Judicial Communications Office

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COURT AWARDS £50,000 DAMAGES TO PATIENT OF CONSULTANT NEUROLOGIST, DR WATT

Summary of Judgment

Mr Justice Colton, sitting today in the High Court in Belfast, awarded £50,000 damages for the psychiatric and medical injuries to Martine Norney ("the plaintiff") who brought a civil claim against Dr Michael Watt, a Consultant Neurologist, ("the first defendant") and Belfast Health and Social Care Trust ("the second defendant") for what she said was grossly substandard medical treatment. The court determined that the liability as between the defendants is 50% against the first defendant and 50% against the second defendant.

Background

In 2015 the plaintiff began to experience headaches, dizziness and nausea along with pins and needles in her right arm and sensitivity to light and sound. In November 2015, she was referred to the Neurology Clinic at the Royal Victoria Hospital ("RVH") where she was seen by Dr Thomas Peukert, Consultant Neurologist. He arranged an MRI scan of the brain which was reported as normal. Dr Peukert diagnosed a cervicogenic headache (which is a headache originating in the upper part of the neck) in combination with migraine and performed an occipital nerve block which gave her immediate relief. The plaintiff's symptoms gradually returned, and she was referred back to Dr Peukert who carried out further nerve blocks in April and June 2016. The relief provided by these blocks diminished on each occasion. The plaintiff decided to seek a private appointment which resulted in a consultation with the first defendant on 20 July 2016.

The consultation on 20 July 2016

The plaintiff recalled that the first defendant asked questions about her symptoms, and she was told that she had a hole in her spine, a leak. He told her that he would arrange to take blood from her arm and would inject it into her back which would close the hole (a procedure known as a blood patch). He told her that this would "cure the headaches." The first defendant also told her that she was suffering from Spontaneous Intercranial Hypotension ("SIH") and that the fluid injected into her back would cure it. He told her that the blood patch would be performed under the NHS rather than privately and that she would subsequently receive notification of when to attend.

The plaintiff said there was no discussion about the risks associated with the procedure, the potential prospects for success or any alternative diagnosis. There was no suggestion of any further treatment such as an MRI scan before the blood patch would be performed. There was no indication that a review would take place. After the consultation she was relieved and felt that she would get a resolution of her symptoms from the blood patch.

Post 20 July 2016

Whilst awaiting the date for the performance of the blood patch the plaintiff attended the A&E Department of the RVH on 28 July 2016 where she was assessed by Dr Donnelly. He noted that "she tells me that she attended Dr Watt privately, who suggested that her problems could be caused by 'fluid leaking out of her spine', I presume she is referring to a CSF leak." Notwithstanding this, he went on to say that in his opinion her symptoms were not in keeping with low pressure headaches.

The epidural blood patch procedure – 21 November 2016

The plaintiff attended for the blood patch on 21 November 2016. Her evidence was that she was shown into a small cubicle where she was seen by the first defendant who was accompanied by a nurse. The plaintiff was wearing her normal clothes and was told to lie down prone on her front on a bed in the cubicle so that the first defendant could carry out the injection. She said he was in his everyday clothes; he was unmasked and was not wearing gloves. The plaintiff said she experienced severe pain in her right leg during the procedure and asked the first defendant to stop, but he continued and said, "just a bit more." She described the pain as excruciating and felt her right leg was going to burst. After a further complaint the first defendant ended the procedure. He told her to stay prone for 5/10 minutes after which she could leave. After lying still for a period, she got up and the first defendant and the nurse had already gone. She said she was very sore with pain in the back and in her right leg. She was not provided with any help or assistance and was not given any leaflets or guidance about what might happen after the procedure. No appointment was made for a review.

The records of the interaction between the plaintiff and the first defendant

The court did not hear any evidence from the first defendant or from any other person who was present on the two relevant occasions other than that of the plaintiff. It said the written records of what took place on those occasions prepared by the first defendant were "woefully inadequate and substandard". The first defendant wrote to the plaintiff's GP on the day of the first examination to say he felt her symptoms were "suggestive of spontaneous intercranial hypotension" and that he had arranged for her to be added to the waiting list for a day case lumbar epidural blood patch in the RVH. The first defendant also prepared a short-written note at the time of the consultation. The court said that neither the first nor the second defendant produced any record of the procedure on 21 November 2016 and that there could be no justification for this failure.

Can the plaintiff establish negligence against the first defendant in respect of the consultation on 20 July 2016?

