Neutral Citation Number: [2024] EWHC 451 (Admin)

Case No: QA-2021-BHM-000009

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

Priory Courts
33 Bull Street
Birmingham B4 6DS

Date: 01/03/2024

**Before** :

**THE HONOURABLE MR JUSTICE HENSHAW**

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**Between :**

**KELLY CHILTON** **Claimant/Appellant**

**- and -**

**MICHAEL PAYNE** **Defendant/Respondent**

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**Gurion Taussig** (instructed by **BLV Law**) for the **Appellant**
**Nadia Whittaker** (instructed by **Medical Protection Society**) for the **Respondent**

Hearing date: 15 December 2023
Draft Judgment circulated to parties: 26 February 2024

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# APPROVED JUDGMENT

**Mr Justice Henshaw:**



## (A) INTRODUCTION

1. The Appellant, Ms Chilton, appeals against the order of Recorder Khangure QC dated 18 November 2021 dismissing her claim against the Respondent, Mr Payne, for negligence. The claim concerns an alleged failure by Mr Payne to provide or ensure adequate follow-up and/or aftercare to Ms Chilton at Dolan Park Hospital ("***the Hospital***"), part of The Hospital Group, following a revision abdominoplasty on 19 June 2014.

2. For the reasons set out below, I have concluded that the Recorder's decision was correct and that the appeal must be dismissed.

## (B) BACKGROUND FACTS

3. Ms Chilton entered into a contract with the Hospital for the provision of the revision abdominoplasty and aftercare. Mr Payne was the surgeon contracted by the Hospital to perform the surgery. He had previously performed an abdominoplasty on Ms Chilton in May 2013.

4. Ms Chilton was followed up on 28 June 2014 and 10 July 2014 by nurses at the Hospital.

5. Ms Chilton's wound became infected, and on 18 July 2014 she attended a walk-in clinic in Walsall. Infection was noted and she was prescribed antibiotics. Unfortunately, Ms Chilton's condition deteriorated and she was admitted to Walsall Hospital on or around 6 August 2014. She subsequently underwent debridement where 2 litres of seroma were drained.

6. The parties' plastic surgeon experts were Mr Christopher Stone, called by Ms Chilton, and Mr Aidan Fitzgerald, called by Mr Payne. They agreed that had Ms Chilton been reviewed by Mr Payne on or around 17 July 2014, i.e. about one month or 30 days post-operatively, Mr Payne would have identified the seroma and treated the same conservatively. The experts agreed that Ms Chilton would have avoided the debridement and the worse cosmetic result.

7. Ms Chilton seeks General Damages in the range £20,000 to £25,000. As to Special Damage, Ms Chilton seeks to recover the cost of care in sum of £1,335 and cost of psychological treatment in sum of £3,150.

8. The claim was issued on 9 November 2016 and, by order dated 31 January 2019, allocated to the Multi-Track. The trial was heard remotely over 5 days, from 12 November 2021 and 15 to 18 November 2021 at Birmingham County Court. The court heard evidence from Ms Chilton, Mr and Mrs Davies (Ms Chilton's parents), Mr Payne and the experts. The judge dismissed the claim for the reasons set out in a detailed (154 paragraph) *ex tempore* judgment given on 18 November 2021.

9. I understand that the reason why the case took so long to reach an appeal hearing was the unfortunate loss by the County Court of the majority of the tape recordings of the evidence. The appeal was therefore conducted on the basis of evidence transcripts comprising an agreed composite of the official transcripts of the judgment, the evidence of Ms Chilton and that Mr and Mrs Davies, together with contemporaneous notes of other evidence taken mostly by the solicitors.

## (C) THE RECORDER'S JUDGMENT

10. The judge summarised the basic facts and noted that Ms Chilton alleged that within 30 days of the procedure Mr Payne (as the operating surgeon) ought personally to have examined her. It was also alleged that the nursing staff ought to have been aware of the delay in healing and contacted Mr Payne (and that it was Mr Payne's position that he should have been contacted). Ms Chilton alleged that Mr Payne (as the surgeon involved) was negligent, by reason of (in summary):

    1. "Inadequate follow-up on the part of the defendant;

    2. The defendant should have followed up sooner;

    3. Failed to inform the nursing staff that if the wound was not healing properly he ought to be informed;

    4. Failed to contact the defendant after the claimant's mother had called; and

    5. Failed to make himself available."

11. The judge noted that The Hospital Group had since gone into administration. It was common ground that Mr Payne was a self-employed independent contractor, whose services were paid for by The Hospital Group, and that he was not responsible for any failings of the nursing staff at (and employed by) The Hospital Group (§ 30).

12. The judge summarised the key allegations advanced at trial against Mr Payne as being (a) the failure to arrange any adequate follow-up of Ms Chilton and (b) a failure to ensure that Ms Chilton was followed up with an examination by Mr Payne adequately or at all.

13. The judge summarised the evidence given by each of the witnesses of fact and the expert witnesses. As part of this, he referred to a number of documents to which Ms Chilton had been taken, which are significant:

> "43. …The first document is at page 499 of the bundle and is termed as a "quotation" but was referred to as "the contract" between The Hospital Group and Ms Chilton. I think what has happened here is, if one looks at the document itself, it is headed: "Your personal quotation. Customer retains a copy" and then at the bottom: "Once the customer has decided to accept the quotation ..." (i.e. which contains details of the type of surgery that is to be carried out and also the account details) there is a part at the bottom which says: "Patient acceptance of quotation" and it reads: "I confirm I have received the patient information booklet and understand that I need to read through each section. I confirm I have read the terms and conditions on the reverse of this sheet." It is signed by Ms Chilton and dated 18 May 2013. Also at the bottom, just above "Patient acceptance of quotation" there are the words: "Post-op ... consultation 7 seven and 14 days, nurse/surgeon three months."
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> 44. Now, as far as the terms and conditions are concerned, Ms Whittaker took Ms Chilton through those and she confirmed that she had read the terms and conditions and the patient care booklet when she got home, and those are quite important because she was taken through these terms and conditions in some detail.
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> …
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> 46. At 5.2: "Aftercare: the initial aftercare period will include standard post-surgical review appointments within the term specified on your personal quotation. Please see our website for full details of your aftercare policy. You may wish to download this information for your records. We do reserve the right to change our aftercare policy ..." et cetera "... and your aftercare policy starts on the date of your procedure. Outside aftercare packages and appointments in any subsequent investigations and/or treatment will be quoted and charged separately."
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> …
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> 50. At page 111 Ms Chilton was taken to a document headed "Body surgery patient information booklet" and she accepted that she had received this booklet and she said she was sure that she had read it.

51. She was referred in particular to page 118, which is the section at the top of the page headed "Abdominoplasty aftercare" and in particular she was taken to, and she agreed she had read: "Post-operative follow-up is of paramount importance. Each patient undergoing abdominoplasty surgery will be given post-operative appointments for wound management and suture removal. Post-operative instructions are vital and we consider it very important that you adhere to them. Failure to follow these guidelines and attending your appointments can adversely affect the outcome of surgery and put your safety at risk. Following the abdominoplasty, the patient is asked to return on specified appointments approximately at seven, 15, 30 and 90 days, or as required. Occasionally it may be necessary to return more regularly than those stated. Transport is not provided by the clinic for post-operative appointments." It is clear that the post-operative follow-up was to be provided by The Hospital Group.

52. At page 102 of the bundle is another document that was provided to the claimant which is headed "Cosmetic surgery post-operative patient information booklet." Again Ms Chilton, quite frankly, said that she was sure that she had received it. Page 103 is important and she said that she would have read this. The reason that it is important is that it states expressly: "If post-operatively you have any concern or doubts or queries about any aspect of your treatment, you should telephone the hospital as follows." A hospital ward number is given and then a telephone number and, underneath that, an emergency nurse number. Further down it says: "However, if you feel that you are developing a more serious problem, do not hesitate to contact the appropriate emergency authority, e.g. local A & E department or GP." It gave the claimant the option of dialling an emergency number to get in touch with The Hospital Group if there were any complications or concerns that she had or, alternatively, quite properly, she was reminded that the NHS provides emergency services also.

53. At page 105 of the same pamphlet, under the heading "Post-operative review/suture removal" the second paragraph: "If you are unable to attend your post-operative review, please contact the outpatients department ..." and it gives another number "... to request an alternative time and date." Next paragraph: "When you attend the clinic for your post- operative review, the type of procedure that you will have had will determine who you will see and what intervals after surgery. You will be given specific instructions for the removal of sutures (stitches) but these will be reviewed at your first follow-up appointment. Your dressing, plaster or suture removal, you will normally see one of our specialist clinic nurses. You should expect to see your surgeon between one to three months after surgery to assess the outcome of surgery. You may, of course, request to see your surgeon post-

> operatively at any convenient time if you wish to discuss anything about your treatment."
>
> 54. All of those documents are quite clear and it has been confirmed to me by the claimant that she had received them.
>
> 55. As to the "protocol" (as it has been called from time to time in this trial) or "procedure" (that is adopted by The Hospital Group) for post-operative care, it seems to me that in the circumstances that such protocol or procedure was quite thorough. It brought to the attention of the patient and it gave the patient clear guidelines information as to what to do if the patient thought that there was a concern post-operatively about the procedure that had been carried out or that she was in some difficulty."

14. The judge noted that the first procedure had taken place on 28 May 2013. On that occasion the post-operative care pattern had been as described in the documents provided by the hospital to Ms Chilton, with Ms Chilton being seen by the nurses within a week of the operation, again a week later then 44 days after the operation, and being seen by Mr Payne about 2½ to 3 months after the operation.

15. After the 19 June 2014 operation, Ms Chilton was seen by the nurses on 28 June, when it was recorded that the wound was healing well. Ms Chilton said in evidence that she was told to return a week later, and booked the appointment for 10 July because her father could only drive her to hospital on Thursdays to Sundays because of work commitments.

