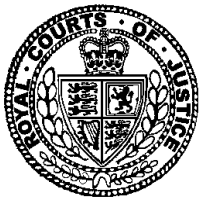

Neutral Citation Number: [2023] EWHC 2765 (KB)

Case No: QB-2022-001479

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14/11/2023

Before:

MASTER STEVENS

- -

Between:

Mr Richard Dee	**Claimant**
- and -	
Welsh Ambulance Services NHS Trust (1)	**Defendants**
Hywel DDA University Health Board (2)	
Swansea Bay University Health Board (3)	

- -
- -

Shahram Sharghy (instructed by **Stewarts**) for the Claimant
Paul Rees KC (instructed by **Legal & Risk Services**) for the Defendants

Hearing date: 27th July 2023 & supplemental submissions following.

- -

Approved Judgment

This judgment was handed down remotely at 10.00am on 14th November 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MASTER STEVENS

Master Stevens:

INTRODUCTION

1. This is an application for an interim payment made on behalf of the claimant who suffered a catastrophic spinal cord injury and very severe pressure sores in the aftermath of what I will term a "freak accident" in 2019 when he fell from a non-motorised scooter. The circumstances are very sad; Mr. Dee was said to be a very fit and active man who had only retired two months before the index event which occurred at the end of a day's regatta sailing with his club in Pembrokeshire. Mr. Dee was an avid sailor, and there appears to have been nothing unusual about the day's events prior to around 22.50 when, following the regatta presentation and dinner, he had walked to a local pub with his friends for a round of drinks. For reasons that are unclear, he then decided to "*have a go*" on one of the adult non-motorised scooters belonging to a friend. Apparently, these are a customary means of transport around many regatta sites, and he had not used one for many years. He had not progressed very far when the front wheel of the scooter became caught on a small ledge by a door, causing him to fall off and sustain a broken nose on impact. Although not diagnosed at the time, it is undisputed that he also suffered a traumatic contusion of the cervical cord at C6 extending down to the disc level. He was unable to get up from the ground and has been unable to walk since. He is now a tetraplegic, wheelchair dependent and requires 24-hour professional care.

2. The claim is brought in negligence against three defendants, the first being the ambulance service called to the scene of the accident, the second defendant being the receiving general hospital where the claimant was admitted through the accident and emergency department and the third being the specialist hospital that reviewed the claimant's CT and MRI images and provided advice on treatment to the second defendant. Apart from a few limited breaches of duty being admitted by the first defendant the claim is fully disputed.

3. Although the accident occurred over four years ago, proceedings are still at a relatively early stage and expert evidence had not been exchanged at the time of the hearing of the application. The claimant's legal team had provided voluntary disclosure of a number of their export reports, but the defendants just relied for this application on 2 brief letters prepared by their orthopaedic spinal and neurosurgical experts a matter of days before the hearing.

4. The claim was advanced at this juncture because numerous voluntary requests for an interim payment had been unanswered, and the claimant is in dire need of monies to rectify what is described as his "*wholly unsatisfactory living conditions*". The defendants considered the application to be premature ahead of full exchange of expert evidence in a disputed claim. Currently, the claimant remains at the marital home he has shared with his wife for over 40 years but due to his injuries is confined to the ground floor where he uses the living/dining room as his bedroom, which is the only reception room in the house. There have been no adaptations to enable him to access other rooms where the door frames are too narrow for his wheelchair, and he lacks privacy or access to any toileting or bathing facilities other than use of the very temporary equipment that has been installed in his bedroom. There is also now a lack of privacy and separation between the carers and the claimant and his wife. The claimant has no emergency access from the property that he can always access.

5. The preliminary Schedule of Loss prepared by the claimant's legal team totals in excess of £7 million. There is not a clear demarcation between all the losses claimed in respect of the spinal cord injury (there being some difficulty in separating "natural" consequences of the fall in terms of damage to the spinal cord and any deterioration said to be due to negligent treatment) and also in respect of losses said to be attributable to the claimant's very severe pressure sore. During the course of the hearing, there was clarification that the losses ; claimed are based on the premise that the claimant would always have suffered *some* permanent neurological deficit in the lower limbs following the accident, even absent any alleged clinical negligence, but that he would have had full use of his upper body and remained independent in bladder and bowel function.

THE LEGAL TESTS APPLICABLE ON AN INTERIM PAYMENT APPLICATION: the essential pre-conditions

6. CPR 25.6-9 sets out the procedural requirements to be met concerning interim payments which are an exception to the general principle that a defendant has a right not to be held liable to pay damages until liability has been established by a final judgment. The original purpose of such payments was to mitigate hardship in injury cases caused by long delays prior to the final judgment being obtained, which is precisely the scenario in this case. Where liability has not been admitted, and no judgment has been entered, the court must be satisfied that if the claim went to trial the claimant would obtain judgment for a substantial amount of money from a defendant from whom he is seeking an order (at 25.7 (c)) or from at least one defendant, where the court cannot decide which of several defendants against whom the sum should be ordered (at 25.7 (e)). All of the defendants in this case are public bodies, so there is no need to look further at their ability to pay any amount ordered to satisfy other aspects of the procedural tests.

7. Further guidance on the correct application of other aspects of the procedural tests is set out in the *White Book* at Volume 2, section 15, paragraphs 99 to 128. The guidance confirms that on the hearing of an application there should be no mini-trial as the procedure is unsuited to cases where factual issues are complicated or difficult points of law arise. Paragraph 15-101 clearly sets out that if a defendant does not put forward any evidence regarding contributory negligence or causation issues a judge is entitled to conclude that an interim payment should be awarded on the basis of the evidence that has been presented.

8. The court has a very wide discretion and one of the cases in the authorities bundle, *Test Claimants in F11Group Litigation v Revenue & Customs Commissioners* [2012] EWCA Civ 57), is most helpful. Aikens LJ held at [36], "*… It seems to me that the first thing the judge… has to do is put himself in the hypothetical position of being the trial judge and then pose the question: would I be satisfied (to the civil standard) on the material before me that this claimant would obtain judgment for a substantial amount of money from this defendant?".* Aikens LJ was keen to point out in that judgment that it is important not to confuse the 2 concepts of burden and standard of proof. The claimant has to satisfy the burden of proof and must also satisfy the standard on the balance of probabilities but to a high degree. He continued at [38], "*The only difference between the exercise on the application for an interim payment and the actual trial is that the judge considering the application is looking at what would happen if there were to be a trial on the material he has before him, whereas a trial judge will have heard all the evidence that has been led at the trial, then will have decided what facts have been proved and so whether the claimant has, in fact, succeeded*".

THE PLEADED ISSUES AND RELEVANT DISCLOSED EXPERT OPINION

9. In summary form, the claimant's allegations are shown below, with the response of the defendants following (they have served a combined Defence). The disclosed expert opinion for either party is set out adjacent to the pleaded issues and is underlined for ease of identification.

The claim against the First Defendant

10. The claims against this defendant are that they:

    i. Failed to properly assess the claimant and recognise "*evidence strongly suggested the presence of spinal injury*" such that immobilisation to the spine was mandated. The Defence admits that the spinal risk was not recognised, and that the spine was not immobilised, but denies that this caused deterioration. Breach of duty is admitted in respect of the failure to immobilise.

    ii. Allowed the claimant to be sat up and lifted onto a trolley and into the ambulance, such actions being "*highly likely to give rise to progression and/or deterioration of the claimant's spinal injury*". The claimant's expert opinion from a consultant in neurosurgery is that "*the action of sitting Mr. Dee upright was unlikely to have resulted in significant spinal column displacement and secondary injury through further cord compression given subsequent CT and MRI findings and my earlier comments on the stability of the injury. Such a manoeuvre however is inappropriate given the physiological vulnerability of Mr. Dee's spinal cord and likely resulted in some transient hypoperfusion of the injured cord. The precise change in clinical outcome resulting from this transient inappropriate positioning is difficult to determine but is probably not a significant contributor to Mr. Dee's overall functioning given the severity of his primary spinal cord injury*". The Defence avers that a crowd of people around the claimant lifted him onto the ambulance trolley and denied that the ambulance crew did this, but it is admitted that the claimant should have been secured on a stretcher with the cervical spine immobilised. It is denied that the manual handling methods caused any deterioration in what is averred to have been a stable fracture.

    iii. Failed to properly monitor blood pressure and detect low blood pressure which "*equated with poor cord perfusion*" requiring urgent IV fluids. The Defence admits that initial readings indicated hypotension and that failure to initiate IV therapy was a breach of duty but denies that this made any difference to the claimant's medical outcome.

    iv. Failed to pre-alert the second defendant to the likely presence of a spinal injury, so they could have prepared for specialist assessment when the claimant arrived at the hospital. The claimant's expert neurosurgeon states "*in my opinion the most important aspect of the paramedics' failure to recognise and manage Mr. Dee as a potentially spinal cord injured patient, is the failure to alert the receiving Emergency Department to the probable severity of his injuries. If Mr. Dee had been transferred to the Emergency Department by the paramedics with full spinal immobilisation, with an appropriate history of an inability to feel or move his legs, and with an appropriate recording of low*

blood pressure, he would, in all probability, have been identified as a patient with a high probability of cervical spinal cord injury. It is likely that the trauma team would have been called. Mr. Dee's hypotension would have been recognised and treated… under the circumstances described above, Mr. Dee would have avoided his sacral pressure sore. He would have avoided any deterioration in his neurological function. At a minimum, this would have resulted in improved hand function". The Defence admits that there was a verbal handover on arrival at the hospital and a triage form was completed marked category "*yellow*" and that the ambulance crew had not recognised the claimant's spinal injury and that the failure to pre-alert the hospital was a breach of duty.

