Case No: F16YM828

IN THE COUNTY COURT AT BASINGSTOKE
SITTING AT SOUTHAMPTON

Date: 9 May 2024

Before :

HIS HONOUR JUDGE GLEN

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Between :

Samantha De Francisci	**Claimant**
- and -	
Hampshire Hospitals NHS Foundation Trust	**Defendant**

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- -

Sarah Edwards (instructed by **Clear Law LLP**) for the **Claimant**
Erica Power (instructed by **Clyde & Co. LLP**) for the **Defendant**

Hearing dates: 4, 5, 6, 7 and 8 March 2024

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JUDGMENT

His Honour Judge Glen:

Introduction.

1. On 17 September 2016 the Claimant gave birth to her first child, Mia. For most families, this is an occasion of great joy. For the Claimant and her husband, it was not. It is not in dispute that the trauma associated with Mia's birth caused the Claimant to suffer from Post Traumatic Stress Disorder ('PTSD') and depression to some degree and for some period. The Claimant claims that it also had other consequences. No one with knowledge of the facts of this case could fail to have enormous sympathy with the Claimant. The primary question for me is however whether such consequences as the Claimant can prove to have resulted from the birth were themselves caused by the Defendant's admitted breach of duty.

2. This judgment focusses on that primary question and upon the additional issues identified below. A number of other issues have arisen on the evidence, (including for example more general complaints about ante-natal care and the precise trigger for the Claimant's PTSD) that do not ultimately bear upon the outcome of this claim. I do not intend to address these issues, nor do I intend to review the quite extensive evidence of fact from the Claimant that appears to bear upon a potential claim against the Defendant arising out of her treatment for a liver cyst in 2018.

Background.

3. The Claimant, who was aged 29 at the time of Mia's birth, had a medical history that included Irritable Bowel Syndrome, a diagnosis of Polycystic Kidney Disease ('PKD') and a liver cyst which had increased in size since being identified in 2007. It is not (at least now) in dispute that as a result of her PKD, the clinical guidelines then in force produced by The National Institute for Health and Care Excellence ('NICE') mandated a prescription of Aspirin at a daily dose of 75mg from the twelfth week of pregnancy. Those guidelines now recommend a dose of between 75mg and 150mg.

4. The Claimant was first seen by a midwife for a 'booking appointment' on 10 March 2016 when she was about 8 weeks pregnant. She was referred by Ms Stonock for a review by a consultant and in the interim had a number of other routine appointments. That review did not take place until 16 June 2016 by which time she was 23 weeks pregnant. She was first prescribed Aspirin 75mg at that stage. At some point (that point not being identified in either her written or oral evidence) the Claimant says that she began to experience severe heartburn to the extent that (possibly by around the end of August 2016) she was consuming a 600ml bottle of Gaviscon every 2 days or so. The only entry in the medical records is a note of a complaint by the Claimant of heartburn to a Midwife (not Ms Stonock) on 15 July when she was prescribed Gaviscon. It is right to note that the Claimant was also complaining of other pain, including right sided upper epigastric pain. On 1 September, she was advised to stop taking Aspirin. I infer that this was related to her continuing complaints of heartburn as no other reason is apparent.

5. On 15 September 2016 (now 36 weeks pregnant) the Claimant attended Basingstoke Hospital for a scan. She was experiencing a severe headache and was found to have very high blood pressure and protein in her urine. As a result, she was admitted, feeling in her own words *"…scared, anxious, and confused."* The following morning she was seen by the treating clinicians who told her that her baby needed to be born within the next 24 hours. She was subsequently told that she had been diagnosed as suffering from HELLP syndrome (Haemolysis, Elevated Liver enzymes and Low Platelets).

6. Initially, it was hoped that a natural birth could be induced but subsequently the Claimant was told that there was no alternative to a caesarean section. All that she can remember about the birthing experience prior to being anaesthetised is described by her as like being in a horror film. When she came round, she describes how she had difficulty in bonding with (or even having an interest in) Mia. Following discharge, these problems continued. In addition, she describes in her witness statement symptoms of fatigue and of being like a different person. She was also continuing to suffer from significant pain associated with her liver. However, she was able to go back to work on a part time basis in March 2017 and then later returned full time.

