Neutral Citation Number: [2023] EWHC 191 (KB)

Case No: QB-2022-002119

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 06/02/2023

Before :

MASTER SULLIVAN

- -

Between :

GBOLAHAN O SOMOYE (on his own behalf and as Administrator of the Estate of OLUYINKA O SOMOYE)	**Claimant**
- and -	
NORTH WEST ANGLIA NHS FOUNDATION TRUST	**Defendant**

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- -

Ms Jo Moore (instructed by **Fieldfisher**) for the **Claimant**
Mr Henry Bankes-Jones (instructed by **Browne Jacobsen LLP**) for the **Defendant**

Hearing dates: 13 December 2022

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Approved Judgment

This judgment was handed down remotely at 12.00 noon on 6 February 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MASTER SULLIVAN

Master Sullivan :

1. In this claim in respect of the death of Dr Oluyinka O Somoye on 7 March 2018, the claimant applies for judgment to be entered based on a pre-action admission of liability made by the defendant on 24 March 2020 and re-iterated as a full admission of liability by letter dated 20 April 2021. The defendant applies to withdraw that admission. It is agreed that if I do not give permission to withdraw the admission, it follows that judgment should be entered so the issue I have to decide is whether to give permission pursuant to CPR14.1A(4) and PD 14 paragraph 7.

Factual Background to the claim

2. The deceased attended the defendant's hospital for myomectomy. She underwent laparotomy on 28 February 2018. She was discharged on 3 March 2018 but suffered a seizure at home and returned to the defendant's hospital the same day. She was again discharged on the same day.

3. She again returned to the defendant's hospital at around 0415 on 7 March 2018 with severe abdominal pain and feeling unwell. Abdominal x-ray at 0651 raised concerns for small bowel obstruction or ileus. At around 1300 she vomited faeces and collapsed and suffered cardiac arrest. The exact chronology and timing of those events is unclear. Resuscitation was unsuccessful and she was pronounced dead at 1452 on 7 March 2018.

Investigations and litigation following the death of Dr Somoye

4. Post mortem examination was undertaken on 12 March 2018 by Dr Penny Wright. An inquest was formally opened the following day. The post mortem report on 21 August 2018 recorded the cause of death as:

> "1a Multiorgan failure
>
> 1b Abdominal sepsis
>
> 1c Small bowel ileus
>
> 2. Uterine myomectomy"[1]

5. The defendant undertook a Serious Incident Report and Root Cause Analysis in July 2018 which identified numerous care and delivery issues from 3 March 2018 including that possible infection was present from 3 March 2018 and not acted upon and a failure to follow a sepsis pathway on 7 March 2018.

6. An external report was conducted by an independent consultant gynaecologist. His report dated 27 June 2019 makes a number of adverse findings in respect of the treatment from 1 March 2018 to 7 March 2018 considering that care was below an acceptable standard and including criticisms about the level of record keeping. There are very limited records and there are doubts about the accuracy of what there is with conflicting retrospective accounts of events existing.

[1] In a post mortem report, 1a is the disease immediately causing death, 1b is the underlying cause of 1a, 1c the underlying cause of 1b and 2 is a disease or condition not causing death but contributing in some way.

7. The Coroner instructed Professor Winslet, Consultant Colorectal Surgeon, as an expert to advise the inquest. His first report was dated 17 December 2018. In it he discussed the findings of the post mortem and the description of the small and large bowel. He discusses that his view was that Dr Somoye aspirated causing cardiac arrest. His view was the cause of aspiration was vomiting and that was from mechanical small bowel obstruction or abdominal wall hernia or ileus. He notes the cause of the appearance of the bowel at post mortem was unclear but as the examination was conducted 5 days after death there may have been some natural autolytic changes. In the alternative, he was of the view Dr Somoye developed a rare bowel abnormality, necrotising enterocolitis, which would not be diagnosed pre-mortem. On balance he was of the view that if the court finds the post mortem appearances of the bowel were natural autolysis then on balance cause of death was aspiration pneumonia which could have been avoided by nasogastric decompression.

8. A subsequent letter dated 8 March 2019 repeated the view that treatment would have avoided death by aspiration pneumonia.