The claim against the Second Defendant

i) The claims against this defendant are that they:

i. Failed to properly and independently (from the ambulance crew) assess the claimant and triage appropriately causing a delay in a correct working diagnosis and therefore delay in appropriate treatment where there was a significant risk of deterioration. The claimant's expert in emergency medicine believes "*no reasonable A&E department would consider 42 minutes an acceptable time to be booked in and to have no clinical assessment at all for 6 hours*". Also, that traumatic spinal injuries should be moved to definitive care within 1 hour and that it is "*entirely possible*" that the failure to immobilise led to deterioration. He further opines that the role of a triage nurse "*is to triage as part of an ongoing assessment process on handover*". The Defence admits that a spinal injury was not considered or appreciated prior to the first doctor's review over 5 hours after admission to hospital and that during this period blood pressure had dropped to 84/52 mmHg. It is denied that the triage was inappropriate given the information passed on by the first defendant and the busyness of the emergency department at the time. The hospital avers that it is reasonable to rely upon information conveyed by the ambulance clinicians. It is denied that there was significant or avoidable deterioration in the spinal injury between admission triage at 01.50 and assessment at 07.00 when the spine was immobilised. The claimant's expert in emergency medicine also believes the injury and its complications should have been treated by 03.00 latest and that from the moment spinal injuries are suspected measures taken should be taken to care for them until they are excluded. The Defence admits the spinal injury was only finally diagnosed at 09.20 on 31st May 2019. It admits that hospital notes record worsening sensation level T1 -T2 the following night after the claimant had been transferred to the critical care unit, from the observations in the admitting notes for that unit the previous evening which had recorded sensory level T6.

ii. Failed to immobilise the claimant until 07.00 on 31st May 2019 as a consequence of the failures at i. above which led to the progression of injury to the upper limbs. The factual timeline for immobilisation is admitted by the defendant. Factually it is averred that clinical assessment at this time recorded 0/5 power in lower limbs and 4/5 in the upper limbs. It is not admitted that this "*rapid*" assessment records a different level of function in fact to a subsequent one by an orthopaedic doctor at 10.00 when hand mobility was recorded as 3/5

and the claimant is put to strict proof. The claimant's expert in emergency medicine believes the "*rapid assessment*" should have been complete and accurate as it was undertaken by an experienced A&E doctor, not a triage nurse.

iii. Failed to properly monitor vital signs such as blood pressure, and detect low blood pressure, or pay attention to the need for appropriate cord perfusion to prevent deterioration. The claimant's expert in emergency medicine believes that hypotension can adversely affect a spinal injury and cause deterioration. The claimant's expert in intensive care believes that "*for any degree of spinal cord injury, the primary principle of management is to avoid any secondary cerebral insults, the most significant of these being secondary traumatic injury due to inadequate immobilisation of an unstable spinal column, and aggravated hypoxic ischemic injury due to impaired cord perfusion and oxygen delivery….. … regardless of whether the spinal injury could be considered stable…. The cervical spine would be immobilised…. to negate any otherwise avoidable aggravation of the injury in association with distortion of the cord due to movement*" …. "*…. This sustained period of hypotension, with accompanying reduction in systemic oxygenation in the initial phases, is likely on the balance of probability to have generated a secondary hypoxic ischemic injury, thereby extending the area of irreversible injury and preventing potential recovery… with optimal care… I would have anticipated some recovery from the neurological dysfunction apparent at the time of injury rather than the consolidation or worsening of the neurological deficit as appears to have been the case*". The claimant's expert neurosurgeon believes that, "*once subject to acute traumatic injury it [the spinal cord] is vulnerable to further secondary injury. The primary drivers of secondary injury are hypoxia and hypotension. Prevention of secondary spinal cord injury is the cornerstone of acute traumatic spinal cord injury management, particularly in cases where surgical intervention is not appropriate….Such patients often require invasive blood pressure monitoring…"* Furthermore, *"Given the failure to recognise and appropriately manage his spinal cord injury, any neurological deterioration suffered by Mr. Dee following initial admission to the emergency department was, on the balance of probability, due to failures in management".* This allegation is denied, and the second defendant maintains that based on the information available to them they acted reasonably. In terms of causation, it is averred that the claimant's medical outcome *"is likely to have been determined at the time of the original spinal cord contusion sustained at the point of impact".*

iv. Failed in the critical care unit to meet the recommended target mean arterial pressure of 90mmHg. The claimant's expert in intensive care believes that "*there is general acceptance of the recommendations of the American Association of Neurological Surgeons for maintenance of mean arterial pressure of 85-90 mmHg for the seven days following injury*". This is denied and the management is said to have been reasonable.

v. Failed to assess the risk of developing pressure sores and to regularly adjust the position of the claimant or supply a pressure relieving mattress thus contributing to deterioration in the claimant's soft tissue damage. It is averred that the initial sore had deteriorated to a grade 3-4 with a necrotic base by 4th

July and that there was no closure, followed by healing, before 12th December 2019. The claimant's expert in emergency medicine believes that there was a negligent delay in diagnosing the spinal injury which caused an increased risk in developing pressure sores and the severity of them. He recognises that the pre-hospital care may also have been responsible. He also opines that pressure sores can develop potentially within 20 minutes. The claimant's expert in plastic surgery opines that, "*it is likely that the pressure damage was initially caused by the unrelieved pressure whilst lying on the road followed by the unrelieved pressure in the A&E department* " (based on assumed facts that the claimant was lying in the road for 1.5 hours pre-ambulance). The claimant's expert neurosurgeon believes that "*with appropriate recognition and management of his spinal cord injury Mr. Dee would and should not have sustained soft tissue damage to his sacrum resulting in a grade 4 pressure ulcer*".The Defence admits that the pressure sores assessment was incorrectly completed in the emergency department and that the assessment incorrectly ticked that the claimant could get up, walk and lift. It is admitted that a tissue viability nurse observed a pressure sore at 23.00 on 31st May 2019 and recorded in the notes *"? caused by laying on a hard surface awaiting admission, damage materialising 21 hours post admission"*. However, it is averred that the likely origin of damage was lying in the road for a significant time awaiting an ambulance and denied that any delay by the second defendant caused or contributed to the soft tissue damage. It is averred that a grade 2 pressure ulcer was healed by the time of discharge to a spinal unit on 5th August. However, the history of worsening of the sore through to December 2019 is admitted.

The claim against the Third Defendant

ii) The claims against this defendant are that they:

i. Negligently advised removal of the c-spine collar, ceased log-rolling and permitted unrestricted movement "*when it was likely that this would progress/deterioration the claimant's spinal injury*".The claimant's expert neurosurgeon opines that the advice given was "*woefully inadequate*" and "*fell below the standard of care expected for an on-call spinal surgeon or neurosurgeon*" and "*whether alternate advice .. would have altered Mr. Dee's eventual clinical outcome depends on the findings of the court about whether there is clear evidence of neurological deterioration from the time of the first call to Morriston Hospital, Swansea*." The claimant's expert neurosurgeon believes that "*the findings of the CT and MRI scans leads to a conclusion that the injury to the spinal column was not mechanically unstable. This means that, despite the injury, it is unlikely that normal physiological movements of the neck would result in significant loss of spinal alignment. That is not to say that uncontrolled neck movements could not further injure a vulnerable spinal cord, but this was not the type of injury where a careless neck movement was likely to cause acute spinal displacement resulting in acute spinal cord compression and a devastating new spinal cord injury….. Most, if not all spinal surgeons would, therefore, advocate conservative management of this injury without surgical intervention*". The Defence admits that this was the advice but denies it was negligent because it avers that the injury was just to the posterior element

of the spinal cord and was not unstable, such that immobilisation is not usual practice.

ii. Failed to advise the second defendant to seek urgent advice regarding the claimant's management from the Regional Spinal Cord Injuries Unit. It is denied that this was reasonable or appropriate according to local clinical judgment and protocol.

