Neutral Citation Number: [2026] EWHC 1088 (KB)

Case No: KB-2024-001248

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
CIVIL

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 08/05/2026

Before :

MR JUSTICE COTTER

- -

Between :

MS CHELSEA WILLIAMS	**Claimant**
- and -	
MR DANIEL WILKISON	**Defendant**

- -
- -

John De Bono KC (instructed by **Moore Barlow LLP**) for the **Claimant**
Ms Anna Hughes (instructed by **DWF Law LLP**) for the **Defendant**

Hearing dates: 30 April 2026

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Approved Judgment

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

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MR JUSTICE COTTER

Mr Justice Cotter :

Introduction

1. The Claimant has brought a clinical negligence claim against the Defendant, an osteopath, in relation to his failure to advise her at an examination/treatment session at 5.00-6.00pm on 14th February 2020 to attend hospital on an emergency basis due to her having symptoms of Cauda Equina Syndrome ("CES"). She went home and only called an ambulance later that evening after her symptoms deteriorated. She was operated on the next day and has been left with significant residual symptoms.

2. There is no dispute that the Claimant has CES with neuropathic pain, urinary and bowel symptoms. She also has back pain although there is an issue as to whether this is related to the CES.

3. Breach of duty was conceded before proceedings were issued, but the Defendant denies that his negligent failure has caused any injury/damage as there was no neurological deterioration in the Claimant's condition whilst waiting for surgery (not accepted by the Claimant), the Claimant would not have been operated on any earlier than she was or to the extent that she would have been the delay made no material difference. The Defendant further argues that any residual injury was caused by non-negligent, intra-operative damage.

4. There are also issues between the parties in relation to the quantum. The schedule of loss contends for £873,395 (including an award for general damages) and the counter-schedule pleads that the proper award should be £86,571.

5. The parties have complied with the directions to trial through to the obtaining of joint expert statements within three disciplines (spinal surgeons, anaesthesia/pain, urology)

6. This matter has been listed for a 7-day trial in a 5-day window commencing on 15th June 2026.

7. By an application dated 16th April 2026 the Claimant seeks:

    a) Permission to amend the Particulars of Claim;
    b) Permission to rely on an additional witness statement from the Claimant;
    c) Permission to rely on the witness statement of Ms Sushila dated 2nd April 2026;
    d) Permission to rely on further expert evidence from the Claimant's urologist and pain management experts; and
    e) Permission to rely on further expert evidence from the Claimant's spinal expert.

8. As I shall explain in due course it is not in issue that if permission to amend is granted the trial date will be lost.

9. The Defendant opposes the application in its entirety.

10. I deal first with the application to amend and start with an overview of the facts.

Proposed amendment

11. It is the Claimant's pleaded case as it currently stands that;

> "With reasonable management by the Defendant the Claimant would have gone directly to A&E and would have been there between 6pm and 6.30pm on 14 February 2020. On assumption of reasonable management it is probable that she would have been assessed as requiring investigating for cauda equina syndrome and would have had an MRI scan, either before or after neurosurgical involvement. Given the recent onset of her symptoms and the likely appearance of the MRI she would probably have undergone surgery as an emergency that evening. It is unlikely that there would have been a decision to delay surgery until the following morning."

12. The proposed amended pleading is

> "With reasonable management by the Defendant the Claimant would either have gone directly to A&E and would have been there between 6pm and 6.30pm on 14 February 2020 or would have gone home and either called 999 (or otherwise 111) for advice about what she should do. Of these two scenarios the more likely is that she would have gone home rather than going directly to A&E because of the need to pick up her son from nursery and because she does not drive. Given that when she called later an ambulance was despatched it is likely that the same sequence of events would have followed and that she would have been taken by ambulance to the Royal Sussex County Hospital and would have been scanned and undergone surgery during the night or alternatively first thing in the morning, around 0900 (rather than 1610). Had she gone directly to A&E then on the basis of the agreed position of the spinal surgeons in their joint meeting it is probable that she would have ended up being scanned out of hours and then transferred either to the Royal Sussex County Hospital (Brighton) or to St George's Hospital, London. She would probably have had surgery starting by 0900, some 7 hours earlier than in fact happened (surgery proper started at 1610). Whatever the precise sequence of events, with reasonable management it is likely that she would have ended up with surgery starting not less than about 7 hours earlier."

Facts

13. It is necessary to set out the facts in a little detail

14. The Claimant's consultation with the Defendant was between 5.00-6.00pm. The Defendant noted the Claimant's symptoms in her right lower back, right thigh and leg with numbness into the groin and an inability to feel the paper when wiping her bottom. He considered that the Claimant had CES and advised her to call 999 if her symptoms increased or she had difficulties urinating. It is accepted by the Defendant that he failed to recognize a medical emergency and that she should have advised the Claimant to attend A&E for assessment on an urgent basis. He should have asked the Claimant if she was happy to make her own way to A&E and, if she confirmed that she was not, then he should have called an ambulance.

