mw 11/09/19

IN THE COUNTY COURT AT BOURNEMOUTH & POOL **Claim No D77YX418**

B E T W E E N :-

PENELOPE ANN SMITH

Claimant

- and -

THE ROYAL BOURNEMOUTH & CHRISTCHURCH HOSPITALS

NHS FOUNDATION TRUST

Defendant

JUDGMENT

THE COUNTY COURT

Background

1. This is a claim for personal injury arising out of the Claimant's employment as a nurse at the Defendant NHS trust. The claim is that, as a result of the Claimant carrying out repeated and prolonged manual cardiopulmonary resuscitation (CPR) (chest compressions) over three successive nights (9-11 October 2014), she suffered an injury to her left wrist requiring surgical intervention. It is common ground that, if the Claimant can establish the factual and legal basis for the claim, the injury accelerated an underlying condition by virtue of which the Claimant would have developed the same symptoms in any event. The parties' experts disagree as to the period of acceleration by between 6 months and 5-7 years, with both experts accepting that the other's position is reasonable.

2. Complicating the factual history of the matter is an incident which took place on 26 October 2014, the details of which are in dispute, but which resulted in the Claimant wrenching her thumb during either a fall following the Claimant having run after a patient (Defendant) or when the Claimant was in the process of assisting a patient who had collapsed through excess drug or alcohol consumption in the A&E department of the hospital (Claimant). The Defendant's case that it was this incident that caused the acceleration of the onset of the Claimant's symptoms.

3. No claim is made by the Claimant against the Defendant in respect of this incident.

4. The Defendant denies liability to the Claimant in every respect: it is denied as a matter of fact that the Claimant carried out the CPRs as alleged – even that she was working on the relevant ward at the time. It is denied that there was any breach of duty: the Claimant was fully trained, and there was no foreseeable risk of her suffering from the injury by virtue of CPR. It is denied that, even if she had carried out those CPRs, the procedures described by the Claimant were not capable medically of causing the injury complained of save, just possibly, in someone who suffered the pre-condition that the Claimant suffered from and, in those circumstances, neither the Claimant nor the Defendant knowing of the pre-condition, there could have been no breach of duty.

5. The Orthopaedic experts provided a joint statement upon which they agreed on most things save for the period of acceleration, including their opinion that the ergonomics expert report relied on by the Claimant was "*a completely unrealistic interpretation of biomechanical data...they are not aware of any cases in the literature of patients with long term wrist pain related to CPR, nor have they ever seen any individual present in their clinics with persisting wrist pain following CPR*". There was a dispute between Counsel as to the status of the ergonomics report given that the Defendant had not required the expert to attend, nor had they asked any Part 35 questions. The Claimant's position was that that meant the Defendant (and the Court) had to accept the ergonomics evidence as read.

The Factual Background

6. The Claimant worked for the Defendant from January 2014 as a grade 5 staff nurse at the Royal Bournemouth Hospital. At the material times, the Claimant was working in the emergency department ("ED") on night shifts from 20:15 until 07:30 hours. The Claimant's work in the emergency department required her to carry out cardiac chest compressions manually. The Claimant had been trained to carry out CPR.

7. The following appears to have been common ground, or at least unchallenged after the evidence had been given. Patients are admitted into the ED for resuscitation for a number of reasons, not just cardiac arrests e.g. sepsis or shortness of breath. It is only those who suffer cardiac arrest who need CPR. Patients are sometimes admitted into the ED having been brought into hospital in an ambulance where CPR has already been administered. Patients

who suffer a cardiac arrest elsewhere within the hospital are not taken to the ED, instead a crash team is sent to their location. It is not alleged that the Claimant would have been involved in these CPRs.

8. When a person attends the ED, their presence is registered on what is called the Symphony System: an electronic system which records the date and time of admission, the person's name, NHS number and other details, and importantly, there are three entries against each patient: what complaint they were admitted in respect of; what the ED doctors diagnosed them with once admitted, and whether, and if so to where, the patient was admitted into the hospital as an in-patient. The Symphony System replaced a manually completed book ("the Book") which recorded the reason for admission; the staff who dealt with each patient and their ultimate destination. The two systems ran parallel for a while, though it seems to have been the consensus that by October 2014 the Book was being filled in less systematically (indeed it had always been a less rigorous system) than the Symphony system that was replacing it.

9. When a patient goes into arrest, a "crash team" is called consisting of between 6 and 9 medics: one doctor or house officer, an anaesthetist, and a number of nurses, including a critical care nurse. Nurses are allocated initial jobs, e.g. airwaves, chest compressions. The number in the team would vary depending on the shift and staffing levels etc. It is common ground, too, that CPR is an energetic and demanding process. When carrying out CPR, a nurse would carry out between approximately 100 and 120 presses per minute. Each press would aim to push the patient's chest down by 5cm. Staff who undertake the physical CPR are trained to rotate every two minutes to ensure that they do not tire and thus the CPR remains effective. There was some dispute as to who was responsible for calling for a rotation: whether it was the lead medic or whether it was the individual giving the CPR depending on his or her own circumstances.

10. The Defendant had carried out no formal risk assessment of injury arising from carrying out chest compressions, though the Claimant accepts that she had been formally trained in CPR.

11. There are some patients for whom prolonged CPR is required and/or whose condition or medical procedure means that manual CPR is not possible. For these patients something called a Lucas Machine can be used. The evidence from all those trained to use a Lucas Machine was that, unless there was some other reason to use it (e.g. another medical

procedure preventing normal CPR) this machine is rarely used for CPR unless the anticipated period of CPR is 45 minutes to 1 hour. The Claimant's ergonomist, Mr Hinkley, appears to have been under the impression that using a Lucas Machine is preferable. The Lucas Machine cannot, the Court was told, be used on particularly large patients simply because the belt into which the patient is required to be strapped is of a limited size.

12. It was common ground, too, that the Defendant was subject to the Management of Health and Safety at Work Regulations 1999 and the Provision and Use of Work Equipment Regulations 1998 in respect of the Claimant's work, although the incident post-dated the Compensation Act 2006.

