting complaints merited a discussion with the neurosurgery department and she was seen by Neurosurgery Advanced Nurse Practitioner Weaver. It could be taken that ANP Weaver had specialist knowledge of, and experience in, neurosurgery. She carried out a full examination of the pursuer and formed the view that she was suffering from lumbar radiculopathy. She wished to admit the pursuer to neurosurgery and provided the first defender with the clinical history and details of her examination. The first defender, despite the fact that he had not even examined the pursuer, told ANP Weaver that the pursuer did not have cauda equina syndrome and that she was not a case for urgent admission. He

made a decision without reviewing the patient and in the face of a request for admission from an Advanced Nurse Practitioner who herself carried out a detailed examination. An urgent scan was not arranged, nor was any follow-up organised. It was admitted that had the scan been undertaken as it ought to have been within 48 hours of the pursuer's presentation at Ninewells Hospital it would have shown the presence of cauda equina syndrome and that spinal decompression would have followed.

[33] Significant moral blameworthiness should be attached to the first defender's failure even to examine the pursuer, to seemingly dismiss the concerns of an experienced Advanced Nurse Practitioner out of hand and then to fail to ensure that an urgent MRI scan took place. Simply to tell ANP Weaver that the pursuer did not have cauda equina syndrome without he himself having carried out an examination, while seemingly recognising that this was a possible diagnosis and while, as a consultant neurosurgeon, being well aware of the potential for catastrophic long-term effects from such a condition was quite simply reckless. This conduct was equally as "morally reprehensible" (to use the language of the second defenders) as the subsequent failure to arrange a further MRI scan in light of his knowledge of an intra-operative injury.

[34] In *Jackson* v *Murray* 2015 SC (UKSC) 105 the Supreme Court held as follows at paragraph 28 (in a case relating to contributory negligence rather than failings by multiple defenders):

> "It follows that apportionment of responsibility is inevitably a somewhat rough and ready exercise (a feature reflected in the judicial preference for round figures), and that a variety of possible answers can legitimately be given. This is consistent with the requirement … to arrive at a result which the court considers 'just and equitable'."

In this case the pursuer was badly served by successive medical teams and suffered injury as a result. The second defenders failed to arrange for an urgent MRI scan despite the fact that

a specialist neurosurgery Advanced Nurse Practitioner was so concerned about the pursuer that she felt she should be admitted to the neurosurgery ward as an emergency. In addition to the failure to arrange a scan within 48 hours there was also a failure to arrange emergency neurosurgery following upon receipt of the result of the scan. But for these failures the pursuer would not have suffered most of the loss complained of in the present action. Because of these failures, and because of the negligently inadequate response of the second defenders to the pursuer's presentation in February 2013, the pursuer ended up seeking private treatment with a view to trying to expedite her recovery. Absent the failures of the second defenders she would never have been in the position of requiring to seek private treatment. Admittedly, the treatment she was provided with on a private basis by the first defender was also negligent, both in terms of the performance of the surgery and the reaction to her symptomatology after the operation was complete, but the critical causative role played by the second defenders in her ending up on the operating table at BMI Fernbrae Hospital in April 2013 could not simply be disregarded.

[35] In cases where the court found itself unable to apportion damages between different defenders with reasonable precision the authority suggested that the burden should simply be shared equally: *Drew* v *Western SMT Co Ltd* 1947 SC 222, referred to in *Widdowson* at p553. Ultimately this was the approach which Lady Wise took in the *Widdowson* case. There was detailed medical evidence about the relative blameworthiness of the two health boards. The circumstances were very much analogous with those of the present case. The deceased required surgery. The first health board failed to identify the necessity for surgery to be performed and arrange for it to be carried out. The second health board was aware of the injury, having performed a CT scan, but negligent in their treatment of it. There was evidence about which of the two medical teams had been worse. Ultimately Lady Wise

