[2025] EWHC 2597 (KB)

Case No: QB-2022-001544

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13/10/2025

Before :

DAVID PITTAWAY KC (SITTING AS A DEPUTY HIGH COURT JUDGE)

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Between :

MOHAMED ATEF HAKMI	**Claimant**
- and –	
1. EAST & NORTH HERTFORDSHIRE NHS TRUST	**Defendants**
2. NORFOLK & NORWICH UNIVERSITY HOSPITALS NHS TRUST	

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Robert Kellar KC (instructed by **Slater Gordon**) for the **Claimant**
John de Bono KC (instructed by **Clyde & Co**) for the **Defendants**

Hearing dates: 4, 5, 9, 10, 11, and 12 June 2025

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Approved Judgment

This judgment was handed down remotely at 10.30am on 13 October 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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DAVID PITTAWAY KC (SITTING AS A DEPUTY HIGH COURT JUDGE)

David Pittaway KC:

1. The claim arises from the decision of the second defendant's stroke consultant, Dr Metcalf, at the Norwich & Norfolk Hospital, not to offer Mr Hakmi thrombolysis to treat a stroke on 16 November 2016, which it is alleged has caused him serious disability. Mr Hakmi had already suffered a stroke on 26 September 2016 when he was treated with thrombolysis. He had made a good recovery and returned to work on 15 November 2016. Quantum has been agreed between the parties, subject to liability in the sum of £1,033,824, including interest to 28 days after judgment and gross of CRU.

2. Mr Hakmi is a distinguished orthopaedic surgeon who has been a consultant at the Lister Hospital, Stevenage since 2003. His achievements are fully set out in his witness statement but include a speciality in foot surgery and a leading role in the development of orthopaedic services within his Trust. He has also had an educational role attached to the University of Cambridge teaching both postgraduate and undergraduate students. It is fortunate that he has been able to develop that educational role since he suffered his stroke on 16 November 2016. He is now unable to carry out surgery.

3. The effect of the consequences of the stroke on Mr Hakmi was plain to see in the witness box when on several occasions he was visibly upset. It has had major consequences on his career, his financial security, his marriage and his family life. In my view, it has affected his sense of self-worth in ending his role in surgery at the comparatively young age of 51.

Breach of Duty

Factual Evidence

4. The first issue I must decide is to establish what occurred in the early hours of the morning of 16 November 2016. There are substantial differences between the accounts given by Mr Hakmi and his wife, Dr Abbas, and the medical records prepared by the clinicians at the Lister Hospital, Dr MacDonald-Nethercott and Nurse Woodward, and to a lesser extent the telemedicine consultation with the on-call stroke consultant, Dr Metcalf at the Norwich and Norfolk Hospital.

5. Mr De Bono KC referred me to Leggatt J's judgment in ***Gestmin* v Credit Suisse** [2013] EWHC 3560 (Com) and to a subsequent case, ***Freeman v Pennine Acute Hospitals Trust*** [2021] EWHC 3378 (QB), 23, which reviewed the authorities on oral evidence. Whilst I fully accept the reservations made about the pitfalls of the preparation of and reconstruction of evidence, there is a distinction, in my view, that can properly be drawn between some commercial cases and clinical negligence cases. In the latter case the events are highly personal to the parties, in a way which would not always be true in commercial cases. The circumstances of the matters being considered may become imprinted upon the minds of the participants, nevertheless,

individual recollections may become reinforced with the constant reconsideration of the matters in the years before cases come to trial.

6. I must give, however, due regard both to the witness evidence of Mr Hakmi and Dr Abbas, and the clinicians involved with his diagnosis and treatment at the Lister Hospital and on the telephone. Mr Hakmi and his wife have lived and relived the events of that night which have, as I have said, had a devastating effect upon their lives both professionally and personally. I must be astute as to the extent to which they have reconstructed the events with the passage of time. At times, both Mr Hakmi and his wife sought to argue his case, whilst giving answers in cross-examination. Although both of their English is fluent, I need to remember that Arabic is their first language and, indeed, the language in which they speak to each other, including on 16 November 2016. It may affect the way in which they give their evidence.

7. The position is complicated by the allegation that Mr Hakmi deliberately underperformed at his neuropsychological testing with Dr Ford and Dr Bach, the examination by Dr Hassan, and in the rehabilitation assessment by Dr Santullo, to advance his claim. Although Mr de Bono fell short of alleging that Mr Hakmi lied about the events that occurred on 16 November 2016, the allegation relating to the neuro psychological tests, and other tests, if found proven, would cast doubt on the credibility of his evidence, including the account of the events that occurred.

8. I also have the medical records which were prepared contemporaneously or near contemporaneously, but they are brief and, in some cases, significantly incomplete. The clinicians were asked in the witness box to recall events that occurred 8 ½ years ago about which they have a limited or no recollection. Dr Macdonald-Nethercott, the Emergency Medicine Registrar, and Nurse Woodward, the Specialist Stroke Nurse, have a very limited recollection of the events on 16 November 2016. Dr Metcalf says he has a very clear recollection of the telemedicine consultation, possibly because of the IT equipment failure which took place. They all rely upon the notes that they made or, in the case of Dr Massyn, were made on his behalf by Dr Lane, who did not give evidence.

9. There are two uncontroversial matters about which there is certainty. Mr Hakmi sustained two strokes in short succession. The first on 26 September 2016 and the second on 16 November 2016.

10. The quality of the note taking on 26 September 2016 is of a high standard. Mr Hakmi sustained his first stroke at about 0630 on 20 September 2016, which was diagnosed as an ischaemic event/TIA, later as a lacunar stroke, following an MRI scan. His NIHSS score on the Stroke Proforma (A) on that occasion was 3, and the power in his upper and lower limbs was recorded as 5/5. Dr Pusalkar, stroke consultant, Lister Hospital, advised against thrombolysis because of the risk of bleeding, however, Mr Hakmi asked for and was provided with it. He made a good recovery and returned to work on 15 November 2016. The symptoms recorded in the records for the first stroke state that he had suffered from problems in coordination, a weak right arm, facial droop, problems in speech and whilst climbing stairs he found his right leg was heavy.

11. Turning to the events of 16 November 2016, Mr Hakmi's evidence is that whilst working late on 15 November 2016 at about midnight he suffered from an episode of light headedness and a very slight weakness in his right hand which lasted a few

minutes. He said in cross-examination that when he went to bed at 1230, he was feeling normal otherwise he would have gone at that stage to hospital. It was put to him that he had given three accounts of the incident lasting 5, 10 or 15 minutes. He said that he had not counted the time, however, he considered that the symptoms had completely resolved. He said he did not feel weakness in his face. He did not feel that he was having a stroke. He had checked his own blood pressure.

12. Mr Hakmi says that he was woken at 0320 by his 4-year-old daughter whom he settled. In his witness statement he states: *"After settling Jenna in bed, which would be around 03:40 hrs, I started to feel lightheaded which came and went. I felt numbness in my right hand up to my elbow. My right shoulder and right hip felt heavy. My speech was alright but the right side of my face felt slightly altered. I woke my wife up and told her that I thought I was having a stroke."* He felt that it was more severe than his first stroke. They dressed and drove to the hospital leaving their three children alone at home. Mr Hakmi telephoned the hospital to warn them that he was coming, speaking to the stroke nurse, explaining his symptoms. The journey by car took 7 minutes.

13. As Mr de Bono has submitted there are varying accounts of the history given in the Lister Hospital records. There are different times as to the first episode that night, which the expert stroke physicians consider was probably a TIA, as to when it occurred and how long it lasted. Whether it was 2345 or around midnight. Whether it was 5, 10 or 15 minutes. Whether it resolved completely before he went to sleep or not.

14. As to what happened when Mr Hakmi arrived at hospital the position is significantly less clear. Mr Hakmi says in his witness statement that he told Dr MacDonald-Nethercott, whose name he did not know: *At around 03:20 hrs, I was woken up by my crying four-year-old daughter, I went to her and took her to the toilet. I was feeling 100% normal. I went downstairs to bring her a glass of water and put her to sleep. At 03:40 hrs, I started to feel proximal weakness in my right shoulder and right hip which felt unusually dense and I had to make a lot of effort to move them, that I had numbness in my right hand up to the elbow, that I felt my speech was slightly affected as I had to make an effort to speak, and I had a disturbed sensation in my right side and light headedness which was coming and going. My wife added that she could see the right side of my face had drooped. This casualty doctor spent a few minutes with me doing a superficial examination whilst I remained on a trolley, then he said to me that the examination was completely normal."*

15. Dr Abbas supports Mr Hakmi's account and emphasis that he was complaining of weakness in his right shoulder and hip. She says that Dr MacDonald-Nethercott did not look at her when he said to Nurse Woodward that she should examine her husband again. She does not have a clear recollection of the nurse's examination other than it occurred after the CT scan and after the discussion with Dr Metcalf.