15. After the consultation the Claimant returned home.

16. At 7.33pm the Defendant e-mailed the Claimant confirming his advice.

17. At 9.27 pm the Claimant called NHS 111. It is her case that she did so because of a deterioration in her symptoms. In her (first) witness statement (served in accordance with the directions) the Claimant stated:

> "34. At some point not long after got home I went for a shower to ensure I was clean before going to hospital or in the ambulance if I had to. Whilst I was in the shower, I noticed that the numbness in my front groin had got worse, as well as in my right leg and right foot. This really shocked me because I thought that I was going downhill quite quickly. I was also in a lot of pain behind my knee (missing my calf) and into my right foot. I sat on my bed for a while and could not decide what to do as I had already seen the osteopath and the GP and did not really know how urgent things were but I was worried about things getting worse.
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> 35. I then called NHS 111 to double check the advice I had received from the osteopath as I thought that if I needed an ambulance they would be able to send one to me. This was at 21:27 on Friday 14 February 2020. The call handler I spoke to asked me about my symptoms and I confirmed I had been recently diagnosed with Cauda Equina Syndrome by the osteopath and I explained my symptoms had got a little worse.
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> 36. I explained that at first, I just had numbness in my groin but that it had now spread to around my pelvis and around my saddle area with pain in my right leg. I was also having trouble opening my bowels.
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> 37. The call handler confirmed I would need an emergency MRI scan and then said that they would have to speak to one of their medical advisors and call me back.

> 38. The NHS 111 service then called back at 21:35 and they asked me further questions about what the osteopath had advised me to do. I explained they advised me to call 999 but I didn't think I ought to call 999 as I didn't feel like it was a life-threatening emergency. The call handler said they wanted to speak with their nurse again and would get back to me.
>
> 39. The call handler called me back again at 21:40 and advised me to call 999 for an ambulance but then said they were able to organise a lower urgency ambulance. I am not sure why that was.
>
> 40. At 22:41 I received a phone call from the ambulance service explaining they were very delayed getting an ambulance to me and asking me about my symptoms again. I explained I had pain in my right leg and my saddle area felt numb, but I could still feel pain. It had been taking me longer than usual to urinate and I had been constipated for the last two days. The caller said they would be sending an ambulance to me later that evening to take me to hospital.
>
> 41. The ambulance did not arrive until around 23:10 on Friday 14 February 2020. When the paramedics asked me about my symptoms, they explained that I had two out of three of the "red flags" for Cauda Equina Syndrome and so they were not sure which hospital would be best to take me to.
>
> 42. My partner, Ross, suggested they should take me to hospital straight away and not delay any longer, so we left at 23:34 and they took me to Brighton and Sussex University Hospital and we arrived there at eight minutes after midnight which was now 15 February 2020."

18. At 10.40 the ambulance service called to say that the ambulance was delayed

19. At 11.10 pm the ambulance arrived at the Claimant's house. So this was approaching 1 hour 40 minutes after the Claimant made her call. The Claimant was taken by ambulance to the nearest spinal unit which was in Brighton (Royal Sussex County Hospital).

20. At 00.08 the Claimant arrived at Royal Sussex County Hospital. She was triaged at 0039.

21. At 03.00 the Claimant was reviewed by Dr Thompson (ST4). The doctor noted that the Claimant was able to pass urine and recorded the diagnosis of "incomplete cauda equina syndrome".

22. At 0500 the Claimant had an MRI scan. So this was five hours after her arrival. The experts agree that this was incorrectly reported as showing no CES.

23. The Claimant was reviewed by a neurosurgery registrar at 0545 who made a plan "For theatre this morning after d/w on call consultant" (this is pleaded at paragraph 14 of the Particulars of Claim).

24. At 11.03 a neuro surgery patient was taken into theatre. In a letter of response to a letter of claim against the Trust dated 23rd June 3023 solicitors acting for the Hospital stated

> "[The Claimant's] case was discussed at the morning handover from the on-call team, where all the patients referred/admitted are discussed and operations for the day planned based on clinical assessment and priority. Of surgeries that needed to take place that day, there was another patient who had deteriorated neurologically in the morning, and who needed emergency burr hole evacuation of a chronic subdural haematoma. Ms Williams was taken to theatre promptly after this procedure had concluded."

25. At 12.23 the neuro patient has cranial surgery (a burr hole operation).

26. The Claimant had surgery at 16:10 that afternoon.

Expert evidence.

27. Mr De Bono KC submitted that the Claimant's pleaded case on causation as set out above (i.e. prior to the proposed amendment) was based on the expert opinion of Mr Clarke (Claimant's spinal expert).

28. In his report Mr Clarke reviewed the pleaded case that "with reasonable management by the Defendant the Claimant would have gone directly to A&E and would have been there between 6pm and 6.30pm on 14th February…it is unlikely that there would have been a decision to delay surgery to the following morning and stated:

> "6.2 I would consider this to be an accurate view of the management of Ms Williams' case, but for the decisions made at the Bridgeham Clinic.
>
> 6.3 If Ms Williams had been advised to attend the local Emergency Department urgently she would have been assessed and diagnosed with possible cauda equina syndrome.
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> 6.4 This would have triggered referral for an emergency MRI scan, based upon the clinical record and then discussion with the local spine service.
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> 6.5 As both of these were available in house, rather than having to transfer for the scan or assessment, then I would have expected that the scan would be performed within 4 hours of attendance at the ED.
>
> 6.6 Then referral and review by the spinal surgical team within an hour.
>
> 6.7 This would take the time to approximately 11pm.

> 6.8 As the diagnosis was CESI, then I would expect Ms Williams to have been offered surgery, with a view to it being performed that evening."
>
> And also
>
> "but for the delay on 14th February 2020, Ms Williams, on balance of probabilities would have undergone surgery on the evening of 14th February 2020 offering the best chances of recovery."

29. Mr Clarke was, at least in part, trespassing into issues of fact which are for the Court to determine on factual evidence.

30. Mr Clarke did not address in his report why surgery was delayed until the afternoon at the Royal Sussex County Hospital or following the assessment at 5.45.

