Case No: 3YS51038

Neutral Citation Number: [2017] EWHC 863 (QB)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/04/2017

Before :

THE HONOURABLE MR JUSTICE BLAKE

- -

Between :

SATVEER RATHORE	**Claimant**
- and -	
BEDFORD HOSPITALS NHS TRUST	**Defendant**

- -
- -

Chris Bright QC and Richard Grimshaw (instructed by **Wadsworths**) for the **Claimant**
Farrah D Mauladad (instructed by **Kennedys**) for the **for the Defendant**

Hearing dates: 25 – 28 October; 10 November, 12 – 13 December 2016; 23 January 2017

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Judgment

The Honourable Mr Justice Blake:

Introduction

1. The claimant in this action sues the defendant hospital trust for damages for injury that she says resulted from a failure to treat her properly.

2. She was born in May 1980. She is a Sikh by community origin and her family live in the Nottingham area. On 1 July 2000 she married Amarjit Singh a member of her community whose family lived in Kempston in the Bedford area. Following her marriage she lived with her in laws and extended family in Kempston.

3. On 3 April 2003 she gave birth to her first child J. She was still living with her in laws. The tradition in her community is that her parents in law take charge of the new born child for the first 40 days. At some point after April 2003 she set up home in the village of Wooton not far from Bedford and Kempston.

4. On 26 January 2004 she started work as a Customer Contact Adviser with Autoglass in Bedford. She continued to work for Autoglass until 16 July 2011 when she was made redundant, although her job description, place and hours of work changed.

5. On 22 September 2005 she gave birth to her second child A in Bedford Hospital. Following his birth she was discharged to the address of her in laws in Kempston who assumed responsibility for the baby's care. However, the period when A stayed with his grandparents was extended beyond the conventional 40 days and he and J stayed with their grandparents for a significant period of time after the claimant returned to her own home in Wooton.

6. On 4 October 2005 the claimant was admitted to hospital with post-partum bleeding. She was transferred to the gynaecological ward where no subsequent bleeding, complaint of abdominal pain, nausea, fever or urinary/bowel symptoms were recorded and she was discharged home with the advice to return if there was bleeding or abdominal pain.

7. Vaginal swabs were taken that showed she was suffering from Chlamydia Trachomatis, a sexually transmitted infection (STI) that is normally treated effectively by antibiotics administered either in a single dose or over seven days. However, neither she nor her GP were informed of the positive swab results with the effect that no treatment was administered until October 2006, a year later. The defendant accepts that the failure to inform the claimant and ensure that both she and her husband received appropriate treatment was a breach of its duty of care.

8. Between 5 October 2005 and September 2006, the claimant's medical records reveals that she complained of abdominal pain on six occasions to either her GP or the Accident and Emergency Department (AED) of Bedford Hospital namely, 8 November, 21 November 2005, 17 March, 31 March, 1 April and 15 May 2006. She was prescribed Co-Dydromol, Domperidone, and Ibuprofen during this period by way of pain relief. On 10 July 2006 she returned to work at Autoglass.

9. On 12 September 2006, she was admitted to Bedford Hospital following attendance at the AED complaining of abdominal pain and bleeding. On 14 September she

underwent a laparoscopy and she was found to have an ectopic pregnancy in her left Fallopian tube that was removed by a salpingectomy. She was discharged the following day.

10. On 18 October 2006, she complained of lower abdominal pain, called for an ambulance and was taken to AED. It was in the course of the investigation conducted on this day that she was told of the positive result for Chlamydia from the previous year. She was prescribed the relevant antibiotic (Doxycycline).

11. On 26 October 2006, she was seen by a gynaecologist complaining of fever and abdominal pain that she said she had suffered from for over a year. By this stage both she and her husband were being treated for the STI. A swab was taken that was subsequently found to be negative when she attended the Sexual Health Clinic on 9 November.

12. On 21 November 2006, both the claimant and her husband repeated the treatment as they had not previously been treated simultaneously. Subsequent tests showed that both were clear although there was no record of treatment with anti-inflammatory medication.

13. Her GP records suggest that until October 2006 she was addressing the pain she experienced through lower strength medication that could mostly be obtained over the counter. On 5 October and 30 November 2006 she was prescribed a heavier opiate based painkiller Tramadol.

14. On 11 November 2006, she was admitted to hospital suffering from vomiting and a severe headache and she told staff that she had taken 20 to 30mg tablets of Morphine Sulphate as she had been feeling depressed for some time. AED staff assessed that this amount would have been a lethal dose. Blood tests were negative for paracetamol and salicyclate. She was referred to her GP to consider treatment for depression and a possible psychiatric outpatient referral.

15. She was in receipt of sickness pay from her employer from mid-October 2006 to mid-January 2007.

16. On 30 January 2007, she was referred to Bedford Hospital by her GP with a history of non- specific abdominal pain that moved. On the same day she made a complaint to the defendant trust about ‘ongoing negligence I have experienced at the hospital’. An ultrasound was found to be normal on 5 February.

17. She contacted her GP to complain of abdominal pain on 9, 12, 15, 16 and 19 February 2007 and was advised to go to hospital if the pain worsens. She was seen in the AED that day complaining of abdominal pain.

18. On 26 February 2007, she presented to AED again with vaginal bleeding and abdominal pain. It was noted that her CRP (an indicator of inflammation) was raised at 53. She was admitted to hospital and was treated with antibiotics for suspected pelvic inflammatory disease. She was seen by the pain team on 28 February and gave a history of abdominal pain for approximately 18 months that was gradually getting worse. She described a sharp stabbing pain which also presents as a spasm type of pain with analgesia of minimal effect. She was discharged on 1 March with a

combination of pain relief medication including Tramadol and given contraceptive advice.

19. In the course of this admission on 27 February she was seen by a psychiatrist, psychologist and a surgeon, It was assessed that there was unlikely to be a physical cause for her pain. An extensive social history was taken. Her notes read:

> 'On reviewing her recent history seems has had many life stresses since 2000 when she had an arranged marriage. Family of husband are v. traditional Asian. She was not allowed to leave house for first 6/12. When finally allowed to get a job was forced to hand over her earnings to mother-in-law.
>
> She was brought up in UK in a much more modern family. Eventually developed EEOH problem drinking one to two L of vodka per day. She has since had two children and her problems are resolving. Still feels lots of pressure from relatives to get better. Money is a concern.
>
> On observation seems pain is coming in waves every 20 minutes or so. Pt asking for "pain-killers" regularly. Especially when I started to explain that it seems that her psychological problems may be contributing to her pain. Between these cramps she seems perfectly well in appearance.
>
> I have explained that it seems her pain may be exacerbated by her psychological problem. I explained the theory of physical, emotional and spiritual pain and that her stressors may manifest in spasms of the bowels.
>
> She is very unwilling to except this explanation of her symptoms. Asking for more strong opiate analgesia. I have explained that since Oramorph is not relieving her pain it is more than likely that further opiate analgesia will be futile. I have also explained that further investigation (e.g. colonoscopy) is very unlikely to uncover a cause for her symptoms. I have recommended anti-spasmodic and have also recommended ceasing the rest of her analgesics. I have tried to encourage her to explore her relational conflict with her family and to continue work as a distraction from her abdominal pain.
>
> She is very unwilling to accept this explanation; although she does accept that further opiates and analgesia is fruitless I have encouraged her to try and stay away from the GP for the next week and to see how she progresses.'

20. In summary her medical records for the next fourteen months indicate:

    i) 21 March: her condition had improved slightly with the use of patches.

    ii) 8 May: following a complaint of chronic pelvic pain there was a gastroenterology referral to Milton Keynes Hospital where a history of both upper and lower abdominal pain was noted. Her abdomen was soft vaguely tender throughout with no focal tenderness.

    iii) 14 June: GP recorded 'abdominal pain different from usual since taking emergency contraception'.

    iv) 25 June: she returned to work for six weeks now working a 32.5 hour week.

v) 3 July: the gynaecological registrar wrote: 'she gives a history of recurrent UTIs for which she is being treated at the moment. On examination there is no abnormality at all. There was very mild tenderness over the bladder but nowhere else'.

vi) 4 July: condition improved slightly back at work, although a skin problem was noted.

vii) 10 August: her condition had improved.

viii) 14 September: her GP referred her to the dermatology department of Bedford Hospital with the observation:

> 'This 27 year old presents with an increasingly impressive facial rash that has failed to respond to local and systemic treatment. I initially felt that she had Impetigo, but she did not respond to treatment Magnapen. Mrs Rathore has a long history of lower abdominal pain which she has been bounced between physicians, gynaecologists and surgeons. This pain now seems to have improved spontaneously to be replaced by her skin problem. I feel that there could be a psychological element to Mrs Rathore's problems if not full blown dermatitis artefacta but I would hesitate to make this diagnosis without your opinion.'

The consultant noted

> 'The lesions on her face appear to be deep excoriations and there could well be a psychological background but I have taken a swab for microbiology.'

ix) 1 October: 'abdominal pain worse no new developments rash worse'.

x) 2 October: 'abdominal pain type refer gastroenterologist'.

xi) 8 October: the consultant dermatologist noted:

> "This lady's patch tests show positive reactions to Nickel and Colophony. She is known to be allergic to Elastoplasts, which is in keeping with Colophony sensitivity but the more I see of her, the more that I am convinced that her problems are essentially of neurotic excoriation of the skin. I am sure there is a lot of stress going on in the back-ground here."

xii) 8 January 2008: she was seen at Milton Keynes General Hospital for abdominal pain. A gastroscopy and a colonoscopy were normal.

xiii) 10 April: she reported pain on urination that was said to have been a recurrent problem since childhood and was associated with intercourse.

xiv) 15 April: she was still being treated for open sores on her face that she reported as having started around the time of her Chlamydia and ectopic pregnancy.

xv) 17 April: Mrs Gill Pugh (a clinician employed at the health centre) took a detailed history from her that is recorded as follows

> "Between the ages of about 9 and 12 she began to develop joint pains and stiffness that were so severe she would need to be admitted into hospital for the contractures to be released by using hotpacks and physiotherapy…the physio was almost constant for around 2 years. Satveer is sure she was told the joint stiffness was linked to the frequent UTIs (urinary tract infections). Between the ages of about 8 and 16 Satveer recalls suffering from frequent abscesses which would come up from time to time on any part of the body. She said that other members of the family got them too. In her teenage years she began to develop frequent UTI's and migraines which she is still suffering with today. These were not as frequent in the first four years of her marriage. She told me that when she was drinking heavily in the year after her marriage, she developed an itchy rash and was told she had problems with her liver and kidney. ….. Over the past 2.5 years Satveer has experienced pain in the pelvic area which spreads to the stomach in a band around her back. The pain has been present in the day after her last child was born. It was so bad whilst eating and drinking that she would scream in agony and vomit not being able to keep water down. She was a frequent visitor to A & E in Bedford almost every day and she would speak to her GP on a daily basis. She was usually just sent home with pain killers. The gynae team could find no cause for the pain and requested a colonoscopy and gastroscopy but this was never done. In November 2005 the constant pain was accompanied with PV bleeding and she had a whole series of STI tests done. She says she received a text message from the chlamydia service to say that she was clear (the diagnosis of ectopic pregnancy and salpingectomy is recorded). The pain was no better after the operation and she recalls a doctor looking through her notes and asking if the chlamydia infection had been treated. Satveer was not aware she had this infection and believes she was not treated until 1.5 years after the initial test. On testing both she and her husband proved positive for chlamydia. They do not use condoms and Satveer is sure her husband has been faithful to her for many years. In frustration she tried to go back to her family in Nottingham to get treatment there. She was seen in Nottingham and referred to a pain clinic but the appointment has never come through. They also suggested acupuncture as she gets pins and needles in her hands and legs too. I informed her of the alternative therapies working from the surgery. In the end her GP referred her to Milton Keynes where she had the colonoscopy and gastroscopy showed she did have some gastric inflammation. Since the ectopic she has developed sores on her face and body that weep and sting. She was given a course of antibiotics but that did not cure the problem. She had a private referral to a dermatologist where the consultant put it down to stress and depression. Satveer has just returned from a holiday in India. She reports that her skin was really clear on holiday, the sores came back after she returned home. The UTI's were also better when she was away and not having intercourse.

> H/O depression. Became depressed when she was aged 21 when she was strongly encouraged to get married. After her marriage she moved away from her family to live with her husband's family who were all complete strangers to her. She was prescribed anti-depressant and beta blockers for a short period. She reports that she became a heavy drinker for around a year at this time. Having witnessed her father drink heavily at home as a child, she thought this might be the answer to her depression. Her husband helped her through this period. After three years she had her first child and she and her husband moved into a home of their own and things got better. Has had further episodes of depression due to her ill health, which is on-going and she is currently taking Fluoxetine. She felt suicidal after having an ectopic pregnancy in 2006 and took an overdose. She was referred to a counsellor but did not have therapy as she was in too much pain at the time."

21. On 26 July 2008, she was involved in a serious road traffic accident on the motorway near Newport Pagnell. Her car was a write-off and her husband collected her. She subsequently wrote in her diary that she was lucky to have survived the crash and had seen her life going past her. She did not attend hospital that day as advised by paramedics but attended Coventry AED on 27 July where the notes record her description of events as follows:

> 'Yesterday involved in RTC going 70 MPH. Hit central reservation. Car spun out of control. No head injury No LOC (loss of consciousness). Today complains of neck pain and over back of shoulder. Some pain over seatbelt distribution. Has chronic abdominal pain. On tramacet patch, tramadol and morphine. Complains of flashbacks and nightmares overnight. Feeling hot and cold today'.

22. On 5 and 6 August 2008, she reported to her GP that she experienced considerable pain in the abdominal region since the accident although has had pain in this area since September 2005.

23. On 21 November 2008, she underwent a diagnostic laparoscopic examination at Milton Keynes Hospital. The findings were all normal with healthy ovaries, tube and uterus and no evidence of pelvic inflammatory disease or abnormality to the pelvis.

24. On 6 March 2009, her present solicitors wrote a letter of claim to the defendant pursuant to the Pre Action Protocol for Resolution of Clinical Disputes. It was said that the consequence of the failure to inform her of the chlamydia results was:

> 'She endured just over 1 year of unnecessary pain and suffering…an ectopic pregnancy.. a higher chance of suffering a future ectopic pregnancy.. extreme stress due to the above events and as a result has developed a stress related skin condition.'

A notional claim was made for resulting voluntary care.

25. There was a prompt admission of a breach of a duty of care and an invitation to serve a schedule of loss. A claim form was issued in October 2013. The parties are very far apart on the consequences of the admitted negligence and the recoverable quantum of damage.