16. The evidence from Dr Macdonald-Nethercott and Nurse Woodward does not take the matter much further. I have summarised what I consider to be the relevant parts below.

17. The curious feature of this case is that the history given by Mr Hakmi and his wife of two separate incidents, at midnight and about 0340, is not recorded in Stroke

Proforma (A) at all. Dr MacDonald-Nethercott merely recorded *"R arm subjective weakness + reduced sensation, Onset 2345. Presented A & E 0415. O/E Power 5/5 throughout. Speech facial muscles normal."* There is no reference to events at about 0340. Dr MacDonald-Nethercott said in evidence that in his rapid assessment he would have concentrated on the onset of the symptoms. The Stroke Proforma (A) records zeros against all the tests required. The clinical note is only partially completed, omitting references to lower limbs and visual fields. Under previous diagnoses and problems, it states: "*Stroke thrombolysed Sept 2016. Supported return to work yesterday."*

18. The deficiencies in the Stroke Proforma (A) were put to Dr MacDonald-Nethercott in cross-examination. He agreed that it was a blank document until after Mr Hakmi returned from the CT scan and had spoken to Dr Metcalf. Dr MacDonald-Nethercott agreed that Mr Hakmi would have said more than he had weakness in his right arm at 2345. He accepted that if Mr Hakmi had said he had weakness in his right leg then the adequacy of the note fell below the required standard. He is now unable to comment beyond the matters he wrote in the records.

19. He said that he was expected to carry out a basic assessment with a more rigorous assessment to be carried out by the stroke team. He says that there was time pressure not to document more because of the urgency of carrying out treatment with thrombolysis within 4 ½ hours of the onset of the stroke. I accept this explanation for the brevity of the history taking although I consider that it fell below the standard required for documenting the history. It may also explain why the later incident at 0340 is not referred to in either his or Nurse Woodward's note. It is referred to briefly in Dr Metcalf's note as 0300.

20. Dr MacDonald-Nethercott said that he delegated the second assessment to the stroke nurse before a decision on thrombolysis was made. He has no recollection of his conversation with Dr Metcalf. He believes he was called back to speak to him. He said he did not believe that he was present when Mr Hakmi and his wife were speaking to Dr Metcalf.

21. Nurse Woodward was a specialist stroke nurse employed at the hospital. She spoke on the telephone to Mr Hakmi when he rang from the car to say that he believed that he was suffering from a stroke. She says that when she arrived at the Emergency Department, Dr MacDonald-Nethercott was already with Mr Hakmi.

22. Nurse Woodward's notes, timed as starting at 0410, do not take the matter much further. She cannot remember whether Dr. MacDonald-Nethercott was beside the trolley bed whilst taking the history or how long they were together. She cannot remember what Dr MacDonald-Nethercott was doing when she arrived. She presumes that they took separate histories. She accepted her history was brief and assumed that it had been taken by Dr MacDonald-Nethercott. She is unclear as to who wrote the scoring other than there were two assessments one on arrival by Dr MacDonald-Nethercott, and then a further one by her at 0520. She does recall that Dr. Abbas did not accept the result of the examination that there was no evidence of a stroke. She remembers Dr Abbas asking for another examination.

23. Nurse Woodward cannot recollect if she was present when Dr MacDonald-Nethercott spoke to Dr Metcalf. She does not think so. She did say that the consultation with Dr

Metcalf, by extrapolation, cannot have been more than 17 minutes. The CT scan was at 0449. The consultation had begun at 0430. Allowing two minutes to get to the CT scanner, the consultation cannot have been more than 17 minutes. She says that she took him to the CT scan in a wheelchair. She accepts that Mr Hakmi would have needed to be on a trolley in a cubicle for an assessment. She does not accept that that the second assessment at 0520 took place in a wheelchair. She said that she has never done an assessment in a wheelchair.

24. Dr Metcalf accepts that he was unable to access the VC software or CT imaging for the remote telemedicine consultation with Mr Hakmi. He says that he now checks the equipment before he comes on duty. He does not recollect whether he told Mr Hakmi the system was not working. The consultation took place, therefore, on the telephone. He could not see Mr Hakmi or examine him. Contrary to the provisions of the telemedicine contract in place at the time, which provides for the presence and participation of a stroke nurse, he does not recollect a conversation with the stroke nurse only with Dr MacDonald-Nethercott. The thought crossed his mind to telephone another telemedicine stroke consultant, Dr Chakrabarti. He did not do so because he was convinced that Mr Hakmi had not had a stroke and was not, to use his word, thrombolysable. He considered that there was sufficient detail from the NIHSS score to make an assessment. He said that it was not the detailed neurological assessment Mr Hakmi was expecting.

25. Initially Dr Metcalf maintained that there was a 50-minute consultation with Mr Hakmi but then later accepted that could not have been correct. He assumed that the conversation took place before the CT scan. He cannot explain why he recorded that the consultation ended at 0520. He does not recollect Mr Hakmi and his wife being unhappy. He explained that the note available to the court was a composite note made from a handwritten note, which he had destroyed, of his conversations with Dr MacDonald-Nethercott and Mr Hakmi. His opinion was that Mr Hakmi had not suffered a stroke. He accepted that he had told Mr Hakmi and his wife on the telephone, that he may have had multiple TIAs and he referred to other causes for his symptoms being epilepsy, a brain tumour and migraines, which he now accepts were unlikely.

26. He says that he has a very clear memory of the discussion and believes that the correct decision not to offer thrombolysis was made. He did not consider that Mr Hakmi had had a stroke and, therefore, there was no need to weigh the risks and benefits of thrombolysis. He agrees that it was a relative, as opposed to an absolute, contra indication that Mr Hakmi had had a stroke within the previous 3 months, which would increase the risk of bleeding. A previous stroke within 3 months in the Norfolk and Norwich Hospital protocol is a relative contradiction. He would have remained on-call until 0800 that morning.

27. Dr Massyn, stroke consultant, Lister Hospital, has no recollection of the ward round or history given to him about Mr Hakmi when he came on duty at about 0800 on the morning of 16 November 2016. He believes that he formed the impression that the stroke had taken place more than 4 ½ hours before. He formed the view that Mr Hakmi was outside the period for thrombolysis. In any event, the protocol at the Lister Hospital at the time considered it was an absolute contra-indication to offer thrombolysis where there had been a stroke within the previous three months.

28. At 1041 on 16 November 2016 an MRI scan was performed and confirmed that Mr Hakmi had suffered a second stroke.

Expert Evidence

Emergency Medicine

29. Turning to the expert evidence, Mr Zoltie and Dr Campbell-Hewson, both experienced emergency medicine consultants, instructed respectively on behalf of Mr Hakmi and the defendants, accept that their expert opinion on breach of duty is dependent upon my findings of fact.

30. As I understand the agreed position, the respective roles of the Emergency Medicine Registrar and the specialist stroke nurse are as follows. The registrar considers the differential diagnosis, carries out a basic neurological examination, organises the CT scan and speaks to the telemedicine stroke consultant before handing over to the specialist stroke nurse. The CT scan informs the decision about thrombolysis in establishing whether there has been any intra-cranial bleeding.

31. Mr Zoltie's evidence in his report is straightforward. He considers that a failure by Dr MacDonald-Nethercott to take an accurate history from Mr Hakmi would fall below the requisite standard of care. He draws attention to the history taken by Dr Metcalf superceding the history taken by Dr MacDonald-Nethercott.

32. Mr Zoltie considers that the history was not in accordance with the standard of care to be expected. The only detail in the history was the time of the onset of the symptoms, later identified as insufficiently accurate. There was no description of any resolution of symptoms, progression of symptoms, change in symptoms, or presence or absence of any other symptoms. The history can be compared with the history taken on the previous attendance.

33. Mr Zoltie considers that if Mr Hakmi was suffering from weakness, when he was seen by Dr MacDonald-Nethercott and Nurse Woodward, then the failure to identify and report it to Dr Metcalf fell below a reasonable standard. He also considers that if Dr MacDonald-Nethercott failed to examine Mr Hakmi's lower limbs, visual acuity and visual fields, then that that fell below a reasonable standard. He also considered it to be a breach of duty not to document an examination of the lower limbs and visual fields.

34. In the body of his report, he draws attention to the fact that it is unclear who completed the Stroke Proforma (A), Dr MacDonald-Nethercott or Nurse Woodward, and to internal inconsistencies of the documentation. It is of note that he considers that if Dr MacDonald-Nethercott did not examine Mr Hakmi fully then any information he gave Dr Metcalf would have been incomplete and below a reasonable standard. He also considers that if Mr Hakmi requested a re-examination which was not undertaken that also fell below an acceptable standard.