7. The Claimant's Health Visitor continued to have concerns and made a referral to iTalk for Cognitive Behavioural Therapy ('CBT'). Either as part of, or as a precursor to, those sessions she undertook what has been referred to as a Birth Reflections session in March 2017 during which she was encouraged to walk through the lead up to the birth. I have listened to that recording.

8. It appears that the sessions proper began in July. As part of these sessions, she was 'scored' based on her self-reporting for some of the indicators of PTSD and depression, of which the IES-R (Impact of Events Score) and the PHQ-9 score are respectively the most clinically significant. Those scores are set out below:

	IES-R	PHQ-9
10.03.17		14
14.03.17	74	
17.07.17	72	17
21.09.17	27	5
05.10.17	23	
12.10.17	19	7
26.10.17	46	1
02.11.17	24	0
14.12.17	15	5
08.02.18	30	0
11.04.18	4	0

9. During the summer of 2017 her liver pain worsened and began to radiate into her left shoulder. She also began to notice that she was suffering from disproportionate bruising. She was admitted as an emergency in February 2018 suffering severe pain and scans showed that the cyst on her liver had become enlarged and had multiplied. The larger cyst also began to bleed. She was eventually readmitted on 15 April 2018 for a partial liver resection. Her recovery was not straightforward and included a subsequent admission for a collapsed lung.

10. The Claimant continued to suffer from severe fatigue and pain. She saw her GP on several occasions regarding this, having been encouraged to do so by her friend Troy Walton who saw in her some of the symptoms of her own Fibromyalgia ('FM'). She was eventually referred for a rheumatological assessment and subsequently to a pain specialist. When seen initially by a Dr Jarrett in September 2019, she was not considered to present with diagnosable FM but by November of the following year, Dr Jarrett had revised his diagnosis in the light of the Claimant's presentation at that time.

11. The Claimant's case is that she continues to suffer with PTSD, depression and FM. The symptoms, including overwhelming fatigue and poor sleep, affect all aspects of her life including work, her care of Mia and her relationship with her husband. She relies heavily on his support and that of Ms Walton and her mother. She is concerned that in the longer term, work may become unsustainable as a result. She continues to experience continuing multi-site pain for which she takes prescription painkillers with her anti-depressant medication.

12. She alleges that she continues to suffer from flashbacks relating to Mia's birth. She says that she is hypervigilant regarding Mia, being reluctant to leave her with anyone else. She cannot countenance the idea of having another child despite being assured that there is no medical impediment. She has lost all confidence in the medical profession. She finds it emotionally hard to see families with more than one child, or to answer Mia's questions about why she does not have a brother or sister.

The issues.

13. It is not in dispute that the Defendant was in breach of its duty of care to the Claimant in not advising the Claimant to take Aspirin 75mg at or about the twelfth week of pregnancy. There is some debate about whether giving this advice at some slightly later stage, at 14 weeks or even 16 weeks, would have been non-negligent. The only aspect of breach of duty that is in dispute is the discrete issue of whether the Claimant should have been prescribed Ranitidine for the relief of heartburn and if so, when.

14. The issues to be determined on the basis of the evidence of fact are limited but, as it seems to me, include the following:

- Whether the Claimant would have complied with a prescription of Aspirin.

- The precise nature and extent of her symptoms of PTSD/depression between September 2016 and April 2018.

- When and in what terms the Claimant complained of heartburn.

15. The issues to be determined on the expert evidence called before me are both numerous and complex. In the absence of the promised statement of issues from Counsel, they are in my judgment broadly these:

(a) Had the Claimant taken Aspirin from 12 (or alternatively 14 or 16) weeks, would she have avoided developing HELLP? The question is formulated in this way on the assumption (not challenged in evidence) that but for the development of HELLP, the Claimant would have had a natural birth.

(b) How is the PTSD and/or depression that the Claimant undoubtedly suffered from following the birth to be categorised, and to what extent (if at all) had it resolved by the time of the April 2018 operation?

(c) To what extent were the Claimant's symptoms attributable to the birth (as opposed to her liver or other issues) prior to April 2018?

(d) To what extent are the Claimant's continuing symptoms/conditions (including her FM) attributable to the birth, as opposed to her treatment in 2018 or some other cause?

(e) Should the Claimant have been prescribed Ranitidine during pregnancy and if so, would it have resolved her symptoms of heartburn?