31. In his report of October 2025, the Defendant's spinal expert Mr Jackowski addressed factual causation in some detail at paragraphs 7.5 to 7.7;

> "7.5 If she had been advised by Mr Wilkinson when seen between 17:00 – 18:00 hours to attend A&E then she would likely have initially attended the local nearest A&E Department at Redhill Hospital. She would then have been assessed and would have required referral to the spinal service at Brighton & Sussex University Hospitals Trust. Allowing for time taken to register at the hospital and to be seen by the A&E service, then to be discussed with the orthopaedic team, followed by contacting the spinal service at Brighton, it would likely have been a minimum of three hours before there was a recommendation that she be transferred between hospitals. There would then need to be an urgent inter-hospital ambulance booked and transfer between the two hospitals with a journey time of approximately one hour. She would therefore, at the earliest, have arrived at Brighton Hospital A&E Department at around 22:30 hours. I consider that timescale to be optimistic and that her arrival at Brighton & Sussex Hospital would likely have been later than that.
>
> 7.6 The Particulars of Claim allege that the Claimant would have arrived at 'A&E' between 6 pm and 6.30 pm. They do not say which hospital the Claimant would have arrived at. Later under Particulars of Causation it is alleged that there was a delay of approximately 16 hours in commencing surgery. In my opinion, even in the most optimistic scenario, the Claimant would likely have arrived in Brighton & Sussex A&E only some two hours earlier than she did. In my expert opinion, an avoidable delay in the Claimant attending the A&E Department of Brighton Hospital of two hours would not, on the balance of probabilities, have made a difference to the Claimant's subsequent treatment and eventual clinical outcome.

> 7.7 The Claimant's case is that she would have undergone surgery on the evening of 14 February 2020 as opposed to 15:11 hours on 15 February 2020. For the reasons I have outlined above, I consider that is incorrect…"

32. Mr Jackowski raised an obvious factual issue; which A&E would the Claimant have attended? He also opined that the Claimant would only have arrived two hours earlier than she did and that such a delay of two hours would not have made any difference to the outcome. Implicit in the comment is that surgery would not have been brought forward by any greater period because of earlier admission. Mr Jackowski also did not address in his report why surgery was delayed until the afternoon at RSCH.

33. In my view the Claimant was put on clear notice by Mr Jackowski's report that factual causation was a likely battle ground. As Ms De Bono KC conceded during oral submissions, the Claimant's legal team should have analyzed this issue, and asked the Claimant for her instructions as to what she would have done, and taken matters forward on the basis of what she told them; but did not do so.

34. Mr Clarke and Mr Jackowski considered the counterfactual in detail in the Joint report. It is noteworthy that they were addressing questions within an agenda. They gave their view as follows;

> "The experts agreed that it is a matter for the Claimant to say and the court to determine as to whether, if Mr Wilkinson had advised her to attend A&E on an urgent basis, whether she would have chosen to go to the nearest A&E to the Bridgham Clinic which would have been the East Surrey Hospital (Redhill) which was 25 minutes away or whether she would have first returned home and from there made her way to the nearest
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> A&E Department which was the Princess Royal Hospital (Hayward's Heath) which was 33 minutes from her home.
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> We are aware that East Surrey Hospital (Redhill) has no on call Neurosurgical service, it does have an Orthopaedic Department with some surgeons who perform elective spinal surgery but "There has never been 24/7 spine on-call at East Surrey (hospital)"
>
> (Appendix). We are aware that at the Princess Royal Hospital A&E Department (Haywards Heath) which was 33 minutes from her home there was neither a Neurosurgery nor an Orthopaedic Spinal on call service for cauda equina syndrome. We further note that when the paramedics attended her home that they the Claimant in her Witness Statement paragraph 41 states that they were not sure which hospital would be the best to take her to but following a suggestion from her partner she was taken to the Royal Sussex County Hospital (also known as Brighton & Sussex Hospital) in Brighton and Hove. We understand that it took around 1 hour and 40 minutes for an ambulance to arrive at her home later that evening when the Claimant called for one and

that it took approximately one hour to transport the Claimant from her home to Brighton & Sussex Hospital.

Determination by the court as to which A&E the Claimant would have gone to if she had been advised to attend A&E on an urgent basis around 18:00 hours on 14th February 2022 will necessarily therefore determine what the timescale would have been for her to be assessed and referred to an on call spinal service and as to when she would have undergone MRI scanning and the earliest opportunity she could have undergone surgery. We are taking the ambulance availability time either to the hospital or her home as similarly being approximately one hour 45 minutes and the transfer time to East Surrey Hospital being approximately 30 minutes with the transfer time to the Royal Sussex County Hospital being around one hour.

With that caveat, we consider that most individuals if advised by an osteopath that they should attend an Accident and Emergency Department on an urgent basis would most likely have first gone home before then making their own way by private transport to the Accident and Emergency Department closest to their home. (If the Court determines she would have gone directly to A&E this takes 1 hour off our triage onward timing below.)"

And

"With the above caveats we agree that the Claimant would likely have attended *an* Accident and Emergency Department around 20:30 hours (Princess Royal or East Surrey Hospital). She would then have been registered by reception, been triaged by a nurse and waited to be seen and assessed by a Casualty Officer. If the Accident and Emergency Department had a protocol for suspected cauda equina syndrome and 24/7 on site MRI scanning availability for scanning such cases, then the process from triage to scan completion would likely be 3-5 hours (was 5hrs at Royal Sussex). In the absence of an agreed protocol, the time to complete that process and for the Casualty Officer to have made a provisional diagnosis of cauda equina syndrome (CES) would have likely taken around the same time as when she actually attended Brighton & Sussex Hospital, ie approximately 3 hours. A decision would then have been made to either refer her to a specialist or organise an in-house MRI scan at 23:30 hours (Princess Royal or East Surrey Hospital). Some hospitals do not allow Casualty staff to order an out of hours MRI scan which have to be ordered either by an on call Neurosurgeon or an on call Orthopaedic Spinal Surgeon. Following the Casualty Officer contacting one of those services they would likely have first assessed the Claimant, adding another hour to the timescale. If there was an out of hours MRI scan available at the attending hospital, then an MRI scan could have been completed and reported around 01:30 hours (Princess Royal or East Surrey Hospital."

