Case No: TLQ/15/0474

Neutral Citation Number: [2016] EWHC 269 (QB)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/02/2016

Before:

MR JUSTICE FOSKETT

- -

Between:

URSZULA JACIUBEK **Claimant**

- and -

DR RAJEEV GULATI (1)

ROYAL FREE LONDON NHS FOUNDATION TRUST (2) **Defendants**

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- -

Katie Gollop (instructed by **Irwin Mitchell LLP**) for the **Claimant**
Gerard Boyle (instructed by **Nabarro LLP**) for the **First Defendant**
Eliot Woolf (instructed by **Bevan Brittan LLP**) for the **Second Defendant**

Hearing dates: 19-22 January 2016

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Judgment

Mr Justice Foskett:

Introduction

This is a clinical negligence claim where the issue at present is liability only.

1. The Claimant, Ms Urszula Jaciubek, who was living in North London at the material time, alleges that a partner in the GP Practice with which she was registered ('The Adelaide Medical Centre' in Hampstead), Dr Rajeev Gulati, and a Senior House Officer in A & E Medicine at the Royal Free Hospital, Dr Karen Shepherd, were each negligent on separate occasions in not identifying and acting upon the signs that she had suffered a subarachnoid haemorrhage ('SAH') or that she required further examination.

2. Her case is that had either acted as they should have acted, namely, by ensuring that she was appropriately examined such that the SAH would have been identified, suitable operative intervention would have prevented a subsequent, more serious SAH, and thus would have secured a better outcome for her than has occurred.

3. It is also alleged that when she was triaged on her arrival at the Royal Free, the triage nurse negligently assigned her to the least urgent category so that she was not seen by someone more senior than Dr Shepherd.

4. The material events occurred in June and July 2010.

What is an SAH and what are the classic symptoms?

5. In simple terms an SAH is a bleed into the brain or, more accurately, a bleed into the subarachnoid space of the brain.

6. The National Study of Subarachnoid Haemorrhage published in 2006 said this:

> "Subarachnoid haemorrhage (SAH) is a type of haemorrhagic stroke caused by bleeding in the subarachnoid space around the brain. The incidence of SAH in the UK is approximately 8 per 100,000 population.
>
> In most patients, the haemorrhage is caused by a cerebral (intracranial) aneurysm. Aneurysms develop at the site of a defect in the wall of the intracranial blood vessels. The weakened wall balloons out to form a blood filled sac, known as a saccular aneurysm. This is unstable and may rupture causing haemorrhage into and around brain structures. In about 10% of patients the haemorrhage is caused by an arteriovenous malformation (AVM), a condition where blood vessels cluster together and form abnormal connections that are weak and prone to bleeding. In another 10% investigation reveals no evident vascular abnormality and the aetiology remains unknown ….
>
> The aetiology of aneurysm formation is uncertain, although there is likely to be a genetic component (congenital

predisposition). A number of other risk factors such as smoking, hypertension and alcohol abuse may contribute.

SAH represents less than 5% of all strokes. However, it is a serious condition associated with a poor prognosis. It is estimated that up to 50% of patients suffering an aneurysmal SAH will either die or be left with serious disability. Without treatment approximately 25-30% of patients would re-bleed within the first four weeks from the haemorrhage. Of these, approximately 70% would die."

7. The same study says this of the clinical features of SAH:

> "Clinical features of SAH include severe headache of sudden onset and neck stiffness, often combined with impaired conscious level and sometimes hemiparesis, impaired speech and/or seizures."

8. In Kumar, Clarke 'Clinical Medicine', (2002 ed), the following is said about the clinical presentation of SAH:

> "The onset of SAH of any cause is a sudden devastating headache, often occipital. This is usually followed by vomiting and often by loss of consciousness. The patient remains comatose or drowsy for several hours to several days. Less severe headaches cause diagnostic difficulties but SAH is a possible diagnosis in any sudden headache."

9. The Oxford Handbook of Emergency Medicine (2005 ed) suggests that it is necessary to "consider subarachnoid haemorrhage in any 'worst ever' or sudden onset headache" and continues as follows:

> "**History:** Up to 70% of patients with subarachnoid haemorrhage report rapid onset or 'worst ever' headache. This is classically describe as 'like a blow to the back of the head', accompanied by neck pain, photophobia and vomiting. In 25%, exertional activities preceded the event. The patient may present after syncope or fits. Drowsiness and confusion are common. 'Warning headaches' may precede subarachnoid haemorrhage. Unilateral eye pain my occur
>
> **Examination**: there may be focal motor and sensory signs due to intracerebral extension of the haemorrhage or vasopasm, sub-hyaloid haemorrhages (blotchy haemorrhages seen in the fundi) or cranial nerve palsies. Oculomotor nerve palsy is characteristic of a berry aneurysm involving the posterior communicating artery. Although neck stiffness is a 'classical' feature, it is often absent in A & E presentations, either because meningeal irritation has not yet occurred or because the patient is deeply unconscious."

10. In this case the three neurosurgeons agreed on the "typical" or "classical" history of subarachnoid haemorrhage as follows:

> "We agree that as neurosurgeons we regard the "typical" history of subarachnoid haemorrhage to be sudden onset severe headache, usually the worst headache the patient has ever experienced. There is often associated neck stiffness, photophobia and vomiting and there may be loss of consciousness and/or focal neurological deficit such as weakness."

11. They also all agreed with the following paragraph in Mr Battersby's report:

> "From a neurosurgical perspective, the association of an unexplained headache, followed shortly after by vomiting and unusual neurological symptoms would normally require investigation with brain scanning, but I appreciate the difficulty the General Practitioners would have in obtaining this investigation, and also the greater frequency of similar presentations in general practice in which a subarachnoid haemorrhage has not occurred."

12. The GP experts in this case (Dr Paul Bracey for the Claimant and Dr Guy Norfolk for the First Defendant) agreed that GPs will see an SAH in general practice very rarely. Dr Norfolk said that "most GPs will only see a few cases throughout their careers" and Dr Bracey said that a GP will see a patient with an SAH on average only once every 5 years. Dr Bracey, who is now aged 73 and retired from full-time practice as a GP some 5 years ago, told me that he had "never [seen] a subarachnoid haemorrhage as a GP, only in a student and health officer capacity." Dr Norfolk said that he had come across two instances of SAH in his time as a GP, but both were of a "classic" presentation and each was sent to hospital straightaway. Both experts were also agreed that headache is one of the commonest complaints made to a GP "and the vast majority of patients presenting with a headache to a GP are not suffering from a serious intracranial event."

13. Dr Bracey described the "classic" presentation as follows in his report:

> "The classical presentation of patients with this condition is well recognised. Patients describe their worst ever headache (the result of red blood cell induced irritation of the tissues surrounding the brain), vomiting and collapse with loss of consciousness."

14. That description says nothing about the speed of onset. Dr Bracey did append some literature to his report, one feature of which was an article entitled 'Subarachnoid Haemorrhage' on the Patient.co.ukemis website (apparently dated February 2011) where the following appears underneath the heading 'Presentation':

> "The most characteristic feature is a sudden headache. This may last a few seconds or even a fraction of a second. The patient may even look round and accuse someone of hitting him

> on the back of the head. In general practice, it may be the only symptom in a third of patients. Of patients who present in general practice with a sudden headache, around 10% have subarachnoid haemorrhage …. SAH should be considered in any patient presenting with sudden onset, severe and unusual headache with or without any associated alteration in consciousness."

15. Dr Norfolk had also referred to various pieces of literature, one of which was The Oxford Handbook of Emergency Medicine quoted in paragraph 10 above.

16. I will return to the criticisms of Dr Gulati and to the views of these two experts in due course (see paragraphs 97 - 116).

The first manifestation of a problem

17. The contemporaneous documentation suggests that the first manifestation of a problem was during the evening of Thursday, 17 June 2010 (see Dr Gulati's consultation record at paragraph 41 below). It may have occurred on the Wednesday evening, but it matters little for present purposes.

18. The background is that the Claimant had been working as a carer for an elderly lady who, in her day, was a famous actress. She was wheelchair-dependent at the time and has died since the events with which this case is concerned. The Claimant was a physiotherapist by profession and, according to the Particulars of Claim, had "considerable experience of working with adults who are recovering from strokes." She was aged 59 (nearly 60) at the time of the material events.

19. The accommodation of the elderly lady was a first-floor flat in the Hampstead area of North London. I do not know whether there was a lift within the property but when the Claimant was taken from it by ambulance on 1 July 2010 (see paragraphs 47 - 54 below), she used the stairs to reach the ground floor. The Claimant's duties required her to be "on call" 22 hours a day. Prior to the material events she had been working in that capacity for about 5 or 6 years. She explained to me that working on that basis required her to take extended breaks from time to time (for 2 or 3 weeks) - after, say, 2 or 3 months of being constantly "on call".

20. She is Polish by birth and has (or at least at the time had) her own apartment in Poland. Her son and daughter had settled in Canada and indeed she has since the events of 2010 moved to and now lives permanently in Canada herself. At the time of the events in question, she had a flight to Canada booked for 6 July for what was doubtless one of the breaks to which I have referred. Indeed one of the records in the GP notes (see paragraph 45) shows that she was due to go to Canada for 2 weeks.

21. As I have indicated, the first manifestation of the medical problems she faced came during the evening of Thursday, 17 June 2010.

