Neutral Citation Number: [2026] EWHC 1534 (KB)

Case No: KA-2025-BHM-000015

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
BIRMINGHAM DISTRICT REGISTRY

Birmingham Civil Justice Centre
Priory Courts, 33 Bull Street
Birmingham B4 6DS

Date: 23/06/2026

Before :

MR JUSTICE SOOLE

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Between :

KERRY LUCAS	**Claimant/ Respondent**
- and -	
(1) DR OSITA ORANUGO **(2) GREYFRIARS SURGERY**	**Defendants/ Appellants**

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Mr Matthew Barnes (instructed by CMS Cameron McKenna Nabarro Olswang LLP and Browne Jacobson LLP) for the **Appellants**

Ms Francesca Martin (instructed by Harris Fowler Solicitors) for the **Respondent**

Hearing date: 13 May 2026

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Approved Judgment

This judgment was handed down remotely at 10.30am on Tuesday 23 June 2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MR JUSTICE SOOLE

1. This is an appeal by the First Defendant GP and the Second Defendant medical practice in which he was a partner against the decision of Mr Recorder Neville dated 20 February 2025 which dismissed their respective applications dated 25 October 2024 and 10 October 2024 to set aside the judgment in default entered against each of them on 25 October 2023 and for relief from sanctions. The Appellant Defendants (hereafter 'Dr Oranugo' and 'the Surgery') in particular contend that the Recorder was wrong to conclude that their respective defences had no real prospects of success.

2. By this action, Ms Kerry Lucas alleges clinical negligence by Dr Oranugo for which it is alleged the Surgery is also liable. The claim was commenced by a Claim Form issued on 19 May 2022 and elaborated by Particulars of Claim dated 15 May 2023.

3. As appears from the Particulars of Claim, the claim is centred on the allegation that when Ms Lucas attended Dr Oranugo for an appointment on 31 March 2017 in connection with an episode of numbness to the left side of her face, he failed to offer her a neurology referral. It is alleged that she would have accepted that offer; that if she had done so her condition of multiple sclerosis would have been detected well before the eventual diagnosis on 20 May 2019; and that with appropriate treatment her condition would be much better than it has become. The particulars of injury and the supporting report of Dr Louis Loizou set out the details of her very serious and disabling condition and prognosis.

4. The particulars of negligence are confined to one allegation in respect of each Defendant, namely failing by Dr Oranugo to refer Ms Lucas for a neurology opinion on 31 March 2017. Thus the Surgery's defence stands or falls with that of Dr Oranugo.

5. Judgment in default of any Acknowledgement of Service or Defence was the result of serious administrative failures by the Surgery and in particular through its then Practice Manager. In his judgment, the Recorder at paragraphs [8]-[12] summarises the story of these failures. Ms Lucas instructed her solicitors in May 2021. Despite repeated chasing correspondence and telephone calls, it took more than six months to obtain her GP records from the defendants. They were finally obtained after notice of intention to apply for pre-action disclosure. With the impending expiry of the relevant limitation period, requests for an agreement to extend time were ignored. In consequence the Claim Form was issued on a protective basis. Orders were obtained from the court for extension of time for service of the Particulars of Claim, Schedule of Loss and expert report (condition and prognosis); and those documents were served on 19 May 2023. During all this time nothing had been heard from either Defendant, notwithstanding numerous letters and telephone calls to the Surgery. Ms Lucas' solicitors sent individual recorded delivery letters to the partners, including Dr Oranugo**.**

6. In consequence, judgment in default of Acknowledgement of Service was requested on 22 June 2023 and entered by the court on 25 October 2023. A number of procedural steps followed, but it was not until 10 October 2024 that the Surgery made an application to set aside the judgment and grant relief from sanctions. This was followed by Dr Oranugo's like application dated 25 October 2024.

7. The explanation for this was set out in a witness statement from the Deputy Manager of the Surgery, Ms Sharon Tainton. This stated that all incoming correspondence to the

practice was at that time handled by the Practice Manager, who would pass them to the partners of the practice as appropriate. That was never done. It was not known why, because the Practice Manager had gone off sick on 16 September 2024 and no further investigation had been possible.

8. Following that departure, Ms Tainton opened the post on 19 September 2024 to find the notice from the Court of an adjourned hearing. She passed it to Dr Oranugo who immediately contacted his insurers, namely the Medical Defence Union and wrote a response. A search of the Practice Manager's office and desk revealed further unactioned documents.

9. Dr Oranugo's witness statement dated 11 November 2024 states that he first became aware of the claim on 19 September 2024. Prior to that date he had no knowledge that a claim had been submitted against him or against the Surgery. He was also unaware that a prior request for records had been received or any records disclosed. He states that records' requests and legal claims were handled by the Practice Manager. Anything mentioning a legal claim was directed to her. Correspondence was not automatically scanned onto a patient's record unless the Practice Manager processed and specifically requested this. The usual system for dealing with legal claims was for the Practice Manager to bring them to the attention of the partners at their daily meeting. He did not know why this claim had been brought to their attention. He stated that the Surgery had implemented a new system for dealing with claims, involving himself, another partner and the deputy manager. He apologised for the delay in the response to the claim.