35. Dr Campbell-Hewson considers in his report that there was a prompt and timely response by the Emergency Team and stroke nurse following Mr Hakmi's attendance at the hospital. He emphasises that the emergency doctor is not taking a full and final

complete history but a brief screening history to see if a CT scan is required to exclude thrombolysis. He accepts there was shortfall in the documentation.

36. He draws attention to the fact that Dr MacDonald-Nethercott's examination involved both objective and subjective assessments. He contrasts his findings with those of Dr Massyn, consultant in stroke medicine, several hours later recording 4++/5 power in the right upper limb at a later examination, which he describes as the most minimal decrease in right upper limb power. He draws attention to the clinical history on the CT request stating *'? Stroke, Right-sided weakness',* which would be evidence that there was right sided weakness on examination*,* which is inconsistent with the findings in the clinical records. He states, however, that clinical records are likely to be more accurate than the CT request form.

37. His opinion, ultimately, depends on whose account is accepted whether it was that of Mr Hakmi or Dr MacDonald-Nethercott. His view is that if Dr MacDonald-Nethercott examination was performed competently then it would have been reasonable to have concluded that there had not been a further stroke. If Mr Hakmi's account is accepted, then the assessment would not have been of a reasonable standard.

38. The joint statement of the Emergency Medicine Consultants records their different interpretations of the history taken by Dr MacDonald-Nethercott.

39. Mr Zoltie states that the information provided by Dr MacDonald-Nethercott should be compared with the previous admission where the NIHSS score was recorded, but the examination was also recorded in full on the stroke proforma. Dr Campbell-Hewson observes that the notes clearly indicate that there was neurological assessment of the lower limbs and visual fields, and that the results of these assessments were recorded and were normal. He believes that that it would be reasonable, and in keeping with standard practice, not to assess visual acuity.

40. The experts both agree that acceptance of the accounts given by the parties would determine whether the assessment of Mr Hakmi was reasonable. Mr Zoltie draws attention to whether Dr MacDonald-Nethercott did in fact complete the examination as documented on the Stroke Proforma (A). He also states that a failure to arrange a second examination, when requested by Mr Hakmi, was below an acceptable standard. Dr Campbell-Hewson believes it was reasonable to entrust it to the stroke nurse. He relies upon the record of a second NIHSS examination at 0520 with similar findings. Mr Zolitie considers that on the handover to Dr Metcalf, as documented by him on the Stroke Proforma (A), would not have provided a full description of the events. Dr Campbell-Hewson considers that "*it would not be usual practice for Emergency Department staff to document an extensive verbatim account of a discussion with a consultant from a* specialty *team."*

41. In cross-examination Dr Campbell-Hewson said that the emergency doctor should ask the nature of the symptoms, the location of the symptoms, the first onset and progress of the symptoms over time. He accepted that if Mr Hakmi provided the material information. then the failure to provide that information was in breach of duty. He agreed that symptoms down one side of the body were indicative of a stroke. Likewise, there is urgency in obtaining a CT scan to rule out a haemorrhage. A more detailed history will then be taken by the stroke team. He said that the critical part of the assessment is the NIHSS score. He agreed that the Stroke Proforma (A) does not

disclose who completed it. He agreed that Dr MacDonald-Nethercott recorded that the upper limb was normal but the lower limb was left blank. The power, however, was recorded as 5/5 throughout. He agreed that if the visual field was not tested it fell below the required standard. He agreed that Dr Metcalf should have been informed if the lower limbs or visual field had not been examined.

42. The Emergency Medicine Experts are agreed that if the history given by Mr Hakmi is fully accepted then the NIHSS score would have been expected to be 4.

Stroke Medicine

43. Dr Baldwin and Dr Hassan, both experienced stroke physicians, respectively on behalf of Mr Hakmi and the defendants, raise similar points on breach of duty to those made by Mr Zoltie and Dr Campbell-Hewson. They both agree that it is for me to determine whether the history taken and the examination made by Dr MacDonald-Nethercott and Nurse Woodward was carried out to a reasonable standard.

44. Dr Baldwin observes that there was no assessment documented of the examination of the lower limbs or visual fields. He does not consider that the documented examination is adequate to complete the Stroke Proforma (A), which was relied on by Dr Metcalf. Further he draws attention to the fact that it is not clear from the witness statements whether the examination by Nurse Woodward was undertaken at the same time as Dr MacDonald-Nethercott or separately.

45. Dr Hassan's view is that Dr MacDonald-Nethercott and Nurse Woodward's findings were consistent with a reasonable standard of care because lacunar strokes/capsular warning syndrome can have a very fluctuating presentation. He also relies upon the further assessment done at 0520 before his admission to the stroke unit, which recorded the NIHSS score as 1, with mild sensory loss. His view is that with a non-disabling symptom the risks of thrombolysis would still outweigh the benefits.

46. As to the use of telemedicine, Dr Baldwin said in his report that it was approved and recommended as an option in the 2016 Royal College of Physicians stroke guidelines. However, it relies on the local examination or directly observed examination by the remote physician. In his opinion, telemedicine without video conferencing is less accurate. Dr Baldwin considers that it was in breach of duty for Dr Metcalf, to begin the shift without knowing whether he could access the network. Dr Metcalf's role was to determine, first, whether Mr Hakmi had suffered an acute ischaemic stroke, then, second, the neurological impairment was sufficient to indicate the use of thrombolysis. He observes that there is an accepted risk of haemorrhagic transformation and anaphylaxis.

47. Dr Baldwin explains in his report that the process involves a trained local stroke clinician, usually a specialist stroke nurse, medical registrar and the remote stroke consultant who can see and speak to the patient and is led through an NIHSS examination by the specialist stroke nurse. Then the stroke consultant reviews remotely the imaging. He considers that it was incumbent upon Dr Metcalf to inform Mr Hakmi and his wife, who was, also a physician, that the telemedicine was not working correctly. It was also incumbent upon Dr Metcalf to offer Mr Hakmi urgent alternative care which included urgent review by medical consultant where Mr Hakmi had reported to Dr Metcalf that the examination conducted by Emergency Registrar

had been inadequate and inaccurate. The importance lay in the timing of the onset of persistent neurological impairment. Dr Baldwin considers that it was a breach in the duty of care for Dr Metcalf to suggest that a stroke mimic was the most likely diagnosis.

48. Dr Baldwin considers that the telephone assessment by Dr. Metcalf, at 04.30, occurred 70 minutes after the onset of symptoms at 03.40 am, so was well within the 4½ hour window for thrombolysis, 270 minutes. The standard approach is to accept the onset time to be the time when the patient was last known to be well. He considers that what occurred at midnight was likely to be a TIA which resolved completely followed by a recurrence. He considers that fluctuation of symptoms is common in acute stroke. He believes that Dr Metcalf was wrong to suggest that the fluctuation was atypical. His view is that the NIHSS should have been repeated hourly until the time window for IVT closed at 08.10 and Mr Hakmi should have been kept under regular review by a medical registrar. On the morning ward round on 16 November 2016 Dr Massyn noted persistent neurological impairment. He did not calculate the NIHSS score but in Dr Baldwin's opinion, it would have been greater than 4.

49. The stroke physicians agree that the onset and interpretation of symptoms is a matter for this court. Dr Baldwin agreed that the finding of power 5/5 was inconsistent with Mr Hakmi's account of weakness on his right side. He considered, however, that the direction of travel at the hospital was one of deterioration. He agreed that, if the stroke score was 3 or 4 at 0810, then it would have been less earlier. Dr Hassan considers that the two scores at 0420 and 0520 accurately reflect Mr Hakmi's neurological condition. They agree that Dr Metcalf should have informed Mr Hakmi that his IT equipment was not working. They disagree that the contact by telephone was inadequate.

50. Following assessment at 0520, Dr Hassan accepts in the joint statement that there should have been a further assessment at 0620 and at 0720. If Mr Hakmi had deteriorated at these time points, he considered that there was a trigger to re-assess for thrombolysis. The treatment decision would still have been balanced, although a failure of antiplatelet treatment and the deterioration would on the balance of probability have tipped the decision in favour of offering thrombolysis.

Findings

51. The conclusion which I have reached is that the first incident, probably a TIA, occurred around midnight, lasted a few minutes and did resolve completely. I do not consider the differences in times in the documentation materially alters that conclusion. I am also satisfied that, having experienced a stroke on 26 September 2016, Mr Hakmi would not have gone to bed unless the symptoms had resolved.

52. The position was significantly different after he was woken by his 4-year-old daughter at about 0320. He says that he noticed symptoms of a stroke at about 0340. Again, I am satisfied that he did notice some symptoms which alerted him to the possibility that he had suffered another stroke. I do not believe that he and his wife would have left three children in their house alone and driven to the hospital unless he believed he was experiencing symptoms of a stroke. He was a highly trained consultant orthopaedic surgeon, who would have been aware of the need for diagnosis and treatment. The extent, however, of the symptoms he suffered is more difficult to judge

in circumstances in which he and his wife have lived and relived the circumstances of that morning with a grievance against the defendants that he would not have suffered his present disability if he had been treated with thrombolysis.