22. In her witness statement made in June 2015, which she adopted as her evidence-in-chief, the Claimant said the following about how the first episode of significance in the case arose:

> "On the evening of either Wednesday 16th or Thursday 17th June 2010, I was a prayer meeting at the church on the opposite side of the road to Finchley Road Underground Station in North London. I was sitting down quietly in Church and at prayer when I experienced a dull ache in my head which built up and up until it became unbearable. The pain was inside my head but seemed to affect my spine and I felt as though I could not stand or move: my neck felt stiff and I could not look down. I had the sensation of my legs being numb and I felt as though I was having a stroke. I realised that I was about to be sick and explained this to those around me and I was escorted to a side room where I vomited. After a period of time the pain subsided and friends took me home where I continued to have vomiting.
>
> When I returned home I helped the lady I cared for get ready for bed. I remember that I vomited a few times that night."

23. That account mirrored what had been said in the letter before claim and it is plain that this is the account that, with the careful questioning of her experienced solicitors, she felt was correct and with which she was comfortable. I do not know when she first instructed solicitors, but it will have been no later than 2012 because the letter of claim was dated 25 January 2013 which itself indicated that she had the benefit of a Public Funding Certificate. The claim will have required detailed consideration to enable proceedings to be contemplated.

24. The account was, in due course, embodied in the Particulars of Claim served in January 2014.

25. That account was, of course, first advanced after the events to which I will refer in paragraphs 39 – 83 below and after the Claimant had suffered two smaller haemorrhages culminating in the SAH referred to in paragraph 84 below. A somewhat more contemporaneous recollection (but also advanced after the final SAH) appeared in two letters of complaint she sent to the GP Practice and to the Royal Free Hospital after she returned to the UK for a short period in November 2010. For present purposes I should quote what she said in her complaint letter to the GP Practice dated 25 November 2010 because it sets out the account of her symptoms:

> "Between June 17th and July 3rd I was examined by three different doctors at your surgery. On June 17th I was complaining about strong headaches, throwing up, stiffness of neck, difficulty in speaking for five to ten minutes, pain throughout my spine and difficulty breathing and weakness in my legs. All those symptoms happened on the evening of July 16th [*which is accepted to have been a mistake for June 16th*] and when I was examined the next day I told the doctor that it felt like I had had stroke. He said he thought I was overstressed and tired and to go home and take painkillers. It seemed strange to me as my job is not stressful and only once a year have I ever experience (sic) a migraine headache.

> I went again to the surgery on June 25th because symptoms of my headache and weakness of my whole body and difficulty to walk increased. Again I was told by a different doctor that I was overstressed and to go home and rest and take painkillers for the headache.
>
> On July 1st or 2nd at 5am, I had another episode of similar experiences, having difficulty to breathe, to move my whole body for awhile, difficulty to talk. I managed to call an ambulance and get to the Royal Free where without any tests they sent me home, because my symptoms had subsided. The same day I went to the Adelaide Medical Centre as I was advised at the hospital and I got again the same response, and no further examination or tests done, even though I told both of them that it felt like I had had a stroke …."

26. I will return to the significance of aspects of that account in due course and to the account of what occurred on 1 July 2015, but one further account she gave was to Dr Sundeep Sembi, a Consultant Clinical Neuropsychologist, in July 2013:

> "Some weeks before her haemorrhage she had visited her GP complaining of headaches. Approximately one month before her Haemorrhage, whilst at church, she remembers experiencing a strange sensation and pain from her head and down her spine. She could not walk or talk, was nauseous and eventually sick in the toilet. Members of the congregation helped her and took her home.
>
> She visited her GP the day after, although does not remember the exact date. By that time she was experiencing a strange smell, head pain, a stiff neck and weakness in her legs.
>
> She thought she had suffered a stroke however the GP had said she had not and informed her that it was a migraine. She therefore continued to work in the weeks leading up to the index event although felt she was slower. She reported visiting her GP regularly over this time although was repeatedly sent home and told not to worry. She reported that *"They assumed it was stress"* but she did not understand this. She emphasised that she loved her job and did not consider her life to be stressful at all …."

27. I have referred to these accounts because, as the Claimant volunteered when she gave her evidence, her earlier recorded recollections are likely to be more reliable than her present memory would permit. I will have to refer later to aspects of what she said even at an early stage that do not fully marry up with the objective evidence available but for the present I am merely recording what she has said.

28. One matter I would mention at this stage is what the Claimant said in both letters of complaint about what happened in Canada. It was as follows:

> "On July 9th I was in Canada BC and I had a Subarochnoid (sic) Haemorrhage caused by a brain aneurism. I was taken to hospital from Castegar to Vancouver General Hospital by helicopter and treated with coiling of the aneurism and external vertical drain. I was in a coma for two days and I was in hospital from 9th – 27th July. I had a consultation on the 15th November with the surgeon who operated on me and when he heard about my symptoms and experience in London he said that I had had mini strokes and that the haemorrhaging could have been prevented if these had been diagnosed accurately and a brain scan had been done."

29. It follows that by the time she commenced making complaints about the treatment received both from her GPs and at the Royal Free, she had been told by her Canadian surgeon that she had suffered some "mini strokes" and that her serious SAH could have been avoided if those mini strokes had been diagnosed and a scan had been performed prior to that final haemorrhage.

30. I do not think that she had taken legal advice before the letters of complaint were written, but what she said in relation to the GPs was that she wished "to make a complaint against the three doctors who examined me for not giving the full medical attention to my symptoms that they deserved."

31. I am focusing on the first manifestation of the medical problem itself, but the way she expressed her dissatisfaction with her treatment at the Royal Free is worthy of note: she said she would have expected "some kind of scan" (see paragraph 137 below).

32. I have, as indicated, focused on what the Claimant had said about the events of 17 June at earlier stages than in her oral evidence. In her oral evidence she was asked about the "strange sensation" she mentioned in her witness statement, whether it started as neck pain and whether it came on gradually. She said it started as a headache and she gave the following description:

> "It was coming in the short time. It was, I do not know, a few minutes or one minute. I do not know how long, but it was a short time. It was weird and I was just, "What is going on?" I was waiting for release, to have this finish, but it did not finish. It came more and more."

33. She repeated that "it was not a long time". She said:

> "It was quick. Something was coming and I did not know what is coming. After that, I could not bear it and I need to leave because I want to throw up. … it was not ten minutes. It was just minutes, like maybe one or maybe two minutes. That was fast."

34. She agreed that she would have used the word "intense" about the pain she suffered and, when asked whether there was a delay before she felt sick, she said it was "one event and it was a short time". She also said that, whilst she could not remember how

the pain started, she did recall a stiff neck and that she could not move her head up and down.

35. Subject to the issues considered later (see paragraphs 75 - 78), this is the first time she has given an estimate of the speed of onset of the headache on 17 June.

36. The neurosurgeons instructed by the parties were asked to consider that part of her evidence and agreed that, as neurosurgeons, an account such as that would have led them to perform a CT scan. They emphasised, however, that everything they say is from their perspective of neurosurgeons and that they have a low threshold for investigation for any patients referred to them with symptoms that might relate to intracranial problems. However, Mr Battersby and Mr Byrne said that, from their perspective, the symptoms were not typical of classical SAH (see further at paragraph 108 below).

37. The issue in the case against Dr Gulati is, of course, whether the Claimant told him about these symptoms in that way, or would have given a sufficient indication following appropriate questioning, such that he should have suspected the possibility of an intracranial event that warranted further investigation.

The Claimant's involvement with the GP Practice

38. Although her letter of complaint to the GP Practice (and indeed the account she gave to Dr Sembi) suggested that she had gone to her GP on the day following the episode in the church, in fact it is clear that the Claimant did not see any doctor until Monday, 21 June 2010. It follows that she did not go to the doctor on the Friday (after the event in the church the previous evening) or seek emergency help over the weekend, but left obtaining an appointment until the Monday, effectively 4 days after what occurred in church.

39. She booked her appointment on the Monday in what the practice calls its "emergency list". The opportunity to make an appointment exists from 8.30 am and is what Dr Gulati called a "book-on-day system". The records show that the Claimant telephoned for an appointment at about 9.15 am that day, the appointment being for about 11.00 am.

40. Computer records show that it lasted about 18 minutes overall (a 10-minute "slot" being provided), but some part of that may have been taken up in Dr Gulati transferring the contents of a handwritten note to an electronic version held on the computerised records maintained by the practice. He made the following note of the consultation:

> "Rx: Clarithromycin Tablets 500mg
>
> E: Upper respiratory infection NOS
>
> P: Imp wants abx (*antibiotics*) for her sinuses, I think it is viral, agrees to delayed script, prn analgesia, warning signs discussed, discussed stress, has few trips abroad coming over next month to see children abroad, adv to relax, declines counselling at this stage, tci after her trips to r/v how she is

O: no meningeal signs, no papilloedema, normal vis fields, other cranial nerves nad, ent nad, afebrile

O2 sats 98% pulse 100, tearful

No pains now

S : last Thurs intense pain in neck and rad up spine, rad to front of head, few hrs intense headache and vom then began to settle, no visual disturbances, residual blocked/congested sinuses, lethargy, no further vom now, also a lot of stress – Works as a carer 22 hrs/day, finding it more difficult

E: Tension headache

T: BP 144mmHg / 70mmHg"

41. If one leaves out of account any other feature of the consultation for present purposes, this demonstrates that, so far as any examination is concerned, he took her blood pressure, temperature, pulse and oxygen saturations and also examined her ear, nose and throat as well as checking her field of vision and examining her eyes for any sign of papilloedema (which is swelling or blurring of the optic disc margins caused by raised intracranial pressure). He checked for any meningeal irritation such as neck stiffness and photophobia (one cause of which is SAH) and conducted a cranial nerve test. Although not mentioned in his report, Dr Bracey agreed that that this was a good and competent examination and indeed it is not criticised.