16. The records from the second appointment, on 10 July 2014, referred to delayed healing, cleaning, iodine and a week's dressing being given. Ms Chilton said she was told to return a week later if it got any worse.

17. Ms Chilton's evidence was that she tried to book an appointment for two weeks later (24 July) while she was there on 10 July, but the system was down; and that she therefore telephoned on 16 July (and possibly on other occasions) to arrange the appointment but was offered dates two weeks later. The judge made reference to some conflicting evidence about whether Ms Chilton's father would have taken her to the Hospital on 17 July (about a month after the operation) or not, but for the reasons given later I find it unnecessary to resolve that point for the purposes of this appeal.

18. On 18 July 2014 Ms Chilton attended a walk-in centre local to her home, complaining of some pain and possible infection. The notes of that visit include: "*Had revision surgery one month ago. … Last two/three days noticed pain in scar and in a couple of places associated with some yellow crust. Feels well in self. On fluoxetine*". There was reference to the linear scar, with two spots of redness and some yellow discharge. Ms Chilton appears to have been treated with antibiotics and advised to review with her GP for swabs if it did not get better.

19. Ms Chilton's evidence was that an appointment was booked for 4pm on 31 July 2014 at The Hospital Group, but when her mother called earlier on in the day to see whether they could bring it forward, she was told that there was no appointment booked that

day. Then on 6 August 2014, Ms Chilton went to the Accident & Emergency Centre in Walsall, who in turn called The Hospital Group and said she needed to see a consultant; and Ms Chilton was offered an appointment the same day.

20. The judge went on to summarise the evidence of Ms Chilton's mother and father, and then that of Mr Payne. The judge found Mr Payne to be an honest and reliable witness who was trying to assist the court as best he could, and that as an experienced qualified plastic surgeon he had reasonable and honestly held beliefs. Mr Payne had been a plastic surgeon since 2003, had worked for The Hospital Group from 2004-2008, and from 2010 until about 2016, and was the head of a department (presumably meaning a plastic surgery department) in Germany.

21. Mr Payne explained that he carried out abdominoplasty surgery approximately once a week. The procedure he carried out on Ms Chilton in 2013 was a fleur-de-lis abdominoplasty surgery, which involved a vertical incision down the chest and a lateral incision across the midriff. The revision surgery in 2014 involved only a vertical incision. It was, he said, less intense than the first surgery, although Mr Payne accepted that it would incur similar risks. Mr Payne also accepted that Ms Chilton had extensive scars from the first surgery, and that a second surgical procedure on or near the scars of the first surgery carries an element of increased risk of infection. He accepted in cross-examination that where a patient is overweight the risk of a wound not healing increases; and that it could be argued that Ms Chilton's second surgery carried as much risk as the first. The judge accepted Mr Payne's evidence that he explained the risks to Ms Chilton.

22. Mr Payne's evidence was that the nurses would conduct the first appointment within seven days post-operation, because they can change the dressing and deal with the wound, and that a seven-day appointment is too soon for any significant signs of infection or non-wound healing to appear.

23. Mr Payne confirmed that he preferred to see the patient one month after surgery because he could still change something. He said: "*I like to see a patient. It is my own preference, but not a rule.*" He said that seroma can appear quickly after surgery or weeks later. Reference was made to another document, a flow diagram or an 'algorithm' which stated "*Day 30: Review with surgeon and see photos from nurse*". Mr Payne said "*I agree we should have a follow-up after two weeks, but not necessarily by me. I like to see the patient in 30 days because if there is an infection, we can do something about it. But she can be seen by the nurses or, if necessary, the nurses call me*."

24. The judge concluded from Mr Payne's evidence that there was a protocol (or a procedure) in place for the surgeon to see the patient after 30 days after this type of surgery, which was, however, not an absolute rule, and that if there were any clinical concerns, then the nurses would inform the surgeon. Mr Payne went on to describe the type of nurses involved, and what instructions and information they were given.

25. Mr Payne had a recollection that an appointment had been booked for Ms Chilton on 17 July 2014, but after The Hospital Group went into administration, it appeared that neither party really made too much effort (as the judge put it) to see whether the Administrators could provide evidence from the booking system that had been in place. On the evidence before him, the judge felt bound to conclude that no appointment had

been booked. He accepted that Mr Payne's schedule meant that he could have seen Ms Chilton on any of 16, 17, 18 July 2014 had the hospital been told of any real problems that Ms Chilton was suffering.

26. Mr Payne was asked about his duty as a surgeon and it was put to him that it was his duty to follow up after a patient had received surgery, to which said: "*No. There are protocols in place*", being the protocols to which the judge had already referred.

27. As to whether Mr Payne should have written on the operation note, the judge said this:

> "106. One of the criticisms made against Mr Payne is that he did not note on the operation note (at page 389) of when he personally wanted to see the patient next. He said that he did not think that he had to write down that he needed to see the patient after four weeks. He said that there is no need to write it on an operation note. He said: "The procedure (or the protocol) that we have is that we see the patient after four weeks. Every nurse knows we want to see the patient after four weeks and it is also on the consent form."
>
> 107. In my judgment that is absolutely correct. I fail to see why it was necessary for a surgeon to write on a particular document (namely the operation note) when he wants to see the patient next when it is common practice within that organisation for the surgeon to see the patient in four weeks. The nurses would know. All the literature sets out when he wants to see the patient, and, as I have said, I will come back to the type of training and the nurses' obligation to inform people of any credible concerns in a moment. I do not accept Mr Stone's evidence in that regard.
>
> 108. I can see that it might be the opinion of certain surgeons that you would write something down on the operation note, but do I not see it as critical if there are other documents or ways that it becomes clear to the patient and the staff who are booking the appointments as to when the surgeon is going to see her or him. In fact he said: "Had I documented or not, the nurse knew that I prefer to see the patient after four weeks."

28. The judge added that Mr Payne had made the important point that, even if he had seen Ms Chilton on 7-14 July 2014, the outcome would have been the same because he would not have done anything different to what the nurses did: at the first appointment the wound was healing well, on the second occasion some preventative steps were taken (by way of iodine) to prevent any infection. The non-healing was not unusual for this type of surgery.

29. Mr Payne gave evidence that *"It's my practice to ask the nurses to inform me if there are any problems,*" and *"If there was an infection, they would tell me. In any event, I have to write the prescription. I told them, if there was a problem, I'd want to see them."* He described how close the nurses' room was to where he was working at the hospital and said he would regularly pop in to make sure everything was OK with the nurses

and ask them if there were any issues or any problems that he needed to sort out or needed to see. The judge accepted that evidence.

30. The judge set out his findings about the expert evidence, starting with Mr Christopher Stone, a consultant plastic surgeon. The judge felt that Mr Stone's report contained no analysis of the key protocol/procedure documents to which the judge had referred, and could not explain why not. Mr Stone had, though, relied very much on the flowchart/algorithm, which he treated as a rigid timetable. Reading that document in the context of the documents as a whole, the judge did not agree, and considered that Mr Stone had not looked at the whole picture.

31. Mr Stone suggested in evidence that the surgeon should see the patient within two or three weeks of the operation. When it was pointed out that that did not occur following the 2013 procedure, Mr Stone suggested that the standard is applicable in the NHS was different to that in private practice, because in the NHS a consultant would have a registrar below him or her. However, he accepted that there was no evidence of any member of the medical team seeing Ms Chilton before October 2013 following that procedure. The judge recorded that, when asked why he said two to three weeks was the appropriate time, Mr Stone replied that that was his preference and experience but that there was no literature or guideline to that effect. Mr Stone accepted that the follow-up duty could be different for different patients, and it all depended upon the type of surgery and the type of risk involved. Mr Stone also accepted, the judge found, that if Mr Payne told the nurses that he should be notified about any concerns then he would have discharged such a duty. The judge had concluded that Mr Payne did so instruct and train the nurses. The judge added:

> "126. Mr Stone said that he makes no criticism of the nurses and he was taken to page 166, which is a document setting out the type of training the nurses would have. In this context it is important to note - which struck a chord with me - what Mr Fitzgerald said. He said that in the National Health Service the nurses are not accustomed to dealing with one type of surgery all the time, whereas in the private sector with a company such as this providing plastic surgery services, those nurses would be dealing with plastic surgery aftercare all of the time. It is likely they would be better trained, better accustomed to know what symptoms to look out for and how to react if they are concerned with anything, which again is in accord with what Mr Payne told me."

32. The judge's assessment of the expert called by Mr Payne, Mr Fitzgerald was as follows. I quote it in full, because it is relevant among other things to the procedural point addressed in section (H) below:

> 127. … Mr Fitzgerald's evidence I found to be not as useful or informative as perhaps Mr Stone's for a number of reasons. I got the impression that he would readily accept propositions that were put to him and then he would think about it and then come back again. For example, it was put to him that the patient ought to have been seen by Mr Payne within three to four weeks after the operation. He first of all said that up to three months is

> sufficient; then he came back to three to four weeks and agreed with Mr Taussig in cross- examination. But at the same time, to be fair to Mr Fitzgerald, it was put to him in cross- examination that the second surgery was again a fleur-de-lis abdominoplasty redo and therefore would have a vertical and horizontal incision, it would be dangerous at the T- junction and also it would be dangerous in respect of going over previous scarring, in that it would be more prone to risk of infection and not healing properly. On that basis he agreed that the patient ought to have been seen within three to four weeks post-operation.
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> 128. In re-examination it was put to him, quite properly, that in fact the second (revision) surgery - as I have already explained - was simply a vertical incision and not a horizontal one, which would appear to be correct from the medical records and the evidence of Mr Payne - and I accept that - that he said: "Well, in those circumstances, the risks are not as great and therefore, as long as the surgeon saw the patient within three months, that would be good practice."
>
> 129. Overnight I think that Mr Fitzgerald was a little bit concerned about the way that he had given his evidence and he felt it necessary to write to me to confirm exactly what he said in his re-examination, which was that if the second procedure was not as extensive as the first, then the risks associated with it would be less also. Now, he had already told me that in re-examination. The problem I had was that he had said something different in cross- examination, but that, as I say, is explained by the way that it was put to him, which I think it was put to him that Mr Payne accepted that the second procedure included both the vertical and horizontal incisions when that was an error. It was an accidental error that was not done deliberately but it was an error in any event upon which he came to the conclusion that three to four weeks post-operation would be the right time for the surgeon to see the patient. And as I say, the letter says that if that is not correct, then it goes back to up to three months as being the right time that a patient would be seen by the consultant surgeon (save that if there are any clinical concerns prior to that), then it is the duty of the nurses to tell the surgeon and an earlier appointment would be made."