53. It is a matter for me to determine the extent to which Mr Hakmi and his wife explained the extent and detail of his symptoms. It remains a matter for doubt but I am satisfied that he explained the material points, namely that the earlier incident had resolved, he had some weakness in his right side. I am not satisfied about the extent to which he went into further detail as to his shoulder and hip, numbness in his right hand and his wife having noticed the right side of his face had dropped. There may have been elements of Mr Hakmi's description explained but nothing that went beyond what Dr Metcalf recorded. I rely upon Dr Metcalf's note of what he was told by Dr MacDonald-Nethercott and Mr Hakmi as being the fullest of the contemporaneous records of what Mr Hakmi said, which falls short of the detail given by Mr Hakmi and Dr Abbas. For the reasons set out below, I also have some reservations about Dr Metcalf's note. As I have said, I do not consider that Mr Hakmi would have been driven to hospital by his wife leaving young children alone at home unless he believed that he was experiencing symptoms of a stroke, which were in fact similar to the stroke he suffered on 26 September 2016.

54. In my view, the history taken by Dr MacDonald-Nethercott probably concentrated on the onset of symptoms at around midnight and that was why it did not differentiate between the two episodes, one at around midnight and the other at around 0340. I accept that he believed there was a degree of urgency as to whether thrombolysis could take place before the expiry of 4 ½ hours. I accept Dr Campbell-Hewson's evidence that the stroke team may have regarded the events at 2345 and 0340 as being evidence of a stuttering stroke rather than two entirely discrete events. The records, however, are to be compared unfavourably to the history taken by Dr Pulsakar, stroke physician, on 20 September 2016.

55. Perhaps a more detailed comparison by the emergency medicine experts at trial of the NIHSS scores obtained on 26 September and 16 November 2016, would, in retrospect have been helpful. Dr Campbell-Hewson, however, records for 20 September 2016: *There is a completed NIHSS (National Institute of Health stroke scale / score) chart which records a score of '3' at 'time', '3' at time plus 2 hours and '3' at time plus 24 hours. The points were given for minor paralysis of the face, mild - moderate aphasia and mild to moderate dysarthria".*

56. On a visual inspection they are similar to the NIHSS score on 16 November 2016 except for the scoring for aphasia and dysarthria both scored at 1. Facial palsy is marked as one two hours later. On the first occasion he also had no loss of power marked as 5/5 on both upper and lower limbs. Dr Campbell-Hewson notes in his report that Dr Pusalkar's record states: *The impression was 'likely lacunar stroke'. The plan was 'CT head - no evidence of bleed. 2. Not for thrombolysis - minor symptoms, low NIHSS score. On further discussion with patient due to his profession (surgeon) and poor co-ordination, Pt discussed with his wife and agreed to go ahead with thrombolysis. Bloods, x-ray abdomen, ECG'*. The risk of bleeding being high with thrombolysis due to a low NIHSS was explained but Mr Hakmi wished to proceed.

57. To me it is unclear whether Nurse Woodward was present when Dr MacDonald-Nethercott examined Mr Hakmi. Dr MacDonald-Nethercott understandably cannot remember, and Nurse Woodward believes she arrived afterwards. Mr Hakmi was admitted at 0406 and Nurse Woodward's note is timed at 0410. It is unclear who completed the Stroke Proforma (A). Nurse Woodward's own note records the NIHSS score as zero but when that was completed is unclear. It is unclear to me whether there were two separate assessments before the telemedicine call with Dr Metcalf. I consider that it is unlikely. Dr MacDonald-Nethercott does state that he asked Nurse Woodward to make a repeat assessment, presumably of the neurology. I do not believe that an assessment was made again, probably by Nurse Woodward until 0520, after Dr MacDonald-Nethercott and Mr Hakmi had spoken to Dr Metcalf. As I have said, Dr MacDonald-Nethercott does not refer in his statement to speaking to Dr Metcalf and has no independent recollection of this consultation.

58. It is not possible to conclude who completed the Stroke Proforma (A), whether it was Dr MacDonald-Nethercott or Nurse Woodward. The form is unsigned and the fact that the circles for all three examinations look similar should not lead me into concluding they were made by the same person. I suspect that it was Dr MacDonald-Nethercott but I cannot be sure.

59. Mr Hakmi described Dr MacDonald-Nethercott's assessment as cursory. In his witness statement he said: *"This casualty doctor spent a few minutes with me doing a superficial examination whilst I remained on a trolley, then he said to me that the examination was completely normal. I knew that this was not correct. Performing examinations is part of my everyday job, and I know what kind of neurological examinations should have been carried out for a suspected stroke patient."*

60. The records shows that the result of the upper limb test was noted but not the lower limb test, again unlike the form for the 26 September 2016. I consider that Mr Hakmi was expecting a full neurological examination which was not the Emergency Registrar's function. This would explain why he considered that the examination was cursory. It is likely that Dr MacDonald-Nethercott carried out an examination of all four limbs otherwise he would not have recorded power 5/5 throughout. The form also leaves blank the test for visual field and visual acuity. Dr Metcalf, however, records that he was told that the visual field was normal. Dr Campbell-Hewson is not critical of a failure to measure visual acuity. I have, however, reached the conclusion on the basis of the examination made by Dr MacDonald-Nethercott that Mr Hakmi did not disclose sufficient signs of a stroke to merit scoring more than an NIHSS score of zero on the Stroke Proforma (A).

61. By comparison there is some consistency with what occurred on 26 September 2016, when Mr Hakmi scored points for minor paralysis of the face, mild/moderate aphasia and mild/moderate dysarthria but power was scored for both upper and lower limbs at 5/5. I am satisfied that Nurse Woodward was asked to perform a repeat examination, probably because Mr Hakmi and his wife insisted, but that examination was not performed until 0520 after Dr MacDonald-Nethercott had spoken to Dr Metcalf. She recorded an NIHSS score of zero except for sensory which was recorded at "??? 1". I accept her evidence that she would not have carried out the examination with Mr Hakmi in a wheelchair and that it would have taken place on a trolley before he was moved to the stroke ward.

62. The position regarding the telephone call with Dr Metcalf is a little clearer but not ideal. First, Dr Metcalf maintained in his statement that the consultation was between 0430 and 0520, which Mr Kellar established was clearly wrong. The CT scan took place at 0449. It could have occurred before the consultation with the stroke consultant but I cannot be sure. The records are equivocal. Dr MacDonald-Nethercott refers in his note *to CT has been done A/W Medical report (Stroke Consultant could not download images)*. Dr Metcalf in his note says *Couldn't see CT head – as couldn't get into IEP*. He added *Get local report on CT head if no haemorrhage, add aspirin to treatment.*

63. In either case, it does not take the matter further, as the purpose of the CT scan was to exclude bleeding. If it did occur before Dr Metcalf's consultation then that would be consistent with Dr Metcalf's note giving the time of 0520 when the consultation ended, and with Nurse Woodward's second examination being timed at 0520. Whether it was before or after the CT scan, Dr Metcalf incorrectly relied in his witness statement upon a period of 50 minutes for the consultation to support his evidence that he had taken particular care with Mr Hakmi because he was a fellow consultant.

64. It emerged at trial that Dr Metcalf kept handwritten notes of the consultations which were destroyed once he had completed a booklet. The history as shown was, he accepted, a composite account of what Dr MacDonald-Nethercott and Mr Hakmi had told him. In my view, Mr Hakmi probably told him what he had told Dr MacDonald-Nethercott. The precise detail of which is unclear. The record nevertheless probably comes close to what occurred except that he records Mr Hakmi waking at 0300 with *"symptoms fluctuating since"*. This is an important record because it is relevant as to when the window started for treatment with thrombolysis. Mr Hakmi denies that the symptoms were fluctuating.

65. The computer supplied to Dr Metcalf malfunctioned and he was unable to use the video communication system to see Mr Hakmi or access his medical records. He accepts that he should have checked that the computer was working before he began his shift and should have informed Mr Hakmi that the situation was suboptimal. He should have raised with Mr Hakmi the possibility of contacting another consultant. Mr Hakmi raised in his statement the alternative of driving to Addenbrookes Hospital, Cambridge but given that time was of the essence, I consider that the length of the journey time made that an unlikely solution.

66. The diagnosis made by Dr Metcalf depended on the information that Dr MacDonald-Nethercott and Mr Hakmi gave him. Although I find that the documentation was below a reasonable standard, I do not find that either Dr MacDonald-Nethercott or Nurse Woodward's neurological examinations were inadequate. Dr Metcalf spoke directly to Mr Hakmi, he clearly did not believe that Mr Hakmi was suffering from a stroke although he erred on the side of caution and admitted him to the stroke ward. Albeit that it should not have been relevant, I accept that he took particular care because Mr Hakmi was a fellow consultant.