26. To complete this summary overview of events, it may be noted:

i) 25 June 2009: she was complaining of pelvic pain, occasional stress incontinence, stress related facial rash, symptoms similar to irritable bowel syndrome, and was assessed to have an extremely complex pelvic pain problem, and was offered amongst other things cognitive behavioural therapy (CBT) .

ii) 7 July 2009: she complained of constant lower abdominal pain, on some days she could not walk because of unbearable pain; constant migraine attacks; recurrent urinary tract infections (UTIs) and difficulty sleeping.

iii) 2 September 2009: she was warned that she was misusing morphine which would not help her pain and was at dangerous level of 400 mg a day.

iv) 30 September: she was found to be five weeks pregnant. She terminated the pregnancy in October 2009 as she was advised that the high level of analgesia would pose a threat to the foetus but felt unable to stop taking it.

v) November 2009: she failed to engage with the CBT therapist after two sessions.

vi) 4 January 2010: she was discharged by her CBT therapist for failing to make contact.

vii) 2 March: she failed to make contact with pain clinic and was discharged.

viii) 15 November 2010: she was assessed by a psychiatrist who considered that she had a depressive episode of moderate severity within the context of chronic pain syndrome but was at low risk of suicide with a supportive family. CBT was again recommended and a fresh referral made as the previous therapist had discharged her in January for failing to make contact.

ix) 15 March 2011: she was a passenger in a rear end shunt low speed car accident. She presented to Bedford Hospital the following day with neck pain. She stopped working.

x) May 2011: The pain consultants consider that she was experiencing chronic widespread pain (CWP) by this month.

xi) Summer 2011: she and her husband formally separated although they both live at the same address. It is said that the matrimonial relationship had ceased some time before.

xii) July 2011: she was made redundant from Autoglass and has not worked since. Her last period of working dated back to March 2011.

xiii) 8 September 2011: a private psychiatrist made a diagnosis of somatoform disorder with mild to moderate depression. CBT and marital therapy were considered to be needed. The claimant was taking two anti-depressants when only one was advised.

xiv) 31 July 2012: by this date a dermatologist advised that her facial scarring was self-inflicted excoriation rather than acne.

xv) 21 November 2012: the claimant reported whole body pain affecting her joints, muscles, abdomen and neck; pins and needles in her legs and pelvis and constant pain. She reported that she had recently been diagnosed with fibromyalgia by her GP.

xvi) 9 December 2012: she received treatment for a laceration to her foot and hand and minor burns to her neck, shoulder, back, legs and arms and had a rash over her body as a result of an adverse reaction to a chemical used in a shower in which she had a fall in a hotel in Edinburgh.

xvii) 24 October 2013: the claimant was seen by a third consultant psychiatrist but she refused the CBT offered as it had not previously benefitted her.

xviii) Between March and August 2014: she attended various appointments at Basildon Mental Health Unit where she was treated for depression and it was considered that her mood had focused on compulsive picking of her face.

xix) August 2014: an occupational therapy assessment was made.

xx) October 2014: Margaret Odell was employed by Telopea, a care provider to attend on the claimant five days a week for one hour to assist with care needs.

xxi) March 2015: she started using a wheelchair.

xxii) 5 June 2015: the claimant was involved in another road traffic accident. She attended AED where X-rays and a CT scan were taken due to concern of a possible vertebral fracture. Her dose of diazepam was increased as she complained of pain down her left side.

xxiii) 17 October 2015: she attended her GP stating that her pain had been worse since the last RTA. She reported difficulty passing urine and requested daily dressing of wounds to her legs that she associated with the accident. Subsequently she was seen by a district nurse with a leg infection described as an ulcer.

27. The claimant's case at trial was as follows:-

i) Before 2005, she had not suffered any or any enduring mental illness or similar condition. Following her marriage in 2000 she was a fit healthy young woman, capable of working and looking after her child although may have had a pre-existing vulnerability to a somatoform disorder.

ii) As a result of the untreated chlamydia she experienced pelvic inflammatory disease, pelvic pain, ectopic pregnancy, removal of a fallopian tube and stress that in turn caused a facial rash/excoriation.

iii) There was a physical cause to her pelvic pain that lasted at least to February 2007 and probably thereafter.

iv) In addition, at some time after October 2006, depending on when a physical explanation for her experience of her pain no longer existed, she developed a persistent somatoform pain disorder (PSPD).

v) The experience of pain spread in 2007/2008 and by May 2011 it had become chronic widespread pain (CWP).

vi) The PSPD and the CWP were caused/materially contributed to by the pelvic inflammatory disease in turn caused by the untreated chlamydia.

vii) Her present state is one of opiate dependency, experiencing constant and regular spasms of chronic widespread pain; she is unable to ever work again; she cannot look after herself independently or care for her children. All these outcomes are the consequences of the untreated chlamydia and result in very substantial damages occasioned by the need for future care as well as a substantial claim for past gratuitous care offered to her and her children by her husband and parents in law.

28. The defendant, by contrast, disputes that the consequences of the untreated chlamydia can explain her symptoms after February 2007 and also contends that the impact of the failure to treat was not as debilitating as the claimant has maintained.

29. The defendant points to inconsistencies between: her accounts to professionals and many of the events recorded in a personal diary that she kept for the period 2006 to 2008; the posts made by her on her Facebook page; what she was telling her employer were the reasons for her absence form work; what she was telling Bedford Social Services in August 2009 who were making enquiries as to the well-being of her children; what she was telling a Dr Manjure who took a history from her in the context of a claim for damages resulting from the 2011 RTA.

30. The defendant submits that the claimant's problems are primarily psychiatric/psychological and her PSPD and any development of it since 2008, is a consequence of her pre-existing psychiatric vulnerability likely to be triggered by any incident of stress. The causative stressors were not the lack of treatment for the STI but :

i) the family and personal difficulties she had experienced in her life by 2005;

ii) some post-natal depression in October 2005 (if her account to the defendant's forensic psychiatrist is to be accepted as reliable);

iii) the shock of learning in October 2006 that she had chlamydia setting that fact against issues in her personal life; and

iv) either the 2008 or 2011 RTA or both, and in any event aggravated in part by the 2012 fall and the 2015 RTA.

31. The defendant further submits that the appropriate treatment for PSPD is a comprehensive strategy of weaning the claimant off opiates, supporting her with CBT, encouraging self-reliance and providing minimum necessary care support so an ability to lead a normal and independent life despite the experience of somatoform pain.

32. This trial was originally listed for five days in Cambridge County Court but was transferred to the High Court in October 2016 by which time the time estimate had extended to seven days. The evidence alone took that time to hear on a number of non-consecutive days. At the conclusion of the evidence after a further adjournment of six weeks, I received written and oral closing submissions.

33. With respect to the primary evidence of fact, I heard from the claimant and her husband. Her in-laws had left the United Kingdom for an extended stay in India and could not be communicated with. Their short witness statements prepared in October 2014 were served as hearsay evidence under the Civil Evidence Act. I heard briefly from Margaret Odell.

34. The remaining evidence was in the form of four pairs of opposing experts on the topics of: gynaecology, Mr Hay (claimant) and Mr Rutherford (defendant); psychiatry, Dr Briscoe (claimant) and Dr Master (defendant); pain management Dr Harrison (claimant) and Dr Valentine (defendant) and care needs, Ms Wills (claimant) and Ms Gooch (defendant).

35. In considering the issues arising in this complex case, I propose to break down the period from October 2005 to trial into four shorter periods:

i) October 2005 to February 2007: negligence admitted but the level of voluntary care claimed by the claimant is disputed.

ii) March 2007 to July 2008: the defendant disputes that there were any remaining physiological consequences of the negligent failure to treat the STD, but the psychiatrists are agreed that if the claimant's experience of pain is reliable, she fits the criteria for a somatoform pain disorder. The claimant contends that is a consequence of the physical pain experienced earlier. The defendant contends that any such disorder was not causally linked to the negligence as such a disorder would have been triggered by then anyway. The defendant also disputes the disabling consequences of the pain and the claim for voluntary care.

iii) August 2008 to May 2011: the position of the parties is similar to the previous period. The defendant disputes that the persistence of any somatoform disorder and the emergence of chronic widespread pain is attributable to the admitted negligence.

iv) June 2011 to trial: the defendant disputes that the claimed worsening of the condition and the assessment of CWP since May 2011 is attributable to the admitted negligence. The claimant contends it is a natural progression of

someone with a pre-existing vulnerability, now dependent on heavy opiate sedatives that are ineffective, and whose experience of pain has spread from abdominal pain once associated with a physiological cause to whole body pain now requiring constant professional care in the light of the breakdown of the marital relationship. The claimant further submits that the prospects of a comprehensive treatment range now improving her condition after ten years of unexplained physical causes for the pain are poor. It is therefore contended she will need indefinite care and the overall capitalised sum for pain suffering damage and future loss of earnings and future professional care is put as in excess of £3 million.

The Claimant's Evidence

36. Pain is a subjective experience that cannot be objectively identified and assessed by this court or treating or forensic professionals. Her account of when, where and how she suffered pain and the intensity of the pain she suffered is thus the foundation of the assessment made by experts: gynaecologists, psychiatrists, pain treatment consultants and care experts. Further, it is largely her account of what she could or could not do from October 2005 onwards that is of prime importance in assessing damages for care support. The court has to determine the services that she once provided and whether, and if so the degree to which, she could no longer provide them as a result of any injury she suffered arising from the defendant's admitted negligence. On any view the claimant's evidence is central to the determination of the central issues in dispute including:

    i) was she experiencing pain of the intensity and disabling nature claimed;

    ii) was any such pain related to the negligence;

    iii) was she receiving and needing the voluntary care claimed;

    iv) does she now need the professional care she is receiving?

37. There is no doubt that at the trial from October 2016 to January 2017, the claimant presented in a sorry state. She arrived in court in a wheelchair and a covering blanket and needed the assistance of her husband to climb into the witness box. Once there she appeared to be experiencing spasms of pain at regular intervals over the three days during which she gave her evidence.

38. It was not put to her in cross-examination that she was faking these symptoms. There was no finding of misrepresentation of symptoms in the clinical records of those treating her. In their joint statement it was common ground between the psychiatrists that she is at least suffering from a somatoform disorder. In simple terms, I understand that such a disorder is where the sensation of pain is experienced but there is no physiological explanation for the pain.

39. My impression of the claimant when she gave evidence is that she is a well- informed and intelligent person. I endeavoured to ensure that she was not suffering from a spasm of pain when answering questions, and that she was alert and aware of the questions before answering them. I ensured that there were opportunities for regular breaks in the proceedings to give her a chance to relax, although at her choice, these

breaks were not so frequent as to require her to climb into and descend from the witness box. I was necessarily reliant on her own assessment of her capacity to proceed in this way, but I was satisfied that when not having a spasm she was alert, focussed and able to instruct her husband, sometimes peremptorily, as to how to navigate the fourteen evidence bundles to which frequent resort was made by the advocates.

40. The defendant mounted a robust challenge to the credibility of much of her evidence as to events between 2005 and 2011 and after. An outline of its contentions has been noted above. In addition to these matters, Ms Mauladad appearing for the Trust, also explored aspects of Mrs Rathore's pre-marital private life as disclosed to her GP. Given the sensitive subject matter of some of these issues, and the hesitation on behalf of the claimant when some questions were first put to her, I acceded to an application that the trial should for a time proceed *in camera* with the exclusion of all other people save for the legal teams. This meant that the claimant's husband left the court room as did the experts who had come to review her evidence in order to be able to give better informed evidence of their conclusions. The effect of the order I made is that the evidence given in camera shall not be communicated to any third party without leave of the court. I granted leave for a summary of that evidence to be provided to the two psychiatric experts for their information, although I appreciate that they were deprived of the opportunity of hearing her give evidence on the topics addressed *in camera*. The submissions on those topics were also heard in camera and will be addressed in a closed part of this judgment (Appendix A) that should remain confidential to the parties and their legal teams and not available to the public without an order of this court or the Court of Appeal.

41. I did not find the claimant a satisfactory witness. In particular, I am sure that on some topics explored in the *in camera* proceedings she was not telling me the truth. On a broader range of relevant issues, I am satisfied that she was not a reliable historian as to the narrative of events and experiences of pain. I am therefore left with a considerable degree of doubt as to aspects of her private and married life that are relevant to determination of this claim, the degree of pain she was suffering from, her relations with her in laws, the reasons why she left her children with them, when and why they returned to live with her in Wooton and her capacity to care for her children between September 2005 and April 2014. This is a composite conclusion reached after careful reflection of all the relevant material on which submissions were based.

42. Mr Bright QC for the claimant, submitted that an over-meticulous analysis of the descriptions she gave to treating and forensic professionals of the location duration and intensity pain suffered five to nine years before is inappropriate, particularly where a psychiatric condition has been diagnosed that provides the perspective through which past events are now experienced. I accept that the accounts she gave to treating physicians and forensic experts from 2010 onwards have to be seen in the context of someone who, in the view of both psychiatrists, has been suffering somatic pain disorder for a number of years and has received very heavy opiate pain relief for most of that time. This may affect her accuracy of recall.

43. The claimant's Facebook page was accessed by Natasha Rutter on behalf of the defendant on 23 February 2016 and she made a statement exhibiting posts back to August 2009. I recognise that reliance on individual posts showing the claimant in glamorous clothing, attending social events with others, including her husband,

should be treated with considerable caution. She has explained in her witness statement in reply and her oral evidence that from the onset of the pain in the winter of 2005, she felt the need to project to her family and friends an image of the dynamic active person she used to be. For similar reasons, she made an effort to attend the numerous social gatherings that are part of social life of two extended Sikh families living in east central England. It is also perfectly understandable why she would want to make an effort to be with her two children as they grew up and go on outings together. I accept that some of these factors may explain her appearance on any given post.

44. Equally, I accept that there is a need for caution in how to assess her diaries, apparently written from January 2006 before any thought of litigation could have occurred. At the earlier part there are regular entries; gaps come later. The fact that a stressful or painful experience is not recorded does not of itself mean that it did not happen, although the diary does contain numerous entries about pain. The fact that the claimant attended social events with her friends and extended family, sometimes travelling considerable distances to do so, does not itself mean that she was pain free or did not pay a pain penalty the next day. Isolated entries have limited significance in forming a view as to the reliability of her evidence.

45. Nevertheless, taking all the strands of the defendant's case on this topic together, and viewing each individual strand with the degree of caution I have endeavoured to summarise above, I am satisfied that on a number of significant topics I cannot rely on her evidence. I shall explain this conclusion by reference to a number of sub topics, namely what the claimant has said about:

    i) the arrangements for the care of her children and her ability to care for them;

    ii) the need for time off work from her employment at Autoglass;

    iii) the impact of pain on her social life 2005 to 2009;

    iv) the other potential stress factors unconnected with untreated chlamydia.

Care of the children

46. The claimant has made three witness statements. The first is dated 4 November 2014. In that statement she does not give a full account of when and where she lived following marriage or where her children lived. At paragraph 9 dealing with October 2006 she states that despite the pain she was trying to be a hands on mother to my boys 'but the pain was preventing this'. At paragraph 11 she explains that after her admission to hospital on 11 November 2006 'due to the level of pain, and my inability to cope with the same, I was unable to care for my sons. We therefore went to live with my parents in law (with the children) for approximately three months…I returned home but the children remained with their grandparents'. At paragraph 15 she states 'In 2010, the children returned to live with Amarjit and I'.

47. On 7 July 2009 the claimant had a meeting with Mr Afnan a consultant gynaecologist to obtain a preliminary opinion on the consequences of the defendant's failure to treat the chlamydia. He noted:

> "Mrs Rathore still has ongoing abdominal pain which is constant and in the lower abdomen. She takes buscopan, tramadol, oromorph and morphine patches. There are days when she cannot walk because she finds the pain unbearable. (She) continues to have constant migraine attacks, recurrent urinary tract infections and has difficulty sleeping. (She) has lost her appetite and eats little. (She) is seeing a counsellor. Her children are now living with her mother in law. (She) reports that the children are having problems at school, especially the eldest child. She says that they feel insecure and wonder whether 'mummy will be home and if she is will she be ill'"

48. The claimant's second witness statement of 27 February 2015 deals with the impact of her illness on her children, the difficulties they have faced at school, and the support being given by Bedford Social Services. She gives no further details as to where they were living and when.