42. I will return to aspects of this note which are said to be (and in part acknowledged by Dr Gulati to be) deficient, but one significant omission is reference to what the Claimant says she said to him, namely, that she thought that the episode on the previous Thursday felt as though she had had a stroke (see paragraph 26 above). I will return to this in due course (see paragraph 136) as I will to the case advanced against Dr Gulati concerning his history-taking (see paragraphs 97 - 116).

43. The Claimant was seen again in the GP Practice two days later on 23 June 2010 by Dr Michael Marks (a trainee doctor) and his note was as follows:

E: Viral illness

S: was here 2 days ago. Saw Dr Gulati. c/o of head/neck and sinus pain. Systematically well – impression was of viral illness +/- tension headache. Not settling yet and legs feel achey/stiff.

O: Legs – normal range of movement, power and sensation. Chest clear, throat NAD heart sounds normal. Cranial nerves nad, no scalp tenderness, temporal arteries normal and pulsatile. Looks systematically well.

T: Pulse 72/minute.

P: Impression is viral illness not yet resolved. General advice, fluids and analgesia.

44. She returned again on 28 June 2010 and was seen by Dr Marcus Craven, another partner in the practice, whose note was as follows:

E: Low back pain.

S: With radiation into legs. Note above history – much improved, still slight right sided headache, but much improved. Now LBP, rad down both legs, some paraesthesia both feet, bladder and bowel okay.

O: SLR 90/90, power 5/5, sens light touch intact.

Rx: Diclofenac sodium E/C tablets 50 mg. Omeprazole capsules (gastro-resistant) 20 mg.

P: Try diclofenac, PPI cover, with food. See few weeks if persisting. Flying to Canada for 2/52 in 1/52. See on return if persisting.

45. Subject to her return to the practice on 1 July 2010 after going to the Royal Free Hospital (see paragraphs 47 - 83 below), that represented the totality of her involvement with the practice in relation to this matter before she left for Canada on 6 July 2010.

1 July 2010 and her attendance at the Royal Free Hospital

46. In the early hours of 1 July 2010 (which was a Thursday and 2 weeks after the first episode in church) the Claimant woke up with the sensations and pain to which I will refer shortly and managed to dial 999. The recording of the conversation was finally made available shortly before the trial and substantial reliance is placed upon it by Ms Gollop on the Claimant's behalf. I will describe the contents of the telephone interchanges below (see paragraphs 71 - 83), but for present purposes all that needs to be said is that the Claimant was plainly in a very distressed state. The person who took the call recorded the time as 05.12 and the chief complaint as "headache" with "Headache with Abnormal breathing" as the "determinant". She recorded the "problem description" as "Cannot walk, nauseous, neck stiff, headache, double vision."

47. The call resulted in the arrival with the Claimant of the First Responder from the London Ambulance Service within the commendably short period of about 4 minutes after the initiation of the call. His note was as follows:

1st set: 05.16: RR 28. P 79. Colour normal. …GCS 15

2nd set: 05.18: RR 16

Presenting complaint: headache, neck pain.

NB: Initially no one answering door, EOC rang back to advise to open door. O/A: pat alert, orientated and mobile

C/c: neck pain (central) and occipital headache.

Hx c/c: woke up with neck pain, headache, initially tingling sensation, hands, double vision.

o/e: pat initially hyperventilating

Coached breathing.

48. It is clear from the 'RR' (respiratory rate) records that the rate was 28 when the Single Responder arrived, but with his support it had reduced to 20 within a couple of minutes. The Claimant confirmed to Dr Mukhtar later that day (see paragraph 66) that she had been hyperventilating because she panicked. As noted above, the First Responder recorded that she was "alert, orientated and mobile".

49. The ambulance arrived at 05.18, again commendably quickly. The notes made by the crew give the following information:

Activation details

Call given as: headache, nauseous

Response details

Mobile: 05.14

Ambulance arrive: 05.18

Ambulance with patient 05.20

Left scene: 05.50

Arrive hosp: 05.57

Clinical handover: 05.59

Patient handover: 06.02

Patient assessment

Presenting complaint: Neck pain/headache

Observations

1st set: 05.40: RR 20; P 79. Pale. 164/85. Pain 5/10. Temp 36.6˚C. GCS 15/15

2nd set: 05.45: RR 20, P80, Pale, 184/83, GCS 15/15

Accident/treatment/Details/Advice given

PC: pain in neck and back of head.

HPC: Pain in neck and back of head for 2 weeks. Stiff neck, blurry vision. Pain radiating to lower back.

OE: Reduced movement in neck, unable to move head from side to side. No chest, no SOB (*shortness of breath*), No DIB (*difficulty in breathing*)

50. I should, perhaps, say that whilst all that information is indeed recorded, it is not, as Dr Shepherd observed when giving her evidence, a particularly easy document to read. It was, as I shall indicate, available to her when she examined the Claimant. The First Responder's note would not have been available and, of course, Dr Shepherd would not have heard the emergency call.

51. The Ambulance Crew record also had a small box on the right-hand side of the part of the document where the "Accident/treatment/Details/Advice given" is recorded which contains two small depictions of mannikins, one facing outwards and the other facing inwards. The crew are to record on those diagrams areas where pain is said by the patient to be experienced. Shaded areas appear on the neck and lower head at the rear, at the top of the head at the front and in the lower back area at the base of the spine.

52. Her respiratory rate remained at 20 during the 30 minutes or so that the ambulance crew were at the property with the Claimant, there was no difficulty breathing and, whilst understandably the Claimant cannot herself now recall it, she gave the assessment of her pain as 5 on the scale of 1-10 where 1 is the least level of pain and 10 is the worst. When she gave her evidence she was able to recall that she walked with the assistance of the ambulance crew down the stairs to the ambulance, the ambulance crew having said that they would prefer to do this if possible because the stairs were steep and dangerous.

53. As will appear below (see paragraph 63), the Claimant was critical of the attitude of the emergency services/paramedics on the basis that they were "very unprofessional and … did not treat [her] seriously, sometimes ridiculing [her]". Although not mentioned in her letter of complaint, in her witness statement she said that she told them that she thought that she had a stroke. That was not recorded by either the First Responder or by the ambulance crew.

54. She arrived at the Royal Free shortly before 06.00 and was seen by the Triage Nurse, Mr Timmy O'Donoghue, very shortly afterwards. His notes reveal that the "Reason for visit" was "Headache/neck pain" and that the "Presenting complaints" were "headache and neck pain for 2/52, seen GP x 4, analgesia taken". Her vital signs were recorded as follows: "Temp: 36.6. Pulse 79; B/P 164. RR: 16. O2 sats 99%."

55. Mr O'Donoghue triaged her as "Priority 5" which is the lowest priority classification. It meant that she was classified as non-urgent and could be seen in a period of "up to four hours". He is criticised for this and I will return to the issue below (see paragraphs 129 - 133). However, despite the classification he gave, the Claimant was seen by Dr Shepherd probably within an hour or so of being triaged. According to the Ambulance records the "clinical handover" took place at 06.02. Mr O'Donoghue's

examination will have taken place shortly after that. Dr Shepherd's note (see paragraph 59 below) was transposed onto the computerised system within the Royal Free at 07.36 (which would have been after her examination was concluded) and it follows that the Claimant will probably have been seen by Dr Shepherd at or around 07.00-07.15.

56. I should say that the Claimant has no recollection of being seen by anyone other than the female doctor (Dr Shepherd), but there can be no doubt that she was indeed seen by Mr O'Donoghue. The Claimant has a recollection of sitting in a large waiting room "for almost an hour". She said it was cold.

57. Unfortunately, despite the letter of complaint (see paragraphs 61 - 63 above) and the Letter of Claim dated 25 January 2013 (in which criticisms are made of what must have been Dr Shepherd's examination), Dr Shepherd was not made aware of the claim and thus the criticisms until June 2015. Dr Shepherd was a Foundation Year 2 doctor in the A & E Department at the time of the material events In August 2010 she left the Royal Free to complete the rest of her training at hospitals in Kent and East Sussex before moving to the Norfolk and Norwich University Hospital in September 2014 as an Orthopaedic Research Fellow. She has since then returned to the Royal Free in the trauma and orthopaedic department. Quite understandably, she had no recollection in June last year (and has none now) of the examination or anything else associated with the Claimant's attendance at the Royal Free that day. She has said, and I accept, that all she can do is rely upon the notes she made at the time and on what she believes her standard practice at the time to have been.