33. The judge summarised his conclusions as regards duty and breach in this way:

> "130. As I have said, I have come to the conclusion that that was the process and procedure that was adopted by The Hospital Group as invoked by Mr Payne in any event, so one can see from there that there is a difference of opinion between the experts as to what the appropriate time for examination of the patient after the operation ought to be and I have come to the conclusion that there is no hard and fast rule on this. It would depend on the circumstances, the nature of the surgery, the physicality of the

> patient and other factors, as opposed to a rule which says that you have to see the patient within a certain time.
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> 131. As both experts said, sometimes there is surgery which does not require any aftercare on the part of the surgeon - albeit it would be minor surgery - whereas there will be other times when you have minor surgery which attracts a complication which, although the surgeon would normally see the patient, it is necessary for him to see the patient and then, as long as the system and procedures are put in place that he is alerted to the same and those are reasonable and it is reasonable for the surgeon to rely on their systems, then I cannot see how there can be any negligence on the part of the surgeon in those circumstances.
>
> 133. … Dr Payne is not responsible for the actions and/or failures of the nursing staff in respect of any administrative tasks. Even though The Hospital Group went into administration, it is still possible to sue the company in administration (with leave of the court) and it is also possible to bring a claim in a case such as this under the Third Parties (Rights against Insurers) Act. ...
>
> 134. There is a duty upon Mr Payne to ensure that the nurses are competent in their medical roles and that they will ensure that he is informed if there are any clinical complications. I am satisfied that Mr Payne is not in breach of that duty because I accept his evidence as to the training of the nursing staff, what he has told them and how he has trained them in the past. ...
>
> 135. I am satisfied that the literature - and I use that as a collective term (all the pamphlets, booklets, guidance et cetera) that was provided by The Hospital Group to Ms Chilton sets out clearly when she would be seen, who she would be seen by and giving her the option to call the emergency number if there were any concerns. I am also satisfied that if such concerns had been relayed to The Hospital Group they would have ensured that she saw a surgeon or Mr Payne whenever that call was made. I am satisfied that it is perfectly reasonable for the 7, 14, 30 and 90 days in the programme to be brought forward and I am satisfied that it is not necessary for it to be Mr Payne to have seen the patient after 30 days (although it was his preference) and that if she had come back on 17, or around then, because he was in the hospital, it is likely that he would have seen her."

34. The judge went on to make findings on the alternative basis of causation, the gist of which was that Ms Chilton did not try to make an appointment between 10 and 16 July 2014; that when she called on 16 July to make an appointment, Ms Chilton's mother (who was a health worker) would not have accepted an appointment for 31 July if she had had serious concerns about Ms Chilton; that that view was consistent with the record of the walk-in visit on 18 July indicating that Ms Chilton had been experiencing

pain for only two or three days; and that Mr Payne would have been able to see Ms Chilton at that time if necessary.

## (D) GROUNDS OF APPEAL

35. The Grounds of Appeal are detailed, but the overarching points may be summarised as follows.

36. The Grounds are divided into two sections. Ground 1 applies if, on analysis, the judge below held that Mr Payne did not owe a duty (a) to ensure that Ms Chilton was reviewed by Mr Payne by writing down on the operation note or on other clinical documents when he wanted to review Ms Chilton; and/or (b) to review Ms Chilton post-operatively within about 30 days. Ground 2 applies in the event that the judge did find Mr Payne to have owed such duties. In that event, Ms Chilton repeated Grounds 1(d) and (e).

37. Ground 1(a) is that the judge was wrong and/or erred in law and/or fact, and/or his decision was outwith the reasonable ambit of his discretion, in finding that the scope of Mr Payne's duty did not include a duty to document on the operation note or elsewhere Mr Payne's wish as to when he wished to review Ms Chilton post-operatively.

38. Ground 1(b) is that the judge was wrong and/or erred in law and/or fact, and/or his decision was outwith the reasonable ambit of his discretion, to find that Mr Payne's duty of care did not encompass a duty to review Ms Chilton by around 30 days post-operatively.

39. Ground 1(c), further and alternatively to Ground 1(b), is that the Judge's decision that there was not a duty to review Ms Chilton by 30 days was unjust because he made a serious procedural or other irregularity by admitting into evidence and/or relying in his judgment upon a witness statement prepared by Mr Payne's expert after the close of his oral evidence.

40. Ground 1(d) is that the Judge was wrong and/or erred in law and/or fact, and/or his decision was outwith the reasonable ambit of his discretion, in finding that Mr Payne was not in breach of the above-said duty of care.

41. Ground 1(e) is that the Judge was wrong and/or erred in law and/or fact, and/or his decision was outwith the reasonable ambit of his discretion, in his analysis of factual causation:

42. Ground 2 repeats Grounds 1(d) and 1(e) in the event that the judge did find the Defendant to have owed the duties referred to in § 36 above.

43. Permission to appeal was granted by Ritchie J, by order dated 23 June 2022, on all grounds apart from the portion of Ground 1(a) based on "*failure to write review requirement into the operation note*". Ms Chilton renewed her application for permission to appeal on that ground, and I consider it in section (F) below.

## (E) PRINCIPLES

### (1) Medical negligence

44. It is common ground that the scope of a duty of care is determined with reference to the harm or risk of harm alleged (cf the six-stage analysis in *Meadows v Khan* [2021] UKSC 21 § 28). The relevant risk in the present case was of post-operative infection.

45. The judge below referred to the test for breach of duty in a clinical context set out by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 § 387:

> "… he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ... Putting it another are way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view."

46. The *Bolam* test was considered in *Bolitho (Appellant) v Hackney Health Authority (Respondents)* [1998] AC 232. Lord Browne-Wilkinson said:

> "… the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the *Bolam* case itself, McNair J. [1957] 1 W.L.R. 583, 587 stated that the defendant had to have acted in accordance with the practice accepted as proper by a '*responsible* body of medical men.' Later, at p. 588, he referred to 'a standard of practice recognised as proper by a competent reasonable body of opinion.' Again, in the passage which I have cited from *Maynard's case* [1984] 1 W.L.R. 634 , 639, Lord Scarman refers to a 'respectable' body of professional opinion. The use of these adjectives - responsible, reasonable and respectable - all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter." (pp. 241-242)

Lord Browne-Wilkinson also quoted the statement of Lord Scarman in *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634, 639:

> "... I have to say that a judge's 'preference' for one body of distinguished professional opinion to another is also professionally distinguished is not sufficient to establish

> negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his judgment he stated the law correctly. For in the realm of diagnosis and treatment, negligence is not established by preferring one respectable body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate speciality, if he be a specialist) is necessary."

Lord Browne-Wilkinson added :

> "I emphasise that in my view it will be very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct fails to be assessed." (p.243)

47. The Supreme Court (Scotland) in *Kennedy v Cordia (Services) LLP* [2016] UKSC 6 made the following statements in relation to expert evidence:

> "49. In the Davie case 1953 SC 34 , 40 the Lord President observed that expert witnesses cannot usurp the functions of the jury or judge sitting as a jury. Recently, in Pora v The Queen [2016] 1 Cr App R 3 , para 24, the Judicial Committee of the Privy Council in an appeal from New Zealand stated:
>
> > "It is the duty of an expert witness to provide material on which a court can form its own conclusions on relevant issues. On occasion that may involve the witness expressing an opinion about whether, for instance, an individual suffered from a particular condition or vulnerability. The expert witness should be careful to recognise, however, the need to avoid supplanting the court's role as the ultimate decision-maker on matters that are central to the outcome of the case."
>
> Thus, while on occasion in order to avoid elusive language the skilled witness may have to express his or her views in a way that addresses the ultimate issue before the court, expert assistance does not extend to supplanting the court as the decision-maker. The fact-finding judge cannot delegate the decision-making role to the expert."

48. In *TUI UK Ltd v Griffiths* [2021] EWCA Civ 1442 , the Court of Appeal, by a majority reversed the High Court's decision the court was not entitled to assess for itself the substance of a CPR-compliant expert report which was "*uncontroverted*". An appeal to the Supreme Court turned on other issues, but Lord Hodge (giving the court's judgment) made these observations:

> "36. In this judgment I address civil proceedings and leave to one side questions of criminal procedure. It is trite law that as a generality in civil proceedings, the claimant bears the burden of proof in establishing his or her case. It is trite law that the role of an expert is to *assist* the court in relation to matters of scientific, technical or other specialised knowledge which are outside the judge's expertise by giving evidence of fact or opinion; but the expert must not usurp the functions of the judge as the ultimate decision-maker on matters that are central to the outcome of the case. Thus, as a general rule, the judge has the task of assessing the evidence of an expert for its adequacy and persuasiveness." ([2023] UKSC 48)

**(2) Appeals**

49. CPR 52.11(3)(a) provides that:

> 'The appeal court will allow an appeal where the decision of the lower court was:
>
> wrong; or
>
> unjust because of a serious procedural or other irregularity in the proceedings in the lower court.