49. On 25 February 2015 Bedford Borough Council sent the claimant's solicitors the historical case records of their dealings with the children. Amongst these documents was a report on an assessment made of the children in July 2009 at the Wootton address. The document reveals the following relevant information under the sub-heading parenting capacity:

> 'Mr and Mrs Rathore stated that extended family provide a high level of support with the children, emotional and practical assistance. Mrs Rathore stated that (J) did stay with paternal grandparents when she went to India to seek further assistance with her health problems….Mrs Rathore stated she has now changed her working patterns therefore collects and drops off (J) from school, as previously this was undertaken by extended family members. Mrs Rathore will now be working from home so is able to manage this. I explained that it is understandable that (J) could have been affected by not seeing his mother and that if primary carers are not able to undertake care duties then extended family are the best option so would encourage this in the future.
>
> Mr and Mrs Rathore stated (J) has a good relationship with his cousins who are of a similar age and aunts uncles and his grandparents. I observed positive interaction between J and his younger brother and both parents during the assessment. Mrs Rathore stated they regularly engage in activities together such as baking cakes, shopping and going to the local park.'
>
> 'Mr and Mrs Rathore share domestic duties within the family home such as preparing main meals and maintaining the family home. The family home is in the process of being redecorated at the present time.'

> ‘Mrs Rathore stated that she has visited India to receive further treatment for her stomach problems, the last time she went she took (A) with her (J) stayed at home.’

50. In cross-examination the claimant thought that the author may have had a misleading impression of how much housework she was able to do, and estimated that she was only making a 5-10% contribution. She stated that she has a compulsive obsession about keeping a clean home. She accepted that she might have been making a small contribution to J’s care at that time due to a shift in her hours. I am satisfied that the note accurately reflects what the claimant was saying.

51. If what the claimant told the social worker in July 2009 is correct, then:

i) The children were back living with her and her husband in Wootton in 2009.

ii) The only time in the interview when J is mentioned as not living in Wootton is when Mrs Rathore went to India, when he went to stay with his grandparents. Such a visit would be a matter of weeks or months rather than years.

iii) On the occasion of at least one visit to India, Mrs Rathore took A with her. She did not seem inhibited from doing so by an apprehended inability to care for him. Cross referencing to her diary indicates that she went to India around March 2008 for a month and again in March 2009 for three weeks. It also records that in October 2007 her husband and his family took A to India for six weeks leaving J with her.

iv) Despite mentioning her medical difficulties since the birth of A and the pain relief she is prescribed, there is no indication that she is not now and has not in the past been able to care for the children, indeed she gives specific examples of her ability to do so and no concern was expressed about her interaction with the children witnessed during the interview.

v) She shares the care and home duties with her husband. This would not be surprising as she was a working mother holding down her job at Autoglass at this time although she was changing her employment arrangements so she could work from home. There is no suggestion that the care that Mr Rathore contributes was only provided as she was unable to do so for health reasons. Further the inference from the reference to the change of employment arrangements is that the reason why extended family members played roles in delivering and collecting the children from their schools is that it enabled Mrs Rathore to go to work.

vi) Although she told the social worker she was ‘now’ working from home, the employment records (see the next section of this judgment below) suggest that this change was made in January 2008.

52. Mr Bright submits that the context of the interview was a social services inquiry into concerns about the well-being of the children and it might be understandable that the claimant was giving an ‘optimistic’ picture of her child-caring capacities. The fact remains that she is either giving social services an accurate account of her arrangements, and if so one that flatly contradicts important aspects of her evidence

given to this court and the account she gave to Mr Afnan a few days earlier, or she was deliberately misinforming the social worker as to important matters relating to the care of her children, in which case there are significant reasons, additional to the conclusions about the Appendix A evidence, for this court to be concerned as to her credibility.

53. Two such radically contrasting accounts given within days of each other cannot be explained by defects in memory. It is not just the date on which the children came to live in Wootton, but the narrative given to the social worker must throw doubt on whether they have ever lived for a significant period of time with the grandparents apart from visits to India, and if so why this was. I incline to the view that what she told the social worker about the children's arrangements was accurate and what she told Mr Afnan was false.

54. Further, the picture of the claimant's ability to care for her children in the period from October 2005 that she presented to the care experts and the court, does not sit comfortably with data recorded in her personal diary that covers in some details the calendar years 2006 to 2008.

55. In evidence she explained that her diary was started after she found she was having memory problems as a result of the heavy opiate based pain relief she was receiving. It was then put to her that the diary started in January 2006 but her prescription record showed that the heavy opiate based pain relief did not start until November 2006. She responded that she also kept a diary to keep an accurate record of medical appointments for herself and the children. Although she could be wrong about the start date, she thought that she was taking opiate pain relief other than prescription free pain killers earlier than was recorded by her GP. I am satisfied that the GP records are comprehensive on this issue, and although they would not reveal use of pain killers that could be purchased in a chemist without prescription (such as codeine), I conclude that the claimant was wrong about when she first started with heavy pain killers.

56. Some weeks the diary is full of details and some weeks it is very sparse. I accept that the keeper of a diary has different purposes in doing so and may present a different level of commitment from time to time in writing things down. In addition to recording visits to the doctor or hospital there are certainly a number of occasions when the claimant records herself as feeling unwell or depressed:

> 2006: 28 Feb (don't feel very well); 14 -16 March 2006 (don't feel very well); 17 March called GP still in pain; 31 March 'A and E abdo pain'; 18 April 'don't feel well'; 15 May 'went to doctor about pains. more medication'; 21-22 'tired. Feel so ill.no energy'; 30 May 'tiring day'; 1 June 'feel wrecked I hope I am not pregnant'; 2 June 'shit day', 6 June 'in a lot of pain' 14 June 'so tired' 20 June 'crap day tired', 13 July 'not feeling well at all'; 15 August 'migraine'; 13 September 'had the op done today, they removed the left tube on keyhole surgery, I feel incomplete. It hurt so much'; 15 September 'still in a lot of pain'; 29 September 'stomach hurts'; 18 October 'abdo pain'; 6 November 'lot of pain, vomiting'; 11 November 'severe migraine'.

> 2007: 2 April ‘fed up and tired’, 8 July ‘too tired’ (to watch a film), 20 August ‘sick on way to work’; 22 September ‘so tired kept falling asleep’.
>
> 2008: 1 January ‘not well migraine attack’ 5 January ‘went to hospital after calling out ambulance..chest infection’ 27 July ‘went to Coventry A and E they gave me diazepam’; 12 December ‘I was so ill I fell asleep’; 16 December ‘ill and tired.’
>
> 2009: 5-8 January ‘ill’, 14 January ‘frustrated depressed trying so hard to be positive’; 19 ‘depressed’, 20 January ‘in so much pain, agony’, 24 January ‘so depressed’ 31 January ‘bad day, very tired not well’; 7 April ‘not well’; 15 April ‘tummy hurts’; 17 April ‘stomach hurts a lot’, ‘doctors- was in so much pain’; 4 May ‘health is very bad’; 21 May ‘went badminton very tired’; 31 May ‘sick rash on body went to A and E was going badminton, cancelled nearly fainted, high temperature’; 25 June ‘Leicester Royal Infirmary second internal examination, didn’t enjoy that they put me on some next medicine..went badminton did have a good game; 3 July ‘not too well .. fed up’; 8 July felt rather ill, 27 August four migraine attacks.

57. As against that, there are a number of entries where she is recording herself as attending weddings, birthdays, or social events with her family and friends, going out to bars and restaurants, shopping and travelling to meet her family and friends in Nottingham area and elsewhere 31 December 2005; 25, 29 January 2006; 5, 9, 16-19, 23, 24, 25, 26, 27 February; 2, 3 4, 8 , 9 March, 3, 7, 8 9, 13, 15, 17, April; 7, 19, 26, 29 May; 2-4, 8-11, 24 June; 6, 7-8 22 23 July; 12, 13 August; 1-2 , 9-10 September, 8 November 2006; 2, 4, 9-10 June 2007 ; 6, 8 12 -13, 16 21 July; 5, 7 18 August; 7 October; 15 December 2007; 13, 14 15, 16, 28 February 2008; 3, 6 March; 12, 13, 19 , 26 September; 4, 14 18 19, 29 October; 8, 9 November; 31 December 2008, 3 January 2009, 13, 14 15 February 6 March, 5 April 13 April 2009.

58. Between January 2006 and December 2008 there are a number entries of her regularly taking J to a pre-school play group: 17, 24, 31 January 2006, 14 March, 25 April; taking either A or J to and from medical appointments: 13, 16, 18 January 2006, 12-13 February; 24 March; 7 February 2007; 26 April; 30 May; 17 June 2008 and taking or collecting her own and other children from school, the Temple or shops (10, 24 January 2006, 10 March, 3 April, 16 May). There are references to her cooking and cleaning. She manages a visit to the Bedford swimming pool or other treats with the children 7, 22 February 2006; 4, 16 April; 4 August 2007; 15 February 2008, 3 March.

59. The claimant’s response to this evidence when it was adduced by the defendant is that she tried to lead a social life for the sake of her family and to maintain appearances but it was a real struggle to do so. The fact that she went out on special evenings or drove to Nottingham should not lead to the conclusion that she was not in pain.

60. Despite the dangers of selective quotation and the need for caution in the reliance to be placed on the diary, I reach the conclusion that the diary for 2006-2008 shows a

much greater level of social functioning and an ability to conduct practical parenting than the claimant has suggested is the case in her evidence to this court or her accounts to medical and care professionals. Mrs Gooch's comprehensive report of 13 May 2016 dealing with her assessment of care needs is a through, careful and useful source of inconsistencies in the claimant's account. I found both her report and her oral evidence on these issues to be pertinent and informative, and she was in no way shaken by her cross examination.

Mr Rathore's evidence

61. The uncertainties as to where the children were residing and who looked after them were not clarified by Mr Rathore when he gave evidence. His witness statement and that of his parents also indicated that the children remained with their grandparents for four years until 2010, but he accepted that this was probably a wrong estimate and he couldn't remember the dates. He was working full time as an electrician at the time of A's birth and this continued until December 2010 when he was made redundant. He would leave the house between 7.00 and 7.30 am and return by 4.00 to 4.30 pm. The children would be at home at Wootton when he got home. By 2009 he was doing the lot for the children, by way of feeding and cleaning. In January 2011 he became self-employed and left home earlier and would get back later but could work flexible hours when needed.

62. He stated that the couple unofficially separated in 2008 while continuing to share the house at Wootton, although clearly the claimant had become pregnant by him in the summer of 2009. Officially they separated in 2011 since this time he has acted as a *de facto* carer for her.

The statements of the claimant's parents in law

63. Mr Rathore's parents did not give oral evidence. Although they had been warned of the pending trial they had gone to India on an extended holiday and could not be contacted by the time the trial had started. They had both made brief statements in identical terms that were signed on 24 October 2014. These statements were tendered as hearsay under the Civil Evidence Act.

64. The statements are in very general terms of observing the pain the claimant experienced, her inability to care for her children and the assertion that the general day to day care of the children was provided by the claimant's mother in law and to some extent her father in law and husband until 'I believe 2010'. The absence of any detail in their statements as to what they did for the claimant, when and why is peculiar. Both Mr Rathore and his parents were making substantial claims for gratuitous care of the children from 2006 onwards.

65. There are conflicting references to her mother in law in the claimant's diary: at times she seems to be resented as domineering and controlling, at others is respected as an important family member who has regular contact with the children. The suggestion that the children lived continuously with the grandparents until either 2009 or 2010 is not supported by the diary. It is now accepted that 2010 was an error, but if there was a false claim made to Mr Afnan that the children were still with the grandparents in July 2009, this looks less like a simple failure of recollection of dates and more like a story that all the participants were presenting to increase a claim for gratuitous care.

66. In the circumstances, I am unable to attach any weight to the little information they provide and I do not consider that they have provided independent evidence in support of the claimant's claim for care.

Employment records

67. The claimant worked for Autoglass from January 2004. When she started her hours were from 9.00 to 2.00pm and would drop J off at her in laws when she was at work. She then started working full time until she took maternity leave in August 2005. She returned to work on 20 July 2006 worked full time (37 ½ hours per week) until October 2006 when she was on sick leave until 20 February 2007. She was then away from work from March to 20 July 2007, and was on sick leave in June 2007. She then works until she stopped working in March 2011.

68. Her monthly take home pay was at its highest in the period February to December 2008, reduces in January 2009, and further reduces in September 2009, probably reflecting a reduction in hours. She had a number of periods of short term sickness between July 2007 and March 2011. She was warned in October 2007 that her levels of absence or sickness exceeded company expectations; was warned again in November 2007 about four occasions of late arrival at work. In December 2007 she was offered home based working in the telephone sales team. She accepted that change and in February 2008 there were disciplinary proceedings about misuse of the home telephone supplied by the company for employment purposes.

69. Between July 2008 and March 2011, there are sickness certification forms showing: one day absence 1 July 2008 (skin and stomach complaint); three day absence in early June 2009 (allergic reaction to unknown source); two days absence in May 2009 (child sick); one day and nine hours absence between 11 and 17 August 2009 (lots of pain in stomach); one day absence 27 August 2009 (migraine attacks, sickness, light sensitive); an absence from 29 September to 4 November 2009 (gynaecological problems and miscarriage).

70. There were disciplinary interviews for an absence in January 2010 where she said she forgot to check the rota and March 2010 when she was found asleep at work. She explained that she fell asleep as her boys were ill and had lost sleep. On 19 October 2010 and between 16 November 2010 and 8 December 2010 she had a number of days off work that she attributed to her son's illness. On 15 December 2010 she was off work (chest infection).

71. Her absences after March 2011 she attributed to the RTA of that month. She provided a doctor's statement of unfitness through back and neck pain resulting from the accident. She was made redundant in July 2011 using a grid where she scored poorly for performance and attendance, although she had no current disciplinary warnings.

72. If the claimant was being truthful in what she told her employer, her pain (whether physical or somatic) did not prevent her working for some four years with Autoglass from July 2007 to July 2011. Apart from the chest infection she did not attribute any absence from work to her own state of health for the last sixteen months of her employment, and the absence from work from March until she was made redundant in July was attributed to the March 2011 RTA. If, for some reason, she was not giving her employers a truthful account, this once again reflects adversely on her credibility.

73. The claimant's answers when cross-examined and re-examined on this topic were neither consistent nor satisfactory. At one point she accepted that the reasons for her absence after November 2009 were her son's health; later she said there were two reasons her own ill-health and her sons' and her employers had forgotten to record the former; when it was pointed that these were self reporting records she completed she suggested that the time off attributable to her own ill health she was able to make up by flexi time.

74. She acknowledged that the information she gave to Dr Harrison her pain management consultant on 23 August 2013 indicated that she attributed the time she had taken off work to the pain resulting from the untreated STI:

> "She started working from home and worked part time. But she continued to have(ing) time off, and gradually reduced her hours to the point where she was no longer able to manage work, and was off work for a period of six months before she was made redundant"

75. She could not explain why she did not mention the 2011 RTA to Dr Harrison but presumed he would have seen the GPs notes. She said she was focusing on the present negligence claim. Her employers knew about her previous ill health and took that into account when deciding to make her redundant, not least because it affected her skill competences.

76. The employment records are contemporary documents rather than retrospective recollection. They are a relevant source of information. Although they record periods of sickness in the period following the events of 2005 and 2006, they do not do so in the latter period leading up the redundancy. It seems to me to be likely that any assistance Mr Rathore's family provided in the period after she returned to work in 2007 was to enable her to maintain employment rather than because of a physical inability to care for her children. This may not be a factor after she started working from home.

77. It is notable that the absence from work after March 2011 was entirely attributed by her to the road accident. If she knew that this absence would eventually lead to the termination of her employment, as she probably did, it is difficult to understand why she did not attribute her inability to carry on working to the deterioration of her pre-existing condition if this were really the case.

Other stress factors

78. In her first witness statement, the claimant describes being 'shocked and upset' to be told that chlamydia had been detected the previous year. Dr Master thought that this might be a significant source of upset for a young woman with a pre-existing vulnerability to somatoform disorder. Dr Briscoe interpreted the shock as being about the failure to treat the STI earlier, with the result that she experienced pain for a year. When giving evidence, she explained that she was more relieved than shocked, as she had at last an explanation for her pain experienced during the previous year.

