Case No: B3/2015/2727

Neutral Citation Number: [2017] EWCA Civ 356
IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE MANCHESTER COUNTY COURT
Mr Recorder McLoughlin
Claim No: 2YM 80028

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/5/2017

Before:

LADY JUSTICE BLACK
and
LORD JUSTICE SIMON

- -

Between:

Sandra Maria Correia	**Appellant (Claimant)**
and	
University Hospital of North Staffordshire NHS Trust	**Respondent (Defendant)**

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- -

Robert Glancy QC and **Christopher Limb** (instructed by **Bde Law Ltd**) for the Appellant
Martin Spencer QC and **Fiona Neale** (instructed by **Weightmans LLP**) for the Respondent

Hearing date: 22 March 2017

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Judgment

Lord Justice Simon:

Introduction

1. The claim in this case concerns the treatment of a painful recurrent neuroma (benign tumour of the nerve tissue) in the appellant's right foot. On 10 January 2008, she attended an outpatient consultation with a consultant surgeon employed by the respondent, Mr Sukhbir Rayatt. On 5 November 2008 Mr Rayatt carried out a surgical procedure, following which she continued to suffer pain, developing a type of neuropathic pain: chronic regional pain syndrome (CRPS). Underlying the claim is the allegation that she suffered this pain due to Mr Rayatt's negligence in performing the operation. It was common ground that the surgery was rare.

2. The appellant began proceedings alleging negligence both in the advice given at the consultation and in the performance of the operation, as well as advancing a claim based on the nature of her consent to the operation, see *Chester v. Afshar* [2004] UKHL 41, [2005] 1 AC 134. A trial on liability was heard before Mr Recorder McLoughlin in January 2015. In a judgment dated 6 March 2015, the recorder gave judgment for the respondent on the issue of liability: in short, he found that the operation had been performed negligently, but that the negligence had not caused the claimant pain or suffering. This is the appeal from that finding.

3. Before turning to the recorder's judgment, and to the evidence and submissions of the parties, it is convenient to turn to facts which were not in issue on the appeal.

The underlying facts

4. The appellant had suffered from pain in her right foot for many years; and on two previous occasions had been operated on for the removal of a neuroma. At the consultation with Mr Rayatt on 10 January 2008, he explained his proposed surgical procedure. This would consist of (1) exploration to locate the suspected neuroma, and neurolysis (a separation of the nerve ending from the neuroma if it were found), (2) excision of the neuroma and (3) the nerve ending either tied or buried, depending on the available length of the nerve. It was common ground at trial that the operation if it were to be competently performed involved these three stages: surgical exploration and neurolysis, excision of the neuroma and relocation of the nerve.

5. The appellant agreed to this operation and there was no subsequent clinical assessment before the day of the operation. On 5 November 2008, she was seen by Mr Rayatt's surgical registrar, Mr Karhikeyan Srinivasan, and signed a consent form, which reads so far as material:

> Name of proposed procedure … R foot – exploration + excision of ? neuroma
>
> The intended benefits … to remove the neuroma + improve symptoms
>
> Serious or frequently occurring risks … scar, infection, bleeding, recurrence, numbness.

The question mark indicates that it was unclear whether there was a neuroma. Prior MRI and ultrasound scans had not been diagnostic of the existence of a neuroma.

6. Following the operation, an 'operation sheet' was completed:

> R foot – exploration and excision of neuroma … through old scar, scar excised, explored, medial plantar nerve identified, neuroma identified … excised + nerve released from scar tissue (ie neurolysis), haemostasis (ie stopping of bloodflow) …

7. There was no reference in either the consent form nor in the operation sheet to nerve relocation following excision of the neuroma.

8. It was common ground at trial that relocation was a necessary part of the surgical process if a neuroma were located and excised. Mr Rayatt's evidence that he believed that he had carried out a relocation procedure was not accepted, and there is no appeal from that finding. It followed that, as the recorder found, the operation was performed negligently.

9. As already noted the appellant failed on the issue of causation.

The issues on the appeal

10. Two broad issues arise on this appeal. These were identified as the 'informed consent issue' and 'the causation issue'.