9. The inquest was due to commence on 25 March 2020. The first admission of liability was sent on 24 March 2020. The inquest was adjourned on 24 March 2020 due to the pandemic (the announcement of the first "lockdown" was on 23 March 2020).

10. In an undated email responding to an email of the coroner dated 9 April 2021 putting further questions to her, Dr Wright commented on the report of Professor Winslet and his supplemental letter. She asks for clarification of what Professor Winslet meant by necrotising enterocolitis as that is a disease affecting premature infants. She stated that the cardiac arrest was most likely due to hyperkalaemia given the elevated level of potassium in the blood.

11. Professor Winslet provided a further report dated April 2021 in which he comments that he does not believe the defects in the post operative care "would have a causation issue" (para 8.1.5). He repeats the same for the failure to provide antibiotics at readmission on 7 March 2018 (8.1.9).

12. He noted the view of the pathologist that the cardiac arrest was secondary to hyperkalaemia. He states if the court finds in favour of that, then on balance of probability the cardiac arrest would have occurred in any event. If the court finds it was the aspiration that resulted in cardiac arrest, then on balance it would have been avoided. He goes on to say the cause of the aspiration was vomiting and with benefit of hindsight that was from mechanical small bowel obstruction. He notes the cause or the appearance of the bowel on post mortem remains unclear and there may have been a degree of natural autolytic changes. In the alternative Dr Somoye developed necrotising enterocolitis, an extremely rare phenomenon.

13. He concluded if the court found the post mortem appearances were due to natural autolysis then on balance the cause of death was aspiration pneumonia in association with cardiac arrest secondary to hyperkalaemia. If the court found aspiration initiated cardiac arrest, then she would not have suffered the arrest with appropriate treatment namely nasogastric decompression. He goes on to say if the court finds the cause of arrest was hyperkalaemia secondary to multi organ failure (and I pause to note this is Dr Wright's consistent view) then on balance it would have occurred in any event.

14. A pre-inquest hearing was listed on 21 April 2021. The re-affirmation of the admission was made by letter the day before, on 20 April 2021.

15. Dr Wright commented on Professor Winslet's report on 11 June 2021 re-affirming her view that cardiac arrest was caused by hyperkalaemia secondary to multi organ failure. She notes that aspiration of gastric contents in the lungs is a relatively common consequence of cardiac arrest rather than a cause of it, She notes a diagnosis of NEC would be extremely unlikely in this case.

16. The inquest was heard on 16 September 2021. Professor Winslet gave evidence and I have seen the transcript of his evidence. He gave evidence that he was of the view Dr Somoye would only have survived if the source of the sepsis was amenable to surgical control and, as the whole of the bowel was abnormal, it would not have been amendable to surgical correction. His understanding was that (although he is not a microbiologist) any antibiotic treatment was supportive not curative. He remained of the view if the aspiration caused cardiac arrest, then with treatment, the cardiac arrest would not have happened at that time but if the cardiac arrest came before aspiration, that would be due to the sepsis and the outcome would have been the same in any event. His conclusion was that different treatment would not have prevented death as whatever was going on in the abdomen would have continued and she would not have survived that. The coroner adjourned for further information from the pathologist.

17. Dr Wright answered further questions from the coroner in November 2021. She was of the view that the findings on post mortem neither supported nor undermined the conclusion that Dr Somoye had a gross pan entero colonic abnormality. She did not identify a localised area of infection in the bowel on post mortem and it would be unusual not to find residual pus if there was a focal point. She was of the view that the pan enteric changes are adequately explained by ileus. The early ischaemic change in the small bowel mucosa was most likely to be due to herniation but it is possible it could have arisen due to a hypoperfusion injury during unsuccessful resuscitation. The major changes occurred pre-mortem. She had seen bowel findings similar to this rarely, in the post operative setting. She was of the view pan enteric changes were adequately explained by ileus. Her opinion on cause of death remained the same.

18. The comments of Dr Wright were forwarded to Professor Winslet who commented on 10 January 2022 that he had never seen such macroscopic changes in association with an ileus and that the cause of cardiac arrest remained unknown with two options, aspiration causing arrest and hyperkalaemia with subsequent vomiting and aspiration. The condition of Dr Somoye's entire bowel could not be explained solely by autolysis.