16. The quantum of the Claimant's loss on a 'full liability' basis (i.e. that the Defendant's admitted and alleged breaches of duty have caused or contributed to her present condition) has been agreed at £430,000. At the outset of the trial, the following alternative scenarios appeared to arise:

(1) The admitted breach of duty did not cause or materially contribute to the Claimant's continuing conditions/symptoms after April 2018. In this respect past losses were agreed at £11,500 but there was no agreement as regards general damages for pain, suffering and loss of amenity ('Scenario B').

(2) The Claimant succeeds in relation to the alleged failure to prescribe Ranitidine, whether alone or as an adjunct to Scenarios B (or now C - see below).

It became apparent during the trial that Ms Edwards contended for an alternative scenario, namely that the Claimant's PTSD and depression have continued ('Scenario C').

The Law.

17. The test for establishing liability in cases of alleged clinical negligence is well known. The primary question is whether the treatment (or lack of it) by the clinician(s) involved fell below the standard of reasonable care. It is however recognised that few issues arising in medicine are capable of an empirical answer and that in reality they are addressed by the exercise of clinical judgment. Accordingly, a clinician will not be castigated as negligent if, although a body of responsible, reasonable and respectable medical opinion would consider him/her to be so, another body of responsible, reasonable and respectable medical opinion would not (see *Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582).*

18. It is of course not enough for a defendant to simply produce an expert opinion supportive of the treatment (or lack of it). The assessment of expert evidence in this context (although some of the observations might equally apply to issues of causation) was considered in *C v North Cumbria University Hospitals NHS Trust [2014] EWHC 61 (QB)* where Greene J held that:

> *"vi) Responsible/competent/respectable: In Bolitho Lord Brown Wilkinson cited each of these three adjectives as relevant to the exercise of assessment of an expert opinion. The judge appeared to treat these as relevant to whether the opinion was "logical". It seems to me that whilst they may be relevant to whether an opinion is "logical" they may not be determinative of that issue. A highly responsible and competent expert of the highest degree of respectability may, nonetheless, proffer*

a conclusion that a Court does not accept, ultimately, as "logical". Nonetheless these are material considerations….The following are illustrations…."Competence" is a matter which flows from qualifications and experience. In the context of allegations of clinical negligence in an NHS setting particular weight may be accorded to an expert with a lengthy experience in the NHS. This does not mean to say that an expert with a lesser level of NHS experience necessarily lacks the same degree of competence; but I do accept that lengthy experience within the NHS is a matter of significance. By the same token an expert who retired 10 years ago and whose retirement is spent expressing expert opinions may turn out to be far removed from the fray and much more likely to form an opinion divorced from current practical reality A "responsible" expert is one who does not adapt an extreme position, who will make the necessary concessions and who adheres to the spirit as well as the words of his professional declaration (see CPR35 and the PD and Protocol).

vii) Logic/reasonableness: By far and away the most important consideration is the logic of the expert opinion tendered. A Judge should not simply accept an expert opinion; it should be tested both against the other evidence tendered during the course of a trial, and, against its internal consistency…….There are 2 other points which arise in this case which I would mention. First, a matter of some importance is whether the expert opinion reflects the evidence that has emerged in the course of the trial. Far too often in cases of all sorts experts prepare their evidence in advance of trial making a variety of evidential assumptions and then fail or omit to address themselves to the question of whether these assumptions, and the inferences and opinions drawn therefrom, remain current at the time they come to tender their evidence in the trial. An expert's report will lack logic if, at the point in which it is tendered, it is out of date and not reflective of the evidence in the case as it has unfolded. Secondly, it is good practice for experts to ensure that when they are reciting critical matters, such as Clinical Notes, they do so with precision……Having said this, the task of the Court is to see beyond stylistic blemishes and to concentrate upon the pith and substance of the expert opinion and to then evaluate its content against the evidence as a whole and thereby to assess its logic. If on analysis of the report as a whole the opinion conveyed is from a person of real experience, exhibiting competence and respectability, and it is consistent with the surrounding evidence, and of course internally logical, this is an opinion which a judge should attach considerable weight to."