The law

10. The relevant law on applications to set aside regular judgments was not in dispute before the Recorder. As clarified by the Court of Appeal in FXF v English Karate Federation Ltd [2024] 1 WLR 1097; [2023] EWCA Civ 891, the court must first consider the merits test as set out in CPR 13.3(1)(a) and (b), namely whether '*(a) the defendant has a real prospect of successfully defending the claim; or (b) it appears to the court that there is some other good reason why – (i) the judgment should be set aside or varied; or (ii) the defendant should be allowed to defend the claim.'*

11. If and only if satisfied on that threshold requirement, the court must next consider the issue of promptness in accordance with CPR 13.3(2). This provides that *'in considering whether to set aside or vary a judgment entered under Part 12, the matters to which the court must have regard include whether the person seeking to set aside the judgment made an application to do so promptly'*. In Standard Bank PLC v. Agrinvest International Inc [2010] EWCA Civ 1400 at [22] the Court of Appeal observed of this sub-rule: '*No other factor is specifically identified for consideration, which suggests that promptness now carries much greater weight than before. It is not a condition that must be satisfied before the court can grant relief, because other factors may carry sufficient weight to persuade the court that relief should be granted, even though the application was not made promptly. The strength of the defence may well be one. However, promptness will always be a factor of considerable significance…and if there has been a marked failure to make the application promptly, the court may well be justified in refusing relief, notwithstanding the possibility that the defendant might succeed at trial.'*

12. Finally, the court must consider the three-stage Denton questions in respect of an application for relief from sanctions pursuant to CPR 3.9, namely whether the breach was serious or significant; whether there was good reason for the breach; and all the circumstances of the case.

13. It was also common ground that the test for a real prospect of successfully defending the claim was the same as in respect of a claimant's application for summary judgment under CPR Part 24, save that under CPR 13.3(1) the burden was on the defendant to satisfy the court that there is good reason why a judgment regularly obtained should be set aside: ED&F Man Liquid Products Ltd v. Patel [2003] EWCA Civ 472 at [7]. At [9] the Court observed: '*…although the burden of proof is in practice of only marginal importance in relation to the assessment of evidence, it seems almost inevitable that, in particular cases, a defendant applying under CPR 13.3(1) may encounter a court less receptive to applying the test in his favour than if he were a defendant advancing a timely ground of resistance to summary judgment under CPR 24.2.*'

14. The parties also relied on the well-known guidelines for summary judgment applications set out in Easyair Limited v. Opal Telecom Ltd [2009] EWHC 339 (Ch). In the hearing there was particular focus on the principles that to have a real prospect of success a claim or defence has to carry some degree of conviction and must be more than merely arguable; that in reaching its conclusion the court must not conduct a 'mini-trial'; that this does not mean that the court must take at face value and without analysis everything that the relevant party says in his statements before the court. In some cases it may be clear that there is no real substance in factual assertions made; but in reaching its conclusion the court must take into account not only the evidence actually placed before it but also the evidence that can reasonably be expected to be available at trial. Further the court should hesitate about making a final decision without a trial, even where there is no obvious conflict of fact at the time of the application, where reasonable grounds exist for believing that a full investigation into the facts of the case would add to or alter the evidence available to a trial judge and so affect the outcome of the case.

15. It was also of course common ground that the substantive legal test for a claim of a clinical negligence was as set out in Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582 as elaborated by the House of Lords in Bolitho v. City and Hackney Health Authority [1998] AC 232. Familiar as they are, those passages deserve repetition. In Bolam McNair J directed the jury that a doctor or any other person professing some skill or competence '*…is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art… Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view'*: p.587 In Bolitho, the House of Lords emphasised the words 'responsible body of medical men' and references in later cases to a 'reasonable body of opinion' and to a 'respectable body of professional opinion.' These adjectives showed that the court had to be satisfied '*…that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis.*': p.242A. Thus '*…if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.*': p.243C. However, *'I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views*

genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed': p.243C-E.

The evidence

16. The Particulars of Claim states that Ms Lucas presented to Dr Oranugo on 31 March 2017 with ongoing numbness of her face with reduced sensation around the mandibular branch of the trigeminal nerve. This occasion followed Ms Lucas' attendance on the Surgery's practice nurse on 27 March when Ms Lucas gave an 8-day history of numbness to the right side of her face. There was no evidence of a facial droop and it was not painful. The nurse had discussed the case with Dr Oranugo who advised treatment with Amitriptyline and to wait an appointment for endoscopy.

17. Dr Oranugo's note of the appointment on 31 March recorded ongoing problems with numbness of her face, *'not getting worse*.' The diagnosis stated '*Numbness of face*'. The plan was identified as continuation of the low-dose Amitryptiline. The note then states '*Advised to return if symptoms worsen, consider treatment with oral steroids.'*

18. In the usual way the Particulars of Claim had been accompanied by an expert report on condition and prognosis, i.e. the report of Dr Loizou. Within its exhibits, the report appended 'Further Comments' from an expert GP, Dr Kearsley. These are set out in four numbered paragraphs starting at '51'. Paragraphs 51 and 52 read: '*51. It is unusual for a patient to present with obvious neuropathy in the form of objective loss of sensation like this. A competent GP would have thought that this was unusual, and a competent GP would not have known the cause. They would have offered referral to a neurologist to establish the diagnosis and cause of neuropathy. This could have been related to diabetes or some other type of neurological problem, including multiple sclerosis. 52. It is recognised in standard medical literature that multiple sclerosis should be diagnosed early if possible.*' Paragraphs 53 and 54 state that it was a matter of evidence whether that offer would have been accepted; and that the effect of earlier referral was a matter for a neurologist.

19. The Appellants' application was supported by the GP expert report of Dr Ian Isaac dated November 2024. This concluded with the opinion that Dr Oranugo's standard of care had been of the standard expected of a reasonably competent General Practitioner: para.3.1. The opinion referred first to the attendance on the practice nurse on 27 March. Dr Isaac then referred to the appointment on 31 March when Ms Lucas presented with the ongoing problems with facial numbness, but which was not getting worse. The report described the three branches of the trigeminal nerve.

20. Dr Isaac noted the absence of history of pain or rash or evidence of facial droop. He stated, that with this presentation, more common conditions to be considered included Bell's palsy. However there was no evidence of facial muscle weakness and no other symptoms, apart from numbness or tingling of the cheek, to suggest Bell's palsy.

Further, since the numbness was in the specific distribution of the trigeminal nerve, this would then 'move away' from such a diagnosis.