apportioned 30% of the damages to the medical defenders and 70% to the negligent driver. The 30% damages apportioned to the medical defenders was simply split on a 50/50 basis, with each of those defenders bearing a 15% share. This was the approach which the court should take in the present case: in the circumstances a just and equitable approach would be to apportion the damages on the basis that the first defender was responsible for a 50% share and the second defenders are also responsible for a 50% share. There was no basis to justify a departure from this default approach. Both defenders could and should have acted in such a way as to prevent the majority of the harm taking place and both failed to do so. While the operation was undertaken negligently by the first defender when working at the BMI Fernbrae Hospital he had some weeks before, while employed by the second defenders, simply dismissed the possibility of cauda equina syndrome when concerns were raised by ANP Weaver without even carrying out an examination himself. The purser had been let down by them both and should be equally compensated by them both. It was not in the public interest for a health board to be allowed simply to evade responsibility for their admitted negligence in failing to secure timely treatment which would have prevented an unfavourable outcome where they have no plea of *novus actus* and where they nonetheless seek to argue that they bear no share of the responsibility for the ultimate outcome. By failing to refer the pursuer for an MRI scan on 4 February 2013 the first defender, while in the employment of the second defenders, deprived the pursuer of the opportunity to be treated properly by the hospital and if she had been she would not be in the seriously disabled state in which she finds herself today. In these circumstances it could not be correct, from the point of view of fairness and reasonableness, to say that the second defenders should bear no responsibility for the damage suffered by the pursuer. The intuitive reaction to the circumstances described in the pleadings is that the second

defenders ought to be liable because the pursuer would never have had the operation at the BMI Fernbrae Hospital if they had fulfilled their duty towards her and arranged an MRI scan and subsequent surgery in February 2013. Their failure to do so was a direct cause of her permanent disability, although not the only cause.

[36] In respect of culpability and blameworthiness there was little to choose between the failings of the first defender when he was employed by the second defenders and his failings when he treated the pursuer as a private patient. Each consisted of a failure to meet the requisite standard of care of a reasonably competent neurosurgeon exercising reasonable skill and care. On the one hand, he failed completely to take the step which would have resulted in the pursuer being operated on in February 2013 and according to the presumption of competent treatment a microdiscectomy procedure which would have allowed her to lead an essentially normal life. On the other hand, when he carried out the operation himself he failed to do so competently and this led to her sustaining the disabilities from which she now suffered. Both defenders had the chance to take steps which would have resulted in the relief of the prolapse and both failed to take the opportunity which they had. The acts of the defenders were very similar. Even if the second defenders were right to characterise their failure to arrange an MRI scan in February 2013 as an omission and the failure competently to carry out the operation in April as a positive act, this was a distinction of little significance. Both the act and omission are similar in character (a failure to meet the requisite standard of care for a medical practitioner of the first defender's standing) and similar in causal potency and blameworthiness. The circumstances of the present case are very far removed from those in *Widdowson* where the driver of the car which had initially caused the accident had committed the deliberate act of driving round a bend at a speed of 80mph or thereabouts with the inevitable consequence

that he lost control of the vehicle. That conduct, described as "morally reprehensible" by Lady Wise, was contrasted with the far less blameworthy conduct of the medical teams who had tried to save him.

[37] In the whole circumstances the correct apportionment of responsibility in this case ought to be 50% to the first defender and 50% to the second defenders.

Submission for the second defenders

[38] The second defenders invited the court to find that the first defender was 100% to blame for the damage sustained by the pursuer and the second defenders were 0% to blame.

[39] The following principles should guide the court's approach to apportionment:

i. It is a fundamental principle of delict that a party should bear the consequences of the damage which they caused, subject to foreseeability and remoteness.

ii. The question of apportionment is one of fact, to be determined with reference to all of the evidence presented to the court and the relative blameworthiness and causal effect of the defenders' respective acts and omissions (*Widdowson* at para [47]).

iii. A distinction falls to be drawn between causing harm (making things worse) and failing to confer a benefit (not making things better): *Poole Borough Council* v *GN* [2020] AC 780, Lord Reed at paragraph 28. The former is of greater causal potency than the latter and ought to carry with it a greater degree of responsibility.

iv. Failing to take positive action which would have avoided an outcome is not the same as committing an act which directly causes harm: *Thompson* v *Toorenburgh* (1973) 50 DLR (3d) 717 at 721, cited in *Widdowson*; Jones, Medical Negligence, 5th Ed, paragraphs 5-150.

v. The extent of a defender's responsibility involved both the degree of their fault and the degree to which it contributed to the damage in question: *Downs* v *Chappell* [1997] 1 WLR 426, Hobhouse LJ at 445.

vi. In a case of contributory negligence the apportionment is made having regard to the claimant's share in responsibility for the damage, not responsibility for the accident: Law Reform (Contributory Negligence) Act 1945, section 1(1), emphasised by Lord Reed in *Jackson* v *Murray* 2015 SC (UKSC) 105 at paragraph 20. A similar approach is adopted in relation to joint wrongdoers, albeit the only expressly stipulated statutory consideration in section 3 of the 1940 Act is what is "just and equitable".