67. The alternative explanations for Mr Hakmi's presenting symptoms were, as both Dr Metcalf and the stroke physicians accepted, unlikely. The CT scan undergone by Mr

Hakmi on 26 September 2016 had not shown any evidence of a tumour. He did not suffer from epilepsy. He did not suffer from migraines.

68. In my view, Dr Metcalf appears to have accepted that the earlier incident had completely resolved, which he acknowledged in his note *"?completely resolved",* however, he did not consider that Mr Hakmi had suffered a stroke. If he had done so, the window after Mr Hakmi began to feel unwell at 0340, would still have been open for treatment with thrombolysis. I accept Mr Hakmi's evidence that there was period of time from when he woke at about 0320 to about 0340 when he was symptom free. Only one to two hours had elapsed of a 4 ½ hour window, which it was agreed was necessary for thrombolysis to be effective.

69. Dr Metcalf did not consider that thrombolysis was an appropriate recommendation because he did not believe that Mr Hakmi had suffered a stroke. In his letter dated 1 December 2016, he stated that he considered dual platelet therapy was appropriate rather than proceeding with thrombolysis where there was a NIHSS score of zero and a recent stroke. He also referred to the possibility of Mr Hakmi suffering from atherosclerosis, which if he had, would not have been assisted by thrombolysis.

70. I do not consider that, if a full repeat examination had taken place before the teleconsultation with Dr Metcalf, and the result had been made known to Dr Metcalf, it would have shown a significantly higher NIHSS score than that recorded probably by Dr MacDonald-Nethercott following Mr Hakmi's admission to hospital. It is of particular significance that the examination at 0520, probably by Nurse Woodward, was also zero except for sensory which was recorded at "??? 1". It is highly relevant that the final examination at 0810, before Dr Massyn came on duty, recorded 3 with facial palsy 1, right arm drift query 1 and right leg drift query 1, sensory loss 1 making a total of 3, or arguably 4.

71. The question of whether Dr Metcalf would have recommended thrombolysis had he seen via video link Mr Hakmi, or indeed, subsequently had he been contacted up until the end of his shift at 0800, is more difficult. In my view, the probability is that he would still have considered that Mr Hakmi had not suffered a stroke. The objective signs, as opposed to the symptoms reported by Mr Hakmi, were still too subtle to register a definite NIHSS score on Stroke Proforma (A).

72. Whilst I have accepted the generality of the account given by Mr Hakmi and his wife, in my view there is a distinction that should be drawn between signs and symptoms. Signs are objective findings made by the physician on examination. Symptoms are subjective experiences reported by the patient. I have concluded that the account given by Mr Hakmi and his wife of the symptoms he suffered on 16 November 2016 has unconsciously become more detailed in their memories over the past 8 or so years, as they have gone over and over again what occurred. I am satisfied that Mr Hakmi would not have had an NIHSS score of 4 at any time between admission and before the examination at 0810, when it was recorded as 3 but may arguably have been 4.

73. Having said that I observe that Mr Hakmi did persuade Dr Pusalkar to offer thrombolysis with a score of 3 on 26 September 2016. If, however, Dr Metcalf had been able to see Mr Hakmi, with the assistance of Nurse Woodward, it is possible, but in my view unlikely, that Dr Metcalf would have come to a different decision.

74. I accept that there is, nevertheless, a considerable difference between a telephone call and visual observation, which should in my view have taken place. Once Dr Metcalf became aware that he could not conduct a full video consultation with Mr Hakmi, he should have informed him of the problem, and contacted another consultant to do so. It is a matter of speculation as to whether if Mr Hakmi had been referred to another stroke consultant, the decision to offer thrombolysis would have been different. In my view, it is unlikely, based upon the agreed evidence of the stroke physicians that a NIHSS score of 4 would have been required, before a recommendation for thrombolysis would have been considered. As I have already said, at 0810 when the next assessment of Mr Hakmi was made the NIHSS score was 3 or arguably 4.

75. Mr Hakmi was admitted to the stroke ward at 0530. I accept Dr Baldwin's opinion that Mr Hakmi should have been checked regularly, probably hourly, following his admission. He had, after all, suffered a stroke on 26 September 2016. Given that Mr Hakmi later required a wheelchair to take him to the toilet, Dr Metcalf should have been contacted again before his on call shift ended at 0800. There was no evidence from Dr Metcalf as to what he would have done on this hypothesis. If he had been contacted at 0630 or 0730, it is probable that the score would have been less than 3 or 3, the closer it was to 0810. Contrary to Dr Hassan's opinion expressed in the joint statement that if Mr Hakmi had deteriorated then the balance would have been tipped to thrombolysis, I am not satisfied that would have been the case. The NIHSS score was likely to have still been less than 4.

76. For completeness, it is clear from Dr Masyn's evidence that had he seen Mr Hakmi after he came on duty sometime after 0800, or indeed beforehand when he arrived at the hospital, he would not have offered thrombolysis even if the period of 4½ hours had not elapsed. Applying the Lister Hospital protocol, the recent previous stroke within three months was an absolute contra indication for further thrombolysis.

Causation

Stroke Medicine

77. I now turn to what would have happened if thrombolysis had been given to Mr Hakmi. I am struck that the clinical position, agreed by Dr Baldwin and Dr Hassan, is that there is an absence of evidence in the literature as to the extent to which thrombolysis is effective with a lacunar stroke, however, it remains recommended.

78. The agreed starting point is that thrombolysis should not be given if the NIHSS score is less than 4. The process is that thrombolysis unblocks the thrombus, thinning the blood. It is agreed that there is a significant risk of bleeding with thrombolysis which should not be given lightly.

79. Dr Baldwin considers that the cause of Mr Hakmi's lacunar stroke was a clot. Dr Hassan's view is that there is no evidence that thrombolysis would have altered the natural history of Mr Hakmi's stroke because the stroke was not due to clot but due to atheromatous plaque disease in the middle cerebral artery stem, the evidence is lacking that thrombolysis is effective in this type of stroke.

80. Dr Baldwin, in his report, states that all people with suspected stroke should be admitted directly to a specialist acute stroke unit. Thrombolysis with Actilyse should

be offered within the product licence. In 2016 the maximum time between symptom onset and treatment was 4.5 hours. If thrombolysis is not given then Aspirin 300 mg should be given within 24 hours and after 24 hours if the patient received thrombolysis. For those treated within 3 hours the benefit was even greater. Dr Baldwin referred to an alternative approach to assessing the outcome of intravenous thrombolysis which was used by Whiteley. They assessed the outcome based on the presenting NIHSS score. Figure 3 taken from their paper outlines the modified Rankin score for the different NIHSS. It can be seen that the benefit of thrombolysis is much better for subjects with a lower NIHSS.

81. The extent of Mr Hakmi's disability is not agreed. Dr Baldwin considers that on the Modified Rankin Scale (mRS) the score is 3. He scored him at 3 in 2022 and again in 2024. Dr Hassan and Dr Santullo consider it is 2. Dr Baldwin did, however, accept in cross-examination that there is a range of assessment that could be 2 or 3. He believes that Mr Hakmi's mRS was recorded at 2 on 23 December 2016 because of the treatment he was receiving at the Danesbury Rehabilitation Centre. He attributed the score to the extent of the rehabilitation he received. Dr Hassan considers that the disability has to be quite marked to take it up to category 3. In his view, assistance must be essential and required to manage life.

82. Dr Baldwin was shown a structured tick-box questionnaire produced by Dr Santullo. His view is that it is reductive and not capable of building in the nuances of disability that is found as a result of his methodology of video training based upon a series of cases. The questionnaire, he believes, cannot include all the activities that are required to be considered in a qualitative approach. He also considers that the questionnaire is of limited use because it has been validated by a small number of people. It has not been directly compared to the conventional approach to the Modified Rankin Scale.