(a) The informed consent issue

11. Mr Glancy QC submitted that the recorder should have found that there was a breach of duty in relation to the issue of consent. The appellant had consented to a three-stage procedure: (1) exploration and neurolysis, (2) excision of neuroma and (3) relocation of the proximal nerve ending so as to minimise the recurrence of neuroma. This was not the operation which Mr Rayatt performed; and the appellant was not warned of the material risks of an operation which omitted the crucial step of relocation (as found at §250 of the judgment): namely, that once the neuroma was excised it was likely to reform unless the nerve ending was kept away (as far as possible) from the pressure points in the foot. If the relocation of the proximal nerve ending were not carried out, the object of the surgery would be defeated.

12. It is logical to take this ground first because, Mr Glancy argued, if the appellant can bring herself within the causation principle established by *Chester v. Afshar*, she would not have to show that the respondent's negligence caused the damage (pain and suffering), an issue on which she had failed at trial. It would be sufficient to show that the injury was within the scope of Mr Rayatt's duty to warn when he obtained her consent to the operation.

13. On any view the facts of *Chester v. Afshar* were unusual. The defendant neurosurgeon advised the claimant to undergo an operation on her spine but failed to explain that, if performed without negligence, the procedure carried a small (1-2%) unavoidable risk of a neurological damage leading to a disabling condition. The claimant agreed to the procedure on a Friday and the operation was performed on the following Monday. She subsequently developed the disabling condition which left her partially paralysed,

and sued the surgeon for negligence. In these circumstances, claimants had needed to show that, if a relevant warning had been given, they would not have undergone the procedure. That finding was not made in *Chester v. Afshar*. The trial judge held that the defendant had not performed the operation negligently, but that he had negligently failed to warn the claimant of the risks of developing the disabling condition and that, if she had been aware of the risks, the claimant would have sought advice on alternatives to surgery and the operation would not have taken place when it did. The judge held that there was a sufficient causal connection between the failure to warn of the inherent risks of the operation and the damage sustained by the claimant, and that the link was not broken by the possibility that the claimant might have consented to the surgery in the future. The Court of Appeal dismissed the defendant's appeal and he appealed to the House of Lords.

14. It was common ground that, whenever the operation was carried out, the same small percentage risk of resulting disability would exist, and that in the light of the degree of risk, the probabilities were that the disabling condition would not arise. The point was expressed by Lord Hope of Craighead at [61]:

> … the failure to warn cannot be said to have increased the risk of injury. The risk was inherent in the operation itself … the evidence indicated that it was also liable to occur at random, irrespective of the degree of care and skill with which the operation was conducted by the surgeon. This means that the risk would have been the same whenever and at whoever's hands she had the operation.

15. The issue was summarised at [40]:

> The question of law which arises from these findings is whether it was sufficient for [the claimant] to prove that, if properly warned, she would not have consented to the operation which was in fact performed and which resulted in the injury, or whether it was necessary for her to prove also that she would never have had that operation.

16. Lord Bingham and Lord Hoffmann concluded that it was necessary to prove that she would never have had the operation. They both would have allowed the appeal.

17. At [8], Lord Bingham set out how in the ordinary run of cases the 'but for' test of causation was a necessary if not a sufficient condition for establishing causation. The claimant had shown that 'but for' the failure to warn her she would not have consented to surgery on the Monday. However, the timing of the operation was irrelevant to the injury she suffered. The injury would have been as likely (or perhaps unlikely) to have occurred whenever the operation was performed since it was a small risk which existed whenever performed and whomsoever performed it. If failure to warn and the occurrence of the injury which should have been the subject of the warning were, without more, enough to found a successful claim where a patient would have consented to the operation even if properly advised, it would amount to a substantial and unjustifiable departure from sound and established principle (see [9]). Lord Hoffman agreed with this analysis in trenchant terms.

18. I have sought to summarise the minority opinions because the majority accepted these general principles, and indicated that they did not intend a wide departure from established principles of causation.

19. At [18] Lord Steyn said this:

> … in the context of attributing legal responsibility, it is necessary to identify precisely the protected legal interests at stake. A rule requiring a doctor to abstain from performing an operation without the informed consent of a patient serves two purposes. It tends to avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept. It also ensures that due respect is given to the autonomy and dignity of each patient.