58. Dr Shepherd's clinical note (which formed the basis for the discharge summary) was as follows:

> Presenting complaint: headache and neck pain for 2/52, seen GP x 4, analgesia taken.
>
> Clinician comments: Patient seen in A & E with a 2/52 history of neck pain with headache. She reports she has seen her GP four times with the same complaint and was given strong analgesia which completely cured her neck pain for one day. On waking this morning the neck pain had returned and the patient experienced some double vision and paraesthesia in the hands which was completely resolved on seeing in A & E. The patient has a known history of arthritis and she is particularly concerned over ? damage to her spinal cord/spinal cord lesion. Otherwise she is well with no regular medications. On examination: apyrexial, not tachycardic, BP stable with saturations of 99%. There is no bony tenderness to c-spine and no muscular spasm to neck. The patient is holding the neck in one position but does have good ROM. No double vision and neurology is grossly intact.
>
> Impression: migrainous headache with ? osteoarthritic changes in spine causing cervical neuralgia. We have discharged this patient from A & E this morning as she has not presented with any acute neurology or any other acute medical problems

> requiring admission. We have recommended that if she continues to suffer with neck pain or paraesthesia then she may benefit from neurology referral with a view to further imaging of the spine. This needs formal referral through the GP.
>
> Diagnosis: neck pain.
>
> Investigations: vital signs, oximetry/sats.
>
> Treatments: verbal advice

59. The "Outcome" was recorded as "Disch for GP F/up – to check progress."

60. In her letter of complaint (see paragraph 63), the nature of the Claimant's complaint in respect of her treatment by Dr Shepherd was as follows:

> "I wish to make a complaint against the Royal Free Hospital doctor who examined me but did not give the full medical attention to my symptoms that I believe they deserved. I do not remember her name but you will have record of it. After one month of struggling with symptoms and seeing my GP, I was expecting that she would at least give me a thorough examination including some kind of scan."

61. To be accurate, it was not, of course, "one month" of symptoms that had preceded her visit to the Royal Free, but about 2 weeks' worth, as had been made clear in an earlier part of the letter (see paragraph 63 below).

62. I will return to the criticisms of Dr Shepherd made in these proceedings below (see paragraphs 117 - 128), but it would be convenient to note what the Claimant had also said in her letter of complaint to the hospital sent on 25 November 2010:

> "On July 1st or 2nd at 5am in my home I experienced stroke-like symptoms: strong headache, stiffness of neck, difficulty in speaking for five to ten minutes, difficulty breathing and weakness in my legs, and difficulty moving my whole body. I called the emergency services and arrived at the Royal Free Emergency Unit around 6am.
>
> I found the emergency services/paramedics very unprofessional and they did not treat me seriously, sometimes ridiculing me. I say that because I wonder if maybe their report to the doctor there may have influenced her. I waited for more than an hour in an empty cold waiting room alone before seeing the doctor. When eventually I did, she did not examine me, but only asked me a few questions. I told her that I had not been well since 17th June and that I had experienced this once before (on June 17th and had been to my GP) and that if felt like I had had some sort of stroke. As my symptoms had by this time subsided she advised me to go back to my GP. The experiences were very frightening to me as I thought at these times that I was dying. I

> shared with her that I planned to fly to Canada on July 6th and she said she believed I would be fine to go."

63. Again, she asserted that she had told Dr Shepherd that what had occurred to her that morning "felt like I had experienced some kind of stroke". There is no reference to that in Dr Shepherd's notes but it is plain that she did examine the Claimant.

Further visit to GP on 1 July

64. After her discharge from the Royal Free the Claimant went home – by taxi, she told me. Although when giving her evidence, she had little recollection of the appointment, the records show that she arranged a further appointment at the Adelaide Medical Centre that day and was seen by a female doctor, Dr Farah Mukhtar. To the extent that she recalls this appointment, the Claimant felt that she was following up what Dr Shepherd had advised.

65. Dr Mukhtar's note was as follows:

> S: Neck pain since this am felt numbness and pins and needles in arms and legs, hyperventilating at the time as panicked, went to A & E who adv to see GP, took solpadol and pain in neck and headache slightly improved, no weakness, numbness or pins and needles in arms at present.
>
> O: no c-spine tenderness, pain on right suboccip region, RROM of neck esp on looking to left c/o pain in same area right side power 5/5 all 4 limbs, sensation intact to light touch, perla bilat, cn 1ii-xii intact.
>
> P: cont with analgesia will do msk ref

66. The Claimant had referred to this appointment in her letter of complaint (see paragraph 26 above), one complaint she made being that "no further examination or tests done" even though she told the doctor she saw that what had happened to her "felt like I had had a stroke". There is no reference to that in Dr Mukhtar's note. Equally, it is to be noted that the predominant complaint that Dr Mukhtar recorded for what occurred that morning was "neck pain" and "numbness and pins and needles in arms and legs".

67. The expression "msk ref" is a reference to a Referral Form to the NHS Musculoskeletal Service. On 2 July 2015 Dr Mukhtar completed the form and noted the "reason for referral" as follows:

> "Neck pain and stiffness past few weeks off and on, sudden in onset, no history of injury, using cocodamol and diclofenac which help slightly but no complete relief."

68. Although there is no reference in that Referral Form to the Claimant's proposed departure to Canada a few days later, it is to be presumed that it was intended that she would be seen on her return.

69. The Claimant told me that she did not work for the few days before leaving for Canada, but stayed with a friend of the lady for whom she worked.

The 999 call

70. Before leaving this part of the chronology I should describe the telephone conversation with the emergency services to which I referred in paragraph 47 above. A transcript has been agreed between Counsel, the recording was played in court and I have, on a few occasions whilst considering the terms of this judgment, listened to an enhanced version with which I was provided.

71. It is, of course, important to recall, when judging the actions of Mr O'Donoghue and Dr Shepherd, that they did not hear this conversation and were undoubtedly confronted by someone whose general presentation had improved significantly by the time they saw her. I will return to this in due course.

72. As far as the call itself is concerned, the Claimant, who is generally quietly spoken, was undoubtedly struggling to get certain words out. She speaks good English, but it occasionally takes a little time for her to retrieve the necessary word from her memory bank. That, I thought, applied when she was giving evidence and the same can be detected in the telephone conversation. The lady taking the call says fairly early on that she was "struggling" to hear the Claimant and said "pardon" twice.

73. Nonetheless, the Claimant can be heard saying that she "just woke up" and that she did not feel well and that she had a "strong headache". She said that she had "tingling in [her] head and hand" and that she could not walk. She says she was "nauseous", that she was lying down with a stiff neck and that she had difficulty breathing. She repeated that she had a headache and that she had double vision. She was able to say that she was a live-in carer. Immediately after having said this there is a passage when it was very difficult to make out what she was saying, but eventually she mumbled that she could not move and that she was sweating.

74. She was asked the address to which the ambulance needed to come and she gave that clearly, together with the postcode. She could not remember the telephone number from which she was calling when she was asked by the lady taking the call. When asked her age, she said initially 55 and then corrected it to 60. There is then another passage where she was struggling to get the words out and indeed she said "I am struggling" and went on to say that her spine was hurting. She also said that "I was for two weeks suffering from headaches". At that point the lady receiving the call asked the following question:

> "When the headaches started, did it start very quickly?"

75. The answer was as follows:

> "Yes, two weeks ago."

76. That, as it seemed to me when I listened to the recording (as indeed it must have seemed to the lady receiving the call when judged by reference to her follow-up question), was simply an answer suggesting that the headaches started two weeks previously. The follow-up question was this:

"And when it started, did it start very quickly?"

77. The agreed transcript suggests that the response is "inaudible". I was not entirely sure whether Ms Gollop was inviting me to conclude, having listened to the enhanced recording, that the Claimant answered "yes" to this question. If so, I think it is very difficult to draw that conclusion even on the basis of the enhanced recording, but even if one were to accept that some form of assent emerged in answer to the follow-up question, I really do not think that this (or indeed the answer to the previous question) can be translated into the conclusion that the Claimant had made a clear and unequivocal acknowledgement that the headache that began some two weeks previously was of sudden onset. Whatever question the Claimant thought she was answering at that time, there is no doubt that she was still in a very distressed state and, indeed, as I shall indicate shortly, she described herself as "disorientated". In her evidence she described herself as "scared" at the time. I do not consider that the contents of the telephone call can be treated as a reliable basis for concluding what had happened or what was said two weeks previously.

78. The lady receiving the call continued by asking whether the Claimant had any numbness or paralysis to which the answer was that her arm was "tingling" and that she had a headache which she repeated as "a genuine headache". The question about numbness and paralysis was repeated to which the answer was "no", I just feel very weak and I can't move and disorientated."

79. At this point in the conversation, it becomes clear that the First Responder was arriving and there was discussion about how the door was to be opened. The conversation concluded very shortly thereafter.

80. As I have already said, it is quite plain that the Claimant was in a distressed state during this conversation. She told Dr Mukhtar some hours later that she panicked. I can quite understand why that was so. She woke up with, at the very least, some degree of headache and neck ache, tingling sensations and numbness, with a feeling that she could not move. There were similarities to the events of two weeks earlier. She was alone with no readily available companion to provide support or to call a doctor or ambulance on her behalf. The hyperventilation was a classic symptom of someone who, quite understandably in the situation, panicked.

81. Panic, of course, is not the full explanation for the symptoms she experienced on 1 July. Prior to the emergence of the terms of the telephone conversation and the recording, the consultant neurosurgeons had agreed that "the likely cause of [the Claimant's] presentation on … 1 July was a [SAH] …." That was presumably based upon the Claimant's account of her symptoms as set out in her witness statement (see paragraph 23 above) or the pleadings and, to some extent, with the benefit of knowing what happened in Canada (see paragraph 84 below). Having heard the recording with the benefit of the agreed transcript during the trial, the neurosurgeons agreed that "taken in isolation" the call is "consistent with an acute intracranial event" and that, on the balance of probabilities, "there was at least some bleeding into the subarachnoid space", but that it was "a relatively small bleed that did not cause impaired consciousness". They agreed that the only symptoms they would regard as "typical of [SAH] were headache and neck stiffness assuming that [the] 'strong headache' was new or a significant exacerbation of pre-existing headache."