The Incidents

13. The Claimant claims that her wrist injury was caused as a result of her having performed manual CPR on patients on 3 occasions, the precise dates of which she said in her witness statement she is "*not 100% certain*", though her case at trial was, as stated above, that they had occurred on the three night-shifts of 9-11 October 2014. Nor can she remember any of the nurses who were working with her on the occasion(s) of any of the 3 CPRs on those shifts.

14. It is pleaded in paragraphs 12 and 13 of the Particulars of Claim that the patients on all 3 of the shifts in question were "*large*", and that "*the patient on the third shift was particularly big and the compressions were particularly strenuous. By the end of the third shift, the Claimant had developed tenderness and soreness in her left wrist and hand.*" It is not contended that the Claimant told anyone at the time about that soreness in her wrist, or that she complained whilst performing the CPR on the third (or any) occasion, or that she ever asked to stop CPR, or to swap places with someone, or anything of that nature. Nor did she mention the allegedly persisting pain in her wrist at any time prior to the injury that she sustained whilst working at the Hospital on the 26th October 2014.

15. The Claimant in her witness statement says that on the 26th October 2014 she "*...felt a massive pain in my left wrist. I could not move my wrist comfortably. I was in severe pain.*" She says the incident occurred when she caught her thumb whilst she was trying to help lift a patient up from the floor in the Emergency Department. That person (not a patient), she says, had been wheeling another person (an inpatient of the hospital) in a wheelchair. Both

of those people were highly intoxicated or under the influence of other drugs and one of them had collapsed and she had rushed to her assistance. It is the Defendant's case, via the evidence of the Sister in Charge of the Emergency Department that day, that in fact the Claimant injured her wrist when she fell to the ground after chasing after a patient who she thought was attempting to leave the hospital (which practice is prohibited).

The Law

16. The law applicable to the instant matter is somewhat dependent upon the factual and expert evidence, and so I shall deal with the law having dealt with the evidence as part of the parties' submissions.

The Factual Evidence – The Claimant

17. For the Claimant I heard from the Claimant herself; Miss Marion Gilmour, a band 5 staff nurse who currently works in the emergency department at the Royal Bournemouth Hospital, and Mr Walvin who used to work for the Defendant in 2014 as a band 5 staff nurse, but has transferred to Derriford Hospital in Plymouth where he also lectures in adult nursing at the Plymouth University.

Ms Penelope Smith

18. Ms Smith's witness statement was at pages 25-41 of the bundle. I have re-read it. The Claimant's evidence is that she recalls doing the three consecutive shifts, alleging that the hospital records which cast doubt on this are frequently wrong.

19. By the end of the third shift, the Claimant alleges that she had developed tenderness and soreness in her left wrist and hand. The pain persisted. The Claimant believed she had strained her wrist and expected it to recover with rest on her following days off. She says that she purchased a wrist splint from Boots which she wore.

20. The Claimant's evidence was that she had previously only carried out CPR once every 15 or 20 shifts and it was her belief that it was the three consecutive shifts which caused the injury.

21. In her witness statement, the Claimant states that on each CPR on each shift (which lasted approximately 40 minutes; 30 minutes and 45 minutes respectively) she was rotating with a

colleague every two minutes or so, the implication being that she was doing manual CPR two minutes on/two minutes off for the period of the CPR.

22. In cross-examination, the Ms Smith was first asked about the difference between the pain suffered immediately upon the 26 October incident, and that suffered after the three shifts a fortnight earlier. She accepted there was a "massive sharp pain in her wrist" immediately upon the later incident, and that she could not move her wrist; that this was a new and different pain from that which she was suffering after the CPR shifts, and which she described as "extreme". She accepted that there was no pain after the first two shifts and that after the third there had been "some pain" which did not feel significant, though she noticed it more when she got home. The Claimant accepted that she had not reported any pain after the third shift or indeed at any time until after the 26 October incident, though she had been off for a week due to a chest infection. Ms Smith said she bought a splint which she used when the wrist was painful and took paracetamol. She accepted that she had not mentioned it when vising her GP for the chest infection. She accepted that she had returned to work on 22 October and, despite being symptomatic, using the splint at home and continuing to take paracetamol as well as the fact that the job is a physical one, she had not mentioned it to the Defendant. Her response was that illness was frowned upon, though she had been prepared to take a week off for the chest infection. She had not worn the splint at work (where it would have been visible to the Defendant) she said because of infection control. When it was put to her that she had worn a splint after the 26 October incident (fitted at the hospital), she said that for that period she had been put on light duties in an observation ward. When asked why she had not got the hospital to fit a splint for 22-24 October, Ms Smith said that it needed a doctor's note, and the pain was not that bad.

23. Ms Smith was cross-examined about the Adverse Incident Report ("AIR") dated 26 October 2014, and the inconsistencies between that (2 days sore wrist and no reference to CPR); the investigation on 10 November when the CPR was first mentioned, and the revised AIR completed in December, to which Ms Smith said that the first one had been done in a rush. When asked why she had described the previous soreness as two days instead of two weeks, Ms Smith said it was a "term of phrase". Ms Smith accepted that, when she had mentioned the CPR, she had not suggested that she felt that she had been doing it too long, but she said the point was that she had been doing it correctly as per her training. Ms Smith could not recall a conversation that the Senior Sister, Ms Aggas, said she had had with her on the evening of 26th when Ms Aggas had found Ms Smith crying with pain because of her wrist

when she had not mentioned any previous injury.

24. Ms Smith's cross-examination turned to the CPRs themselves. She accepted that she could not be 100% certain about the dates, though accepted that her case had been put on the basis of three consecutive shifts. She accepted that she had not been recorded as being on the Resuscitation Ward on two of the dates (10th and 11th), but said nurses were very often pulled in from the other two wards if an arrest occurs. When asked whether she was saying that she had been pulled off her team on both those dates, Ms Smith's reply was "I have said around those dates".