iii) Overall, the claimant alleges that the failures identified above caused or materially contributed to a deterioration in his injury:

i. but for the negligence his injury would have been classified as AIS-C and would have recovered to AIS-D. The claimant's expert neurosurgeon considers that "*findings in the Emergency Department suggest Grade1/5 power and therefore AIS-C spinal cord injury*" and with proper treatment he would have avoided deterioration. The claimant's expert spinal surgeon agrees with that classification but states "*it is well established in the literature that examinations performed in the emergency room can be difficult and may lead to errors*". Separately he opines, "*in my opinion, spontaneous neurological deterioration is rare. The expected outcome in the majority of those with incomplete SCI with rehabilitation is improved outcomes by one Frankel grade with rehabilitation*". He accepts that "*even absent negligent treatment, secondary injury can occur but it is very rare*". Furthermore, that "*on the balance of probabilities, had he been properly immobilised, he would not have developed an additional and higher level of disabilities and impairment*." Commenting upon the expert opinion of the claimant's expert in intensive care, he says "*I note that in his report Dr. Bell has set out the secondary injury which occurred as a result of multiple factors rather than an isolated single factor. I consider that amongst those multiple factors the crucial factor was sustained hypotension for 12 hours… which led to hypoxic insult and hence secondary injury to the initial incomplete spinal cord contusional injury… Dr. Bell also considers that the claimant would have recovered more as it was an incomplete lesion and seen some improvement… without that consolidation of secondary injury over that first 12 hours and to some extent beyond… with which I agree*"…. "*If it is accepted by the court that there was at least residual spinal cord function below the level of injury, I consider that, on balance, the claimant's neurological deterioration to significant and substantial spinal cord injury.. was preventable…AIS -B tetraplegia was caused by ischemic damage to his cervical spinal cord. The ischaemia was caused by hypoperfusion..I defer to [an expert in intensive care] as to whether or not the hypoperfusion could and should have been avoided*" "*With early and appropriate non-surgical management, the claimant would have recovered to the extent that he would have retained useful motor power and sphincter control, up until the latter years of life, he would have been able to walk indoors unaided and outdoors aided.. and be independent in some aspects of daily living.*" "*On the balance of probabilities, Mr. Dee would probably have improved to AIS-D with good care*". The Defence however does not admit to any specific classification of the claimant's injury ahead of their own examinations and denies that the claimant's outcome would have been improved but for the alleged negligence. The defendant's spinal surgeon, by signed letter but not including a statement

of truth, opines "*on the balance of probability, that there is sufficient doubt as to there being any motor function in the lower limbs. Dr. Lyness found no function and Dr. Griffiths found no function*.". He does not believe that there was any worsening of the neurological injury and takes the view that the pattern of injuries sustained by Mr. Dee was an uncommon type which has an extremely poor prognosis for recovery. The defendant's neurosurgeon's letter similarly unsigned by a statement of truth, opines that the spinal cord was "*irreversibly injured at the time of the fall. From the moment of injury the neurological assessments concur that there was no movement in the legs. No subsequent events changed the neurological disability of the claimant. There was no possibility that the claimant could have recovered to AIS-D.*" He goes on to state that "*there is no evidence that this claimant was ever C (incomplete motor). In reality he was B (incomplete sensory) and remained B throughout.*"

ii. Due to the negligence, it is claimed that Mr. Dee suffered avoidable loss of functional power in his upper limbs, trunk, lower limbs such that his mobility is significantly worse than it should have been. The defendant's neurosurgeon opines that spontaneous neurological deterioration is rare but states that the spinal cord was irreversibly damaged from the point of fall when there was no movement in the legs. The claimant's neurosurgeon accepts that a trial judge will need to make a finding of fact as to whether there was no movement in the legs in the early period following injury, in order to conclude that Mr. Dee sustained a severe AIS-B spinal cord injury at the moment of impact. His opinion continues, "*if the court finds that there was evidence of good hand grip strength and otherwise good arm and hand function in the initial period following injury and on admission to the Emergency Department, then subsequent deterioration in hand function was on the balance of probability due to the identified deficiencies in spinal cord injury care.*"

iii. the inability to spontaneously void his bladder or bowel. The claimant's expert opinion from a consultant in spinal cord injury is that "*with early and appropriate non-surgical management, the claimant would have recovered to the extent that he would have retained useful motor power and sphincter control*. He goes on to indicate that he would have been able to void his bladder spontaneously and manage his bowel care independently.

iv. a higher risk of syrinx, autonomic dysreflexia and other difficulties associated with a spinal cord injury.

v. a higher risk of development of further pressure sores (risk increased by 25-50%)

vi. a greater need for care, therapies and rehabilitation throughout his life

THE ISSUES THAT I AM ASKED TO DECIDE

11. Counsel for the claimant identified the threshold issue on eligibility for an interim payment on this application as set out below:

"Is there compelling evidence for the claimant that the defendants breached and caused (to a high degree of probability)

a) the lower limb injury to become permanent/ not to improve.

b) deterioration of the injury into the arms.

c) pressure sores."

12. It is also clear that I need to determine whether one specific defendant is liable to make an interim payment (CPR 25.7 (1) (c) or whether I am satisfied that the claimant would obtain a judgment for a substantial amount of money against at least one defendant, but I am unable to determine which one (CPR 25.7(1)(e)).

CHRONOLOGY

13. As the dispute involves factual disputes about the claimant's immediate injury and treatment, upon which I must reach a view, I consider it necessary to set out the chronology in some detail, extracted from the material presented to me, which included pleadings, witness statements, and clinical records. The witnesses of fact were:

For the claimant

i) Richard Dee (claimant) ("*RD*")

ii) Andrew Prosser (claimant's friend ("*AP*")

iii) Colin Anderson (claimant's friend ("*CA*")

iv) Dr. Jack Lyness (passing by off-duty doctor "*JL*")

For the defendants

v) Dr. Nicola Drake (consultant in emergency medicine at second defendant hospital "*ND*")

vi) Dr. Wojcieh Groblewski (consultant in anaesthesia at second defendant hospital "*WG*")

vii) Mr. Rupert Kett-White (consultant in neurosurgery at third defendant hospital "*RKW*")

viii) Dr. Sunita Agarwal (consultant in anaesthesia at second defendant hospital "*SA*" who first saw the claimant on 7/6/2019)

ix) Nicholas Leahy (root cause witness statement only- paramedic crew member "*NL*")

x) Jane Cole (root cause witness statement only- paramedic crew member "*JC*")

14. In the following table numbers in square brackets denote paragraph numbers in the source document.

Facts pleaded in the Particulars of Claim	**Lay witness evidence**	**Facts pleaded in the Defence**

At [5] The claimant was unable to move/feel his legs post-fall.	*RD* statement at [8] "*I was still able to move my arms*".	This is not admitted as outside the defendants' knowledge.
At [6] the claimant was able to move and had sensation in his upper limbs.		Claimant is put to proof - outside the defendants' knowledge.
At [7] at approximately 23:10 call to the ambulance service recorded loss of sensation and immobility in lower limbs.	*RD* says at [9] my friend Matt Smith told the ambulance I was unable to move my legs.	Admitted.
At [8] around 23:00 an off-duty doctor attends before the ambulance arrives and says 0/5 power and absent sensation in lower limbs.	At [10] *RD* told *JL* he could not feel or move his legs. *RD* believes he used his arms to help move into the recovery position. *CA* recalls *RD* could not feel *JL* touching his feet at [10] but could squeeze with his hand at [11]. *JL* says in his statement at [8] that he arrived on scene at around 23:00 and performed a visual assessment neurology was normal apart from the absence of lower limb power and sensation (and GCS of 14). He says at [12] these observations were repeated at intervals.	Admits what the lay witness said at [8].
At [9] At approximately 23:42 second 999 call when the off-duty doctor explained the claimant complained of no sensation or movement in his legs.		Admitted.
At [11] without him mobilising the claimant to any degree he was placed into a seated position on	At [11] when the ambulance arrived *RD* told them he could not move his legs. *RD*	At [9(i)] defendants aver says crowd lifted the claimant onto the trolley Admitted at [29(a)] the

the ground and then carried onto a trolley by lifting him from under his knees and arms.	says he was lifted onto a trolley and helped by grabbing hold of the lifters. Statement of *JC* that *RD* complained of no pain and injury was isolated to his face. Also states that *JL* confirmed no C-spine injury. Says the crowd took it upon themselves to lift *RD* onto the trolley. Statement of *AP* at [15] -The method of moving onto the trolley was confirmed as pleaded and in the statement of *CA* at [17]. Statement of *NL* – a member of the public grabbed *RD* by the leg to put him on the stretcher.	ambulance should have immobilised, but it is said this made no difference as a stable fracture. At D3 29 (a) it is also said that immobilisation for cord contusion is not usual practice. Denial claimant was lifted off the ground.
At [12] the ambulance crew lifted the claimant's jumper over his head, with assistance from the claimant who was still able to move his arms. Blood pressure readings indicated hypotension at 02:04, 02:16 and 02:20.	At [13] and [14] *RD* repeats he told ambulance crew and A&E staff he could not move/feel his legs. At [13] he recalls gripping a paramedic with his hands on request and his friend *AP* (at [16]. Statement of *AP* confirms at [18] crew told by *RD* he had difficulty with moving his legs but that he had strong hand grip and could move his arms above his head . At [19] he confirms the method of jumper	The defendants aver that the jacket was not difficult to remove and required very little movement and it is denied that the claimant's arms were lifted over his head. The blood pressure readings are admitted. Admitted at [29 (e) and (f)] the first defendant should have done timely IV fluids but aver it made no difference.

