[2025] EWHC 1907 (KB)

Case No: QB-2022-BHM-000148

IN THE HIGH COURT OF JUSTICE
KINGS BENCH DIVISION
BIRMINGHAM DISTRICT REGISTRY

Date: Double-click to add Judgment date

Before :

HIS HONOUR JUDGE CHARMAN

- -

Between :

REBECCA HEPWORTH **Claimant**

- and –

DR AMANDA COATES **Defendant**

- -
- -

Richard Baker KC (instructed by Anthony Collins Solicitors) for the Claimant
Sarah Pritchard KC (instructed by Hempsons LLP) for the Defendant

Hearing dates: 7, 8, 9, 10, 11, 14, 15, 16, 17, 21, 22, and 24 April 2025

- -

JUDGMENT **22 July 2025 (draft judgment 30 June 2025)**

This judgment was handed down remotely by circulation to the parties' representatives at 10.30 am on 23 July 2025 and by release to the National Archives

His Honour Judge Charman :

Introduction

1. This is a claim brought by Rebecca Hepworth ("Ms Hepworth") against Dr Amanda Coates ("Dr Coates") for damages for clinical negligence. In November 2018, Ms Coates was a 27-year old flight attendant. Dr Coates was at the material time a General Practitioner ("GP"). She has since retired. Ms Hepworth says that as result of her negligence, Dr Coates failed to diagnose red flag symptoms of cauda equina syndrome at a face to face consultation on 5 November 2018 ("the 5 November Consultation").

2. Ms Hepworth was admitted to Pembury Hospital in Tunbridge Wells on 9 November 2018 and had emergency spinal surgery at Kings College Hospital in London ("KCH") in the early hours of 10 November. She says that had Dr Coates asked the right questions and listened to the answers, Ms Hepworth would have been sent to Pembury Hospital on 5 November and had her operation at KCH either later that day or on 6 November. Ms Hepworth says that had she been operated on four days earlier, she would have had a materially better outcome.

3. Experts agree that had Ms Hepworth been operated on four days earlier she would have had a better outcome in a number of respects, although they do not agree about all of the aspects of her condition which Ms Hepworth says would have been materially better.

4. Liability, aspects of causation and quantum are in dispute. It is common ground that the effect of her suffering cauda equina syndrome on Ms Hepworth's life has been devastating. Ms Hepworth claims in her Schedule of Loss, special damages in excess of £5 million in respect of past and future losses.

5. The Cauda Equina is a bundle of nerve roots emanating from the base of the spine and descending into the pelvis. It is so called by reason of its resemblance to a horse's tail. The nerve roots are involved in perineal sensation, bladder and bowel control and sexual function, as well as leg motor function.

6. Cauda Equina Syndrome ("CES") occurs when the cauda equina is compressed following a disc prolapse which occurs centrally, rather than the prolapsed disc bulging out to the side of the spine. It is treatable by prompt surgery to relieve the pressure, but to do so it needs to be diagnosed early. If it is not treated

promptly it can lead to permanent nerve damage. Such damaged nerves do not regrow and so the nerve damage leads to permanent loss of neurological function.

List of Issues

7. The first issue is whether Dr Coates was in breach of duty at the 5 November Consultation by failing to diagnose possible CES and/or sending Ms Hepworth to hospital for urgent investigation.

8. The second issue is whether if there was such a breach of duty, it caused Ms Hepworth to have a worse outcome from her surgery for CES than she would have had if she had undergone surgery following being referred to hospital at the 5 November Consultation and so suffer general and/or special damage which she would have avoided.

9. The remaining issues are as to quantum, in respect of which counsel helpfully agreed a list of issues as follows:

(i) General Damages;

Past Losses

(ii) Past loss of earnings;

(iii) Past care and assistance;

(iv) Past travel;

(v) Past equipment;

(vi) Past DIY and decorating;

(vii) Past gardening;

(viii) Past window cleaning;

(ix) Home adaptations;

(x) Miscellaneous past expenses;

(xi) Physiotherapy;

(xii) Interest on past special damages;

Future Losses

(xiii) Future loss of earnings;

(xiv) Future care and assistance;

(xv) Case management;

(xvi) Physiotherapy;

(xvii) Occupational therapy;

(xviii) Continence management / medical treatment;

(xix) Dietician;

(xx) Travel and transport;

(xxi) Orthotics;

(xxii) Equipment;

(xxiii) Accommodation and accommodation equipment;

(xxiv) Miscellaneous;

(xxv) Services.

The Evidence and Approach to It

10. I have considered and borne in mind all of the oral evidence and the evidence included in the trial bundle, including the evidence introduced during the trial. I cannot sensibly summarise everything I heard or read in evidence or determine each and every dispute of fact however tangential its relevance and I do not propose to do so. I have however considered and taken into account everything that was before me and I will refer to the evidence as necessary throughout this judgement. I have attempted to distil into this judgment only such material as is necessary for the parties to understand what I have decided and why. My not mentioning a particular matter should not therefore be treated as my having overlooked it.

11. When considering the evidence, I bear in mind the observations of Leggatt J in *Gestmin SGPS SA v Credit Suisse (UK) Ltd* [2013] EWHC 3560 Comm at paragraphs [15] - [22]. These include that:

(a) Memory is especially unreliable when it comes to recalling past beliefs, which are revised to make them more consistent with present beliefs.

(b) The process of civil litigation itself subjects the memories of witnesses to powerful biases because witnesses often have a stake in a particular version of events.

(c) Considerable interference with memory is introduced into civil litigation by the procedure of preparing for trial; the effect of the process of preparing to give evidence is (1) to establish in the mind of the witness matters in his or her own statement (whether they be true or false) and (2) to cause the witness's memory of evidence to be based increasingly on this material and later interpretations of it rather than on the original experience of events.

12. Leggatt J went on to state that in commercial cases, the best approach is to base findings of fact on inferences drawn from documentary evidence and known or probable facts, rather than the recollections of witnesses. As explained by Floyd LJ in *Martin v Kogan* [2020] FSR 3, a proper awareness of fallibility of memory is necessary but does not relieve judges of the task of making findings of fact based upon all of the evidence.

13. This approach applies to all cases and not just commercial ones, as explained by Mostyn J in <u>*Carmarthenshire County Council v. Y*</u> [2017] EWFC 36:

"In my opinion this approach applies equally to all fact-finding exercises, especially where the facts in issue are in the distant past. This approach does not dilute the importance that the law places on cross-examination as a vital component of due process, but it does place it in its correct context."

14. In addition, as was observed by Arden LJ in *Wetton v Ahmed* [2011] EWCA Civ 610 at [14], contemporaneous written documentation is also important in assessing credibility.

<u>The Witnesses of Fact</u>

15. Ms Hepworth relies upon factual evidence from herself, Michael Hepworth, her father, a friend who accompanied her to the 5 November Consultation Ms Krystina Dixon, her boyfriend in November 2018 Limahl Davies, and her godmother and close friend, Maggie Gray . Dr Coates relies upon her own factual evidence and also evidence from a physiotherapist who Ms Hepworth saw about her back issues on 7 November 2018, Christopher Kryzwon.

16. Ms Hepworth was cross examined at some length. I found Ms Hepworth to be an essentially honest witness who generally made appropriate concessions. In her oral evidence she did not tend to exaggerate her condition or the limitations on her life which resulted from the index events. However, in my judgment, her recollection of some of the key events is not as reliable as she believes it to be. For example, she gave evidence about her recollection of her appointment with Dr Coates on 29 October 2018 confidently relating how she drove herself to the surgery and reporting what she remembered occurring. In fact, the appointment that day was a telephone appointment. Ms Hepworth was also unable when first questioned to recall whether she fell downstairs and vomited leading to a trip to hospital with her father and a CT scan before or after the index incident or both. When presented with medical notes from Pembury

Hospital relating to just such an incident before the index events, she was unable to say whether it was the incident she had in mind. She eventually stated that she recalled that on that occasion she had gone to Haywards Heath Hospital, which was the hospital where her mother died, having been driven there by her father. Her father later confirmed that it was after the index events. No medical notes from Haywards Heath Hospital have been disclosed. I am satisfied on the balance of probabilities that there were two such incidents with the second being after the index incident and resulting in a trip to A&E at Haywards Heath. However, this evidence also indicates that Ms Hepworth's recollection of events around the time of the index incident and in the period shortly after it, is incomplete and may be unreliable. Ms Hepworth, unsurprisingly, did not make contemporaneous notes of events or make reference to them in a diary.

17. Ms Dixon gave evidence about the 5 November Consultation. As with Ms Hepworth, understandably, she did not make contemporaneous notes of the relevant events or make reference to them in a diary. I found her to be an honest witness who came to Court intending to tell the truth. Ms Dixon generally made appropriate concessions and volunteered matters that she could not recall. It was put to her directly that both when making her witness statement and having sat through Ms Hepworth's cross examination, when answering questions, she was tailoring her evidence to seek to assist her friend. She rejected this suggestion, as do I. There were a number of matters of potential significance where Mrs Nixon either does not recall matters put forward by Ms Hepworth or gives contradictory evidence. Two examples are that Mrs Nixon recalls only that Ms Hepworth told Dr Coates of pain in her right leg, whereas Ms Hepworth's evidence is that she told the doctor of pain in both; and Ms Hepworth says that she told Mrs Nixon about her bowel issue on the night of 4 November in a telephone call that night, whereas Mrs Nixon says that it was during another telephone call on the morning of 5 November. I also find that Mrs Nixon's recollection of the 5 November Consultation and events around it is incomplete and not wholly reliable. As she herself accepted in cross examination, there are number of matters about which she has no recollection. There are others where her recollection appears to have changed over time. For example, in her witness statement she reports Ms Hepworth telling her on the telephone and telling Dr Coates on 5 November that "she thought" she had lost

her bowels but in her oral evidence she maintained that Ms Hepworth said in each case that she "had" lost her bowels. In the context of this case that distinction is of significance and in my judgment, that significance would certainly not have been lost on the solicitor preparing Mrs Nixon's witness statement. Therefore, if Mrs Nixon had reported when her statement was being taken that Ms Hepworth "had" lost her bowels, that is what her statement would have said.

18. Mr Hepworth gave his evidence in a direct and open manner and volunteered information. He was a transparently honest witness who made negative observations about his daughter where they reflected his honest belief. In general, I consider his evidence to be reliable.

19. The evidence of Mr Davies is very much peripheral and its principal relevance is to confirm his understanding of a WhatsApp message he received from Ms Hepworth at the time of the index events. I found him to be an honest witness but one whose evidence makes a very little contribution to the issues that I have to decide.

20. Mrs Gray's evidence is also peripheral to the main issues. I found her to be an honest and straightforward witness who was candid in reporting what she did and did not know.

21. Dr Coates was also cross examined at some length. Understandably in the circumstances, she was somewhat defensive in many of her answers. In my judgment she was an essentially honest witness who believed in the accuracy of what she reported. However, she was reluctant to make concessions, including as to matters which in my judgment were matters of common sense and must have been obvious to someone of her intelligence. For example, she was very reluctant and initially unwilling to concede that working under pressure of time increased the risk of mistakes and that delay in writing up notes of a consultation led to a greater risk that the notes would contain inaccuracies. Dr Coates also maintained she had an independent memory of details which in my judgment, is simply not credible. Examples are her expressed independent recollection include how Ms Hepworth was walking when she walked from the waiting room to the 25 October Consultation, and looking at the clock and making a mental note of the time when Ms Hepworth left her room at the end of the 5 November Consultation. In my judgment, parts of her oral evidence as to her

expressed recollection were classic examples of the three points as to unreliability of memory referred to by Leggat J in *Gestmin*. None of this detracts from my conclusion that prior to her retirement she was a conscientious doctor who cared about her patients, but it does mean that I cannot treat her recollection as reliable and complete.

22. Mr Kryzwon was in my judgment an honest witness. He gave considered answers and made appropriate concessions. He was very clear that he has no independent recollection of seeing Ms Hepworth and that his evidence about their encounter reflects what is in his notes. I regard his evidence as generally reliable.

23. It will be apparent from my general findings as to the accuracy and reliability of the evidence of each of those present at the 5 November Consultation that I regard the oral evidence of each of them as to what occurred to be unreliable at least in part. This is not surprising given the passage of time. It means that documentary evidence and inherent likelihood are of particular importance in respect of the factual disputes going to liability.

24. I comment on my impressions of the various expert witnesses who gave oral evidence where I consider necessary to do so when I address the issues to which their evidence goes.

Medical Records

25. It follows from observations about the witnesses of fact that documents are of particular importance in the fact finding process. Dr Coates relies upon medical records including the notes made by her during each of the consultations and the notes made by Mr Kryzwon when he saw Ms Hepworth on 7 November. Medical notes and records are also important evidence on issues of causation and quantum as they chart the development of and changes in Ms Hepworth's condition over time.

26. The approach which the Court should take when considering the weight to be attached medical notes and records was explained by Tomlinson LJ in *Synclair v East Lancashire Hospital NHS Trust* [2015] EWCA Civ 1283 at [12] as follows:

"*… simply because a document is apparently contemporaneous does not absolve the court of deciding whether it is a reliable record and what weight can be given to it. Some documents are by their nature likely to be reliable, and*

medical records ordinarily fall into that category…As a contemporaneous record that Dr Johnson was duty bound to make, that record is obviously worthy of careful consideration. However, that record must be judged alongside the other evidence in the action. The circumstances in which it was created do not of themselves prevent it being established by other evidence that that record is in fact inaccurate."

27. As Mr Baker KC pointed out, this approach has been followed in many subsequent cases, including in *Richins v Birmingham Women's and Children's NHS Foundation Trust* [2022] EWHC 847 (QB) at [82] where HHJ Emma Kelly sitting as a Judge of the High Court, helpfully summarised the approach as follows:

"In my judgment a court can and often will take a starting point, but no more than a starting point, that a contemporaneous entry made by a medical professional is likely to be a correct and accurate record of what was said and done at a consultation/examination."

28. It follows that medical records and notes made by clinicians are important evidence but, as Mr Baker KC submits, not per se more important than other contemporaneous documentary evidence. That means in this case that there is no presumption that medical notes and records are by their nature more likely to be accurate than the WhatsApp messages relied upon by Ms Hepworth.

29. Mr Baker KC sought to persuade me that the starting point in this case should be that the medical notes are inconsistent with what he says is the less ambiguous evidence provided by the WhatsApp messages; while Ms Pritchard KC sought to persuade me that the medical notes and records should be the starting point. In my judgment, in the light of the clear conflict between these contemporaneous documents and the cogent arguments advanced by the parties, the approach which should be taken is not to start with either, but to attach appropriate weight to both when making the findings of fact required to determine liability, and deciding how they can be reconciled or which is to be preferred from the totality of the evidence and inherent likelihood.

Agreed Facts

30. The following relevant facts are agreed between the parties:

(a) Ms Hepworth experienced a tragic childhood spent in part with an alcoholic mother who died when Ms Hepworth was just 11 years old. This

left her with an Emotionally Unstable Personality Disorder ("EUPD"), which she had in November 2018 and still has.

(b) In October 2018, Ms Hepworth was 27 years old, worked as cabin crew for EasyJet and was physically active, attending the gym regularly and occasionally taking part in body building 'bikini' competitions. She also travelled extensively, with friends and on her own, taking advantage of the favourable terms for international travel available to her as a result of her employment. She had a close relationship with her father and had a number of close friends.

(c) She was a regular user of alcohol, and of cocaine in relatively modest amounts, but not dependent on either.

(d) She had a history of some back problems and in December 2013, degenerative changes in her lumbar spine had been identified on an MRI scan. She had experienced sciatica in 2017 and suffered intermittent right sided sciatic pain as a result.

(e) She travelled to Canada on a holiday with her father in late September and early October 2018 and spent significant time during the trip travelling by road. During the trip, Ms Hepworth felt lower back pain and sciatic pain in her left leg.