25. Ms Smith denied that manual CPRs rarely take longer than 20 minutes, and can last anything up to 45 minutes.

26. Ms Smith accepted that it was the policy of the hospital that records of resuscitations should be kept, but could not explain the fact that the Symphony System indicated that no CPR had been carried out on the three shifts in question. There were entries which might on one reading suggest this, and these had been explained as not being the case by cross-referencing other records by a witness for the Defendant Ms Wilkins in her statement (see below). Ms Smith did not accept that the records were accurate or properly reflected what had occurred on the shifts in question, though she did not in her evidence go so far as to say that they had been doctored. It was, however, part of the Claimant's case that there had been incomplete and unexplained disclosure. When Ms Smith was asked whether it was her case that three records had been lost or failed to have been entered, she did not reply. When asked whether any of the patients she had carried out CPR on had died, Ms Smith said that the third patient had, and agreed that in those circumstances, there should certainly have been a record of what had occurred, but she could not put her confidence in that happening as beyond a "hope so".

27. Ms Smith emphasised the size of the third patient and, when asked, confirmed that she understood that the Lucas Machine could not be used on what she termed "massively obese" patients because of the limitations of the belt. In any event, Ms Smith's position was that she was not trained on the Lucas Machine and so did not use it, and couldn't say whether the third patient was of such a size such that it could not be used.

28. Ms Smith confirmed that she had never had any problems in carrying out CPR, nor made any

complaint about any aspect of having to carry out the procedure. When asked whether she was always able to swap over from giving the compressions, Ms Smith said that she swapped every two minutes and she did not think that anything was wrong; that adrenalin took over and you "just get on with it".

29. Ms Smith confirmed that she had not been trained on the Lucas Machine, but had been promised the training for that autumn.

30. Finally, Ms Smith was cross-examined at some length about the events leading to the 26 October 2014, as to whether she was running after a patient (against all training and guidelines). Given that she is not making a claim in respect of this incident, I do not consider that this has much of a bearing on matters, save as to credibility. Ms Smith was adamant that she would not chase a patient; her experience and training had embedded that in her, and that she had been going to the assistance of a collapsed patient, and she described the circumstances. She also emphasised that she had not been the subject of any disciplinary measures which she said she would have been had she really been observed chasing a patient.

31. I interrupt my examination of the factual evidence here to mention that the hospital records became the subject of a post-trial disclosure order which neither party objected to me making. It became apparent during the subsequent cross-examination of the Defendant's witness, Ms Wilkins, that a search might not have been made for certain of these records, namely the CPR audit records, which Mr Bennett, Counsel for the Claimant suggested in his closing submissions could have been conclusive. It seemed to me that the best way of clarifying whether the audit records shed any light on the core factual issue of whether the CPRs had in fact occurred on the dates in question was to order that a search be carried out, hence the Order. That search was carried out post-trial and a witness statement with a statement of truth was provided by the Defendant's Head of Litigation and Inquests, Ms Moffat, which confirmed that all of the relevant records, including the resuscitation audit records had already been disclosed, and a further search confirmed the Defendant's position that there was no record of any resuscitation on any of the three shifts in question. An email from the Defendant's Senior Resuscitation Officer, Mr McConnell was appended to the statement confirming the same.

32. In re-examination, Ms Smith's evidence was that her initial injury felt like tendonitis for which she would not attend a GP in any event. She was also asked several questions, the

answers to which suggested that the notion of her chasing a patient had never been put to her or recorded in any of the accident documents.

Miss Marion Gilmour

33. Miss Gilmour's witness statement was at pages 49-54 of the bundle. I have re-read it. The first section deals with the 26 October incident, and I will not detail that, save that Miss Gilmour generally corroborates Ms Smith's version of events.

34. As regards CPR, Miss Gilmour's statement confirmed that she had performed CPR 2-3 times per week on average when she was working full time; and that it was a strenuous and tiring procedure.

35. Miss Gilmour's statement also confirmed that the written rotas do not necessarily reflect where an individual nurse spent his or her time on a ward because they simply record their base location which could easily change during the shift due to demands on the day.

36. In cross-examination, Miss Gilmour accepted that in her own experience, CPR had been positive and it works; since starting in 2000, she had carried out 2-3 CPRs per week and she had never had any injury, nor had she heard of any injury suffered by other nurses, though paramedics may have had some. She had used the Lucas Machine about 5 times in that period, and that it was designed for very specific circumstances as per the guidance e.g. percutaneous coronary intervention.

37. Miss Gilmour stated that CPRs can last a variety of times and would not accept that it was unusual for them to last in excess of 30 minutes. She went on to state that there would usually be a 2-minute rotation for the person carrying out the manual compressions, and that a 2-10 minute compression session would be too long as it would be too tiring and therefore ineffective.

38. Finally, Miss Gilmour gave evidence that the resuscitation Book used to be filled in manually, often retrospectively, and sometimes the staff forgot to make entries in it. She had no real knowledge of the Symphony System.

Mr Thomas Walvyn

39. Mr Walvyn's statement was at pages 55-60 of the bundle. I have re-read it. Mr Walvyn stated that he carried out CPR about once per week in practice and now teaches it. It is, he says, a strenuous task and a 2-minute stint is about the maximum that can be effectively maintained. He felt that a lot of pressure is placed on the nurse's wrist when carrying out CPR, though he had no specific knowledge of anyone suffering injury as a result, other than anecdotally with 1 or 2 people. His statement referred to Lucas Machines and rota records.

40. In cross-examination, Mr Walvyn confirmed that he had not been involved in CPR for more than an hour; he said that he had seen CPR last 1 minute before death, and had seen CPR of 1 hour 30 minutes. When asked if that was unusual, he said that certain circumstances involved long procedures e.g. especially with young people, a reversible core, but the most frequent example would be a pulmonary embolism. Mr Walvyn's evidence was that it was increasingly common for staff to be moved around within the ED, and that it was rarely recorded when they were. However, he was aware of the Symphony System and he said that it would be most unusual for a clinician to miss out a record of a cardiac arrest.

41. As regards the 26 October incident, Mr Walvyn was adamant that Ms Smith would not have run after a patient; that if she had, other staff would have noticed it and it would have led to a record being made and further steps being taken against Ms Smith. He also felt that the focus of the injury was on Ms Smith's thumb rather than her wrist following the incident.