The court said the plaintiff could establish negligence against the first defendant in respect of the consultation on 20 July 2016 for the following reasons:

- The original defence drafted with the approval of the first defendant, by an experienced senior counsel, unequivocally accepted that he had made a diagnosis. In the defence he sought to defend that diagnosis as "reasonable and appropriate."
- The plaintiff gave uncontradicted evidence, which the court accepted, that she was told without any qualification by the first defendant what her condition was and, importantly, that the treatment he was prescribing would "cure her."

- The actions of the first defendant subsequently supported the contention that a diagnosis had been made. When the plaintiff attended hospital the first defendant proceeded directly to perform the epidural blood patch without further review or discussion.
- At no stage in the first defendant's notes or correspondence relating to the 20 July 2016 examination was there any suggestion of an alternative diagnosis.
- The first defendant did not arrange for a review appointment after he performed the blood patch. If the purpose of the procedure was to assist in diagnosis, then such a review would have been required.
- If the diagnosis was a "provisional" or "preliminary" one, one would have expected further investigations to see if an invasive procedure was needed.

The court was satisfied that on 20 July 2016, the first defendant had made a diagnosis that the plaintiff suffered from SIH and that arising from this diagnosis he had arranged for her to attend for treatment based on that diagnosis, namely an epidural blood patch: "This was a treatment plan, not a suggestion."

Was it negligent to diagnose the plaintiff as suffering from SIH on 20 July 2016?

The medical experts instructed on behalf of the plaintiff and the second defendant both agreed that there was no evidence of SIH based on the medical records or history, and no reasonable body of neurologists would have made this diagnosis. They agreed that a definite diagnosis should not have been made on 20 July 2016. In light of the court's factual findings on this issue, it found that the first defendant's diagnosis was negligent and not within an acceptable body of medical practice at that time. This negligent diagnosis was compounded by other actions of the first defendant, including his failure to conduct a neurological examination, his failure to obtain informed consent and his failure to consider alternative approaches.

The procedure in November 2016

The only evidence about what occurred during the procedure came from the plaintiff and there are no notes or records in relation to the procedure. The court accepted the plaintiff's account of what happened adding that "It is trite to say that the conduct of the first defendant was appalling. This would be clear to any lay person."

Dr Bricker, a Consultant Anaesthetist, informed the court that this procedure is not something normally carried out by neurologists. He outlined a litany of unacceptable behaviour including:

- There was no reassessment of the plaintiff.
- There was no, or any informed consent, obtained.
- There was no proper pre-procedure preparation. She remained dressed in her outdoor clothes but should have been dressed in a hospital gown that allowed ready access to the site of the epidural injection.
- The cubicle as described by the plaintiff was an inappropriate area for the performance of an invasive procedure which requires sufficient space to establish two separate sterile fields. It should also have contained resuscitation equipment.
- At the very minimum the first defendant should have worn gloves and a mask, dressed in surgical scrubs and be bare below the elbows. This practice risks introducing infection with the formation of an epidural abscess which is a potentially disastrous complication.

- The position of the plaintiff during the procedure was substandard and placing her in a prone position had significant disadvantages.
- The first defendant persisted beyond the plaintiff's complaint of pain and discomfort. Dr Bricker explained "My view is it is not something you should persist with because of risk of compressive nerve damage. Stop the procedure. You can come back another week, try another space."
- The post procedure management was substandard. Ideally the patient should remain recumbent for at least one or two hours post procedure. There was no post procedure observation, review or information about follow-up care or what the plaintiff should do in the event of any delayed complications.

First defendant's expert evidence

In contesting the plaintiff's claim, the first defendant primarily relied on the expert evidence of Dr Simon Ellis, an eminent and experienced Consultant Neurologist. There was no statement before the court from the first defendant and he did not give evidence at the trial. The court said the uncontradicted evidence of the plaintiff together with the absence of any record of a neurological examination led it to conclude that no such examination took place. It added that, in relation to the performance of the blood patch procedure, there seemed little dispute that the plaintiff received an "appalling standard of care".

When cross examined by counsel on behalf of the plaintiff, Dr Ellis confirmed that he had provided advice in relation to 30 claims alleging negligence against the first defendant. He further accepted he was aware as a result of publicity concerning the first defendant in 2017/2018 that he had been restricted from practice and further that he had been found guilty by a tribunal of medical practitioners of various failings. The court said that this knowledge should have influenced opinions expressed in his expert report. It considered this should have tempered his acceptance of what he was told about the first defendant's "normal practice" and expressing views about what would have been likely or unlikely when assessing the allegations made by the plaintiff. The court had no hesitation in determining that the patch procedure was carried out in a wholly substandard way and that the plaintiff had clearly established negligence in respect thereof.