	removal as pleaded. He also recalls the paramedic's hand grip. Statement of *NL* –he helped pull the jacket over *RD*'s head -*RD*'s neck and arms did not move when this took place. He does not recall *RD* having any problems with movement whatsoever. Statement of *JC* that *RD* was thoroughly examined by her and had excellent grip and complained of no movement problems at any time.	
At [15] At 02:30 blood pressure recorded at 167/125 which was probably incorrect as there had been no fluids given.		Readings admitted at [14(1)] but Defence does not admit inaccurate. The Defence admits there was no assessment of mobility/sensation of lower limbs. It is denied at [29 (a)] for D2 that waiting 42 minutes was unreasonable in view of the lack of information from the ambulance crew as the department was very busy.
At [15] 05:20 blood pressure had dropped to 84/52 and at [16] no IV fluids were given until 08:15 when the claimant was also taken off the trolley.		This is admitted.
At [16] 1st doctor review at 07:07 over 5 hrs after admission		Admitted and aver 0/5 power lower limbs and 4/5 power upper limbs

07.55 loss of sensation recorded.		recorded by Dr Griffiths.
At [18] 09:20 consultant review No movement of lower limbs Wrist/elbow/shoulder power intact. Sensation at around level @around T3,	*CA* statement at [24] records that *RD*'s upper limb movement had reduced by this time. *ND* states at [21] she suspected a spinal injury and considered the cause of the low blood pressure could be spinal injury.	Admitted.
At [19] trainee trauma doctor review -reducing sensation/mobility from C8 level down. Hand mobility now 3/5.		Admitted at [18] abnormal motor 3/5 from C8 down but averred that this was a rapid assessment fraught with difficulty, so the claimant is put to proof that it really was a deterioration.
At [20] 11:05 CT scan – C5 vertebra and C6 acute fracture MRI small area cord contusion C6-7.		Admitted at [19] the imaging results and averred this indicates a stable single-column injury with fractures confined to the posterior aspect of the cord. At D2 [29 (d)] it is averred this was a reasonable timeframe for scans "*in the circumstances*".
At [22] 23:00 Grade 1 pressure ulcer recorded.		Admitted at [21] regarding sores. At [22] causation is denied as due to time on the trolley and averred that the cause was due to a long time on the road pre-ambulance.
At [24] 1st June morning worsening sensation from T6 on admission to CCU to		At [23] admitted.

T1-2 and limited hand function.		
At [25] 17.6.19 paraesthesia down arms into palms and unable to grip + grade 2 pressure sore -cannot use a wheelchair.	At [22] *RD* says his ability to move his hands and arms fluctuated but he could use his phone and pull himself using a side rail. By the time he was on an orthopaedic ward upper limb function had noticeably declined as he could only use a phone with a touch pen.	At [24] defendant adds words of the claimant from his notes that paraesthesia following his accident had improved but now returned and unable to grip.

SUBMISSIONS

Claimant's submissions

15. The claimant relied upon the fact that the case law, to which I have referred earlier, confirms I should make my determination on the material presently before me. To that end, it was submitted that there is robust expert evidence adduced from multiple clinicians relied upon by the claimant confirming both breach of duty and causation of Mr. Dee's current catastrophic injuries. I will not repeat that evidence which has already been set out above. It was clarified that the claimant would have expected to suffer some long-lasting deficit in his lower limbs, but it was the extent of the deficit and the deterioration into other parts of his body that was the subject of the claim.

16. Counsel also referred me to the hospital's own protocol for handling spinal injury which had not been followed in Mr. Dee's treatment and the fact that the defendants' lay witnesses have not justified their position in not adhering to such guidance, simply stating they were unaware of it. I was reminded that the case is brought on both the usual "but for" causation test and also pleaded in the alternative on the basis of material contribution.

17. I was also urged to carefully consider the factual evidence which it was said clearly indicates a gradual deterioration in Mr. Dee consistent with the alleged failures by clinicians. I was referred specifically to the three lay witness statements, the liability statement of Mr. Dee, his medical records and the statement of the paramedic, *JC*, which was prepared as part of an internal investigation. I have already summarised the relevant content of those documents at paragraph 14 above.

18. Acknowledging the dispute in the claimant's spinal injuries rehabilitation consultant's (Mr. Kumar's) classification of Mr. Dee's precise injury, which a trial judge might well examine further, it was submitted that I needed to look at the totality of the opinion advanced by the spinal injuries rehabilitation consultant and other experts and the trial judge would not ignore what Mr. Kumar had to say about deterioration in the upper limbs. It was drawn to my attention that the defendants' letters from 2 experts only

considered damage in the lower limbs and do not address the apparent deterioration into the upper arms, nor the pressure sore, although the defendant has indicated that there may be concessions in regard of the latter injury. The claimant resisted the suggestion that there should be an adjournment of the application based upon the tissue viability issue until after the exchange of expert evidence, as a disproportionate approach.

19. In relation to quantum, it was submitted that the Schedule of Loss gives full credit for Mr. Dee's clinical position following the fall and absent any clinical negligence.

Defendants' submissions

20. The defendants' approach to the application was to highlight why they believed the claimant could not demonstrate, to the required standard, that the evidence before me was adequate for my determination. There were 2 main aspects to this argument.

(a) Wrong categorisation of injury impeding a correct view on prognosis and avoidable damage

21. First, Counsel submitted that the difference in opinion between the parties' experts was "unresolvable" on the basis of the written material concerning the "but for" expected improvement in spinal outcome. The defendants' chief focus was the expert causation opinion of the claimant's spinal surgeon, Mr. Kumar. It was said that it is wrong to seek to apply the generalised thesis about spinal cord injury improvement adopted by the claimant's expert, when the defendants' spinal surgery expert's view was that the specific anterior cord syndrome from which he says Mr. Dee suffers is less common and very poor prognostically compared to the majority of spinal cord injuries (being those with central cord syndrome). It was argued that the medical literature relied upon by Mr. Kumar was therefore not sufficiently specific or focussed on the facts, in this case, to be helpful or instructive regarding rehabilitation and scope for improvement following initial injury. It was further submitted, that if Mr. Kumar had relied on literature that dissected out the different syndromes, and provided data about them, the defendants would have been able to reply specifically upon it.

22. Furthermore, I was taken to the letter from the defendant's expert neurosurgeon where he disagreed with Mr. Kumar's classification of initial injury as category C status rather than category B, which the defendant's expert maintained had been the injury level throughout. The defendant's expert spinal surgeon concurred, on the balance of probabilities, that there was no motor function in the lower limbs from the point of impact, hence a category C status was unsound, which is the claimant's pleaded case.

23. It was suggested the very starting point of the claimant's causation argument is flawed, in part due to the claimant having focused inappropriately on clinical examinations at 10:00 and 12:41 and not having taken proper account of the contradictory and "*cogent and compelling data at the scene of the fall: at 07:07 and at 09:20*".

24. Dealing with each of the examinations in turn:

    i) It was submitted that the examination by the off-duty doctor at the roadside, recording neurology as normal except for 0/5 in the lower limbs was only a visual inspection, not a neurological assessment and could not be relied upon to support a claim for progression of avoidable injury.

ii) The examination at 07:07 by Dr. Griffiths, a middle-ranking accident and emergency doctor, recorded at page 50 in the hearing bundle referenced 0/5 power in both lower limbs and no sensation which is contrary to Mr. Kumar, believing that the claimant was ever category C (incomplete motor).

iii) The examination at 09:20 by Dr. Drake, an accident and emergency consultant, recorded at page 49 in the hearing bundle referenced no movements in the lower limbs upon her examination which once again undermines the proposition of this ever being a category C case.

iv) At 10:00 the examination by a junior orthopaedic doctor who recorded power of 1/5 in L1 and L2 in the right leg, has been criticised by the defendants' neurosurgeon who states, "*There is no L1 myotome in the leg. Movement of the trunk can often be misinterpreted by an inexperienced doctor as movement of the upper leg. Grade 2 power is movement unable to overcome gravity. This is a very subjective finding and does not fit the rest of the neurological picture*".

v) Similarly, Mr. Laing, (the defendants' expert neurosurgeon) is critical of the examination at 12:41 by Dr Ashoka, said to be an anaesthetist not experienced in neurological examination, who noted 1/5 power in the lower limb. Mr. Laing suggests that "*It is more likely that recording1/5 was his shorthand for there being a severe weakness/paralysis of the legs*".