The Factual Evidence – The Defendant

42. For the Defendant, I heard from Ms Jennifer Wilkins, Practice Educator for the Defendant; Mrs Leanne Aggas, a Matron with the Defendant, and at the relevant time was a Senior Sister in the ED, and Mrs Debbie Straw, Senior Sister with the Defendant, now working in Poole Hospital.

Ms Wilkins

43. Ms Wilkins' statement was at pages 65-68 of the bundle. I have re-read it. It deals with the hospital records. In it, Ms Wilkins states that there were no recorded CPRs on 8 or 9 October. As regards the 10 October, and Claimant being asked to move from the "majors ward" to the "resus ward" because the latter was short-staffed, Ms Wilkins stated that the resus ward was fully staffed on 10 October. She also stated that she checked the individual patient record of the patient who had been admitted as suffering a cardiac arrest on 10 October. That showed

that the patient had suffered the arrest in the ambulance and CPR had successfully been given in the ambulance and no further CPR was required. Ms Wilkins carried out the same exercise with the log of a cardiac arrest on 11 October (although this one had a manuscript note "not cardiac arrest" next to it which was said to be in the Matron's handwriting), and in her statement, she says the records showed the same situation: the arrest had happened in the ambulance and the patient had been revived successfully. The one record correctly showing a cardiac arrest after which the patient died was for 12 October 2014 at 16:38 – long after the Claimant had finished her shift.

44. Ms Wilkins teaches the resuscitation course prepared by the Resuscitation Council (UK) and the guidelines were in the bundle from p309, and she also made reference to the International Liaison Committee on Resuscitation on the use of Lucas Machines which, Ms Wilkins stated, was not recommended to be used on a routine basis: it had application in specific and rather unusual circumstances where the use of manual CPR would be impractical. Ms Wilkins was also taken to the Defendant's policy on CPR which, she said, reflected the RC(UK) guidelines.

45. Ms Wilkins' cross-examination had as its theme, what was said to be the Defendant's thoroughly unsatisfactory approach to disclosure, alleging that the Defendant had been obstructive, elusive and disclosure had not been complete. Ms Wilkin denied these allegations. She said that the investigation had originally been conducted by Clare Rivers, a Matron who no longer worked for the Defendant, and so some of the sources of the information were simply accepted by Ms Wilkins at face value.

46. Ms Wilkins gave evidence that she was not involved in copying the Book referred to above, but that the Book was not reliable; it did not give the patient number, and was often not filled in or it was filled in retrospectively. She said that the entry in the Book referring to "cardiac arrest" with the names "Penny and Veronica" could be cross-referenced to the Symphony System record which identified the patient, and that patient's individual record showed that there had been a non-resuscitation order in place, and so no CPR had taken place.

47. Ms Wilkins was then taken to the Defendant's CPR Policy, ¶11, which requires the hospital to complete a CP Arrest Record form after every CP arrest (the "audit records"). She said that that was now done electronically, but that she had not consulted those records. In answer to the assertion that those records would have resolved any doubt about the CPRs carried out

by the Claimant, Ms Wilkins said that it would not have identified the team members involved. It was suggested to Ms Wilkins that the Symphony records were a poor substitute and could be misleading, given only the 3 lines of information, to which Ms Wilkins replied that the full information could be obtained by consulting the patient's individual records by using the patient number that Symphony recorded. She was much more familiar with the Symphony System and she did not need to go to the audit records. It was suggested to Ms Wilkins that, for example, the Symphony record "unwell adult/shortness of breath" could have been an arrest, which Ms Wilkins denied. She said that she had checked all of the individual patient records which the Symphony records might have ever suggested have involved CPR, and found none. In relation to the patient with the "do not resuscitate" notice, Ms Wilkins accepted that it was not common to have wrongly entered codes on Symphony.

48. It was next put to Ms Wilkins that the lack of activity in the resus ward for 6 hours suggested by the records for 9-10 October night intimated that they were deficient or inaccurate. She replied that it was not unusual to have no activity for 6 hours in that ward: it did not refer to the whole of the ED department which could be full or empty depending on many factors.

49. In relation to the allocation of nurses to wards and the nurses' subsequent movement, Ms Wilkins said that the records were accurate for the beginning of the shift, but accepted that people were moved around, but it was much less likely from the "minors ward" because there was only one nurse on that ward at night looking after 20/30 patients and the waiting area. The movement of nurses is not recorded, said Ms Wilkins, because they return to their allocated ward after a resuscitation event.

50. It was put to Ms Wilkins that the Defendant's policy was all aimed at patient safety, and did not focus at all on the safety of its employees, who had to work out how to do things safely for themselves. Ms Wilkins responded that there were sections in the policies on safe handling, and it was always stressed to all staff when being trained that the "safety of the rescuer is always primary", and there was a professional duty to "keep our safety to the forefront". As for the Lucas Machine, Ms Wilkins stated that best practice was, as per the ILCOR guidelines, to use manual CPR where possible; there was no evidence to suggest better outcomes using the machine, though it is useful for physically awkward situations such as theatre or a CT scan.

51. Ms Wilkins' evidence on the CPR procedure was that all members of the crash team are

available to participate in the CPR and rotations should not be between just two people – that goes against all training and should not occur. Ms Wilkins had never attended a CPR where only two people had been rotating between themselves for more than a couple of rotations. It was up to the person doing the CPR to indicate when they are tiring, because that is in the best interests of the patient. As to timings, Ms Wilkins said she was surprised to hear of CPR going on for over 30 minutes – the majority of patients respond or die within 10-15 minutes, or at least the likely outcome is known by then.

52. In response to questions from me. Ms Wilkins said that the cardiac arrest audit forms are not part of the Trust, by which I inferred that the audit was a requirement of external, perhaps, national body. The process was that the team leader submitted the forms which showed the time in hospital, the procedure adopted and the outcome. They would not show the length of the CPR or the people who had carried out what in the CPR process.

Mrs Debbie Straw

53. Mrs Straw gave evidence about 26 October: that there had been a patient about to "abscond" from the ED and that Ms Smith had started to run after her; Mrs Straw had told her to stop running but that Ms Smith had ignored her, and "*as a direct result Penny ended up on the floor with the patient*". However, she also said in her statement that "*the department was full which meant that I was not in attendance at the point of the incident*". She said that Penny was later in tears because of the pain arising out of the incident.