20. He expressed his conclusion at [24]:

> Standing back from the detailed arguments, I have come to the conclusion that, as a result of the surgeon's failure to warn the patient, she cannot be said to have given informed consent to the surgery in the full legal sense. Her right of autonomy and dignity can and ought to be vindicated by a *narrow and modest departure* from traditional causation principle (emphasis added).

21. This approach reflected the views of Professor Honoré in a commentary on the Australian case of *Chappel v. Hart* (1998) 195 CLR 232, an extract of which was referred to by Lord Steyn at [23] of his opinion:

> Do the courts have the power in certain cases to override causal considerations in order to vindicate a plaintiff's rights? I believe they do though the right must be exercised with great caution.

22. The opinion of Lord Hope concluded with the following passage:

> 86. I start with the proposition that the law which imposed the duty to warn on the doctor has at its heart the right of the patient to make an informed choice as to whether, and if so when and by whom, to be operated on. Patients may have, and are entitled to have, different views about these matters. All sorts of factors may be at work here - the patient's hopes and fears and personal circumstances, the nature of the condition that has to be treated and, above all, the patient's own views about whether the risk is worth running for the benefits that may come if the operation is carried out. For some the choice may be easy - simply to agree to or to decline the operation. But for many the choice will be a difficult one, requiring time to think, to take advice and to weigh up the alternatives. The duty is owed as much to the patient who, if warned, would find the decision difficult as to the patient who would find it simple

> and could give a clear answer to the doctor one way or the other immediately.
>
> 87. To leave the patient who would find the decision difficult without a remedy, as the normal approach to causation would indicate, would render the duty useless in the cases where it may be needed most. This would discriminate against those who cannot honestly say that they would have declined the operation once and for all if they had been warned. I would find that result unacceptable. The function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content. It will have lost its ability to protect the patient and thus to fulfil the only purpose which brought it into existence. On policy grounds therefore I would hold that the test of causation is satisfied in this case. The injury was intimately involved with the duty to warn. The duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent. So I would hold that it can be regarded as having been caused, in the legal sense, by the breach of that duty.
>
> 88. The reasoning of Kirby J in *Chappel v Hart*, 195 CLR 232, para 95, which I would respectfully endorse, supports this approach. I am encouraged too by the answer which Professor Honoré gave to the question which he posed for himself in his case note on that case at p 8: 'is this a case where courts are entitled to see to it that justice is done despite the absence of causal connection?' I would hold that justice requires that Miss Chester be afforded the remedy which she seeks, as the injury which she suffered at the hands of Mr Afshar was within the scope of the very risk which he should have warned her about when he was obtaining her consent to the operation which resulted in that injury.

23. The opinion of Lord Walker of Gestingthorpe contains a further analysis of the arguments for and against extending the principles of causation, leading to his conclusion at [101]):

> … there would be a danger, as Lord Hope points out, of an honest claimant finding herself without a remedy in circumstances where the surgeon has failed in his professional duty, and the claimant has suffered injury directly within the scope and focus of that duty. I agree with Lord Steyn and Lord Hope that such a claimant ought not to be without a remedy, even if it involves *some extension* of existing principle, as in *Fairchild v. Glenhaven Funeral Services* [2003] 1 QB 32 (emphasis added).

24. Each of Lord Steyn, Lord Hope and Lord Walker endorsed the opinions of the other; and in my view the ratio of the decision is contained in [87] of Lord Hope's opinion. If there has been a negligent failure to warn of a particular risk from an operation and the injury is intimately connected to the duty to warn, then the injury is to be regarded as being caused by the breach of the duty to warn; and this to be regarded as a modest departure from established principle of causation.

25. The question then is, how such an approach should be applied on the facts of the case? Mr Glancy submitted that the matter was straightforward. The appellant had consented to an operation which involved a three-stage procedure and had not been warned of the material risks of an operation which omitted the third and crucial step of relocation. If she had been warned, she would not have undergone the operation. This failure entitled her to damages since the risk of damage from the material omission was something about which she should have been warned.