25. Another illustration of what was said to be the flawed approach of Mr. Kumar was his description, at page 800 in the bundle, of the initial insult to the spinal cord following the accident as both mild and relatively stable, whereas the defendants' spinal surgeon, examining the MRI scan, commented upon it as a "*catastrophic spinal cord injury*".

26. As the submissions had centred on the lower limb injury I asked counsel about the defendants' experts' position on upper limb loss, as I could not find reference to it in the 2 letters relied upon. It was submitted that it was not feasible, or a fair expectation, for the defendants to respond to every single point at this stage when expert evidence would be exchanged shortly. Furthermore, it was submitted that the claimant's causation expert, Mr. Kumar, had not demonstrated in any explicit fashion how any alleged progression was said to be negligent, especially as he had based his opinion on literature concerning the wrong type of spinal cord injury; as Mr. Kumar's starting point was said to be wrong that was the essential focus of the defendants for this application.

27. Finally, regarding the pleaded failure to meet the recommended target mean arterial pressure set out in a disclosed document headed "South West Trauma Network (SWTN) Clinical Guideline (CG) Spinal Injury (Adult Major Trauma Patients) dated January 2020, it was submitted that it post-dates the accident and the document provides guidelines, not tramlines. It was further submitted that NICE guidelines make it plain the defendants' conduct was perfectly reasonable.

(b) the incorrect drafting of the Schedule of Loss

28. The defendants were very critical of the Schedule of Special Damage for not demarcating which alleged injuries relate to specific losses claimed, such that it was said that I faced an insuperable task in trying to disentangle the items within the Schedule of Loss which would have been due to the initial non-negligent injuries arising

on impact, and any which related to the pleaded case of secondary deterioration. Furthermore, it was argued that any damages relating to the pressure sore would be insubstantial and therefore not satisfy the threshold eligibility requirements of CPR Part 25.

29. I will return to these quantum issues, as necessary, when I have set out my conclusions regarding the likelihood of avoidable injury.

ANALYSIS & CONCLUSIONS ON THE ESSENTIAL PRE-CONDITIONS (excluding whether quantum can be established as "substantial")

i) Findings of fact for the purpose of this application.

30. I remind myself that the claimant bears the evidential burden of proof and that I am required to look at the material before me and to make a determination on the balance of probabilities (to a high degree). For the purposes of this application, I need to make findings of fact if the issues are not too complex, always recognising that they will not be conclusive of the issues for the trial judge who will have the totality of material available to them when reaching their decision.

Was there any residual function in the lower limbs after the fall?

31. I have studied the records of the treating ambulance crew and the 3 lay witness statements in addition to the statement of the claimant and summarised them at paragraph 14 above. Mr. Dee is quite clear that he could not feel or move his legs after his fall. Such was his immobility that, despite being an active sportsman pre-fall, he remained on the spot where he had fallen, blocking part of the highway, until the ambulance crew moved him approximately 1 1/2 hours later. None of the witnesses claim that he could feel or move his legs apart from the 2 members of the ambulance crew whose non-CPR-compliant statements I found to be most unconvincing in this regard. Jane Cole said she performed a thorough examination and he had "*full MSC x 4*" which simply cannot be accurate given the subsequent findings of clinicians in the emergency department before and after scanning, and indeed the testimony of the claimant himself. Her paramedic colleague, who was the ambulance driver that night, also said he did not "*recall the patient claiming to have any difficulty with any movement whatsoever*" but his testimony is similarly uncompelling to that of Ms. Cole. Both colleagues put the lack of movement down to alcohol intoxication which simply does not fit the picture recorded by any of the other lay witnesses nor indeed the claimant's experts.

32. Whilst 2 doctors at the treating hospital recorded some minimal limb power a few hours after admission within their treatment notes, the expert clinical evidence is sufficiently unclear at present for me to form a view to the necessary standard of proof, that this was indeed possible or likely given the findings on MRI scanning. Neither of those doctors has produced a witness statement. Furthermore, 3 other doctors had previously and separately examined Mr. Dee, and all had reached conclusions that there was no power in the lower limbs which is a high evidential bar to overcome. I am not saying it would be an insuperable bar at trial but confining myself to the task in hand regarding the interim payment application I cannot be satisfied to the appropriate standard.

Was there any deterioration of the spinal cord injury into the arms or was the totality of the injury fixed at the initial point of impact?

33. Contrary to the defendants' submissions, I am satisfied that the pleaded case is sufficiently clear that the claimant is not only seeking damages for a failure to *improve* in function with appropriate treatment, but also for a failure to *prevent deterioration* into the upper limbs. For example, paragraphs 6, 29, 30 at (f) regarding the first defendant, at (b), (g), (h), and (k) regarding the second defendant, and at (a) regarding the third defendant, as well as paragraphs 32-34 generally within the Particulars of the Claim address this topic. I will therefore turn to consider the factual matrix.

34. As a finding of fact, I consider the testimony of the claimant's witnesses is compelling with regard to the initial existence of fully retained power and sensation in Mr. Dee's upper limbs after the fall. All of those witnesses are candid about the loss of function in the lower limbs and all of them are clear that there was still upper limb function following the fall, and notably hand grip. I have set out their testimony in the table at paragraph 14 so I will not repeat it. I specifically note that the evidence includes testimony from an off-duty doctor at the scene of the fall who was the first clinician to recognise the potential spinal injury and to conduct repeat observations over a period exceeding 1 hour. He found no upper limb diminution in power or sensation. For the sake of completeness, I record that shortly prior to handing down judgment counsel for the defendants drew my attention to a paragraph in the claimant's expert neurosurgeon's report where he noted that he had listened to the audio recordings of the calls to the ambulance service (which were not made available to me, by way of transcript or any other form). The expert recorded that the first call placed a few minutes after the accident described Mr. Dee as "*complaining of a loss of feeling in his hands. He was noted to be struggling with feelings in his hands and feet. He was on the floor*". The other material available to me indicates the call was made by Matt Smith. I have no lay witness statement from him, and I do not consider that I should place any weight on the summary of the ambulance call, made in the immediate aftermath of the fall, when it is contradicted by all the other witnesses who were with the claimant for some time after the accident occurred and had a better opportunity to observe the claimant and to listen to what he was saying over an extended period.

35. The ambulance service PCR shows the control room receiving a very clear message from those at the scene of the fall that the claimant was complaining of a complete lack of movement in his feet and legs i.e., the contemporaneous account taken by the first defendant does not indicate any difficulty with the upper limbs. Whilst I am critical of the generalised assertions made by Jane Cole about what she did or did not examine, her reference to "*excellent grip*", stands out for its specificity, and the fact of her testing the claimant's grip is corroborated by the claimant and Andrew Prosser who accompanied him in the ambulance; I have no reason to doubt them on this. Thereafter the chronology shows some diminution in upper limb function over time which is clinically recorded as 4/5 power at 07:07 and "*reduced tone in hands*" but wrist, elbow and shoulder power intact at 09:20. Colin Anderson, the claimant's friend who sat with him in the emergency department agrees that upper limb movement was reducing by this time. The deterioration gets worse through the claimant's time in the critical care unit as recorded in the unit's own observations and at the spinal rehabilitation centre after that. When he comes to leave that centre in April 2020, his discharge summary notes, "*Richard has some useful movement in his arms. He has very limited movement*

in his hands and cannot grip anything very well". Furthermore, on examination of his joints by the claimant's expert spinal surgeon (in March 2021) on page 215 of the bundle he had a moderate reduction of shoulder abduction and external rotation on both sides and the range of motion of the arms is impaired. The defendants have examined the claimant but not chosen to release their evidence, save what has been recorded in the treatment clinical records.

The sacral pressure sore.

36. The fact of the development of a sacral pressure sore some hours after initial injury is not contested, nor further tissue breakdown subsequently through to a grade 4 sore before it finally healed up. The dispute is around medical causation which I will address further below although the opinion expressed by the claimant's expert is tempered by how long the claimant lay on his back in the road. I therefore need to consider that factual issue and make a finding for the purpose of this application alone.

37. Colin Anderson believes he was by Mr. Dee's side within 2-3 minutes of the accident occurring, that Dr.Lyness arrived around 5 minutes later and "*not long after we got to him he started to vomit. My wife and I had to roll Richard to stop him from choking whilst the doctor tried to immobilise his head*". On the basis of that testimony the claimant was not lying on his back for longer than around 10 minutes or so.

38. Andrew Prosser says the accident occurred at around 11pm and about 5-10 minutes later that Dr. Lyness arrived and that Mr. Dee began to vomit before the arrival of the ambulance and that the doctor had assisted him into the recovery position. This account does not assist me in my assessment of the amount of time Mr. Dee was lying on his back.