And

> "*f) When would she probably have had surgery?*
>
> If she had attended either one of the A&E's close to her home, the Princess Royal Hospital or East Sussex Hospital, then because there is no cauda equina emergency operating service at either hospital the Casualty Department would have had to have referred her, likely to the Royal Sussex County Hospital in Brighton. Allowing time to make referral and discuss her case with the on-call spinal surgeons (30mins) time to arrange for an ambulance to pick her up (1hr 45mins) and transfer time to Royal Sussex (1hr) she could have arrived at Royal Sussex A&E at around 04:45hrs. Whilst she could potentially have had surgery out of hours, we consider it more likely that she would have had surgery at the earliest practicable opportunity on the Saturday emergency list at the Royal Sussex County hospital commencing that morning.
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> If she had attended the Royal Sussex County Hospital, as in fact she did, then the regional spine service was in house, then surgery could have occurred at the earliest safe opportunity."

And

> "If she had attended an A&E or hospital locally that did not have a 24/7 spinal surgical service then she would likely have been transferred to the Royal Sussex County Hospital (Brighton) and her surgery would likely have been deferred until the Saturday emergency list on 15th February 2020. Her surgery could have been performed approximately 6 hours earlier *if* it had commenced at 09.00.
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> Mr Clarke considers that if she had attended the Royal Sussex County Hospital, then based upon the potential time lines above, she could have undergone surgery 12 hours earlier.
>
> Mr Jackowski considers that based upon the potential time lines above her surgery would have followed the same time line as occurred in any event. He understands the Claimant is not alleging any delay against Royal Sussex Hospital as regards the timing of their performing surgery."

35. The comment that the Claimant's surgery could have been performed approximately 6 hours earlier *if* it had commenced at 09.00 has to be seen in the context of their view that any delay of 6 hours or less would not have made any material difference to the outcome.

36. The agreed position in general is therefore that:

    (a) if the Claimant arrived at the Royal Sussex County Hospital at 4-5am:

> "Whilst she could potentially have had surgery out of hours, we consider it more likely that she would have had surgery at the earliest practicable opportunity on the Saturday emergency list at the Royal Sussex County hospital commencing that morning."

So they are of a view that a delay of some hours would have been likely and (it appears) reasonable notwithstanding the history of symptoms and time of onset

(b) If she arrived in hospital before that time then then surgery could have occurred at the earliest safe opportunity. Mr Clarke and Mr Jackowski did not expand upon what this meant and did not address the assessment by the neurosurgery registrar at 0545 and the plan which was made "For theatre this morning after d/w on call consultant".

Further evidence

37. Before considering the proposed amendment, it is necessary to consider what the Claimant has now said in a further statement (in respect of which permission to rely is sought) as to what she would have done if she had been advised as she should have been. She has stated that;

> "13. If I would still have had to collect my son from the after school club at his school and return home before doing anything. The journey from the clinic to school and then home is only around 15 - 20 minutes, so had I been told at around 17.30 that I needed to go to A&E, I would probably have arrived home by around 18.00 having picked up my son.
>
> 14. My normal routine of getting from work to the primary school and home at that time was that I would have taken a bus as this was right outside my office which went straight to the primary school and then we would usually walk home, or sometimes catch a bus, but I definitely recall getting a lift on that day. This was not unusual as my colleague would often drop me off if I had to go somewhere to do with childcare or something else.
>
> 15. I would then, as I did, have called my partner Ross to come home as I knew I needed to go to A&E and I would have required help with childcare.
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> 16. After calling my partner Ross and asking him to come home, I would then have telephoned either NHS111 or 999 in order to double check the advice I had received from the osteopath in terms of going to A&E which is what I did when my symptoms worsened and I had seen the email from the osteopath that he sent to me at 19.33 and which arrived that evening."

38. The Claimant does not set out what the cumulative effect of these steps would have been and when she would have called NHS 111 or 999. This is a significant omission.

39. The Claimant confirmed that she did not drive and would not have suggested to her partner going by car as she would have been "dragging" her son along.

40. By a statement of 2nd April Ms Sushila, the Claimant's solicitor has explained that given the Claimant's further instructions:

> "9 . I have sought to establish the referral pathway from A& E (had she gone there) to a spinal unit and I have sought to establish what would probably have happened had the Claimant called NHS 111 or 999 as she did on 14.02.2026 on the counter factual scenario (hence the email chain to Mark Sephton who is an Advanced Nurse Practitioner. I exhibit hereto marked "MXS3" the email chain between myself and Mark Sephton and his CV.
>
> 10. I have also made enquiries with South East Coast Ambulance Service (SECAS) which is the ambulance service that was requested by NHS 111 to attend her house on 14.02.2020 about a destination policy. On 14.02.2020 the SECAS took the Claimant, not to any of the local hospitals but to Royal Sussex County Hospital. I also made an FOI request. I exhibit hereto marked "MXS4" the email chain between Moore Barlow and the South East Coast Ambulance Service and exhibit marked "MXS5" the Freedom of Information Act request dated 11/3/26.
>
> 11. In light of this additional information counsel amended the Particulars of Claim which I exhibit hereto marked "MXS6"."

41. The first point to make is that Mr Sephton is clearly not a factual witness and permission would be needed for expert evidence on the issue. Also I am unsure of his expertise as regards the NHS 111 line (or 999 calls) and the likely responses/ action taken.