vii. In considering what is just and equitable the claimant's share of responsibility cannot be assessed without considering the relevance of each party's acts in causing the damage apart from his blameworthiness: *Stapley* v *Gypsum Mines Ltd* [1953] AC 663, Lord Oaksey at p682.

viii. Acts and omissions which are not causative of loss can be considered for the purpose of assessing apportionment but non-causative factors play a very limited role in that assessment. Causative responsibility is the most important factor in assessing apportionment: *Brian Warwicker Partnership plc* v *HOK International Ltd* [2005] EWCA Civ 962, Arden LJ at paragraphs 42 and 45 on the parallel, but not identical, English provision of the Civil Liability (Contribution) Act 1978, section 2.

ix. Blameworthiness involves consideration of a defender's conduct. Relevant factors include whether a party's conduct is dishonest or whether they have tried to do their best in the circumstances, albeit negligently. Where one party has committed a wrong deliberately and another has not this factor will be taken into

account when determining apportionment. Negligent and dishonest conduct attracts a greater degree of liability than negligent but honest conduct: Goff and Jones, The Law of Unjust Enrichment, 9th Ed, paragraphs 20-96 to 20-98; *Widdowson* at paragraphs [56], [59] and [60].

x. Mathematical precision is not required when assessing apportionment: the assessment should be qualitative and not quantitative. It is open to the court to find that one defender is 100% to blame: *Re-Source America International Ltd* v *Platt Site Services Ltd* [2003] EWHC 1142 (TCC) at paragraphs 201 to 203, a finding upheld on appeal at [2004] EWCA Civ 665 at paragraphs 52 and 53 (Tuckey LJ), or, in such a situation, that the degree of causative potency of another defender's act is not of sufficient significance to trigger a finding of apportionment: *McEwan* v *Lothian Buses plc*, 2006 (SCLR) 592 Lord Emslie at paragraphs [32] –[34].

The basis of the pursuer's case was that she suffered from cauda equina syndrome. The second defenders contended that the first defender was entirely to blame for causing this and, in accordance with the principles noted above, it was just and equitable that he should bear the full consequences of his causal responsibility, for the following reasons.

i. The admitted negligence of the second defenders consisted of a failure to arrange an urgent MRI scan on 4 February 2013. It was a one-off failure. It was not a positive act. It failed to confer a benefit (i.e. earlier treatment, with pain being experienced for a reduced length of time). It did not make the pursuer's condition worse. Failing to confer a benefit was less culpable than positively making things worse. Moreover, an MRI scan was arranged, just not on an urgent basis. The second defenders' staff did recognise that a scan was required and took steps to make that happen, which it did. There was no omission of follow-up care.

ii. The admitted negligence of the second defenders did not cause any significant harm to the pursuer. It did not cause any major, indeed any, neurological deterioration. At most it might have resulted in the pursuer experiencing pain for an additional two weeks, being the period between the date she would have had a scan (6 February 2013) and the date she in fact did have one (20 February 2013). It did not contribute to the damage for which reparation is sought in the current action: cauda equina syndrome developed only after (and as a result of) the first defender's negligence, not as a direct consequence of the failure to arrange an MRI scan urgently. The omission of the second defenders' staff was less culpable than the positive act which caused the pursuer's major neurological deterioration. The causative potency of the second defenders' negligence, in relation to the actual harm suffered by the pursuer, was nil. That should be reflected in the court's approach to apportionment.

iii. The first defender's approach to surgery was negligent. It was a positive act. A positive act bore a greater degree of culpability than an omission on the basis that the act positively made the pursuer's condition worse.

iv. As a result of his positive act the first defender caused an intra-operative injury to the pursuer, major neurological deterioration and cauda equina syndrome. All of these had an incalculably greater effect on the pursuer's condition and prognosis than the failure to arrange an urgent MRI scan on 4 February 2013. The causative potency of these acts eclipses any potency of the omission for which the second defenders are responsible. In other words, the cause of the pursuer's current condition was the admitted negligence of the first defender and that should be reflected fully in the apportionment of damages.

v. In addition to his positive act of negligence the first defender also failed to follow up on the fact that the pursuer's condition was worse when she came round from surgery. He ought to have arranged an urgent MRI scan on 16 April 2013. Had he done so, the pursuer would have had a materially better outcome. His negligent omission was more blameworthy than the negligent omission for which the second defenders are vicariously liable: at the time of their omissions, and prior to his negligence, the pursuer did not have cauda equina syndrome. On the other hand, after his negligence she did have cauda equina syndrome due to his negligence. He failed to remedy his negligence, despite evidence that he knew he had caused an intra-operative injury. Failing to take immediate action, in the knowledge that he had caused an intra-operative injury to the pursuer, was morally reprehensible conduct which demonstrated a flagrant disregard for professional duties, being a clear breach of the General Medical Council's guidance in relation to the duty of candour. It ought to attract a significant degree of culpability when apportioning damages.