50. CPR 52.11.4 states that: ""*wrong" presumably means that the court below (i) erred in law or (ii) erred in fact or (iii) erred (to the appropriate extent) in the exercise of its discretion".*

51. In determining whether the decision of the lower court was 'wrong' for the purposes of CPR 52.11(3)(a), regard must be had to the way in which the parties' cases were formulated below: *King v Telegraph Group Ltd* [2004] EWCA Civ 613 § 54. Brooke LJ there said:

> "53. It therefore turned out that the court was not being invited to set aside Eady J's order on the grounds that he should have accepted the arguments Mr Price was advancing to him. Instead, Mr Caldecott was now submitting that in the light of the very serious and novel concerns which this case raised this court should on its own initiative make a different type of order from that which the defendant had sought from the judge. Alternatively, at the very least the court should explain what steps a court might take to control the situation and similar situations in the future.

> 54. It needs to be said at once that this court is an appellate court and not a court of original jurisdiction. Its power to interfere with a judge's order are derived from CPR r 52.11(3), and in the absence of consent I do not consider that the court has any power to make a quite different type of order from the order the judge was asked to make if it is satisfied that the judge's approach cannot be faulted. For this reason I would dismiss this part of the defendant's appeal."

52. As to what constitutes a sufficient error in the exercise of discretion to warrant interference by the appeal court, it was stated in *Phonographic Performance Ltd v AEI Rediffusion Music Ltd* [1999] 1 WLR 1507, 1523 that:

> "Before the court can interfere it must be shown that the judge has either erred in principle in his approach or has left out of account or has taken into account some feature that he should, or should not, have considered, or that his decision was wholly wrong because the court is forced to the conclusion that he has not balance the various factors in the scale".

53. As to interference with the decision of the lower court on grounds of procedural irregularity, in *Tanfern Ltd v Cameron-Macdonald* [2000] 1 WLR 1311, Brooke LG stated:

> "…the appeal court has power to interfere if the procedural or other irregularity which it has detected in the proceedings in the lower court was a serious one, and that this irregularity caused the decision of the lower court to be an unjust one". (§ 33)

54. An appeal can sometimes succeed on the ground of procedural irregularity without showing that the decision of the lower court was 'wrong', i.e. even if the same decision would have been reached without the irregularity: *Dunbar Assets plc v Dorcas Holdings Ltd* [2013] EWCA Civ 864. The court there said:

> "28. Perhaps more importantly, it is not every case in which a conclusion that a judge's decision was right prevents a serious procedural irregularity from amounting to an injustice. As the Labrouche case makes clear, the denial to a party of any opportunity to make submissions in support (or defence) of its case is a fundamental denial of procedural justice in its own right, regardless of the consequences. While there will be many cases in which, (as noted in the 2013 White Book Vol. 1 at page 1754), the absence of any adverse consequences flowing from a serious procedural irregularity will mean that an appeal based upon on it will fail, there is a residue of cases of grave procedural irregularity, and the present case is one of them, where the absence of consequences does not displace the injustice constituted by the inappropriate treatment of the complaining party." (§ 28)

The lower court in that case had given judgment for the claimant on a residential possession claim without conducting a trial and without hearing submissions as to whether the defence should be struck out.

55. As to judicial assessment of facts, in *Prescott v Potamianos (also known as Re Sprintroom)* [2019] EWCA Civ 932, the court reviewed the authorities and stated that the proper approach on a challenge to an evaluative decision of a first instance judge was as follows:

> 'The appeal court does not carry out a balancing task afresh but must ask whether the decision of the judge was wrong by reason of some identifiable flaw in the judge's treatment of the question to be decided, 'such as a gap in logic, a lack of consistency, or a failure to take account of some material factor, which undermines the cogency of the conclusion'. (§ 76)

## (F) GROUND 1(A): DUTY TO RECORD TIME OF NEXT REVIEW

56. Ritchie J did not give permission, on the papers, for the part of Ground 1(a) relating to *"failure to write review requirement into the operation note".* Ms Chilton renews her permission application orally to that extent.

57. The first question is whether the judge did find that Mr Payne had a duty to write the date of review on the operation note.

58. Ms Chilton relies in this respect on the last sentence of § 150 of the Judgment. Paragraphs 150 to 153 read as follows:

> "150. Firstly, the scope of duty. Now, as I understood the claimant's case, it was put quite forcefully to me that the duty is on the surgeon to act in a way that is compliant with a reasonable body of surgeons- which I accept – and that would be that he will see the patient within 30 days of surgery and one of the ways that he would do that is to write down that he wanted to see the patient within 30 days on the operation note. Now, it seems to me on the facts of this case that there is little more that Mr Payne could have done.
>
> 151. … This is not a case of strict liability and there are - as I have already pointed out - no strict rules as to when a surgeon should see a patient and, therefore, it is difficult for me to accede to or accept the submission that if the patient was not seen within 30 days, or a month, or four weeks after the operation then it automatically follows that the surgeon is in breach of his duty. I am supported in this conclusion by what Mr Fitzgerald said and also by the hospital literature. It was expected by Mr Payne that he would see Ms Chilton within 30 days but that is not a hard and fast rule and there was nothing to alert him prior to after the first and second appointments.

> 152. We then come to one other factor, which is that the claimant says that the failure to record on an operation note, or any of the other three documents that Mr Fitzgerald referred to in his evidence, is negligent on the part of Mr Payne because it would have been more likely than not that he would have seen the patient within the timescale as set out.
>
> 153. Again, I do not accept that, because you cannot look at that allegation in isolation and exclude all of the circumstances or the context of the case, especially where there is an abundance of literature that I have referred to which sets out, and it was made clear, and the nurses understood, as to when the surgeon wanted to see the patient. Because the whole purpose of adding that note to the operation note is to make sure the nurses knew when Mr Payne wanted to see the patient, if, as I have found, they already knew that because of the procedure and protocols that were in play, then it seems to me neither here nor there but he failed to write that down and it does not seem to me to be critical in anyway."
>
> (emphasis added)

59. Ms Chilton submits that in the last sentence of § 150, the judge accepted that Mr Payne had a duty to write the review date on the operation note. I disagree. The sentence must be seen in the context of, first, the judge's findings in §§ 106-108, which I have quoted earlier. The judge there accepted Mr Payne's evidence that there was no need to write on the operation note because the protocols, including the patient being seen within four weeks, were in place and the nurses would know that. It was also, he said, stated on the consent form. Although certain surgeons might consider that something should be written on the operation note, that was, the judge concluded, not critical if there were other documents making it clear to the patient and the staff when the surgeon was going to see her or him.

60. Secondly, the judge's observation in § 150 must be read in conjunction with the immediately ensuing paragraphs quoted above. In § 153 the judge specifically rejected the allegation that something had to be written on the operation note, on the basis that the nurses knew when the surgeon would want to see the patient again because of the procedure and protocols in place. Accordingly, the statement in § 150 on which Ms Chilton relies can sensibly be construed as meaning no more than that there is little more Mr Payne could have done, apart from writing on the operation note, <u>if</u> (a premise which the judge in fact rejected) there was anything further he needed to do.

61. Alternatively, Ms Chilton renews her application for permission to argue that the judge was wrong to find that Mr Payne had no duty to write the next review date on the operation note or other clinical record.

62. The expert called by Ms Chilton, Mr Stone, said in his report:

> "9.12. In my experience as a Consultant Plastic Surgeon since 2001, and as a plastic surgical trainee for around five years prior to that, no responsible body of plastic surgeons would fail to

> review their patient personally in the post-operative period, usually within two to three weeks of surgery, or to ensure that a consultant colleague is able to do so on their behalf.
>
> 9.13. In my opinion, if it is the case that Mr Payne failed to make reasonable efforts to review Ms Chiltern himself after the second operation, or to ensure that she was seen by a Consultant colleague, then the care that he provided to Ms Chiltern fell below the standard that could reasonably have been expected.
>
> 9.14. However, if Mr Payne, instead of seeing his patient within two to three weeks, chose instead to rely upon the nursing staff to assess his patient post-operatively, then it was his duty to ensure, and to satisfy himself, that the nursing staff would timeously communicate any problems to him directly, notwithstanding the guidance set out by the hospital provider. This would have applied to the observation of wound healing problems on 10 July 2014 as well as to the report of pain and a possible infection on 16 July 2014."

63. In cross-examination, Mr Stone said:

> "Q. Right at no point in any report or JS criticised Mr Payne for not writing on op[eration] note for appointment with her.
>
> A. What I have said – failing to make reas[onable] efforts to make sure not difficult to do write on op[eration] note see me on 17th July see me 4 weeks or document to nursing staff see me in four weeks and not onerous to do and reas[onable] steps to do write on bottom of op[eration] not[e] see me in 4 weeks.'

64. In responding to the question whether he was '*jumping on the band wagon joining in with the obs[ervations] of Mr F[itzgerald]*", Mr Stone replied:

> "Not the case as have already stated no reas[onable] steps were taken – one of those write on op[eration] note and simple measures and are routine."

65. Mr Fitzgerald, called by Mr Payne, said in his report:

> "The Hospital Group guidelines provided for the Claimant to be reviewed at 1 week and 2 weeks following procedure and with the surgeon at 4 weeks. This would be regarded as an entirely appropriate level of practice. In my experience, both within the private sector and the NHS, initial wounds assessments as long as provided by an appropriately trained nurse with experience of dealing with plastics surgery procedures, is entirely appropriate. Indeed, for a surgeon to review the Claimant at 4 weeks following an abdominoplasty, in my opinion, would be much quicker than occurs on the NHS or in private practice. Review by the surgeon would be reasonable so long as it occurred within

> 12 weeks of the surgery. There is an expectation on the part of a surgeon that should there be an earlier than expected problem with any aspect of the patients ongoing wound care, for the surgeon to be informed by the nursing team at which point, an earlier assessment can be arranged by the surgeon. Thus, it was entirely appropriate that the Claimant was initially reviewed by a member of the nursing staff at the Hospital Medical Group / Dolan Park Hospital, initially on the 28 June 2014 and subsequently on the 10 July 2014, at which point arrangements had been made for the Claimant to be reviewed once again a week later on the 17 July 2014.
>
> …
>
> There is an expectation that a reasonable body of competent Consultant Plastic Surgeons would state on the operation note as to when they wished a patient to be first reviewed by them in the subsequent outpatient clinic. The operation note does not appear to suggest the approximate date at which the Claimant was to be seen by Mr Payne on an outpatient basis."

and:

> "From my perusal and assessment of the medical records, my only criticism of the Defendant as I have previously stated is the fact that he has not documented precisely as and when he wished to see the Claimant following the abdominoplasty procedure … It would be my expectation that Mr Payne as the surgeon involved should have clearly documented his wishes as regards the post-operative follow up of the Claimant".