42. In the e-mail exchange exhibited to the statement Mr Sephton initially doubted that the Claimant would have called NHS 111. He then stated that if the Claimant had reported the same symptoms as she reported to the Defendant i.e. not the symptoms after she deteriorated, then if NHS 111 called the ambulance then she would probably have been taken straight to Royal Sussex County Hospital but not if

> "NHS 111 didn't call the ambulance and simply signposted her to AED which they can do".

43. It does not appear to be the case that Mr Sephton had considered what the Claimant set out in her first statement as to the reactions of NHS 111 and the ambulance service to the symptoms post deterioration.

44. The freedom of information request of South East Coast Ambulance Service received the following response;

> "1. What is the criteria for determining which hospital to take a patient to? Is there a policy used or referred to by the ambulance crew?
>
> Normally crew would take the patient to the nearest A&E. Exceptions are:
>
> 2. Specific clinical pathways eg stroke, heart attack, major trauma
>
> 3. If the patient has a Patient Specific Instruction
>
> 4. Operational reasons eg a particular A&E being closed, on divert or dealing with a major incident.
>
> 5. Crew recognise that patient is likely to need specialist input only available in a particular centre in the region."

And

> "There is no formal pathway for cases of suspected cauda equina syndrome. However, spinal surgery is carried out a the RSCH. Whilst an urgent MRI scan should theoretically be available at all acute hospitals, service and timing can be patchy, especially out of hours, resulting in ambulance crews not infrequently taking suspected CES patients to the RSCH so that the MRI scan can be carried out without the risk of delay at a local hospital."

45. Given the above, there is an obvious lacuna of direct/admissible evidence as to when the Claimant is likely to have phoned NHS111/990 (so how many hours earlier than 9.27 pm) and what is likely to have occurred as a result of the call. These issues are now critical as the Claimant does not seek to maintain her currently pleaded case that the only pathway was that she would have gone directly to A&E and would have been there between 6.00 and 6.30 pm.

46. The proposed amended pleaded case is that given the ambulance crew took the Claimant to Royal Sussex County Hospital this is what is likely to have happened if she had called earlier, although, importantly on her evidence she would not have suffered a deterioration at this stage so would just have been reporting the symptoms as recorded by the Defendant. In any event a period of delay (1 hour 40 minutes having been told of the Claimant's deterioration).

47. There is then the issue was to what would have occurred when she arrived at the Royal Sussex County Hospital; given that she in fact arrived at 0008 and was not operated in until after 4.00pm. The proposed amended claim states that she would have undergone surgery during the night or alternatively first thing in the morning around 9.00am. This pleaded case does not address the time taken to arrange as scan (it took 5 hours) and the assessment by the registrar at 5.45 that surgery could wait until the morning (the emergency Saturday list) an entry which has been pleaded.

48. Given that the Claimant would (on her own evidence) have gone home and waited for her partner to return and also that the combined total of the ambulance delay and the time taken for a scan was in fact 6 hrs 40 minutes; it is understandable that the Claimant's case that she would have undergone surgery on the evening of 14th is no longer thought maintainable and by the proposed amendment is that surgery would have been

   "during the night or alternatively first thing in the morning".

49. The alternative pathway pleaded (the Claimant going directly to A&E) as alleged in the proposed amended pleading still has the Claimant probably having surgery at 9.00; some seven hours earlier (the significance of 9.00 being that the experts agree a delay up to an including six hours is unlikely to have materially affected the Claimant's outcome).

50. Importantly neither of the factual scenarios set out in the proposed pleading or the joint statement deal with the decision taken at 5.45 and also the delay that occurred the next morning after the evaluation of priority at the morning handover.

51. Mr De Bono KC recognized that if the Claimant is granted permission to amend her case to argue that surgery would have been performed during the night or at around 9am on 15th February 2020, then the Defendant will want to advance a positive case that this would not have been possible.

The relevant legal principles

52. The Claimant can only amend the Particulars with the Court's permission: CPR 17.2.

53. An application for permission to amend will not be granted where the proposed amendment has no real prospect of success (see **Groveholt Ltd v Hughes** [2010] EWCA Civ 538 at [50].

54. In exercising the discretion under CPR 17.3, the overriding objective is of central importance. Applications always involve the court striking a balance between injustice to the applicant if the amendment is refused, and injustice to the opposing party and other litigants in general, if the amendment is permitted.

55. The timing of the application should be considered and weighed in the balance. An amendment can be regarded as 'very late' if permission to amend threatens the trial date.

56. In **Quah Su-Ling v Goldman Sachs International** [2015] EWHC 759 Mrs_Justice Carr as she then was set out a review of the authorities (as subsequently approved by the Court of Appeal in **Nesbit Law Group v Acasta European Insurance Company Limited** [2018] EWCA Civ 268 [at 41]) :

