IN SUMMARY

Jock Mackenzie and Amy Wedgwood outline an important decision relating to summary judgment in clinical negligence

The case of *Hewes v Dr Tanna* is one which earlier this year caused some rumblings in the clinical negligence world.

The case concerned Cauda Equina Syndrome (CES), but the rumblings related to an application for, and a granting of, summary judgment to one of the defendants before the exchange of expert evidence - which ultimately culminated in an appeal by the claimant (C).

Cauda Equina Syndrome

Before reviewing the road to appeal, to understand C's claim it is worth looking briefly at the medicine and understanding CES.

The spinal cord is made up of a bundle of nerves which, at each cord level, control different functions in the body.

The cauda equina (Latin for horse's tail) is a bundle of such nerves at the lower end of the spinal column, namely at L2-5 and S1-5, and including the coccygeal nerve.

These nerves supply the motor and sensory function of the bladder, bowel, genitals and saddle area and assist with lower body motor function.

CES occurs when the cauda equina nerves become compressed. There are many causes of CES, but the commonest is a lumbar disc prolapse.

Most such prolapses occur laterally and compress the nerve roots emerging from the lumbar canal sideways at the relevant level, usually causing leg pain on the side of the compression (sciatica) and altered sensation in the leg and/or foot, and possibly weakness.

However, in about 2-3% of lumbar disc prolapse cases, the prolapse occurs centrally, which can compress not only the nerve roots to the leg and foot, but also to the perineum (saddle area), as well as the parasympathetic nerves involved in bowel and bladder function.

When nerves are compressed, they may become damaged, which may cause a patient to experience symptoms.

Over time, as the nerve compression persists, the damage worsens and, unless the compression is relieved sufficiently rapidly and within a critical window of opportunity, the damage will be likely to become irreversible.

Different nerve fibres are capable of withstanding different degrees of compression: motor fibres are larger than sensory fibres and are more resistant to pressure; pain fibres are small and susceptible, as are the parasympathetic fibres.

Given this, there are various 'red flag' symptoms that should alert clinicians to a possible CES diagnosis, including: (a) bilateral sciatica; (b) reduced saddle/perineal, perianal, genital region and urethral sensation; (c) reduced or loss of control of bladder, bowel and sexual function; and, (d) reduced anal tone on rectal examination.

Given the function of the cauda equina nerves, irreversible damage can cause life-changing consequences for patients.

It is important to be aware that not all of the nerve fibres of the cauda equina need to have normal function for bowel and bladder control to be retained, which is at least in part why the prevailing view is that time to surgery is of the essence, within the reasonable logistical and practical constraints of a hospital.

Without going into detail, it is generally accepted that surgery while the patient is in incomplete CES (CESI) will probably result in a significant degree of recovery,

whereas surgery when the patient has developed complete CES (CESR) is less likely to do so.

The claim against Dr Tanna

In summary, C had a central lumbar disc prolapse causing CES. This resulted in symptoms of saddle numbness noticed shortly after waking.

C telephoned the out-of-hours GP, the third defendant (D3), who advised him to attend A&E.

C's case against D3 was that, having appropriately suspected CES, he failed to refer C directly to the on-call orthopaedic team at the local hospital.

C asserted this would ensure that he was an 'expected' orthopaedic patient, in effect bypassing A&E and avoiding the inevitable delay that would (and did) occur in C having first to be seen by A&E doctors, before onward orthopaedic referral.

This demonstrates the value of setting out a party's position as soon as possible in the litigation

D3 denied breach of duty in full, asserting D3's actions were in accordance with a responsible body of medical practitioners.

The first defendant (D1) was the hospital and the second defendant (D2) was the ambulance Trust.

The first instance decision:

Following close of pleadings and the Costs and Case Management Conference, D3 (represented by the Medical Protection Society) applied for both a striking out of C's case and summary judgment.

The strike out application was withdrawn prior to the hearing, leaving just the summary judgment application.

In support, D3 initially only relied on his solicitor's witness statement, before subsequently serving his GP expert's liability report.

This was served unilaterally and prematurely, a number of weeks before the date ordered for exchange of expert evidence.

In response, C served a very short letter from his own GP expert, merely confirming his ongoing support for the pleaded case. A couple of weeks prior to the hearing, factual witness statements from all parties were exchanged.