82. However, it is quite clear (and the Claimant herself accepts this, as I understood her evidence) that whatever symptoms she may have experienced upon waking, some had substantially, if not completely, subsided by the time she got to the Royal Free. Dr Shepherd recorded that the double vision and the paraesthesia in her hands had "completely resolved" (see paragraph 59 above) and in her letter of complaint the Claimant said her symptoms had subsided by the time she saw Dr Shepherd. It is an inescapable conclusion, whatever criticism might by made of the paramedics and/or Mr Donoghue, that once the Claimant was in professional hands her panic subsided and some of the symptoms subsided. That is not to suggest that she did not genuinely experience those symptoms, but it goes some way to explaining the 5 out of 10 score she gave for pain and why she was triaged as she was: her essential presentation then was not as the telephone call would have suggested.

What happened in Canada?

83. On 9 July 2010 the Claimant suffered an SAH secondary to a ruptured left posterior communicating aneurysm. It was treated surgically with drainage and coiling and she remained an inpatient at Vancouver General Hospital until 27 July 2010.

The thrust of the Claimant's case against both Defendants

84. It is not suggested that Dr Gulati or Dr Shepherd should have diagnosed SAH. What is said is that if either had heeded what they had been told by the Claimant or had taken a proper history they would have obtained a picture of an acute headache and other symptoms which required further investigation.

85. I am proposing to consider the case against each separately but, as I shall indicate later (see paragraphs 134 - 139), the overall picture has to be looked at before reaching a final conclusion on where the evidence leads in this case. Its outcome depends as much on my assessment of what the Claimant is likely to have said (against the background of what she is likely, on the medical evidence, to have experienced) as it does upon my assessment of each of the doctors, their examination and note taking. As I will observe later, I have the advantage of the broader picture than each of the experts will have who have given their view of matters within their own particular field and in respect of narrow aspects of the case and often on an assumed basis of fact. I will return to this later (see paragraphs 134 - 140).

86. Ms Gollop, in her closing submissions, focused on the "structured approach to history taking" adumbrated in an article published in March 2013 in "Medicine" by two Scottish Consultant Neurologists. It (or at least part of it) was attached (without comment) to the report of Dr Richard Evans, an Honorary Consultant in Emergency Medicine at the University of Wales Hospital, Cardiff, who was called as an expert witness for the Second Defendant in relation to Dr Shepherd's conduct. Ms Gollop cross-examined Dr Gulati about it and re-examined Mr Peter Richmond, the Claimant's A & E expert, by reference to it.

87. I do not, of course, suggest that the passages in the article are not relevant or helpful, but it does have to be borne in mind that (a) the article was not in circulation in 2010, (b) there was no full examination in the evidence about where it stands in the light of other written material and (c) it cannot <u>of itself</u> assist in determining what doctors in the position of Drs Gulati and Shepherd knew, or ought reasonably to be expected to

have known, about acute headache when they dealt with the Claimant. Their training and experience is more relevant to that issue. Each said something about that to which I will now refer before considering the case advanced against each.

Dr Gulati

88. At the time of the material events, Dr Gulati was aged 35 and had been a partner in the practice from January 2009, having been a salaried GP with the practice for some part of the previous year. He has an impressive CV and has co-authored three text books. I note that he received a Certificate of Merit for Outstanding Performance in his MB BS Written Finals. This gives the impression of someone who is ordinarily very conscientious. Indeed the nature of his examination of the Claimant would suggest that this is so. That does not, of course, mean that on occasion, like many conscientious people, he may not be capable of falling below his normal standards of investigation of a patient, but it is a factor to be considered when evaluating the likelihood of this occurring. It does have to be acknowledged, however, that some aspects of his note keeping on this occasion have been criticised as sub-standard and he accepts that criticism.

89. Dr Gulati had been a GP for two years prior to the relevant consultation/examination. He told the court of his past experience, particularly of working in a casualty department for 18 months and as an emergency registrar for 10 months. During that time he said that he saw, perhaps, a dozen or two dozen cases of SAH or intracerebral bleeds of which at least half had been patients who presented with a bad headache and the challenge, as he put it, was to elicit the relevant history to determine what further investigation was required.

90. He also spoke of what he had been taught to look for when he was confronted by Ms Gollop with the extract from the article referred to at paragraph 87 above. The suggestion was being made, based upon the article, that a "thunderclap headache" was a headache that reached peak intensity within a matter of seconds to five minutes. His response was to say that there are also guidelines that say "seconds to one minute" and that is what he had been used to and that was what he had been taught. He described the key characteristics that he and colleagues of his generation were taught to look for in relation to a thunderclap headache was one that came on suddenly and severely (a "devastating" headache which was as if the person had been hit over the head) and built up over a minute.

91. I see no reason not to accept that that is the way he was taught and it is certainly in keeping with the literature highlighted in paragraphs 8 – 15 above. I will be referring again below to the question of whether a slower onset of a serious headache than something effectively instantaneous should be seen as a warning sign (see paragraphs 98 - 106).

Dr Shepherd

92. Dr Shepherd was aged 26 (nearly 27) at the time she saw the Claimant. I have already indicated her career path after July 2010 (see paragraph 57). She graduated with her MB BS in 2008. In 2010 she would have been less experienced than Dr Gulati, but she has a wide ranging and impressive CV, both prior thereto and indeed thereafter. Again, in her case, an impressive CV does not mean that her professional conduct on

this occasion may not have fallen below an appropriate standard, but there are clear indications in the CV of someone who takes her job seriously.

93. When the Claimant presented herself to the A & E Department Dr Shepherd was undertaking her A & E rotation period. Her medical school training was quite recent. What she said about SAH and sinister headaches was that these matters were all part of the medical school training. She had been taught about presenting conditions, including headache and other neurology presentations and how to assess them. She said that this was also part of her module specific A & E training. If that is correct, and I have no reason to doubt it, she would have been made familiar relatively recently with the kind of issues with which she would be faced when a patient presented with a history of severe headache. She said in her witness statement that a history of sudden onset severe headache with neck stiffness and nausea would have been 'red flag' symptoms that would have resulted in the Claimant being seen by a more senior clinician. "Sudden onset severe headache with neck stiffness and nausea" as a warning sign would be consistent with the literature and standard teaching at that time and she would doubtless have received similar teaching to that which Dr Gulati had received.

94. Leaving aside for the moment issues concerning the quality of her history taking, Ms Gollop sought to suggest to Dr Shepherd that her note taking fell below acceptable standards, doubtless based upon the views of Mr Richmond. She replied that, whilst she accepted that she had not documented all the negative findings, her note taking generally had been reviewed regularly by "senior bodies and consultants in the A & E Department" and that at no time had she been pulled up on her documentation or told that it was inadequate or substandard. It was part of a modestly expressed answer to a question and it had the ring of truth about it. I accept it. If follows that, whilst she could not answer by reference to her notes certain questions about what did or what did not occur when she saw the Claimant, she was tolerably comfortable with the notes themselves. Inevitably, because she had no recollection of the Claimant, she had to fall back on those notes as they were to try to deduce what was in her mind and on what she said would have been her standard practice at the time. She maintained her composure during a searching cross-examination.

95. I should say that merely because her note taking had not attracted criticism from those who supervised her does not of itself mean that, objectively speaking, they are above legitimate criticism. However, it is important to recognise what goes on in the "real world" rather than adopting an unrealistically high expectation of notes made in the early hours of the morning in what was probably a busy A & E Department at the end of a night shift starting at 8 pm the previous evening. (On that broad issue Ms Gollop submits that there is no evidence that the department was busy and the staff under pressure. She draws attention to the fact that the Claimant says she was left alone in a cold waiting room for an hour and that there were two "weird" male patients walking up and down but that was all. I agree that on that evidence alone it might be concluded that the department was not busy. On the other hand, the Claimant did have to wait for an hour before she was seen by Dr Shepherd, suggesting that Dr Shepherd herself was engaged during that period, and Dr Shepherd's witness statement contains the statement that the A & E Department "starts to get busy" at about 6 am. It was not an issue ventilated with Dr Shepherd or Mr O'Donoghue.) There is always a temptation in the courtroom to subject these hastily written notes to

a contextual and linguistic interpretation that the circumstances of their creation do not justify.

The case advanced against Dr Gulati

96. The Claimant's case is that when she went to see Dr Gulati on 21 June it was about the episode that occurred on 17 June and not because she wanted antibiotics for sinusitis (which appears in his note). It is said that he should have obtained a history of strong headache, neck stiffness, vomiting and weakness all coming on as part of the same episode as a result of which he should have sent her to hospital for investigation of a possible intracranial event. The essential criticism is of his history taking reflected in notes which, it is said, are inadequate.

97. The literature shows, and the neurosurgeons agree, that a sudden onset severe headache is the characteristic presentation that requires further investigation if the cause of some intracranial event cannot be excluded. That I understand to have been agreed also between Dr Bracey and Dr Norfolk. They agreed as follows in their joint statement:

> "We agree that, if the Court accepts Dr Gulati's account that the headache developed gradually, was not severe or unbearable but was just like a band round her head, that there had been no neck stiffness and that she vomited some time later after the headache had developed then it was not mandatory for him to refer the Claimant to the hospital on 21.6.10."