Causative responsibility between the first and second defendants

The issue to be determined as between the first and second defendants was whether the negligence found by the court in respect of the first defendant acting in a private capacity was in any way causative of the plaintiff's injuries. As in most aspects of the law, context is key. The answer to this question must lie within the facts of the case.

The thrust of the submissions made on behalf of both the plaintiff and the second defendant was that it is artificial to suggest that the first defendant's responsibility acting in his private capacity ended when he referred the matter to the health service. The court said that, on the facts of this case, it was satisfied that a decision to carry out the epidural blood patch was made on 20 July 2016. The first defendant arranged the transfer of the plaintiff's care to himself in his capacity as an employee of the second defendant. There was no review, and he was the only consultant neurologist carrying out this procedure. When the plaintiff attended with the first defendant on 21 November 2016, he proceeded directly to carry out the treatment plan decided on 20 July 2016, based on his negligent misdiagnosis. In those circumstances, the court considered that the

causative potency of the negligence of the first defendant on 20 July 2016 to the plaintiff's injuries sustained on 21 November 2016 is strong and compelling:

> "I do not consider that the court's findings on these facts could have significant ramifications for the transfer of patients between the private sector and the health service here. It cannot always be the case, as a matter of principle, that the act of transferring a patient from private to health service care should automatically end any established negligence on behalf of the same clinician acting in a private capacity before the transfer. The court must look at the facts of the case and the contribution, if any, the initial negligence has contributed to the harm suffered by the patient. Subsequent negligence on behalf of the health service does not automatically vitiate any negligence on behalf of the clinician acting in his private capacity prior to referral."

The court said its factual findings are entirely consistent with the case law in relation to causation and do not support the first defendant's argument that the transfer of the plaintiff to the second defendant constituted a *novus actus interveniens* which could obliterate or eclipse the original wrongdoing. It said the performance of the epidural blood patch was the implementation of the treatment plan directed by the first defendant on 20 July 2016 and flowed naturally from his actions on that date. The first defendant referred the plaintiff to his own blood patch treatment list, knowing that he was not a consultant anaesthetist, who invariably perform those procedures. It agreed that the first defendant cannot rely on his own negligent performance of the blood patch, whilst employed by the second defendant, as a *novus actus interveniens* sufficient to "obliterate" or eclipse his own original wrongdoing.

Ultimately the court is engaged in an evaluative exercise based on all the circumstances. Applying the law to the facts established in this case, it was satisfied that when acting in his private capacity the first defendant's actions had a causative effect on the plaintiff's injuries. That causative effect had not been obliterated by the subsequent negligence of the first defendant when acting on behalf of the second defendant. The court was satisfied that the plaintiff had established liability against both defendants on a joint and several basis. As to apportionment between the first and second defendants, issues having been joined between them, the court said there was no exact science on which to base this assessment:

> "It could be said that the root cause of the plaintiff's injuries was the negligent misdiagnosis of the first defendant acting in his private capacity. The epidural blood patch procedure flowed inevitably from that decision. That said there clearly was a failure on behalf of the second defendant to ensure proper governance (including a lack of review and failure to obtain informed consent) in respect of the first defendant's actions. Furthermore, the negligent performance of the blood patch was the immediate cause of the harm to the plaintiff, albeit some of that harm would have been caused even if carried out in a proper manner. Taking all these factors into consideration it seems to the court that the just and fair apportionment between the defendants is a 50/50 split."

Assessment of damages

There were a number of elements to the plaintiff's claim.

Unnecessary procedure

This related to the fact that the plaintiff was subjected to a wholly unnecessary procedure. The court said that in itself entitles her to compensation. This was:

".. an invasive procedure and one which was carried out in an appalling fashion. Even properly performed, in addition to the invasive nature of the procedure, it involves a degree of discomfort for a patient."

The court concluded that the plaintiff in this case suffered above and beyond what would normally have been expected in respect of such a procedure and it was a distressing, painful and unpleasant experience. It assessed damages in respect of this aspect of the claim at £15,000.

Personal injury

The court assessed damages for the plaintiff's personal injuries at £35,000.

Conclusion

The court awarded the plaintiff £50,000 damages to be divided equally between the first and second defendants.

NOTES TO EDITORS

1. This summary should be read together with the judgment and should not be read in isolation. Nothing said in this summary adds to or amends the judgment. The full judgment will be available on the Judiciary NI website (https://www.judiciaryni.uk/).

ENDS

If you have any further enquiries about this or other court related matters please contact:

Alison Houston
Lady Chief Justice's Office
Royal Courts of Justice
Chichester Street
BELFAST
BT1 3JF

Telephone: 028 9072 5921
E-mail: LCJOffice@judiciaryni.uk