At first instance (www.bailii.org/ew/cases/EWHC/QB/2018/1345.html), Master Cook awarded summary judgment to D3 on the basis that C had shown no 'real prospect' of establishing breach of duty against D3.

The Impact of Bolitho

D3's solicitor's witness statement asserted that, because D1's defence pleaded that C would not, as a matter of fact, have been accepted by D1's orthopaedic team (and C would not have bypassed A&E), C had no reasonable grounds for bringing a claim against D3.

At the time of this statement, liability factual witness statements had not yet been served.

C asserted that D3 could and should have referred directly to D1's on-call orthopaedic team, relying on D1's CES Trust Policy, which indicated that GPs could refer directly to the orthopaedic team.

On the point of *Bolitho* hypothetical fact, namely that C would have been accepted by D1's orthopaedic team if directly referred as a matter of fact, C also asserted that it would have been in breach of duty for D1's orthopaedic team to refuse to accept C, based on his orthopaedic expert evidence.

Further, C asserted that it was *Bolitho* illogical for D3 not to refer directly to orthopaedics given that this was a case of a surgical emergency and time was of the essence.

It was C's position that, in light of significant issues in dispute in relation to both factual and expert evidence, the claim was not capable of summary judgment.

However, the Master was unpersuaded that C's expert evidence when served would raise a realistic *Bolitho* issue, although it is a little unclear from the judgment whether this view related to the evidence of C's GP expert or his orthopaedic expert.

Nevertheless, the Master concluded that, on the matter of hypothetical fact and whether the hospital would have accepted a referral from the GP, there was a potential dispute of fact which could be resolved in C's favour, such that summary judgment was not appropriate on this basis alone.

Premature service of expert evidence

As outlined above, D3's GP expert's report was served many weeks ahead of the ordered date for exchange of expert reports, as well as prior to the exchange of factual witness evidence.

On receipt of D3's export report, C faced an invidious decision: what evidence should be served in response? The factual matrix of the claim was incomplete, the date for the summary judgment hearing fixed for 14 days after the exchange of factual witness statements and the ordered deadline for exchange of expert reports was still some three months away.

Further, D3 was not the sole defendant: there were two others involved in the proceedings.

As stated above, C elected to serve a short letter from his GP expert which simply and briefly confirmed his expert's continuing support for the pleaded claim despite the defences (there was also an issue as to C's GP not having time to prepare a full response in any event).

It was C's position that he had permission to serve his GP expert evidence in due course, and the provision of detailed expert evidence at a summary judgment hearing could result in the court having to conduct a mini-trial on only part of the evidence, compared to that which would subsequently be available to the trial judge.

The Master expressly recognised the need to avoid conducting a mini-trial, but was unsympathetic to C's stance.

He was also implicitly critical of C's GP expert and instructed solicitors, and considered that C had had 'ample time' to obtain his expert's

relatively detailed view on the central question in the case.

The Master was also dismissive of the Trust's Policy (and other documents adduced by C), stating that he could find nothing within which could be realistically deployed to undermine D3's GP expert's opinion that referring to A&E rather than directly to orthopaedics was reasonable.

Permission to appeal

C proceeded to appeal the decision and was awarded permission by Mr Justice Andrew Baker (www.bailii.org/ew/cases/EWHC/QB/2018/2528.html). The Judge's decision is interesting, as it makes a number of observations on C's appeal and the crux of the issue, stating:

'...the appeal is very starkly focused on this question of the appropriate approach to, and in this case assessment of, an expert report, as I have put it, pre-emptively served by one party to the litigation and on the basis of it an application asserted that the case should be disposed of, without allowing the remaining processes envisaged by the case management order to be followed through' [at 3].

The Judge was of the view that there was a real prospect that, after fuller argument, a different view to the Master would be taken by an appeal Judge and that there were powerful arguments to be put forward that needed 'a full outing'.

The appeal

The appeal and associated applications came before Mr Justice Foskett some four months after the Master's judgment (www.bailii.org/ew/cases/EWHC/QB/2018/2715.html), C having applied for an expedited appeal on the basis that the liability trial was listed to take place only nine months after judgment. Mr Justice Foskett concluded that C's appeal should succeed.