26. In my view, there are difficulties with this argument. On the recorder's findings there can be no justifiable complaint about the process of consultation and consent up to the moment when the operation began: the procedure was to be an appropriate three-stage operation (assuming a neuroma were found) and it was to this operation that the claimant consented. However, it does not follow that the negligent omission of the third stage negated her consent. In my judgment it did not. The negligent failure to deal appropriately with the nerve ending did not make this either a different operation for the purposes of consent, nor an operation for which specific consent was required. It was a breach of duty which had the potential to give rise to liability for damages if all the other elements of the tort of negligence were made out. The claimant made an informed choice to have the surgery, and the injury was not 'intimately linked' with the duty to warn.

27. I have reached this conclusion without reference to the submission of Mr Spencer QC that the implications of a finding that a negligent act in the course of an operation vitiates consent would have potentially far reaching consequences. It plainly would. The result of such an approach, particularly where (as here) the precise form of the operation could not be determined until the operation had begun, hardly require elaboration; the decision in *Chester v. Afshar*, envisaging a 'narrow and modest departure' from (per Lord Steyn) or 'some extension' to (per Lord Walker) traditional causation principles, is scant support for the appellant's argument. It follows that in my judgment there was no breach of the defendant's duty in relation to the appellant's consent to the operation.

28. Furthermore, there is an additional problem for the appellant in the present case. The crucial finding in *Chester v. Afshar* was that, if warned of the risk, the claimant would have deferred the operation. In contrast, in the present case, it was not the appellant's case that she would not have had the operation, or would have deferred it or have gone to another surgeon. There was no such contention in either her Protocol Letter, the appellant's pleading or her witness statement. Nor was it part of her evidence. To some extent, the reason for this omission is the artificial nature of the appellant's argument on this part of the case. Nevertheless, it seems to me that if a claimant is to rely on the exceptional principle of causation established by *Chester v. Afshar*, it is necessary to plead the point and support it by evidence. In the event, the material evidence, such as it was, did not support the appellant's case on this aspect of the

causation argument. As the recorder found (at §220), the appellant did not say she would not have had the surgery if advised differently.

29. On any view of the matter this was an entirely different situation to that in *Border v. Lewisham & Greenwich NHS Trust* [2015] EWCA Civ 8 to which we were referred.

(2) The causation issue

30. Expert evidence had been called by each side at the trial: Consultant plastic surgeons (Mr Miller for the appellant, and Mr Henderson for the respondent) and Consultant pain specialists (Dr Simpson for the appellant and Dr Harrison for the respondent).

31. In summary, the recorder held that, although a neuroma had probably re-formed and the appellant continued to suffer from pain following the operation, he was not satisfied that the pain was caused by the re-formed neuroma. This finding was based largely on the joint statement of the pain specialists. First, they agreed that the Median Plantar Nerve damage predated the surgery in November 2008 and was unrelated to it. Secondly, they agreed that the appellant suffered from neuropathic pain before the surgery; and there was further evidence that the appellant continued to suffer neuropathic pain during the period immediately following the November 2008 operation and before a new neuroma could have formed. Thirdly, the symptoms of CRPS were the result of the operation but were not caused by any breach of duty in relation to it.

32. The appellant had relied on the evidence of Mr Miller on the issue of causation. In his original condition and prognosis report (dated 6 January 2013, based on his examination of the appellant on 10 September 2011) he had not attributed her pain to a neuroma. His views on causation emerged gradually and were subject to qualification. His concluded view was that the nerve stump would inevitably have formed a new neuroma, and that if it had been relocated it would have been likely to be 'less symptomatic' because it would not be walked on. On this basis, in his view, the re-formed neuroma materially contributed to the pain suffered by the appellant.

33. The primary question on this issue was framed by Mr Glancy as being whether the recorder was entitled to reject Mr Miller's opinion and, if so, whether he gave sufficient reasons for doing so. He submitted that Mr Miller's evidence was a proper foundation for a finding that leaving the nerve stump exposed led to the formation of a new neuroma which proved symptomatic due to the pressure from walking; and this materially contributed to the appellant's pain. He realistically accepted that, although he had accepted Mr Miller's evidence on breach of duty, the recorder was not bound to accept his evidence on causation.

34. The appellant's case on causation was not straightforward.

35. The recorder summarised the effect of Mr Miller's evidence:

> 108. In terms of clarification regarding his condition and prognosis report he thought that post-operatively in either days or weeks the [appellant's] pain should subside and extra pain was due either to a recurrence of the neuroma and additional

> damage to the main trunk of the medial plantar nerve and thirdly due to CRPS.