19. The inquest resumed on 26 January 2022. I am told both experts gave evidence but have not seen any transcript of their evidence. The coroner maintained the cause of death as per the post mortem. The coroner found that it was not possible to say whether aspiration led to cardiac arrest or whether the cardiac arrest caused the aspiration on balance of probabilities.

Proceedings

20. The defendant notified the claimant on 22 March 2022 that it was re-considering causation and requested further disclosure on quantum. A limitation extension was

offered to 29 July 2022 which the claimant's solicitor accepted. In June 2022 the defendant offered a further 4 months' limitation extension.

21. The claimant issued proceedings on 6 July 2022 which were served on 11 July 2022 along with an application to enter judgment on the admission for damages to be assessed.

22. The particulars of claim set out a brief chronology and reliance on the pre-action admissions that:

> "the failings of the Trust's provision of care following the deceased's surgery on 28 February 2018 led to her untimely death."

23. No other particulars of negligence or causation are pleaded. No letter of claim was served at any stage prior to issue of proceedings with any specific allegations of negligence or causation.

24. On 13 July 2022 the defendant made an application to withdraw the admission. The defendant served expert evidence from consultants in intensive care and cardiology in support of their application shortly prior to the hearing of the application.

The defendant's application

25. The defendant's application notice states that the admission was made based on the evidence of Professor Winslet and that:

> "at the remote inquest on 16 September 2021, Professor Winslet completely changed his mind whilst on the witness stand…
>
> It was the coroner's finding that even if steps had been taken, no difference would have been made to the deceased's outcome and she concluded that it was not possible on the evidence available to say whether the admitted breach i.e., failure to insert a nasogastric tube led to the cardiac arrest or whether the cardiac arrest was caused by something else altogether…
>
> As a consequence of the Professor Winslet's change of opinion, the Trust, a publicly-funded body, obtained independent expert evidence in cardiology and intensive care which took several months to obtain given the complexity…"

26. Mr Bankes-Jones rightly conceded with apologies that the coroner did not make any finding that even if steps had been taken, no difference would have been made to the deceased's outcome, but the basis of the application that Professor Winslet had changed his evidence and that there was now new evidence which gave rise to a good defence of the claim remained. He also helpfully confirmed that the application for withdrawal was only in respect of admissions as to causation, not in respect of any admission of breach of duty.

The legal test

27. The court has a discretion whether to give permission for a pre-action admission to be withdrawn. PD 14 paragraph 7.2 states:

> "In deciding whether to give permission for an admission to be withdrawn, the court will have regard to all the circumstances of the case, including –
>
> (a) the grounds upon which the applicant seeks to withdraw the admission including whether or not new evidence has come to light which was not available at the time the admission was made;
>
> (b) the conduct of the parties, including any conduct which led the party making the admission to do so;
>
> (c) the prejudice that may be caused to any person if the admission is withdrawn;
>
> (d) the prejudice that may be caused to any person if the application is refused;
>
> (e) the stage in the proceedings at which the application to withdraw is made, in particular in relation to the date or period fixed for trial;
>
> (f) the prospects of success (if the admission is withdrawn) of the claim or part of the claim in relation to which the admission was made; and
>
> (g) the interests of the administration of justice."

28. The factors are not listed in any hierarchical sense. Each must be given due weight and along with all the circumstances of the case and a balance must be struck to achieve the overriding objective. I should of course, especially when considering the prospects of success, avoid a mini trial. I will deal with the parties' submission in respect of each in turn and then put all relevant matters in the balance to reach my conclusion.

The grounds upon which the applicant seeks to withdraw the admission including whether new evidence has come to light which was not available at the time of the admission

29. The defendant's position is that new evidence has come to light which was not available at the time the admission was made. The defendant's position is that it made its admission based on the written evidence of Professor Winslet and that it was only following his oral evidence at the inquest that they were aware the basis of the admission was no longer supported by Professor Winslet. In any event, the evidence of the expert intensivist and cardiologist which has now been produced is clearly new evidence.

30. The claimant's position is that the evidence which the defendant relies on was not new. Professor Winslet's evidence at the inquest hearing was that there was a rare underlying

abnormality of the whole bowel which means that proper treatment on 7 March 2018 would not have avoided Dr Somoye's death. That theory was in fact raised for the first time in 2018 and repeatedly thereafter and the claimant says each time it was undermined by the evidence of Dr Wright the pathologist. The same theory underpins the evidence from the two new experts.