39. Dr. Lyness thinks he arrived at the scene of the accident at "*roughly 11pm*" and that the accident occurred "*about 20-30 minutes prior to my arrival*" and that "*an ambulance had been called approximately 30 minutes before my arrival*". Then "*Approximately 45 minutes after my arrival the claimant vomited ..I therefore helped him move to recovery position… A second 999 call was made shortly afterwards to give an update ..with regards to the new vomiting*…"On the basis of that testimony the claimant was lying on his back for about 1hour and 15 minutes. I do not think these approximate timings can be correct by reference to the actual ambulance records which I consider below. As to the initial time of the fall, Dr. Lyness was not a witness to it, so I prefer the evidence of those who were with Mr. Dee on the evening prior to the accident and who attended him immediately after it.

40. The ambulance records note that they were first contacted at 23:10 and that a second call was made at 23:42 by which time Mr. Dee had vomited. I believe that these are the most reliable records which together with the lay witness accounts would indicate a maximum time of the claimant lying on his back in the road (not the recovery position) of about 40 minutes, but it may have been rather less. All of the accounts confirm that those at the scene before the arrival of the ambulance crew had been determined to move Mr. Dee as little as possible and nobody says he was moved out of the recovery position after vomiting.

ii) **Findings on breach of duty and causation for the purposes of this application**

41. Apart from the limited admissions of breach by the ambulance crew recorded at paragraph 9 of this judgment (failure to recognise the spinal risk, failure to immobilise, failure to initiate IV therapy and failure to pre-alert the hospital to the spinal injury), there is a whole catalogue of poor handling of the claimant's medical treatment, some of which is not sufficiently serious to be considered negligent, based on the material before me, but overall amounting to what could well be considered a very good training case study for clinicians in how not to treat a spinal cord injured patient. It is of course my task to focus on the areas of negligence, not poor practice which ultimately made no difference to the overall outcome, even if that was more by luck than judgment on occasion.

42. The sad chronology begins with the incorrect categorisation/triage of Mr. Dee by the ambulance service as somebody who had only sustained a minor facial injury whilst under the influence of alcohol. From that point onwards, until the clinical examination by a mid-ranking accident and emergency doctor at 07:07 the following morning, none of the treating professionals appears to have taken proper independent observations of his vital health signs or exercised good judgment as to his correct medical status. The evidence before me from the claimant's consultant in emergency medicine, Dr. Kennedy, which is not contradicted by expert opinion, is that Mr. Dee had only consumed a moderate amount of alcohol and "*by the time he was delivered to the A&E department his alcohol levels would have been very low if even present. Dismissing significant symptoms as being due to intoxication is very poor practice, and specifically warned against*".

Damage negligently caused by failure to immobilise.

43. Although much of the claimant's expert evidence points to the necessity for immobilisation of a damaged spine, at least until it has been fully scanned and diagnosed, there are a number of reasons why I cannot reach a finding, at this stage, that failure to do so was negligent (i.e., that this was a breach of duty causing or materially contributing to injury in the specifics of this case). For example, Dr. Kennedy (expert in emergency medicine) only opines that it is "*entirely possible*", that this failure led to deterioration and the claimant's expert neurosurgeon concludes it is *not* "*a significant contributor*" to Mr. Dee's overall functioning now. This is against a backdrop of opinion from the defendants' experts that the fracture was stable, and the spinal cord was irreversibly injured from the time of the fall.

Negligence leading to a failure to improve upon baseline condition at the time of the fall.

44. Similarly, on the basis of the expert opinion evidence currently before me I am not satisfied that it can be demonstrated that the original spinal cord injury to the lower limbs was of the type where there could be any significant improvement to the baseline condition following the fall, even with good rehabilitation. Mr. Kumar may well be able to satisfy a trial judge of his thesis upon cross-examination, and assisted by further medical literature and expert reporting but I am not in that position. None of the remaining clinical experts relied upon by the claimant apart from Dr. Bell opine as to the potential or likelihood of improvement of symptoms; rather their focus to date has been on avoiding deterioration. Dr. Bell says it would be reasonable to suggest that there would be some anticipated recovery with good care, but he has not suggested what that improvement might mean in terms of function or reduced loss.

Negligence causing bladder and bowel damage.

45. On the basis of the expert opinion evidence before me I am also not satisfied that it can be demonstrated that the original spinal cord injury to the lower limbs, would not have included some damage to the bowel and bladder. The timing of onset is unclear. There is insufficient detail within the expert opinions provided by the claimant for me to determine this issue for the purposes of the interim payment application. That evidence, with the exception of Mr. Kumar, focuses on other parts of the body and Mr. Kumar's views are heavily predicated on the classification of injury at the point of the fall which is strongly contested by the defendants' experts.

Deterioration into the upper limbs caused by negligent failure to manage blood pressure.

46. The allegations of breach which are supported universally by the claimant's experts focus on the failure to manage Mr. Dee's sustained period of hypo- tension which they do say quite strongly and clearly, on the balance of probability, generated a secondary injury and extended the area of irreversible injury. Dr. Kennedy, specialist in emergency medicine, references the *European Trauma Course Manual* on the need to exercise care to manage symptoms of neurogenic shock following spinal cord injury by ensuring optimal fluid resuscitation, as too little will lead to increased tissue ischaemia, and any episode of hypotension should therefore be avoided. At page 161 in the bundle, he states that the failure of medical review when Mr. Dee became hypotensive is below an acceptable level of care. I accept the claimant's submissions that his opinion is clear, persuasive and unlikely to result in there being a range of reasonable opinion as regards to the failures on the part of the first and second defendant. He defers to other experts on factual causation in the specifics of this case.

47. The claimant's intensive care expert, Dr Bell, describes "*the primary principle of management*" of this type of injury as one avoiding secondary injury by, inter alia, managing cord perfusion and oxygen delivery. He has expressed his opinion on the balance of probabilities that the sustained hypotension experienced by Mr. Dee, and the accompanying reduction in systemic oxygenation, generated a secondary hypoxic ischaemic injury extending the area of irreversible injury. The claimant's expert neurosurgeon also identifies this breach of duty and expresses his view on the balance of probability that "*any neurological deterioration suffered by Mr. Dee following initial admission to the emergency department*… was.. *due to failures in management*". Mr. Kumar has stated on the balance of probabilities that with proper care Mr. Dee would not have developed additional impairments and has identified "*the crucial factor*" responsible for secondary injury as "*sustained hypotension for 12 hours*."

48. I have taken note of the discrepancies in opinion as to what the target mean arterial blood pressure should have been, but I do not believe that undermines my conclusions in a situation where there was a total failure to do anything to properly monitor or manage blood pressure in the crucial hours post-injury. I am satisfied on the balance of probabilities (to a high degree) that Mr. Dee's blood pressure was not properly managed by the ambulance crew, who did not even record a number of their readings (which is uncontested) and, who inserted a cannula, they say because they were concerned about blood pressure, but failed to hook it up to any IV fluids at any time (again uncontested). The second defendant does not contest treatment records showing a fall in blood pressure some hours prior to clinical examination in the emergency department, and

many hours after arrival, and the fact that no IV fluids were administered at all before 08:15.

49. Furthermore, there is nothing in the 2 expert opinion letters obtained by the defendants addressing the upper arm injuries. The phraseology about deterioration being rare is all within the context of lower limb injury and directed towards the question as to whether the claimant could have recovered any useful lower limb function after the initial fall. There is a brief reference to it being "*sensible to maintain a normal blood pressure*" and to monitor for postural hypotension in the context of the issue of whether to immobilise or not. This does not contradict what the claimant's experts are saying loud and clear about blood pressure management. Where a defendant has not put forward evidence on causation issues, I am entitled to order an interim payment if I am satisfied with the claimant's evidence to the requisite standard. I am satisfied on the material before me that the claimant will succeed at trial in recovering losses for this mismanagement and the resultant injury. The only expert evidence that I have from the defendants is incomplete, does not comply with CPR part 35 and I have not had sight of the letters of instruction resulting in the opinions being drafted which appear to be incomplete concerning the issues this claim raises; the instructions are not summarised within the letters either.

Negligence leading to development of the sacral pressure sore.

50. I have previously mentioned that the defendants have quite candidly stated that they may admit liability for damages shortly concerning this aspect of the claim. The Defence admits breach of duty but denies causation due to the amount of time that the claimant spent on the road before any care commenced by any defendant. I have already made a finding, purely for this interim payment application, that the claimant was not lying on his back in the road for more than 40 minutes. The ambulance arrived at 00:46, 1hour 45 minutes post-injury. Dr. Kennedy says that pressure sores can potentially develop within 20 minutes but there is no record on admission that his skin was not intact. He is critical of the delay of 6 hours by the hospital in recognising the risk of pressure sores developing and steps being taken to address this. He classifies this omission as both a breach of duty and causative of damage. Mr Parkhouse, expert plastic surgeon for the claimant has opined that the causative element of the sore was "*likely*" to have been unrelieved pressure while lying on the road "*followed by a further period of unrelieved pressure on the trolley in the A&E department before the spinal cord injury was diagnosed*". Further, that the time spent by Mr. Dee sitting up in ITU caused direct pressure on the sacrum which was "*likely to have aggravated* [the sore] *that had already begun*". However, his opinion is based upon him considering that Mr. Dee had spent "a *period of just over one and a half hours before the ambulance arrived*" which is contrary to my finding of fact which indicated a much lesser period of time. Accordingly, I find that the defendants' various omissions caused or made a material contribution to the development of the initial pressure sore and to its deterioration and that the claimant would succeed on this point at trial, based upon the material before me.