19. Causation is generally a binary issue. The Claimant must prove to the usual civil standard that, but for the alleged or admitted breaches of duty in this case, the various conditions and symptoms that she suffers from would not have arisen. The issue of causation is however complex in this case for two reasons; (a) the Claimant seeks to prove her case by reference to statistical probability; and (b) in respect of the FM, the Claimant alleges that it is sufficient that the Defendant's breach of duty made a material contribution to its development, even if it was not the primary cause.

20. The Claimant cannot show by direct evidence what would have happened had she taken Aspirin 75mg at 12 weeks, or what the difference would have been at 14, 16 or 23 weeks. Accordingly, she must succeed by establishing probability based on statistical outcomes. In *Gregg v. Scott [2005] AC 176* Lord Nicholls held that:

> *"27. In cases of medical negligence assessment of a patient's loss may be hampered, to greater or lesser extent, by one crucial fact being unknown and unknowable: how the particular patient would have responded to proper treatment at the right time. The patient's previous or subsequent history may assist. No doubt other indications may be available. But at times, perhaps often, statistical evidence will be the main evidential aid.*
>
> *28. Statistical evidence, however, is not strictly a guide to what would have happened in one particular case. Statistics record retrospectively what happened to other patients in more or less comparable situations. They reveal trends of outcome. They are general in nature. The different way other patients responded in a similar position says nothing about how the claimant would have responded. Statistics do not show whether the claimant patient would have conformed to the trend or been an exception from it. They are an imperfect means of assessing outcomes even of groups of patients undergoing treatment, let alone a means of providing an accurate assessment of the position of one individual patient."*
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> ...

> *32. The value of the statistics will of course depend upon their quality: the methodology used in their compilation, how up to date they are, the number of patients involved in the statistics, the closeness of their position to that of the claimant, the clarity of the trend revealed by the figures, and so on. But to reject all statistical evidence out of hand would not be acceptable. This argument, if accepted, would effectually nullify the use of statistics in all cases of delayed treatment save perhaps where the figures approached 0% or 100%. Despite its imperfection, in practice statistical evidence of a diminution in perceived prospects will often be the nearest one can get to evidence of diminution of actual prospects in a particular case. When there is nothing better courts should be able to use these figures and give them such weight as is appropriate in the circumstances. This conclusion is the more compelling when it is recalled that the reason why the actual outcome for the claimant patient if treated promptly is not known is that the defendant by his negligence prevented that outcome becoming known."*

21. It is important that I should add that my task is not to review the epidemiological papers presented in this case and choose between them. Rather, my task is to examine the evidence of the experts called before me and test that evidence against the medical literature when assessing the validity of their conclusions. That task involves assessing the weight that I can attach to their analysis having regard to the considerations identified by Greene J in *North Cumbria*. The following dicta of Stuart-Smith LJ in *Loveday v. Renton (No. 1) [1990] 1 Med LR 117* are apposite:

> *"The mere expression of opinion or belief by a witness, however eminent ... does not suffice. The Court has to evaluate the witness and the soundness of his opinion. Most importantly this involves an examination of the reasons given for his opinions and the extent to which they are supported by the evidence. The Judge also has to decide what weight to attach to a witnesses opinion by examining the internal consistency and logic of his evidence; the care with which he has considered the subject and presented his evidence; his precision and accuracy of thought as demonstrated by his answers; how he responds to searching and informed cross-examination and in particular the extent to which a witness faces up to and accepts the logic of a proposition put in cross-examination or is prepared to concede points that are seen to be correct; the extent to which a witness has conceived an opinion and is reluctant to re-examine it in the light of later evidence, or demonstrates a flexibility of mind which may involve changing or*

modifying opinions previously held; whether or not a witness is biased or lacks independence. ... There is one further aspect of a witnesses evidence that is often important; that is his demeanour in the witness box. As in most cases where the Court is evaluating expert evidence, I have placed less weight on this factor in reaching my assessment. But it is not wholly unimportant…"

22. In cases where an injury can properly be categorised as 'indivisible', the test for causation is concisely set out in the judgment of Waller LJ in *Bailey v. Ministry of Defence [2008] EWCA Civ 883 at [46]:*

> *"In my view one cannot draw a distinction between medical negligence cases and others. I would summarise the position in relation to cumulative cause cases as follows. If the evidence demonstrates on a balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the claimant will have failed to establish that the tortious cause contributed. Hotson's case exemplifies such a situation. If the evidence demonstrates that "but for" the contribution of the tortious cause the injury would probably not have occurred, the claimant will (obviously) have discharged the burden. In a case where medical science cannot establish the probability that "but for" an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the "but for" test is modified, and the claimant will succeed."*

23. 'Succeed' in this context means that the Claimant will recover 100% of her loss, regardless of whether there may be other, possibly more potent causes. Where however the injury is properly to be characterised as divisible, the Claimant will still succeed if she can prove contribution but will only recover to the extent of that contribution.