31. In my judgment the issue of whether the cause of death was something other than cardiac arrest arising out of aspiration of vomit was an identified issue from 2018. Whilst it is correct that Professor Winslet was of the view in 2018, on balance, that aspiration was the cause of death, he raised the alternative view in his report of 17 December 2018. I also note that the pathologist Dr Wright was always of the view that the cardiac arrest was caused by multiple organ failure and in April 2021, at around the time of the second admission, was of the view it was probably due to hyperkalaemia. Professor Winslet's report in April 2021 is very clear that there were two possible causes. It is right that his opinion changed in evidence in September 2021, but it was not a new theory or new evidence. It was a change of opinion on which theory was most likely on the balance of probability. The theory was a clear possibility at the time of the admissions.

32. The fact the defendant then obtained further expert evidence, which is new evidence, to support Professor Winslet's theory is not, it seems to me, the grounds for the application. It is evidence in support of the application and so is not new evidence for the purpose of this subsection. The grounds for the application was Professor Winslet's change of view.

<u>The conduct of the parties, including any conduct which led the party making the admission to do so</u>

33. The defendant submits that it acted properly at all times. The making of an admission on expert evidence cannot be criticised and especially so where the making admission "was designed by the defendant to avoid the need for the claimant to endure the rigors of a full oral inquest". It is submitted that once the true position of Professor Winslet was made clear in September 2021, the defendant took appropriate steps to obtain evidence from disciplines recommended by Professor Winslet. It is said despite having been made aware in March 2022 that the defendant was obtaining evidence of causation the claimant has not taken steps to obtain their own expert evidence. The claimant could have obtained their own expert evidence for the purposes of this application or could have agreed a limitation extension while the defendant carried out its investigations. It is submitted that the defendant's conduct cannot be criticised.

34. The claimant's position is that the defendant had ample opportunity to investigate the claim prior to the inquest and the admissions. It had advice from specialist solicitors prior to making the admissions. The defendant's motivation for the admission pre inquest was in part to restrict the costs the claimant would be able to recover in respect of the inquest process. Its express refence to *Veevers v Greater Manchester Fire and Rescue Service* [2020] EWHC 2550 in the second letter of admission indicates that was a consideration.

35. The defendant's application is made on the basis that the defendant was relying on the evidence of Professor Winslet. He was an expert instructed by the coroner and not the defendant. The defendant could at any time have instructed their own expert to

investigate the issues raised by Professor Winslet which were raised from his very first report. Although Professor Winslet's opinion was clarified in oral evidence at the inquest in September 2021, there was no indication form the defendant that they were investigating causation until March 2022 and no written or formal request was made to resile from the admission until after the claimant had made an application for judgment in July 2022.

36. In my judgment, it is right to criticise the defendant's conduct. A defendant is expected to take independent legal and medical advice at an early stage and before making an admission. That is especially so where an expert not instructed by the defendant raises issues which show there may be an argument on causation which would provide a defence to the claim.

37. The second admission made was to spare the claimant the rigour of a full inquest, but also to reduce costs. That is obviously something to be encouraged but it is proper to take into account the context in which such an admission is made. An NHS Trust is likely to be represented at an inquest whether or not an admission is made. The family of the deceased may not be represented fully or at all if the costs of the inquest are unlikely to be recovered in any civil litigation. That is largely the case where liability is admitted. That leads to the consequence that a claimant's opportunity to investigate for the purposes of a civil claim may be affected by the admission. In this case it led to agreement that the factual clinician witnesses need not be called. The expectation that a defendant who has access to proper representation should be held to an admission has particular force in that context.

38. When Professor Winslet changed his opinion in September 2021, the defendant did not notify the claimant that it was investigating causation until March 2022 and there was no express reference to an application to resile from the admission until July 2022. That, it seems to me, is also a significant delay in the context of the claim given the time that had passed since the date of death and the admissions.

<u>The prejudice that may be caused to any person if the admission is withdrawn and the prejudice that may be caused to any person if the application is refused;</u>

39. The defendant submits it will suffer significant prejudice if the admission is not withdrawn as it will not be able to properly defend the claim. It submits the claimant will not suffer any prejudice as he will still be able to investigate and bring the claim. The claim will succeed or fail on the basis of expert evidence rather than factual evidence and the experts instructed by the Defendants have been able to provide opinions despite the deficiencies in the medical records.