54. In cross-examination, Mrs Straw accepted that this was 4½ years after the incident and her witness statement was the first time she had recorded the incident. She accepted that she did not remember the date, only the incident, and that it was pinpointed only by the record of injury. She made it clear that she had no involvement with the incident itself, and accepted that she had not seen the incident at all, but had only heard about it later. She had not spoken to any direct witness to the incident, e.g. Marion Gilmour. Mrs Straw was referred to the AIR which recorded the Claimant being injured "moving" a patient, to which Mrs Straw replied that it was not her document and her evidence was limited to that regarding the chasing of a patient.

Mrs Leanne Aggas

55. Mrs Aggas' evidence was that she had been alerted to an incident outside the "minors ward"

26 October 2014 by some noise. She had went out to see, and came across the Claimant on the floor. Later, Mrs Aggas found the Claimant in tears because of the pain and the Claimant had said she had hurt it earlier helping the lady off the floor. She said she was under the impression this was the first injury to the Claimant's wrist, i.e. there was no mention of any earlier injury. Mrs Aggas said that she did not see the incident, though when she arrived she did not see a wheelchair. Mrs Aggas was not significantly cross-examined.

Disclosure

56. During the course of the trial, the Defendant produced the (anonymised) personal medical records of the individuals to whom Ms Wilkins had referred in her evidence where she had followed up those Symphony records that suggested a CPR or might have indicated one. There was no request to recall Ms Wilkins.

57. As stated above, at the end of the trial I ordered that a further search and disclosure statement be made. The statement dated 15 May 2014 was signed by Ms Jennifer Moffatt, with a statement of truth and certification that no further documents were disclosable and no further evidence of any CPRs taking place on 9th, 10th or 11th of October 2014 could be found. The Cardiac Arrest Audit Forms were submitted on paper at that time and retained in the Resuscitation Training Department. The Defendant's Senior Resuscitation Officer confirmed (by email to Ms Moffatt) that he had made a search of those files and there were no cardiac arrest forms for the ED CPRs during the Claimant's shifts on those dates. Mrs Moffatt stated that she herself undertook the same search with the same results. Unfortunately, I did not receive this statement until 5 June 2019 through an administrative oversight within the Court.

58. No request to re-convene the trial was received from either party, and so on 7 June 2019, I made an Order in which I adjourned the trial to await this judgment.

59. This is a slightly unusual case in the context of an injury arising out of a clinical process, in which the Defendant denies the very factual basis of the claim. As such, I shall deal with primary findings of fact before moving on to the expert evidence, causation, etc.

Submissions by Counsel as Regards Facts

60. Both Counsel acknowledged that this was a relatively short trial, and the findings of fact were a matter for the impression of the Court. This was subject to the *caveat* that Mr Bennett

submitted that there were suspicious and unanswered questions over the Defendant's disclosure which should cause an adverse inference to be drawn by the Court.

61. I shall deal with that aspect first. I found Ms Wilkins to be a compelling witness. She was clear and straightforward. In addition, she was frank: knowing the Claimant's factual case, she nevertheless accepted certain matters which would have damaged the Defendant's case quite badly, e.g. that it would be wholly wrong to alternate between only two compression nurses. Ms Wilkins also made concessions where appropriate e.g. that she had not carried out the search for the audit forms, and gave a reasonable and plausible explanation for that. The documentary evidence that was disclosed corroborated what she said, though I accept that if Mr Bennett is correct, that would be a foregone conclusion; however, the in-trial disclosure did support what Ms Wilkins had said.

62. I accept Ms Wilkins' evidence that the Defendant complied with its duties under disclosure. Disclosure in a case such as this is difficult for a Trust in the Defendant's position. It is also difficult for the Claimant, particularly one in the Claimant's position, who feels that there is an institutional resistance to her claim. There is a balance to be struck between throwing open the records to allow a Claimant to examine everything, and the over-protection of records in the interests of proportionality and patient confidentiality.

63. I bear in mind that the Defendant has professional people in statutory posts carrying out statutory responsibilities in relation to this litigation. In addition, it is represented by competent and respected solicitors, some of whose partners and employees are Officers of the Court. I have heard Ms Wilkins and seen her react to some robust (but entirely fair – no criticism is raised against Mr Bennett in this regard) cross-examination, and seen the results of disclosure that occurred as a result.

64. I come to the conclusion that the Defendant may have given disclosure more in line with the letter rather than the spirit of the law. However, I take into account that it holds information of probably the most sensitive sort when it comes to members of the public: their intimate health records involving, in this case, potential fatalities.

65. Despite Mr Bennett's submissions, I do not draw any adverse inference from the extent of the pre-trial disclosure, or even in-trial disclosure. Having seen and heard Ms Wilkins, and seen the overall approach to disclosure, including the quasi-corroboration provided by the

individual medical records produced by the Defendant, I accept the evidence from Ms Wilkins and Ms Moffatt that the Defendant has disclosed all the material it has in its possession, custody or control that is relevant to this case, whether adverse to the Defendant's case or not.

Findings of Fact (ignoring Expert Evidence)

66. Ms Smith appears to be a dedicated nurse who cares about her role and her patients. I do not consider that she is setting out to deceive the Court, nor that she is being cynical or disingenuous.

67. However, on the evidence I have heard and seen, I am bound to conclude that Ms Smith did not carry out the number and length of CPRs on 9-11 October 2014 as she claims. Of course, there are many factors in assessing a witnesses' ultimate credibility, but the following factors have weighed most heavily in the scales in this matter:-

67.1 The Symphony records are in my judgment an accurate record of the activity in the resuscitation ward in the ED. The chances of them being so drastically inaccurate as would be required for the Claimant's case to be correct are, in my judgment, very small indeed.

67.2 The Symphony records are corroborated by the checks made by Ms Wilkins against the relevant patients' individual records which removes any doubt that one or more of the allegedly ambiguous Symphony records could have been referring to a CPR incident in respect of those patients. I accept Ms Wilkins' evidence that she examined (and subsequently disclosed) the individual records of those patients whose Symphony records were even remotely capable of referencing a CPR.