(f) On her return home, Ms Hepworth consulted her GP, Dr Coates. She consulted Dr Coates on 25 October ("the 25 October Consultation"), 29 October ("the 29 October Consultation") and then for the 5 November Consultation. Ms Hepworth's case is that Dr Coates was negligent in her conduct of the 5 November Consultation.

(g) Ms Hepworth saw a physiotherapist, Mr Kryzwon, on 7 November 2018.

(h) Ms Hepworth called NHS 111 on 9 November 2018 and that led to her being taken by ambulance to Pembury Hospital in Tunbridge Wells that evening. At the hospital she was diagnosed with CES and after an unexplained but fairly short and apparently irrelevant delay, was transferred to Kings College Hospital ("KCH") where she underwent spinal surgery to relieve pressure on her cauda equina nerves in the early hours of the morning of 10 November 2018.

(i) She subsequently spent periods of rehabilitative care in Stoke Mandeville Hospital (twice) and Pembury Hospital.

(j) CES occurs when the relevant disc prolapses centrally, rather than protruding to one side. It results in compression of the cauda equina nerves and presents with neurological symptoms relating to perineal and genital sensory disruption and bladder and/or bowel dysfunction.

(k) CES is treatable if detected promptly by surgery to relieve the compression of the cauda equina. If not treated promptly CES leads to permanent neurological dysfunction. Ms Hepworth has been left with some such dysfunction, the precise extent of which is in issue.

Law as to Liability

31. The law as to liability in this case is long established and not controversial. The relevant test in determining whether a clinician has been negligent remains that stated by McNair J in *Bolam v Frien Hospital* [1957] 1 WLR 582 at 587. McNair J stated that "*a man is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art … a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who take a contrary view."*

32. There have been comments on that decision in many subsequent cases but counsel are agreed that it remains the law and is a sufficient statement of the law for the purposes of considering liability in this case.

Expert evidence as to Liability

33. Ms Hepworth's liability expert, Dr Desor, and Dr Coates's liability expert, Dr Lord, each gave live evidence. In each case they were cross examined on points of difference in their individual reports. I found both to be clear and helpful in their evidence and each engaged with the questions they were asked and sought to assist the Court with their answers. Each also made appropriate concessions.

34. Most importantly, as they stated in the Joint Statement dated 31 July 2024, they agree all of the most important points.

35. I accept in its entirety the evidence in their Joint Statement and agreed by them during cross examination, which is that:

(a) The 'red flag' signs of CES which would have been known to GPs in 2018 are (i) bilateral sciatica; (ii) severe or progressive bilateral neurological deficit of the legs, such as major motor weakness with knee extension, ankle inversion or foot dorsiflexion; (iii) difficulty in initiating micturition or

impaired sensation of urinary flow; (iv) loss of sensation of rectal fullness; (v) perianal or perineal or genital sensory loss (saddle anaesthesia or paraesthesia); and (vi) laxity of the anal sphincter.

(b) On 5 November 2018, all reasonable and responsible GPs would consider CES as part of their differential diagnosis if Ms Hepworth reported having soiled herself the previous evening by losing control of her bowels and/or a history of numbness or altered sensation in her bottom and/or genitals even if only to one side; but not in isolation numbness in her right leg with pain in her foot and lower leg and back or a reduction in straight leg raising bilaterally, even if combined with severe pain on both sides when straight leg raising.

(c) Given Ms Hepworth's history, all reasonable and responsible GPs would have asked her whether she was experiencing numbness or altered sensation in her perianal / genital area. If Ms Hepworth's evidence is preferred, she did not.

(d) If Dr Coates' evidence in her witness statement is preferred then she appropriately asked Ms Hepworth about numbness and altered sensation in her perianal / genital area.

(e) Given Ms Hepworth's history, all reasonable and responsible GPs would have asked her whether she had experienced any issues with controlling her bladder or bowels.

(f) If Dr Coates' evidence in her witness statement is preferred then she appropriately asked Ms Hepworth whether she had experienced any issues with controlling her bladder or bowels. If Ms Hepworth's evidence is preferred, she did not.

(g) If Dr Coates' evidence is preferred regarding the history given to her by Ms Hepworth, the examination performed by Dr Coates was appropriate.

(h) If the account given by Ms Hepworth in her witness statement is preferred, the steps taken by Dr Coates referring Ms Hepworth for an outpatient MRI scan and recommending she have an urgent private consultation with a physiotherapist were not appropriate.

(i) If a GP suspected CES or a patient reported 'red flag' symptoms in November 2018, a competent GP would not have referred her for an urgent outpatient MRI but would have contacted the acute orthopaedic admissions

team or its local equivalent and referred the patient to the local hospital to be assessed in accordance with local protocols.

(j) CES is fairly rare. Many GPs never see it during their career.

(k) GP notetaking is very important. The falsifying of medical notes would be a very serious matter and if done knowingly would be likely to lead to a GP being struck off the Medical Register. Accidental error in a note would not ordinarily be a disciplinary offence.

36. The expert neurosurgeons, whose evidence I address in more detail below, agree that had the local hospital been consulted on 5 November, they would have advised that Ms Hepworth be sent to hospital immediately. She would have been referred to an appropriate orthopaedic or neurosurgical specialist, had an MRI scan and been operated on within much the same time scale as in fact occurred when she was taken to hospital on 9 November.

37. I accept all of this agreed expert evidence, as does each of the parties.

38. In her note of the 29 October Consultation, Dr Coates noted no urinary retention as well as no incontinence. Dr Desor said that was indicative that Dr Coates had quite a detailed understanding of CED. I accept that evidence and so find.

39. In answer to questions from me, the GP liability experts confirmed that any single red flag symptom would have led a competent GP to investigate further and in the absence of a simple explanation refer the patient to the local hospital as an urgent referral and/or contact the acute orthopaedic admissions team. I also accept that evidence.

40. The GP experts also agree on the importance of good notetaking by GPs.

<u>Liability – The Facts</u>

41. On the factual issues going to liability I have taken particular account of the oral evidence of Ms Hepworth, Ms Dixon, Dr Coates and Mr Kryzwon, the medical records referred to by them and the WhatsApp messages between Ms Hepworth and Mr Davies and Ms Hepworth and Ms Dixon. Based on that evidence and all of the other evidence in the case and paying particular regard to inherent likelihood, I make the following findings of fact relevant to the issue of liability and concerning matters other than what occurred at the 5 November Consultation:

(a) At the 25 October Consultation, Ms Hepworth reported pain in her left upper buttock/ilac crest and into the back of her left thigh down as far as

the knee. She also had some pain horizontally across her back and into her right buttock but not into her thigh. Dr Coates asked her whether she had numbness in the saddle area, or any change in bladder or bowel sensation or function. Ms Hepworth stated that she did not. I make these findings because they are reflected in the notes of the 25 October Consultation made by Dr Coates and are not challenged by Ms Hepworth. I find support for this finding in the fact that the previous day, Dr Coates had attended a training course which included CES and the red flag symptoms. In my judgment, it is highly unlikely that the day after attending that course Dr Coates would have overlooked the need to ask Ms Hepworth about the red flag symptoms for CES when she presented with the symptoms I have described and I find that she did not do so.

(b) Further, the information provided by Ms Hepworth to Dr Coates was true at that time. I make this finding because there is no evidence which suggests that it was not true.

(c) At the 25 October Consultation, Dr Coates decided to refer Ms Hepworth for musculoskeletal physiotherapy and told Ms Hepworth this. Dr Coates also gave Ms Hepworth prescriptions for a non-steroidal anti-inflammatory drug (NSAID), and for codeine to be taken together with paracetamol. I make this finding as it is recorded in the record made by Dr Coates and is not disputed by Ms Hepworth.

(d) Ms Hepworth's mental health was then discussed. This is recorded in the record made by Dr Coates and is not disputed by Ms Hepworth.

(e) I find that both Ms Hepworth and Dr Coates have a general rather than detailed recollection of what occurred at the 25 October Consultation. As a result, I make no more detailed findings as to what occurred at that consultation as it is not necessary for me to do so.

(f) I find that the 29 October Consultation was a telephone consultation at around 18.45. In doing so I prefer the evidence in the medical record of the 29 October Consultation to the oral evidence of Ms Hepworth that she attended in person. I so find because Ms Hepworth accepted in cross examination that she had little recollection of that consultation and that she may well be wrong in her recollection of an in person consultation to which she drove and at which she was examined as stated in her witness

statement. In my judgment, in her recollection Ms Hepworth confused the 25 October Consultation and the 29 October Consultation, her recollection of each of them is limited and she is unable to distinguish between her recollection of each of them.

(g) By the time of the 29 October Consultation, Ms Hepworth was in more pain than she had been in at the 25 October Consultation. This is what is recorded in the record made by Dr Coates and together with a request for a sick note due to her inability to work was the reason why Ms Hepworth had requested that appointment.

(h) Ms Hepworth also reported that the codeine was not helping with her pain and Dr Coates prescribed tramadol as an alternative. Dr Coates refused to prescribe diazepam as requested by Ms Hepworth as she considered that it would not help her. Further, Ms Hepworth reported that she had not had any bowel movement for 3 days. That combined with the previous prescription of codeine and the new prescription of tramadol led Dr Coates to also prescribe lactulose for constipation. Again, I so find because this is what was recorded by Dr Coates and it is not disputed by Ms Hepworth. Indeed, Dr Coates' position with regard to the prescriptions is agreed by Ms Hepworth.

(i) I further find that Dr Coates did ask Ms Hepworth about the red flag symptoms relating to bladder, bowel, and perianal and genital numbness. I so find because it is stated in the medical record and there is no express evidence to the contrary to undermine what is stated in the record of the consultation.

(j) In my judgment, neither Dr Coates or Ms Hepworth has a particularly clear and detailed recollection of what occurred during the 29 October consultation. In Ms Hepworth's case, I so find as she failed to recall that it was a telephone consultation rather than in person and claimed to positively recall various parts of an in-person consultation which did not in fact occur. In Dr Coates' case, I so find because her evidence of what occurred was in substance simply a restatement of what is recorded in the medical notes and also, because it is inherently unlikely that a GP will recall details of a short and unremarkable telephone interaction at the end of a busy surgery session over 6 years ago.

(k) I find that on 3 November 2018, Ms Hepworth sent a WhatsApp message to Mr Davies at about 20.56 in which she stated that she was numb. He asked whether she meant emotionally numb and she replied, "No arse and mini". This meant that she was experiencing numbness in her perianal and genital areas. I so find because this is clear on the face of the message exchange, a copy of which is exhibited by Ms Hepworth to her witness statement. Mr Davies confirms his understanding of the meaning of the words she used and neither the sending of the message nor the meaning of the words is seriously challenged by Dr Coates.

(l) I further find that Ms Hepworth was in fact experiencing perianal and genital numbness at that time. I so find because there is no reason to doubt that she was telling the truth when she sent the message 2 days before the 5 November Consultation, and which had almost certainly not even been arranged at the time that the message was sent. Further, it is inherently unlikely that Ms Hepworth would send such a message to Mr Davies if it were not true. In addition, the agreed evidence of Mr Todd and Mr MacFarlane is that Ms Hepworth's symptoms in October and November 2018 were caused by a prolapse of a central disc at L4/L5, from which she went on to develop CES. It is also their evidence that the first red flag indication of developing CES is saddle anaesthesia. Her suffering the numbness she describes is consistent with this agreed expert neursurgical evidence. Finally, the way in which Ms Hepworth described becoming aware of the numbness is as a result of noticing a lack of feeling when she wiped herself after going to the toilet. This coincides with the question which both the GP Experts and the neurosurgical experts agree should be asked of a female patient when asking about red flag symptoms of CES; namely whether she noticed any loss of sensation when wiping herself after going to the toilet. I bear in mind the expert neurosurgical evidence that subjective reports of numbness are not always supported by clinical examination. However, Ms Hepworth's numbness was not the subject of clinical examination until after her admission to hospital on 9 November.

(m) The expert evidence of Mr Macfarlane and Mr Todd is that from the onset of perianal and genital numbness in a patient who develops CES, that numbness continues and may develop to extend to a wider area. Further,

the same experts agree that once a patient develops saddle anaesthesia connected with CES, it continues until the pressure caused by the prolapsed disc is relieved. I accept that evidence and on the basis of it find that Ms Hepworth continued to experience perianal and genital numbness from the evening of 3 November so that it was continuing at the time of the 5 November Consultation and until she underwent surgery at KCH.

(n) I find that Ms Hepworth made an appointment to see Dr Coates on 5 November at 15.10 because she was in a good deal of pain and concerned about her condition. However, the time of the appointment was brought forward to 12.45 by the surgery. I so find because this is apparent from the WhatsApp exchange that she had with Ms Dixon on the morning of 5 November which is exhibited by Ms Hepworth. The appointment may have been brought forward because Ms Hepworth asked when making the original appointment for an earlier appointment if one became available but it is not clear why the time was changed and I make no finding as to why it was. However, I do find that Dr Coates was not involved in the decision to offer Ms Hepworth an earlier appointment and was not aware of the reason for the change. I so find because there is no evidence as to how the change in time came about but given what Dr Coates said about her general practice of allowing patients as much time as they needed rather than sticking rigidly to 10 minute time slots; and her evidence that she was often running behind at the end of a session, it is inherently unlikely that she would have initiated the bringing forward of an appointment from the afternoon session to the morning one.

(o) I have considered whether Ms Hepworth subjectively experienced such numbness but objectively had no such loss of sensation, as Mr Macfarlane says is quite common. It is possible, but on the evidence before me, on the balance of probabilities, I find that Ms Hepworth did have some perianal numbness at that time.

(p) Ms Hepworth was collected from home and driven to the appointment by Ms Dixon as Ms Hepworth was in too much pain to drive herself. This is the evidence of them both which was is not really challenged and I accept. There is conflicting evidence as to when the arrangement for Ms Dixon to

provide the lift was made but nothing turns on it so I make no finding about it.

(q) I find that Ms Hepworth was suffering with severe pain when she attended the 5 November Consultation. This is her evidence and that of Ms Dixon. Whilst I do not find either of them to have a particularly reliable recollection of precisely what was said at the 5 November Consultation, I accept Ms Hepworth's recollection that she was in severe pain and Ms Dixon's that she was very concerned about the pain that Ms Hepworth was in. Their evidence in this regard is supported by the fact that Ms Hepworth was unable to drive herself to the appointment and by WhatsApp messages sent by Ms Hepworth on 5 November hoping that she would be sent to A&E, her pleading with the Horder Centre later that day to be seen by them and willingness to pay for a private appointment rather than wait for the NHS and her WhatsApp message the next day to a friend stating that she could barely walk or sleep. Dr Coates said during cross examination that her recollection is that Ms Hepworth was not in especially great pain. As I have already noted, I do not consider Dr Coates' recollection of the 5 November Consultation to be particularly reliable either and on this point, I prefer the evidence of Ms Hepworth and Ms Dixon.

(r) I find that Ms Hepworth had an incident with her bowels on the evening of 4 November. It is agreed that some sort of incident occurred but not the precise nature of it. I return to that below.

(s) Ms Hepworth told Ms Dixon about the bowel incident on the morning of 5 November. This is Ms Dixon's evidence which I prefer to Ms Hepworth's evidence that she told Ms Dixon of it shortly after it occurred on the evening of 4 November. As explained elsewhere, I have some significant doubts as to the accuracy of the recollections of Ms Hepworth and Ms Dixon, but on this point Ms Dixon's evidence in cross examination was clear and firm whereas Ms Hepworth was rather more unsure.