21. Dr Isaac then noted that Ms Lucas had type II diabetes; and that these can cause neuropathies, although usually peripheral and commonly in the feet and hands. He then noted that some patients can experience facial numbness prior to pain or rash, as a precursor for shingles. However with an 8-day history this became a less likely diagnosis to consider.

22. In respect of the appointment on 31 March Dr Isaac then concluded: '*General Practitioners frequently encounter symptoms which do not always have an obvious diagnosis. In this situation with odd symptoms patients can be monitored and return. Dr Oranugo reasonably advised the Claimant to return if her symptoms persisted or deteriorated. This episode of facial numbness settled.'*: para.8.12.

23. Dr Isaac noted that at a later appointment (4 May 2017) Dr Oranugo had referred Ms Lucas for a rheumatological opinion in view of generalised joint pain and abdominal pain; and that in the referral letter he had recorded an episode of numbness in the right side of her face which had spontaneously resolved.

24. Dr Isaac continued that Dr Oranugo had reasonably monitored the claimant. Further, his management was '*…consistent with reasonable and responsible practice. I consider that it was reasonable to not refer to a neurologist for an isolated episode. It is my opinion that many other reasonable General Practitioners would not have referred to a Neurologist with this presentation'*: para. 8.18.

25. Dr Isaac noted the comments of Dr Kearsley as attached to the condition and prognosis report. In response he stated that it was reasonable to monitor and then consider a referral. Dr Oranugo did monitor and then in view of her widespread pain referred her to a consultant rheumatologist. The rheumatologist in turn did not refer Ms Lucas to a neurologist.

26. Dr Isaac stated that, with the benefit of hindsight, an isolated episode of facial numbness could have been an initial presentation for multiple sclerosis: para. 8.22. However Ms Lucas did not present with any other symptoms at that stage. It was reasonable not to refer her to a neurologist at that stage.

27. Dr Isaac's report also exhibited a section of - or related to - the National Institute for Health and Care Excellence (NICE) guideline, published 22 June 2022 (revised May 2024). The guideline is entitled 'Multiple sclerosis in adults: management'. The section is headed 'When should I expect that a person has multiple sclerosis'.

28. Dr Kearsley responded to Dr Isaac's opinion by a report headed 'Clinical negligence addendum report'. This ends 'I have no reason to change my previously stated opinion in this case'. The only disclosed previous opinion is that apparent extract appended to the condition and prognosis report of Dr Loizou.

29. Dr Kearsley criticises Dr Isaac in the following particular ways. First, as to the list of references in his report. These include trigeminal neuralgia, a painful condition. Ms Lucas did not have pain. Then Dr Isaac's reference to 'www.patient.co.uk' dealt with multiple sclerosis. Under a heading of diagnosis, this said there is no single specific

diagnostic test and the diagnosis can be made clinically by a consultant neurologist in most people. As to when a GP should suspect multiple sclerosis, it identified the NICE guideline for primary care. Consistently with Ms Lucas' case, it said that patients may have symptoms that evolve over more than 24 hours, may persist and then improve; and that it can affect nearly any part of the central nervous system; and that presenting symptoms and signs can vary greatly. Further, it states that people suspected of having multiple sclerosis should be referred for diagnosis by a consultant neurologist or a specialist under supervision: para. 11.5. Dr Isaac had not exhibited that part of the NICE guideline.

30. As to other potential diagnoses, the presentation was not of Bell's palsy. Shingles was very unlikely.

31. As to monitoring, there was a record of the patient being advised to return if the symptoms deteriorated. However, there was no such record of advice to return if the symptoms persisted. It was wrong to say that Dr Oranugo had reasonably monitored Ms Lucas. At the consultation on 31 March, he wrote nothing about follow-up and did not monitor. It was illogical to monitor the episode, given that the guidance provides that numbness can persist and then improve – as happened in this case.

32. It was the history of the symptoms and the objective sensory loss, with no alternative credible explanation, which mandated referral. The episode of facial numbness was typical of multiple sclerosis. A competent GP would have offered neurology referral because of the symptoms of isolated facial numbness. It was widely recognised in standard medical literature that early diagnosis of multiple sclerosis was important. This was an unusual diagnosis, but there was objective loss of sensation.

33. As to rheumatology, referral to such a specialist would not be expected to deal with a neurological presentation that had spontaneously resolved. It was no defence to the failure to refer to a neurologist.

34. Prescription of a low dose tricyclic antidepressant was not a treatment for facial numbness and the GP did not know the cause. Dr Oranugo's diagnosis of 'numbness of the face' was not a diagnosis but no more an assessment of the problem.

The judgment

35. The Recorder agreed with the submissions on behalf of Ms Lucas that Dr Isaac's report was lacking in any real detail and that the references to Bell's palsy, type II diabetes and shingles took the matter no further.

36. As to Dr Isaac's disagreement with Dr Kearsley's opinion, Dr Isaac did not substantiate his opinion. He provided no real principled objection as to why the presenting symptoms should not have been considered to be unusual. He did not address why a referral should not be made even if the underlying cause was thought to be diabetes. It was not clear from his report how the NICE guideline had informed Dr Isaac's opinion. Further his appended citation from NICE did not include its recommendation to GPs that a patient presenting with relevant symptoms should be referred to a neurologist.

37. Counsel for Dr Oranugo had advanced three responses to these criticisms. First, that the NICE guidelines were no more than that and did not establish liability in themselves.

Secondly, that they post-dated the examination in March 2017, so could not provide real assistance. Thirdly, that they referred to 'symptoms and signs' in the plural, whereas this was just one symptom. As appears below, Counsel for the Appellants, Mr Matthew Barnes, submits that this was an incorrect summary of his third point.

38. The Recorder rejected all three points. The burden of establishing a real prospect of success was on the Defendants. If the guideline did not apply at the time, that further undermined Dr Isaac's opinion. In any event it was not clear from his report how and to what extent he had taken the guideline into account.