79. A review of the expert evidence as to what might have caused the claimant's reports of pain, if there is no physical explanation for it, will follow later in this judgment. It

is sufficient at this stage to note the list of possible candidates from the opinions of Dr Briscoe and Dr Master:-

i) Pain of childbirth that has continued in someone prone to somatisation.

ii) Depression.

iii) The effect of stress in her private and married life on someone prone to somatisation.

iv) A physical and psychological reaction to the RTAs of 2008 and 2011, potentially exacerbated by the 2012 fall and the further RTA of 2015.

v) Conversion disorder (where clinical findings provide evidence of incompatibility between the symptom and recognised medical condition, although the patient believes the condition exists).

vi) Factitious disorder (inventing or misrepresenting pain).

vii) Malingering (intentionally feigning a condition to obtain an incentive such as money).

80. The claimant disputed that her experience of a high speed motorway crash in 2008 might have triggered a response in the way of a somatoform disorder. She said although she had been shocked at the time no significant injury was caused. No one else was involved in this accident and so legal proceedings resulted from it.

81. The position was different with respect to the RTA of 14 March 2011. The claimant was a front seat passenger in a van when another vehicle was at fault. Civil proceedings were instituted and a settlement reached. In the course of preparation for those proceedings, the claimant was examined on 16 March 2012 by Mr Manjure, a consultant orthopaedic surgeon. He recorded the symptoms suffered a few hours after the accident: neck pain, shoulder pain, pain in both knees, middle and upper back pain. The neck and shoulder pain had resolved by the end of 2011 (9 months) but upper back pain continued in March 2012 as did the pain in both knees that had got worse in the few months before examination. Mr Manjure recorded the consequences of the accident as: 'lost job made redundant because of absence', and

> 'unable to perform the following household chores following the accident: cooking, cleaning, washing, ironing or vacuuming.'

The inference is that she was able to do things before the accident although Mr Manjure recorded her existing chronic stomach pains, fibromyalgia, skin condition and the mental health problems she said she suffered from for the previous six years.

82. A potentially significant source of stress is the issue relating to her private life. Some of these issues are mentioned in Appendix A as regards premarital life. She had told others about tensions in her marriage (see [19] and [20] (xv) above and [122] below). Ms Mauladad has emphasised in her closing submissions passages in the diary pointing to emotional turmoil and possible attachment to someone other than her husband: see entries for 9 February, 14, 17 July, 29 September 2006, 12 October and

13 November 2006. On 6 February 2008 her diary records an argument with her husband. There is in addition a notable sequence of references to matrimonial conflict following the accident on 26 July 2008.

83. The diary for 2008 is largely empty apart from a few details of working hours. There is an entry about a visit to Milton Keynes on 24 July and then an entry on 26 July that reads:

> "Went to see Mani last night to take her to see her nan. On way back had a Major Road accident. Car is a write off. I'm lucky to be alive. Amo came to get me from Newport Pagnell. Had a chat with him. He don't trust. A part of me wishes I didn't survive. I remember seeing my whole life go past me in flash backs. I called Norwich Union."

84. The diary is then largely blank for the rest of the year saves for a flurry of entries in November. More frequent entries are reverted to for 2009. There then follow a number of entries about matrimonial arguments and dissatisfaction with her husband Amo. I have set these out in Appendix B to this judgment. These entries suggest: first, that there was significant matrimonial conflict with her husband in 2009 and second, her claim that her husband was taking on 90% of the burden of caring for the children and housework during this period is inaccurate. In cross examination the claimant said that her husband was supportive but was not always so, and she now realised how supportive he has been. I do not accept that is an honest answer about the state of affairs in 2009.

85. Although part of the conflict between them appears to be about concerns that her husband has not sufficiently recognised her ill health and experience of pain, it equally seems to be about disputes about her travel away from Bedford and social life outside her immediate family. These entries have to be read alongside what the claimant was telling social services in July 2009. They reveal a picture of a woman deeply dissatisfied with her marriage and her life. Other entries up to this time suggest a degree of boredom and lack of stimulus in her life. On the other hand it is notable that on 30 September she was found to be five weeks pregnant, although that pregnancy was terminated the following month. In my judgment there is a persistent theme of emotional turmoil about her feelings, her marriage and relationships from before 2005 and after. This turmoil becomes a dominant issue in 2009 and follows the reference to lack of trust on the day of the 2008 RTA.

Claimant's reporting of her pain and abilities

86. In the course of the trial, Ms Mauladad put to the claimant and the professional witnesses called on her behalf descriptions of persistent agonising pain from the time of A's birth in October 2005 to the present. These were both inconsistent with the clinical records of when complaints about pelvic pain were first made by her and inconsistent with a diagnosis of pelvic inflammatory disease itself (discussed in the following section of this judgment). In his closing submissions Mr Bright recognises that she is an unreliable (but not dishonest) historian of the history of her illness and experience of pain, but submits that this is an understandable consequence of the passage of years and the disorder that the psychiatrists assess she is suffering from.

Ms Mauladad responds that there is evidence of a complaint of persistent pain since A's birth made to Ms Pugh as early in April 2008.

87. I agree that the claimant is an unreliable historian of her experience of pain in statements she has made to forensic professionals in 2010 and after. Whilst Mr Bright makes the observation to disarm some of the high points of Ms Mauladad's cross examination, it also has the result that it leaves this court unable to rely on the claimant's description of past events, feelings and care needs given in the pleadings, schedules compiled on her instructions and in her witness statements. It also creates a real difficulty for psychiatrists and other forensic experts whose process of evaluations is to take a clinical history from a patient/litigant as well as compare that history with data recorded in medical notes. Ultimately, reliability is a matter for this court to assess having received and evaluated the combination of relevant available materials at trial.

88. By 2011, at least, it is apparent that the claimant is engaged in seeking financial payment for her conditions. In addition to what she told professionals concerned with assessing the present claim, there were compensation claims made for the 2011 RTA and the 2012 fall in the bathroom. She made a claim for disability living allowance on 28 June 2011. The form was completed by her in September 2011 where she identifies the following conditions:

    i) Abdominal pain since 2005.

    ii) Mental health/depression since 2005.

    iii) Restless leg for three years (i.e. from 2008 approximately).

    iv) Facial rash/depression for four to five years (i.e. 2006-7).

    v) Migraine attacks for fifteen years (i.e. since 1996).

    vi) Joint pains for five to six months (i.e. from March to April 2011).

89. In this form she states that her physical condition is 'so bad that when I do work my whole body hurts in particular my knees so I avoid going out and walking where possible.' 'When having a migraine attack I need full support or when my knees are stiff. I need support because I fall. I sometimes stumble but I don't go out much.' 'I have no confidence and hate going out. I am most times in such a bad state I won't event go to the school gates to collect the children'. Walking difficulties started March 2011. 'I constantly feel tired. I sleep an awful lot during the day. When I wake up I am always in pain to I need pain relief to help me get up. My body feels stiff.' 'I suffer from constant migraine attacks when I'm having an attack I cannot move my neck I'm sensitive to light'. 'When taking a shower when I am washing my hair my arms hurt so I need help with this, combing my hair is also difficult'. She stated that she had about 20 falls in 2011 and falls 3-4 times a month and has difficulty getting up after a fall. 'I have completely lost my confidence. I feel I have nothing to talk about so barely talk to family and friends'. The form records that she states that her care needs started 23 September 2005 and she has been ill for six and a half years now (since March 2005).

90. Taken at face value, these answers suggest that some of her problems (e.g. migraines) preceded any failure to treat an STI and her mobility problems starting in March 2011 (when she had her RTA). The issue of chronic widespread pain and its connection with any negligence admitted by the defendants will be further explored below.

91. However, the defendant advances the proposition that the diary entries for 2009 and 2011 and the Facebook posts around this time throw doubt on these claims. In 2009 she attended the gym for badminton or other exercise: 14, 21, 24 May 4, 10 18 and 25 June (the last two occasions 'good game'), 6, 7, 9 July (the last occasion 'a good workout'), 14 July, 30 November and 1 and 4 December. There is no diary for 2010. Entries for 2011 include 8-10 April (London), 14 April (hen party) 20-22 April (Skegness), 25 April party, 9 May (walk with kids) 13 and 14 May (Casino), 20 May (boys swimming), 24 September 2011 (Nando's good night) 4 November (party at mine Diwali) 16 November ('no yoga Zumba 6.00'). The court understands that Zumba is a particularly energetic form of Latin dance movement. There are also complaints of pain, but it is difficult to see how these activities are consistent with the picture portrayed in the DLA form. When Zumba was put in cross examination, her answer was that she did not do it and doesn't know why the entry was in the diary. I am satisfied that this was not an honest answer.

92. There are numerous Facebook posts in 2011 of the claimant looking very glamorous with elaborate hair, make up and Indian dress. I appreciate that some of these photographs may have been from earlier occasions as one or two were claimed to be and that the claimant's appearance is important to her self-image. A particularly glamorous picture of the claimant posted 23 April 2014 excited an exchange of admiring comments about the claimant's hair to which she 'it's just layers, I did it myself'. In cross examination she explained that she was trained as a make-up artist but 'did it myself' just meant did not go to hairdressing saloon and Amo did the hair. I do not accept that answer as an honest one.

93. On 7 June 2014 there was a post from Legoland Windsor, and later at Crown Plaza Beaconsfield. The caption was a lovely day out with the family. In cross examination the claimant said that she was making an effort for the children. She did walk around a lot but her sister was there to help if it all became too much. I accept the defendant's point that it is difficult to reconcile the prospect of her undertaking such an expedition at all with the picture in the DLA form or the claimant's account of her limited mobility given to Mrs Gooch in 2014.

94. Although no single entry or photograph presents a knockout blow to the claimant's credibility, and I take into account that in Facebook the claimant may be presenting a positive image of herself, I am satisfied that her social life and her mobility was considerably greater than she claimed for the purposes of the present case and the DLA application. Her unreliability on these issues is not a problem of recollection of the trajectory of her illness as seen through the spectrum of someone with a psychiatric condition, rather she has given exaggerated or untruthful accounts of her social life at a time when she claims to have undergone a significant deterioration in her condition and was making a number of different claims for compensation.

95. It is very difficult to find information extraneous of her reporting to others that might be used to support her account. For the reasons given in the previous part of this judgment the evidence of her husband and the statements of her in laws singularly fail

to do this. Margaret Odell gave evidence of her perception that the claimant's pain had got worse since she started working for her in October 2014 and that she has good days and bad days but the latter predominate over the former. She says that the claimant still tries to attend social gatherings and keep up appearance although the couple are separated. I do not doubt Ms Odell's integrity, and I recognise that she would have an opportunity to observe the claimant during her regular visits. Nevertheless, she, like the treating professionals, is reliant on what the claimant is saying or doing. Her evidence relates only to the most recent period when the trial of these issues was approaching. I do not find that it gives me independent support for the claimant's case.

96. Taken as a whole, I have very serious doubts as to the honesty and reliability of much of the claimant's own narrative account. I now turn to the expert evidence to determine whether or not it provides independent evidence on which the court can rely despite these doubts.

Gynaecological Issues

97. It is common ground between the gynaecological experts that the claimant's untreated chlamydia caused, at least in the sense of materially contributed to her ectopic pregnancy and the consequent removal of her fallopian tube.

98. Childbirth offers an opportunity for an untreated infection to enter the body and the reproductive organs, making an ectopic pregnancy more likely. Chlamydia is known to cause pelvic inflammatory disease (PID). There is no doubt that the claimant is entitled to reasonable compensation for the pain and suffering and loss of facility caused by the untreated infection whose existence was negligently not notified to her.

99. What is not agreed is the extent to which a physical cause for pain existed after the claimant's STI was successfully treated with antibiotics in early November 2007.

100. The claimant first obtained an expert gynaecological forensic opinion from a consultant Mr Afnan in September 2010, following a consultation in July 2009. He was of the opinion that on balance of probabilities, the 2006 ectopic pregnancy was caused by the untreated chlamydia. He was also of the opinion that the pain in the lower and upper abdomen that the claimant was reported suffering from during his examination in July 2009 was PID in turn caused by the chlamydia. Although he noted that depression and or alcohol abuse (issues outside his area of expertise) may have contributed to the experience of the severity of the pain, he thought that the fundamental cause was more likely than not to be the chronic pelvic inflammatory disease.

101. By the time of trial, Mr Afnan had retired and the claimant relied on the opinion of Mr Hay, a consultant in obstetrics and gynaecology who provided a report dated 14 September 2013 based on a consultation a few days earlier. He noted that the claimant assessed her pain as fluctuating between 6-8 out of 10 in severity, and it was worse in the lower left quadrant of the abdomen. He expressed the opinion that chlamydia is the most common cause of PID in the UK and by the time it was treated, woefully late after its discovery, the damage was done. He was pessimistic about the prospects of recovery at this stage, although he thought that a laparoscopy would be useful in determining the degree of damage. His report makes no reference to or comment on

the fact that a diagnostic laparoscopy had been performed at Milton Keynes Hospital on 21 November 2008 where no evidence of PID or endometriosis had been detected.

102. The defendant's gynaecological expert Mr Rutherford, produced a report on 15 November 2015 reviewing the documentary material then in existence. He was of the opinion that on balance the untreated chlamydia caused the claimant's ectopic pregnancy and associated symptoms until October 2006. However, following treatment there was no physical evidence of gynaecological abnormality and on balance he contended that the untreated STI did not cause her alleged chronic PID. He pointed to 'a long history of psychiatric illness' and noted that the claimant appears to have multi-factorial issues that do not seem to relate to her ectopic pregnancy.

103. By the time of the joint conference in 2016 Mr Rutherford remained of the view that there has been no further evidence of a continuing disease process, with an externally normal Fallopian tube and no evidence of intra-abdominal adhesions, as confirmed by two independently performed laparoscopies. However, he had advanced forward to 27 February 2007 the date after which 'it is hard to put her persisting symptoms down to her chlamydial infection'. This change was prompted by Mr Hay's observation that on admission to Bedford Hospital in February 2007 complaining of pelvic pain, she was found to have a markedly elevated score of C-reactive protein (CRP) that is a marker of inflammation.

104. At the joint meeting, Mr Hay remained of the opinion that continuing PID resulting from the untreated chlamydia explained the symptoms of pain in 2013 and thereafter. He did not consider that the negative laparoscopy should lead to a change of opinion as laparoscopy carries a false negative rate. He adhered to that view at trial, observing that laparoscopy is not the basis for a diagnosis of PID and is no more accurate than a clinical diagnosis. A laparoscopy examines the exterior and not interior of the Fallopian tube and is better for detecting signs of endometriosis or adhesions than PID.

105. Mr Rutherford disagreed with Mr Hay's opinion. PID is caused by inflamed organs. As a consequence a sufferer will tend to lie still rather than rolling around in agony. For a diagnosis of PID, the experience of pain is not sufficient; there must be evidence of persistent inflammation causing the pain. The condition becomes chronic if it persists for more than three months. Although successfully treated chlamydia may still result in PID, this is because antibodies may be produced even after the STI has been cleared, but this would manifest itself in damage to the Fallopian tube, that would be visible to the exterior of the tube in all likelihood. Although internal damage to a Fallopian tube can't be detected by laparoscopy, in his 30 years' experience having examined many damaged tubes, his view is that small adhesions within the Fallopian tube are not the cause of pelvic pain. An infected Fallopian tube will show signs of inflammation and reddening that should be detected by a laparoscopy. There is a 26% risk of a false negative depending on the experience of the operator but here there were two laparoscopies in 2006 and 2008 and the notes from Milton Keynes record the findings and the images taken at the time, giving confidence in the overall assessment.