(t) Ms Hepworth states in her witness statement and maintained during cross examination that she lost control of her bowels on the evening of 4 November, that she thought she was going to pass wind but soiled herself

and was in bed at the time so also soiled the bed. Ms Dixon says in her witness statement that Ms Hepworth told her that she thought she had lost control of her bowels overnight and also that Ms Hepworth told Dr Coates that she thought that she had lost control of her bowels overnight. Dr Coates' evidence is different again. She says in her witness statement, and maintained under cross examination, that she asked Ms Hepworth whether she had experienced any bowel problems and that Ms Hepworth said that she had thought that she was going to pass wind but in fact nearly soiled herself and only just made it to the toilet in time. Dr Coates says that she considered this to be an explosive stool caused by Ms Hepworth's previous constipation eventually being relieved as a result of the lactulose that she was taking. In cross examination, Dr Coates said that Ms Hepworth initially replied "no" when asked about loss of control of her bladder or bowels but then added "oh yes", as if her memory had been jogged, and reported the incident in the manner to which I have already referred. Both Ms Hepworth and Ms Dixon say that Dr Coates appeared unconcerned by what was reported and just acknowledged it. There is thus a straightforward clash of evidence as to what was said about the bowel incident. It turns principally on my impression of the witnesses when giving evidence on this point but is also affected by some of the other evidence in the case and inherent likelihood.

(u) The neurological experts (Todd and Macfarlane) and the urology experts (Chapple and Reynard) agree that loss of bladder control precedes loss of bowel control in the overwhelming majority of CES cases. There is no indication at all that Ms Hepworth had lost control of her bladder at this time, or indeed that she had done so 2 days later when she saw the physiotherapist.

(v) Based on this evidence and on inherent likelihood, I find that Ms Hepworth had not in fact lost control of her bowels on 4 November. What occurred was that she was expecting to pass wind when it became clear that she was going to pass a stool. She was taken by surprise and rushed to the toilet and only just made it. I make this finding not because I accept the account given by Dr Coates as I consider that Dr Coates' recollection of precisely was said at the consultation is limited; but because it is inherently the most

likely and broadly reflects Ms Dixon's original evidence. I also reject Ms Hepworth's recollection of what occurred and of what she told Dr Coates at the consultation.

(w) I make this finding for a number of reasons. First, because as I have already noted, it would be very unusual for Ms Hepworth to have lost control of her bowels due to CES while retaining control of her bladder and the evidence is that she did retain control of her bladder. Second, because there is ample evidence that her recollection of other matters at about that time is not reliable and she herself accepted in cross examination that she does not recall much detail of the consultation and what she does recall is in her witness statement. Third, because it is her own evidence that she was "off her head on tramadol" at that time and as she said in cross examination, that the pain was the main thing at the 5 November Consultation and the main thing that she recalls from it. Fourth, Ms Hepworth did not report losing control of her bowels to Mr Kryzwon on 7 November, or to NHS 111 or to the ambulance staff who took her to hospital, or to the medical staff she saw on arrival at Pembury Hospital all on 9 November. Ms Hepworth's evidence was that she did tell Mr Kryzwon about the bowel incident but he recorded that there was no issue. That indicates that she did talk about the bowel incident but the conclusion that Mr Kryzwon drew from what she told him was that she had not lost control of her bowels. In my judgment, had she in fact lost control of her bowels and soiled herself it is inherently very unlikely that she would not have told any of these medical professionals, all of whom she saw within a week of it occurring, as what would have been a highly memorable and indeed traumatic event, had occurred and that they would have recorded being told and followed it up. Whilst there may be an explanation for why she may have not provided the information to some of these medical professionals, it is inherently unlikely that she would not have told any of them. As Ms Hepworth said, full loss of control of bowels and self-soiling would have been traumatic and not something that a patient is likely to forget. The failure to report such a loss of control on multiple occasions when asked about it by medical professionals within a week of the incident indicates that at the time, Ms Hepworth did

not consider that she had lost control of her bowels. Fifth, Dr Coates recorded in an unchallenged note during the 29 October Consultation that Ms Hepworth had experienced no bowel movement for 3 days. This indicates that Ms Hepworth was suffering from constipation at this time, probably as a result of the large doses of pain relief medication she was taking. A relatively sudden explosive stool is inherently more likely. Finally, in my judgment, had Dr Coates been told by Ms Hepworth that she had lost control of her bowels or soiled herself, it is inherently unlikely that Dr Coates would not have asked further questions and noted that fact. She did not note it, although there is a dispute as to whether she asked any further questions about it.

(v) It is agreed that on 7 November, Ms Hepworth attended a physiotherapy appointment with Mr Kryzwon. She was driven there by her father as she was unable to drive herself. That is their unchallenged evidence which I accept. I accept Mr Kryzwon's evidence that he would have looked at the referral sheet from Dr Coates before seeing Ms Hepworth and that he then saw her and filled out the pro forma Horder Centre MSK Patient Treatment Chart by asking a series of questions of Ms Hepworth and carrying out an examination, filling out the pro forma document as he went. That was his evidence and it is not really challenged. It follows that his notes are a fully contemporaneous record of his encounter with Ms Hepworth.

(w) In my judgment, Mr Kryzwon's notes are detailed and indicate that he undertook a thorough examination of Ms Hepworth and asked her a large number of questions. In them, he makes notes which it is accepted mean that Ms Hepworth had no bladder or bowel abnormalities – evidencing that he asked her about her bowels and she did not report losing her bowels. Also recorded is a note which it is accepted means no saddle anaesthesia. This indicates that the Mr Kryzwon asked a question about saddle anaesthesia. I find that as the notes record, he did so. I find this because there is no evidence to contradict the note and because I accept Mr Kryzwon's oral evidence that he would always do so and would not have noted that Ms Hepworth reported no saddle anaesthesia unless he had asked about it. Further, in his note he recorded that he provided

reassurance with regard to spinal pathologies and made Ms Hepworth vigilant of red flag symptoms (which would have included saddle anaesthesia) and that any such symptoms should be treated as an emergency. That Mr Kryzwon provided this information if he had not already asked about saddle anaesthesia makes no sense. In his witness statement he says that he conveyed to her how important it was that Ms Hepworth watched out for changes in her condition and that he made her aware of the red flag symptoms by referring back to the questions that he had already asked. I am satisfied that this was Mr Kryzwon's usual practice and that included speaking to Ms Hepworth about the red flag symptoms twice, the second time by referring back to questions asked the first time. This indicates that in order to overlook asking about the red flag symptoms, Mr Kryzwon would need to overlook them and depart from his usual practice twice. It is not suggested that Mr Kryzwon made the notes knowing when he did so that they were false. As the notes were fully contemporaneous, I am satisfied that he cannot have been mistaken as to what he asked about. The notes also indicate that Ms Hepworth answered in the negative. The note, unsurprisingly, does not record the words used to ask the question. I return to this below. The note also records in a combination of words and diagrammatic form that Ms Hepworth was experiencing pain across her lower back and down her left buttock and the back of her left leg all the way to her left foot and that the worst pain was in her back on a scale of 8 out of 10. All of this is broadly consistent with what others say Ms Hepworth reported to them, although there is no report of any pain at all to the right leg, whereas Ms Hepworth did complain of lesser pain in that leg to others.

(x) Ms Hepworth says that she had taken a high dose of tramadol and was spaced out by pain at the appointment. It was also clear from her evidence in cross examination that her recollection of her appointment with Mr Kryzwon is not comprehensive nor particularly clear. However, she does recall that she was told that if she wet herself or lost control of her bowels or the pain got worse that was something to watch out for. This seems to be a reference to what Mr Kryzwon and his notes say that he told her to be vigilant about. However, Ms Hepworth's version does not make sense

in that by her account she told Mr Kryzwon that she had lost control of her bowels a few days earlier yet he took no action and asked no further questions when told it and then told her that she needed to seek medical help urgently if she lost her bowels. Where there is an inconsistency between Ms Hepworth's recollection of what was said and the evidence of Mr Kryzwon based on his contemporaneous record, I prefer the evidence of Mr Kryzwon unless I specifically find to the contrary.

(y) I then come to the question of whether Mr Kryzwon asked Ms Hepworth about saddle anaesthesia using words that meant that she understood the question. Under skilful cross examination from Mr Baker KC, Mr Kryzwon accepted that it is possible that when recalling now how he would have asked Ms Hepworth about it, he substitutes what he would ask now as a significantly more experienced physiotherapist for what he in fact asked at the time. It is to his credit that he made that concession, one of a number of reasonable concessions that he made. I agree that it is possible. However, the form or words which he says that he would have used when asking a woman about saddle anaesthesia – "whether they can feel when they clean/wipe themselves after passing urine or faeces" – is a form of question that was in general use at the time, being the form which Dr Coates says that she would have used and a form favoured by the expert neurolosurgeons. Mr Kyrzwon in his witness statement explains that it was part of his duty to satisfy himself that every patient has fully understood the question that he is asking them and has answered them truthfully. After considering the evidence as a whole, I find that on the balance of probabilities, Mr Kryzwon did ask Ms Hepworth the question as to feeling after going to the toilet in the form that he says that he did.

(z) I further find that, as Mr Kryzwon's contemporaneous record indicates, Ms Hepworth answered the question in the negative. Again, this is because Mr Kryzwon's note recording his communication to Ms Hepworth of the need for vigilance and to seek emergency medical help if she experienced any of the red flag symptoms, including saddle anaesthesia, are only consistent with her doing so. I find those notes to be reliable for the reasons which I have already given.

(aa) On 9 November 2018, Ms Hepworth woke up in severe pain in both legs. She recalled being told by Mr Kryzwon to call an ambulance if things got worse but instead, she rang NHS 111. There is a transcript of the call so what she was asked and what she said is clear, save for whether at one point she refers to her foot or glute where the transcriber found the recording unclear. It is not a point that I consider to be of great importance. I agree that the recording is not very clear, I consider that the word stated by Ms Hepworth sounded like "glute" and did not sound like "foot." Ms Hepworth was asked during the call about her bowels and reported no change in bowel function. It is also notable that early in the call when asked why she is calling she states that she has had significant sciatic pain on her left side, has seen her GP, is on tramadol and was told to call if the pain spread to the other side as well and if she got numbing in her foot, and she reports that she has the pain on both sides and has numbing in her foot. This indicates that Ms Hepworth had been given and had taken on board the warnings about seeking urgent medical help if she developed any of the red flag symptoms. It indicates she received and understood in general terms such advice given by one or both of Dr Coates and Mr Kryzwon – but not which. Ms Hepworth was asked by the NHS 111 call handler whether she had numbness around her back passage and in both legs. She replied just in one leg and glute. No follow up question was asked by the call handler. The question was a compound one and therefore the answer given by a woman with no particular medical knowledge and in a state of distress is one to which I attach less weight than I would if it had been clearer, as the answer is also ambiguous. As various of the experts indicated orally, the word "glute" is ambiguous for the purposes of the issue that I have to decide, as it may or may not extend to the perianal area. A further history was taken by the attending paramedics and then by the ambulance crew.

(bb) Ms Hepworth was then taken to Pembury Hospital in Tunbridge Wells. The notes indicate that on admission to Pembury, Ms Hepworth reported the loss of perianal sensation and loss of perianal sensation to the right side on examination is reported. There is no record of when she started to experience it, probably because she was not asked.

42. Turning to the 5 November Consultation, there is a clash of evidence as to what was said by each of Ms Hepworth and Dr Coates and none of the witnesses present has demonstrated a reliable and complete recollection of what occurred. My determination of what occurred is therefore significantly influenced by the principle of inherent likelihood. Bearing in mind the factual findings which I have already made, I make the following findings of fact as to what occurred:

(a) The 5 November Consultation was brought forward from the afternoon to the end of Dr Coates' morning surgery. This was at the instigation of surgery staff but not of Dr Coates herself. This is the effect of the oral evidence of Ms Hepworth and Dr Coates.

(b) Ms Dixon drove Ms Hepworth to the surgery and attended the 5 November Consultation throughout. Her attendance is the evidence of them both and that of Dr Coates.

(c) I make no finding as to the precise length of the 5 November Consultation but find that it lasted significantly longer than the usual 10 minute consultation which was the norm at the surgery at that time. This is consistent with the evidence of Ms Dixon and Dr Coates. However, I do not find that it lasted as long at the 47 minutes advanced in Dr Coates' witness statement, which it emerged during cross examination, is simply a reflection of the time between when she opened the computerised patient record for Ms Hepworth and when she opened the record for her next patient. I also reject Dr Coates' evidence that she recalls looking that the clock when Ms Hepworth left the room and noting that she had 10 minutes until her 2.00 pm patient. In my judgment, such a recollection from 2018 in relation to what was at the time one unremarkable patient encounter among potentially as many as 40 that day alone is not credible.

(d) I find that like most, if not all, GPs, Dr Coates invariably worked under considerable pressure. Her own evidence was that she would typically see between 16 and 20 patients in a session and her sessions invariably were behind schedule as a result of allowing each patient as long as she considered that they reasonably required, as she did with Ms Hepworth. I accept that evidence. It is to her credit as a conscientious doctor who cared about the well-being of her patients, but it was a practice that in my judgment added to the pressure under which she worked. It will have

generally led to her surgeries becoming progressively more behind schedule and created greater pressure to put off referral forms and the completing of notes and records until the end of the session.

(e) I find that it was Dr Coates' invariable practice to complete all records and referral forms and other necessary tasks before she left the surgery at the end of the day. This was her evidence and I accept it.

(f) I find that Dr Coates' general practice was to listen and look at patients while they were talking to her and to type notes directly into the computerised records system as and when the opportunity allowed, such as when a patient was getting undressed, moving onto the couch or there were otherwise gaps on conversation. I find that she adopted this practice at the 5 November Consultation. She would type up most of her notes after the diagnosis was complete but there was not always sufficient time for her to complete her note before the next patient. This was her evidence which I accept. As a result of this practice, it was frequently necessary for Dr Coates to complete the record of a particular consultation after the consultation had ended and before the next patient. Sometimes the completion of a record would be delayed until the end of the session. Dr Coates accepted this in cross examination.

(g) As Mr Baker KC submits, this creates a greater risk that notes will be inaccurate than would be the case if notes were always completed during the consultation or before seeing the next patient.

(h) In cross examination, Dr Coates was reluctant to accept that working under the pressure I have described and adopting the note taking practice which I have described gave rise to a risk of error. In my judgment, that these matters create a greater risk of error than would be the case if they were not present is self-evident.

(i) I find that Dr Coates' note taking with regard to Ms Hepworth was far from ideal but was not in breach of duty. I find that, as she accepted in cross examination, she failed to include in her note of the 25 October Consultation that she had tested the power in Ms Hepworth's legs and that she included in the MRI referral form that she completed on 5 November but did not include in her note of the 5 November Consultation that Ms

Hepworth had sensory numbness down to her foot. She also failed to record even on the form which of Ms Hepworth's legs was affected.

(j) I find that Dr Coates began to make notes into the medical records system during the 5 November Consultation. Dr Coates stated in cross examination that she had no independent recollection of when she made the notes of the 5 November Consultation. However, it was her usual practice to make at least some notes while the patient is present and there is no reason to conclude that she did not do so.

(k) Dr Coates also stated that it was her usual practice to complete notes of an examination either during, straight after or within an hour or so. She completed administrative tasks at the end of the day such as forms and letters but not notes of patient consultations. I accept this evidence as it is inherently likely. The risk of error by inaccurate recording where such notes are left until after more than a couple of further patients have been seen is obvious. It is inherently likely that a conscientious doctor, as I consider that Dr Coates generally was, would not run such a risk unless it was completely unavoidable, for example due to a patient presenting with a medical emergency.

(l) I find that on the occasion of the 5 November Consultation, Dr Coates completed her notes immediately after or virtually immediately after the conclusion of that consultation. We know that Dr Coates was working an afternoon session that day as Ms Hepworth was due to be seen by her later that afternoon. In my judgment, that is what is more inherently likely as Ms Hepworth was the last patient of the morning session. Therefore, Dr Coates would have been aware that if she left the completion of the record until after she saw the first patient of the afternoon session, it may not be until the end of that session, after around 4 hours and up to 20 patients, that she would have the opportunity to do so.

(m) Consistently with my finding that Ms Hepworth had not in fact lost control of bowels, I find that she did not report to Dr Coates that she had. She reported that she had been concerned that she would do so as she was expecting to pass wind but became aware that she was going to pass a stool and only just made it to the toilet in time, where she passed an explosive stool. As this is what I have found in fact occurred, it is

inherently likely that this is what Ms Hepworth reported. This is also broadly consistent with Dr Coates' note of normal bowel and bladder function. An explosive stool in such circumstances can be described as normal for a patient who has been taking heavy painkillers and lactulose for several days.