39. By contrast, Dr Kearsley gave clear and comprehensible reasons as to why diagnosis of other conditions was unlikely; and why, as a matter of general clinical practice, watching and waiting was not the appropriate response. Dr Isaac's report contained nothing that substantively countered those core points.

40. Conversely, Dr Kearsley's report was validly corroborated by the NICE guideline. Whether or not it applied at the relevant time, the guideline provided corroboration for what a proper clinical response would have been. It would have been open to the Defendants to adduce evidence that accepted clinical practice differed at the relevant time.

41. Dr Isaac presented no reasoned basis for his assertion (para.8.12) that with symptoms which did not have an 'obvious' diagnosis, a reasonable response was to advise the patient to return if the symptoms persisted or deteriorated; nor for why an 'obvious' diagnosis was necessary in order to make a referral, given the nature of the condition and the importance of prompt investigation.

42. As to the phrase 'signs and symptoms', the guidance should not be construed as if it were a contract or a statute. In any event the plural did not as a matter of ordinary language exclude the singular.

43. The Recorder concluded that this was not a case of 'expert versus expert', whose opinions require testing at trial. Taken at its highest, '*Dr Isaac's report might show that a barely arguable quarrel* could *be had at the edges of the claimant's case on liability*'. That fell well short of properly setting out that quarrel itself; and came nowhere near establishing a reasonable prospect of successfully defending the claim.

44. The Recorder was also satisfied that there was no good reason within the meaning of CPR 13.3(1)(b) for the judgment to be set aside.

45. Accordingly, the applications each failed to satisfy the threshold merits test. However, the Recorder also went on to consider the Denton 3-stage test, albeit not the prior question of whether the applications had been made 'promptly'.

46. The Recorder concluded that the relevant breach was 'obviously serious', for which there was no good explanation. As to the third stage, Ms Lucas would be substantially more prejudiced than the Defendants by the granting of relief from sanctions. For a considerable time she had had the knowledge of a judgment on liability to which she was properly entitled. By contrast, a doctor must make arrangements for his practice to be properly run and must bear the consequences of a failure to do so. The argument that there was a professional stigma from the judgment ignored the fact that it was a

judgment in default of acknowledgement of service. There have been no judicially reasoned and conclusive finding that Dr Oranugo was to blame. If the liability of the Surgery were met by the public purse through the NHS, that was not a relevant factor. A public authority could not be in a better position than a private litigant.

The appeal submissions

47. Mr Barnes submits that in concluding that there was no real prospect of a successful defence, the Recorder fell into error in three ways. First, by conducting what amounted to a mini-trial. Secondly, by failing to apply the appropriate Bolam/Bolitho test. Thirdly, in reaching a conclusion on the medical evidence which fell outside the ambit of his overall discretion. As to the latter, he accepted in argument that the question of whether the defence had real prospects of success was a matter of judicial evaluation, not the exercise of discretion.

Mini-trial

48. In criticising the report of Dr Isaac and comparing it unfavourably with the report of Dr Kearsley, the Recorder had in substance conducted a mini-trial on matters which could only properly be investigated in the course of a trial. In a clinical negligence case the evidence reasonably to be expected to be available at trial (Easyair, points (v) and (vi)) would include disclosure of all medical records; the preparation by each party of expert reports on liability issues; meetings between experts; and preparation of joint statements. As observed by Foskett J in Hewes v. West Hertfordshire Hospitals NHS Trust [2018] EWHC 2715 (QB) at [45], when allowing an appeal against an order for summary judgment in a clinical negligence case: '*…there will be few cases…where such an application could ordinarily be contemplated before the relevant experts' reports have been exchanged and, in most cases, until after the experts have discussed the case and produced a joint statement. Experts do from time to time change their views in the light of discussions with their counterparts and, whilst it is not to be encouraged and is ordinarily unsuccessful, there are occasions when a party will make a credible application to substitute another expert at some stage. This means that the task of considering, on a summary judgment application, evidence "which can reasonably be expected to be available at trial and the lack of it"…is one that needs to be undertaken with caution.*'

49. In this case, the Particulars of Claim were terse, containing one allegation of negligence namely '*The First Defendant was negligent on 31st March 2017 in that he did not offer the Claimant a neurology referral.*' When making their application, the Defendants did not have the benefit of sight of an expert report in support of this allegation. All they had was Dr Kearsley's brief comments appended to the condition and prognosis report. This provided very little for Dr Isaac to work with.

50. Turning to Dr Isaac's report, this identified other potential explanations for Ms Lucas' symptoms of facial numbness; and did not exclude these. Mr Barnes then pointed to para. 8.12 where Dr Isaac observed that '*General Practitioners frequently encounter symptoms which do not always have an obvious diagnosis. In this situation with odd symptoms patients can be monitored and return. Dr Oranugo reasonably advised the Claimant to return if her symptoms persisted or deteriorated. This episode of facial numbness settled.'* Mr Barnes acknowledged that the GP notes did not show advice to return if symptoms persisted, rather than deteriorated.

51. Mr Barnes then pointed to para. 8.18: *'In my opinion, Dr Oranugo's management is consistent with reasonable and responsible practice. I consider that it was reasonable to not refer to a Neurologist for an isolated episode. It is my opinion that many other responsible General Practitioners would not have referred to a Neurologist with this presentation.*'; and para. 8.22: '*An isolated episode of facial numbness with the benefit of hindsight could have been an initial presentation for multiple sclerosis. She did not present with any other symptoms at this stage. I consider that it was reasonable to not refer the Claimant to a Neurologist at this stage.*' Mr Barnes emphasised the reference to 'the benefit of hindsight'. Whilst these observations were made under the report's heading for 20 July 2017, he submitted that they must also apply to the consultation on 31 March 2017.