67.3 I have no reason to reject the evidence given by Ms Moffatt in the witness statement I have referred to above, in relation to both the paper cardiac arrest forms and the Symphony records. This is so particularly in light of the absence of a request to reconvene the trial or cross-examine Ms Moffatt in respect of her statement.

67.4 The fact that the Claimant cannot recall any of the names of any of the members of any of the teams that took part in the CPRs she alleged took place on those three shifts is really quite surprising as well as telling. She had worked in the ED for some time; the Book only records people's first names which indicates that the number of

potential team members must be quite small. I am quite sure that it would have been open to the Claimant to ascertain the members of staff on duty at the relevant times which could have jogged her memory, and there is no evidence that she undertook that enquiry.

67.5The Claimant said that she recalled a comment she made to someone during the second lengthy CPR that she felt she was having a déjà vu. This indicates the rarity or novelty of the situation which would have been magnified on the third day. In those circumstances, I find it implausible that the names of at least one or two of the staff involved could not have been recalled by the Claimant. This is then rendered even more surprising when the Claimant can recall those involved in the 26 October incident.

67.6The Claimant blew hot and cold about the dates. In her pleaded and written case, she was certain about the dates being 9-11 October 2014, but in cross-examination, possibly in light of the documentary evidence, she rowed back on occasion to suggest that the dates were approximate.

67.7As a matter of fact, in light of the uniform nature of the factual evidence of how staff are trained to do CPR in teams, rotating the compression-givers every two minutes but with several members of the team taking on that role, I find it wholly implausible that the Claimant would have been involved in three lengthy CPRs in which this highly unusual (in fact unheard of by the factual witnesses) practice of just two nurses rotating the manipulations between themselves. In particular when these were unusually long CPRs. On the clear balance of probabilities, the likelihood that three team leaders/teams as a whole would allow such a practice to occur on three consecutive nights is vanishingly small. Had this occurred, there would have been no difficulty in finding other members of the team(s) to confirm this extraordinary series of events (or even one of them).

67.8Although it is something like the other side of the same coin, in light of the foregoing, it is highly relevant that there is no evidence in support of the Claimant's assertions other than her own uncorroborated recollection that the CPRs took place as and when they did, and in the manner described by the Claimant.

67.9Had the highly unusual series of events occurred as per the Claimant's description, and the Claimant suffered even the level of injury that she described so shortly after the

event, and given the way that she was willing to engage with the Defendant regarding her injury after the incident on 26th, I find that she would have said something and sought to have worn the splint and undertaken lighter duties upon returning to work. I do not accept that she was reluctant to come across as being a complainer because "it was frowned upon" to show signs of illness. On the contrary, I accept the evidence that I heard that the staff are trained to ensure their own health and safety above all else because that is the best way to ensure the wellbeing of patients. The Claimant had showed a willingness to indicate to the Defendant when she was not feeling at her best.

68. Having seen and heard Ms Smith, I do not consider that she has set out to deceive the Court or deliberately misled the Court. I conclude that, as regards the CPR, she has convinced herself that she carried out some long CPRs in which she played the role she described, though they could not have been on the days she suggested or consecutively as suggested. Perhaps it was the effect of the adrenalin that she referred to. She may have reverse-engineered the situation so that, having convinced herself that her injury arose as a result of doing CPR, she sought to establish a series of events in her mind which would make sense of that.

69. One of the reasons I so conclude is that I entirely accept Ms Smith's evidence as regards the 26 October incident. The Defendant's witnesses' statements were over-stated and did not stand up to cross-examination. In particular, it became clear that neither Mrs Straw nor Mrs Aggas had actually seen the incident. I am satisfied that Mrs Straw had had occasion to warn Ms Smith about running at some point, but that that was a separate incident. I found Ms Smith's description of the events entirely convincing and she also had corroboration.

70. However, it follows from my findings as regards the lack of CPRs during the relevant shifts on the relevant dates that I reject the factual basis for the Claimant's claim. That means I must dismiss the claim, and I do not strictly need to proceed further in my judgment. I should, however, make further findings *inter alia* on the expert evidence in case the matter is to go further. The claim in fact fails on several grounds.

The Orthopaedic Expert Evidence

71. I heard from Mr Cowey for the Claimant and Professor Giddins for the Defendant. There was a very large measure of agreement between these experts as is apparent from their joint

statement, which both men stood by in their cross-examination.

72. The most striking element of their agreement was the all-but dismissal by both Mr Cowey and Professor Giddins of the ergonomics report provided by Mr Hinkley on behalf of the Claimant, which they categorise as a "*completely unrealistic interpretation of biotechnical data*", to which I shall return.

73. The orthopaedic experts are agreed about the symptomatic history, the treatment, the current condition and Ms Smith's prognosis. They agree that there was an underlying constitutional tendency to scapho-lunate ligament instability.

74. The experts agree that the "*CPR could not realistically have caused an acute scapho-lunate rupture in a normal ligament*", but they also agree that in a patient with Ms Smith's underlying constitution, any CPR may cause wrist pain. They note that the 26 October incident marked the beginning of her clinical pain, and that that is the only direct causative link in Ms Smith's notes. Mr Cowley and Professor Giddins agree that they do not feel the causative effects of the injury are directly related to the CPR, and Mr Cowey wanted to make it clear that his comment in his first report could be misinterpreted – he meant that Ms Smith's *precondition* was the *cause* of the current symptoms; the CPR (if accepted that it occurred and led to the immediate symptoms) may have caused the acceleration.

75. The experts also agree that they would have treated Ms Smith slightly differently than she was in fact treated, though no claim or allegation of negligence is raised in respect of the treatment the Claimant received.

76. The areas of disagreement were in relation to acceleration. Both experts agreed that the other's position was reasonable, even though at first glance they are quite a long way apart. Although both experts were impressive witnesses, I preferred, marginally, Professor Giddins over Mr Cowey, largely because of his experience and clinical position, though he also delivered his opinion with a little more conviction than Mr Cowey. I was urged to take a mid-position by Mr Bennett for the Claimant, but would have erred towards Professor Giddins' opinion, and would have decided that the acceleration was a period of 1.5 years.