(n) Whilst Dr Coates' failure to document what in fact occurred with Ms Hepworth's bowel is, to me as a non-medical professional, rather surprising, it makes no difference to the questions of breach of duty and causation arising in this case.

(o) The question of what (if anything) was said about saddle anaesthesia is one that involves resolving the inconsistency between what Ms Hepworth said in her WhatsApp message to Mr Davies on 3 November and Dr Coates' note contained in the medical record of the 5 November Consultation. Mr Baker KC does not suggest that Dr Coates deliberately made an inaccurate note but submits that inherent likelihood points towards either Dr Coates forgetting to ask the questions that she would normally ask (or at least the question going to saddle anaesthesia); or that Dr Coates asked about saddle anaesthesia in a way which was not understood by Ms Hepworth, or she misunderstood the answer and/or failed to ask any necessary follow up question – as he says (with some justification) was what the transcript of Ms Hepworth's conversation with the call handler from NHS 111 indicates that the call handler did. I agree with Mr Baker KC that a key question to be resolved is the apparent inconsistency between the WhatsApp message and the medical records. However, for one of his proffered explanations for it to be correct, it is necessary to find that as well as Dr Coates' record being inaccurate, so is Mr Kryzwon's, or that Ms Hepworth gave different answers to Dr Coates and Mr Kryzwon. It is inherently unlikely that Ms Hepworth would give inconsistent answers to the same questions asked two days apart.

(p) Further, Dr Coates noted on the MRI Referral Form completed on 5 November that Ms Hepworth had sensory numbness down her leg to her foot. Dr Coates says that Ms Hepworth told her of this. The note indicates that sensory numbness was discussed and Ms Hepworth does not dispute that she had change in sensation in her leg and that this was discussed at

the 5 November Consultation. It is inherently unlikely that numbness in Ms Hepworth's leg having been discussed, Dr Coates would not have gone on to ask about numbness in the saddle area if she had not already done so.

(q) In my judgment, taking into account in particular, that the observations in *Gestmin* apply with some force to the evidence of all three of those present at the 5 November Consultation; unsurprisingly, (1) none of them have a reliable recollection of what occurred; (2) Mr Kryzwon's note, which I have found to be reliable, records that he did ask about saddle anaesthesia and warn about it; (3) Dr Coates had been on a training course which covered CES on 24 October and the records record that she asked Ms Hepworth about the red flag symptoms including saddle anaesthesia in both the 25 October Consultation and the 29 October Consultation; (4) as any GP would, it is inherently likely that she looked at the notes of those consultations either immediately before or shortly after the beginning of the 5 November Consultation; (5) as I have found, Ms Hepworth was in severe pain when she attended the 5 November Consultation; and (6) that Ms Hepworth did report to Dr Coates that she was experiencing some numbness down her leg to her foot, as recorded in the MRI Referral Form so numbness was discussed; it is inherently more likely that Dr Coates did ask about saddle anaesthesia at the 5 November Consultation. I find that on the balance of probabilities she did ask.

(r) All of the experts who addressed the question of how a female patient should be asked about saddle anaesthesia agreed that the appropriate way to ensure understanding is to ask the patient if they can feel when they wipe themselves, front and back, after going to the toilet. Mr Kryzwon says that this is how he would have asked Ms Hepworth about it. I accept that evidence. Dr Coates says the same. No doubt the precise words used by an individual clinician will vary over time, but there is no evidence which indicates a change of best practice or of common practice since November 2018 when asking questions about saddle anaesthesia. There was no suggestion by any of the clinicians who gave evidence that there has been any reason for such a change. All agree on the importance of asking about it in such a way that the patient understands the question. Dr

Coates confirmed her agreement with this during her cross examination. In my judgment, the evidence establishes that asking a female patient about saddle anaesthesia by asking about change in sensation when wiping after going to the toilet is and was in November 2018 the usual way of asking the question. It is inherently likely that Dr Coates asked Ms Hepworth the question in that form at the 5 November Consultation. There is no basis to conclude that she asked the question in a different form, other than the inconsistency between Dr Coates' note and the answer that Ms Hepworth would be expected to give in the light of her report of numbness on the evening of 3 November. I find that Dr Coates asked Ms Hepworth whether she had experienced any numbness when wiping herself front and back after going to the toilet and that Ms Hepworth answered that she had not. This answer is, of course, inconsistent with her WhatsApp message to Mr Davies. The wider evidence provides a number of indications of how she came to give this inconsistent answer. In cross examination, Ms Hepworth stated that she did not think the numbness was important and that she thought it was caused by the pain she was in or as a result of her "sitting funny". Mr Davies also stated that he and Ms Hepworth did not take the numbness seriously at the time and that neither of them mentioned it again after the WhatsApp exchange on 3 November. Ms Hepworth was also in significant pain leading up to and during the 5 November Consultation. In those circumstances, I find that she had not been especially aware of the numbness on 5 and 7 November as it was over-shadowed by her pain, that other than the incident when she only just made the toilet, she had not evacuated her bowels over that period, and that when asked about it by Dr Coates on 5 November and Mr Kryzwon on 7 November she overlooked the numbness which she had identified on 3 November before her pain became so great.

43. It follows from these findings and the evidence of the GP liability experts that Dr Coates did ask the necessary questions in a form that Ms Hepworth understood and that she understood the answers. The alleged breach of duty is not made out on the evidence. Therefore, the claim fails. However, it is

necessary for me to go on to determine the issue of causation and what the quantum of the claim would have been if it had succeeded.

Causation

44. If breach of duty had occurred, Ms Hepworth would be entitled to damages to reflect the difference between her actual condition and future needs and the condition she would have been in and what her future needs would have been had she been referred to her local hospital, Pembury Hospital in Tunbridge Wells, by Dr Coates at the conclusion of the 5 November Consultation.

45. As to factual causation, each of the experts agrees that what would have happened if Dr Coates had referred Ms Hepworth to hospital urgently is what in fact happened when she was taken to hospital by ambulance on 9 November. Matters would have proceeded at the hospital much as they did when she was eventually taken there, and she would have been operated on probably in the early hours of 6 November rather than the early hours of 10 November,

46. So far as medical causation is concerned, although there is a good deal of agreement between the relevant experts as to how that would have affected the outcome and that Ms Hepworth would have suffered fewer permanent effects from the CES, they are not entirely agreed as to what Ms Hepworth's condition would have been, what her future needs would have been and as to how her condition will change over the remainder of her life.

47. The question of how Ms Hepworth's medical condition would have been improved had she undergone surgery earlier is primarily a matter of expert neurosurgical evidence.

Causation and Prognosis - Neurosurgery

48. I heard expert neurosurgical evidence from Mr Todd on behalf of Ms Hepworth and Mr Macfarlane on behalf of Dr Coates. Both are undoubtedly eminent experts in their field. I found both to be helpful witnesses who assisted me in understanding the neurological pathology of both CES generally and its effects on Ms Hepworth in particular. Both generally gave direct and clear answers to the questions they were asked and made what I consider to be appropriate concessions.

49. Both were the subject of criticism from opposing counsel. Mr Todd was criticised by Ms Pritchard KC for being partisan and failing to comply with his duties to the Court under CPR Part 35. She pointed to his admitted inclusion in

his report of matters reported to him by Ms Hepworth at meetings on unspecified occasions without referencing them and his statement that he if he obtained information at a meeting with or examination of a claimant, he would email the relevant solicitor and advise them of matters which should be added to the witness evidence. He then backtracked saying only that he would put out to the solicitor information that he had elicited which was absent from a claimant's witness statement. Ms Pritchard KC submitted that this conduct meant that Mr Todd was involving himself in the witness evidence preparation process which is improper for an independent expert witness. Further, Mr Todd's failure to record in his report the dates of the witness statements he saw is improper.

50. In my judgment, there was no indication that in this case Mr Todd emailed Ms Hepworth's solicitors to ask that something be added to the witness evidence. I agree with Ms Pritchard KC that if he had done so that would have been improper and inconsistent with the role of an independent expert and his duties to the Court under CPR Part 35. As to whether Mr Todd meant to say that it is part of his usual or even occasional practice to email solicitors for claimants and tell them what to add to witness statements and whether he actually does this, I make no finding. I have already stated that such conduct would be improper and I leave that point there.

51. I accept Ms Pritchard KC's submission that a failure to identify when and how information from a claimant is elicited is unhelpful and a failure to comply with at least the spirit of the Practice Direction to Part 35. The same applies to Mr Todd's practice of not identifying the dates of witness statements he has seen and taken into account. Mr Todd's explanation for the latter by reference to administrative inconveniences which arise due to witness statements being updated is not an adequate excuse.

52. However, despite these criticisms as to practice in preparing reports, in his actual evidence and under cross examination, Mr Todd was in my judgment properly independent. He engaged with the questions asked of him, gave clear and direct answers, and made appropriate concessions. He also volunteered at the outset in his original report that on one matter on which he and Mr Macfarlane differ, his view is very much a minority one among experts in the field. I regard that as an indicator of independence. Therefore, although I

consider that while parts of the process by which he prepared his reports are open to fair criticism, Mr Todd's evidence should be regarded as independent and impartial in this case.

53. Mr Macfarlane was criticised by Mr Baker KC for showing dogmatism and being unwilling to depart from the case pleaded in the Defence to an unreasonable degree. I deal separately with his evidence as to rehabilitation, but so far as his evidence on neursurgery was concerned, I do not agree. I found Mr Macfarlane's evidence on matters of neurology to be clear and his use of language to be precise. He engaged directly with the questions he was asked and provided careful explanation for his answers which were generally very clear and helpful. He also generally made what I consider to be appropriate concessions. The fact that I may prefer other evidence on some points is not a ground for criticising his evidence generally or the way in which he gave it.

54. The experts have considered what the outcome for Ms Hepworth would have been had she been operated upon following an urgent referral to hospital by Dr Coates on 5 November. Mr Todd and Mr Macfarlane are in agreement that had she been operated on following being referred to hospital on 5 November, Ms Hepworth would have avoided:

(a) All of the bladder dysfunction she has experienced;

(b) Right lower limb numbness; and

(c) Right lower limb neuropathic pain.

55. There is disagreement between Mr Todd and Mr Macfarlane as to whether had she been operated on promptly after the 5 November Consultation, Ms Hepworth would have suffered the same:

(a) Ongoing back pain;

(b) Neurogenic bowel dysfunction;

(c) Saddle sensory loss; and

(d) Motor weakness in the lower right limb (including reported 'foot drop').

56. I address each of these issues in turn.

Ongoing Back Pain

57. I can deal with this issue very shortly. Mr Macfarlane says that Ms Hepworth would have suffered the same ongoing back pain had surgery taken place earlier. Mr Todd says that her ongoing back pain would have been significantly reduced with earlier surgery. However, Mr Todd acknowledges both in his original

report and in the Joint Statement, and did so again in oral evidence, that most neurosurgeons would disagree with his view.

58. The explanations provided by Mr Todd for his view did not persuade me that I should depart from what he accepts is the view of the overwhelming majority of neurosurgeons, that earlier surgery in a case such as Ms Hepworth's would not affect ongoing back pain. I prefer the evidence of Mr Macfarlane on this point and find that earlier surgery would not have reduced the ongoing back pain which Ms Hepworth experiences.

Neurogenic Bowel Dysfunction

59. The expert evidence is clear that the onset of neurological dysfunction as CES develops is in at least the overwhelming majority of cases that loss of saddle sensation is the first symptom, followed by bladder dysfunction and then bowel dysfunction. I accept that evidence.

60. Ms Hepworth did not report and there is no other evidence that she suffered any bladder dysfunction until around 9 November. The notes made on her admission to Pembury Hospital indicate no bladder or bowel incontinence. I accept Mr Todd's evidence that only about 20% of CES patients have bowel dysfunction and only about 10% have faecal incontinence. In my judgment, the evidence indicates that it is unlikely that the bowel incident which Ms Hepworth suffered on 4 November was neurologically mediated. In my judgment, on the balance of probabilities, it was a response to the lactulose she had been taking, as a laxative following a period of earlier constipation following the taking of powerful pain relief medication.

61. In the light of that finding, both Mr Todd and Mr Macfarlane opine that Ms Hepworth would have recovered normal bowel function if she had been operated on earlier. I accept their evidence and so find. It follows that all of the continuing bowel issues which Ms Hepworth has would have been avoided by earlier surgery.

Saddle Sensory Loss

62. I have found that Ms Hepworth did experience saddle anaesthesia on 3 November 2018. There is no evidence that her saddle sensation declined between then and 9 November. The medical notes indicate that on admission to Pembury Hospital, Ms Hepworth had impairment in perianal sensation to the right side. This is consistent with her report of loss of sensation on 3 November.

Mr Todd did not ask Ms Hepworth about changes in saddle sensation. Mr Macfarlane says that he asked Ms Hepworth whether her saddle numbness changed between 5 November and surgery and she said that it did not. I accept that evidence and find that Ms Hepworth continued to experience some saddle anaesthesia from 3 November onwards but that it did not change between then and her surgery in the early hours of 10 November.

63. Mr Todd and Mr Macfarlane are agreed that CES causes neurological dysfunction as a result of the compressions of the nerve tissue and that once damaged by compression, the nerve tissue ordinarily does not regenerate. Therefore, a CES patient will usually have the same level of sensory loss post-surgery as they had pre-surgery. It follows from my finding that Ms Hepworth's sensory loss was substantially the same as at the date of surgery as it was at the 3 November, that had she undergone surgery earlier as she contends, she should have, her saddle sensory loss would have been no different to the sensory loss that she has in fact experienced. Accordingly, I find that Ms Hepworth's saddle sensory loss would have the same as it in fact is if she had undergone surgery earlier.

Motor Weakness in Right Lower Limb

64. Ms Hepworth reports motor weakness in her right leg and 'foot drop.' Her evidence is that if she really concentrates, she can walk without any element of foot drop for short periods, but she cannot walk normally for sustained periods or without paying careful attention to how she walks. Her foot drop has been observed by various clinicians. I accept this evidence and so find.

65. The essential dispute between the experts on this issue in their reports was that Mr Todd considers if Ms Hepworth had received surgery prior to the onset of motor weakness she would currently have normal motor power in her right leg, whereas, Mr Macfarlane says that the position is complicated by a psychological element. Therefore, Mr Macfarlane's opinion is that whether there would have been a difference in Ms Hepworth's motor weakness in her right leg depends on what her psychological response to the earlier surgery would have been.

66. At the time of his report Mr Todd was not aware of the psychological element. Once aware of it, his evidence is that Ms Hepworth's foot drop could be psychological in origin. He considers that she had marked symptoms and

objective signs of foot drop but in the absence of organic pathology, the cause may be psychological.

67. Mr Macfarlane points to the fact that on discharge from Stoke Mandeville, Ms Hepworth was recorded as having normal motor power in her right leg. Both experts consider that records made at Stoke Mandeville should be regarded as reliable due to the particular expertise in neurosurgery and neurological rehabilitation of the clinicians there. I agree.

68. Mr Macfarlane says that as Ms Hepworth achieved normal power after surgery, it must follow that there was no irreversible damage to her motor nerve. Therefore, any weakness in power is not neurological in origin. I accept that evidence and so find. The absence of a neurological cause to the foot drop is supported by Ms Hepworth's physical ability to walk normally at times.

69. Mr Macfarlane accepts that Ms Hepworth's weakness in her right leg is genuine but questions whether it is irreversible.

70. Mr Todd and Mr Macfarlane agree that Ms Hepworth's foot drop may be caused by her reaction to pain and/or her psychological response to her CES and surgery. In my judgment, it is caused by one or both of those factors and is not neurological in origin. However, this means that the question of whether Ms Hepworth would have experienced the same foot drop with earlier surgery depends, as Mr Macfarlane says, on what her psychological response would have been and/or whether the outcome in terms of pain would have been different.