52. In reaching his opinion of Dr Isaac took due account of the Bolam/Bolitho test: see para. 8.18, cited above, also para. 3.1 and 9.1.

53. As to Dr Isaac's list of references, this included the topic section of the NICE guideline, as noted above. It did not include the NICE topic section headed 'How should I confirm a diagnosis of multiple sclerosis'. However Dr Isaac did not identify the NICE guideline as dictating the appropriate management in this case. His report was not misusing the guideline.

54. By contrast, Dr Kearsley's 'addendum' report did rely on the NICE guideline in support of his opinion; and for that purpose exhibited that further topic section. Such reliance was problematic, because the NICE guideline was published in June 2022 and last revised in May 2024; thus post-dating the events of 2017. Further, in the course of the appeal hearing, Ms Martin had informed the Court that Dr Kearsley's researches had not found any relevant guideline to have existed in 2017. This all provided material for robust cross-examination at trial.

55. In any event, even if applicable, the NICE guideline did not support Dr Kearsley's opinion. The topic section which he relied on began: '*If a person has symptoms and signs…suggestive of multiple sclerosis…Refer promptly to a consultant neurologist – early diagnosis and treatment may improve prognosis.*' Thus, before any such referral, the GP had first to make a judgment as to whether the symptoms and signs were suggestive of multiple sclerosis. Dr Kearsley's addendum report then set out a list of 12 'symptoms and signs', derived from a source ('www.patient.co.uk') within Dr Isaac's list of references; one of which was 'paraesthesiae and numbness'. In this case the only symptom was numbness.

56. The Recorder had been wrong summarily to conclude that the NICE guideline undermined Dr Isaac's opinion and corroborated that of Dr Kearsley. The Recorder had stated:

> *'28. If Dr Isaac's opinion is informed by NICE guidelines that did not apply at the relevant time then his opinion is undermined. In any event, it is not clear from his report what he made of those guidelines, and nor does he identify an alternative source for his opinion. Rather than supporting the first defendant's case on what a competent physician would do in response to the claimant's symptoms, Mr Barnes' arguments instead establish further deficiency in Dr Isaac's report.*

> *....30. Dr Kearsley's report is validly, in my opinion, corroborated by the NICE guidelines, whether they applied at the relevant time or not, simply as providing corroboration for what a proper clinical response would have been. As argued by Ms Martin, they cut well against the notion of watching and waiting and instead emphasise the importance of referral without delay. It would have been open to the defendants to adduce evidence that accepted clinical practice differed at the relevant time, and indeed such evidence would be highly likely to be at the heart of the defence to the claim that had a real prospect of success.*
>
> *...32. The point on the phrase "signs and symptoms" in the guidelines being plural rather than singular impermissibly seeks to construe NICE guidelines as if they are a contract or a piece of legislation. The use of the plural does not as a matter of ordinary language exclude the singular. Moreover, if the authors had intended for, say, "two or more of the relevant symptoms" to be the threshold for referral then that is what would have been written.'*

57. As to the reasoning in [28] and [30], the reality was that Dr Kearsley, not Dr Isaac, was basing his opinion on the NICE guideline; and was wrong to do so. That was now further emphasised by the revelation that Dr Kearsley had sought, but not found, any relevant guideline to be extant in 2017.

58. As to the reasoning at [32], this was based on a misunderstanding of Mr Barnes' submission, which was misrecorded at [27]. His central proposition had been that the NICE guideline, if applicable, required the GP first to make a judgment as to whether there were symptoms and signs suggestive of multiple sclerosis. His submission was that, in circumstances where only one of the possible signs and symptoms (numbness) was present, there was no basis to conclude – and certainly not summarily – that Dr Oranugo's judgment had been negligent. This was an issue to be tried.

59. The Recorder was likewise wrong to conclude, in respect of Dr Isaac's opinion at para.8.12, that he '*...presents no reasoned basis for the assertion that this was an appropriate response in this particular case, nor for why an "obvious" diagnosis would be necessary for a competent physician to make a referral, given the nature of the condition and the importance of prompt investigation.*': [31]; see also his like criticisms at [23]-[25].

60. By the very process of comparing the rival expert reports, the Recorder had conducted a mini-trial. He had done so when disclosure was incomplete; full expert reports had not been prepared; and no joint meetings had taken place or joint statements produced. Further, neither party had found any authority for the grant of summary judgment in a case of dispute between the rival experts.

Bolam/Bolitho

61. The Recorder had not set out the Bolam/Bolitho test nor otherwise dealt with the question of whether Dr Oranugo had acted in accordance with a reasonable body of

opinion. Rather, he used the language of what he 'should' have done or what was 'appropriate': see e.g. [25], [29], [31].

Evaluation of the expert evidence

62. Mr Barnes' submissions on this ground reflected those which he had deployed on the 'mini-trial' ground. Dr Isaac was a reputable and experienced expert witness. There was no reason to doubt his relevant experience or his approach. On any view he had presented an opinion which was reasonable on its face. The Recorder was wrong to reject that opinion summarily.

63. The Recorder should also have taken into account that the report had been provided quickly, in response to the terse allegation of negligence and without all the various steps which would otherwise take place before a final report was served. Dr Isaac's report should have been considered as sufficient for the purpose of establishing that there was a real prospect of success in the defence: see also Hewes at [47].

Promptness

64. The Recorder did not deal with this issue. I interpose that the parties sensibly agreed that I should do so, whatever my decision on the threshold question. For that purpose Counsel supplied, at my request, further written submissions on the question of when time starts to run for the purpose of considering whether the application was made promptly.