Party against whom the interim payment order should be made.

Given the various failures of the defendants which I have identified and held to be causative of the claimant's deterioration in upper limb function and development of

pressure sores, I believe it is appropriate I order an interim payment pursuant to CPR 25.7(1)(e).

Quantum of the interim payment to be ordered.

51. Happily, I do not believe there is any dissension between the parties as to the correct methodology for determining the amount of an interim payment pursuant to the two-stage test derived from the case of *Eeles v Cobham* [2009] EWCA Civ 24. First, I must make a conservative estimate for each relevant head of loss. Those estimates will then be discounted globally in paragraph 68 by 10%, so that only a reasonable, albeit high, proportion of my overall conservative estimates is allowed for the final sum approved by way of interim payment at this stage.

(i) The upper limbs -Pain, suffering & loss of amenity.

52. Whilst I accept the defendants' criticism that the pain suffering and loss of amenity award pleaded in the schedule of loss is taken from the *Judicial College Guidelines ("Guidelines)* (16th edition) in respect of tetraplegia, and therefore inappropriate, I do not consider it a particularly difficult task to consult the *Guidelines* for a more appropriate valuation pertaining to reduced range of motion in the shoulder and arms and weakness in the hands, especially with grip and dexterity.

53. First, I remind myself what has been recorded about the degree of the upper limb injury so far. I have previously referenced (at [35] above) that on 07/04/2020 in a hospital discharge summary the claimant had very limited movement in his hands and could not grip anything very well. That same report recorded that his finger joints (MCP and PIP) were at ¾ flexion. Also, that in March 2021, on page 215 of the bundle, he had a moderate reduction of shoulder abduction and external rotation on both sides and the range of motion of the arms was impaired. At page 246 it was recorded that he has severe generalised spasticity including his arms. His expert occupational therapy evidence dated 21/04/2022 and found at page 342 in the bundle noted a loss of the natural arches in the hands, giving a "*flattened appearance*", an ability to "*use an adapted grasp to hold a pen with his right hand once he had "woken up" his hand. He could hold a thermal cup by sliding his fingers through the handle and with a lot of focus could hold a sheet of paper but only with his left hand. Mr. Dee was able to demonstrate these actions a few times before being impacted by fatigue. Mr. Dee reported that to cope with the pain and spasms in his hands he is regularly set up with a bowl of warm water to soak them in, which he finds beneficial*". Mr. Dee's expert physiotherapy report at page 762 in the bundle records his function as at November 2022, following a rehabilitation programme, as having upper limb power around the shoulders, elbows and wrists at grade 5, but weakness in the hands of the long finger extensors and the intrinsic muscles, more so on the right than the left (prior to the injury he was right hand dominant).

54. I have studied the claimant's quantum witness statements and at paragraph 55 of Mr. Dee's statement dated April 2022 he says, "*My hands continue to be an issue for me in terms of the lack of strength and dexterity which limits what I can do*". Mr. Dee's wife, Dawn, states at paragraph 49 of her witness statement, similarly dated, that she usually has to help her husband towards the end of a meal when his hands become too weak to scoop the food onto the fork. Mr. Dee's Immediate Needs assessment dated September 2022 at page 873 in the bundle records that he can wheel himself around in his

wheelchair using bike gloves, but that he cannot cut up meat at meals though he can hold cutlery, using a fork or spoon to eat with. A prior case management assessment in March 2022 referenced at page 664 of the bundle that, "*He was able to form a loose fist with both hands and could partially oppose his thumb towards his fingertips, but movements were slow. Active movement within the right-hand was more limited and movements were poorly co-ordinated*".

55. Returning to the *Guidelines*, the orthopaedic bracket C for shoulder injuries that are serious, has a range from £12,770 - £19,200 and includes functional difficulties with restricted movement and weakness of grip. It also includes brachial plexus-type injuries which are not severe. It cannot be appropriate to consider the less severe bracket titled "moderate" as that only encompasses injuries lasting more than 2 years where they are soft tissue injuries.

56. Another orthopaedic bracket within the *Guidelines* which might be of assistance with the valuation is bracket I, for hand injuries. That section begins with a general introduction stating, "*The hands are cosmetically and functionally the most important component parts of the upper limbs*". There are five brackets for injuries which do not involve the total or effective loss of both hands, but which are not confined to loss however severe, to individual digits. They overlap somewhat in terms of valuation, so I will set them out fully:

(I) (b) Serious Damage to Both Hands	Such injuries will have given rise to permanent cosmetic disability and significant loss of function.	£55,820-£84,570
(I) (c) Total or Effective Loss of One Hand	This bracket will apply to a hand which was crushed and thereafter surgically amputated or where all fingers and most of the palm have been traumatically amputated. The upper end of the bracket is indicated where the hand so damaged was the dominant one.	£ 96,160-£109,650
(I) (e) Serious Hand Injuries	Such injuries will, for example, have reduced the hand to about 50% capacity. Included would be cases where several fingers have been amputated but rejoined to the hand leaving it clawed, clumsy and unsightly, or	£ 29,000-£61,910

	amputation of some fingers together with part of the palm resulting in gross diminution of grip and dexterity and gross cosmetic disfigurement.	
(I)(g) Less serious Hand Injury	Such as a severe crush injury resulting in significantly impaired function without future surgery or despite operative treatment undergone.	£14,450-£ 29,000
(I)(h) Moderate hand Injury	Crush injuries, penetrating wounds, soft tissue type and deep lacerations. The top of the bracket would be appropriate where surgery has failed and permanent disability remains. The bottom of the bracket would be appropriate for permanent but non-intrusive symptoms.	£5,720-£13,280

57. I invited counsel to make brief submissions prior to the handing down of this judgment on the correct place within the valuation bands for me to conservatively estimate the loss. Counsel for the claimant invited me to adopt a "*reasonable starting point*" of comparing the difference between awards for tetraplegia and paraplegia but I indicated that I felt there would be significant overlap and without the benefit of reported cases within the bundle declined that approach. I wished to focus instead upon functional outcomes as best I could, rooted in the available expert evidence. Thereafter he contended for a figure of £50,000 and referenced bracket (I) (b) "serious damage to both hands, emphasising the bilateral nature of the injuries, if I was not minded to accept that the correct guideline was 7(F) "Other Arm Injuries".

58. Counsel for the defendants submitted that the correct approach was to utilise bracket 7(C) for the shoulder injury, stating that it was at most midpoint if not lower quartile of the serious category which I have referred to at [55] above. Contending for the lower quartile the defendants submitted £14,377 was a suitable figure. As regards the hand injury the defendants maintained that the more appropriate bracket was category (g) or (h), which when combined with the award for the shoulder injury would produce a RPI inclusive PSLA award of £20,000 on a conservative basis. They alerted me to the narrative description attaching to hand injuries at category (I) (e) where there is a 50% loss of capacity as being inappropriate and drew my attention to the narrative overlap

with the even higher value category (I) (b) contended for by the claimant, which was for more serious injuries where function is significantly impaired.

59. I conclude that as there is reference in the shoulder injury bracket to impairment of the whole arm including grip, and after noting some level of recovery in the upper arms following rehabilitation, but continuing significant deficit in both hands, I would do best to focus on the *Guidelines* available for injury to two hands. I do not doubt that in due course there is likely to be further consideration of the loss of some other upper limb function but given the overlap potential and some apparent recovery through therapeutic input, I think it is better to focus the hands today as that is where I have the best level of detail. I therefore also decline to value the interim award on the basis of an "arm injury" as contended for by counsel for the claimant, rather than injury to the hands simply due to the material before me evidencing functional outcomes. Notably, since the hearing I have read the claimant's own occupational therapy report dated 21/04/2022 which states at 3.1.3 "*Mr. Dee was able to lift both arms above his head and reach behind his back to low thoracic level, demonstrating a good range of active movement in his shoulders. Full active flexion and extension of his elbows, with full pronation and supination of his forearms was noted. He was able to resist passive flexion of both wrists when actively extended*".