24. The distinction between divisible and indivisible injuries was considered in *Holmes v. Poeton Holdings Ltd. [2023] EWCA Civ 1377* where the Court of Appeal expressed considerable reservations as regards the principle enunciated in *Bailey* whilst recognising that they were bound by it. At paragraph 36 Stuart-Smith LJ said this:

> *"First, the terms "divisible" and "indivisible" disease or injury are ubiquitous. They are (or should be) now well understood but have been a source of confusion in the authorities. It is a characteristic of divisible diseases that, once initiated, their severity will be influenced by the total amount of the agent that has caused the disease. By contrast, once an indivisible disease is contracted, its severity will not be influenced by the total amount of the agent that caused it. The classic distinction in asbestos-related diseases is between asbestosis and mesothelioma. Mesothelioma is an indivisible disease because, although the risk of developing a mesothelioma increases in proportion to the quantity of asbestos dust and fibres inhaled, the condition once caused is not aggravated by further exposure and the severity of the condition, if it occurs, is not thought to be affected by variations in the victim's overall exposure. Asbestosis is a divisible disease because all of the victim's exposure to asbestos will contribute to the severity of his eventual disease… Noise-induced hearing loss and pneumoconiosis are divisible diseases."*

The evidence.

Fact

25. The Claimant prepared a lengthy witness statement (much of it apparently directed at a potential claim relating to the treatment of her liver cysts) and gave oral evidence. I do not propose to provide a summary of that statement as this is largely encapsulated in the statement of the factual background to this matter set out above.

26. In cross examination, the Claimant was taken to several parts of her statement and her medical records but the actual number of challenges were few. She agreed that her liver pain persisted after the birth and said that it took a while to get her GP to take this seriously. She said that the pain continued until the surgery in 2018 which she accepted was a 'horrid and frightening' experience.

27. She told me that she had a good relationship with her Health Visitor, although she was still ‘a stranger’. She was taken to an entry in the Health Visitor’s notes for 29 September 2017 which suggested that she had now bonded with Mia. She said that she was not being honest with the Health Visitor and did not want to admit to the truth. In relation to a later entry which suggested that she was feeling better with occasional tearful days linked to her parents’ separation, she said that she did not recall having discussed this. She was taken to other entries in which she is recorded as denying that she is depressed and declining CBT. She told me that she was embarrassed to admit to being depressed.

28. She was next taken to the records relating to her CBT. She agreed that, as recorded in the note of the last session on 11 April 2018, she had stopped taking Fluoxetine but was still ‘doing ok’. She said that at that stage she had been positive, thinking that her pain would cease after the liver resection. She was managing her anxiety using techniques learned during the iTalk sessions. Asked about a note in her GP records for 18 July 2018 which read *“Patient was asked to come for Depression review but this is now resolved”* she said that her concern was pain and that she did not recall any discussion regarding her mental health. The Claimant agreed that having returned to work, originally part time and then full time, she had a stress reaction to being made redundant in October 2020.

29. She was taken to a record prepared by Dr Harmer, a Clinical Psychologist, of an outpatient appointment on 23 October 2019. The history given by the Claimant (having dealt with the birth, its consequences and the treatment which she describes as 'helpful') goes on as follows: *"Liver resection April 2018 – major surgery. Never felt well since – fatigued…exhausted…pain all the time…".* She said that this was in fact a description of what she had been suffering since the birth. Dr Harmer followed this up with a letter dated 23 October 2019 in which she repeated these notes and also recorded the Claimant as reporting that her PTSD was 'better managed now' and that her mood was 'good' most of the time. The Claimant agreed that she had said this. She agreed that she had had fatigue in pregnancy and in the immediate post-natal period. She did not however agree that her fatigue was much worse after the liver resection. She said that it was there 'pretty much all of the time' but that she had initially dismissed it as a consequence of motherhood.