65. Mr Barnes accepted that the period of delay between the entering of judgment and Dr Oranugo's first actual knowledge of the claim (19 September 2024) could not be excluded from the consideration of whether his application had been made 'promptly'. This reflected Mullock v. Price [2009] EWCA Civ 1222 where the Court of Appeal stated at [22] and [23]: '*It seems to me wrong that a party should shield behind his representatives…for two reasons. First, the language of CPR 13.3 is explicit: it requires "the person seeking to set aside the judgment" to make the application promptly. So it focuses on that person's action. Secondly, the Civil Procedure Rule in fact imposes duties on the parties to the litigation, and it seems to me that must mean the parties themselves irrespective of the help and advice they are or are not receiving. Their duty under CPR 1.3 is this: "The parties are required to help the Court to further the overriding objective". One of those objectives is of course to ensure that the case is dealt with expeditiously, and I am therefore quite satisfied that it was the duty of Mr Price, a personal duty, to ensure that the case was dealt with expeditiously and in the particular circumstances of this case to act promptly to set aside any judgment entered in default of his having put in his appearance.*' The Court went on to observe that it was '*beyond question that the defendant knew that judgment had been entered against him*' [24]. The defendant having delayed for two years in making the application to set aside judgment, the application was refused.

66. Whilst accepting the broad principle which that case establishes, Mr Barnes submits that there is a marked difference between a case of reliance on a legal representative or insurer and the present case of reliance on an employee to deal with administrative matters including legal claims. Further he points to the fact that in Mullock, unlike the

present case, the individual defendant knew from the outset that judgment had been entered against him.

67. Next, Mr Barnes emphasises that applying promptly is not itself a threshold condition. Rather it is one of the matters to which the Court must have regard: see the language of CPR 13.3(2) and the decisions in e.g. Agrinvest and FXF. This contrasts with the language of CPR 39.3 where acting promptly is one of the conditions for grant of the application.

68. Next, albeit in the context of CPR 39.3, he cites Court of Appeal authority that 'acting promptly' (i) requires '*…not that an applicant has been guilty of no needless delay whatever, but rather that he has acted with all reasonable celerity in the circumstances*' (Regency Rolls Ltd v. Carnall [2000] 10 WLUK at [45]) and (ii) is '*very fact sensitive'* (Bank of Scotland v. Pereira [2011] 1 WLR 2391 at [26]). I add that in Khan v. Edgbaston Holdings [2007] EWHC 2444 (QB), HHJ Coulson QC (as he then was) applied Regency Rolls to applications under CPR 13.3.

69. Next, Mr Barnes notes observations in Mullock, in respect of the weight to be given to the failure in that case to act promptly, e.g. per Sedley LJ at [30] that '*It is quite understandable that the defendant will have thought that his insurers were taking care of the claim…That is in my judgment enough to take the sting out of the defendant's lack of promptness.*' That said, in circumstances where the defendant had known of the judgment and the delay had been two years, the application to set aside was refused.

70. In the light of these authorities, Mr Barnes does not contend that the Defendants acted promptly in respect of the period from the valid service of the default judgment until 19 September 2024. However he submits that this failure should be given little weight. First, because of the circumstances in which that delay occurred. The Defendants had put in place a system whereby they employed a practice manager to deal with administrative matters including legal claims and to keep the partners notified; and they were not aware that the system had failed. Secondly, because there would have been a substantial delay in any event. The Court made an order on 14 February 2024 which allocated the claim to the Fast Track and the application to set this aside was not concluded until 14 November 2024. In respect of the period after 19 September 2024, the Defendants had acted promptly.

Denton

71. Mr Barnes submits that the Recorder's evaluation of the Denton three-stage test had taken no account of the necessary hypothetical finding that the Defendants had established a real prospect of a successful defence and its consequences. That was a significant factor when considering the third stage of 'all the circumstances of the case'. Having failed to take that into account, the exercise of discretion was flawed. In consequence this appellate court must exercise the discretion afresh.

72. Mr Barnes duly accepted that the original breach was serious and significant; and that there was no good explanation for the default.

73. As to the third stage, he did not pursue the submission made below in respect of public money. The circumstances of the case included the delay for which Ms Lucas was responsible. Three years elapsed between a diagnosis of multiple sclerosis in May 2019

and the issue of the claim. In the intervening period there had not been a letter of claim or compliance with the pre-action protocol. The Particulars of Claim were then not served until May 2023. Those four years had to be set against the one-year delay for which the Defendants were responsible. Then, within that latter period, there was independent delay because of the time taken by the court to deal with the application to set aside the allocation of the matter to the Fast Track.

74. Mr Barnes acknowledged the evidence in the witness statement of Ms Lucas' solicitor that the delay in responding to the claim had caused Ms Lucas significant psychological distress to a Claimant with very significant disabilities. As to the prejudice from loss of a judgment in default, he submitted that that would simply put Ms Lucas back in the position which every claimant faces.

75. Conversely, a refusal to set aside judgment would involve very substantial prejudice. It was a marker of the importance which the Defendants attached to defending the claim that they had acted very promptly once they discovered what had happened. Contrary to the Recorder's observations on stigma of the judgment, it was very unlikely that members of the public would appreciate the difference between a judgment in default and a judgment on the merits. When the balance was weighed, it should favour the setting aside of the judgment so that the merits of the claim could be determined at full trial.

Ms Lucas' response

76. On behalf of Ms Lucas, Ms Francesca Martin submits that the Recorder was right to refuse the applications for the reasons he gave.

77. In finding that there was no real prospect of a successful defence, the Recorder had not conducted a mini-trial. On the contrary he had taken proper account of the EasyAir principles which included that the court must not take at face value everything that a party had stated; and that a real prospect of success requires merits which are more than merely arguable. The Recorder had properly scrutinised the evidence of the rival experts.