60. The importance of injury to both hands for someone who has no use of their legs cannot be understated. Whilst I have a fairly good level of detail around Mr. Dee's ongoing functional hand impairments, the *Guidelines* contain functional descriptive overlaps that are not as clearly worded for this type of injury as one might wish, no doubt due to the paucity of suitable supporting case law. I did have a cursory look at both *Kemp & Kemp, The Quantum of Damages* and *Lawtel Quantum* reports to see if I could find any authorities to assist but nothing relatively recent seemed comparable, and no cases were put before me in the bundle. Doing the best I can, I do not believe the award for the hand injuries could be less than £29,000 which needs to be uprated as set out in the following paragraph. Only category (I) (b) appears to relate to injuries to both hands, but category (b) is too broadly drafted for me to apply it at this interim stage. The phrase "*significant loss of function*" is not measurable in the way I would wish or need to justify applying such a high level of award. It is something short of total loss of both hands which is category (a) above it. The description at category (e), (valued at less than (b)), sounds more serious than Mr. Dee's situation (at least as currently measured in reports) but only applies to one hand, whilst the broad description at (g) of significant impairment, but only to one hand is again very generic but is not inconsistent with Mr. Dee's injuries, which affect <u>both</u> his hands and therefore includes his dominant hand. I do not forget that the appearance of Mr. Dee's hands is also permanently altered due to muscle atrophy causing "*flattening*". £29,000 is the overlap figure at the bottom of category (e) and at the top of category (g) which is why I have chosen it. Category (h) is simply too low, relating to lacerations and soft-tissue injuries to one hand only, albeit with some permanence at the higher end of the bracket.

61. The introduction to the *Guidelines* reflects RPI increases to September 2021 only and therefore needs to be uprated further to reflect recent inflation. I am reliably informed that the Hargreaves Lansdown inflation calculator produces an uprating to 10th November 2023 of 22.6% which I will apply in my summary. For completeness, I note that the defendants had submitted that any RPI adjustment should be considered in the context of being a guideline not a tramline so they did not favour the application of a

precise statistical sum, but I considered that there was no justification in this case not to apply a real-life percentage uplift where I was relying upon the *Guidelines* rather than reported cases to value this particular injury.

ii) The upper limbs -interest on general damages ("PSLA").

62. Interest is claimed at 2% per annum from the date of service of proceedings which amounts to £751.10 on the PSLA award for the period from 29th July 2022 to hand down of this judgment on 13th November 2023 (being the composite rate of 2.59% as submitted by counsel for the claimant).

iii) The upper limbs -past losses.

63. Counsel for the claimant submitted that even if Mr. Dee had been rendered paraplegic by the original fall he would still have been able to self-propel, transfer, do his personal care and drive with hand controls. I cannot find authority for all those functional skills within the present material before me. Mr. Kumar does state on the balance of probability that the claimant "*would have recovered to the extent that he would have retained useful motor power and sphincter control, up until the latter years of life he would have been able to walk indoors unaided and outdoors aided ... and be independent in some aspects of daily living*" (at page 816 in the hearing bundle). However, that opinion is expressed within the context of his spinal classification which I have been unable to safely determine at this juncture. The other experts relied on by the claimant do not address the actual functional outcomes for the claimant in their opinions on causation which support avoidable deterioration in the upper limbs, as they might relate to out-of-pocket expenses. I have already mentioned that the defendants sought to dissuade me from approaching any calculation based upon the Schedule of Loss because it did not separate out the various claims adequately.

64. I accept that the Schedule of Loss does give some credit for a baseline unavoidable injury, but it is still not possible to extract losses purely associated with the upper limb disorder for the vast majority of sums claimed. I am confident that the upper limb injury itself, and the factual evidence in support of consequential losses merits an award for some gratuitous care, but on the present material I am unable to distinguish the relevant amount of care from that claimed for other aspects of injury, where I cannot yet be satisfied the claimant will succeed at trial in proving negligence. The items that I can separate out are for de minimis amounts in the Schedule, i.e., for adapted cutlery (£91.35), large-handled mugs (£194.88), replacement electrodes for FES upper limb (£2012.40) and active hands (£488.40). I recognise that some additional therapy will be needed to optimise upper limb function (over and above therapy directed towards strains placed on those limbs by having a lower limb spinal cord injury) but I cannot calculate the amount from the Schedule. There will be additional heads of loss no doubt, which I have not mentioned. For now, I would place a conservative valuation on the items I have been able to identify at £2500.

(i) The pressure sore -pain, suffering & loss of amenity.

65. There is no Judicial College Guideline to assist with valuing pressure sores. Counsel for the claimant handed up 2 case authorities to try and assist me. The first, *PW v Abertawe Bro Morgannwg University Health Board & Others* [2014] reproduced from a Lawtel report, related to an out-of-court settlement on behalf of a 34-year-old woman

who was hospitalised for major spinal injury, rendering her paraplegic and who developed a Grade 4 pressure sore, similar to the claimant. She had to undergo numerous debridement procedures followed by vacuum-assisted closures. Liability was admitted but causation was denied. She alleged her spinal rehabilitation was much delayed due to the sores and that she now required a care package more akin to a tetraplegic as a result. The settlement on a global basis was for £1,000,000 (suggested to be worth £1,500,000 after allowing for inflation) with an estimate of the pain and suffering award by the claimant's solicitors of £100,000.

66. The second case put before me was *PH v Great Western Hospital NHS Foundation Trust* and was similarly reached an out-of-court settlement in 2018. The claimant was a 77-year-old paraplegic man (at the date of settlement although his injury had occurred at age 72) who developed a full-thickness sacral ulcer that developed into a large cavity wound. He required prolonged hospital care and remained at risk of further ulceration at the site. He had been noted to have a grade 1 sore on admission. He was in hospital for just over a year (on and off) with a (deteriorating) sore throughout. He had increased care needs when finally discharged. Negligence was admitted and a global settlement reached of £250,000. It was estimated that the pain and suffering award amounted to £80,000 and past losses of £20,000. I was not supplied with the uprated figures.

67. The defendants did not supply any alternative cases, nor a detailed critique of the authorities supplied by the claimant, simply submitting I was facing an insuperable task and this aspect should be adjourned as it was possible some admissions would be made, relatively shortly. If any such admissions have been made, they have not reached me or the court CE file.

68. I remind myself that whilst Mr. Dee's sore lasted from May 2019- December 2019 (approximately 7 months) and the wound has remained healed since then, he is left with scarring and vulnerability. His expert plastic surgeon states that he will now require pressure-relieving devices for the rest of his life. He also underwent 5 debridement procedures and had a vacuum dressing applied. He has also had pressure areas on his heels. I am entitled to form a view on the material presented to me, and the defendants have not chosen to put in evidence of their own. I take account of the fact that Mr. Dee is closer in age to the claimant in the second case but did not suffer quite as long as him. I am content to value the injury for present purposes at £80,000 (without adding any uprating element).

ii) The pressure sore -interest on general damages.

69. I will allow the usual 2% pa interest from service of proceedings to be added to the general damages figure.

iii) The pressure sore -past losses.

70. I am aware that the occupational therapy report relied upon by the claimant states at paragraph 3.1.7 that to reduce the likelihood of further skin breakdown Mr. Dee now wears alternative clothing and footwear. He had a pressure-relieving cushion on his wheelchair, a pressure-relieving mattress on his bed, a Toto turning bed to change position during the night and used pillows to position his legs. These items then appear in the Schedule of Loss. What is much less clear to me is how many of the items would have been required anyway as good preventative practice for his paraplegia, regardless

of his actual pressure sore history. I am therefore not able to include any element for these items within the interim payment being ordered at this juncture.

CRU and the calculation of the final award.

71. Neither the hearing bundle nor the Schedule of Loss contained any details of the DWP recoverable benefits which should ultimately be taken into account. However, subsequently, a certificate was produced, and it appears that given the heads of loss which I have taken into account for the purposes of this interim payment, I do not need to consider that aspect further.

72. Having reached a total conservative estimate for each of the identified heads of loss I have prepared a summary of those estimates below. It can readily be seen that these total £121,118.85. I am then discounting that total by 10% to achieve a suitable proportion, albeit a high one, in accordance with my discretion and previous case authorities which can be readily referenced in the notes to CPR part 25 in the White Book. The total amount to be awarded today is in the sum of £109,006.96. My assessment does not bind the claimant to spend the interim award on the items I have used as a basis for my calculations, and nor does it fetter a trial judge in their independent assessment of the correct heads of loss in due course. I am satisfied on the material before me that the claimant will succeed in his claim for the 2 injuries that I have described. I am also satisfied that the sum ordered does meet the threshold test of being a "*substantial*" award even though it is rather less than the claimant was seeking in their application. A six-figure award in the context of personal injuries for just 2 aspects of injury claimed, namely some loss of function/impairment in both hands, and a Grade 4 pressure sore is not a negligible figure. It exceeds the portal, fast track, and intermediate track limits for damages claimed in personal injury cases and is a substantial amount.

ITEM	**AMOUNT in £**
PSLA	29,000 +80,000
RPI uplift	@ 22.6% on 29,000 only= 6554
Cumulative PSLA total	115,554
Interest on PSLA @2% pa. from 29.7.2022 to 10.11.23 (i.e., 2.59%)	2992.84
Equipment & miscellaneous past losses	2500
Interest on past losses from 30.5.2019 to 13.11.23 at the half rate=2.88%	72.01
TOTAL	121,118.85
FINAL TOTAL after discount of 10 %	109,006.96

73. Accordingly, an interim payment is ordered in the sum of £109,006.96 and consequential directions will follow.