66. Ms Chilton submits that, in saying (in the second paragraph quoted above) that '*a reasonable body of competent Consultant Plastic Surgeons*' would state the date for review on the operation note, Mr Fitzgerald couched the duty in accordance with the standard required by the *Bolam* test.

67. Mr Fitzgerald's evidence in cross-examination is recorded as having included the following exchanges:

> "Expectation of reas body of com body of PSA would state on the op note when they wish patient to be reviewed in subs outpatient clinic …
>
> Now that's your report – question right you are using there the legal test for negligence the reas body of comp plas surgeons use the test
>
> Yes
>
> If you are a reas body of com PS you would state on the op note when you wanted the patient to be seen by YOU

Yes that's what I would do

What every competent PS you know of would do

Not every PS

Reas body

Yes a reas body to put this down reason helps with direct the clinic nursing staff as to when the surgeon wishes to see the patient

…

Expressly you are criticism of the def is for not documenting on the op note or anywhere as and when he wanted to see the claimant

Yes

Does it not follow what you are saying is he breached his duty

Have to put it into context in terms that he had reasonable expectations appt would be made as would claimant and ts and cs of contract of HG so they will arrange them would say he would have breach of duty if he was aware from past experience that he was struggling to get his patients seen on time - …

Suggest to you you do not say any of that what you say in your report is much more straight forward … reas body of com PS would document on op note when they want to see patient

Yes

That is the standard duty of care

Yes

Nothing written down

Agree with that reas body of PS

Yes

…

This is the standard and you are saying he did not do what the standard requires must follow he is in breach

Does not because you have to put into the site in which he was working

…

> You are critical and not done what a reason body of plas surgeon
>
> Yes
>
> You must be saying is breach of duty
>
> When you take into account the context
>
> Right could have documented when he wanted to see patient in cont notes of nurse
>
> Yes
>
> Mr P suggested he could even written to GP
>
> Yes
>
> …
>
> Any other mechanism he wanted to see Claimant
>
> Op[eration] note, cont[inuation] note, discharge letter or GP letter"

68. In light of the above expert evidence as a whole, including the points that were common ground, Ms Chilton submits that it was not open to the judge, and/or the judge was wrong, not to accept that the scope of Mr Payne's duty extended to writing on the operation note or elsewhere when he wished to review the patient.

69. I do not accept that submission. Although at some points in his evidence Mr Fitzgerald indicated that Mr Payne could be criticised for not having made a record on the operation note (or elsewhere), he also drew attention to the context in which Mr Payne was operating, in particular the protocols in place at the hospital and the fact that a specialist nursing team was involved. The judge was entitled to take that context into account in assessing the evidence.

70. In addition, Mr Fitzgerald's evidence was not consistent in suggesting that it would be negligent for the surgeon not to have made an annotation on the operation note. For example, in the exchange recorded thus:

> "If you are a reas body of com PS you would state on the op note when you wanted the patient to be seen by YOU
>
> Yes that's what I would do
>
> What every competent PS you know of would do
>
> Not every PS
>
> Reas body

> Yes a reas body to put this down reason helps with direct the clinic nursing staff as to when the surgeon wishes to see the patient"

the first answer, agreeing on the basis that that is what Mr Fitzgerald would do, does not address the relevant issue i.e. whether Mr Payne must have been negligent for not making a note. The second answer, read in context of the question, appears to indicate that not every competent plastic surgeon would make a note. The third answer, to the effect that a reasonable body of surgeon would make a note, does not necessarily lead to the conclusion that no competent surgeon would fail to do so. More generally, as the extract quoted above shows, when pressed on the question of failure to meet the required standard, Mr Fitzgearld would keep returning to the context in which Mr Payne was working.

71. Ms Chilton draws attention to the fact that Mr Payne accepted in cross-examination that if he had written on the operation note that he wished to see Ms Chilton again in four weeks' time, then something would (he guessed) have been put it into the diary; and Mr Fitzgerald accepted in cross-examination that had Mr Payne made such a note, then it was more likely than not that it would have been actioned. This shows, Ms Chilton says, the surgeon's central role in arranging the post-operative review. In my view, that does not follow. The fact that a note made on the operation note would likely have been actioned, or might have provided a form of 'safety net' for the patients, does not show that that is the only non-negligent way for post-operative care to be arranged; nor that the arrangements in place at The Hospital Group and Mr Payne's role in them fell short of the required standard. Ms Chilton cross-refers in this context to her case on Mr Payne's '*leadership*' duties, which I address in section (G) below. I do not consider that those responsibilities entailed a duty to make an annotation on the operation note of the kind Ms Chilton suggests Mr Payne should have made.

72. Further, this issue is in part linked to the issue discussed below in relation to Ground 1(b). On the basis that there was no hard and fast rule as to when the patient should next be seen personally by the surgeon, there is no specific length of time that the surgeon ought reasonably to specify in a note made immediately after the operation. It would all depend on how the patient progressed and the information coming back from the skilled and specialist nursing staff involved.

73. Viewing the matter in the round, I consider that the judge was correct, for the reasons he gave, to conclude that Mr Payne owed no such duty. Mr Payne was working as part of a specialist team, including experienced nurses, with whom he worked closely. There were protocols in place for the regular monitoring of the patient by the nursing team, referring back to the surgeon as appropriate in the light of the patient's post-operative progress. Symptoms could appear, if at all, after varying periods of time, and it was not unusual for some healing problems to occur. Mr Payne could reasonably expect the nurses to refer the patient to him at an early stage if problems emerged such as to make that appropriate. The expert evidence of Mr Fitzgerald was that this context was important in assessing Mr Payne's duties, and the judge was entitled to take it into account in the way he did.

74. For these reasons, I would not accept this aspect of Ms Chilton's case; and in those circumstances, I do not consider it appropriate to grant permission to appeal on this point.

## (G) GROUND 1(B): DUTY TO SEE PATIENT WITHIN ABOUT 30 DAYS

75. There are a number of strands to this part of Ms Chilton's appeal.

76. First, Ms Chilton submits that in § 153 of his Judgement, which I have quoted above, the judge appeared to reason that the surgeon owed no duty to arrange post-operative review where there is an independent aftercare protocol and/or where nurses owe a duty under such protocol. That, Ms Chilton says, fails to acknowledge that the surgeon and the hospital's nursing staff owed separate and concurrent duties of care to her. In addition to the hospital's contractual duties, which included the provision of aftercare, Mr Payne as an independent surgeon plainly owed Ms Chilton a duty of care in tort. The experts agreed that a surgeon owed a continuing responsibility to show '*leadership*', and Mr Stone referred to the Royal College of Surgeons' Guidelines, '*Good Surgical Practice*' to the effect that the surgeon should:

> "take full responsibility for patient management, leading the surgical team to provide best care. Responsibility should encompass preoperative optimisation and postoperative recovery…
>
> [The Surgeon should] ensure that patients receive satisfactory postoperative care and that relevant information is promptly recorded and share with the relevant teams, the patient and their supporters."

77. Ms Chilton notes that the experts agreed in the Joint Statement that the Guidelines were relevant. In cross-examination Mr Fitzgerald agreed that the surgeon had a responsibility to ensure that he sees patients within a reasonable time, and said:

> "Surgeon has a leadership role and to ensure that the team works in harmony and everyone does their part of the role in the surgical role and not for surgeon to turn up at every post op[erative] check."

The judge is recorded as having noted that the experts agreed that *"surgeon has a duty to review the patient both experts agree that reas[onable] efforts need to be made by the surgeon in order to have patient timeously [reviewed]".*

78. Ms Chilton submits that in his judgment, however, the judge failed to explain why the surgeon's duty to review should cease to exist merely because the Hospital also owed a duty of care towards her; and did not address her submissions that their duties overlapped, thereby providing a safety net for a patient.

79. Those submissions in my view misstate the nature of the judge's conclusions. The judge did not conclude that the duties owed to Ms Chilton by the hospital removed Mr Payne's duties. Rather, he found that the manner in which Mr Payne could discharge his duties had to be assessed in the context of the systems that were, as a matter of fact, in place at the hospital. In the context of a specialised private clinic, with the protocols in place which the judge had described, Mr Payne was entitled to fulfil his duties (including leadership duties) by instructing and monitoring the nurses in the way the judge found he did, and by ensuring he was satisfied that the system was working and

could be expected to result in the patient being referred to him whenever appropriate (see, e.g., Judgment §§ 100-101, 106-108, 110, 125-126 and 134-135, including the points summarised or quoted in §§ 23, 24, 27, 29, 31, 33 and 58 above). There is no error in that approach.

80. Secondly, Ms Chilton submits that (similarly to the first aspect of Ground 1(a)) the judge in fact held, in the last sentence of Judgment § 150 (quoted in § 58 above), that Mr Payne had a duty to review Ms Chilton within 30 days of the procedure. However, it is clear from § 151 that the judge did not so hold.