78. In his application of the relevant law, the Recorder had taken appropriate account of the Bolam/Bolitho principle that a responsible, reasonable and respectable body of contrary opinion must have a logical basis. As the Recorder had set out and explained in his judgment, the evidence of Dr Isaac failed that requirement. Dr Isaac accepted that Ms Lucas had presented with one of the potential symptoms of multiple sclerosis: para. 8.22. That paragraph supported the case that an 'isolated episode' of facial numbness could have been an initial presentation for multiple sclerosis. Ms Martin acknowledged that the list of 'symptoms and signs' from the source referred to by both experts (bundle p.424) did not expressly refer to isolated episodes. However Dr Kearsley stated in his addendum report (para.21) that '*This episode of facial numbness did settle but this was typical of multiple sclerosis.*' That was an isolated episode which mandated referral. It made no sense to watch and wait. Dr Kearsley's evidence was that it was illogical not to refer in the face of the presenting symptom of numbness and when the guidance was not to delay. Dr Oranugo should have concluded that the presenting symptoms were suggestive of multiple sclerosis.

79. In appending the NICE pages Dr Isaac had failed to include the critical part of the guideline which unequivocally mandated referral to a consultant neurologist in such circumstances. Ms Martin made clear that it was not being alleged that this was a deliberate omission.

80. In this application under CPR 13.3 the burden was on the Defendants to show that on 31 March 2017 it was not mandatory to refer the patient to a consultant neurologist. The Recorder was right to conclude that Dr Isaac had provided no reasoned or logical basis to discharge that burden.

Promptness

81. Ms Martin pointed first to Gentry v. Miller [2016] EWCA Civ 141 where in respect of an application under CPR 13.3 and the issue of promptness, the Court stated at [33] '*The first question is…when the insurer either actually received the default judgment in question, or had or could with reasonable diligence have obtained a sufficient knowledge of it to enable it to apply to the court to set it aside. As both counsel accepted, a person cannot be criticised for failing to make an effective application to set aside before that stage is reached.*' However that was in a context where a copy of the default judgment '*was not immediately served on the insurer as it should have been'* [ibid.].

82. In the present case, there was no dispute that the Defendants had been validly served with the default judgment. Accordingly that was when time started to run on the issue of promptness. In any event, if it were necessary to consider reasonable diligence, the Defendants had failed to provide any adequate explanation for what had happened. The evidence about the Practice Manager was very limited. It did not explain what the system was for dealing with pre-litigation and litigation correspondence; nor whether her sickness had any part to play in the matter; nor why there have been persistent non-engagement with telephone and written communication for a period of more than three years commencing in June 2021. The witness statement of Ms Lucas's solicitor exhibited print-outs from the medical records which referred to letters and requests for information from Harris Fowler in June 2021, 26 and 27 June 2023 and 29 April 2024 which were 'placed in insurance tray'. This appeared to involve several employees, not just the Practice Manager. Further, the Defendants had failed to explain why Dr Oranugo and every partner served with the judgment had failed to take action in respect of the claim. Copies of the judgment had not been found in the Practice Manager's office, which was consistent with partners having opened their post personally. The default was not just of one employee.

83. The importance of providing evidence and explanation of procedures for dealing with post and other communications was noted in the authorities, including Gentry where the Court observed at [31] that the insurer had '*…failed to provide any evidence of the procedures that it adopts in dealing with its post or give any reason why the numerous letters sent to it…might have failed to reach its file.*'

84. As to the Denton test, by a Respondent's Notice Ms Martin submits that there were additional grounds for upholding the Recorder's decision. If the Defendants had demonstrated a defence with a real prospect of success, the Recorder should nonetheless have held that it would not be right to exercise his discretion in their favour and grant relief. Ms Martin accepted that the fact of a defence with a real prospect of success would be a relevant factor in that exercise. However the court would and should not

have concluded that the defence was strong. Further the Recorder would have taken account of the history of non-response from the Defendants, the consequential delays and the resulting significant psychological distress to a severely disabled claimant. He should have found that the prejudice to Ms Lucas from setting aside the judgment would outweigh the prejudice to either Defendant. The Recorder had rightly rejected the various other arguments on prejudice which the Defendants had advanced. If the appellate court were to exercise the discretion afresh, it should reach the same conclusion. There was no good reason to deprive Ms Lucas of the judgment which she had properly obtained.

Discussion and conclusions

Whether real prospects of successful defence

85. As Counsel rightly agreed, the decision on whether the defences in each case have a real prospect of success is not an exercise of judicial discretion, but requires an evaluative judgment. The question for the appellate court is whether the Recorder's decision was right or wrong.

86. I am satisfied that his decision on this issue was wrong, for the following essential reasons. First, in my judgment and with respect, the Recorder took inadequate account of the fact that on each side the reports were evidently not in a final form and that there had not taken place the usual further steps of completion of disclosure and witness statements; preparation of final reports; joint expert meetings; and preparation of joint statements. As experience shows – and the observations of Foskett J in Hewes underpin - those further steps have potentially great importance in the development and adjustment of the opinion evidence. In further consequence, no or no adequate consideration was given to the prospect that there would be such further evidence and fuller investigation of the facts and opinions: cf. Easyair points (v) and (vi).

87. Secondly, the Recorder did not give sufficient consideration to the Bolam/Bolitho test. The Recorder evidently had the overall test in mind - hence the submissions below on behalf of Ms Lucas which contended that Dr Isaac's opinion had no logical basis and the Recorder's consideration of whether there was any reasonable basis for Dr Isaac's opinion. However there was no express consideration of whether the impugned conduct of Dr Oranugo was in accord with the practice of a body of responsible practitioners: cf. Dr Isaac's para. 8.18 which included the opinion that '*…many other responsible General Practitioners would not have referred to a Neurologist with this presentation.*' Dr Kearsley's response to that paragraph did not directly engage with that part of Dr Isaac's opinion. Nor did the Recorder take adequate account of Dr Isaac's reference (para.8.22) to 'the benefit of hindsight'.