30. In re-examination, she was taken to a letter prepared by Dr Everington, a consultant Haematologist, dated 1 March 2018. This records a discussion in which the Claimant is said to have described herself as being *"…in a better place but not yet recovered".* The Claimant agreed with this and said that she had opened up to Dr Everington as she was very sympathetic. She was also taken to medical records which stated that she was 'recovering' as opposed to 'recovered'. On the subject of heartburn, she was taken to her complaint regarding her treatment by Ms Stonock. She confirmed that the contents were an accurate record.

31. The Claimant's husband also gave evidence. His witness statement gives a similar account to that of his wife, seen from his perspective. It does not assist regarding the timing of the Claimant's severe heartburn, other than to suggest that this was a feature of the later stages of her pregnancy. In paragraph 107 he says that after the birth, the Claimant *"…became a different person. She was very tired and couldn't focus properly".* He was cross-examined briefly in relation to the birth but not otherwise.

32. Ms Power elected not to cross-examine Ms Walton or the Claimant's mother Mrs Fuller. She indicated that this was in the interests of proportionality but that does not alter the fact that their evidence went unchallenged. Ms Walton states that she too has a diagnosis of FM and says that she recognised some of her symptoms in the Claimant's presentation. She describes the care and assistance that she has given to the Claimant. She states that the Claimant seemed to be 'exhausted all of the time' during pregnancy. In paragraph 36 she states that *"Her symptoms were more pronounced after her liver surgery but in my mind, they were there from…after Mia was born"*. Mrs Fuller's statement is also focussed predominantly on the care that she gave to her daughter. Her memory of events has been affected by 'Long Covid'. She describes her daughter as tired, more absent minded and 'foggy' than she used to be.

33. The Defendant elected not to call its witnesses of fact; Ms Stonock (the Midwife who was largely responsible for the Claimant's antenatal care) and Ms Green (also a Midwife who gives evidence about the birth). No notices under the Civil Evidence Act were served. Both witnesses do no more than recite the contents of the medical records and do not profess to have much, if any, in the way of independent recollection of events. It is not obvious that their evidence bears heavily upon the issues that remain for me to decide. Ms Power invited me to attach such weight to them as I felt able to.

Obstetrics

34. In order to understand the evidence of the consultant obstetricians, it is necessary to provide a thumbnail sketch of the relevant medical literature. What appears in the table below is not a comprehensive review of all the literature, but an attempt to identify what I regard as the important elements of some of the more important papers. I have of course taken into account all of the literature relied upon by the experts in reaching my decision.

Explanation of terms:	RCT	Randomised Clinical Trial
	RR	Relative Risk (e.g. an RR of 0.90 equates to a 10% effect)
	CI	Confidence interval (the range of possible outcomes with a 95% confidence ratio. The wider the range, the less persuasive the outcome)
	PE	Pre-eclampsia
	IPD	Individual Participant Data
	AD	Aggregate Data