36. The recorder concluded his summary of Mr Miller's opinion as follows:

> 125. With regard to post-operative pain, he said the neuroma [that was removed] was not a huge size and that following nerve surgery there would be a honeymoon period of six weeks when the neuroma would re-form in the foot.
>
> 126. He had not suggested in his condition and prognosis report that any pain was caused as a result of a recurring neuroma.
>
> 127. When commenting about neuropathic pain pre-operatively at court, he said he hadn't seen anything that would measure it as worse since the operation took place and he couldn't explain why he said in his report [of] January 6, 2013 and his report of May 19, 2013 that the surgery had caused significant worsening of neuropathic pain.

37. Mr Glancy accepted that this summary of Mr Miller's evidence was fair so far as it went. His complaint was that there was no further analysis of Mr Miller's evidence on causation or of why the recorder rejected it.

38. In the light of this submission it will be necessary to consider further parts of the recorder's judgment; but, before doing so, it is convenient to set out this Court's approach to a judge's findings of fact, and the inferences which may properly to be drawn from those facts. Three points may be noted.

39. The first, is a general observation in relation to findings of fact. In *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 at [97], Lord Kerr and Lord Reed (in a joint judgment with which other members of the Supreme Court agreed) restated the proper approach under the heading 'causation'.

> This court has reiterated in a number of recent cases, including *McGraddie v. McGraddie* [2013] 1 WLR 2477 and *Henderson v. Foxworth Investments Ltd* [2014] 1 WLR 2600 that appellate courts should exercise restraint in reversing findings of fact made at first instance. As was said in *Henderson's* case, para 67:
>
> > in the absence of some other identifiable error, such as (without attempting an exhaustive account) a material error of law, or the making of a critical finding of fact which has no basis in the evidence, or a demonstrable misunderstanding of relevant evidence, or a demonstrable failure to consider relevant evidence, an appellate court will interfere with the findings of fact made by a trial judge only if it is satisfied that his decision cannot reasonably be explained or justified.

40. The second point relates to a submission that the fact-finder failed to refer to parts of the evidence. This was another point addressed in the *Montgomery* case. At [102] Lord Kerr and Lord Reed referred to the speech of Lord Simonds in the curiously named case of *Watt or Thomas v. Thomas* [1947] (Sc) AC 484 at 492, where Lord Simonds said:

> The trial judge has come to certain conclusions of fact: your Lordships are entitled and bound, unless there is compelling reason to the contrary, to assume that he has taken the whole of the evidence into his consideration. If his conclusion is inconsistent with the evidence of certain witnesses, it is not the proper or necessary inference that he has forgotten or ignored them …

41. Lord Kerr and Lord Reed noted the exception 'unless there is compelling reason for the contrary', which they found existed on the facts of the *Montgomery* case. Nevertheless it is clear that the wider principle is that there is no requirement for the fact-finder to refer to, or discuss, every point in the evidence.

42. The third point relates to the reasons why an appellate court does not interfere with findings of fact, the evaluation of those facts and the inferences to be drawn from them, unless there are compelling reasons to the contrary. These were described strikingly in the judgment of Lewison LJ in *Fage UK Ltd and anor v. Chobani UK Ltd and anor* [2014] EWCA Civ at [114], and include:

> …
>
> iv) In making his decisions the trial judge will have regard to the whole of the sea of evidence presented to him, whereas an appellate court will only be island hopping.
>
> v) The atmosphere of the courtroom cannot, in any event, be recreated by reference to documents (including transcripts of evidence).

43. These observations are particularly relevant in the present appeal in view of Mr Glancy's necessarily selective references to the evidence.

44. As indicated above, the difficulty with an appeal based on Mr Miller's views on causation is that much of his evidence was quite properly rejected. His view that damage to the Median Plantar Nerve had been caused by the operation in November 2008 was rejected in the light of the contents of the pain experts' joint statement (see [31] above). Mr Miller had also attributed the appellant's pain to the development of intrusive neuropathic pain caused by the operation on the basis that she had not suffered prior neuropathic pain. In fact, she had (see also [31] above).