[40] Against the above background the first defender's negligent acts and omissions were of far greater causative potency than the single omission, which did not cause cauda equina syndrome, for which the second defenders were responsible. It was just and equitable that he should bear the consequences of the damage which he caused and thereafter failed to mitigate. It was not just and equitable to hold the second defenders responsible for that. Thus, he should be found 100% liable for the pursuer's loss, injury and damage.

Discussion

[41] In carrying out the exercise of apportionment I am enjoined by section 3(1) of the 1940 Act to decide what contribution to damages or expenses by the first defender and the second defenders respectively I deem just. It follows, therefore, that I must not make a finding which I do not consider to be just. In reaching my decision I must consider moral blameworthiness and causative potency. In the words of Hobhouse LJ in *Downs* v *Chappell* [1997] 1 WLR 426 at p445:

> "The extent of a person's responsibility involves both the degree of his fault and the degree to which it contributed to the damage in question. It is just and equitable to take into account both the seriousness of the respective parties' faults and their causative relevance."

I do not find myself unable to apportion damages in this case and so no question of a 50%/50% apportionment arises as a default approach. In any event I doubt the soundness of such an approach, which seems to me to involve the court abdicating the jurisdiction conferred upon it by section 3(1) of the 1940 Act to make an apportionment which it deems just.

[42] Following the above approach, it seems to me that the moral blameworthiness and causative potency of the negligence for which the second defenders are responsible is vastly outweighed by that for which the first defender is responsible. I think it is correct to say, as was submitted for the second defenders, that their negligence did not cause any significant harm to the pursuer and that the causative potency in relation to the neurological harm suffered was nil. The negligence for which they were responsible was part of the sequence of events leading up to the serious negligence of the first defender which caused the nerve root injury. All new neurological deficits appeared after the operation carried out by the first defender on 16 April 2013: there was no major neurological deterioration before then.

No doubt the negligence for which the second defenders are responsible was a *sine qua non* of the subsequent negligence by the first defender (the *causa causans*), but that does not in itself mean that it is just that the second defenders should contribute to the damages for the neurological injury caused by the first defender during and after the operation on 16 April 2013.

[43] I reject the submission for the first defender that there is a similarity between the circumstances in the case of *Widdowson* and the circumstances of the present case. In *Widdowson* the major damage was caused by the negligent car driver and that was compounded by negligence on the part of the two hospitals at which Mr Widdowson was treated. That situation is quite different from the situation in the present case, in which it was the negligence of the first defender at and after the operation which caused the pursuer's cauda equina syndrome for which she has been awarded damages.

[44] Moreover, I think it is unhelpful to draw a general distinction between acts and omissions in the present context. What matters is the moral blameworthiness and causative potency of the negligent act, whether it be a positive act or an omission. An omission, particularly in the field of clinical negligence, is capable of causing serious harm or even death.

[45] In my opinion the submission for the second defenders that the negligence of which they are responsible did not cause any significant harm to the pursuer and did not cause her any neurological deterioration is correct. It is also correct to say that at most it might have resulted in her experiencing pain for an additional two weeks and that it did not contribute to the damage for which reparation is sought in the present action, cauda equina syndrome having developed only after and as a result of the first defender's negligence, not as a direct consequence of the failure to arrange an urgent MRI scan. I agree with the submission for

the second defenders that the causative potency of the negligence for which they are responsible, in relation to the actual harm suffered by the pursuer, is nil. In my judgment it would be unjust to find the second defenders liable to contribute to the damages for the cauda equina syndrome which the pursuer has suffered. This conclusion does not involve resurrecting the last opportunity doctrine: it is reached by an application of the statutory provision in light of the guidance given by Hobhouse LJ in *Downs* v *Chappell* [1997] 1 WLR 426

Decision

[46] For the above reasons I conclude that a just apportionment of damages and expenses is 100% contribution by the first defender and 0% contribution by the second defenders.