Document	Observations
Ebrashy et al 2005	A RCT which studied 139 women at risk of PE and at 14-16 weeks gestation with abnormal uterine doppler findings. Women with normal doppler findings were excluded, as were women with chronic renal or hepatic disorders. Dosage for Aspirin group 75mg.
Zhao et al 2012	A RCT which studied 242 women at high risk of PE and at 14-16 weeks gestation. Dosage for Aspirin group 75mg. Abstract only.
Xu 2015	A systematic review examining the effect of administering Aspirin to high risk women. Overall sample size 29 RCTs of 21,403 women. RR found to be 0.71 (CI 0.57 – 0.87) for PE and 0.37 (CI 0.23 – 0.61) for severe PE (sample size 1930 women). It is of note that approximately half of the included RCTs involved administration of >75mg Aspirin. Regarding timing, authors note that *"How risk of severe preeclampsia compared before and after the 16-week cut off is unclear, because limited sample size prevented us from performing this subgroup analysis".*
Meher et al 2017	A systematic review using IPD to investigate the effect of administering Aspirin before and after 16 weeks. Sample size 32,217 women from 31 RCTs. No significant difference found – in each case the RR was 0.90 (CI for <16 weeks 0.83 – 0.98). Critical of studies based on AD as vulnerable to bias or other distorting effects.
Roberge et al 2017	A systematic review using AD to investigate the effect of different dosages of Aspirin before and after 16 weeks. Overall sample size 20,909 women. Overall effect for severe PE at ≤ 16 weeks RR 0.47 CI 0.26 – 0.83 (sample size 4,079). For analysis of effect of 75mg Aspirin at ≤ 16 weeks on severe PE, relies on Ebrashy and Zhao only (373 women). RR 0.24 CI 0.09 – 0.65 in this sub-group. At 60mg RR 0.96. Recognises limitations including use of small RCTs/Subgroups. Only two dosages (60mg and 100mg) capable of study at sufficient depth to enable direct comparison.
Tong 2017	An editorial seeking to rationalise the difference between Meher and Roberge. Identifies advantages of IPD over AD. Meher considered to have greater statistical power and protection against bias. Dose response conclusions of Roberge 'pretty convincing'. Outcome of ASPRE awaited.
ASPRE 2017 (Rolnik et al)	A large RCT (1776 women) studying the effect of 150mg Aspirin at 11-14 weeks. Adherence reported to be good. Dosage chosen *"…on the basis of previous evidence of dose-dependent benefit to therapy; in addition, the commonly used dose of 81 mg of aspirin per day has no appreciable effect on platelet function in up to one third of pregnant women"*. Overall conclusion that Aspirin at that dose 62% effective in preventing PE.
Poon et al 2017	Secondary analysis of ASPRE data to study effect on patients with different characteristics/histories. Finds there may be a reduced effect where mother has chronic hypertension.
Wright et al 2017	Secondary analysis of ASPRE data to examine effect of compliance on outcomes. Concludes that beneficial effect of Aspirin depends on compliance.
Cochrane (Duley et al) 2019	Systematic Review of 77 RCTs and 40,249 women using IPD where available (for 34,514 women) but also AD (including ASPRE). Overall RR found to be 0.82 (CI 0.77 – 0.88) with 0.90 (CI 0.82 – 0.98) for high risk women, 0.78 (CI 0.66 – 0.92) for doses of 75mg or more, 0.78 (CI 0.48 – 1.26) for severe PE (described as a 'wide confidence interval substantially crossing the line of no effect') and 0.77 (CI 0.48 – 1.36) for HELLP (sample size 'underpowered'). No significant difference found between pre- and post- 16 weeks. Noted that AD data consistently showed greater effects and possible reasons for this analysed, including lower quality, publication bias, population difference and higher dosages.

Richards et al 2022	Systematic review of 6 RCTs and 3 retrospective cohort (observational) studies (2150 women). Concluded that Aspirin has no effect in women with pre-existing hypertension but results had wide confidence intervals. Evidence described as being of low or very low quality and limited by risk of bias in the majority of the studies, heterogeneity, and imprecision. States further research required. Noted that there was conflicting evidence on the differential impact of Aspirin pre- and post- 20 weeks.
Mendoza et al 2023	RCT studying discontinuation of Aspirin at 24 – 28 weeks. Sample size 936 women. Concluded that no statistical proof of non-inferiority.

35. Professor Siassakos is a Professor in Obstetrics and an honorary consultant at UCH, London. He has authored numerous papers in his specialist field and has led or been a member of numerous national initiatives. His experience as an expert in litigation is not stated.

36. In his opinion, the Claimant, as a patient with a high risk factor for PE due to her PKD, should have been referred for a consultant review by 14 weeks and have been recommended to start Aspirin by 16 weeks. In his report dated November 2023, he draws primarily on the conclusions in *Roberge* for his opinion that, had this occurred, the Claimant would have avoided developing HELLP.

37. Referred to the RCOG Guidelines 2010, he comments that they cite literature which is now 'outdated' and refers to *Roberge* as the most recent analysis. He is also clear, based on *Roberge*, that administration beyond 16 weeks would have little or no effect. Later in his report he draws attention to *ASPRE* as demonstrating a 60% effect, or greater if adherence is high and pre-existing chronic hypertension is excluded (relying also in this respect on *Poon*).