83. It is common ground that the Emberson paper was trying to establish the benefit of giving thrombolysis, depending on the number of hours that had elapsed after the onset of symptoms. In his report Dr Baldwin considered that the window is 3 ½ hours from the onset of the stroke and that if thrombolysis is given within this time there would probably be a good outcome. In his report and Part 35 answers, he agrees that after 3 ½ hours the outcome would probably be the same because the effect of thrombolysis reduces over time. In his report Dr Baldwin relied on the papers by Emberson and Whitely, to show that on the balance of probabilities, the thrombolysis would have prevented the disability associated with the second stroke. His reliance, however, on the Emberson paper fell away in cross-examination by Mr de Bono. He accepted the difference in principle between an odds ratio, which is a way to compare the relative odds of an event happening in two groups, and the probability of an event occurring. Indeed, the Emberson paper refers itself to thrombolysis "*increased the odds of a good stroke outcome, with earlier treatment associated with bigger proportional benefit.*"

84. In the Emberson paper the proportion of patients treated with thrombolysis was greater than those who had not been treated with it. The example put by Mr de Bono in cross-examination of Dr Baldwin was that if out of 100 patients, 33 had a better outcome with thrombolysis within 3 hours than 23 who had not been treated with it, then it could not be said that, on the balance of probabilities, Mr Hakmi would have had a better outcome. Dr Baldwin accepted that he could not say, based on the

Emberson paper, that Mr Hakmi would probably have had a good outcome had he been treated with thrombolysis. The most that he could say is that he lost the chance of a better outcome. He also agreed that the paper did not distinguish between different types of stroke. Lacunar strokes affect small vessels deep in the brain. He accepted that the Whiteley paper did not take the case further as it was concerned primarily with the risk of intracerebral haemorrhage.

85. Dr Baldwin relied upon the DRAGON score, developed in Finland. The DRAGON score was developed to try and predict what a patient's outcome would be if they had thrombolysis by comparing people who had a good outcome with those who had a miserable outcome, respectively 0-2 and 5-6 on the Modified Rankin Score.

86. He believes that the Mr Hakmi's DRAGON score would have been 2 which predicts a 96% likelihood of good outcome (mRS 0-2) and a 2% likelihood of a miserable outcome (mRS 5- 6). In his opinion, based on the DRAGON score Mr Hakmi would have survived with a Modified Rankin Score in the range of 0 to 2 with the result that at worst he would have a slight disability.

87. Dr Hassan considers that the DRAGON score shows no more than that Mr Hakmi would have ended up in same position whether he had had thrombolysis or the not, if he has a score of 0-2. It does not compare what happens if a patient was given thrombolysis or not given thrombolysis. It helps to predict the outcome for individual patients. If Mr Hakmi had been given thrombolysis, he would have ended up with a Modified Rankin Scale of somewhere between 0 and 2, which is the assessment when he left Danesbury. He relied on a paper by Wardlaw which concluded that it was uncertain whether current treatment or prevention approaches are best suited for treatment in lacunar ischaemic stroke. His view is that there is no good evidence to show whether it helps patients with lacunar stroke to give them thrombolysis but the cautious recommendation is that treatment should continue. He also referred to the European Stroke Organisation in 2024, which said that the data on alteplase in lacunar ischaemic stroke is very limited.

88. Dr Hassan does not consider that the DRAGON score is used in a clinical context. His view was that the main factors in the DRAGON score would equally apply to patients who had not received thrombolysis and probably predict the same outcomes.

89. They disagree as to whether Mr Hakmi's NIHSS score was less than 4 and whether he should have been offered thrombolysis. Dr Baldwin considers that if Mr Hakmi was presenting with right hemiparesis, right hemisensory loss, right facial weakness and slurred speech, them his score was likely to be 4.

90. Dr Baldwin accepts that the policy in place at the Lister Hospital, that a stroke within the previous three months was an absolute contra-indication because the risk of symptomatic haemorrhagic transformation is too high, was within the range of reasonable practice in 2016. At Dr Metcalf's Trust the policy was that it was a relative contraindication for the use of thrombolysis. The experts are agreed that a stroke 3 months before is a relative not an absolute contradiction for treatment with thrombolysis.

Findings

91. Although I have considered Dr Hassan's opinion carefully as to the cause of Mr Hakmi's second stroke, I prefer Dr Baldwin's opinion that its probable cause was a clot and not atherosclerosis. He considers that he had a second thrombus in one of the adjacent lenticulostriate arteries to where he had the first stroke. It seems to me that on this issue Dr Hassan raises a possibility that falls short of a probability. In my view it seeks to find another cause, which would rule out the effectiveness of thrombolysis, which I consider to be unlikely.

92. It is common ground that the window for giving thrombolysis which, according to the manufacturer's guidance, is 4½ hours after which time it would not be effective. It becomes less effective the longer the delay in treatment. Based on the Emberson paper, Dr Baldwin in his report considered that thrombolysis up to 3½ hours from the onset of the stroke will, on the balance of probabilities, have had a good outcome. Dr Baldwin accepted that after 3½ hours the outcome would probably be the same whether or not Mr Hakmi had been treated with thrombolysis.

93. Dr Baldwin relied initially on the Emberson paper and the DRAGON score developed in Finland to support his opinion that it would have been effective within that period. His CV sets out his extensive experience of stroke medicine from its early development as a sub-speciality. I found his evidence impressive and helpfully presented. He was ready to make concessions where appropriate. As set out above, he accepted that the Emberson paper did not show that on the balance of probabilities thrombolysis would have been effective within 3 ½ hours in Mr Hakmi's case.

94. I am therefore left with reliance on the DRAGON score, and Dr Baldwin's experience, to demonstrate that if Mr Hakmi had been treated with thrombolysis within 3 ½ hours of the onset of the stroke, he would have had a good outcome. I accept Dr Baldwin's evidence that the DRAGON score is a useful tool to determine in advance the likely outcome of treating a patient with thrombolysis. The problem with the DRAGON score, as identified by Dr Hassan, is that it only deals with patients who are treated with thrombolysis. There is no outcome for a separate cohort of patients who have not been treated with thrombolysis. It does not seem to me that use of the DRAGON score enables me to conclude that Mr Hakmi would have had a better outcome if he had been treated with thrombolysis.

95. There was much discussion about the Modified Rankin Scale, which is accepted as a universal measure of stroke outcome. I accept Dr Hassan's evidence that Mr Hakmi is properly categorised at 2. In doing so I observe that Dr Baldwin considered that the category 2 or 3 would be within a reasonable range. I find support for this conclusion in the records from the Danesbury Rehabilitation Centre who placed Mr Hakmi in category 2 on his discharge in December 2016. He was in category 3 on arrival.

96. I find Dr Santiullo's questionnaire too simplistic as a box ticking exercise to be of great assistance other than in gross cases. I accept Dr Baldwin's view that it is not sufficiently nuanced to assess the Modified Rankin Scale. I accept Dr Hassan's evidence that for Mr Hakmi to come within category 3, he would require a greater level of assistance than he presently requires with daily living. Although Dr Baldwin did rely on other factors, I am not satisfied that his principal contention that assistance washing his back in the shower brings him within that category or indeed difficulties

in walking upstairs or driving long distances are sufficient to put him into a higher category. I note that on discharge from the Danesbury Rehabilitation Centre in December 2016 Mr Hakmi was recorded as being independent in washing and dressing.

97. I have concluded that thrombolysis would probably not have altered the outcome in this case, in circumstances where Mr Hakmi has made a very good, if imperfect, recovery from his second stroke. I am also inclined to accept Dr Hassan's evidence that thrombolysis did not alter the outcome of his first stroke on 26 September 2016. In my view the evidence regarding treatment with thrombolysis for lacuna strokes is lacking. I accept Mr De Bono's submission that at best Mr Hakmi lost the chance of a better recovery. If I am wrong about that, Mr Hakmi's Modified Rankin Scale of 2 is within the range of a good outcome from his second stroke whether he was treated with thrombolysis or not.

Fundamental Dishonesty

98. The outstanding issue for me to decide is fundamental dishonesty. The allegation that Mr Hakmi had been fundamentally dishonest in the presentation of his claim first surfaced in the counter schedule, which followed his examinations by Dr Bach in March and April 2024. He was seen by Dr Ford in April 2024. Mr Hakmi said that it had a caused him three months of sleepless nights and weeping. It arose because of Dr Bach's assessment that Mr Hakmi had not put effort into his testing with the result that he had scored lowly on the IQ Test at 84 and lowly on other tests. He had also taken the Test of Memory and Malingering (TOMM) from which Dr Bach concluded that Mr Hakmi's test results could not be relied upon. The allegation is also supported, less emphatically, by the evidence of Dr Hassan and Dr Santullo.

99. Similar results, but not as low were recorded when Mr Hakmi underwent his testing by Dr Ford. They were substantially below his expected level of performance before his stroke. The defendants' solicitors requested that Mr Hakmi disclose these documents to the Responsible Officer at the Lister Hospital, on the grounds of patient safety, which he initially refused to do. After an application to the court was made and before the hearing he did so. Following inquiry by Mr Hakmi's Trust, the Responsible Officer considered that he was safe to continue with his role, which is primarily one of educational training.

100. I consider that it would be useful to set out what Dr Baldwin's report on condition following an examination is April 2022 says about Mr Hakmi's recovery from his stroke, which, as I understand it, was before his role became mostly educational.