71. When giving evidence on neurological rehabilitation, Mr Macfarlane said that there were indications that Ms Hepworth's leg power is limited by pain as the wider evidence indicates that the motor nerve has recovered but the sensory nerve has not. I accept this evidence and find that chronic neurological pain is a cause of her foot drop.

72. I address the evidence of the psychiatric experts further below but note at this point that they agree that Ms Hepworth has a reciprocal interaction of her pain symptoms and her psychological symptoms and that her foot drop is psychologically mediated and could be regarded as a Dissociative Motor Disorder. It follows and I find that her foot drop also has a psychological cause. It is not possible to apportion the cause between pain and psychological factors.

The reciprocal interaction means that in my judgment, such an apportionment is not possible on current evidence.

73. Doing the best I can from the evidence I have been provided with, I find that had Ms Hepworth received the earlier surgery that says she should have, she would still have suffered some neurological pain to her right leg, but that pain would have been notably less severe than the pain she has in fact suffered.

74. I accept the evidence of the psychiatric experts that Ms Hepworth suffered an exacerbation of her existing Emotionally Unstable Personality Disorder ("EUPD") and that she would have also experienced an exacerbation of her EUPD if she had received surgery earlier, but in that eventuality, the exacerbation would have been less severe. They agree that even with the less severe exacerbation she would still have developed a degree of foot drop.

75. Again, doing the best I can, I find that had she received the earlier surgery she contends for, Ms Hepworth would still have experienced functional motor weakness in her right leg caused by pain and exacerbation of her EUPD, but in that eventuality, although she would still have developed foot drop, it would have been less severe.

76. Mr Macfarlane emphasised that as there is no neurological cause for her motor weakness, with one or both of psychological therapy and pain management there is no reason why Ms Hepworth's right leg function and in particular her foot drop might not improve. The expert psychiatrists also agree that it is common for EUPD to moderate with age, which could lead to a relative improvement in Ms Hepworth's foot drop. I agree that it is possible. However, I am not persuaded that on the balance of probabilities there will be any meaningful improvement by any particular time. I therefore find that Ms Hepworth's right leg pain and her foot drop will continue as they now are, subject to the eventual further decline in her physical condition generally due to old age and likely acceleration of that in her case, which I consider separately.

<u>Causation and Prognosis - Psychiatry</u>

77. The parties' expert psychiatrists, Dr Moosa and Dr Amin, both gave oral evidence. Neither was cross examined for long as they are essentially agreed on all significant points. Both gave their evidence in a clear way and made appropriate concessions. I accept their evidence.

78. They agree that Ms Hepworth has an EUPD dating from traumatic events in her childhood. Also, prior to the onset of her CES, she engaged in harmful use of alcohol and harmful use of cocaine. I should make clear that there is no suggestion that Ms Hepworth is, or was at any time, either an alcoholic or a drug addict.

79. Dr Moosa and Dr Amin agree that Ms Hepworth's EUPD was vulnerable to exacerbation due to adverse life events. They agree that post-surgery, Ms Hepworth has EUPD which has been exacerbated by her CES and surgery and that she engages in harmful use of alcohol which has also been exacerbated, but no longer engages in harmful use of cocaine.

80. On the face of their reports and their Joint Statement, it appeared that there was a disagreement between them as to whether Ms Hepworth developed an Adjustment Disorder following her surgery. However, it became apparent during cross examination that the difference between them was more apparent than real. Dr Moosa would describe the symptoms which Ms Hepworth experienced following surgery and for a period thereafter as an Adjustment Disorder while Dr Amin would not, but it was clear from their oral evidence that both found the same symptoms and they agree that nothing turns on the label put on those symptoms.

81. It is not necessary for me to decide whether the agreed symptoms should or should not be labelled an Adjustment Disorder for the initial period and therefore I shall not do so.

82. Dr Moosa and Dr Amin agree that the exacerbation of the EUPD and harmful use of alcohol have a mild impact on Ms Hepworth's normal activities of daily living. They agree that it has as a result contributed to the effect of her EUPD on her relationships with others, which has led to her forming unstable relationships. They agree that her physical symptoms from CES caused her to have an abortion, which in turn caused her to experience significant guilt. They also agree that her exacerbated EUPD has had a minimal direct impact on her ability to work and is not what has prevented her from continuing to work as cabin crew. In addition, they agree that her ability to engage in social activities has not been affected by her exacerbated EUPD. I accept all of that evidence.

83. Dr Moosa and Dr Amin are agreed that in the light of my finding that Ms Hepworth has suffered a worse physical outcome as a result of the delayed

surgery, she has suffered a greater exacerbation than she would have after earlier surgery, but that there would have been some exacerbation in any event.

84. So far as Ms Hepworth's psychological prognosis is concerned, Dr Moosa and Dr Amin agree that as Ms Hepworth's physical prognosis is poor, although how poor depends upon the evidence of other experts that the Court prefers, the on-going EUPD and harmful use of alcohol will continue and continue to be worse than they would otherwise have been. They also agree that she would benefit from both 10- 12 session of Cognitive Behavioural Therapy and 16 – 20 session of Dialectical Behaviour Therapy. However, she would have required this therapy in any event due to her pre-existing EUPD and it is not possible to identify additional psychological therapy needs arising from her CES.

85. Dr Moosa and Dr Amin also agree that Ms Hepworth would benefit from a Pain Management Programme.

86. I accept all of the agreed expert evidence of Dr Moosa and Dr Amin and so find. In my judgment, as a result of her physical prognosis being significantly poorer than it would have been with the earlier surgery she says she should have received, the exacerbation to Ms Hepworth's EUPD is also significantly greater than it would have been.

Causation and Prognosis - Urology

87. Expert urology evidence was called from Professor Chapple for Ms Hepworth and Mr Reynard for Dr Coates. Both gave oral evidence at trial, although at no great length given the extent of the agreement between them as to the most important matters of urology in the case. I found both to be impressive witnesses, giving clear and direct answers to questions with helpful explanations where necessary. Each also made appropriate concessions.

88. Professor Chapple and Mr Reynard agree that Ms Hepworth has had a poor urological outcome from her CES. She does not experience a normal desire to pass urine but rather an ache in her abdomen which can become severe if her bladder becomes very full. Her blader sensation is severely impaired and she has a failure of bladder contraction (acontractile detrusor) and is reliant on intermittent self-catheterisation ("ICS") for bladder emptying. I accept this evidence.

89. One area of slight disagreement between the experts is when she passed from incomplete CES ("CESI") to complete CES ("CESR"). Mr Reynard's view is

that Ms Hepworth became CESR at some stage on 9 November 2018 between 09.00 and 13.05 and that the records from Pembury Hospital indicate that she was still CESI at the point of catheterisation there. Professor Chapple is more reticent about expressing a view on this as he observes that urologists are seldom involved in the acute phase of CES so lack relevant experience. However, he suggests that the wider evidence indicates that Ms Hepworth may have gone into CESR sooner. They agree that the urological evidence indicates that she was in a state of CESR by the time of the spinal decompression surgery in the early hours of 10 November.

90. Professor Chapple and Mr Reynard agree that had Ms Hepworth undergone surgery while still in a state of CESI, she would have avoided ICS. They also agree that recovery of normal saddle sensation would have required surgery within hours when saddle sensory disturbance commenced. I accept this evidence and note that it is consistent with the evidence of the neurosurgeons and my finding that Ms Hepworth would have suffered the saddle sensory loss on the counterfactual scenario.

91. In light of these areas of agreement, I do not need to determine precisely when Ms Hepworth moved from CESI to CESR. I find that at the time of her surgery she was in CESR. At the time when surgery would have occurred had she been sent to hospital at the 5 November Consultation, I find that on the balance of probabilities she would still have been in CESI. Therefore, had she received surgery at that time she would have avoided the need for ISC.

92. Professor Chapple and Mr Reynard are agreed that on the balance of probabilities, Ms Hepworth will lose the ability to ISC at the age of 70 and from that point will need suprapubic catheter bladder drainage. They also agree that suprapubic catheters are provided by the NHS, with community nurses changing the catheters and that NHS care is preferable for this, as it provides continuity of care. I accept that evidence.

Neurorehabilitation

93. Ms Hepworth relies on expert neurorehabilitation evidence from Dr Bavikatte. Dr Coates relies on expert neurorehabilitation evidence from Mr Macfarlane. It is necessary for me make some general observations about each of these experts before turning to their evidence.

94. Parts of Dr Bavikatte's evidence in his report, the Joint Statement and his oral evidence at trial gave me cause for concern. Dr Bavikatte stated during cross examination that he did not have Ms Hepworth's witness statement when he prepared his report, nor when he met with Mr Macfarlane and when the Joint Statement was prepared. In fact, he was only provided with it a few days before the start of the trial. There is no indication in Dr Bavikatte's report that he had seen such a witness statement (or any witness statements or other reports) when he wrote it.

95. Ms Pritchard KC suggested that I might reject that evidence as it would amount to a serious failing by Ms Hepworth's solicitors and by Dr Bavikatte himself if it is correct. In the absence of any other evidence on that point, I do not reject Dr Bavikatte's evidence as to it. If it is correct, then it is a very serious failing by Ms Hepworth's solicitors. However, I make no finding as to whether it is correct or not. It is not necessary for me to do so and it would be unfair on those solicitors if I were to do so without giving them the opportunity to respond. The admission of further evidence about this would be disproportionate and could lead to further difficult potential conflicts between solicitor and client interests.

96. It is sufficient for me to find that Dr Bavikatte's evidence is that he prepared his report and met with Mr Macfarlane and signed the Joint Statement without having consulted Ms Hepworth's witness statement. His evidence is that he also did so without seeing the reports of the expert neurosurgeons or urologists, whose evidence would self-evidently be potentially relevant to the issues that he addressed and did not ask to see them. It was not Dr Bavikatte's fault if he was not provided with the witness statements and other reports, but that he did not ask to see them before finalising his report is, in my judgment, a serious omission.

97. Dr Bavikatte's not having seen Ms Hepworth's statement directly affected his reports and in particular his second report in 2024. He reported that Ms Hepworth told him that she used a Zimmer frame inside to get up from the sofa 3 – 4 days per week and may need a Zimmer frame for indoor mobility; in addition, she uses a crutch or a Zimmer frame outdoors. Ms Hepworth's own evidence, both in her witness statements and orally is inconsistent with this. Her evidence, which I accept, is that she needs a Zimmer frame to get up from the sofa when she has a very bad day about once every 3 – 4 weeks. She generally

walks with a crutch outside but does not need or use a Zimmer frame to walk either inside or outside. These are serious discrepancies between the actual position and what Dr Bavikatte has recorded it to be.

98. Dr Bavikatte was also unaware that since her surgery, Ms Hepworth has been on a number of overseas holidays, including on long-haul flights, as he had not read her witness statements.

99. It also became apparent during cross examination that when preparing his reports, Dr Bavikatte had not read the Stoke Mandeville discharge reports concerning Ms Hepworth which recorded the extent of her abilities and impairments at that point. He was therefore unaware of her having normal motor power at that time, even though, as Dr Bavikatte accepted, her current neurological condition should be the starting point when reporting on neurological rehabilitation.

100. These serious discrepancies lead me to conclude that Dr Bavikatte either did not take, or did not record, an accurate history of Ms Hepworth's condition. He also based his conclusions on his inaccurate history. Those conclusions are therefore likely to be unreliable.

101. In his oral evidence at trial, Dr Bavikatte did revise his opinion in the light of the accurate information as to Ms Hepworth's use of a Zimmer. However, I also have concerns as to the reliability of Dr Bavikatte's oral evidence. During his cross examination, Dr Bavikatte referred to having seen in the medical notes which he had looked at recently, a note of Ms Hepworth falling down the stairs and attending hospital where a head scan was carried out. A break was taken to give Dr Bavikatte time to find the relevant note. After the break, he referred to a note of another fall which was very clearly not the one he referred to as it did not have the features he had previously described. He was given a further opportunity to find the note overnight. Next morning, he identified a note which referred to an MRI head scan. However, the scan related to reported sinus issues and not a fall. There was in fact no such record of Ms Hepworth having a fall which met the description given by Dr Bavikatte.

102. Ms Pritchard KC submitted that it was open to me to find that Dr Bavikatte had attempted to deliberately mislead the court although it was not necessary to do that. It was sufficient that this course of evidence demonstrated that Dr Bavikatte was not prepared to acknowledge that he had made a mistake and that

he repeatedly tried to find evidence to support an error which he must have at least suspected that he had made.

103. I bear in mind that Dr Bavikatte gave his evidence in circumstances where his father was reportedly seriously ill in India and that Dr Bavikatte was anticipating being called to India urgently. This is not relevant to the inadequacies in his reports but it may be a contributory factor to the deficiencies in his oral evidence. In my judgment, having heard Dr Bavikatte, he did not deliberately set out to mislead the Court; but made a mistake and rather than admit it, in order to try to save face, sought to justify it. He did in his oral evidence make appropriate concessions but his unwillingness to admit a clear error in answer to a question in cross examination and attempts to justify it remain. They cast serious doubt on the reliability of his oral evidence generally.

104. Ms Pritchard KC drew to my attention criticism of Dr Bavikatte, and his report in particular, in the Judgment of HHJ Emma Kelly sitting as a Judge of the High Court in *MJF v University Hospitals Birmingham NHS Foundation Trust* [2024] EWHC 3156 (KB). HHJ Emma Kelly criticised Dr Bavikatte's report in that case for similar reasons to some of those that I have expressed and the party calling him did not rely upon his evidence in closing submissions in that case. She submitted that this indicated a troubling pattern of a partisan approach by Dr Bavikatte. I am not persuaded that Dr Bavikatte's evidence in this case is deliberately partisan. In my judgment, the inadequacies in his report to which I have referred stem from a lack of care and attention to detail and not any partisan intent. However, they have a similar effect in that they render his report unreliable.

105. In the light of the troubling features of Dr Bavikatte's report and oral evidence, I am unable to rely with any confidence on either Dr Bavikatte's reports or his oral evidence unless they are supported by other compelling evidence.

106. Mr Baker KC is also particularly critical of Mr Macfarlane's evidence on neurorehabilitation. He criticised Mr Macfarlane's reluctance to accept the role of neurorehabilitation specialists such as Dr Bavikatte in long term care of CES patients. Mr Baker KC submitted that Mr Macfarlane's obtaining about 80% of his instructions from defendants was something to weigh in the balance when considering his overall approach to the evidence, which it was said was to take the route most favourable to the defendant whenever presented with an

alternative course. Mr Baker KC also suggested that Mr Macfarlane's position on the prognosis for Ms Hepworth was to dogmatically stick to a prediction that she would need sticks outside in her 70s but not indoors. It was further pointed out that Mr Macfarlane's position was contradicted by Mrs Moya and Mr Porter. Finally, it was observed that Mr Macfarlane's position was predicated on his belief that Ms Hepworth's condition would improve somewhat due to their being no neurological reason for foot drop and wider motor weakness.

107. In my judgment, Mr Baker KC's criticism of Mr Macfarlane's position on the role of neurorehabilitation specialists has some justification. I am satisfied that in many parts of the country, a specialist in neurorehabilitation centre would treat Ms Hepworth, as indicated by Dr Bavikatte and Mr Reynard. For this reason, I consider that in theory Dr Bavikatte would be the more suitable expert to opine on Ms Hepworth's neurological rehabilitation, including both prognosis and further needs. His experience makes him potentially better suited to opine on such matters generally than Mr Macfarlane. It is therefore unfortunate that I have had to conclude that I cannot rely on Dr Bavikatte's evidence for other reasons. However, in my judgment, Mr Macfarlane was simply expressing his view based on his experience in and around Cambridge, where he has worked for much of his career. I do not regard the fact that I prefer the evidence of others as a basis to criticise Mr Macfarlane's evidence more widely.

108. I accept as a general proposition the fact that an expert reports overwhelmingly for one side is something which may be taken into account when considering their approach to the evidence. However, in this case the alternative expert evidence is that of Dr Bavikatte, which is not reliable for reasons I have already given. Further, in my judgment, Mr Macfarlane's evidence is not partial in favour of the defendant (unwittingly or otherwise). It reflects the fact that he comes to the case as an expert neurologist and so tends to be particularly influenced by matters of neurosurgery which can colour his approach to some wider issues relating to rehabilitation. I bear this in mind when considering his evidence.