106. Mr Rutherford was cross-examined at some length about the relevance of the CRP. It had been recorded at 5 in November 2006 and around 50 in February 2007 that was abnormal although levels may reach as high as the 100s. The next record of an

elevated CRP was in November 2015 when other factors (such an injury from the 2015 RTA) might have been responsible. He was criticised for referring to psychiatric factors outside his expertise and it was in any event disputed that there was 'a long history of psychiatric illnesses.'

Conclusions on the gynaecological evidence

107. Both experts were experienced gynaecologists giving evidence within their speciality. Both opinions were plausible and consequently there is a possibility that the claimant's experience of abdominal pain after February 2007 may have been an enduring legacy of PID caused by the untreated chlamydia.

108. However, having reviewed the evidence given and the submissions made about it, I prefer Mr Rutherford's views on the issues that divide them. I recognise that a negative laparoscopy cannot be regarded as conclusive evidence of the absence of PID, but taking the evidence as a whole, I am persuaded that his opinion is more likely to be accurate.

109. I accept that if PID is caused by pelvic inflammation, there must be inflammation rather than just the experience of pain for a diagnosis to be made. It is more probable than not that any such inflammation would be detected by one means or another. There were two independent laparoscopies, the second of which has left a visible record tended to suggest that it had been competently undertaken. Mr Hay's hypothesis that the PID could be caused by damage to the interior of the Fallopian tube that could not be detected by laparoscopy does not accord with Mr Rutherford's experience and was not supported by other scientific evidence disclosed at trial. There was no supporting evidence that PID may be caused by microscopic changes to the interior of a Fallopian tube that could not be detected by laparoscopic examination. If there had been, either Mr Hay or Mr Rutherford could be expected to mention it. Mr Hay's preference for clinical examination necessarily places trust in the patient's account, which is a significant problem in the claimant's case.

110. I am not persuaded that Mr Rutherford's opinion is undermined by his earlier failure to refer to the CRP count. It is to his credit and what one would expect from a responsible forensic expert that he was prepared to modify his views when this clinical record was pointed out. I accept that the heightened CRP count is not diagnostic of PID and may have been explained by something else, but it is some evidence of inflammation that had previously been absent.

111. Mr Rutherford pointed out that in February 2007 there were countervailing factors to a diagnosis of PID: upper abdominal discomfort (whereas PID is confined to the lower abdomen); a history of constipation possibly caused by prolonged taking of codeine that may have caused pain; an account of pain radiating to her kidneys and apyrexia (absence of fever). In addition, Mr Rutherford was entitled to comment on the existence of psychiatric factors in the documentary material as of potential relevance, even though he was not competent to make a psychiatric diagnosis of causation. In my judgment he did not do so either in his report or oral evidence. There were good reasons why a tissue sample (that might have been conclusive) was not taken from the remaining Fallopian tube as that would have damaged the prospects of the claimant from becoming pregnant again.

112. On the basis of the expert gynaecological evidence, I conclude that whatever pain the claimant was experiencing after 27 February, it was not PID caused by the delay in treating her chlamydia.

Psychiatric Issues

113. The summary medical history reveals that by 27 February 2007 a possible psychological component to her symptoms was being discussed, when no physical explanation for her symptoms could be found.

114. On 21 January 2010, the claimant had a consultation with Dr James Briscoe, her consultant psychiatrist, who reported on 9 September 2010. Having reviewed her medical records and taken a clinical history he concluded:

i) Her pre-marital and childhood history revealed incidents of urinary tract infections, painful joints, aching muscles and difficulty walking that were not due to organic causes and the view was then taken that were psychosocially related.

ii) In the absence of any convincing physical explanation for these symptoms, he concluded that the claimant had developed what would now be classified as a conversion disorder: the expression of mental distress in physical symptoms as per International Classification of Diseases (ICD-10, F44.4).

iii) He suspected that there was more emotional conflict in her childhood than she had disclosed. He further noted that she had turned to alcohol and had become alcohol dependent during the conflicts resulting from an arranged marriage into a traditional family that had curtailed her freedom and independence. This dependency was another indication of difficulty in processing her emotions. She projected herself as outgoing confident and resilient but one would not expect such a person to develop a conversion disorder or alcohol dependency.

iv) He noted that she had overcome her alcohol dependency and had not developed a similar problem since she moved away from her in laws. He concluded that she had made a complete recovery from this disorder prior to October 2005.

v) He noted that the claimant was very clear that her history of abdominal pain started on 4 October 2005 after the birth of her second child. He assessed that her abdominal pain was influenced by her psychological state and vice versa.

vi) He recorded a history of her anger and frustration at not being believed by treating professionals; her view was that if she had been treated for chlamydia promptly she would not have been in so much pain and that four years of her life had been taken from her. She had been neglected and her feelings invalidated.

vii) He believed that some of the claimant's symptoms of pain are influenced by her feelings subsequent to the discovery of the missed diagnosis.

viii) Some of her symptoms, tiredness, emotional lability, apathy and sleep disturbance are side effects of the medication she was taking. She was now likely to be addicted to this medication.

ix) He noted her account that the pain from the rash on her face was at times worse than her abdominal pain, two dermatologists believe that the rash is strongly liked to her emotional state and is as a result of her picking at her face. This fits with the overall psychiatric formulation that her rash and symptoms of abdominal pain are manifestations of extreme emotional distress.

x) The relationship between emotional state and her pain, means that the claimant now fitted the diagnosis of Persistent Somatoform Pain Disorder (PSPD) (ICD-10 F45.4).

xi) She presently has mild depression as a result of her experience of pain, the ectopic pregnancy and the discovery of her untreated infection. In the past (for example when she took an overdose in November 2006) she had moderate depression.

xii) Her past experience of pain is not denied, but her extreme response to the pain and associated pain relief taken with her psychiatric history and contemporary stressors and her pre-morbid personality traits means that she fulfils the criteria for PSPD.

xiii) If there is no physical explanation for the rash and it must be caused by the psychological distress that has come about since the Defendant's negligence in October 2005.

xiv) Although the claimant had previously experienced migraines, the exacerbation of them since she became aware of the untreated infection means that on balance this has been caused by the negligence.

xv) She has not previously been assessed by a psychiatrist or psychologist for treatment for her depression and related disorders. Psychological therapy was recommended as a valuable contribution to the package of treatments. A monthly psychiatric review was advised during the therapy.

xvi) If such treatment was provided there was a reasonable likelihood that depression rash and migraines caused by the negligence could be resolved. It would also be expected that the psychological component of the pain could be effectively treated through therapy.

115. Following this report she was seen by an NHS consultant psychiatrist Dr Jayalath on 23 May 2011, and 28 November 2011. She missed an appointment in July 2011. She was also seen by a private psychiatrist Dr Kamath on 8 September 2011, 3 November 2011 and 15 March 2012. She failed to attend or cancelled other appointments and it was noted that she had also missed a number of appointments with psychological therapist Candace Johnson. Both psychiatrists noted that debt was another source of stress (claimed to be £30,000 in May 2011 and around £50,000 in September 2011).

116. In his 20 September 2011 letter to the claimant's GP, Dr Kamath indicated his impression that she was experiencing a moderate depression that was being treated with anti-depressants; she was being advised to reduce her pain medication on which she appeared to be dependent, and

> "All of these disorders must be viewed in the context of disordered familial relationships, particularly with her husband and with her extended family, leaving her isolated, vulnerable, depressed and desperately unhappy."

117. In his final report of March 2012, Dr Kamath noted that future psychiatric supervision would be through the NHS only, her problems needed to be addressed by a multi-disciplinary effort and that while some progress had been made in reducing pain medication, she was still on a lot of medication. He observed:

> "Treatment efforts will continue to be hampered by Satveer's inability to engage for whatever reason and this adversely affects prognosis."

118. Dr Briscoe saw the claimant again on 21 November 2012. He concluded that there had been no coordinated multi- disciplinary treatment. Her condition had not deteriorated but had not progressed to any form of sustained recovery. He noted that she was now separated from her husband although they live in the same house.

119. He noted that her pain was not confined to abdominal or pelvic region but is affecting other parts of her body such that 'her GP has apparently now diagnosed fibromyalgia'. There was no reference in this report to the 2011 RTA.

120. Dr Briscoe wrote two further reports on 14 October 2013 and 11 March 2016. There had been no further consultation with the claimant. He had advised on a treatment plan with the claimant's pain specialist on 20 February 2015. In his 2016 report Dr Briscoe reviewed the medical records and noticed that there had been a change of GP in February 2015. He noted the RTA on 8 June 2015. His opinion remains unchanged.

121. The defendant instructed its own a consultant psychiatrist, Dr Dinshaw Master, to report on the claimant. He interviewed her for 140 minutes on 9 December 2014 and produced a single lengthy report on 19 April 2016. He had the advantage over Dr Briscoe in that by the time of his report he had seen:

    i) trial witness statements of the lay witnesses;

    ii) copies of the claimant's diaries and Facebook pages;

    iii) copies of the reports of the experts including the report of Sally Gooch on care needs.

122. In recording her personal history, he obtained from the claimant the information that she had disclosed to her husband three years previously (which if accurate would be about 2011) the fact that she had had a previous boyfriend but not the fact of prior sexual intimacy with that previous boyfriend on one occasion. The disclosure to her husband was prompted by the fact that the previous boyfriend's current wife had

contacted Mr Rathore to tell him that 'I know my husband still loves your wife'. Mrs Rathore told Dr Master 'I know he still loves me. He was always there in the back of my mind and I wish I could have married him. I really missed him'. She also explained that she remains in infrequent touch with him.

123. She gave further details of conflict with her in laws following marriage when she was not let out of the house for the first six months and just cooked and cleaned. Following the breakdown of marital relations in her husband wanted a divorce but both families were unwilling to allow this. She lives as best friends with Amarjit since their separation.

124. She told Dr Master that immediately after A's birth 'she suffered symptoms of excruciating abdominal pain-absolute agony-excessive bleeding' which caused her to roll around crying. She was told that the vaginal swab taken on 4 October was negative. She started borrowing money when off sick from work and was now £37,000 in debt.

125. The medical record review also disclosed that there had been three counselling sessions with KB Primary Care Counselling Service up to February 2009. The claimant was leaving for India and uncertain of her return. The author doubted much progress had been made in three sessions and there had been a number of late cancellations and was inclined to think she was struggling to keep up her defence mechanisms which lead to the cancellations to avoid any risk to them.

126. Dr Master noted that there was no sign of pain behaviour for the first 90 minutes of the interview with him until a question about her facial rash prompted her to ask for a break to take an analgesic. Although she sat stiffly she was able to bend forward and pick up a prescription form that she dropped without apparent difficulty. No impairment of memory or concentration was detected in interview.

127. Dr Master reached the following conclusions:

i) Her medical history suggested somatoform incidents when aged 12/13, 19 and 21.

ii) This history of medically unexplained symptoms indicates a diagnosis of Somatic Symptom Disorder using the Diagnostic and Statistical Manual (DSM-V) although in the absence of other details it was difficult to be certain that the symptoms had sufficient impact on daily life to warrant a formal diagnosis.

iii) The disclosure of the pre-marital relationship had not been made to other treating professionals and the ramifications of this relationship have extended and caused significant problems within her marriage.

iv) If there was no gynaecological evidence of ongoing pelvic pain, these symptoms were somatoform in nature and consistent with the previous history.

v) The crucial question is what triggered the somatoform pain disorder? It was likely to be multifactorial with a short list of possible factors being:

a) ill health following A's birth;

b) post-natal depression (PND) based on her current account;

c) if the symptoms of chronic pelvic pain started after the ectopic pregnancy, a strong contender was the discovery of the fact of infection by her husband up to six years previously;

d) the disclosure of the previous affair following the call to her husband 'must be a significant factor in causing ongoing symptoms of stress which will inevitably feed into the somatoform pain disorder';

e) conflicts in the presentation of the separation from her husband and the impact on her children who required support from outside agencies;

f) financial difficulties;

g) medically induced opiate dependency.

128. There was no material difference between Dr Briscoe's diagnosis of PSPD and Dr Master's diagnosis of SSD. Dr Master disagreed that the disorder was a consequence of the negligence. He did not think that the disorder resulted from the negligence. She would have suffered these in any event.

129. He commented on the proposed treatment plan and observed that the goal should be to focus on improving day to day functioning rather than reduction of self rated pain. He did not think home visits were required and this treatment can and usually is conducted in outpatient settings.

130. There was a meeting held by telephone in August 2016 following which a joint statement was prepared. The following relevant points emerged:

i) Dr Briscoe did not think the pre-2005 disorders caused sufficient disruption to normal life to classify for a diagnosis of PSPD/SSD. The symptoms passed after relatively short periods of time and she was in a stable marriage, working, socialising and caring for her children. She was however vulnerable to development of a somatoform disorder.

ii) Dr Master thought that the combination of the pre-2005 conditions noted in the medical history had sufficient impact to merit the diagnosis but, in any event, the history indicates a high degree of vulnerability to SSD and this itself indicates a strong likelihood of developing future somatic symptoms.

iii) Dr Briscoe did not think there was sufficient medical evidence of depression following A's birth to justify a diagnosis of Post Natal Depression, despite an Edinburgh Post Natal Depression score of 16 recorded on 14 November 2005 by a health visitor. Any emotional distress following A's birth was more likely to be due to abdominal pain experienced though the untreated STD.

iv) Dr Master noted that the claimant's account of such ill health that she left her new baby with her in laws was not supported by the medical records. In assessments made on two occasions in October 2005 by different doctors the

claimant did not claim to have abdominal pain. If her children stayed with her in laws as claimed, the inability of a mother to look after her new born child is likely to indicate very severe health or social problems indicating PND.

v) Both agree that the claimant was suffering from PSPD/SSD from some point after 7 October 2005 Dr Master added the observation:

vi) 'The diagnosis of SSD necessarily requires a high degree of consistency in the presentations of symptoms and observed levels of related disability in everyday functioning. Evidence of rapid variation in the apparent impact of the pain symptoms and the rapid variations in the patient's presentation would give rise to major concerns about the validity of the diagnosis which is wholly dependent on the patient's account. (He) has concerns about the inconsistencies between the claimant's account of the severity and impact of chronic abdominal pain and the relative paucity of references to such symptoms in the claimant's diary entries. As noted above, the validity of a diagnosis is SSD is wholly dependent on a truthful account from the claimant. If concerns arise about the veracity of the patient's account consideration should be given to possible exaggeration. (He would wish to reconsider) if any further evidence should arise that indicates deliberate deception about the severity, extent and impact of the claimant's symptoms. From the clinical perspective a doctor will tend to accept a patient's account at face value and it is on this basis that (he) diagnoses SSD.'

vii) Dr Briscoe adhered to his view that the undisputed pain experienced between October 2005 and 2006, together with the negative emotions of sadness frustration and anger at not being believed and the distress of an ectopic pregnancy, caused by a treatable condition caused the PSPD. There is no evidence of the claimant reporting distress that she caught the disease from her husband. There is evidence of her anger of the negligent failure to inform her of the diagnosis in her statements made to Dr Collett the Pain Consultant in her report of 10 July 2009. Subsequent psychosocial issues are maintaining rather than causative factors.

viii) Dr Master identified fourteen factors likely to have caused or maintained the SSD including the diary account of domestic violence (see Appendix B), the 27 July 2008 RTA after which she developed more widespread pain, which cannot be attributed to the negligence. The fact of ongoing litigation is likely to play a significant part in causing stress that maintains the condition. He considered that the shock of learning of the infection along with other vulnerabilities is far more likely to have been the cause of the SSD rather than delayed diagnosis whether the only or main cause.

ix) Dr Briscoe believed that without the year's pain caused by the untreated infection, there would have been no psychiatric disorder and there was no mechanism by which chronic abdominal pain could be due to a psychiatric cause.

x) Dr Master maintained his view that the discovery of the infection was of great significance in the precipitation of the SSD with its focus on abdominal symptoms. He noted that symptoms became more widespread after the RTA.

xi) Dr Briscoe considers that the facial rash is evidence of emotional distress caused by the abdominal pain and the PSPD.

xii) Dr Master considers that the rash would have emerged as an incident of the SSD in any event.

xiii) Both consultants agree that the claimant was suffering from the PSPD/SSD before the July 2008 RTA. Dr Briscoe did not think the 2008 RTA had any impact on the PSPD. The symptoms of pain to the legs were recorded by Dr Collett in July 2009 a year later. Dr Master considers that the 2008 RTA was significant in causing the more widespread pain as part of the pre-existing SSD.

xiv) Dr Briscoe equally did not conclude that the RTAs of 2011 and 2015 would cause psychiatric symptoms. Dr Master noted these collisions were less severe and would have caused minor anxiety by themselves.

xv) Dr Briscoe did not consider the images on her Facebook pages were inconsistent with her account that the severity of her condition fluctuates. They can also be explained by the pressure on her and her husband to maintain the outward appearance of a couple.

xvi) Dr Master thought the appearance on the Facebook pages contrast sharply with her presentation at interview in 2014 and are matters going to her veracity that is for the court to decide.

xvii) Dr Briscoe thought the details in the diary entries were consistent with account of chronic widespread pain as reported to him in 2012 as pain experience will vary.

xviii) Dr Master concluded that her appearance in interview in 2014 was one of gross invalidism. Her ability to pick up a form was inconsistent with that presentation and her Facebook and diary entries of social activities contrast sharply with that presentation.