40. Additionally the same issues are likely to arise when it comes to looking at the but for scenario in order to be able to calculate damages. There will be an issue as to Dr Somoye's condition and life expectancy. It was submitted that would make it very difficult for a trial judge to tease out the difference between cause of death and acceleration of death when looking at what might have ensued in the future. The fact that argument will be in issue means that any prejudice to the claimant is reduced.

41. The claimant's position is that they would suffer significant prejudice if the admission is withdrawn. The admission was made nearly three years ago in the context of negligence nearly five years ago.

42. The claimant submits that the timing of the defendant's admission meant that the claimant agreed to the inquest proceeding with very limited evidence, including no clinical staff giving evidence. That is in the context of a case where there has been criticism of the defendant's record keeping of the events leading up to Dr Somoye's death, and in particular the retrospective accounts given by nursing and clinical staff are not consistent. The defendant's intensive care expert commented that the conflict between the clinical accounts and lack of clarity as to the precise sequence of events "compromise the goal of triangulating the key elements of evidential material". The cardiologist also comments about the lack of recorded timeline and says it would be important to know specifically what happened and when.

43. The claimant has not investigated liability further. He has however investigated quantum and obtained evidence and drafted a schedule in respect of quantum. If liability were in issue those steps and their associated cost would not have taken place until after liability evidence and a split trial may have been sought.

44. Additionally there is a personal prejudice to the claimant. He was much relieved by the admission and told Dr Somoye's parents of the admission. He supports them financially. Dr Somoye's daughter was 15 at the date of death and will soon turn 20. There would be significant distress caused if the admission was withdrawn.

45. I accept there is prejudice to the claimant as alleged if the defendant is allowed to resile. I do not accept this is case where the only relevant evidence is likely to be expert evidence. There are clearly deficiencies in the medical records such that factual witness evidence would likely be relevant for the experts to establish what happened. An opportunity has been lost to obtain that evidence at a time closer to the events with obvious consequences as to its cogency. The claimant has also spent money investigating quantum that would probably not have occurred if liability was in issue until after that issue had been resolved. Whilst I have sympathy for the emotional effects on the claimant's family if permission is given for the withdrawal of the admission, that does not have significant weight in the balance of factors.

46. Whilst it is right that if I do not allow the withdrawal of the admission, the defendant will not be able to dispute liability and that is a prejudice to the defendant, that is mitigated by the fact they will still be able to challenge the extent of the losses. I do not accept that would cause the difficulties suggested.

<u>The stage in the proceedings at which the application to withdraw is made, in particular in relation to the date or period fixed for trial;</u>

47. The defendant relies on the fact this application has been made at an early stage in these court proceedings. There is no date or period fixed for trial. The claimant points to the fact the admission was made two years (and repeated three years) after Dr Somoye's death and the initial admission was made nearly three years ago and notes the timing already explained in relation to the inquest.

48. It is right that in the civil proceedings the application has been made at the first opportunity and at a very early stage. But that is of limited weight in the circumstances of this case given the time that has passed both since the accident and the admission, and that there has been an inquest investigating the facts albeit to answer different questions to those in the civil proceedings.

The prospects of success (if the admission is withdrawn) of the claim or part of the claim in relation to which the admission was made

49. Both parties' skeleton arguments and oral arguments argue that this is a factor that favours their position. In the defendant's view, there is a very good case on causation. From the claimant's point of view, the defendant's case is fundamentally flawed. The argument was detailed with reference to substantial parts of the evidence before me. I will not recite the detail of that argument but summarise the arguments.

50. The defendant's position is that the evidence of Professor Winslet at inquest, combined with the two reports now served, show that the defendant has a good prospect of success in its causation case. The claimant has not produced any expert evidence to the contrary. I should assess the merits of the argument on the evidence before me, and there is clearly on that basis a good, indeed strong case.