109. The areas of difference between these experts narrowed significantly as a result of Dr Bavikatte becoming aware of Ms Hepworth's actual abilities and activities since surgery, rather than relying upon his previous erroneous understanding.

Significantly, they now agree that Ms Hepworth will not require the use of a hoist at any point, which reduces the cost of her future care. I accept this agreed position.

110. Dr Bavikatte also modified his position in the light of the new (to him) information as to Ms Hepworth's current need for a Zimmer and agrees with Mr Macfarlane that she will not require a wheelchair indoors at any point. Again, I accept this joint evidence.

111. Dr Bavikatte's modified opinion as to mobility outside is that Ms Hepworth is likely to need a wheelchair outside due an anticipated decline in functionality and risk of falls, from the age of about 65. He stated in cross examination that if I find that there is no neurological element to the restrictions on her movement and that she can completely go about her day to daily life without fluctuation in her ability, then he agrees with Mr Macfarlane that her need will be for sticks only when she is in her 70s.

112. I have found that the restrictions in movement which Ms Hepworth experiences are not neurological in origin but the causes are a mixture of pain and psychological. However, in my judgment, there is fluctuation in her mobility which affects her ability to go about her day to day activities.

113. Whilst I note that Mr Macfarlane's opinion is that Ms Hepworth will probably achieve some level of improvement in her right leg function and therefore her mobility, he is not able to say what the level of improvement will be or whether such improvement will be sustained. In my judgment, the evidence overall is that on the balance of probabilities, Ms Hepworth will not make any particular sustained improvement in her mobility by any particular point in time.

114. After consideration of the reports of both Dr Bavikatte and Mr Macfarlane and their Joint Statement, and after considering their oral evidence at trial, as well as the evidence of Ms Hepworth and Mr Hepworth going to matters relevant to neurorehabilitation, I find that Ms Hepworth:

(a) Will not require a hoist at any time;

(b) Will not require a wheelchair for indoor use at any time;

(c) Requires a crutch or stick for longer walks outside now;

(d) Will require sticks or a crutch for all or virtually all walking outside from the age of 65;

(e) Will require a wheelchair for longer outside walking from the age of 75;

(f) Requires a frame to be able to get up from the sofa occasionally at present;

(g) Will require a frame or similar aid to be able to get up from the sofa frequently at age 65;

(h) Will require a stick or crutch for some indoor mobility from the age of 75.

115. I find that despite her current reluctance to be seen as disabled, by the age of 70, Ms Hepworth will be willing to use a wheelchair outdoors in order to live a reasonably active life.

116. I accept the evidence of both experts that Ms Hepworth fulfils the definition for a disability under the Equality Act 2010. She is disadvantaged in the labour market in that the range of jobs available to her has been reduced. I address this in more detail when considering the quantum of her future losses.

117. By reason of the difficulties with the evidence of Dr Bavikatte to which I have already referred, I prefer the evidence of Mr Macfarlane that with a reasonably sympathetic employer, which on the balance of probabilities she will be able to find, Ms Hepworth will continue to be able to work in a suitable occupation until her normal retirement age

Quantum

118. In the light of these findings, I turn to matters of quantum. As I have noted, counsel have agreed a list of issues relating to matters of quantum and I work through that agreed list determining the issues of quantum by reference to the findings of fact that I have already made and making such further findings as are necessary to do so.

General Approach to Quantum

119. There is no real dispute between counsel as to the approach to be taken to the assessment of damages. If breach of duty had been made out, Ms Hepworth would be entitled to a sum in damages which would put her in the same position as she would have been in had the breach of duty not occurred in respect of those injuries which the Court finds were caused by the breach of duty.

120. As was stated by Lord Woolf MR in *Heil v Rankin et al [2001] 2QB 272* the guiding principles are that:

(a) The principle of "full compensation" applies to pecuniary and non-pecuniary damages alike.

(b) The compensation should be fair, reasonable, and just.

(c) That means at a level which does not result in injustice to the Defendant and it must not be out of accord with what society as a whole would perceive as being reasonable.

121. In my judgment, the guidance provided by Cox J in *Manna v Central Manchester University Hospitals NHS Foundation Trust [2015] EWHC 2279 QB* at [13] is helpful: *"This Claimant is therefore entitled to damages to meet his reasonable needs arising from his injuries. Reasonableness always depends on the particular circumstances and it applies both to the head of loss claimed and to its amount. Disputes as to future losses will often require the court to make an assessment of the chances of various future events."*

122. A number of the matters in dispute in respect of quantum turn on what is required to meet Ms Hepworth's reasonable needs. I consider each in the light of Ms Hepworth's particular circumstances now, and on the basis of the findings as to her prognosis which I have made. In each case, she is not entitled to payment in respect of all services and assistance that it would be of any benefit to her to have, but nor is she restricted to those items which are absolutely essential and without which she would be unable to survive.

123. The usual civil burden and standard of proof applies. To be entitled to any particular award by reason of any breach of duty which is established, Ms Hepworth would need to prove her loss on the balance of probabilities.

<u>General Damages</u>

124. If I had found that breach of duty occurred, I would have awarded Ms Hepworth a sum by way of general damages for pain, suffering and loss of amenity. Mr Baker KC submits that Ms Hepworth's injuries fall within Orthopaedic Injuries section (B) – Back Injuries in the Judicial College Guidelines and within the "Severe" bracket, as Ms Hepworth has suffered neurological damage with very serious consequences not normally found in cases of back injury; in her case, impaired bladder, bowel, and to an extent, sexual function. I agree. In my judgment, this is the appropriate bracket, rather than to treat her bladder as the main injury and increase to reflect the other features, as that properly reflects the cause of her injuries, being a spinal neurological injury with wide consequences for other areas.

125. I need to keep in mind my finding that Ms Hepworth would have suffered back pain and loss of saddle sensation on the counterfactual scenario. The range for

that bracket is £111,150 to £196,450. Mr Baker KC says that her case falls towards the top of the bracket due to her double incontinence as well as pain and numbness. He says that an appropriate sum in general damages is £180,000.

126. Ms Pritchard KC does not disagree as to the bracket and the factors to take into account within the bracket but submits that a slightly lower sum towards the middle of the bracket would be appropriate.

127. Mr Baker KC referred me to reports of the settlements reached in a number of cases of claims by claimants suffering CES. Each case depends upon its own particular facts and the particular extent of the pain and injuries suffered by the particular claimant, but I have found it helpful to have regard to the cases *JR v Oxford University NHS Trust* (2015) WL 13794565; *VL v University Hospitals Leicester NHS Trust* (2015) WL 13798483; *X v University Hospitals of Leicester NHS Trust* (2019) WL 10248381; *C v Buckinghamshire Healthcare NHS Trust* (2019) WL 01777034 and *SL v Dr B* (2023) WL 06130324. I bear them in mind, and also note the fact that save for the last, they are between 6 and 10 years old.

128. Taking account of the factors emphasised by Mr Baker KC and the exacerbation of Ms Hepworth's EUPD, her chronic neurological pain and her prognosis, in my judgment an appropriate award by way of general damages would have been £170,000.

The Care Experts

129. It is appropriate that I make some general observations as to the evidence of Mrs Wright, Ms Hepworth's care expert, and Ms McGovern, Dr Coates's care expert. Each was the subject of significant criticism by opposing counsel. In my judgment, there was some basis for this criticism in each case, but it was also exaggerated in each case.

130. Ms Pritchard KC criticised Mrs Wright for the failure to provide explanation in her report for many of her conclusions. Mrs Wright explained that her report was a 'slimline' report as that was what she had been instructed to provide. I consider that there is merit in this criticism of Mrs Wright's evidence. The absence of explanations has made the Court's task more difficult than it needed to be and really should have been. However, that is not primarily a criticism of Mrs Wright but of the instructions that she was given. However, it is unfortunate that Mrs Wright did not explain this on the face of her report.

131. The point was also made that Mrs Wright provides around 90% of her expert reports to claimants and that this influences her approach. In addition, Ms Pritchard KC observed that parts of Mrs Wright's evidence and approach reflected the practice of the particular agency which employs her. This included her use of a 'blended' rate for the costs of care to reflect the extra costs of care provided on weekends and bank holidays, which is calculated using a formula operated by that agency and the workings of which Mrs Wright herself was unable to explain.

132. In my judgment, there is some merit in these criticisms too. In general, Mrs Wright's approach was to lean towards including claims for all matters which might be of some benefit to Ms Hepworth and which are provided or arranged by Mrs Wright's agency, rather than always focusing on what is or will be required to meet her reasonable needs.

133. Mr Baker KC criticised Ms McGovern's report and approach as being focussed on the lowest possible cost of providing what it was essential for Ms Hepworth to be provided with, rather than what is or will be required to meet her reasonable needs. He suggested that this reflects Ms McGovern's background of experience in the public sector where the provision available may be dominated by the need to make provision for a large number of people from limited resources.

134. In my judgment there is also merit in these criticisms when applied to Ms McGovern's report. Her approach did tend to lean towards minimising costs. However, at the meeting of experts and her oral evidence Ms McGovern was prepared to alter her position and accept additional provision and higher costs where she could see that they were justified.

135. It will be apparent from what I say below about heads of loss to which these experts' evidence goes that I accept the criticisms of the evidence of each of these experts, up to a point. I make clear that in my judgment, the evidence of each of these experts was a reflection of their particular experience and mode of working; neither set out to be partisan and each provided the court with their genuine opinions.

Past Losses

136. There are eleven heads of past losses claimed. A few are admitted.

Past Loss of Earnings

137. Ms Hepworth claims past loss of earnings in the amount of £54,302.83. She has provided documentary evidence of what she would have earned as cabin crew and what she in fact earned, which show a difference of £33,120.61. The difference between the parties is that her claim includes an annual increase of 5%.

138. No evidence that Ms Hepworth's earnings would in fact have increased by that or any amount has been advanced. Ms Pritchard KC says that accordingly, Ms Hepworth has not discharged the burden of proof as to such increases. Mr Baker KC says that the Court can infer that Ms Hepworth's income would have increased over that period and that it would be disproportionate to require detailed evidence to prove such a relatively modest sum.

139. I agree that I can infer that there would have been some increase in Ms Hepworth's earnings as cabin crew since 2018. The difficulty is what increase, in circumstances where there is no evidence at all of what pay increases awarded by her employer, Easy Jet, were over that period; what increases were awarded to cabin crew generally, or even what increases were awarded by airlines generally. Whilst I would be prepared in principle to accept that very detailed evidence on this point would be disproportionate, and potentially to infer that an industry average or an employer average would have applied to Ms Hepworth; in my judgment, it is not appropriate for the Court to infer a particular increase in pay in the absence of any evidence at all on which to base that inference.

140. There is merit in Ms Pritchard KC's point that there is burden on a claimant to prove their loss. Whilst I may have been prepared to be relatively generous in what could be inferred from evidence advanced, there must be something on which any such inference can be based. In the absence of any evidence at all as to what her pay increase would have been, I would limit Ms Hepworth's entitlement to past earnings to that which is supported by evidence, which is £33,120.61.

Past Care and Assistance

141. The claim is for £35,195.81. Damages of £20,832.19 is admitted. Part of the difference relates to the discount to be applied by reason of gratuity. It is now accepted for the purposes of this case, in my view wisely as it is what I would have found, that the appropriate discount is 25% and not 33%. The remaining

difference arises from a difference between the experts as to the rate to be applied and specifically whether an aggregate rate should be used to reflect provision of care at weekends and on bank holidays; and the number of hours which Mr Hepworth in fact provided.

142. On the issue of whether to adopt the nationally accepted Spinal Point 2 Rate from the National Joint Council Rates as proposed by Ms McGovern; or the blended or aggregate rate put forward by Mrs Wright, I regard the National Joint Council Rates as the starting point. It is then a question of whether evidence has been provided to satisfy the court that it is appropriate to depart from those rates in the particular case. I see merit in the use of a rate which reflects the fact that some of the care is provided outside usual working hours. However, Mrs Wright was not able to explain what was added and how, other than to explain that the amounts added were particular to the agency for whom she works. She could not explain the methodology or the assumptions used in arriving at the blended or aggregate rate she proposed. In my judgment, that is not sufficient evidence to enable me to find that the alternative rate that she proposes is more appropriate than the National Joint Council Rate. Therefore, I would apply the Joint National Council Rate proposed by Ms McGovern.

143. So far as the number of hours is concerned, having heard Mr Hepworth's evidence and read his witness statement, I find that whilst the amount of time he spent on care varied from week to week, in aggregate the time he spent providing gratuitous care is accurately reflected in the hours he reported to Mrs Wright and which are claimed. However, as Mrs Wright accepts, her calculation is in error in starting from 25 October 2018. The correct starting date is 9 November 2018.

144. Accordingly, I would allow the claim for past care in the number of hours claimed starting from 9 November 2018, and at the National Joint Council Spinal 2 Rate, with a deduction of 25% to reflect that the care was provided gratuitously.

Past Travel

145. The sum claimed for past travel expenses is £8,704.82. The claim is opposed on two grounds; the mileage rate at 45 pence per mile is said to be excessive and there is said to be no evidence in support of the travel claimed for. The point is made that Ms Hepworth's witness statement does not include any

material as to such travel. Ms Hepworth's Schedule of Loss provides a breakdown by year but no evidence for the number of miles claimed. While I can infer that Ms Hepworth will have incurred travel expenses in driving to medical appointments, there is no material from which I can infer how much. I am not told how many appointments she attended or the distance from her home to the various clinics she attended. In those circumstances, Ms Hepworth was unable to prove any particular loss in respect of past travel expenses and therefore, I would not make an award of damages in her favour in respect of it. Had I been willing to make a mileage-based award, I would have regarded the rate of 45 pence mile, the rate regarded as reasonable compensation by HMRC, as a reasonable rate on which to base an award of damages.

Past Equipment

146. The quantum of this claim is agreed in the amount of £2,020.

Past DIY and Decorating

147. Ms Hepworth claims £1,000 in respect of past DIY and decorating. The claim is denied in its entirely on the basis that Ms Hepworth would have had back pain in any event and there is no evidence that she would otherwise have undertaken such tasks herself.

148. I have found that Ms Hepworth would have had back pain in any event. However, her right leg pain and motor restrictions would not have been suffered in any event. There is no evidence at all, whether of fact or of expert opinion, as to the extent of the disability caused by her back pain as the Occupational Therapists agree that it is not possible to do so. Therefore, the significance of my finding so far as this head of loss is concerned is limited and I would not refuse to award damages for that reason.

149. However, in my judgment, this head of claim faces the same difficulty as others relating to past losses; it is not supported by any evidence at all. There is no evidence that Ms Hepworth would have done DIY, did her own DIY and decorating in the past, or that any actual DIY or decorating was done during the period to which the claim relates. In those circumstances, no loss has been proved on the balance of probabilities so I would not award any damages under this head.

Past Gardening

150. Exactly the same analysis applies to this head of past loss as to DIY and decorating. For the same reason, I would not award any damages under this head.

Past Window Cleaning

151. Again, exactly the same analysis applies to this head of past loss as to DIY and decorating. For the same reason, I would not award any damages under this head.

Home Adaptions

152. The damages in respect of this are agreed between the parties in the amount of £1,000.

Miscellaneous Expenses

153. The sum claimed is £3,442.01. The sum admitted is £346.86 in respect of a parking blue badge and continence products. The balance is claimed in respect of increased heating costs.