131. In cross-examination Dr Briscoe maintained his opinions. Dr Master made a number of concessions that will be reflected in the conclusions reached.

Conclusions on psychiatric issues

132. The ICD definition of Persistent Somatoform Pain Disorder is as follows:

> "The predominant complaint is of persistent, severe and distressing pain, which cannot be explained fully by a physiological process or a physical disorder. Pain occurs in association with emotional conflict or psycho-social problems that are sufficient to allow the conclusion that they are the main causative influences. The result is usually a marked increase in support and attention either personal or medical.
>
> **Differential diagnoses**.

The commonest problem is to differentiate this disorder from the histrionic elaboration of organically caused pain. Patients with organic pain for whom a definite
physical diagnosis has not yet been reached may easily become frightened or resentful, with resulting attention seeking behaviour. A variety of aches and pains are common in …disorders but are not so persistent or dominant over the other complaints.

Excludes:

Back-ache NOS (Not Otherwise Specified),

Pain NOS (Acute/Chronic) Tension type headache."

133. The DSM Somatic Symptom Disorder diagnostic criteria are:

"A. One or more somatic symptom that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings or behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2. Persistently high level of anxiety about health or symptoms. 3. Excessive time and energy devoted to these symptoms.

C. Although any one somatic symptom may not be continuously present. The state of being symptomatic is persistent (typically more than 6 months).

Diagnostic features.

Individuals with somatic symptom disorder typically have multiple, current, somatic symptoms that are distressing or resulting in significant disruption of daily life (Criterion A), although sometimes only one severe symptom, most commonly pain, is present. Symptoms may be specific (e.g. localised pain) or other non-specific (e.g. fatigue). The symptoms sometimes represent normal bodily sensations or discomfort which does not signify serious disease. Somatic symptoms without medical evidence are not sufficient to make this diagnosis. The individual suffering is authentic whether or not it was medically explained.

The symptoms may or may not be associated with another medical condition. The diagnosis of somatic symptoms disorder and a concurrent medical illness are not mutually exclusive and these frequently occur together…..If another

> medical condition or high risk…is present (e.g. strong family history) the thoughts, feelings and behaviour associated with this condition are excessive (Criterion B).
>
> Individuals with somatic symptom disorder tend to have very high levels of worry about illness (Criterion B). They appraise their bodily symptoms as unduly threatening, harmful or troublesome and often think the worst about their health. Even when there is evidence to the contrary, some patients still fear the medical seriousness of the symptoms. In severe somatic symptom disorder, health concerns may assume a central role in the individual's life, becoming a feature of his or her identity and dominating inter-personal relationships.
>
> Individuals typically experience distress that is principally focused on somatic symptoms and their significance. When asked directly about distress some individuals describe it in relation to other aspects of their lives, while others deny any source of distress other than the somatic symptoms. Health–related quality of life is often impaired, both physically and mentally. In severe somatic symptom disorder, the impairment is marked, and when persistent, a disorder can lead to invalidism.
>
> There is often a high level of medical care utilisation, which rarely alleviates the individuals concern. Consequently, the patient many seek care from multiple doctors for the same symptoms. These individuals often seem unresponsive to medical intervention, and new interventions may only exacerbate the presenting symptoms. Some individuals with the disorder seem unusually sensitive to medication side effects. Some feel that their medical assessment treatments have been inadequate."

134. It is common ground between the two experts that the two descriptions are of essentially the same disorder. In my view, the fuller DSM diagnostic criteria seem a particularly good fit for the symptoms described by the claimant.

135. On analysis, the experts are not far apart on what factors may have caused her to suffer the disorder although I prefer Dr Master's multi-factorial approach and reference to the DSM. I note that both agree that her significant medical history before 2005 made her vulnerable to a somatoform disorder. The question is not whether she can be diagnosed with having had such a disorder before the negligence. There is an absence of sufficient information about the impact on her daily life then. The issue is whether she was vulnerable to a further disorder in adult life if a relevant trigger event or stressor occurred.

136. In my view, the combination of features recorded in the medical notes support Dr Master's view that there was a high degree of vulnerability to SSD. Ms Gooch in her report of May 2016 gives a lengthy list of medical conditions and dates that reveal an impressive range of conditions complained of before the negligence. Of interest are

suspected/actual urinary tract infections (1990, 1991, 1992, 1993, and 2001) as well as migraines, unexplained pain in arms, legs and chest and elsewhere. There seems to have been some family history of UTI and migraines. All these conditions form part of the medical history following the negligence in 2005.

137. Dr Master acknowledged in his report that ill health at the time of A's birth might well be a contributory casual factor to the onset of the condition. Although he was primarily considering the pain and bleeding from childbirth, in my judgment, the abdominal pain that the claimant suffered following A's birth as a result of the untreated chlamydia also falls into that category. Dr Master expressly acknowledged in cross-examination that this was a contributory factor to the somatoform disorder. Accordingly, it is not in dispute between the psychiatrists that the physical consequences of the untreated infection are a causative factor in the experience of somatoform pain. Dr Master also acknowledged that another candidate that he had favoured in his report, PND, was based exclusively on the claimant's clinical reporting to him and was not supported by medical records. Given the admitted unreliability of the claimant as a historian of her own symptoms, even apart from the more general assessment of credibility and reliability made earlier in this judgment, PND could not be considered established and therefore could not be assessed as making a causal contribution.

138. Although there are many issues with the claimant's evidence, nothing emerged at trial to undermine her reports of abdominal pain before and after February 2007, when in my view, on balance of probabilities, there is no gynaecological evidence of a physiological basis of the pain. The medical records and the diary are consistent on this question.

139. Despite, my concerns about the reliability of the claimant's own account, I am, therefore, satisfied from the consensus of expert opinion that the claimant did suffer from an SSD by February 2007 and that disorder was materially contributed to by the experience of abdominal pain caused by the untreated infection. It is causally related to the defendant's negligence.

140. It is common ground that the facial rash is a manifestation of a psychological disorder. Dr Master considered it was unconnected with the PID, but as I understand it, that is because he did not consider that the PID from the untreated STI caused the SSD. Since I have reached the conclusion that the SSD was materially contributed to by the PID, and there is some consensus that the skin disorder is connected with the same emotional distress that caused the SSD, I also reach the conclusion on balance that the negligent act of leaving the infection untreated materially contributed to the onset of the rash in the latter part of 2007. Whether it continued to make a contribution in 2008 or 2011 is a different question.

141. This leaves two issues in dispute:

    i) would the SSD have occurred when it did in any event; and

    ii) was the chronic widespread pain that the pain experts are agreed was established by 2011 caused/materially contributed to by the negligence?

Would the SSD have occurred in any event?

142. I have concluded that there was at least a very significant possibility that the communication of the diagnosis of an STI in October 2006, combined with the pre-existing vulnerability of the claimant and the various psycho-social issues in her life at the time would have triggered the SSD whether or not there had been negligent delay in treating the infection. I consider that the disclosures of conflicts in her private life made to Dr Master, the information about emotional turmoil that can be gleaned from the diaries, as well as the matters dealt with in the closed judgment are significant risk factors in this case, and ones that Dr Briscoe did not identify in his 2010 report. Neither did he have the advantage of the additional material from which their significance might have emerged.

143. It is, however, common ground that for the chain of causation to be negated by this new cause, it is for the defendant to establish on balance of probabilities that the SSD would have occurred when it did in any event. The distinction between emotional upset at the disclosure of the infection and upset at the failure to treat it for a year with the consequence of both the pain and the salpingectomy is, in my view, too subtle to be able to conclude that the former outweighed the latter, or that the latter did not make a material contribution to causation.

144. Dr Briscoe rightly observes that there is nothing in the claimant's recorded accounts to clinicians at the time or in her diary to substantiate the proposition that her dominant emotion was resentment of her husband for the predicament that she found herself in. In my view, some evidential basis is needed for a conclusion that the disorder would have emerged by February 2007 in any event, for this possibility to have become a probability.

145. Despite my finding that there was a significant possibility that this was so, I am not satisfied that it is more probable than not such an occurrence would have in any event occurred by February 2007. It follows that I am satisfied on balance of probabilities that the SSD suffered from February 2007 was materially contributed to by the negligence, and I am not satisfied on balance that the SSD would have occurred by that date in any event. The claimant succeeds on this limb of causation and is entitled to compensation for injury loss and damage that she can prove flowed from this condition.

Did the negligence cause the CWP diagnosed by May 2011?

146. The substance of the present claim, however, is for future loss said to result from her present predicament, where there was a qualitative decline in her experience of pain in 2011, and a further apparent deterioration in the autumn of 2014, and March 2015. For shorthand I will describe this condition as CWP, although use of this term is itself a source of debate and expert disagreement.

147. It is for the claimant to establish causation of her loss. In my judgment she has not established that any CWP she has experienced since May 2011 was materially contributed to by the negligence in 2005 to 2006. Indeed, after careful assessment of the available evidence I am satisfied that it is more probable than not that the CWP manifest by May 2011 was caused by other factors triggering her pre-existing vulnerability to somatoform pain wholly unrelated to the negligence.

148. Accordingly, the defendant is not liable for the care costs and other loss flowing from that condition. In reaching this conclusion I take full account of the evidence of the pain experts that I will consider in this section of the judgment as well as the debate between the psychiatrists.

149. Mr Bright's case for the claimant relies on inferences to be drawn from the chronology of events. He submits that the PSPD/SSD was established by February 2007 and thus before any other trigger event such as the July 2008 RTA had occurred. The first indications of the spread of the experience of pain from the abdomen area (whether upper or lower) had been recorded by the treating pain consultant Dr Collett in July 2009 and thus preceded the later RTA of 2011. Although the nature of CWP and its development is still a matter of debate, the court should be satisfied that the CWP was a logical progression of the SSD that has now been established to have been caused by the negligence. Attractively as that submission is made, and recognising the support it receives from Dr Briscoe and Dr Harrison, I do not accept it.

150. First, and foremost, by contrast with the claimant's reports of abdominal pain, I consider her evidence of the experience of CWP, and when and why it occurred are highly unreliable and materially influenced by financial advantage in the litigation then contemplated. The diary entries for 2009 and 2011 dealing with her social life and physical activities are significantly at odds with her claims of generalised pain and its debilitating effect. Mrs Gooch's care report carefully draws together the different threads of what the claimant was saying to people at this time. Dr Briscoe's opinion was formed in 2010 without the benefit of this material but I am surprised that in cross-examination he did not accept that there was a conflict between his assessment and this material or that it made any relevant difference to his assessment.

151. In addition to her ability to have a good game of badminton from time to time, let alone to even contemplate attending a Zumba class, the fact that the claimant held down her employment until March 2011 (albeit with some sickness absences and home working), was telling Bedford Social Services in July 2009 that she shared care of the children with her husband and there were no issues of concern about her capacity to do so throws serious doubt not merely on her account of the consequences of the CWP but its existence or extent. I note Dr Master's observation in re-examination that despite his extensive clinical experience in running a somatoform pain clinic he had never encountered a patient able to undertake that degree of activity when complaining of pain of the gravity claimed here.

152. It is also unfortunate that in his 2012 report Dr Briscoe missed the RTA of March 2011. Whilst I would accept that the details as to what happened do not suggest a severe impact, the fact is that the claimant issued proceedings for compensation for injury caused by this RTA and attributed the onset of pain that restricted her previous ability to care for the children and before domestic tasks to this incident. She also lodged a DLA claim in September 2011 largely identifying restricted mobility arising from shortly after this accident. She told her employer that she was unable to work after March 2011 was because of this accident. In the previous year she had not claimed that her absences were caused by her own medical condition as opposed to those of her children. She was clearly significantly in debt at this stage and had a financial incentive to attribute responsibility to others in order to receive compensation. Legal proceedings against the defendant were already in train by 2011.

153. In my view there was a temptation for the claimant to both exaggerate symptoms and their consequences in daily life and to attribute them to the defendant without cogent or consistent evidence to do so. I incline to the view that Dr Briscoe first reached his conclusions relying on the narrative reporting of the claimant without the benefit of the materials that would throw serious doubt on the reliability of her reporting to him. He has subsequently adhered to his views and accepted the claimant's explanations for inconsistencies and discrepancies, which for the reasons given above and further considered below, I do not.

154. Second, it seems to me that the effects of the July 2008 RTA on the claimant, with her vulnerability to somatisation, were more significant than Dr Briscoe was willing to acknowledge. From her diary account, she considered this to be a clearly a traumatic event in which she thought she was going to die and her life was passing in front of her. The GP record of 5 August 2008 shows that she was complaining of more pain since the auto accident and seeking more pain medication as a result. The entry on 6 August records her getting a lot of pain where her seat belt was. She told Dr Briscoe that it still made her anxious when driving. This was not the first such accident she had experienced. It seems to have been an impact at high speed, although a psychological reaction to events does not necessarily depend on the force of the impact.

155. Apart from indicating the traumatic nature of the incident when there was no possibility of seeking compensation from another person, the diary entry is also significant in that this is the first recorded suggestion of tension with her husband 'he don't trust'. This is one of the few incidents recorded in 2008, and when more regular entries resume one of the persistent themes in the entries over the next nine months noted in Appendix B is resentment and criticism of her husband with more than one suggestion of domestic violence.

156. This period coincides with the record of spreading pain noted by Dr Collett. Whilst evidence of emotional conflict with or resentment of her husband was absent in the 2006-2007 period, in my view it is amply indicated at this time. Matrimonial conflict in the context of the pre-existing vulnerabilities of this claimant is likely to be a very significant source of stress and I am persuaded by Dr Master's assessment of the importance of this factor. In my judgment, this is a source of stress independent of the defendant's negligence.

157. I recognise the difficulty in separating the causal effect of a progressive deterioration of a somatoform disorder that in its inception was materially contributed by the physical pain resulting from the defendant's negligence, from a significant new stressor. However, my overall evaluation of the evidence is that the feelings expressed by the claimant are not the product of an SSD caused by the defendant, but emotional conflicts, suspicion and resentments that erupted independently in this relationship and may well have its origins in events and emotions and feelings long preceding October 2005. Further I consider it highly likely that the July 2008 RTA was itself an independent source of stress in this relationship.