98. This formulation raises the question of what constitutes a "gradual" onset of a headache and whether the headache itself is "severe or unbearable". On the issue of the speed of onset, I have already drawn attention to the suggestion made during the proceedings that a "sudden" onset can be something that takes up to five minutes or maybe longer (see paragraphs 91 - 92). Ms Gollop, in her closing submissions, referred to the Al-Shahi review paper (to which I make reference below at paragraph 115). That paper contains this passage:

> "Patients with subarachnoid haemorrhage usually present with a characteristic combination of symptoms …. Sudden severe headache is the cardinal symptom, but it may be the only symptom in up to one third of patients with aneurysmal subarachnoid haemorrhage. When patients were asked how long it took for their headache to reach its maximum severity half of those with subarachnoid haemorrhage described it as instantaneous, one fifth said it developed over 1-5 minutes, and the rest said it escalated over more than five minutes. The headache usually persists for several days but may occasionally be much shorter. Even in the emergency department the positive predictive value of instantaneous severe headache for aneurysmal subarachnoid haemorrhage is only 39% (95% confidence interval 29% to 50%), so the speed of onset cannot be relied on to identify all cases of subarachnoid haemorrhage."

99. The source for the second two sentences (according to the footnotes) is an article entitled 'Headache characteristics in subarachnoid haemorrhage and benign thunderclap headache', Linn and ors (*J Neurol Neurosurg Psychiatry 1998;65:791-793*). It is the same source (or at least one of the sources) as the source for part of the Scottish Intercollegiate Guidelines Network ('SIGN') clinical guidance to which Dr Bracey drew attention at a very late stage in the proceedings. I will refer to that guidance now.

100. The guidance, issued by the NHS in Scotland, is entitled "Diagnosis and Management of Headaches in Adults" and was issued in November 2008. It is said in the body of the document that it "will be of interest to healthcare professionals in primary and secondary care including general practitioners, community pharmacists, opticians and dental practitioners, and patients with headache." Under the heading "Secondary Headache", certain "Red flag" features are identified including "new onset or change in headaches in patients who are aged over 50" and the following:

> "… thunderclap: rapid time to peak headache intensity (seconds to 5 mins)"

101. The text, however, says this under the heading 'Thunderclap headache':

> "Thunderclap headache may be primary or secondary. It is defined by the ICHD-II as a high intensity headache of rapid onset mimicking an SAH from a ruptured aneurysm with maximum intensity being reached in less than a minute. In most patients thunderclap headache peaks instantaneously. In a small case series 19% of patients with SAH had headache that reached maximum severity more gradually (up to 5 minutes). Sudden severe headache may also occur during sexual activity or exercise.
>
> Other causes of sudden severe headache include: intracerebral haemorrhage, cerebral venous sinus thrombosis, arterial dissection and pituitary apoplexy.
>
> There are no reliable features to differentiate between primary and secondary thunderclap headache and SAH can present with milder sudden onset headache. A significant minority of thunderclap headache is secondary. In one case series 11% of patients with thunderclap headache had SAH. When a patient presents for the first time with a sudden severe headache they should be referred immediately for consideration of a secondary cause, particularly SAH (this includes delayed presentation)."

102. The source for the sentence beginning "In a small case series …" is the article by Linn and others.

103. When I questioned the evidential status of the SIGN guidelines for the purposes of this case, Dr Bracey said that they constituted recommendations for GPs and that it would represent unacceptable practice for GPs to be unaware of them or, at least for

the purposes of this case, to be unaware that a thunderclap headache should now be considered as one that could take up to five minutes to reach maximum intensity. On that view, and given the issue concerning "gradual" onset of headache, Dr Bracey appeared to have been advancing the proposition that Dr Gulati would have been falling below the standards of a reasonably competent general practitioner if he did not realise that a severe headache that took five minutes to develop was a "red flag" sign that suggested the need for further examination.

104. I gave Mr Boyle the opportunity to cross-examine Dr Bracey further on this and, if I may say so, he quickly exposed the weakness of Dr Bracey's position. The SIGN guidelines are not referred to in Dr Bracey's report, did not figure in his discussions with Dr Norfolk, he could not say how they were disseminated to GPs in England and could not say whether, in June 2010, they were indeed circulated to GPs in England. He had to accept that the "up to five minute" approach had not found its way into other literature, for example, the Oxford Handbook of General Practice. Dr Norfolk, when he gave his evidence, said that he, as a GP, had never been circulated with the SIGN guidance he also said that the guidance was, in any event, not to be seen as setting minimum standards of care. Mr Richmond, the Claimant's A & E expert, said that he would not expect the average A & E junior doctor to be *au fait* with the SIGN guidelines.

105. It is not for me to say whether the standard of care in cases of this kind is to be set by reference to what 19% of patients in a small series said they experienced – that would essentially be a matter for the medical profession to decide subject, if the issue arose, to a court considering whether such a view withstood logical scrutiny. However, it is clear to me that the "received wisdom" at the time that the Claimant's case was being considered by Dr Gulati (and by Dr Shepherd) was that the red flag would be raised if there was a sudden onset of severe headache and that "sudden" for this purpose meant either instantaneous or within a minute or so. I quite accept Dr Norfolk's view that a doctor should not adopt an obviously rigid distinction between, say, 60 seconds and 75 seconds, and that there is an element of judgment involved. However, where there is a reasonable perception on the basis of the history given that it took longer than this for the headache to reach maximum intensity, then it is not unreasonable for the level of suspicion and concern to be reduced.

106. Whatever may be said about Dr Gulati's history taking, he <u>did</u> obtain the information from the Claimant that she experienced an "intense" headache. Notwithstanding the paucity of his note in relation to the history in some respects, I find it impossible to accept that he did not go on to ask the question "how quickly did it come on?" or words to that effect. His detailed neurological examination suggests that he did ask himself whether there might be some intracerebral cause and he must have been alert, as all reasonably competent GPs must be, to the need to find out how quickly the headache occurred. If he had been told that it was instantaneous or came on very quickly (say within a minute or so), I accept that he would have been alerted to a red flag symptom that required further investigation - and indeed so did he. However, what his notes suggest is that the way the Claimant had described things to him was that she had suffered intense pain in the neck which radiated up the spine and into the front of the head and that she had a few hours of intense headache, with some vomiting, which had settled. This suggests that he asked where the pain had started and that she gave a description which he understood. In her evidence to the court she

has now said that everything happened very quickly, but I am afraid I cannot accept that that is likely to be an accurate way of describing what happened or, if it is, it is not what she said to Dr Gulati. I will have to draw attention later to some problems with the account she has given (see paragraphs 134 - 138), but what he has recorded positively about her presentation is not wholly dissimilar to what she said in her letter of complaint to the practice (see paragraph 26 above) which is her earliest recorded account of what she recalled happened. The "strong headaches" are not explained in that letter as, for example, "an unbearable headache that came on very quickly". Indeed, it has to be said that what she said subsequently in her witness statement (see paragraph 23) is not a description that really mirrors the "thunderclap" type of headache to which so much reference has been made – a "dull ache … which built up and up until it became unbearable" does not connote such a headache.

107. Since the majority of neurosurgeons in the case agree that what occurred on 17 June was not typical of a classical SAH, the likelihood is that it was a smaller bleed with symptoms that were not themselves classic in presentation. If that is so, no matter how the questions were framed by Dr Gulati, he would not have received a description of the classic presentation or necessarily of something else that raised the red flag.

108. Another usual feature of the classic presentation is neck stiffness caused by meningeal irritation. Dr Gulati does not record any complaint of neck stiffness (merely neck pain), but excluded on his examination any meningeal signs. So far as vomiting is concerned, he certainly recorded it as having occurred, but not that it was more or less coincident with the onset of the headache. If it was in fact the case that the Claimant vomited more or less at the same time as a headache developed, then given the likelihood that the headache built up gradually (in the sense described above), there would not have been the classic presentation of vomiting. That again is consistent with Dr Gulati's note.

109. Overall, and taken with the other, more general, factors in the case to which I will refer below (see paragraphs 134 - 139), I do not consider that it has been established that Dr Gulati conducted a negligent consultation with the Claimant. He accepts that he would now record more negative features (in other words, features that negated a more sinister presentation) than he did at the time, but I do not consider that this evidences a failure to conduct appropriate and necessary questioning of the Claimant about the history of her condition.

110. He is being criticised for concluding that her headache was a tension headache and for thinking that her concern was her sinuses. Dr Norfolk (who I thought was an impressive and balanced witness and whose approach was much less partisan than that of Dr Bracey) acknowledged that the diagnosis of tension headache would not have been correct if Dr Gulati had thought that the vomiting was associated with the headache. However, he felt that the overall diagnosis was reasonable.

111. It is important to see what presented itself to Dr Gulati. The Claimant plainly did tell him about her job involving working 22 hours per day. It is difficult to see why this was raised at all if it was irrelevant - and Dr Gulati clearly saw it as relevant because he noted it. She told me that it was necessary to take breaks from her work from time to time (see paragraph 20 above). It is possible that Dr Gulati thought that she was complaining about her job when, in truth, all she was saying was that she was in need

of a break. However, it is quite possible to see why he may have thought that at least part of her presentation (which involved being tearful) was tiredness from overwork. That, coupled with what he found on examination to be residual blocked sinuses, makes his overall diagnosis a perfectly reasonable one and one at which Dr Norfolk felt he was entitled to arrive. These factors could, of course, have misled Dr Gulati into lowering his level of suspicion concerning an intracerebral event, but since the index of suspicion had been lowered for the reasons already given, I do not think that there is anything culpable about Dr Gulati's approach. It is, of course, easy to be wise with hindsight and suggest that something should have been spotted when it is now known that an SAH had probably taken place four days earlier, but that is a completely different issue from concluding that the failure to spot the problem at the time was negligent.