81. Thirdly, it is said that the judge should have reached that conclusion, and instead failed to state what the reasonable time for Mr Payne to review Ms Chilton might be, taking into account all her individual features (such as her weight) and the relatively extensive nature of the surgery. Ms Chilton submits that evidence overwhelmingly indicated that post-operative review should take place within around 30 days/4 weeks, relying on:

i) the experts' agreement in their Joint Statement;

ii) Mr Stone's evidence in cross-examination;

iii) Mr Fitzgerald's evidence in cross-examination;

iv) Mr Payne's statement in his witness statement that *"[o]ne month post-surgery, I see the patient in person as set out in the post-operative information booklet"*; and

v) Mr Payne's evidence in cross-examination.

I consider these in turn.

82. In the Joint Statement, the experts agreed that *"that reviewing a patient at three to four weeks post-operatively would be acceptable*". However, Mr Fitzgerald went on to add:

> "AF: I accept it would be ideal to review a patient following abdominoplasty at 3 weeks. However, that is not the usual practice of a significant number of Plastic Surgeons either in private practice or the NHS. It is not unusual for Plastic Surgeons not to review their patients for a period of up to 12 weeks following an abdominoplasty particularly if in the meantime a system is in place whereby the patient can be reviewed earlier within the first few weeks by an experienced nurse in the field of cosmetic surgery. Given that the Hospital Group deal almost exclusively in Cosmetic Surgery, one can assume as a Plastic Surgeon that the nurses who provided this post-operative care at the Hospital Group were indeed experienced and qualified enough to do so.
>
> Furthermore, there was an expectation that Mr Payne would have seen Mrs Kelly at about one month following her abdominoplasty, in accordance with the clinical algorithm provided by the clinic. The flow of this algorithm appears to

> have been disrupted by the claimant given that arrangements were made for follow-up in one week when seen by the nursing staff on 10th July 2014. However, the claimant's mother rang the Hospital Group on 16th July 2014 following which the follow-up appointment was put back to the 7th August 2014."

(Paragraph break interpolated for ease of reference)

83. The first paragraph of the above statement of opinion is entirely consistent with the judge's findings, and (if accepted) inconsistent with Mr Payne having been subject to a legal duty to see the patient personally within 30 days. The second paragraph refers to the flowchart, which the judge considered to form only part of the context, and any event I do not read Mr Fitzgerald's comments as meaning that the presence of the flowchart meant Mr Payne had a legal duty to review Ms Chilton within 30 days (nor do I consider the judge should have so found).

84. Mr Stone said during cross-examination:

> "Q. How do you envisage would happen with nurses expect surgeon to pop into assessments
>
> A. Expect surgeon personally see his patients in 30 days and could well be had complex patients who had big op[eration] and have quick look at the wound takes 5 mins
>
> Q. Consider to be breach of duty for surgeon not to be present
>
> A. Have to see patient at least once in 30 days."

85. However, the judge was not bound to accept that evidence (particularly given the points Mr Fitzgerald made as quoted above), and gave logical reasons for not doing so, including that Mr Stone had failed to look at the full picture.

86. Mr Fitzgerald in his report had expressed the opinion quoted in § 65 above, and also said:

> "As already stated, it is entirely the norm for abdominoplasty procedure both in the private sector and the NHS to be followed up initially by appropriately qualified nursing staff. In the NHS and the private sector, I have seen Plastic Surgery Consultant colleagues make arrangements for abdominoplasty patients to be as long as 12 weeks following surgery and this is entirely reasonable as long as there is appropriate nursing oversight to whom the consultant can be contacted should there be a potential complication.
>
> Wound healing issues are almost the norm with abdominoplasty patients and are more prevalent in those like the Claimant who have an extensive wound and are overweight.
>
> An experienced Plastic Surgery Nurse would be more than adequate to cope with routine difficulties such as minor wound

> dehiscences, seroma formations or small patches of skin necrosis. If these were to become more extensive or there was significant evidence of infection, at that point the Consultant should be informed. As long as the Claimant had a documented follow up appointment by the Consultant within the first 3 months following an abdominoplasty procedure and was being kept under review by appropriately qualified Plastic Surgery Nurses, the Defendant followed an entirely recognised clinical pathway both in the private sector and the NHS."

That evidence was consistent with the judge's approach.

87. Mr Fitzgerald's cross-examination on this issue began with it being suggested to him that the procedure on 14 June 2014 was an abdominal fleur-de-lys redo surgery, to which he responded that his understanding was that the 2013 operation was a fleur-de-lys but the 2014 operation was a standard abdominal procedure. Later, however, Mr Fitzgerald appeared to assume and/or accept a suggestion that the 2014 procedure was itself a fleur-de-lys operation:

> *"What you are saying in report risks of delayed wound healing normal but here particularized increased risks of overweight and extensive nature of the wound, wound cl had once surgery done more extensive that one might see in common run of mill in normal abdo*
>
> *Yes because standard Abdo just get scar or wound hip to hip in FDL you get that scar plus vertical incision*
>
> *Because Cl had Fdl ado redo*
>
> *Yes*
>
> *Because FDL abdo redo wound more extensive than just abdo*
>
> *Yes"*

88. Mr Fitzgerald said the specific standards or good surgical practice did not specify a time when one needed to see a patient. The surgeon had a leadership role and (a duty) to ensure everyone played their part. However, it was not for the surgeon to turn up at every post operation check: a registrar would be sufficient in some circumstances, and equally the procedure might be such that it was appropriate for nurses to see the patient on some occasions. He was then asked about the position where the patient has had *"a FDL or a normal one"*, with higher risks of the kind that existed in the present case (meaning, in particular, due to Ms Chilton being overweight), and replied *"Ideal 4-6 weeks"*. Asked to explain that, Mr Fitzgerald said by 4-6 weeks types of complications such as seroma, infection or skin necrosis, declared themselves, *"but there are consultants are going beyond that date if they have very experienced nurses that can look after the patients those who are quite obsessive and those [a] bit more laissez faire go to 12 weeks"*. Mr Fitzgerald agreed that a laissez faire consultant "*might*" fall outside the reasonable body of competent surgeons.

89. Asked why he referred in the Joint Statement to review after 3 weeks, Mr Fitzgerald said it reflected a discussion with Mr Stone, who had suggested 2 weeks, a period which Mr Fitzgerald regarded as too short. Mr Fitzgerald went on to say:

    i) that he thought review would be "*ideal*" at 3 weeks;

    ii) *"Three weeks is a reasonable time I will put that down"*;

    iii) *"In actual perfect world then three weeks in reality you cannot do that and you push it out by a few weeks like to see patient in three weeks in perfect world by three weeks pick up vast majority of issues"*; and

    iv) (in reply to a question from the judge) that he was saying that three weeks was ideal but 4-6 weeks was acceptable.

90. However, in reply to further questions, Mr Fitzgerald said it was *"more preferable"* to see the patient after 3-4 weeks, that that was when he liked to see his patients. Asked whether it was unacceptable to see the patient later than 3-4 weeks, Mr Fitzgerald said it depended on whether the patient was skinny or overweight. He then assented to the proposition that, as Ms Chilton was a patient with relatively high BMI, it would be unacceptable for her to be seen after 3-4 weeks, and that Ms Chilton should have been seen by 17 or 18 July.

91. Unsurprisingly, the judge at this stage of the cross-examination pointed out that Mr Fitzgerald appeared to have gone in one direction and then another. Asked to clarify whether he was saying the surgeon would be in breach if he did not ensure he saw the patient within 3-4 weeks, Mr Fitzgerald replied *"It could possible be if no [appointment]"* but also that *"Mr Payne should have ensured that the appointment should have been made on 17th July"*.

92. In re-examination, Mr Fitzgerald was reminded that the 2014 operation was not a fleur-de-lys operation, and thus did not involve a horizontal incision or a T-junction; and was shown the operation note dated 19 June 2014 and photographs of the marking for the surgery. On that basis, he said the procedure was *"not really proper abdo just a slice of tissue"* and that he would happily review the patient at three months, noting that the nurses were experienced in cosmetic surgery. Asked how that related to his evidence about review after 3-4 weeks, Mr Fitzgerald replied that a fleur-de-lys was a much bigger procedure than effectively what happened, which was *"a melon slice of tissue and shorter and less risk of complications and simple excision"*. Mr Payne's counsel reminded Mr Fitzgerald that the judge would have to address the date beyond which no reasonable surgeon would have failed to review the patient in person, to which Mr Fitzgerald is recorded as answering *"3 months it is not a FDL or a revision of a FDL"*. Again unsurprisingly, the judge intervened to observe that Mr Fitzgerald appeared to have changed direction again. Mr Fitzgerald agreed that now that he had been shown the operation note, he had gone back to 3 months, and told the judge that he was quite clear about that now.

93. In the light of the totality of that evidence, the judge was in my view (and contrary to Ms Chilton's present submissions) entirely correct not to conclude that Mr Fitzgerald's evidence supported the view that no reasonable surgeon would have failed to ensure that he/she personally reviewed Ms Chilton within 4 weeks of the 2014 procedure.

94. Turning to Mr Payne's own evidence, the passage quoted in §81.iv) above does not support the case that no reasonable surgeon would fail to review more than a month after surgery: it merely expresses Mr Payne's preference. The same applies to his statements in cross-examination that 30 days is *"I like to see them personally myself or nurse"* and *"I like to see them at four weeks"*. Ms Chilton relies on the fact that it was then put to Mr Payne that *"this 30 day mark is precisely set out in the guidelines when patient should be seen"*, to which he agreed, and *"[l]ike to see her by me"*. However, in the immediately ensuing questions, when asked whether that was because it would be too late to do anything if infection occurred at an early stage but the patient was not seen for 6, 8 or 10 weeks, Mr Payne replied *"No then would be seen by nurse at 4 weeks"*. It was put to Mr Payne that the reasonable time to see Ms Chilton was no more than one month, to which he is recorded as having answered *"Like to see patient at four weeks but either me I like to see them then nurse will have to see her or someone will have to see her"*.