158. Third, the mechanism by which somatic experience of pain extends from a part of the body (here the abdomen) to other parts is obscure. Dr Collett was a consultant pain specialist to whom the claimant was referred by her GP in 2009. She wrote two letters giving opinions on 12 July and 17 September that year. In the first she records

her account that her pain is 'constant and it is band-like around her abdomen going down into her legs. She also has paraesthesia in her legs and her arms and she has restless'. In a passage to which Dr Briscoe draws attention she expresses empathy with 'the anger she must have feel having had pain symptoms for a year, being told no reason can be found and then suffering an ectopic pregnancy which results in the removal of her fallopian tube which was attributed to untreated infection.' She expresses the opinion:

> 'there is obvious activation of the viscero somatic convergence reflex and there is obvious viscero visceral hyperalgesia. It is now known that when animals and people have chronic viscero pain from one organ for a period of time, they actually cause nerve cells related to other viscero organs tobecome sensitive. Thus I see many patients who have for example endometriosis who then go on to develop painful ladder syndrome'.

She thought that this progression was developing in the claimant's case but in addition there was a musculo-skeletal element to her pain. Amongst the treatments she recommended were pelvic floor exercises and cognitive and behavioural therapy (CBT).

159. In the follow up letter he informs the GP that she told the claimant that she was alarmed at the combination of pain relief treatments she was taking, that whatever the aetiology of her pain it is not responsive to opioids, it may not be possible for medication to take this pain away and she is in significant need of seeing a psychologist with a view to helping her with some pain management strategies. She was pleased to hear that the GP had found someone who could assist with CBT.

160. Dr Harrison and Dr Valentine are the two pain management experts whose own reports conflicted on the questions of causation in a way that reflected the differences of opinion between Drs Briscoe and Master. There was a joint discussion in July 2016. They both agreed that by May 2011 the claimant suffered from CWP, although there were some earlier indications of the onset of the condition noted by Dr Collett. At Question 6 Dr Harrison was of the view that the CWP would not have developed if she had been treated promptly for the infection without the pain from the negligence. Dr Valentine was of the opinion that the CWP was unrelated to the litigated event; even if she had been treated promptly on balance she would have developed the CWP.

161. At Question 7, Dr Harrison was of the view that the majority of people who have been in RTAs do not suffer long term chronic pain. The claimant had been involved in RTAs in 2003 and 2005 without chronic pain symptoms, and on balance would not have developed chronic pain symptoms following the RTAs in 2008, 2011 and 2015 without the negligent failure to treat. Dr Valentine was of the opinion that the claimant was at significantly greater risk than the average person of developing a chronic pain with more severe pain, more distress, and more functional impairment than might be predicted on the basis of organic pathology after the RTAs. On balance chronic pain would have and indeed has evolved out of the RTAs especially the incident in July 2008. The claimant's presentation with CWP is much more likely to have evolved out of such musculoskeletal trauma or other mechanism than out of a presentation with chronic pelvic pain.

162. The experts made opposing observations on the relevance of the Facebook and diary entries to their opinions, whilst recognising that these were ultimately matters of evaluation by the court. Dr Valentine was concerned that the material raised veracity issues and in particular noted a smiling Facebook post from Nando's with her husband on 7 August 2014, the same day as his examination of the claimant. Although she would needed to eat something that day he would not have predicted the activity recorded after seeing her presentation with severe and disabling pain and her account of her relationship with her husband. Her claim that she does not go anywhere unless she has to is undermined by the Facebook material and does not support a genuine presentation at the time of her examination. He also noted her ability to pick up a form spontaneously that was documented by Dr Master, four months later.

163. In cross examination, Dr Harrison expressed the view that CWP was a description rather than a diagnosis. He considered it to be a development of the PSPD. He agreed that the predominant medical change occurred after the March 2011 accident but that accident was insufficiently traumatic to account for it. When asked how the CWP developed from PSPD. I recorded his answer as:

> ''I am not clear about it and it is difficult to explain. It is persistent somatoform pain but I can't explain any more why CWP has occurred. In my view there is no proven link to the 2011 RTA, temporally related does not mean it is causally related..,if somatoform in nature the RTA may be related as opposed to not related and the severity of the impact may be irrelevant. If there is somatisation the accident may have some bearing on it but the degree of bearing is for the psychiatrists not me and they should be dealing with it.'

164. When asked about the employment records the fact that employment was maintained until March 2011 and the RTA at that time and the last absence recorded for reason of abdominal pain was in January 2010 he responded:

> 'That history would suggest that things changed (around March 2011) and something happened at that stage to be off work. It is a possible cause (of the CWP) and given that somatisation is the most probable cause, there is a greater likelihood of it being the cause than when the joint report where I was still considering an organic cause.'

165. He agreed it was surprising that the claimant went to Legoland if she claimed to be lying down 80% of the time, but it depended on what she was doing once there and she might have been trying to give an impression of a lifestyle in her Facebook posts.

166. In re-examination he confirmed his view that the CWP would not have occurred without the negligence whilst emphasising that it was not understood why it spread but it was part of the somatisation process. If there was medical evidence of abdominal pain after January 2010 that might diminish the inferences to be drawn from the employment evidence.

167. Dr Valentine adhered to his opinions in cross examination. He regarded CWP as a descriptor that is widely used as a diagnosis, although it does not yet appear in the ICD or DSM and fibromyalgia is the conventional diagnosis using the American College of Radiologists description. He deferred to the psychiatrists as to how CWP develops from a somatoform disorder. He accepted that Dr Collett's July 2009 letter was insufficient to support a diagnosis of CWP although there were developing symptoms in 2008 to 2009 and the claimant's account to him was she had those pain experiences then.

168. He thought the 2008 accident significant because of the severity of the physical and psychological consequences and considered that the CWP may have been caused by it or the 2011 RTA. In cross examination he was asked whether the SSD materially contributed to the CWP; he said that was a matter for the psychiatrists but he could not recall a case of this happening. In re-examination he told the court that in his extensive clinical practice he had never previously encountered CWP being caused by a somatic disorder, although ultimately he deferred to the psychiatrists.

169. On reviewing the evidence on this difficult question, I concluded that the psychiatrists should have the opportunity to comment on this expression of opinion by Dr Valentine. I posed two questions for written answer:

i) Have either of them had clinical experience of somatic disorder causing CWP?

ii) Is there professional literature supporting or doubting any such link?

170. Both gave substantial answers that I have recorded at Appendix C to this judgment. I am grateful for their responses. Dr Briscoe's literature review led to a supplementary report from Dr Master commenting on the same. It seems to me that both psychiatrists have experience of pain that is widespread and persistent that is somatoform in nature, but that this pain may need to be distinguished from a neuro-biological diagnosis of fibromyalgia as defined by the American College of Radiologists that can be considered to be CWP in a conventional diagnosis. Both Dr Harrison and Dr Valentine as pain experts distinguished between fibromyalgia as a physiological diagnosis of description and a somatoform experience of pain.

171. I note Dr Briscoe's observation in response to the supplemental questions that treating psychiatrists do not tend to explore causation as opposed to treatment where the two conditions coincide. Dr Harrison had said something similar.

172. However, the centrepiece of this claim is the loss said to result from the CWP which requires adjudication on causation. It seems to me that the literature cited by Dr Briscoe is inconclusive on this issue I remind myself that the ICD diagnosis states:

> 'Pain occurs in association with emotional conflict or psycho-social problems that are sufficient to allow the conclusion that they are the main causative influences.'

173. The claimant has previously indicated that she had an experience of some pain and injury from the July 2008 and 2011 RTAs. There was also some evidence of physical injury caused by the 2012 incident in the shower and complaints by the claimant to her GP of leg injury including ulcers that may have affected mobility that she

attributed to the 2015 RTA. I accept that these latter incidents cannot be said to have caused the experience of CWP diagnosed in May 2011. At best they may have contributed to the prolongation and heightening of any experience of pain. No persuasive physiological explanation has been identified for this pain. She informed the experts that her GP had diagnosed her with fibromyalgia, but in the light of the discussion briefly alluded to above, I cannot conclude on the evidence before me that she probably does suffer such a condition within the description used by the American College of Radiologists.

174. Any current genuine experience of pain, must therefore be psychological and somatoform in nature. The experience of pain does not seem to be constant. At various times since May 2011 she seems to have had pain free periods when she is able to achieve a great deal by way of normal social activity. By way of expert observation, I note that her pain did not prevent her from picking up a document during Dr Master's examination of her. There are some pointers to malingering but overall perhaps not enough to positively conclude that this explains her complaints.

175. I, therefore, proceed on the assumption that her pain experience from July 2008 onwards is a recognised psychological condition. The severity of such a condition in turn depends on the reporting of the patient. In the light of my earlier conclusions about the unreliability of the claimant as a historian of her experience of pain in this period, and my conclusion that financial considerations have caused her to distort and exaggerate the pain she complains of and the nexus between the pain and the negligence, I therefore have very great difficulty making a positive finding as to what she has experienced since July 2008 or May 2011 and why.

176. The pain experts defer to the psychiatrists and the psychiatrists have a significant difference of opinion. Reviewing the evidence as a whole, on this issue I am more persuaded by Dr Master than Dr Briscoe. Accordingly, by contrast with the earlier conclusions about the impact of the PID on the SSD, I conclude that the psychiatric evidence as a whole does not form an independent source of support for the claimant's claim.

177. I do not accept that the psychiatric evidence means it is more likely than not that the CWP is materially connected to the PID in 2005-2007 that resulted from the negligence. Indeed, the evidence as a whole satisfies me that it is more probable than not that the psychological experience of pain in places other than the lower abdomen would have occurred in any event given the emotional and other stressors in the claimant's life from July 2008 onwards

Conclusions on causation

178. In the result I am satisfied that the defendant's negligence caused physical injury loss and damage to the claimant for which she is entitled to be compensated. This includes the somatic pain disorder related to her abdominal pain and psychologically induced facial scarring. It is probable that these conditions could have been satisfactorily addressed if the claimant had been willing to accept the medical advice that they were predominantly psychological in nature and could be resolved by CBT. There is evidence to suggest that she either did not accept this, or was unwilling to have her defensive mechanisms challenged by CBT with which she did not co-operate for any sufficient period of time.

179. I will now relate my conclusions to the four periods indicated at the outset of this judgment;

180. Period One (October 2005 to February 2007): The claimant suffered pelvic pain, an ectopic pregnancy, loss of a fallopian tube caused by the negligence.

181. Period Two (March 2007 to July 2008): The claimant's experience of pain was somatoform in nature but the PSPD/SSD was material contributed to by the pain resulting from the negligence. Further the emergence of a skin disorder during this period was an aspect of the psychological disorder materially contributed to by the negligence. These symptoms could have been resolved if they had been treated as recommended.

182. Period Three (August 2008 to May 2011): An independent cause of stress arose and triggered effects in a person with a pre-disposition to somatoform disorder. It was the independent cause of any prolonged psychological pain experienced or the maintenance of such symptoms as the facial rash. It may even be that the disclosure made to Dr Master are those mentioned in Appendix B and relate to this period rather than 2011. If what she told Dr Valentine during his examination of her is accurate the widespread pain begins around this time. Although a precise cut-off date is difficult to determine, I am satisfied that the July 2008 RTA was an important source of stress along with the matrimonial conflict evidenced from January to August 2009, in part triggered by the July RTA and other aspects of the claimant's personal life unrelated to the negligence. I conclude that by the autumn of 2009, any lingering causal contribution made to the claimant's psychological disorders was negligible or non-existent.

183. Period Four (June 2011 to trial): During this period the independent stressors arising in Period Three had been joined by other stressful events wholly unconnected with the defendant's negligence. I am satisfied that the development of CWP in May 2011 is not attributable to the defendant's negligence. There is another significant stressor in the form of the March 2011 RTA to which she attributed consequent pain and the inability to continue working. I recognise that at other times she states otherwise. The stress in the marriage at this time led to the separation of the parties. If the event she described to Dr Master with respect to matrimonial relationship did indeed arise in 2011 this may be a yet further cause of stress on the relation and a reason for a new and heightened experience of pain. She was clearly in financial difficulties at this time, both a source of stress for a somatoform disorder and a reason to exaggerate symptoms and/or attribute them to events five years previously.

184. Future loss: Accordingly I am satisfied that the defendant is not liable for future pain and suffering, care, loss of earnings or other heads of future loss.

Head of damages

185. I shall now give my decision on the facts relevant to the heads of loss of claimed for which I conclude that the defendant is liable. I shall also briefly indicate my conclusions on the disputed issues relating to future loss, in the event that I am wrong on causation. It was agreed at the final hearing that the advocates should have an opportunity to consider my conclusions on the issues relevant to causation and loss before any final concluding submissions are made in writing.

Voluntary Care

186. For period one and two the claimant makes significant claims for voluntary care provided by her husband and in laws because of her inability to look after her children.

187. To recover for gratuitous care, the claimant needs to identify care that 'goes distinctly beyond that which is part of the ordinary regime of family life' see Mills v British Rail Engineering Ltd [1992] 1 PIQR per Staughton LJ. At 138-9. Mr Rathore never gave up his employment to care for his wife and children. She maintained her own employment for most of periods one and two. In my view, it would be absurd to compensate Mr Rathore for playing football with his sons or making the occasional family meal. I have in any event considered his evidence of what he did, when and why to be unreliable in the earlier section of this judgment dealing with the credibility of the claimant.

188. In principle, I accept that there may be a head of claim of care for the children that was needed during the time the claimant was in hospital, on sick leave, or experiencing symptoms that were disabling. Given the diary entries it is very difficult to determine the duration of any such periods of need for assistance. I am particularly surprised by the amount of driving or other forms of travelling that the claimant undertook between Nottingham Leicester and Bedford 2006 to 2008 as well as local shopping.

189. I have already explained why I cannot accept the statements of the parents in law as valid basis for a gratuitous care claim. Looking at the references to the in laws in the evidence I have the impression that much of any time the children spent with the paternal grandparents was either to enable Mrs Rathore to go to work or because this was the cultural tradition in a large family.

190. Her diary suggests that the claimant was able to perform most of the range of tasks associated with child care between January and December 2006. It does not exclude the possibility that she did need additional assistance with children at times of acute abdominal pain.

191. As to the rival assessments of the claimant's needs in the event that loss is recoverable for period three (or any part of it) and period four, I unhesitatingly prefer Ms Gooch's assessment of future care needs over those of Ms Wills. Ms Wills seems to have limited her task to putting a figure on the heads of claim made by the claimant. I have found the claimant's evidence to be unreliable, exaggerated and liable to be distorted by financial considerations. Ms Gooch examined all the pointers in the evidence including the diary entries, reporting to professionals and others, and made assessments of care needs that may have been filled by family members during disabling period of pain experienced by the claimant. Her assessments mirror my own conclusions on the issue.

192. For period one, Ms Gooch concludes that the only periods identified by the diary and other sources when voluntary care was needed was 4 September 2006 to 26 February 2007 when she assessed a maximum average of 64 ¼ hours a week personal care in various ways. I agree the period of care need but consider the estimate of hours needed is on the high side. I will reduce it to 50 hours a week removing any element

of care that Mr Rathore may have provided during this time, and to account for weeks when the pain was less severe. This is still an over estimate of care needs, but I make no further reduction recognising that this is an overall assessment with imperfect evidence. Conventional discounts for the costs of such care will be applied to these periods.

193. Ms Gooch is of the opinion that no allowance should be made from March 2007 through to September 2009. I agree with that assessment. Any care that the grandparents were providing for the children during this period was of a sort expected in an extended Asian family to help a mother go to work. Her account to social services in July 2009 was that she was able to care for the children and did so and was observed doing so. This period takes us well into period three and beyond the time when I conclude the negligence made a causal contribution to any pain experienced.