77. Professor Giddins was clear that, on the balance of probabilities, the incident on 26 October was the cause of the onset of the Claimant's symptomology. Mr Cowey was understandably more reluctant to so conclude; he emphasised that he was reliant on Ms Smith's history to

conclude otherwise, but conceded that the 26 October incident was "the better candidate" for the acceleration. He was rightly concerned to emphasise that it was for the Court to decide whether the CPR had occurred as claimed and whether the Claimant had developed the immediate symptoms prior to the 26 October that she said she did. Having seen him in cross-examination, I conclude that Mr Cowey would support the proposition that, on the findings of fact that I have made, the onset of the Claimant's symptoms was on the balance of probabilities caused by the incident on 26 October, although that is a matter for the Court, of course. Mr Cowey was also of the opinion that *any* physical trauma e.g. lifting a patient could have brought on Ms Smith's symptoms because of her pre-existing condition.

The Expert "Liability" or Ergonomic Evidence

78. The parties disagreed about the status of this evidence, as referred to above. Given my findings of fact, I do not intend to dwell extensively on this aspect of the matter.

79. For the well-argued reasons given by Mr Piper in his skeleton argument (¶¶25-53), I reject Mr Bennett's submission that, just because the Defendant did not ask questions of Mr Hinkley nor require him to be called, nor call their own ergonomic evidence, the Defence was obliged to accept his evidence, as was the Court, as unchallenged evidence. The Defendant did not feel that ergonomic evidence would assist the Court, particularly in light of the orthopaedic evidence, and chose not to adduce its own. The Defendant was entitled to criticise the relevance of Mr Hinkley's evidence generally, and use the joint orthopaedic opinion to criticise it from a substantive perspective. I shall return to the substance of this criticism below.

Factual Causation

80. Given that I have found the facts as I have, the Claimant's case on causation must fail. But for the purposes of dealing with issues in case the matter goes further, some additional findings of fact might be helpful.

81. I accept that Ms Smith may have had a minorly sore wrist prior to the incident on 26 October. However, it must have been really rather minor: she did not seek to wear a splint at work; she did not mention it to her GP; she did not mention it to anyone at work despite the fact that patient safety is very important, the well-being of her colleagues is very important and the fact that the job is a physical one. This sort of very minor injury, as Ms Smith herself said

in evidence, was the sort of injury that one would dismiss. I take from that that it was the sort of injury that one could pick up doing any sort of physical task. It was not sufficient for Ms Smith to refer to these symptoms in the initial AIR completed for the 26 October incident. I conclude that Ms Smith has failed to prove on the balance of probabilities (the burden being on her) that such symptoms as she did suffer prior to 26 October were caused by any CPR.

82. On the other hand, the incident on 26 October was much more significant from the outset. The pain described by Ms Smith was, as Mr Piper pointed out, and was accepted by Ms Smith, in a completely different category from that which she had previously experienced, and was immediate. Although the incident involved, directly, the thumb rather than the wrist, the experts were agreed that the "twang" felt by Ms Smith during that incident was the sort of sensation consistent with the resulting symptomology.

83. I have taken into account Counsel's submissions on causation both oral and in writing in their skeleton arguments.

84. Based on the orthopaedic experts' opinions and the evidence that saw and heard I find that on the balance of probabilities, Ms Smith's symptoms were brought on by the 26 October incident. Even if there had been extensive CPR on the three occasions, based on the joint orthopaedic evidence, the difference in the pre- and post-26 October symptoms, as well as the differences in the trauma caused to the body based on the expert evidence (subject to Mr Hinkley – see below), I would have held on the balance of probabilities that the 26 October incident was the likely cause of the onset of Ms Smith's symptoms.

Counsel's Submissions on Breach of Duty and Remoteness

85. Given my findings of fact, I shall deal with these issues in a slightly unusual way – dealing with Mr Bennett's submissions in turn, taking into account Mr Piper's submissions. No disrespect to Mr Piper is intended by my not setting out his submissions separately.

86. Mr Bennett criticised the Defendant's disclosure, and suggested that there was ongoing material non-disclosure. Whilst I accept that there has been some reticence on the part of the Defendant, any technical shortfall or deficiency in disclosure has been remedied. I do not accept that e.g. the "pages" from the Book for the dates of 11 or 12 October are missing for any reason other than there is no relevant information for those dates. Looking at the format of the Book, I do not accept that there are specific pages for specific dates. Rather the dates

are filled in as and when information is added.

87. Mr Bennett submitted that the authority of *Keefe v Isle of Man Steam Packet Company* [2010] EWCA Civ 683 is applicable, and that there should be adverse findings against the Defendant: it is not fair, he submitted, that a Claimant in the instant circumstances should be penalised for the absence of records which the Defendant was under a duty to keep. I reject that submission. There was a statutory duty to record noise in *Keefe*, precisely because, I presume, that a lay person cannot be expected to measure noise levels. There is no such duty here. The instant case on the factual basis for causation is well within the Claimant's capability to prove. I have found in any event that the Defendant did keep records: they merely do not support the Claimant's factual recollection of her work patterns.

88. Mr Bennett criticised the Defendant's policies and their guidelines as all being formulated with the patient in mind instead of the workforce. He submitted that Ms Wilkins' surprise at the length of time Ms Smith had said she had been doing the CPRs demonstrated that the Defendant did foresee risk to their workers by virtue of the training requiring rotation between more than two members of the team. He relied on *Buck v Nottinghamshire NHS Trust* [2006] EWCA Civ 1576, the case of the nurse injured by the psychiatric patient.

89. Mr Bennett developed this line of reasoning to submit that there therefore had to be a breach of duty in this case because foresight of any risk of harm was sufficient, no matter how small. He relied on *Smith v Leech Brain* [1961] 2QB 405, in which the Defendant was held liable for the death of the worker who died of cancer which had unforeseeably developed from a foreseeable risk of a burn injury: because the Defendant had to take their victim as they found him, they were under a duty to protect the worker from the type of foreseeable injury which he suffered. He referred the Court to Clerk & Lindsell ¶2-166 to submit that there is a duty to protect against the whole range of injury, not just the one that happens.