> "38 Drawing these authorities together, the relevant principles can be stated simply as follows:
>
> a) whether to allow an amendment is a matter for the discretion of the court. In exercising that discretion, the overriding objective is of the greatest importance. Applications always

involve the court striking a balance between injustice to the applicant if the amendment is refused, and injustice to the opposing party and other litigants in general, if the amendment is permitted;

b) where a very late application to amend is made the correct approach is not that the amendments ought, in general, to be allowed so that the real dispute between the parties can be adjudicated upon. Rather, a heavy burden lies on a party seeking a very late amendment to show the strength of the new case and why justice to him, his opponent and other court users requires him to be able to pursue it. The risk to a trial date may mean that the lateness of the application to amend will of itself cause the balance to be loaded heavily against the grant of permission;

c) a very late amendment is one made when the trial date has been fixed and where permitting the amendments would cause the trial date to be lost. Parties and the court have a legitimate expectation that trial fixtures will be kept;

d) lateness is not an absolute, but a relative concept. It depends on a review of the nature of the proposed amendment, the quality of the explanation for its timing, and a fair appreciation of the consequences in terms of work wasted and consequential work to be done;

e) gone are the days when it was sufficient for the amending party to argue that no prejudice had been suffered, save as to costs. In the modern era it is more readily recognised that the payment of costs may not be adequate compensation; it is incumbent on a party seeking the indulgence of the court to be allowed to raise a late claim to provide a good explanation for the delay;

g) a much stricter view is taken nowadays of non-compliance with the Civil Procedure Rules and directions of the Court. The achievement of justice means something different now. Parties can no longer expect indulgence if they fail to comply with their procedural obligations because those obligations not only serve the purpose of ensuring that they conduct the litigation proportionately in order to ensure their own costs are kept within proportionate bounds but also the wider public interest of ensuring that other litigants can obtain justice efficiently and proportionately, and that the courts enable them to do so."

57. In **Pearce v East & North Hertfordshire NHS Trust** [2020] EWHC 1504 (QB) at [10], Lambert J stated;

> "The timing of the application should be considered and weighed in the balance. An amendment can be regarded as 'very late' if permission to amend threatens the trial date, even if the application is made some months before the trial is due to start. Parties have a legitimate expectation that trial dates will be met and not adjourned without good reason. Where a very

> late application to amend is made the correct approach is not that the amendments ought, in general, to be allowed so that the real dispute between the parties can be adjudicated upon. A heavy burden lies on a party seeking a very late amendment to show the strength of the new case and why justice to him, his opponent and other court users requires him to be able to pursue it. The timing of the amendment, its history and an explanation for its lateness, is a matter for the amending party and is an important factor in the necessary balancing exercise: there must be a good reason for the delay.
>
> ..
>
> d) The prejudice to the resisting parties if the amendments are allowed will incorporate, at one end of the spectrum, the simple fact of being 'mucked around' to the disruption of and additional pressure on their lawyers in the run- up to trial and the duplication of cost and effort at the other. The risk to a trial date may mean that the lateness of the application to amend will of itself cause the balance to be loaded heavily against the grant of permission. If allowing the amendments would necessitate the adjournment of the trial, this may be an overwhelming reason to refuse the amendments.
>
> e) Prejudice to the amending party if the amendments are not allowed will, obviously, include its inability to advance its amended case, but that is just one factor to be considered. Moreover, if that prejudice has come about by the amending party's own conduct, then it is a much less important element of the balancing exercise."

Submissions

58. Mr De Bono KC submitted that

> "The spinal expert's meeting has led to a focus on the pathway to surgery and the specific route or routes by which the Claimant would have come to surgery. This was not done before on behalf of the Claimant because Mr Clarke's position was that with attendance at an A&E department in the early evening of 14 February she would probably have come to surgery that night."

He argued that prior to the spinal experts' meeting there was little evidence before the Court as to what probably would have happened but for the Defendant's breach of duty. However I do not see how this submission assists the Claimant given the obvious issues that arose on known facts and which the Claimant had failed to address. As I have set out the Claimant's own evidence was that she would have gone home and there would have been some delay whilst she waited for her partner and given that what happened was that there was 6 hours and 40 minutes through the ambulance and scan it should have been appreciated that the case that she would have been operated on that evening

would be untenable unless there was other evidence. The Claimant was also well aware of what had occurred at 5.45 and in the morning (the decision as to priority)

59. Mr De Bono KC also submitted that Mr Clarke had changed his opinion that surgery would have taken place on the evening of 14th February and agreed with Mr Jackowski that (unless the Claimant went directly to Brighton) she would probably not have had surgery prior to the morning emergency list on 15 February. However it was unsurprising that he changed his view when there was greater focus on the timings. Also he has still not addressed the decisions taken at 5.45 and on the morning of 15th February.

60. Mr De Bono KC also referred to the fact that the Defendant had not pleaded a positive case and he challenged the admissibility of the records relating to the neurosurgery patient who was given priority on 15th February.

61. Ms Hughes submitted that

a) The proposed amendments were bound to fail as surgery could not have been performed at the time alleged.

b) This is a "very late" amendment which would lead to the loss of the trial date.

62. As regards the prospects of success of the proposed amendment Ms Hughes argued that

a) the Claimant arrived at the Royal Sussex County Hospital at 00.08 on 15th February 2020

b) After undergoing initial assessment and an MRI, the Claimant was reviewed by the neurosurgical registrar who, at 05.45 on 15th February 2020 concluded:

"for theatre this morning after d/w consultant on-call"

c) Despite being at the relevant hospital, and assessed as requiring surgery on the morning list, the Claimant was not taken to theatre until 15.36 on 15th February 2020.

d) The reason for this delay was not mere inaction on the part of RSH. On the contrary, it was for reasons explained in the Letter of Response in June 2023.

There was therefore no basis for alleging that surgery would have been carried out during the night or at 9.00.

63. Further, the Defendant had given disclosure of the theatre records which confirm what had happened on 4th March 2025 and the Claimant did not take issue with these records or seek to challenge them until 21st April 2026, which was after the issue with the new factual pleading had been aired. Then the Claimant for the first time indicated that they did not accept the "content of these notes and we do not accept that they are in evidence in this case". No explanation has been forthcoming as to why they have taken this stance and/or why they have waited until two months before Trial to challenge these records, despite having been aware of their existence for over a year. The Defendant maintains that records are in evidence, relevant and that the contents are clear.