194. Ms Gooch is unable to make an assessment for the period September 2009 and November 2009. She leaves to the court the question whether the termination of the pregnancy was caused by the opiate dependency that had in turn been caused by the somatoform disorder in February 2007 which was materially contributed to by the negligence. My conclusion is that it was not. The claimant had a pre-existing tendency to substance dependency, as evidenced by her period of alcohol dependency. She was regularly warned she was taking too many strong analgesics. Sometimes she reduced the dose at other times she carried on regardless. She did not persist in CBT that should have helped her address her excessive use of opiates and experiences of somatoform pain. There may have been psychological reasons for her dependency but I have concluded that by this time this psychological stressors were entirely independent of the defendant's negligence. The defendant is consequently not liable for voluntary care needs for this period or indeed any subsequent period given my findings on causation.

195. I cannot find any reliable evidence of significant voluntary care from the end of this period until March 2011. If there was then an assessment of some 20 hours per week marginally discounting the figure given by Mrs Gooch would be a reasonable estimate.

196. In March 2011 the claimant is injured in the RTA and stops working, as it turns out permanently. This is a not a consequence connected to the negligence. Assessments of what degree of material causation there may be during this period if I were wrong in my firm conclusions identified above, would be extremely imprecise, but at the highest in my view would be 40% given all the other factors in play in this complex case.

197. I accept that her care needs would increase after March 2011. In July 2011, Mr and Mrs Rathore separate although live in the same house. If the defendant had been liable for care needs from this time onwards I accept that any care then offered to her by Mr Rathore would be different in nature from the reasonable contribution expected of a husband to family care where both parents work. Of course a separated husband who wants to maintain a relationship with his children will want to spend time with them and look after them despite the mother's inability to do so. A reasonable estimate of voluntary care for the period March 2011 through to August 2012 would be 39 hours per week assessed by Mrs Gooch for the period September 2011 to August 2012.

This has increased to 48 ½ hours a week by the time of trial as her condition is perceived to have deteriorated.

198. As for future care, if the defendant were to be responsible for it, I accept that compensation should be directed to the additional costs of care not provided by statutory agencies, but that the purpose of care provided to someone with a somatoform disorder is to encourage a move to greater independence and living with pain, rather than assuming a position of total dependence on such care. As between Ms Gooch and Ms Wills I prefer the former's assessment of how much it would cost and for how long it should be provided for. I understand that the parties are agreed that in the event of an award for future loss it should be delivered in the work of periodical payments.

Future loss of earnings

199. This head of loss does not arise following my findings on causation. If it had I would have concluded that the net loss from earnings would be the appropriate figure in assessing loss. The claimant was working from home for the last 3 1 /2 years of her employment. She had previously undertaken a cosmetics advice business. If she had been fully fit and with her children growing up I conclude that self-employed activity would have been her preferred option.

200. I recognise that the psychiatrists were not optimistic about the prospects of improvement by the claimant from her present presentation because of the duration of her symptoms. My own assessment is that there is a significant element of exaggeration of those symptoms and the exigencies of litigation are itself a significant factor in maintaining them. On that basis, I consider that once the issue of compensation has been resolved and the nature of any disabling condition being identified as psychological, the claimant will have the incentive to move her life on. I consider that there is a reasonable chance that she will drastically reduce the medication that is doing her no good, reduce her care needs to the minimum to get by. Perhaps she will take her children for a holiday to India where previously her condition seemed to have remarkably improved and pick up the threads of socially active life, whether with a revived relationship with her husband or not.

Assessment of quantum

201. Following the procedure discussed at the hearing I invited the advocates to reflect on these findings and seek to reach consensus as to the quantum of loss or at least the relevant range for each head of damage recoverable.

202. I acknowledge that this has been a fiercely contested trial with little opportunity for consensus to date, but the court expects the advocates to rise above the fray at this particular stage in the proceedings, and give particular attention to the overriding objective of assisting the court, and reducing further costs.

203. Following disclosure of a draft of the preceding paragraphs of this judgment, I received concise submissions on quantum from both advocates. I do not propose to set out in any detail the respective submissions of the parties but will proceed to reach my conclusions on them by reference to those submissions.

General Damages for pain suffering and loss of amenity:

204. The claimant identifies five heads of injury from October 2005 to the autumn of 2009 and claims £60,000. The defendant approaches the issue as being closest to one of delayed diagnosis of an ectopic pregnancy and a short period of somatoform disorder and submits that £20,000 is the appropriate sum.

205. I prefer the claimant's analysis of the injuries flowing from the negligence. The negligence was the failure to treat the chlamydia that caused pain, an ectopic pregnancy, removal of a fallopian tube, a reduction of opportunity for future conception, a somatoform disorder lasting from March 2007 through to the autumn of 2009, and a skin rash from September 2007 to the same end period. I have had regard to the JC Guidelines and the defendant's submission on the level of social functioning during this period. I award £50,000. It is agreed that interest at 2% from 26 February 2014 should be added making an aggregate rate of 6.11% or £3,055.

Loss of earnings

206. The claimant acknowledges that the schedule of loss did not make a claim for loss of earnings from November 2006 to July 2007, but observes that the primary findings identify a loss of average earnings over sick pay as £4,257. It is contended that there is no disadvantage to the defendant in making an award for this sum, despite the loss of opportunity to make submissions on the issue. I accept that this loss is recoverable in principle and will award it, but not award interest at 14.03% from August 2007 given the failure to plead this head of claim.

Care and assistance

207. The parties are agreed that 50 hours per week for gratuitous care between 4 September 2006 and 28 February 2007, but disagree as to the level of discount for voluntary care and whether the rate should be the basic or aggregate rate. Given that such care was provided over weekends and at evenings I accept the claimant's submission that the rate should be £8.43 and the discount rate 25% that results in a figure of £8,032.74. I am prepared to accept the claimant's submission on the interest on this sum should be £1329.42 making £9,362.16.

208. I do not accept the claim for any further period for the reasons given in what is now [192] of the judgment.

Decorating

209. I reject this head of claim for the reasons given by the defendant

Prescriptions charges

210. A consequence of the injuries including the somatoform disorder was a heavy reliance on medication. I accept the claimant's assessment of £1,000 over the defendant's submission. With interest this award is for £124.70.

Travel

211. The degree of medical treatment for the recoverable period was as high, but the claimant lacks particularity. I will award the median figure between the rival submissions of £750 and interest at the aggregate rate of 12.47% of £93.52.

Conclusion

212. For these reasons, the total is £53,055 plus £4257 plus £9362.16 plus £1124.70 plus £943.52 making a grand total of £68,742.38. Accordingly the claimant will recover this sum by way of damages.

APPENDIX A

CLOSED JUDGMENT

(edited out of judgment handed down)

APPENDIX B

Extracts from diary for 2009 dealing with matrimonial tensions

27 January 2009. "Me and Amo had a barny. Well he did anyway. I couldn't understand there was no reason. He just sat there from 5 to 11:30 watching TV, dickhead. I hate him so much sometimes. I had to read my med neg file it was like reliving it. I wanted to cry. Sorted out some paper work. He just sat there like a prick."

5 February. "Amo can't go to work. 9:45 took J to docs"

6 February. "Amo can't go to work he did fuck all day."

7 February. "Amo wasted another day. I came on. NB I am very upset and pissed off. I need to go away and be on my own."

13 February. "We went to London today with N. Stayed in a family room at the Sheriton. Got there about 7pm got ready went to the Asian night really good night I got pissed danced until we dropped had a few snacks room was bad my face was awful."

14 February. "Got up early had two and a half hour breakfast. It was so nice. Amo looked… Checked out late."

15 February. "Amo birthday. Got out late our bodies are in agony. Got home had a laugh made Roti everyone had fat weekend. Me and Amo had a fight pathetic."

28 February. "Went out to do a few jobs. Very tired and pissed off as I haven't got energy to do anything. I've got no help. Amo is being a prick."

1st March. "Went to Coventry in so much pain in the morning. Amo being a prick again he is so useless, good for nothing. He can't do anything on his own except….."

Between the 9 – 28 March the claimant A and her mother in law went to Punjab, India. She returned to Coventry airport 28 March having recorded her journey home the diary for the 28 March continues,

"Amo couldn't find Airport I kept hurting myself. Amo read some old message had a big fight he hit me hard.

5 April. "Went to Coventry. He said to me, I should go to him if I want. He doesn't understand that's not what I want."

6 April. "Me and the kids went to Mum's stayed there until 6 pm came home. Me and Amo had a tiff he said to me if I want to speak to Sohn then I should it had nothing to do with that. I am due on I am having mood swings. I am very stressed out I feel like I have been accused of something I haven't done. I don't know what to do. I'm going to go insane have a nervous breakdown."

7 April. "Not well. Me and Amo had another tiff. He keeps saying if you want to talk to Sohn then I I talk to him. When the argument has nothing to do with that he has said four times now and

I'm getting sick of it. I can't talk crap like that. I'd rather die than live like this. I can't live I can't die god help me.

13 April 2009. "Went to Coventry had a very bad day I am so fed up I am going to have a nervous break-down. I do not want to carry on like this I just want to close my eyes and stay with God. The baby came home today from hospital. I couldn't go. Had another tiff with Mum and major one with Amo.

15 April. "Made Spag bol. Kids enjoyed… Me and Amo were sitting down. I was falling asleep with my tea in my hand made some calls spoke to the girls. Feeling very suicidal. My faith is getting bad my tummy hurts so I prayed."

17 April. "Went to hospital A & E the doctor can't believe they haven't got to the bottom of my problem. My stomach hurts so much yet Amo thinks I am making it up. He thinks I am making it up. He told me to get up and make the kids something to eat. I could barely move though I went down and tried to do my Jorth (prayer) he just sat there in bed doing fuck all. I will never forget these days of my marriage. Their supposedly to be the best but they are the worst."

23 April. "Went to Mums everyone was there. Told Amo to get on with stuff in the house. I've really had enough I just want to die. I can't live, I can't die I feel so lonely I have God I have my kids I am so fed up. I can't cope anymore I am losing my mind."

24 April. "Had a very weird day. Feel like crap I just want to get better I am trying so hard… (The claimant goes out shopping and returned home). House was a tip me and Amo had a fight. I don't want to live my life like this.

7 May. "Amo said he is going to Manchester…we had a big misunderstanding had a pathetic row sorted things out. Amo's mum had a go at me I don't understand the people; they think it's my fault. I am unwell and I just make it up… I don't to live I don't want to leave my kids what to do. I just want my health back.

9 May (The claimant's birthday). "He didn't even say happy birthday just went… We had a few words but it's the same every year SSDD*. My lot all called took kids to park."

(* I understand as Same Shit Different Day).

10 May. "Got up feel crap. I miss Amo I want to see him but I don't. Took all the kids to park made burgers for all they loved it. Amo came home I just hate it I hate my life I really hate it.

11 May. "Had a chat with Amo didn't get anywhere what is the point. I can't live a lie I hate it."

25 May. "Worked. Went to mum to ask her what she was upset about. She laughed Amo wasted a whole weekend nothing new SSDD he is such a waste.

29 May. "Woke up with a mad rash all over my body, dinner, big brothers. Amo told me not go to hospital because he was being a knob."

30 May. "Milton Keynes branch day out. Took kids to see the play. Amo had done fuck all no surprise the man is completely useless."

31 May. "Sick rash on body. Went to A & E was going to ……..Council I nearly fainted, high temperature was dizzy again. Amo had done Jack Shit even with kids."

5 June. "Had to pick Amo up from work was so SOOO tired. I couldn't drive them….
Tried to work had to go to Mamma's for dinner….down it was nice to see her."

9 June. “Amo had an accident in van. I am really fed up.”

27 June. “Amo done fuck all again. Went to Tesco. GP.”

28 June. “Cleaning up… Amo getting on with odd jobs. Congrats.”

29 June. “I had a big fight with Amo. He is so damn lazy – just can’t admit it.”

30 June. “Went out spoke to Lee. Me and Amo had a fight so stupid not talking.”

1 July. “Over drawn. Well overdrawn at bank. It’s our ninth anniversary. Went to cinema to watch Transformers.”

3 July. “Not too well today really fed up. Want to do so much more with my life. I feel so stuck held down. God help me and others to have a better life.”

7 August. “Went to Brighton had a decent day. I froze on the train. Nice weather, kids had a nice time. Me and Amo had a big bust up when we got back he very drunk he hit me. I had to call cops out on him. He was being such a knob. I don’t want to be here anymore. I can’t take this bull shit anymore. I just want to be happy.”

9 September. “Me and Amo had a fight. Suz came round. Me and Amo had a long bust up because I was going to go W/E. I had a??? he drinks so out of order.”

27 September. “Amo did fuck all again all weekend. Anyone would think he is ill.”

APPENDIX C

Further information from Psychiatrists:

Dr Master responded as follows:

> "I distinguish between the use of the term chronic widespread pain as a descriptor of a condition characterized by longstanding diffuse pain symptoms and Chronic Widespread Pain (CWP), defined as Fibromyalgia by the American College of Rheumatology.
>
> Longstanding widespread pain symptoms are a feature of psychiatrically defined somatoform conditions such as Persistent Somatoform Pain Disorder (PSPD) (ICD-10 F45.4) and Somatic Symptom Disorder with Predominant Pain (SSD) (DSM-5 300.82). These psychiatric diagnoses are essentially descriptive. The diagnosis of Persistent Somatoform Pain Disorder states "*the predominant complaint is of persistent, severe, and distressing pain, which cannot be fully explained by a physiological process or a physical disorder".* By contrast, in Somatic Symptom Disorder, symptoms may or may not be associated with another medical condition.
>
> If the Court finds that the Claimant suffers from CWP, in the sense of the American College of Rheumatology definition, in my opinion the diagnosis of Persistent Somatoform Pain Disorder is not applicable, for reasons explained in the paragraph above.
>
> The diagnosis of Somatoform Symptom Disorder (DSM-5) may co-exist with the diagnosis of CWP.
>
> My understanding of the definition of CWP is – widespread pain on the left side of the body, the right side of the body, above the waist, and below the waist, in addition axial skeletal pain has to be present. I defer, however, to rheumatology and pain expert colleagues as to the precise, currently accepted definition of CWP.
>
> Commonly, individuals suffering with CWP have co-morbid psycho-affective symptoms, such as symptoms of depression and anxiety. My understanding of modern thinking on the causes of CWP is that there is an underlying neurobiological basis for this disorder. As a psychiatrist, I can confirm that PSPD/SSD conceptualizes pain symptoms arising as a result of psychogenic mechanisms, not neurobiological. There is no causal link between these psychogenic mechanisms and neurobiological factors of which I am aware. I can confirm that I know of no scientific literature that supports or suggests such a link."

Dr Briscoe answered the first question as follows:

> "I have clinical experience of patients with CWP in addition to or linked to a somatic disorder. Where CWP is linked to a somatic disorder, the link is usually a condition of depression or anxiety, i.e. the progression of the somatic disorder to CWP is usually associated with a mental disorder such as depression. In an individual case I will often correspond with colleagues in terms of the somatic disorder having developed into CWP i.e. where initially localised somatoform pain in whichever part of the patient's body has subsequently developed into (CWP).
>
> However I would wish to point out that (the).. question, while simple is not one which we would ask in clinical practice i.e. where one comments that an existing somatic disorder

follows through and ‘causes’ CWP. We can infer a causative link but to establish it in an individual case would take a level of inquiry into the patient’s individual history which we do not do, as opposed to prioritising treatment of the co-existing conditions that are present.”

In answer to the second question he undertook a literature review of studies showing instances of widespread and somatoform pain. He also comments on whether CWP is a description or a diagnosis.

Whilst this judgment was in an advanced stage of preparation the court received Dr Master’s second supplementary report dated 12 February 2017 and a flurry of emails about its admissibility. I have looked at the contents. For reasons given in the judgment I do not propose to go further into what the literature examples show or not.