154. Ms Hepworth has not put forward any evidence in respect of actual expenditure on heating over the relevant period, nor any evidence of her heating costs (or use) before November 2018. However, both Occupational Therapy experts accept the principle of extra heating costs going forward if Ms Hepworth suffers significant neuropathic pain and spends more time at home. I have already found that Ms Hepworth suffers significant neuropathic pain and I also find that she does spend more time at home as a result of working from home. I have found that she would have suffered back pain in any event, but that she would avoided right lower limb neuropathic pain if she had undergone surgery when she says that she should have. For reasons explained below, I also find that had Ms Hepworth undergone surgery sooner and avoided bladder and bowel dysfunction and right leg pain, she would have either continued to work as cabin crew or worked outside the home in a role involving substantial contact with the public.

155. I therefore find that Ms Hepworth has incurred additional heating costs by reason of the delay in her surgery. The difficulty is that there is again no evidence at all of the amount of those costs, or any evidence of her actual costs at the relevant period or at any other time. There is some evidence from Mrs Wright as to what she says the increased costs were. However, in cross examination she explained that the figures she has put forward were not based

on any bills that she had seen but simply the application of a formula which the agency she works for uses.

156. It follows that there is no evidence from which I can make a finding as to what the actual increased heating costs were. In those circumstances, I would only award damages in respect of the admitted amount of such extra costs, being £346.86.

Physiotherapy

157. Although initially in issue as to the amount, following the evidence at trial, the parties are agreed that the costs incurred by Ms Hepworth for past physiotherapy were £1,155, so that is the sum that I would award for this loss.

Interest

158. The parties are agreed that an aggregate interest rate of 6.8% to the date of trial should apply to past special damages.

Future Losses

Future Loss of Earnings

159. It is admitted by Dr Coates that Ms Hepworth will remain unable to return to work as a flight attendant. The parties have also agreed the multipliers which should apply to her future loss of earnings. The figure for her annual loss of income is in dispute.

160. I have found that Ms Hepworth's on-going back pain is not materially different to what it would have been had she undergone surgery on 5 or 6 November 2018. In my judgment, bearing in mind the evidence from Ms Hepworth that she loved her work as a flight attendant, which I accept, Ms Hepworth would have returned to work as a flight attendant if it had been possible for her to do so. I find that her back pain would not have prevented Ms Hepworth from returning to work as a flight attendant.

161. I have also found that Ms Hepworth would have recovered near normal bowel function if she had received the earlier surgery. It follows that in my judgment, Ms Hepworth would have been able to and would have returned to work as a flight attendant if she had undergone surgery earlier, as she claims she should have.

162. The parties agree that Ms Hepworth has suffered a disadvantage in the open labour market as a result of her CES. In the light of my findings, it follows that

Ms Hepworth would not have suffered that disadvantage if she had undergone surgery when she says that she have.

163. I understand that the differential multiplier which has been agreed to reflect the fact that Ms Hepworth is disabled within the meaning of that term in the Equality Act 2010 also deals with any question of her being prematurely separated from the labour market. Therefore, I make no specific finding about that.

164. I have already found that there is no evidence to support any finding as to any particular pay increase that Ms Hepworth would have received since 2018. Therefore. the damages I would award for loss of future earnings would be based upon her earnings in 2018.

Future Care and Assistance

165. Before addressing this head of loss, I say something about the expert physiotherapists whose evidence goes to it. Ms Hepworth relies on the expert evidence of Mrs Moya, a specialist neurophysiotherapist. Dr Coates relies on the evidence of Mr Porter, a more general musculoskeletal physiotherapist, but with some specialist experience of neurological patients, including some with CES, but little or no experience of working long term with CES patients. Mr Porter has substantial experience of patients with back pain and sciatica. He suggested that these are comparable conditions. In my judgment, they are partially comparable. They are comparable in that they involve back pain and limits on mobility resulting from back pain. However, in my judgment, CES patients have potentially more complex needs as a result of the urological consequences of their condition and particular issues with fatigue which tend to be less common and less severe in patients with sciatica.

166. Whilst I found both Mrs Moya and Mr Porter to be honest witnesses who made reasonable concessions and gave their evidence in a clear and informative way, I found Mrs Moya's particular expertise apparent under cross examination. Her greater experiences of patients with CES meant that at times her evidence was more authoritative. That is not to disparage Mr Porter in any way, it is simply that Mrs Moya has more directly relevant experience of CES patients and their long term care.

167. There are a number of general issues of dispute which bear in the various heads falling under future care and assistance. A number of findings which I have

already made and points on which the relevant experts are agreed are relevant to these issues. They are:

(a) The experts agree that Ms Hepworth will not experience any improvement in her neurological condition.

(b) The experts are agreed that Ms Hepworth's physical prognosis is poor on any view; and that she is unlikely to experience a significant improvement in her psychological condition as a result.

(c) That includes her 'foot drop' which is psychologically mediated.

(d) Ms Hepworth's mobility problems are the result of a combination of pain and the psychologically mediated foot drop and would have been avoided with the earlier surgery that she says that she should have received.

(e) The expert physiotherapy evidence is that the experts are agreed that Ms Hepworth has impaired balance but is at low risk of falls. However, her balance has declined measurably since she was discharged from Stoke Mandeville. They also agree that Ms Hepworth is not achieving her potential in terms of physical function and she will be able to improve it with appropriate physiotherapy, which will in turn improve her quality of life. They also agree that Ms Hepworth's physiotherapy needs are greater than would be available on the NHS so she should have access to private physiotherapy for her future needs.

(f) I have found that Ms Hepworth would not have avoided her back pain had she undergone earlier surgery but she would have avoided pain and numbness in her right leg.

(g) The expert psychiatrists agree, and in my judgment, it is very clear, that Ms Hepworth would benefit from a pain management programme to assist her in coping with her experience of pain.

168. I find that while it is certainly possible that she will improve her mobility, endurance, and confidence to enable her to be more mobile and more active outside the house, the evidence does not support a finding that on the balance of probabilities Ms Hepworth will achieve any particular improvements over any particular timeframe. I reach this conclusion having considered the evidence of the neurorehabilitation experts and the expert physiotherapists. I bear in mind Ms Moya's evidence that it is now over 6 years since Ms Hepworth's surgery

and she has consistently had limitations resulting from fatigue and pain for some years. Whilst both physiotherapy and a pain management programme should help with that, the evidence does not support a finding of any specific improvements by any particular date.

169. The parties agree that Ms Hepworth's mobility will decline in later life. Mr Macfarlane says that she will experience a decline in her mobility from her mid-60s and will be reliant on sticks outdoors from her early 70s but not will not be a wheelchair user at any point.

170. Dr Bavikatte modified his position in oral evidence and opined that Ms Hepworth would need a wheelchair for outside mobility from her mid-60s and for indoor mobility from her mid-70s but accepted that there is range of reasonable opinion and that Mr Macfarlane's view is within that range.

171. Having considered all of the written and oral expert evidence, as well as Ms Hepworth's own evidence and taken into account my other findings as to her wider prognosis, I find that as a result of the consequences of her CES, Ms Hepworth is likely to undergo faster musculoskeletal changes as she ages than an average person. I have already set out my concerns about Dr Bavikatte's evidence and I am not persuaded that Ms Hepworth is likely to ever be a wheelchair user indoors. I am also not persuaded that she will become an outdoor wheelchair user in her mid-60s. This is because I am not satisfied that her decline in mobility will be as rapid and as early as Dr Bavikatte suggests in the light of underlying neurological condition as described by Mr Macfarlane, but also because it is clear from Ms Hepworth's own evidence that she is keen not to appear to be disabled but present in a way that she regards as 'normal' whenever she can. Therefore, in my judgment, she will work hard to avoid having to use a wheelchair when out and about and will be able to do so at least for a while.

172. However, in my judgment, Mr Macfarlane's opinion is to some extent based on his view that Ms Hepworth will achieve the potential improvements to her mobility as a result of improvements to her pain management and psychological state which I have found are somewhat speculative. Balancing these matters, I find that on the balance of probabilities, Ms Hepworth will not become an indoor wheelchair user at any time. However, she will need a stick or crutch indoors to assist with balance from the age of 70 as her balance will decline with

age and she will become at risk of falls and will lack confidence due to her declining balance. She will require a wheelchair outside for longer walks such as outdoor walks and to get around large shops and the like, but not to move to and from a car or a destination building such as a house or a doctors' surgery, from the age of 75.

(a) Ad Hoc Support

173. Mrs Wright recommends two hours of emotional / psychological support as the effects of CES on Ms Hepworth's life have exacerbated her EUPD. This is not accepted by Ms McGovern. She observes that Ms Hepworth had pre-existing EUPD and so would have required this additional support in the counterfactual scenario.

174. The expert psychiatric evidence indicates that Ms Hepworth's EUPD was not a particular issue prior to her CES and in my judgment, the extra consequences in the form of her bladder and bowel issues and the greater neuropathic pain she has experienced has caused a material exacerbation of her EUPD and caused her to be more socially isolated than she would have been had she been operated on when she says that she should have been.

175. Mrs Wright proposes two hours per week of support and motivational assistance. However, Ms Hepworth is working and it was clear from her evidence that she has regular contact with family members and some friends. I therefore consider that two hours per fortnight of such support would be reasonable to meet her needs.

(b) Domestic Assistance

176. The parties agree that some domestic assistance is reasonably required and it was limited by agreement to age 75. However, since the change in position by Dr Bavikatte during his oral evidence, Ms Hepworth's case is now that she would become a wheelchair later and not inside. I have found that she would become a wheelchair user outside only at age 75.

Care to Age 75

177. In the light of my finding that Ms Hepworth's functional difficulties have a psychological and not a neurological cause, in their Joint Statement, the Care Experts disagree as to whether Ms Hepworth would need domestic assistance to the age of 65. Ms McGovern says that she would not. Mrs Wright says that Ms Hepworth will require domestic assistance for 3 hours per week until the

age of 65 and now agrees that the rate cited by Ms McGovern in the Joint Statement is the correct rate for such care. Having read and heard the evidence of both experts, I find that Ms Hepworth reasonably requires domestic assistance but that her reasonable need is for 2 hours each week, at the rate specified in the Joint Statement of £17.95 per hour.

178. Mrs Wright says that Ms Hepworth will also require 2 hours per week long term ad hoc gratuitous care from family members. Ms McGovern says that such care would not be required. Having heard the evidence from Mr Hepworth as to the amount of care that he has in fact provided and taking account of the variation in fatigue and the effects of pain, as well as her psychological state, I prefer the evidence of Mrs Wright that such care will be needed and accept her assessment that Ms Hepworth needs 2 hours per week of such care, so would have awarded the sum posited by Mrs Wright for that care.

179. Mrs Wright says that Ms Hepworth would also need 2 hours of agency care per week whereas, Ms McGovern says that in those circumstances, no agency care would be needed. In my judgment, with the domestic assistance and ad hoc care from family members that I would allow for, Ms Hepworth does not reasonably require agency care in addition. Therefore, I would not award any sum in respect of agency care.

Post 75

180. Given my finding that from aged 75, Ms Hepworth will not be an indoor wheelchair user, she will not require live in agency care. However as she will by then require a stick for balance indoors, she will have difficulty with some indoor tasks as a result. In my judgment, at that point she will reasonably require some agency care in addition. I would award her a sum in respect of 4 hours of agency care per week from age 75 and at the rate specified by Ms McGovern.

Case Management

181. As a result of my findings that Ms Hepworth will not require agency care until the age of 75 and will not be an indoor wheelchair user and will not need live in care at any point, in my judgment, the justifications advanced by Mrs Wright for case management, lose their force. Had I found that Ms Hepworth needed multiple sources of extensive professional care, I would have found that she should receive a sum in respect of case management. In the light of what I have

found as to her reasonable needs, I would award a sum in respect of case management from the age of 75 only, for 20 hours per year at a cost of £2,340 per year, as proposed by Mrs Wright.

Physiotherapy

182. The parties are agreed that Ms Hepworth reasonably requires long term physiotherapy but not how much or at what rate. Ms Moya opines a total cost of £77,315.50, whereas Mr Porter agrees only £22,862.48. They disagree as to the number of sessions Ms Hepworth reasonably requires and as to whether she needs to be seen by a specialist neurophysiotherapist or a general musculoskeletal physiotherapist, and hence the charging rate for the sessions. They also disagree as to whether Ms Hepworth reasonably requires acupuncture and massage therapy.

183. I accept the evidence of Mrs Moya that CES patients such as Ms Hepworth have more complex needs than patients with back pain and sciatica and that therefore she reasonably requires therapy from a specialist neurophysiotherapist. I also accept her evidence that Ms Hepworth would benefit more from and reasonably requires access to sessions to be used flexibly over the course of her life to reflect change in her condition and needs over time. I would therefore make an award of the sum for physiotherapy proposed by Mrs Moya.

184. I also prefer Mrs Moya's evidence as to personal training. Mr Porter agrees that Ms Hepworth reasonably requires 6 sessions with a personal trainer following her first round of physiotherapy. In my judgment, Mrs Moya's points that Ms Hepworth reasonably requires annual top up sessions to maintain motivation and to assist her with changes in equipment and changes in her condition and needs are made out. In respect of that, I would award an annual sum of £240 per year each year as recommended by Mrs Moya, until the age of 70.

185. Mrs Moya recommends 12 sessions per year of acupuncture or massage (or mixture of the two) each year for pain management. Ms Hepworth said that these sessions give her 2 – 3 days of pain relief. Her chronic neurological pain is a major consequence of Ms Hepworth's CES and the right leg pain would have been avoided if she had undergone surgery when she says that she should have. The evidence is that her chronic pain affects her mobility and energy levels. Whilst I note Mr Porter's view that the evidence for the efficacy of acupuncture in such cases is weak, I bear in mind that Ms Hepworth's condition

has a psychological component and I accept her evidence that she gets real benefit in the form of several days 'pain relief from it. In my judgment, the provision of a monthly session of either acupuncture or massage for pain relief is within the scope of reasonable provision and would award the sum of £660 per year, as recommended by Mrs Moya, in respect of it.

Occupational Therapy

186. The positions of Mrs Wright and Ms McGovern have changed from the Joint Statement due to the change in the evidence of Dr Bavikatte and my finding that Ms Hepworth's condition will not deteriorate as far or as fast as Dr Bavikatte originally suggested.

187. The experts disagree as to the hourly rate which should be allowed for the work of an Occupational Therapist. Mrs Wright says £105 whereas Ms McGovern allows £90. Each expert stands by their chosen rate. It is not a matter about which there is much to go on in reaching a determination. I bear in mind the general observations I have made about each of the Care Experts when considering this question and take into account the hourly rates put forward for other therapy and support professionals in this case. In my judgment, the time found to be reasonably required should be included at a rate of £100 per hour.

188. So far as the number of hours are concerned, in view of my finding that Ms Hepworth will not become an indoor wheelchair user and will not need walking aids inside or a wheelchair outside until her 70s, I prefer the hours proposed by Ms McGovern, being 16 hours for initial assessment and a further 16 hours when Ms Hepworth's condition deteriorates. However, I would make an award for those hours charged at a rate of £100 per hour, with the costs of travel at the rates agreed between the experts.

Continence Management

189. I have found that the incident on 4 November 2018 was not one of true bowel dysfunction but a consequence of taking lactulose. I have also found that had Ms Hepworth undergone surgery when she says that she should have, she would have avoided serious bladder and bowel dysfunction.

190. The parties agree that Ms Hepworth has severely impaired bladder function and that she is dependent on intermittent self-catheterisation ("ISC"). They also agree that she currently manages her ISC well and should be able to do so until her mid-70s and that she will then require a suprapubic catheter. The parties

also agree the cost of suprapubic catheter insertion, of ISC catheters and of catheter management if Ms Hepworth is entitled recover the cost of these matters privately. However, Ms Pritchard KC says that Ms Hepworth would not be entitled to recover damages in respect of those costs because she would not be likely to in fact incur them.

191. Ms Hepworth's urology expert, Professor Chapple, expressed the view that patients invariably obtain these services on the NHS and that NHS provision in this area is superior to private provision as it provides continuity of care. I find that Ms Hepworth will be advised that this is the position and that she will take that advice.

192. As Ms Pritchard KC submits, since I have found that Ms Hepworth will not in fact take up such private provision but will use the NHS for continence management, she is not entitled to recover damages in respect of the costs of the private provision. This follows from *Eagle v Chambers (No. 2)* [2004] EWCA Civ 1033 as explained by Waller LJ at [70] – [71].