112. Subject to the more general factors to which I will return (see paragraphs 134 - 139), I think Dr Norfolk may well have given the essential answer to the problem faced by Dr Gulati in the following way:

> "The real difficulty for GPs is that sometimes subarachnoids can present with what we refer to as "the sentinel bleeds", which are small bleeds of headaches before the main bleed. Those can sometimes be far more subtle, as I understand it. Sometimes, you can get a headache just from the enlarging aneurism and sometimes from very small bleeds. Sometimes, they just do not present classically and that is the real difficulty. You can do a perfectly competent examination, but you can still get it wrong. That, sadly, is the nature of general practice sometimes. You do your best, but still you can miss things because they are just not typical."

113. I imagine Dr Norfolk was referring to what are referred to as "warning headaches" (see paragraph 10 above) or "premonitory headaches" in one of the pieces of literature referred to by Dr Bracey (the General Practice Notebook) - probably also the "mini strokes" referred to by the Canadian surgeon (see paragraph 29 above) and the "relatively small bleed" referred to by the neurosurgeons in this case (see paragraph 82 above). In the General Practice Notebook it is said that "premonitory headaches occur in the preceding week in 25 to 50% of cases [which are] overlooked as often by the patient as the physician." By "preceding weeks" is meant the weeks preceding the onset of the "sudden severe headache" that constitutes the true SAH. Whilst, of course, in this case, the headaches that occurred on 17 June and again 1 July were not overlooked by the Claimant, its presentation was probably less than the "classic" presentation because each was a "sentinel" or "premonitory" event.

114. For completeness I should record that in a review article in the British Medical Journal (BMJ. 2006 Jul 29; 333(7561): 235–240) by Rustam Al-Shahi and others it said this:

> "Although some believe that "sentinel bleeds" or "warning leaks" precede aneurysmal subarachnoid haemorrhage, the evidence is that headaches preceding the haemorrhage are rare and do not help in its diagnosis. Overestimation of the importance of sentinel bleeds arose from recall bias in hospital

based studies. We recommend that the terms sentinel bleeds and warning leaks should be abandoned: people either have had a subarachnoid haemorrhage or not and the important task is to recognise when they have."

115. However, notwithstanding this opinion, it would seem that the expressions "sentinel bleeds" and "warning leaks" continue to be used by experienced practitioners, but what is probably more significant for present purposes is that, however these "leaks" or "bleeds" are described, (a) they occur and (b) they contribute to the diagnostic difficulties of identifying a true SAH.

The case advanced against Dr Shepherd

116. The case against Dr Shepherd is similar in some respects to that advanced against Dr Gulati. One difference is that, unlike the position before Dr Gulati, the Claimant came to hospital in an ambulance having telephoned the emergency services herself early that morning. She was not sent there by a GP. Ms Gollop submits that had Dr Shepherd asked the right questions, she would inevitably have received an account that reflected all the symptoms of which the Claimant complained about on the telephone.

117. Whilst one might think that to be likely, I am not sure I can accept that it would necessarily follow. For reasons I will set out below (see paragraph 134 - 138), I think that there are difficulties with the Claimant's account of what she said to various people at various times - not, I hasten to say, difficulties associated with her honesty, but about her reliability as a historian. I do not, of course, think that there is any difficulty in knowing what she was saying on the telephone to the emergency services (subject only to being sure what precise words were used in some respects), although, as I have already indicated (see paragraph 78 above), I do not think it is possible safely to conclude anything about the speed of onset of her headache on 17 June from the terms of the conversation. The question is whether, when she herself was far more composed (which she was even by the time she arrived at the Royal Free) she did actually spell out to Mr O'Donoghue and then to Dr Shepherd what she had experienced.

118. This was a few days before she was due to leave to see her family in Canada to which plainly she was looking forward. There may have been a temptation to downplay the symptoms at the time (or simply to see them in a different light) given that she had recovered her composure significantly. There is also the somewhat unusual feature of this case that, according to the Claimant's letter of complaint, she had suffered a migraine headache once a year, but there is no reference to this in any of the available medical records. However, it would seem that she had experienced occasional serious headaches in the past. Whilst this was not explored with her, it is perhaps possible that she perceived that what occurred was some form of manifestation of that symptom. However, an alternative interpretation of the events is that when she explained the symptoms to Dr Shepherd, they may have sounded nothing more than a continuation of the problem she had been experiencing for the past two weeks. That does not minimise the need for careful inquiries to be made, but it reduces the index of suspicion in a case like this. Ms Gollop is correct when she says that the Claimant does not ordinarily overplay things - she does not dramatise or exaggerate. Obviously, I have seen her only since she suffered her significant SAH and must bear

that in mind in any assessment I make. However, I sense that she was quietly spoken and undemonstrative before that happened, as indeed she is now.

119. Her description of what occurred that morning (according to Dr Shepherd's note) was of a resurgence of neck pain, together with double vision and paraesthesia both of which had resolved by the time she saw her. The Claimant says that Dr Shepherd did not examine her, but that simply cannot be right: Dr Shepherd records her examination in her note which included an examination of the Claimant's neck movement. The note of the ambulance staff (and indeed the First Responder) focused on neck pain, although headache was also mentioned.

120. As I have said, the essential criticism of Dr Shepherd is that she did not elicit the relevant history of headache, either in respect of 17 June or of 1 July, and she failed to document it. As I have concluded in respect of Dr Gulati, I do not believe that Dr Shepherd did not know of the importance of discovering the circumstances of the onset of a severe headache if that was one of the presenting symptoms. She was a relatively recent trainee and the need to consider this kind of condition would have been well known to her for the reasons I have mentioned previously (see paragraphs 93 - 94 above). I think it more likely than not that, if the onset of a severe headache had been mentioned by the Claimant (or Dr Shepherd had simply noted the complaint of headache generally in the ambulance records which she had available to her), she would have asked the Claimant about it and how it came on. She says that she believes that she would have done so and, on the balance of probabilities, I accept that she did. Dr Shepherd plainly did obtain some history of headache because her note refers to "migrainous headache", but, for whatever reason, the essential message conveyed by the Claimant that morning was that it was resurgence of her neck pain, rather than specifically the headache, that had caused her to seek hospital attention that morning and that she did not convey to Dr Shepherd that she had experienced a very severe headache that morning. Dr Shepherd would not have recorded matters in the way she did unless that had been conveyed to her nor would she necessarily have conducted the examination of the Claimant's neck that she did. All the records made by anyone who saw her that morning (including the First Responder) refer to the neck pain. The records do also refer to headache, but none give the impression that she said to anyone "I woke up this morning with this terrible, blinding headache, like the one I had a couple of weeks ago" or words to similar effect.

121. Dr Shepherd accepts that had she elicited a history of sudden onset serious headache (with vomiting) two weeks previously or of sudden onset serious headache that morning she would have sought a second opinion. Mr Richmond accepted that if she had questioned the Claimant about the onset of her headache that morning (or two weeks previously) and had established that there was nothing unusual about it in her experience and that it had not come on "acutely", Dr Shepherd's response to her presentation would have been understandable.

122. In his oral evidence Mr Richmond did appear to suggest that a headache developing after 10-20 minutes would not be "acute" for this purpose and (by inference) that a headache developing in less than that time would be. If that is what he was suggesting then (as with Dr Bracey) he was, in my view, endeavouring to extend the meaning of "sudden" beyond what has been in the literature for many years and, accordingly, in the teaching of many doctors (certainly of the generations of Dr Gulati and Dr Shepherd), whether for those who become GPs or those who remain in

hospital practice. That extension has yet to be justified. If it is, many more patients will be sent for CT scans when they complain of a serious headache than are currently sent. (Of those who present to an A & E Department with a serious headache, only 10-15% have a serious problem.)

123. However, as to what may or may not have happened on 17 June, Dr Shepherd would have been in no better position than Dr Gulati (or indeed his two colleagues in the practice who saw the Claimant in the intervening time) to discover what happened. The questions to ask would have been the same. If I am right to have concluded that the Claimant did not convey the history to Dr Gulati and his colleagues that is now said to have occurred, I am unable to see how Dr Shepherd can be blamed for not obtaining a better history of the events of that day. As I have said before (see paragraph 108), if the symptoms were the kind of symptoms associated with the lesser kind of bleed that the neurosurgeons consider to have occurred, no amount of questioning by Dr Shepherd would have revealed anything different. Equally, in view of those conclusions, I do not see how a more experienced clinician than Dr Shepherd would have elicited a history that, on the balance of probabilities, would have led to the taking of a CT scan.

124. As to the headache suffered by the Claimant on 1 July, I have already indicated (see paragraph 121) that her primary complaint, certainly once she got to the Royal Free (albeit this is consistent with what she told the First Responder and the ambulance crew also), was her neck pain. Given that I accept that Dr Shepherd will have asked all the relevant questions concerning the headache if the headache was part of the Claimant's presentation, I do not think that she can be criticised for recording that the headache seemed merely to be a continuation of a headache that first manifested itself two weeks previously. Unless she received a history of a sudden onset of a really serious headache that morning, I am unable to see what else she was able to do or ask. Whilst, for reasons already given, there are difficulties with accepting the Claimant's present account of what occurred, it is to be noted that she said in her evidence that she did not have an unbearable headache that morning because she did not "throw up", as she put it. Mr Richmond, who was critical of Dr Shepherd, approached his analysis on the basis that the Claimant had said clearly in the telephone conversation that the original headache was of rapid onset as was the headache that occurred that morning. As I have said (paragraph 78), I do not consider that such conclusions can be drawn from the recording.