101. *"Mr Hakmi has always been very keen for both professional and financial reasons to return to work as an orthopaedic surgeon, and much of the therapy was focused on achieving that aim. He was encouraged to practice writing using the right hand and this slowly improved, and he attended courses on cadaver suturing to improve his clinical skills. Although initially there was some concern about the cognitive effects of the stroke, it was deemed that he was safe to return to work and in November 2017, he was approved by the Trust's Occupational Health department to return to work, initially on a phased return seeing only outpatients and ward rounds. It was always his hope to return to theatre, but because of the reduced grip and the requirements for repetitive hand function, the hand fatigue prevented this happening, and he was*

not permitted to return to surgical treatment. He has more recently returned to the operating theatre but not operating on his own patients but assisting and guiding colleagues."

102. *"Although he desires to return to orthopaedic surgery, the impairment of hand function together with the fatigue involving the right arm, and probably the movements of the right arm, have precluded surgery. It was deemed that he had sufficient cognitive function but following my assessment, I would have concerns that he has sufficiently impaired attention and concentration and executive impairment that would make it difficult for him to adapt to a rapidly changing surgical event."*

103. *"Mr Hakmi was able to return to work as a consultant in the Lister Hospital beginning in November 2017 and since then he has gradually increased his work such that he now works as a full-time consultant, but this does not include his own operating lists, although he has attended theatre sessions assisting colleagues. He does outpatient clinics, ward rounds, and has taken on sessions jointly in the diabetic foot clinic. In addition, he has taken on an increased role in teaching, departmental administration, appraisal, and educational supervision and job planning."*

104. It was agreed that based on his educational and employment history, Mr Hakmi's pre-index cognitive functioning is estimated as being in the high average range. It was also not in contention that not all subtests of intellectual functioning could be administered due to his right-sided weakness. There is no dispute that Mr Hakmi presents with global cognitive deterioration, including intellectual functioning, memory, the speed at which he is processing information and executive functioning. The issue is the extent of the deficit.

105. In cross-examination Mr de Bono put to Mr Hakmi that he had deliberately reconstructed the case to give it the most favourable appearance. He had deliberately failed to put the required effort into the neuro-psychological testing to produce artificially results below his actual cognitive performance. Mr Hakmi vehemently denies that this was the case and points to several matters that he had found unsettling at the time of Dr Bach's interview at home, including the disorganised structure of the interview, familial problems and length of the interview. He maintained in cross-examination that he had always been straightforward.

106. Dr Bach, clinical neuropsychologist, for the defendants, currently works in the acute stroke unit of a large NHS teaching hospital in London.

107. She noted from the occupational health records that Mr Hakmi received good feedback from himself, juniors, and peers in all domains. His last review dated 10 May 2024 documents that Mr Hakmi has the support of his colleagues and keeps up to date on his clinical skills for good patient outcomes. He has vast experience accumulated through years of training and work. He works towards keeping himself updated with his skills and knowledge through clinical and CPD activities. Mr Hakmi works well within his clinical capabilities and is aware and practises safety measures which are in place for good clinical outcomes. He ensures a culture of safety within his team and wider organisation. He has good working relationship with his colleagues. He participates in regular clinical governance meetings. He has shown good clinical practise and maintained the GMC standards for good medical practise.

108. Mr Hakmi was seen by Dr Bach on two occasions. The first was at his home on 9 March 2024, when Dr Bach conducted a cognitive psychometric assessment, and the second was a remote video assessment using Zoom on 20 April 2024. Dr Bach states in her report that her neuropsychological opinion is based both on test scores and observation of Mr Hakmki's performance in the context of other possible influencing factors, for example, clinical history, psychological/psychiatric presentation, fatigue and pain.

109. She states that TOMM is a widely used, reliable and valid cognitive assessment of effort/PVT. Mr Hakmi performed well below cut-off, nearly at chance level, on trial 1, and well below the cut-off for the normal range, cut-off trial 2. Her opinion is that Mr Hakmi's strikingly poor performance on TOMM indicates that his cognitive test scores should not be taken at face validity. She accepts that there are several reasons why he may have failed this test of effort, including reduced concentration, anxiety or intentional malingering. Her view is that a low TOMM score makes it virtually impossible to arrive at a clinical diagnosis.

110. The results of Dr Bach's tests showed that Mr Hakmi's verbal comprehension fell within the low average range, perceptual reasoning fell within the borderline range, working memory fell within the extremely low range, and speed of information processing fell within the extremely low range. On 9 March 2024, he scored 20 for depression and 18 for anxiety. Each of these scores indicate moderate to severe depressive symptoms. On 20 April 2024, he scored 16 for depression and 16 for anxiety. Each of these scores indicate moderate-to-severe depressive symptoms.

111. Dr Bach concluded that her neuropsychological assessment found Mr Hakmi to demonstrate significant cognitive impairments in attention, memory, learning and speed of processing. He failed tests of performance validity, indicating that his cognitive performance cannot be taken at face validity.

112. Dr Bach considered the TOMM assessment is very robust. It is very widely used. It is considered a gold standard test. It has been extensively researched and there is a large empirical base of evidence to use it with a variety of neurological patients, including stroke patients, patients with traumatic brain injuries, and patients with mild dementia and learning disabilities. The test is not a test of malingering, it is a test of performance validity and whether somebody is putting their best effort into the test.

113. In cross-examination, Dr Bach did not accept that the TOMM assessment should not being used on stroke patients or with patients with moderately severe brain injury. She conceded that Mr Hakmi's fatigue, pain and psychological features were caused by the stroke. She said she was not saying that it was inconsistent with organic brain injury but that the level of cognitive difficulties was inconsistent with the brain injury. The paper by Tombaugh was put to her in cross-examination and she agreed that diagnosis of malingering should not be made on basis of TOMM assessment alone. She agreed that on the basis of the embedded effort testing and the RFIT, Mr Hakmi was applying an appropriate degree of effort when he was assessed by Dr Ford. She agreed that Mr Hakmi's limitations on what he can and cannot manage are plausible.

114. She was also cross-examined about the circumstances of the first interview. She did not accept that the structure of the first interview was disorganised or conducted in a way that made it difficult for Mr Hakmi. She said she was aware that he had

undergone recent familial problems. She did not consider that he was fatigued otherwise she would have stopped the assessment. She agreed that Mr Hakmi was anxious. She said he was fixated on thrombolysis and wanted to talk at length about the topic. She accepted that inadequate effort is qualitatively different from intentional failure.

115. I also turn to Dr Hassan's evidence on this issue. In cross-examination he said that he considered that there was a functional element, which was not organic, in Mr Hakmi's cognitive presentation, however, he defers to the neuropsychologists. Mr Hakmi's witness statement and that of a colleague Mr Mordecai was put to Dr Hassan where they both referred to Mr Hakmi's impaired memory. He accepted that Mr Hakmi has some cognitive impairment, which is organic, but he had come concerns about elements of the Montreal Cognitive Assessment (MoCA) he performed on Mr Hakmi. He did not consider that it was conclusive, he said that it was not normal but accepted that it could be due to fatigue. I observe that he did not go as far as accusing Mr Hakmi of malingering. He accepted that there was organic impairment. He accepted that there was a problem with his gait. He accepted that his own approach to Mr Hakmi's history of falls suggesting a functional element was incorrect. He also accepted that the way he holds his foot and ankle was inconsistent with functional overlay.

116. I should mention that I also heard evidence from Dr Santullo, stroke rehabilitation expert on behalf of the defendants, who assessed Mr Hakmi on 8 February 2024. She accepted in her report that he suffers with right side hemiparesis, facial weakness, chronic neuropathic pain, fatigue, memory impairment, depression. She agreed in cross-examination that the physical disabilities that Mr Hakmi suffered were because of his second stroke but she considered that he tended to exaggerate his symptoms during the consultation. Her view was that "*he appeared to exert minimal effort during the evaluation, particularly noticeable when assessing the strength on his weaker side, which seemed inconsistent with his level of functioning."* She formed the impression he was not putting maximum effort when the strength in the upper limb was tested notwithstanding she agreed that he had right sided hemiparesis. She considered that exaggeration is a possibility, not a probability. She however, accepted that an assessment of cognitive impairment was outside her expertise.

117. Dr Ford, clinical psychologist, was instructed, on behalf of Mr Hakmi, to assess his neuropsychological functioning. She interviewed Mr Hakmi on 2 April 2024. He told her that "*his concentration is not good, and he cannot concentrate. It is more of an effort to remember things. He used to have an excellent memory. Remembering details about his patients and procedures was easy, but now it is a challenge. Before the second stroke, he described himself as a high achiever and was a very busy surgeon … In addition, the speed at which he processes information is slow. This means he struggles to process information when in conversations."*

118. Dr Ford personally administered, scored and interpreted all the neuropsychological tests. The Wechsler Adult Intelligence Scale-IV-UK (WAIS-IV-UK) was administered. Full-Scale IQ score of 84 (14th percentile) placed him in the low average range. Verbal Comprehension Index (VCI) of 87 (19th percentile) placed him in the low average range. Perceptual Reasoning Index (PRI) of 82 (12th percentile) placed him in the low average range. Working Memory Index (WMI) of 102 (55th

percentile) placed him in the average range. Processing Speed i.e. Symbol Search his scaled score of 5 placed him at the 5th percentile and in the borderline range. From this she extrapolated that his Processing Speed Index (PSI) is in the borderline range. The Beck Depression Inventory (BDI-II) was administered. His score of 40 places him in the severe depression range.