193. Ms Hepworth also claims for the costs of urinary catheters. She says that the current catheter delivery service she uses is complicated and inconvenient. She did not explain why it is and, in my judgment, she will most likely continue to use the NHS and not incur the costs of alternative provision. Therefore, I would not award any sum in respect of catheters.

Dietician

194. Dr Bavikatte recommends a dietician so assist Ms Hepworth in maintaining a healthy lifestyle. Mr Macfarlane considers that she has no need of one and that to provide one would go beyond what would be reasonable provision.

195. The evidence is that Ms Hepworth was very fit and healthy before she suffered CES. She attended a gym regularly and took part in body building shows. In my judgment, she is aware of what healthy eating requires. She does not need a dietician and reasonable provision for her needs does not require that she be provided with one. The personal trainer for whom I would make allowance as I have already said, will assist Ms Hepworth with the issue of motivation to follow healthy eating practices.

Travel and Transport

196. This head of claim also changed during the trial as a result of the change of view of Dr Bavikatte when he became aware of the actual current mobility of Ms Hepworth. Her claim for a wheelchair accessible vehicle is no longer pursued.

197. It is agreed for the purposes of this action that Ms Hepworth requires a vehicle with automatic transmission and that she will require her vehicles to be adapted by the installation of a flip pedal due to the functional limitations in her right leg.

198. The parties disagree as to whether Ms Hepworth should be taken as continuing to rely upon the Motability Scheme or whether she should recover a sum to reflect her need to privately purchase future vehicles. Ms Pritchard KC makes the point that, as Ms McGovern explained, the Motability Scheme includes numerous benefits with insurance and other running costs as well as any necessary adaptions being provided in exchange for a single monthly payment in the amount of a particular benefit payment received. I accept that. Had I been able to be confident that the Motability Scheme will continue to be available to Ms Hepworth for as long as she requires it, I would have taken a different view. As Mr Baker KC submits, Ms Hepworth will only qualify for the Motability Scheme for as long as she qualifies for a Personal Independence Payment ("PIP"). The rules around qualification for PIP and other disability benefits are changed from time to time, frequently by increasing the requirements for entitlement. Ms Hepworth will need a vehicle for probably four decades. I cannot be satisfied that on the balance of probabilities the Motability Scheme will continue to be available to her for that period, or that it will continue to be available on substantially the same terms as currently. Therefore, I would make an award of damages to reflect Ms Hepworth's need for a privately provided automatic vehicle with adaptions in the amount of the extra costs for such a vehicle and adaptions claimed, which is £16,000 every 3 years to age 65 and every 5 years thereafter. I would also award £645 for adaption by fitting a folding accelerator pedal to each vehicle.

199. The experts agree, as do I, that Ms Hepworth will need to purchase a blue badge for the reminder of her life. I would have awarded her £170 to reflect that cost.

Orthotics

200. The relevant experts have agreed the sum of £38,000 would be an appropriate award of damages under this head if any award in respect of orthotics would be

appropriate. Ms Pritchard KC points out that Mr Macfarlane stated in oral evidence that whilst orthotics provide an easy way to overcome an issue with Ms Hepworth's right ankle, if they are overused, they will inhabit improvement in her right ankle and foot. In my judgment, whilst Mr Macfarlane's point has some merit, the balance of the evidence is that Ms Hepworth has right foot drop as a result of chronic pain and psychological issues and that she does have a reasonable need for orthotics the use of which gives her benefits in mobility and comfort when walking longer distances. The orthotics do assist with the mobility effects of her foot drop. Whilst that does not have a neurological cause, as Mr Macfarlane accepts, it is a condition that she has, albeit due to pain and psychological factors. The fact that Ms Hepworth would benefit from not using orthotics all of the time is not a reason to make no provision for them when she obtains real benefit from using them some of the time.

201. For those reasons, I would award Ms Hepworth damages in the agreed amount of £38,000 in respect of her future need for orthotics.

Equipment

202. In accordance with my findings that Ms Hepworth will not become an indoor wheelchair user but will use a wheelchair outdoors for longer distances from about age 75, I would not award sums for a manual wheelchair or equipment used for transiting from a wheelchair inside. I would award a sum in respect of a powered outdoor wheelchair from age 75, with a replacement after 7 years, and annual insurance and maintenance costs in respect of it in the sums claimed for each.

203. I would not make an award in respect of a mobility scooter. This is said to be based on current need. Ms Hepworth is able to drive an automatic car and the evidence is clear that Ms Hepworth is very keen not to present in a way that indicates the extent of her physical disability. There is no basis for concluding that is likely to change at any particular point. Further, the evidence in Mrs Wright's report is that Ms Hepworth is able to walk for 20 – 30 minutes before needing to stop for a rest. In my judgment, her needs are not such as to make a mobility scooter reasonably necessary and I find that if she were provided with one, she would not use it. As I would expect that Ms Hepworth will continue to be able to drive an automatic car at least until her 70s, and have made

provision for a motorised wheelchair from the age of 70, she will not reasonably require a mobility scooter in addition

204. The claims in respect of open cuff crutches and walking poles are agreed together with the claim for ferrules. I would award the sums claimed for those. I would also award a sum to reflect the need for an adjustable two-wheeled walking frame for use indoors when needed, but only from the age of 70.

205. The claim for the Vela Salsa stool and footrest is also now agreed and I would award the sum claimed in respect of it with provision for replacement every 5 years, as recommended by Mrs Wright, who has more experience of its use than does Ms McGovern.

206. The sums claimed in respect of quilted mattress protectors and duvet protectors are also agreed and I would award the sum claimed for each.

207. I would not award a sum in respect of a four wheeled walker from the age of 70. Nor in respect of an adjustable profiling bed and associated accessories. I would not award any sum in respect of a hoist and accessories. None of these are reasonably required by reason of my findings as to the rate and extent of the decline in Ms Hepworth's mobility.

208. I would award the sum claimed for a riser recliner chair from age 70, with one replacement.

209. I accept Mrs Wright's evidence that Ms Hepworth reasonably requires adaptions to her kitchen in the form of a carousel kitchen corner unit and a kitchen pull out tier 2 platform. In my judgement, Ms Hepworth reasonably requires this as a result of her restricted mobility and leg pain, as well as the back pain which she would also have had if she had been operated on when she says that she should have been. They make if difficult and painful for her to bend and lift and to stand to cook for long periods. I would award the sums claimed in respect of those items.

210. The claim in respect of a recumbent cross trainer is opposed. Ms Pritchard KC says that Ms Hepworth will attend a gym as she did regularly previously and does now, albeit to undertake different exercises, and that she does not need a recumbent cross trainer at home in addition. If she does not wish to attend the gym for psychological reasons or is unable to attend due to pain or uncontrolled bowel or bladder issues as Ms Moya proposes, then she will not want to engage in exercise such as using a cross trainer at home either.

211. Whilst I accept that Ms Hepworth may well use small gym equipment at home if she is unable to go or does not want to go to the gym for the reasons Ms Moya postulates, I agree with Ms Pritchard KC that in such instances she is very unlikely to use a recumbent cross trainer. The same pain and/or bladder/bowel issues would be very likely to mean that she would not wish to use a cross trainer either. That Ms Hepworth will even have such significant bladder or bowel issues is also rather speculative. The urology evidence is that she is able effectively to self-catheterise and has done for some time. I accept that Ms Hepworth is a greater risk of UTIs but there is no evidence to suggest that they will prevent her from attending the gym but leave her able to use a cross trainer. The evidence also indicates that she manages her bowels effectively. There is no reason to believe that will change. For all of these reasons, I would not award damages to reflect provision of a recumbent cross trainer.

212. The claim for small gym equipment is agreed and I would award damages for that in the sum claimed.

Accommodation

213. Ms Hepworth has no need for single storey accommodation now. The evidence is that she continues to live in the same two storey house belonging to her father than she occupied in 2018 and can manage the stairs without particular difficulty.

214. I have found that Ms Hepworth will not become an indoor wheelchair user. However, I have also found that she will require some use of walking aids indoors at the age of 70. I have considered whether it follows that when she needs walking aids in doors, Ms Hepworth will become unable to use the stairs and will require single storey accommodation. In my judgment, it does not follow. A 70 or 75 year old with mobility issues which require the use of a stick or crutch inside would not ordinarily require a single storey property.

215. Accordingly, my provisional view is that an award of damages to reflect the need for the purchase of a bungalow and its adaption would not be appropriate. However, I am conscious that a very substantial sum by way of damages turns on my conclusion on this point and that I did not hear detailed submissions on the issue in the circumstances of my having made the findings I have made as to the extent of Ms Hepworth's mobility from age 70. Had I found in her favour on liability, I would have invited further submissions on this issue. As I have

found against her on liability it would not be appropriate to proceed it that way. If my conclusions on liability are not maintained, then in my judgment, the issue of her need for a single storey accommodation from aged 70 should be the subject of further submissions.

216. I would also have invited further submissions as to increased running costs, which depend on whether Ms Hepworth requires a new single storey property.

217. In my judgment, but for the accident, Ms Hepworth would have remained in her current property. If she had been forced to move, it would have been to a shared property. This is because the evidence indicates that she would have been unable to afford to either purchase a property or to rent one by herself. Mr Fisher says that the cost of a like for like replacement would be about £400,000 and to rent would cost about £18,000 per year. On Ms Hepworth's earnings as cabin crew, to which I have already referred above, she would have been unable to afford either.

218. Presuming Ms Hepworth remains in her current property, I would award a sum in respect of additional heating, electricity, and water costs. The accommodation experts' suggested additional costs assume a move to a four-bedroomed bungalow so there are no relevant figures and I would invite further submissions as to the amount of such extra costs of heating and electricity in the event of Ms Hepworth remaining at her current property, I do not consider that her increased water use would be any different and I would award in respect of that the sum of £340 per year proposed by Mr Lamptey, to reflect Ms Hepworth's increased use of the washing machine and need for more frequent washes by way of personal hygiene as a result of her condition.

219. My provisional view is that as a result of spending more time at home, being less mobile and suffering with chronic pain, Ms Hepworth will require greater heating of her home than she otherwise would have. Further, due to her bladder and bowel issues she will use her washing machine significantly more frequently and use a tumble dryer, so that her electricity costs will be notably higher. My provisional view is that while the precise figures provided by the experts relate to a notional new single storey property, figures for those costs increased by the sorts of sums proposed by Mr Lamptey will be appropriate.

220. As to other accommodation related needs; in my judgment, in general I prefer the view of Mr Fisher and find that Ms Hepworth has not established that she

will reasonably require her accommodation to include a multi-use room for a carer and nor will she need a car port or a video entry system. In each case this is because I have found that she will not be an indoor wheelchair user and will not therefore need the level of care nor encounter the difficulties in transferring to a vehicle which would follow from her being confined to a wheelchair.

221. In my judgment, as she lives in a 3 bedroomed property, Mr Porter is correct that Ms Hepworth will not require a dedicated therapy / gym room and can use a bedroom for that, using the small gym equipment for which I have found that provision should be made. In my judgment, it is not necessary for air conditioning to be provided for Ms Hepworth's exercise space where only small gym equipment will be used and not a cross trainer.

222. In my judgment, there is no compelling evidence that it is necessary for Ms Hepworth to have a dedicated utility room to house her washing machine and tumble dryer. There is no evidence which indicates that her using those appliances in her kitchen causes her any problems or is otherwise unsatisfactory such that it is reasonable for provision to be made for a dedicated utility room. Ms Hepworth would have required a washing machine in any event. However, I would have awarded a sum to reflect the fact that a tumble dryer is essential due to her condition and would not have been essential in the counterfactual scenario of earlier surgery.

223. It follows from my findings that Ms Hepworth does not require specialist bathroom equipment at the present time. If she were to remain in her current property or move to a new property without one, I would allow a sum for the installation of a shower with a seat. I would also award a sum for the installation of an adapted oven, as provided for by Mr Lamptey.

224. For the equipment for which I would award a sum in damages, I would make provision for periodical replacement as provided for by Mr Lamptey in his report.

225. So far as annual replacement costs for equipment are concerned, the costs should reflect the equipment which I have found that Ms Hepworth reasonably requires; which is substantially less than allowed for by Mr Lamptey but more than Mr Porter provides for. As with the provision of single storey accommodation, had I found that a breach of duty had occurred, I would have invited the parties to make further submissions on this head of loss as the sum

in issue which is to continue every year is substantial. As I have not found that there was a breach of duty it would not be appropriate to do so.

Miscellaneous Items

226. The experts agree that Ms Hepworth reasonably requires careers advice and its cost. I accept that evidence and would award the sum that they agree.

227. Ms Hepworth's expert urologist, Professor Chapple, expressed the opinion that patients usually obtain their incontinence products from the NHS, as Ms Hepworth currently does. In my judgment, Ms Hepworth will in fact continue to obtain her incontinence items from the NHS. Therefore, I would not award any sum in respect of future incontinence products.

228. It is agreed that Ms Hepworth will reasonably require business class travel when travelling by air in future and I would award the agreed sum in respect of that.

229. She also claims £408,244 to pay for a companion to travel in business class with her on the basis that she would not necessarily travel alone so should be able to travel with her companion as she did previously. This claim faces two particular hurdles. First, the evidence is that Ms Hepworth has travelled on her own since her CES, to the Galapagos and to Antigua. Therefore she frequently travels without a companion and has continued to do so. Second, in my judgment, such provision is not required to meet her reasonable needs, bearing in mind that the need is said to be for a travelling companion to talk to and not that one is required for her care; and that the sum required to make such provision is very high for such relatively limited benefit. For those reasons, I would not make any award in respect of business class travel for a companion.

230. Ms Hepworth also claims in respect of increased taxi costs when travelling abroad. Ms Pritchard KC makes the point that there is no evidence to support this head of claim. That is correct. However, the points made by Mr Baker KC as to proportionality as well as an obvious difficulty in providing much evidence, and my findings as to her mobility issues and the prognosis for them mean that in my judgment, I can and should infer such a need. The sum claimed of £400 per year is not challenged and appears reasonable for the two holidays contemplated. I would award that sum for this head of loss.

231. The parties have not agreed the appropriate sum in respect of future heating and laundry costs. I am satisfied that Mrs Wright's figure for future additional laundry costs is reasonable in the sum of £20.28 per year and I would award that

sum. The position in respect of future increased heating costs is less straightforward as it depends upon whether Ms Hepworth requires alternative single storey accommodation.

232. I am satisfied that by reason of being at home more, being less mobile and suffering chronic pain, Ms Hepworth will have increased heating costs. If I had found that breach of duty had occurred, I would invite further submissions as to the amount of such extra heating costs assuming that Ms Hepworth stays in her current home. If I were to find following further submissions that she would need to move to an alternative single storey property, I would award the sum in respect of increased heating costs put forward by Mr Lamptey in the amount of £1,146 per annum.

Services

233. Ms Hepworth claims in respect of future costs of gardening, window cleaning, DIY, and decorating. I have found that she would have suffered essentially the same back pain if she had undergone surgery when she says that she should have.

234. In my judgment, while her back pain would have made each of these tasks more difficult, she would have been able to perform them, albeit more slowly. The sums claimed in the Schedule of Loss for these items have not been seriously challenged as to their amount. They relate to a presumed alternative 4-bedroomed single storey property which is larger than Ms Hepworth's current home. If she were to move to such a property, I would award the sums claimed for these items. If she is to remain at her current property, I would reduce the sums by 20% to reflect her remaining in a smaller property.

<u>Conclusion</u>

235. I have found that Dr Coates was not in breach of duty and therefore the claim must be dismissed.

236. If I were wrong about that, then the breach of duty did cause Ms Hepworth both general and special damage. I have set out what I would have awarded by way of general damages and made findings which should enable counsel to calculate what special damages Ms Hepworth would be entitled to; save that I would invite further submissions as to whether Ms Hepworth will need single storey accommodation in the light of the findings I have made as to her prognosis.