125. Although the essential criticism is that she did not obtain the history of sudden onset severe headache (which I have dealt with), Dr Shepherd's actual diagnosis (or provisional diagnosis) is also criticised. Mr Richmond said in his report that Dr Shepherd's view that "osteoarthritic changes in spine causing cervical neuralgia" might be the cause of her presentation was "possible" but that it would not explain the sudden onset of severe headache and would not have caused vomiting and double vision. Since her examination of the cervical spine revealed a good range of movement, his view is that the diagnosis was an unlikely cause of the Claimant's symptoms.

126. As I have already concluded, I do not consider it to have been established that the Claimant's presentation on the morning of 1 July (or indeed on 17 June) was of a sudden onset of severe headache nor was there any evidence of vomiting on the morning of 1 July. On that basis the diagnosis was not inconsistent with the

presentation. In regard to the double vision (which, given that it had subsided by the time the Claimant arrived at the hospital, has to be treated as relatively short-lived), the neurosurgeons agree that this is one of the "nebulous" symptoms complained of by the Claimant that morning and that it is a symptom that is not always present in SAH. Given that it is accepted that there was probably a small bleed that morning, it has to be accepted, with the wisdom of hindsight, that it occurred because of that bleed. However, the issue is whether, the double vision having resolved by the time the Claimant saw Dr Shepherd, it was negligent for her to believe that it may have been associated with cervical problems such that she ought, in effect, to have gone back to look again for another cause than those problems.

127. In my view, this is an unrealistic scenario and I am not sure that Mr Richmond was contending for it. If Dr Shepherd was justified in not suspecting an intracranial issue such that further investigation was necessary (which I have concluded she was), the mere fact that she may have ascribed temporary double vision to an unlikely cause does not, in my judgment, render that conclusion wrong.

The triage

128. I have left this until last although, logically and chronologically, it comes before Dr Shepherd's involvement.

129. As will be clear from what I have already concluded (see paragraph 124), I do not think that a more experienced clinician than Dr Shepherd would have elicited a history that, on the balance of probabilities, would have led to the taking of a CT scan. To that extent, even if the Claimant was wrongly (and negligently) triaged as category 5, the negligence would have had no causative impact.

130. As Green J said in *Mullholland v Medway NHS Foundation Trust* [2015] EWHC 268 (QB) at [90], "the task of the triaging nurse is to make a quick judgment call as to where next to send the patient" in circumstances where there is "no opportunity … to devote a great deal of time to the taking of a detailed history or the performance of an extensive diagnosis". Whilst, of course, if a clear case of negligent misjudgement is made out which has causative potency, a court cannot ignore such a finding. However, there is, in my view, even less scope for minute and detailed analysis of a triage nurse's brief notes than there is in relation to an A & E doctor's notes. There would be a massive incentive to adopting a defensive technique (by referring virtually everyone who presents to an A & E department to a senior clinician) if such became the norm.

131. Mr O'Donoghue, when challenged by Ms Gollop, said that he had seen people with sudden onset thunderclap headaches and that they would be seen quickly. He could not say precisely why he categorised the Claimant as he did (because he has no recollection of her), but said that he must have made an assessment based upon what he saw when she came in and what he was told by the ambulance crew. He said that had he triaged her on the sole basis of the ambulance crew's written record, he would probably have placed her in category 3, but something must have changed his view. The evidence suggests that he was faced with a patient who was ambulant and whose symptoms had largely resolved by the time he saw her. As I understood an answer he gave to Ms Gollop, he believes this must have been his reason for making the assessment he did. I suspect that is so.

132. Whilst I accept that Mr Richmond had relevant evidence to give on this subject, I do think it is impossible to characterise the judgment Mr O'Donoghue made as negligent. As I will be saying below, Mr O'Donoghue is one of several people who saw the Claimant over a period of 14 days who, despite being technically better medically qualified than him, failed to pick up the serious presentation that it is now said she displayed. The pattern is quite striking. It adds force to the conclusion that whatever may be said now about her presentation, it was not how it appeared to him at the time.

Overview

133. I have endeavoured to deal with the cases against Dr Gulati and Dr Shepherd (and indeed Mr O'Donoghue) in isolation from each other and by reference to the evidence directly affecting each case even though there is clearly an overlap in the knowledge that each had (and ought reasonably to have had) about the warning signs for an SAH or other intracerebral haemorrhage. However, I have observed at various stages that I felt that an overview of the case may help to reach the right answer, an overview that is not available to the individual experts who have expressed their views on isolated parts of the case. There are a number of features of the whole case that I have found troubling and which have led me to the overall view that the Claimant's case cannot succeed against either doctor. Some of the features that I will mention have greater weight than others, but overall they built up a sufficient picture of doubt to make acceptance of her version of some important parts of the chronology impossible.

134. First, it is surprising, that the Claimant waited for four days before seeing a doctor after the incident in church. Because she gave some aspects of what she says occurred to Dr Gulati when she saw him ("intense headache", "vomiting" and so on), I do not doubt that it was a very unnerving experience at the time. However, she has said subsequently that the headache improved after she vomited and indeed this is essentially what Dr Gulati recorded. But by the Monday things had settled down somewhat and one wonders whether the Claimant in fact gave as clear a picture of what had occurred on the Thursday evening as she might have done had she gone to see a doctor on the evening in question or the day after. Allied, however, to the consideration I have just mentioned is this: after she had suffered her final SAH in Canada and when she returned to England and sent her letter of complaint, she asserted that she had gone to see the GP the day after the incident in the church. Whilst she got some of the dates wrong (and that is entirely understandable), the very clear assertion that she saw the doctor "the next day" is striking and it is a position to which she was adhering several years later (see paragraph 27). The courts are familiar with the proposition that people will persuade themselves after an event that the obvious course in that event would have been to do a particular thing and that they did do it when in fact they did not. Might it be that the Claimant, in hindsight and in the knowledge that she had suffered a "mini stroke" that evening, has thought subsequently that the incident in the church was so serious that she ought to have seen a doctor about it immediately and she has persuaded herself subsequently that she did? I can only raise the question without answering it directly, but taken with certain other matters to which I will refer there is a basis for thinking that this may be so.

135. Second, she asserted in her letter of complaint to the GP practice that she told Dr Gulati that she thought she had had a stroke on 17 June. She said in her witness statement that she had said the same to the paramedics on the morning of 1 July. In her letter of complaint about the emergency services and Dr Shepherd, she said that

she had said the same to Dr Shepherd. Finally, she said in her letter of complaint about the GP practice that she had said the same to Dr Mukhtar. Not one of the doctors or the paramedics recorded this. I find it impossible to accept that every single one of them would have ignored this without making a note about it if it had been said. Both Dr Gulati and Dr Shepherd said they would have done. Whilst there are aspects of their note keeping that were not adequate, I think it highly likely that each would have recorded it even if they felt that it was a diagnosis they would dismiss. Dr Gulati, in particular, noted what he perceived the Claimant's complaint to be. Whilst I have no doubt that the Claimant now genuinely believes she did say this on each of the occasions referred to, I cannot accept that she did. Her belief that she did so maybe derived from the fact that she was told in Canada that what happened on 17 June and 1 July were "mini-strokes" and she now feels that she said something along these lines to the doctors and paramedics as indicated. Regrettably, I do not think I can so conclude.

136. In relation to 1 July, the Claimant has said that she would have expected "some kind of scan". If that really was her feeling by that date then, bearing in mind the history and that she was as scared as she said she was, I am a little surprised that she did not raise the issue directly with Dr Shepherd, particularly as the Claimant herself had considerable experience of dealing with those who had suffered a stroke (see paragraph 19 above). At all events, she has said that Dr Shepherd did not examine her. As I have observed (see paragraph 64), that simply cannot be right. She said that Dr Mukhtar did not examine her. Again, that cannot be correct.

137. Finally, it has to be said that the Claimant saw four general practitioners, the paramedics/emergency staff, Mr O'Donoghue and Dr Shepherd over the course of two weeks. Not one of them recorded the kind of presentation that would lead to the suspicion of an intracerebral bleed that required investigation. I have only had the benefit of hearing from two of the doctors involved. Merely observing them for a while in the witness box may not be the most reliable way of assessing them as doctors. But both impressed as honest and open people who did not try to obfuscate about their own role in assessing the Claimant. Each had relevant training and experience and each was aware of what needed to be looked for in this kind of situation. I find it impossible to accept that all these practitioners, including Dr Gulati and Dr Shepherd, would have failed to pick up significant warning signs if those warning signs existed and/or they were highlighted by the Claimant when examined and questioned.

138. When all these factors are put together with the likelihood (advanced by the neurosurgeons) that the two episodes that occurred on 17 June and 1 July involved "small bleeds" without manifesting the typical symptoms of an SAH, there is a credible explanation for why no sufficient warning bells rang for any doctor who saw the Claimant.

139. I observed during the closing submissions that this case was not an easy one from the point of view of deciding the facts. It became no easier whilst reflecting on the evidence again for the purposes of writing this judgment. However, I do not consider that the evidence justifies the conclusion that either Dr Gulati or Dr Shepherd (or Mr O'Donoghue) failed in their duties of care towards the Claimant.

140. Dr Gulati and Dr Shepherd has each expressed regret that the Claimant should have suffered her final SAH and I am sure those expressions of regret were genuine. I too regret not being able to find in her favour so that she would be entitled to compensation. However, the law requires her to establish her case and I am afraid that, for the reasons I have given, she has not done so.

Expression of thanks

141. I should like to express my appreciation to Ms Gollop, Mr Boyle and Mr Woolf for their help in a very difficult case.