51. The claimant submits that Professor Winslet's evidence is based on a premise that there was a gross pan enteric abnormality. That is based on his understanding of the findings at post mortem. Dr Wright however did not support the argument that there is a pan enteric abnormality. Her view, accepted by the coroner, was that the appearances of the bowel were consistent with small bowel ileus. It is argued that it would require expert evidence from a pathologist for that view to not be accepted. The expert evidence of the cardiologist and intensivists are based on the same flawed premise of gross abnormality of the bowel as Professor Winslet and therefore do not take matters further. The prospects of the defendant succeeding in the causation defence is poor.

52. It seems to me that, on the evidence I have seen, the defendant does have a real prospect of success in their case on causation in respect of 7 March 2018. I accept that Professor Winslet's theory of a gross pan enteric abnormality is not accepted by Dr Wright. But nor is the theory that death was caused by aspiration of vomit causing a cardiac arrest. Her view is that the cardiac arrest was caused by hyperkalaemia which in turn was caused by multiorgan failure, caused by sepsis caused by small bowel ileus. What her evidence does not assist with, and what seems to have been troubling Professor Winslet, is what caused the sepsis, multi organ failure and ileus where theree is no focus of infection.

53. The evidence is that post operative ileus normally resolves within 2-3 days and it would be rare for it to progress to non viability of the bowel (evidence of Dr Bell). The claimant's case that with treatment of mechanical bowel obstruction, the ileus would have resolved is not something supported by Dr Wright either. The three medical experts reports I have seen are all based on a theory of an unknown gross abnormality of the bowel. If they are correct that would provide a defence to the claim. The claimant does not have clear evidence supporting that with treatment of obstruction or ileus the cardiac arrest and death would have been avoided. Therefore, and reminding myself I must not conduct a mini trial, it seems to me the defendant has a real prosect of success in respect of causation on 7 March 2018.

54. On the other hand, the admission is that the treatment of Dr Somoye following her procedure on 28 February 2018 was below an acceptable standard and caused her untimely death. The admission is not specific. The defendant has not provided any evidence that deals with causation of the earlier substandard treatment, in particular on 3 March 2018. I have seen that there are comments in Professor Winslet's early reports

that suggest the earlier negligence was not causative. But that evidence pre-dates the repetition of the admission in 2021 and so must have been considered by the date of the admission and the defendant nonetheless made an admission in respect of that period. Mr Bankes-Jones accepted in submissions that his evidence went to treatment on 7 March 2018.

The interests of the administration of justice

55. The defendant submits that it could not be said justice would be brought into disrepute if it is allowed to withdraw the admission. It has good, cogent evidence at an early stage of proceedings. It would not be in the interests of the administration of justice to allow a trial to proceed on the artificial basis that the death was caused by the negligence when arguments that the deceased would have been critically unwell had she survived and would not have lived for any significant period of time would be allowed to proceed.

56. The claimant argues that it would not be in the interests of justice to allow a defendant who has made an admission prior to the inquest to withdraw when that admission has been relied upon. It would mean claimants would not be able to rely on admissions pre inquest in case there was a tactical decision to admit pre-inquest and then withdraw later. They would have to incur the expense of fully investigating matters at inquest in the knowledge that they probably would not be able to recover the costs.

57. The claimant also argued that the admission was a full admission and so the defendant would not be able to argue that she would not have recovered when looking at life expectancy and the deceased's prognosis had she lived.

58. I accept the defendant would be able to raise arguments going to the claimant's condition and life expectancy had she lived. An admission on liability leads to a judgment on liability for damages to be assessed. That leaves open to a defendant the ability to argue about the extent of injury and loss provided the defendant does not raise an argument inconsistent with some injury (including death) having been caused by the negligence. That is the well recognised position. It seems to me that would not cause a judge any real difficulty or cause any problems with administration of justice.

59. The claimant's argument that there is a wider impact on the administration of justice when looking at admissions before inquests is very much connected with the issues discussed in conduct above and I do not repeat matters here.

Conclusion

60. In my judgment, weighing the different factors in the balance and taking account of the circumstance of the case, the defendant should be held to their admission and I do not give permission for it to be withdrawn. Whilst the fact that the defendant at this stage has a realistic defence is a strong factor in favour of giving permission it seems to me to be outweighed by the conduct and prejudice issues discussed above.

61. In the circumstances I will refuse permission to withdraw the admission and give judgment for the claimant for damages to be assessed.