88. Thirdly, in concluding that Dr Isaac's opinion had no clear, comprehensible or reasoned basis (see at [29] and [31]), the Recorder took account of the NICE guideline in a way which was inconsistent as between the opinion of the two experts. Thus he stated that Dr Isaac's opinion was undermined if it were informed by a guideline which did not apply at the relevant time ([28]), but that Dr Kearsley's opinion was corroborated by the same guideline even if it did not apply at the relevant time ([30]). Further, a comparison between Dr Isaac's report and Dr Kearsley's addendum report suggests, on their face, that it was Dr Kearsley, not Dr Isaac, whose opinion relied on the NICE guideline. In my judgment the Recorder's conclusion in this respect is further

undermined by the revelation at this appeal hearing that Dr Kearsley had upon search found no relevant guideline to be extant in 2017.

89. Fourthly, in his focus on the distinction drawn by Mr Barnes between the singular and plural in the NICE reference to 'symptoms and signs', the Recorder did not consider the necessary primary question of whether Dr Oranugo should have made a judgment that the single symptom/sign of numbness was suggestive of multiple sclerosis.

90. Thus in my judgment there is real force in Mr Barnes' submission below that the NICE guideline did not provide assistance; at the very least, not such as to support summary rejection of Dr Isaac's opinion.

91. Fifthly, in rejecting these arguments and submissions and concluding that only Dr Kearsley's opinion could be correct, the Recorder did in effect conduct a mini-trial; and did so at a stage where the expert evidence was incomplete and subject to the further necessary stages of elaboration and examination. In my judgment there was no sound basis for summary determination on the clash of expert opinion.

92. In reaching these conclusions, I have given due account to the burden which is placed on the defendant in such applications. However, in all the circumstances, I am satisfied that the Recorder should have concluded that in each case the respective defences have real prospects of success.

Promptness

93. In my judgment, Mr Barnes was right to identify Mullock v Martin as the critical authority. In consequence he was right to accept that the Defendants cannot escape responsibility for the delay between the default judgment in October 2023 and its actual discovery on 19 September 2024; and therefore cannot be said to have acted promptly within the meaning of CPR 13.3(2).

94. As both parties agree, it is also clear from the wording of that sub-rule and the authorities that (i) prompt application is not a threshold condition but (ii) its absence is a matter expressly to be weighed in the balance and which may justify dismissal of an application to set aside judgment where the defence has a real prospect of success: see e.g. Agrinvest at [22]; FXF at [71].

95. I also accept that, when considering the weight to be given to the absence of promptness, the Court should take into account the need for an organisation to have an adequate and effective system for dealing with the response to legal claims; and the explanation of what has gone wrong.

96. In the present case, there is no doubt that something went very wrong with the Defendants' system for dealing with legal claims; including in the relevant period (i.e. for the promptness issue) between October 2023 and September 2024. The explanation is centred on the failings of the departed Practice Manager. I accept that the evidence supports this central explanation. However I think it likely that this problem must also, at least to some extent, reflect inadequate systems for dealing with administrative matters and for the supervision of staff.

97. Conversely, I am not persuaded that the references in the exhibited medical records to documents 'placed in the insurance tray', nor the fact of valid service of documents on and addressed to the partners, put in doubt Dr Oranugo's evidence that his first knowledge of the matter was on 19 September 2024. Service of documents was effected by post, not personally. If the claim had come to the direct attention of Dr Oranugo - or any other partner - at any earlier date, I have no doubt that there would have been the same prompt response which followed the discovery on 19 September 2024.

98. In all the circumstances I consider that the lack of promptness – i.e. the delay between October 2023 and September 2024 – deserves significant weight. However, when set against defences which in each case have a real prospect of success, I conclude that the absence of a prompt application is not of such a weight that the application to set aside should be dismissed on that ground alone. I therefore turn to the Denton tests.

Denton

99. Having concluded that the defences had no real prospect of success, the Recorder's consideration of the Denton tests was strictly obiter. In any event, his consideration of its third stage did not take account of the necessary counterfactual that there were real prospects of success. In these circumstances the parties sensibly agree that I should consider the Denton questions afresh.

100. As the Defendants have rightly recognised throughout, there can be no dispute on the first and second stages of the test. Thus the focus is on 'all the circumstances of the case'.

101. On the one hand, the Claimant and her legal advisers have suffered a prolonged and serious lack of response from the Defendants in their attempts to pursue this claim. This is contrary to the particular needs identified in CPR 3.9(1)(a) and (b) for litigation to be conducted efficiently and at proportionate cost and to enforce compliance with rules, practice directions and orders. These failings have forced Ms Lucas to take the course of seeking and obtaining a default judgment. I readily accept the evidence of the frustration and distress which all this will have caused Ms Lucas. Further distress from a decision to set aside the judgment which she has obtained can be readily envisaged.

102. I am also not persuaded that the weight to be given to these delays and their consequence is diminished by the delay of three years between the diagnosis of multiple sclerosis and the issue of this claim; the further delay until service of the Particulars of Claim; or the delay in setting aside the order for the allocation of the case to the Fast Track. The Limitation Act provides a primary limitation period of 3 years. The delays after the instruction of solicitors in May 2021 were principally the result of the absence of response from the Defendants. As to the allocation issue, the strong likelihood must be that the order would have been set aside by consent if the Defendants had been engaging with the litigation.

103. On the other hand, I have no doubt that the loss of ability to pursue a defence which has a real prospect of defeating this claim of professional negligence would constitute a very substantial prejudice to the Defendants. In this respect I am also not persuaded that the distinction between a judgment in default and a judgment on the merits would be readily appreciated outside informed legal circles. In weighing the competing factors, I also think it a material factor that, whatever the failings of the Practice Manager and/or

the system for dealing with the claims, Dr Oranugo and his partners had no actual knowledge of the existence of this claim before 19 September 2024.

104. I have not found this an easy decision. The rival factors are finely balanced. Having regard to all the circumstances and in the overall exercise of my discretion, I have concluded that the balance just falls in favour of permitting the Defendants to defend this claim. Accordingly, the appeal is allowed.