95. Viewing this evidence from Mr Payne in the round, I do not accept Ms Chilton's submission that he accepted that it would be unreasonable not to see the patient personally within a month of the procedure.

96. Ms Chilton makes the further submission that if, as the judge indicated, he did not find Mr Fitzgerald's evidence "*as useful or informative as perhaps Mr Stone's*", then the judge was bound to accept Mr Stone's evidence. I do not agree. The judge gave cogent reasons for not accepting Mr Stone's evidence, and he was entitled to assess the expert evidence as a whole and in the context of the evidence of fact, including the documentary evidence and Mr Payne's own evidence.

97. Ms Chilton submits that *"[t]he Judge's reason for not accepting Mr Fitzgerald's initial evidence as to the 4-week timeframe for post-operative review was that the expert had been confused by questioning into thinking Ms Chilton had undergone a full 'fleur de lys' abominoplasty redo whereas she had 'only' had the vertical incision revised"*, referring to Judgment § 127 quoted earlier. Ms Chilton suggests that that was incorrect, because (a) Mr Fitzgerald did not premise any of his conclusions on it having been a fleur-de-lys procedure, (b) he introduced his remarks about timeframe by stating that *"at some point the surgeon has to review the patient who has had a FDL <u>or normal one</u>"*, and (c) in his report, Mr Fitzgerald drew no such distinction when he said *"[w]ound healing issues are almost the norm with abdominoplasty patients and are more prevalent in those like the Claimant who have an extensive wound and are overweight"*.

98. However:

i) there are clear indications in the cross-examination and re-examination evidence referred to in §§ 86 and 92 above that Mr Fitzgerald was at times labouring under a degree of confusion about the nature of the 2014 procedure;

ii) the passage in Mr Fitzgerald's report on which Ms Chilton relies on this point was immediately followed by the statement that:

> "An experienced Plastic Surgery Nurse would be more than adequate to cope with routine difficulties such as minor wound dehiscences, seroma formations or small patches of skin

> necrosis. If these were to become more extensive or there was significant evidence of infection, at that point the Consultant should be informed. As long as the Claimant had a documented follow up appointment by the Consultant within the first 3 months following an abdominoplasty procedure and was being kept under review by appropriately qualified Plastic Surgery Nurses, the Defendant followed an entirely recognised clinical pathway both in the private sector and the NHS"; and

iii) Mr Fitzgerald was very clear in re-examination, having been reminded by the operation note and photographs of the nature of the 2014 procedure, that it was not unreasonable for the surgeon to review the patient after 3 months.

99. I therefore do not accept Ms Chilton's submission that the judge erred in his approach to Mr Fitzgerald's oral evidence, or in having proper regard to the evidence given in re-examination. I consider that the judge was correct to conclude, in substance, that Mr Payne was not subject to a duty to ensure that he saw Ms Chilton again within 30 days or thereabouts; and that there was no hard and fast rule as to when this should occur: it depended on how the patient progressed and the information coming back from the skilled and specialist nursing staff involved.

## (H) GROUND 1(C): PROCEDURAL UNFAIRNESS

100. Ms Chilton submits that the judge's finding that there was no duty to review the Claimant within 30 days was also wrong and/or unjust because he made a serious procedural or other irregularity by admitting into evidence and/or in his judgment relying upon a witness statement prepared by Mr Fitzgerald after the close of his oral evidence.

101. Mr Fitzgerald's re-examination brought the oral evidence to an end, and the trial was then adjourned for closing submissions the following afternoon. Just before submissions commenced, on day 4 of the trial, Mr Payne filed and served a witness statement from Mr Fitzgerald in which he confirmed that the evidence he gave in re-examination, that review up to 12 weeks post-operatively was reasonable, reflected his true position.

102. It is appropriate to quote the new witness statement in full:

> "I have reflected upon the evidence that I gave to the Court yesterday and I wish to inform the court of the following
>
> - It was put to me by the Claimant's counsel that the second procedure was a fleur-de-lys abdominoplasty redo. My answer was that this was not my understanding based on my reading of the operation note.
>
> - It was then put to me that Mr Payne had agreed that the 2014 procedure was also a fleur-de-lys abdominoplasty redo.
>
> - My recollection was that the second procedure was much simpler and not a fleur-de-lys abdominoplasty redo, however

> because it was put to me that Mr Payne had agreed to this in his testimony, I believed that I was not in a position to disagree with the Claimant's counsel.
>
> - As a result, I had to re-think the evidence concerning the time scales for review and my evidence given in relation to Claimant's counsel questions and to His Honour's questions was given on the basis that the 2014 was a fleur-de-lys abdominoplasty redo.
>
> - When I was given the opportunity to consider the operation note on page 557, it was clear to me that the second procedure was a much smaller procedure, just as I had originally understood. This gave me an opportunity to say in response to the Defendant's counsel's questions that the less serious nature of the procedure made a difference to my evidence about the timescale for review by the Consultant. I was then able to confirm to the Court that the 2014 procedure was less extensive, without a T junction and was not even a proper abdominoplasty, just a slice of tissues along the vertical line. I confirmed that, as the procedure was not a fleur-de-lys abdominoplasty redo, my original opinion about reasonableness of review by the Consultant up to 12 weeks applied.
>
> I wish to confirm to the Court that, if the Court finds that the 2014 procedure was less extensive as described in the operation note and Mr Payne's testimony and confirmed in the evidence I gave to the Court when questioned by the Defendant's counsel, then it remains my opinion (as set out in my written evidence) that a reasonable timescale for personal review with the Consultant is up to 12 weeks as I confirmed to the Court yesterday when replying to the Defendant's counsel's questions at the end of my evidence.
>
> I, believe that the facts in this letter are true. I understand that proceedings for contempt of court may be brought against anyone who makes or causes to be made a false statement in a document verified by a statement of truth without an honest belief in its truth."

The statement is signed by Mr Fitzgerald.

103. Ms Chilton objected to the witness statement being admitted into evidence, after the close of oral evidence, on that basis that *"it would constitute a significant procedural irregularity in the proceedings without further opportunity to scrutinise*". In response to the judge's question whether Mr Fitzgerald was merely repeating what he had stated in re-examination, Ms Chilton further submitted that it would be "*wholly inappropriate for a document to be adduced in evidence where they may be points that [the Claimant] would want to pick up from this document*". However, the judge allowed the statement into evidence, stating:

> "I am going to allow this letter from Mr F[itzgerald] to be filed [I] heard whole of the evidence and bear in mind [cross-examination] on the basis of the premise that was not entirely accurate and can clarify that position and in Re-exam already said this but do not think that disqualifies the letter from going in."

104. Ms Chilton submits that the judge ought not to have admitted the statement at all, alternatively without a chance to cross-examination Mr Fitzgerald further, particularly when it was not simply confirmatory of evidence already given but gave new emphases.

105. Ms Chilton submits that the description of the surgery in Mr Fitzgerald's further statement minimised it in a way not expressed in his report or the Joint Statement, where termed the procedure straightforwardly as '*abdominoplasty*' and emphasised the relatively serious nature of the surgery in that "*wound healing issues are almost the norm with abdominoplasty patients and are more prevalent in those like the Claimant who have an extensive wound*".

106. Ms Chilton suggests that the need to allow cross-examination, were the statement to be admitted, was augmented given that Ms Chilton had raised concern in argument that the witness statement was not in Mr Fitzgerald's typeface and looked as if it had been prepared by lawyers. In response, the judge simply accepted the assurance given to him by Mr Payne's counsel that *"my [instructing solicitors] tell me that when she called him and explained the evidence and then sent to him and then I am being told he amended it and returned it to [the Defendant's solicitors]".*

107. Ms Chilton cites *Dunbar Assets plc v Dorcas Holdings Ltd* [2013] EWCA Civ 864, where the Court of Appeal held that the decision of the judge below to give judgment on a possession claim without conducting a trial and without hearing submissions as to whether the defence should be struck out had amounted to a fundamental denial of procedural justice in its own right; and that an appeal against his decision could not therefore be dismissed on the basis that his decision to make the possession order had plainly been right. The court said:

> "26. … I have concluded that it would not be right to dismiss this appeal, based as it is on a fundamental denial of fair procedure to the defendants, upon the analysis that the judge was obviously right, so that the remission of the case would serve no useful purpose. I have two reasons for that conclusion.
>
> 27. The first is that I am not quite persuaded that the claimant's case, namely that there is no pleaded defence to its claim for possession sufficient to warrant a trial, has the quality described in the *Labrouche* case [*Markus Albert Frey v Labrouche* [2012] EWCA Civ 881] as being "overwhelming". Mr. Paget's qualifying principle may perhaps have some application in the present context, albeit far removed from the context from which it has emerged in the authorities.
>
> 28. Perhaps more importantly, it is not every case in which a conclusion that a judge's decision was right prevents a serious

> procedural irregularity from amounting to an injustice. As the *Labrouche* case makes clear, the denial to a party of any opportunity to make submissions in support (or defence) of its case is a fundamental denial of procedural justice in its own right, regardless of the consequences. While there will be many cases in which, (as noted in the 2013 White Book Vol. 1 at page 1754), the absence of any adverse consequences flowing from a serious procedural irregularity will mean that an appeal based upon on it will fail, there is a residue of cases of grave procedural irregularity, and the present case is one of them, where the absence of consequences does not displace the injustice constituted by the inappropriate treatment of the complaining party."

108. In *TUI UK Ltd v Griffiths* [2023] UKSC 48 at §§ 60ff, the Supreme Court considered the potential unfairness of rejecting an expert's findings without cross-examination; noted with apparent approval Floyd LJ's statement in *Edwards Lifesciences v Boston Scientific Scimed* [2018] EWCA Civ 673 § 69 that the question for the appellate court is *"whether the decision not to cross-examine has led to unfairness to the extent that the judge's decision on the relevant issue is thereby undermined"*; and considered some of the circumstances in which cross-examination might not be essential.