Analysis

64. The Claimant recognizes that the current pleaded case is untenable on her own evidence. It is her case that she would have gone home and then, at some point, phoned NHS 111. Assuming that the response from NHS 111 was to summon an ambulance (or to tell her to do so) there would have been some delay (if the case is that she would have followed the same pathway). So she would not have been at Royal Sussex County Hospital between 6.00-6.30 pm. Given the need for an MRI and subsequent assessment alone it appears to be conceded that it is unrealistic to assert that surgery would have been carried out that evening.

65. As a result the Claimant has applied to amend to assert that surgery would be likely to have been performed during the night or by 9.00 the next morning.

66. The proposed amendment would radically alter the Claimant's case on causation in circumstances where assessment of the likely time of surgery is a central issue and if the operation had taken place at 10.00am or later on 15th February there would have been (on the experts view); no material difference in outcome. The Defendant would need to have the opportunity to assess and then plead to the amended case. This first requires the ability to assess/obtain evidence as to the timeline on the basis of the new case (i.e. that she would have gone home and called NHS 111 prior to the deterioration of her symptoms).

67. Also obvious difficulties with the Claimant's proposed amended case have already been raised given what in fact happened i.e. a decision was taken at 05.45 that surgery could be delayed until the morning (when in the morning this was expected to be has not yet been investigated) and that there was a further analysis as to surgical priorities in the morning meaning that the Claimant was not operated on first thing.

68. Not only would the pleading have to be amended there would also have to be a facility for further factual evidence and re-consideration by the experts (and possibly, I put it no higher, expert evidence as to the workings of NHS 111).

69. In such circumstances it is properly conceded that if the amendment is allowed the trial date must be vacated.

70. The Court and parties have a legitimate expectation that trial dates will be kept and the longer and more complicated the trial to fix the greater the expectation. As a result any amendment which has the effect of loss of the trial date can be considered late or very late. Here given the proximity to the trial date it properly be categorized as the later. This immediately throws focus upon the explanation as to why the application is being made late

71. In the witness statement in support of the application Ms Sushila states that

> "Mr Jackowski introduced a great deal of factual evidence as to the various options and routes by which the Claimant could have got to hospital with consequences for the timing of surgery…I was taken by surprise because none of this had been pleaded in the defence and

had only been briefly addressed in the Mr Jackowski's served causation report dated October 2025."

72. However this explanation has the following difficulties.

73. Firstly it should always have been recognized that the Claimant had to make out her case on causation. It is difficult to see how the issue was overlooked given what the Claimant now says would have happened, the delay caused by the ambulance and what happened at the hospital as explained in the Trust's response to the letter before action. Alarm bells should have been ringing that this issue was not as straightforward as simply asserting that surgery would have taken place on the evening of 14th February. The Claimant was also put to proof on the issue within the defence i.e. no concessions were made.

74. Secondly Mr Jackowski made his views clear in his October 2025 report. Even if the issue was overlooked at an earlier stage then this report clearly required consideration of the timeline within the counterfactual.

75. Thirdly Mr Clarke's opinion could reasonably have been discovered by discussion of these matters had there been appropriate focus on the issue.

76. Reliance is also placed upon the Defendant's failure to plead a positive case. However this provides little excuse in the circumstances set out above. The burden of establishing causation in clinical negligence cases rests on the Claimant and up to the making of the application the Claimant had not sought to argue surgery would have taken place on the morning of 15th February 2020: her case had always been that the surgery would have been on the evening of 14th and that "it is unlikely that there would have been a decision to defer surgery until the following morning". The Defendant was reasonably entitled to respond to the case pleaded, and so there was no onus on the Defendant to address the factual causation issue of what would have happened if the decision had been taken to operate on the Claimant the morning of 15th February 2020. The Defendant was entitled not to incur the costs of investigating a case that was not pleaded.

77. In my opinion there is no good reason for the late application. The reality is that the issue of the likely timeline through to an operation was not properly analysed when it was appreciated that delay in operating was at the very heart of the case.

78. I turn next to the detail of the amendment. In my judgment it is not possible to say with certainty that the proposed amendment, to the extent that asserts a counterfactual, is bound to fail (i.e. does not have a real prospect of success). A more realistic assessment is that it has failed to address obvious issues leaving its prospects of success very uncertain. Whether in response to a request for further information or by reply to an amended defence if the proposed amendment is allowed the Claimant would have to deal with what she says would have happened at the hospital based on a likely arrival time in greater detail.

79. First she would have to deal with the issues of when she would have called NHS111/999. This is necessary because of the need (assuming that an ambulance was called and took her straight to Royal Sussex County Hospital, which would remain an issue as her symptoms had not deteriorated) to factor in the likely delay in the ambulance arriving. There would then have to be assessment of the delay in obtaining

and assessing an MRI and thereafter the likely evaluation of the degree of urgency (given what actually occurred at 5.45). The Claimant would also have to deal with what occurred in the morning of 15th February.

80. It appears to me that there is an element of a holding position in the proposed amendment. Indeed Mr De Bono KC conceded that the proposed amendment was "the best that could be done" at present.

81. That the proposed amendment is pregnant with obvious issues that have not yet been addressed is a matter which should properly be weighed into the assessment of whether permission should be granted as it effects the amount of work that will be required in the future and the strength of the new case, which impacts on the degree of injustice to the Claimant if the amendment is not allowed.

82. I should clarify that I attach little weight to the argument that the medical records which have been disclosed are (or would remain) inadmissible.