Evidence available at trial

The Judge agreed with C's submissions that the Master's approach to the test for summary judgment had been incorrect.

In particular, he concluded that, 'the task of considering, on a summary judgment application, evidence "which can reasonably be expected to be available at trial and the lack of it" (*Royal Brompton Hospital NHS Trust v Hammond* [2001] EWCA Civ 550; *Tesco Stores Ltd v Mastercard Incorporated* [2015] EWHC 1145 (Ch)) ... is one that needs to be undertaken with caution.

'The Master acknowledged in his judgment the need to take into account the likely evidence at trial, but would appear to have been of the view that C's expert evidence at trial, even on the best case analysis, would not be a sufficient response to [D3's GP's] view and that, accordingly, C would not be able to establish his case against D3.

'I do not, with respect, think that that view was justified' [at 45].

In other words, the Master had failed to have sufficient regard to evidence likely to be present at trial, in this case alluding to C's full GP expert evidence and the outcome of the GP expert discussions and their joint statement.

PAP correspondence and the benefits of setting out the claim properly early

In reaching his conclusion, Mr Justice Foskett also relied in part on the contents of the Letter of Claim, which had stated in express terms that C had GP expert support for his claim in the same form as subsequently formally pleaded.

In our opinion, this reliance by the Judge on the Pre-Action Protocol (PAP) correspondence demonstrates the importance of properly constructed PAP letters and the value of setting out a party's position as soon as possible in the litigation, as well as the benefits of obtaining a concluded expert opinion (insofar as the evidence allows) at an early juncture.

It is encouraging to see that assertions contained within a Letter of Claim which are consistent with the subsequent pleadings may be used positively by the Court in formulating its conclusion.

In this case, it was apparent that the appeal Judge felt that the Master should have factored in that C had stated clearly some 2½ years earlier in his Letter of Claim that he had expert support on the same basis as his pleaded case, and nothing since had altered that expert opinion.

The dangers of an infelicitous expression

Mr Justice Foskett was also alive to the difficulties C would face in producing a detailed response to D3's expert report in short order, not least the future difficulties C's expert may face at trial, given that 'Any omission or infelicitously expressed observation would doubtless be seized upon in cross-examination at trial, as would any failure to mention some relevant document, piece of research or guidance note' [at 47] should the expert have produced a hastily prepared substantive response.

The Judge went on to highlight potential costs implications, too, especially in a budgeted case, as well as the pressures on a medical expert in full-time practice.

The Judge considered that 'an expectation that [C's GP] should produce even brief reasons in response was an unreasonable expectation.

'Whilst, in one sense, the Master was right that C had had "ample time" to obtain his expert's view ... – and indeed he had obtained that view – the important factor was that, as at the hearing before the Master, that view had not been fully articulated and developed in a final report and there was no obligation on C to produce that fully articulated and developed view until [the date for exchange of expert evidence]' [at 49].

Fresh evidence

Finally, although the Judge did not need to decide the appeal on this basis, prior to Master Cook's judgment C had in fact served his full GP report in accordance with the directions timetable and sought on appeal to adduce this report as fresh evidence in the appeal.

The Judge concluded that, had it been necessary to decide, he would have allowed the fresh evidence, on the basis there was 'ample support in the authorities for a slightly more liberal approach to the reception of new evidence if the court considers it just to do so...' [at 54] and in the context of an interim application (*Aylwen v Garrett* [2001] EWCA Civ 1171; *Terluk v Berezovsky* [2011] EWCA Civ 1534; and *Lemos v Lemos* [2016] EWCA Civ 1181).

Concluding thoughts

Ultimately, the tool of summary judgment is one which is still available in the clinical negligence practitioner's arsenal; however, it is a tool which must be deployed with care and consideration, and most likely after the exchange of expert reports and production of the joint statement following the experts' discussion.

The appeal Judge observed that: 'There will be few [clinical negligence] cases, in my view, where [a summary judgment] application could ordinarily be contemplated before the relevant experts' reports have been exchanged and, in most cases, until after the experts have discussed the case and produced a joint statement' [at 45].

Dr Jock Mackenzie and Amy Wedgwood of Anthony Gold act for the claimant, who was represented by Joel Donovan QC and Martyn McLeish of Cloisters