119. In cross-examination, Dr Ford considers that failure in testing in stroke patients is not evidence of malingering. There are genuine memory and attention problems in this patient group. She explained in some detail the unreliability of TOMM testing stroke or moderately severe brain injury patients.

120. Dr Ford explained that the cutoff score in the TOMM test is 45 out of 50 on the second trial or test. If the score is below 45, the participant is deemed to have failed the test. The problem with that cut-off score, Dr Ford believes, is that it is too high for patients who have had strokes or moderate to severe brain injuries. Stroke patients and severe to moderate brain injury patients really struggle and find it hard because it is genuinely difficult for most of them. They struggle to recall the data because they have genuine memory and attention problems. The cut-off scores are inappropriate for certain age groups and for certain population groups, for example, strokes, dementia, moderate to severe brain injuries.

121. Dr Ford believes that Mr Hakmi functions in his educational role, where there are a lot of allowances and adjustments, and he has support and supervision. It was put to her that one would not expect that degree of variation between two tests within a month of each other by competent assessors. Her answer was that it is called *"practice effects"*. The scores are low but he should be able to cope with adjustments in some areas.

Findings

122. Mr de Bono referred me to the decision of Ritchie J in ***Cojanu v Essex Partnership University NHS Trust*** [2022] 4 WLR 33, where at paragraph 38, he sets out section 57(2) of ***Criminal Justice and Courts Act*** ("CJCA") 2015. The section provides inter alia:

> *(1) This section applies where, in proceedings on a claim for damages in respect of personal injury ("the primary claim")—*
>
> *(a) the court finds that the Claimant is entitled to damages in respect of the claim, but*
>
> *(b) on an application by the Defendant for the dismissal of the claim under this section, the court is satisfied on the balance of probabilities that the Claimant has been fundamentally dishonest in relation to the primary claim or a related claim.*

123. At paragraph 47 of his judgment, Ritchie J set out the five requirements which must be satisfied before a finding of fundamental dishonesty could be made out, namely (i) the section 57 defence should be pleaded; (ii) the burden of proof lies on the

Defendant to the civil standard; (iii) a finding of dishonesty by the Claimant is necessary; (iv) as to the subject matter of the dishonesty, to be fundamental it must relate to a matter fundamental in the claim. Dishonesty relating to a matter incidental or collateral to the claim is not sufficient; (v) as to the effect of the dishonesty, to be fundamental it must have a substantial effect on the presentation of the claim. Mr de Bono also referred me the review by the Supreme Court of the law on dishonesty in ***Ivey v Genting Casinos*** [2017] UKSC 67, Lord Hughes JSC at paragraph 62, which I have not set out in this judgment. As Mr de Bono accepts, the question in this case, which determines whether the defence is made out, is whether Mr Hakmi has deliberately exaggerated either his physical or cognitive limitations.

124. Mr de Bono accepts that the evidence for exaggeration of Mr Hakmi's physical symptoms is limited and impressionistic. It relies primarily on Dr Santullo's evidence that he was not trying as hard as he could, in particular that he was exaggerating the weakness on his right-hand side and balance. I observe that Dr Santullo had seen Dr Bach's report when she prepared her own report. It is not possible to say the extent to which that influenced her thinking.

125. The focus of Mr de Bono's submission relate to the neuropsychological testing by Dr Bach of an apparent lack of effort being relevant to the physical tests. He relies on the different results obtained by Dr Baldwin in the TOMM assessment, and the Digit Span sub-test, and Dr Hassan in the Montreal Cognitive Assessment (MOCA). He submits that the variation in test scores is highly suspicious and point to a non-organic cause. He submits that, if his performance was deliberate and self-serving, then he was dishonest and the test in section 57 of the ***CJCA*** is made out.

126. Having considered the totality of the evidence, I have concluded that the claim that Mr Hakmi has been fundamentally dishonest fails. I do not consider that the defendants have established to the civil standard that Mr Hakmi was dishonest whilst being examined by the defendants' experts. I have had the advantage of observing Mr Hakmi being cross-examined for a full day. Whilst I saw that he had difficulty in answering questions, without arguing his case, I do not consider that he was trying to mislead the court in any way. He is a proud man against whom a serious allegation has been made which, if found proven, could have serious consequences on his registration and employment by his Trust.

127. Having carefully considered the evidence of Dr Ford and Dr Bach, I prefer the evidence of Dr Ford. I accept her evidence that the TOMM assessment, on which a large part of this aspect of the claim depends, is not suitable for all stroke patients, certainly not Mr Hakmi. I am satisfied that the poor performance in Dr Bach's tests, and to a lesser extent in Dr Ford's tests, can be explained by Mr Hakmi's psychological condition at the time the assessments were made. In March and April 2022 he was exhausted following serious familial issues which were explored in evidence. I accept the particular circumstances of Dr Bach's first examination probably explain the disparity in the results obtained by Dr Ford. There may also be an element of practice effect between the respective examinations. Mr Kellar also drew attention Dr Bach's transposition of a table in her report, which undermines her opinion on disparity, and also Dr Hassan's mischaracterisation of Mr Hakmi's disability in the MCA assessment. I have taken both those matters into account in reaching my conclusions.

128. I do not consider that Mr Hakmi was performing badly on the tests with Dr Bach to exaggerate deliberately the extent of his impairment. I observe that there is a recognition by Dr Baldwin and Dr Hassan that Mr Hakmi's disability may be organic as well as psychological. I consider that organic damage did not assist him in completing the assessments. If Mr Hakmi had deliberately been underperforming, it would run contrary to all that he has done to rehabilitate himself following his stroke. He has also adduced statements and letters from four colleagues at the hospital which attest to his honesty and integrity, as well as the steps that he has put in place to mitigate his disability following his stroke.

129. I find that Mr Hakmi honestly believes that the diagnosis and treatment he received was suboptimal and that if he had been treated with thrombolysis, then, he would have made a full or nearly full recovery. The loss of his career and the consequent fall out on other aspects of his life manifested itself in his evidence.

130. For the reasons set out above, however, I have concluded that the claim is dismissed.

131. Following the distribution of the draft judgment for typographical corrections, I have received submissions on costs from both parties, which deal with the costs of defending the claim on the issue of fundamental dishonesty. Both parties accept that otherwise costs should follow the event.

132. I have carefully considered the correspondence between the parties before the trial which has been provided. I do not consider it is necessary for me to set out it in detail in this judgment. It provides context for the period in the lead up to the trial, including Mr Hakmi's solicitors putting the defendants on notice that, in the event that the issue of fundamental dishonesty failed, there would be an application for costs, and the defendants making two *"drop hands"* offers shortly before trial. In any event, the trial went ahead and the defendants pursued the issue of fundamental dishonesty until the end. I raised the issue with Mr de Bono during his submissions, who assured me that careful consideration had been given to making and maintaining the allegation right through to submissions.

133. The conclusion that I have reached is that, notwithstanding that the defendants will not be able to enforce an order for costs on the claim, I should make an order that reflects that the defendants failed to establish fundamental dishonesty on the part of Mr Hakmi. I do not accept that to make such an order, where a claimant fails, undermines the costs regime. If anything it is the converse, not to make such an order would give a defendant a free tilt at raising the issue of fundamental dishonesty. The evidence in this case was properly explored at the trial and found increasingly wanting. It would have been open to Mr de Bono to have abandoned the issue after the close of evidence, or indeed earlier, but he did not do so.

134. It seems to me that I should make an order for costs that reflects that the defendants failed to establish fundamental dishonesty. As Mr Kellar has pointed out there was unfavourable national press coverage on the first day of trial and the consequences for Mr Hakmi, as I have said above, if the allegation had been found proved, would have been disastrous for his reputation and career. In my view, the order I make should reflect a percentage of the costs from the time that the issue was raised in the defendants' counter-schedule, which is dated 18 March 2025. I consider that Mr

Kellar's submission that it should be 25% is too high, and accept in part Mr de Bono's submission that some of the costs would have been incurred in any event.

135. I order that the defendants pay 15% of Mr Hakmi's costs from 18 March 2025, subject to a detailed assessment on the standard basis in default of agreement. Otherwise I order that Mr Hakmi pay the defendants' costs of the action not to be enforced without the leave of the court.

136. I shall leave it to leading counsel to agree an order for my approval.