83. As Ms Hughes pointed out, no explanation has been forthcoming as to why they have taken this stance. The theatre records which confirm the reasons given by the Trust were disclosed on 4th March 2025 yet there was no challenge to their admissibility until 21st April 2026,

84. A more obvious point is that the extracts from the Claimant's own records; specifically the review by the neurosurgery registrar at 0545 who made a plan "For theatre this morning after d/w on call consultant" is pleaded at paragraph 14 of the Particulars of Claim. So the Claimant has relied on medical records (the records are also relied on for other factual assertions) which do not explain why she was not in operated on in the morning; an obvious lacuna.

85. In my judgment (to a degree leaning on long experience in this field) the reality is that it is highly likely that the records would have ended up admitted as evidence (through on route or another).

86. Faced with the issue of delay (actual and counterfactual) at the Royal Sussex County Hospital, Mr De Bono KC referred to the analysis of the Court of Appeal **in Wright v Cambridge Medical Group** [2011] EWCA Civ 669 per Lord Neuberger of Abbotsbury MR, para 61 of the judgment:

> "Accordingly, it seems to me that, in a case where a doctor has negligently failed to refer his patient to a hospital, and, as a consequence, she has lost the opportunity to be treated as she should have been by a hospital, the doctor cannot escape liability by establishing that the hospital would have negligently failed to treat the patient appropriately, even if he had promptly referred her. Even if the doctor established this, it would not enable him to escape liability, because by negligently failing to refer the patient promptly, he deprived her of the opportunity to be treated properly by the hospital, and, if they had not treated her properly that opportunity would be reflected by the fact that she would have been able to recover damages from them."

However this simply highlights the nature and extent of the unresolved issues thrown up by the proposed amendment. Any expert reviewing the fact that the Claimant was not operated on during the night or in the morning would have to consider all the relevant facts, and specifically the urgency of the other case and resources, before giving a view as to what had happened, or would in all likelihood have happened was negligent. All this against the backcloth that a delay of six hours or less would, in the view of the experts, not have materially altered the outcome.

87. The submission further highlights the need for the Claimant's case to address issues not yet addressed in the proposed amended pleading. The Defendant has not argued that prejudice may arise from the failure to be able to obtain evidence which could have been obtained at an earlier stage had the issue been pleaded; but the process has not even begun.

88. As I have set out the overriding objective is a central consideration when considering applications to amend. The aim of the Court must be to deal with cases justly and at proportionate cost.

89. There can be no doubt that allowing the amendment would mean that the claim was not dealt with expeditiously. Expedition is a matter that directly affects the party who faces the amended claim. Whilst at first blush trite to say that Justice delayed is justice denied there are a number of reasons why this may be so. Here the Defendant would be faced with exploring issues which could have been addressed years earlier and, as a broad generality, with the passing of time factual issues are more difficult to investigate and resolve. Also the likely delay would be significant. If the trial were to be relisted the first available slots would be in May 2027; another year and a trial more than six years after the event.

90. Grant of permission would also mean that the case is allocated more than an appropriate share of the Court's resources; it would receive 10 days of court time (assuming no need for any additional interim hearings).

91. The above factors weigh heavily against the grant of permission to amend at such a later stage; the Claimant already having a heavy burden.

92. What Mr De Bono KC relied upon to tip the scales in the Claimant's favour is that this is a large value claim where breach is admitted. If permission is not granted the claim will face obvious difficulty and that will result in very substantial injustice to the Claimant who will not be able to advance her case.

93. It is necessary to consider the proper weight to be attached to these factors within the balancing exercise.

94. In **Cobbold v. Greenwich London Borough Council** *(*unreported CA, 9 August 1999) a case referred to by Nicklin J in **Hewson v Tomes Newspapers Limited** [2019] EWHC 1000 (QB) Peter Gibson LJ stated that

> "The overriding objective of the CPR is that the court should deal with cases justly. That includes, so far as practicable, ensuring that each case is dealt with not only expeditiously but fairly. Amendments in general ought to be allowed so that the real dispute

> between the parties can be adjudicated upon, provided that any prejudice to the other party caused by the amendment can be compensated for in costs and the public interest in the administration of justice is not significantly harmed."

95. However as Carr J (as she then was) observed in **Quah**, where a very late application to amend is made the correct approach is not that the amendments ought, in general, to be allowed so that the real dispute between the parties can be adjudicated upon. Rather, a heavy burden lies on a party seeking a very late amendment to show the strength of the new case and why justice to him, his opponent and other court users requires him to be able to pursue it. The risk to a trial date may mean that the lateness of the application to amend will of itself cause the balance to be loaded heavily against the grant of permission.

96. Faced with an individual claimant who has allegedly suffered serious/significant injury, loss and damage it is tempting to revert to the analysis of Peter Gibson LJ. However this would not be the correct approach. If it were very many late amendments would be permitted despite the impacts on the other party, the Court and other Court users. That is not to say that some weight should not be attached to the need to allow the real dispute to be determined and also to avoid any secondary litigation arising from the failure to address the issue earlier. Such matters amount to injustice to the party applying for permission that require to be taken into account with all other relevant factors.

97. The degree of injustice to a Claimant requires some assessment of the strength of the case with the amendment allowed. Here for the reasons which I have set out in some detail the proposed amendment fails to address some obvious issues. Whilst I do not accept Ms Hughes's submission that, taken on its face, it is bound to fail, there is clear merit in her arguments as to the difficulties faced. The amendment is no more than the best that can be done at present, and much would remain to be done. The strength of the case is uncertain and, in some respects, the proposed amendment is no more than a holding position.

98. Given the burden on the Claimant and the weight of factors in favour of refusing permission it is my judgment that injustice to the Claimant on the basis of the proposed amendment does not redress the balance. Accordingly, I must refuse permission of the amendment.