109. In the present case, Ms Chilton submits that the judge compounded the irregularity by relying on the new witness statement in his judgment as confirmation that Mr Fitzgerald's opinion was that the limit of the acceptable timescale to review Ms Chilton post-operatively was not one but up to three months (Judgment §§ 129-130 quoted in §§ 32-33 above), which in turn he treated as a basis for dismissing the claim. Thus, the irregularity fundamentally tainted the judgment.

110. In principle I see no difficulty with a judge allowing a witness who has given evidence to correct or clarify something he/she has said, if on private reflection the witness feels correction/clarification that to be necessary in order to avoid the judge being left with an incorrect account of events or (in the case of an expert) of the expert's opinion. On the other hand, if in substance the witness is being allowed to give additional evidence in chief, then fairness would generally require an opportunity to be given for the opposing party to cross-examine.

111. In the present case, however, I do not consider any material irregularity to have occurred, nor one which have undermined the judge's findings on the issues; nor (in any event) a serious or grave irregularity amounting to a denial of justice. As the judge said in Judgment § 129, after outlining the gist of the further statement, *"he had also told me that in re-examination"*, adding in § 130 that he (the judge) had come to the conclusion that Mr Fitzgerald's evidence was consistent with *"the process and procedure that was adopted by The Hospital Group as invoked by Mr Payne in any event"*. (I note in passing that the quotation of Judgment § 129 in Ms Chilton's skeleton argument notably omitted that sentence, without the use of omission marks.) Counsel for Ms Chilton was unable to point to any aspect of the new witness statement that added any of substance to what Mr Fitzgerald had already said in his report or in his oral evidence. Further (as to Ms Chilton's complaint about minimising), the way in which the witness statement described the seriousness of the operation was fully in line with Mr Fitzgerald's evidence in re-examination (after being reminded of the operation

note and photographs) quoted in § 92 above. The fact that the statement appears to have been written up by the legal team is not a reason for doubting that it reflected Mr Fitzgerald's views, particularly in circumstances where it did no more than to repeat what he himself had said in re-examination.

112. In all these circumstances, I consider that (a) there was no serious irregularity before the judge, and (b) this court, as an appeal court, is entitled to form its own view as to whether the judge's conclusions were correct, in any event, even without having regard to the new witness statement. For the reasons given in section (G) above, I consider that they were.

## (I) ERROR IN FINDING NO BREACH OF DUTY

113. The points made under this Ground are in large part repetitive of those made under Grounds 1(a) to (c). As expressed in Ms Chilton's skeleton argument, Ground 1(d) includes the points that:

i) the judge erred in not finding breach in respect Mr Payne's failure to mark on operation note or elsewhere when he wished to see Ms Chilton;

ii) it was agreed evidence that Mr Payne did not note on the operation note or elsewhere when he wished to review Ms Chilton, and Mr Fitzgerald confirmed this;

iii) in cross-examination, Mr Payne agreed that Mr Fitzgerald was criticising him in his report for not clearly documentation on the operation note or elsewhere when he wanted to see Ms Chilton again;

iv) if the court accepts that the judge found or ought to have found that Mr Payne owed a duty to put the date of review on the operation note or other document, then, in circumstances where no such date was written by Mr Payne, then Mr Payne must have been in breach;

v) the judge was wrong to find Mr Payne was not in breach of duty and/or negligent because the Hospital had a protocol for aftercare upon which Mr Payne could rely, and erred by concluding that Mr Payne was not in breach of duty because the '*nurses would already know*' (Judgment § 153) that Ms Chilton would need to be reviewed. Mr Payne as surgeon owed Ms Chilton a duty concurrent with the Hospital to ensure appropriate aftercare, and what the nurses did or did not know is wholly irrelevant to the question whether he breached his own duty;

vi) insofar as Mr Payne failed to fulfil his separate and concurrent duty of care to Ms Chilton in respect of her aftercare – whether to put the review date on the operation note or to review at 30 days – he was in breach independently of any concurrent breach by the Hospital; and

vii) in finding that Mr Payne was not in any event in breach because he could rely upon the nurses, the judge effectively allowed Mr Payne passively to rely upon the Hospital's aftercare protocol and abrogate the '*leadership*' role that even the Mr Payne's expert considered Mr Payne owed for Ms Chilton's post-operative aftercare.

114. I have addressed the substance of all these points in section (F) and (G) above.

115. Ms Chilton also submits, as part of Ground 1(d), that the judge was wrong to find there was no breach, in circumstances where the judge had found Mr Payne's pleaded Defence that there had been a review by 4 weeks i.e. on 17 July 2014 to be unmeritorious. Paragraph 16(a) of Ms Chilton's Amended Particulars of Claim alleged that Mr Payne '*[f]ailed to arrange any or any adequate follow up for the Claimant*', and paragraph 16(b) alleged that he had '*[f]ailed to ensure the Claimant was followed up with examination by the Defendant, adequately or at all*'. In response, Ms Chilton says, Mr Payne pleaded only that:

    i) it was reasonable to review Ms Chilton within 3 months post-operatively; and

    ii) Ms Chilton had an appointment for review on 17 July 2014 which she failed to attend.

    (Amended Defence §§ 14(a) and (b)) Further, Ms Chilton says, Mr Payne and Mr Fitzgerald in their oral evidence relied heavily on there having been an appointment on 17 July 2014 which Ms Chilton failed to attend.

116. Defence (i) was wrong, Ms Chilton submits, for the reasons discussed earlier. As to defence (ii), the judge did not find any such appointment to have existed, the defence (which Ms Chilton describes as Mr Payne's *"central positive case"*) could not assist Mr Payne. It follows, Ms Chilton submits, that the only reasonable conclusion to reach was that Mr Payne had breached his duty in not reviewing Ms Chilton by around 17 July 2014, i.e. by 4 weeks post-operatively; and by not so finding, the judge failed, in accordance with *King* to give proper regard to the way Mr Payne had formulated his case. Further, in circumstances where there was no remaining substantive defence to the key allegations of breach, the judge's decision not to find breach was wrong in law and/or in fact and a decision no reasonable judge could make.

117. Those contentions are in my view entirely without merit. Paragraphs 8 and 10-14 of the Defence set out Mr Payne's position in detail and went well beyond the two bare propositions formulated by Ms Chilton mentioned in § 115 above. His case included, for example, the points that wound healing problems are common after this sort of procedure; that wound care is commonly and reasonable provided by nurses; details of the arrangements in place at The Hospital Group and Mr Payne's involvement in them; and that it was a recognised pathway for nurses to keep the patient under review and for a review by the surgeon to take place within three months of surgery. The judge's conclusions were entirely consonant with Mr Payne's pleaded case.

## (J) FINDINGS AS TO FACTUAL CAUSATION

118. Ms Chilton alleges, in summary, that:

    i) the judge was wrong because he found the key factual issue as to causation to be the irrelevant issue whether Ms Chilton's mother, on calling the hospital on 16 July 2014, considered there to be any urgent need for Ms Chilton to be reviewed on or around 17 July 2014;

ii) Ms Chilton's case on causation was straightforward: Ms Chilton would have attended on 17 July 2014 had an appointment been arranged: and it was common ground that had Ms Chilton been assessed on 17 July 2014 the seroma would have been identified, treated with antibiotics and Ms Chilton would have avoided debridement and the worse cosmetic outcome;

iii) in Judgment §§ 143-148, the judge wrongly puts the onus on arranging the appointment on Ms Chilton as opposed to Mr Payne (and it had not been Mr Payne's pleaded case that it was Ms Chilton's responsibility to arrange an appointment);

iv) the causation issue the Judge had to determine was simply whether Ms Chilton would have gone to an appointment had one been arranged for her on or around 17 July 2014;

v) as to that issue, the judge wrong to find (in Judgment § 77, in particular) that Ms Chilton's parent were clear that they would not have taken Ms Chilton to an appointment on that date. The evidence of Ms Chilton's father (whom the judge regarded as an honest and reliable witness) was this:

> "A. I wouldn't have wanted for appointments to have been made during that period but, as I say, the golf was for a period of four days. I had tickets for four days. I had a hotel booked for five nights. If there was an appointment during that period of time I would have taken Kelly.
>
> Q. Sorry, if there was – are you saying if there was an appointment during between the 17th and the 20th of July, you would have taken her, but you went to the Open?
>
> A. Yes I – if there was an appointment between that period, prearranged, then I would have arranged for Kelly to get her to the hospital. As I said, the golf was for four days, the best days are Saturday and Sunday, so I'd have arranged for Kelly to go to the hospital.
>
> …
>
> I love my golf but I love my daughter even more."

vi) thus, Mr Davies was clear that he would not have himself chosen a date for an appointment to see Mr Payne which clashed with his attendance at the golf in Royal Birkdale, but equally clear that had an appointment been made for Ms Chilton to see Mr Payne on or around 17 July 2014 he would either have taken her himself or otherwise arranged for Ms Chilton to travel to the Hospital; and

vii) the judge, however made no reference whatsoever to the above evidence, and so failed to take account of a material factor.

119. I do not find it necessary to resolve these points, because I have already concluded in sections (F) to (I) above that the judge was correcting in holding Mr Payne not to have

been in breach of duty. The causation issue would arise only on the premise, which I have not accepted, that Mr Payne had a duty to ensure that an appointment with him was arranged for 17 or 18 July 2014.

## (K) GROUND 2

120. As noted earlier, Ground 2 would have arisen had I concluded that Mr Payne owed duties (a) to ensure that Ms Chilton was reviewed by the Defendant by writing down on the operation note or on other clinical documents when he wanted to review Ms Chilton; and/or (b) to review Ms Chilton post-operatively within about 30 days. I have not found such duties to exist, so Ground 2 does not arise.

## (L) CONCLUSION

121. For these reasons, the appeal must be dismissed.