90. As Mr Piper submitted, the overarching and extremely important factor to take into account in this case is the fact that manual CPR, in its current form, has been in use for decades with not a single reported strain injury arising from it. Mr Cowey accepted Mr Piper's estimate of the number of manual CPRs being carried out in the UK as being in the tens of thousands *per annum*. Manual CPR is the primary CPR recommended in all the national and international guidelines that were brought to my attention. All of the literature that I was referred to suggests that the use of the Lucas Machine does not bring about any better results,

in any event and is only used in unusual circumstances. No literature to the contrary was adduced by the Claimant, save for the rather bizarrely referenced study of firefighters from the United States by Mr Hinckley, which I do not consider helpful (and neither did the orthopaedic experts). The orthopaedic experts could not see how prolonged undertaking of CPR could lead, orthopaedically, to the sort of injury suffered by the Claimant absent the Claimant's underlying condition, of which it was common ground that the Defendant had no knowledge. In these circumstances, I cannot see for a moment how the Defendant could be said to have had reasonable foresight of any injury arising out of the use of manual CPR – even probably to the extent alleged by the Claimant. I will deal with Mr Hinkley's effect on this conclusion below.

91. The principle established in *Buck* was that the employer could not discharge its duty to its employees by simply pointing to the fact that it had discharged its duty to its patients. If it could take steps to avoid known risks to its employees, then it was under a duty to do so. In that case, there was a known and universally accepted risk that the patient concerned was a danger to the employees, and so the Defendant had to show that it had taken the appropriate steps to avoid those risks. That is not the case here: the Defendant did not know of <u>any</u> risk from CPR; indeed had it spoken to any of the accredited bodies, even expert orthopaedic surgeons, it would have been told that there was no appreciable risk (and probably no risk at all) from carrying out manual CPR, even for relatively prolonged periods. And this would have been backed up by the decades of incident-free use of the procedure.

92. Mr Bennett also referred me to Clerk & Lindsell ¶2-160*ff* citing the well-known authorities of *The Wagonmound* and relied on the eggshell skull principle. These authorities and principles, as Mr Piper pointed out, relate to remoteness of damage. Before they would have come into operation, negligence needs to be established. The Claimant here would have failed to establish breach of duty and causation, even on her assumed facts, and so these principles would not have come into play, even if I had found the facts in Ms Smith's favour.

<u>Risk Assessments and Mr Hinkley's Report</u>

93. The principle reason that Mr Hinckley's report was adduced was an attempt to show that the Defendant could not discharge its duties to the Claimant without establishing whether a person in the Claimant's position (excluding the underlying condition) was at risk of injury from carrying out manual CPR. In order for that to be done, it was argued, a risk assessment

had to be carried out, not just by the Defendant's managers but by an ergonomist. In this regard, Mr Bennett relied heavily on *Allison v London Underground Limited* [2008] EWCA Civ 71. In particular, he took me to ¶¶57-62 of Smith LJ's judgment which I have re-read. Mr Bennett submitted that the orthopaedic experts had said that CPR can bring on some level of pain, and so there should have been, not only a risk assessment, but one carried out by a qualified ergonomist as suggested by Smith LJ in *Allison*. He submitted that I should prefer Mr Hinkley's views on the effect the physical forces generated by CPR had on the wrist over and above those of the orthopaedic experts.

94. Mr Piper's skeleton (in the same paragraphs as referred to above) also deals with the substantive relevance and weight to be given to Mr Hinkley's report. Because of my findings of fact above, I do not consider it proportionate to go through in detail what Mr Piper has set out, but I agree with his submissions for the reasons he gives. Given the history of manual CPR; the national and international guidance; the frequency with which the Claimant was asked to carry out CPRs; their usual duration; the adequate (as I find) training given to the Claimant and the teamwork involved in a CPR, I find that it would have been disproportionate for the Defendant to have undertaken an ergonomic study of manual CPR. I take into account, the observations of Hale LJ, as she then was, in *Koonjul v Thameslink Healthcare Services* [2000] EWCA Civ 3020, ¶¶10-18.

95. In addition, for the reasons the experts gave in their cross-examination and summarised in advance in their joint statement, namely that they considered Mr Hinkley's report to be "*a completely unrealistic interpretation of biomechanical data*", and Mr Cowey's response to my questions on ¶2.14 of the joint statement that the data and the information relied on by Mr Hinkley "doesn't marry up"; he said that "it doesn't fit in with what we do clinically – any of the stuff that is in there".

96. I therefore accept Mr Piper's submissions that the content of Mr Hinckley's report is unhelpful and unrealistic, amounting in reality to a construct to support Ms Smith's case.

97. Furthermore, on the question of a risk assessment, had the Defendant carried one out, there would have been a conclusion, based on all of the same considerations as those in relation to foresight of harm, that manual CPR was perfectly safe, and it would in fact have been a perverse conclusion that the Defendant should avoid the use of manual CPR in favour of the Lucas Machine.

98. Even further still, I would have found that even with the Claimant's alleged frequency and repetition of the CPR, she would not have been able to bring herself within the HSE guidelines as to repetitive work as referred to by Mr Piper in his skeleton argument.

Conclusion

99. For the reasons set out above, I dismiss the claim. The Claimant did not establish the factual basis for the claim. There was no reasonably foreseeable harm arising out of even the level of CPRs the Claimant claims to have been asked to undertake (though I may have had my doubts if the rotation had been limited to two people). There was no breach of duty in failing to carry out a formal risk assessment. Even if one had been carried out, the overwhelming likelihood is that the Defendant's current practices would have been endorsed (including having more than two in the compression team). Causation was not established.

100. Counsel will please attempt to agree the question of costs together with an Order, failing which they should please provide short written submissions so that I can establish whether a further hearing is required.

101. Finally, would Counsel please provide a single Word document containing any corrections, errors, omissions etc. they each suggest. If the time scale set out in the heading to this draft judgment causes difficulties, Counsel should please contact my diary manager to the email address above.

HHJ Berkley
23 August 2019

6.9.19.