45. The high point of the appellant's case on this issue was the reference to the cross-examination of Mr Miller in which he said that the recurrence of the neuroma would 'significantly contribute' to any post-operative neuropathic pain, adding:

> My understanding, but again I defer to the pain experts, is that a symptomatic neuroma or damage to the main trunk of the medial plantar nerve, … will trigger CRPS. But again, I think this is a topic which will be better considered by the pain experts.

46. Mr Glancy submitted that although the recorder had rightly accepted that a neuroma was likely to reform unless the nerve ending was relocated, he had failed properly to indicate why he did not accept that the substandard surgery had, at least, materially contributed to the appellant's persisting pain. On the issue of 'material contribution' he referred to the decision of this court in *Bailey v. Ministry of Defence* [2008] EWCA Civ 883 and the judgment of Waller LJ at [46]:

> … I would summarise the position in relation to cumulative cause cases as follows. If the evidence demonstrates on a balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the claimant will have failed to establish that the tortious cause contributed. *Hotson* [*v. East Berkshire Area Health Authority* [1987] AC. 750] exemplifies such a situation. If the evidence demonstrates that 'but for' the contribution of the tortious cause the injury would probably not have occurred, the claimant will (obviously) have discharged the burden. In a case where medical science cannot establish the probability that 'but for' an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the 'but for' test is modified and the claimant will succeed.

47. I would accept some of Mr Glancy's criticism of the recorder's judgment. It was not well-structured and too much consisted of a recitation of the evidence. However, he analysed the causation issue in the course of five material findings.

48. First, although it was likely that a neuroma had re-formed, neither the experts nor the appellant's treating physician had been able to say whether a neuroma had in fact re-formed and, if so, where it had reformed. This was in part due to the appellant's extreme sensitivity to any examination of her foot. It followed that there was no evidence that a re-formed neuroma was positioned in an area of the sole of the foot which would cause pain. Secondly, no Tinel's test (a test for detecting nerve damage by tapping) could be carried out, and the CRPS had created an occlusion (or masking) of the cause of the post-operative pain. Thirdly, as noted above, the recorder specifically rejected Mr Miller's evidence that the Medial Plantar Nerve was damaged during the operation. He found that the damage was most likely to have been caused by earlier operations. That conclusion, supported as it was by a close examination of the evidence, was not challenged on this appeal. Fourthly, the pain specialists agreed that the post-operative neuropathic pain was the continuance of the pre-operative pain due to the 'remapping of the nervous system' prior to surgery. Fifthly, although the CRPS was due to the carrying out of the surgery in November 2008, it was not caused by any negligence in the surgery. It followed that the pain which was undoubtedly caused by CRPS was not caused or contributed to by the negligent surgery.

49. Looking at the totality of the evidence, although the recorder accepted that the appellant clearly suffered pain, he found that the evidence was not sufficiently clear to satisfy him that the breach of duty (the failure to relocate the nerve ending) was the cause of the appellant's pain.

50. In my view the recorder was entitled to reject Mr Miller's opinion on causation and his reasons for doing so were sufficient. First, Mr Miller had espoused a theory that the pain had been caused by damage to the Medial Plantar Nerve during the surgery. The recorder was fully entitled to reject this opinion for the reasons set out above. Secondly, Mr Miller had initially thought that there was no preoperative neuropathic pain when it was clear that there had been. Thirdly, Mr Miller had expressly deferred to the opinions of the pain experts on what might be the trigger for the CRPS. Fourthly, although his view was that the neuroma was likely to re-form, it could not be established that it had re-formed, or (more materially) where it had re-formed. Finally, there was the difficulty that, not only was there a combination of possible causes of pain, including damage to the Median Plantar Nerve and CRPS which were not caused by the failure to relocate the nerve ending, but the existence of these symptomatic conditions provided a real obstacle to proving that the negligence caused or 'materially contributed' to the appellant's pain and suffering.

51. Not every judge would have concluded that the appellant failed on the issue of causation, but unlike this court the recorder had heard the entirety of the evidence and was very much better placed to form an overall view of the issue.

Conclusion

52. For these reasons, I would dismiss the appeal.

Lady Justice Black

53. I agree.