38. Turning to the issue of heartburn, he considers that this might have been a side effect of the Aspirin. Competent care would mandate an obstetrics review once it was reported, and that review would have resulted in a prescription for Ranitidine in order to enable the Aspirin to continue. He acknowledges that the manufacturer states that use in pregnancy should be avoided unless essential but asserts that this is common for a number of drugs.

39. Mr Tuffnell is also an experienced consultant in Obstetrics and Gynaecology, although he left clinical practice in 2019. He has authored a number of publications (including Cochrane reviews) and was involved in the development of the NICE guidelines. He has provided reports for both claimants and defendants in clinical negligence matters.

40. He agrees that the Claimant should have been advised to take Aspirin 75mg when seen by a consultant, which should have occurred between 12 and 16 weeks. He however rejects the proposition that the delay in treatment in this case can be demonstrated to have been causative of the Claimant's HELLP, relying on the findings in *Cochrane/Duley* and *Meher*. He describes Professor Siassakos' reliance on *Roberge* as 'cherry picking' given the small size of the sample for that analysis. Relying on *Tong*, he also points to the greater statistical power and reduced risk of bias flowing from the use of IPD over AD. Overall, he considers that the RR cannot be shown to approach the threshold for balance of probabilities. He also rejects the suggestion that it can be demonstrated on an individual patient basis that there is a significant advantage in starting Aspirin before 16 weeks. He points out that *ASPRE* used a far higher dose and was in any event considered as part of *Cochrane/Duley*.

41. On the question of heartburn, he describes this as an extremely common feature of pregnancy and not one that warranted an obstetrics review. Advice in relation to the use of over the counter antacids such as Gaviscon was appropriate clinical management. Alternatively, stopping Aspirin would be an appropriate response as in fact happened.

42. There was little common ground found in the experts' joint statement as regards the issue of causation. They largely restate and expand upon their primary conclusions and the reasons for them. In the answer to question 10 they attempt an explanation of the aetiology of PE. There is broad agreement that it is the result of poor placentation and specifically the failure of the secondary wave of trophoblast invasion that establishes the intervillous blood supply with the mother. This process is normally complete by 12 – 16 weeks. Mr Tuffnell however considers that secondary effects on further blood vessel development and clotting also have a part to play.

43. The experts provide further detail of their thinking in respect of the medical literature in answer to question 12. In concluding his analysis, Mr Tuffnell states that *"Statistical methodology is complex and whilst I have some expertise I would not suggest I am fully conversant with all the details. Therefore I rely on Tong to help explain the differences and why Meher is more likely to be correct."*

44. Question 13 invited the experts to consider the probability that the Claimant would have avoided HELLP had she been prescribed Aspirin at 12 weeks. Professor Siassakos described HELLP as part of the 'spectrum' of severe PE with a similar pathophysiology. It is for this reason that he considers research on severe PE to be relevant. Mr Tuffnell describes HELLP as a 'specific variant' of severe PE which presents in a different way with haematological and biomedical issues rather than hypertension. He points to the findings of *Cochrane/Duley* as showing that Aspirin does not assist in cases of HELLP. Professor Siassakos criticises *Cochrane/Duley* in this respect on the grounds that it is based on a single trial (ERASME) where the treatment only started at 16.8 weeks. Mr Tuffnell criticises *Roberge* for relying on *Ebrashy* which was not placebo controlled and therefore at significant risk of bias.

45. Invited by subsequent questions to undertake a general review of the literature, Professor Siassakos asserts that *Meher* rather than *Roberge* is the 'outlier' on this issue. He describes the larger reviews such as *Meher* and *Cochrane/Duley* as lumping together 'all fruits' (variable dose, adherence, start time etc.) and as therefore having less statistical significance than a 'large trial of apples alone'. He repeats the criticism of *Meher* as including 'old studies'. Professor Tuffnell points out that the use of AD does precisely what Professor Siassakos decries; it lumps all women together. IPD enables the factors for each participant to be identified.

46. In relation to heartburn, Professor Siassakos stated that severe heartburn mandated an obstetrics referral. Ranitidine was used routinely until discontinued for other reasons and indeed was given to the Claimant whilst she was in labour. Mr Tuffnell says that the usual approach would be to give a second 'white medicine' before considering something more potent and that another approach would be to stop Aspirin (as I infer was in fact was done in the Claimant's case).

47. In cross-examination, Professor Siassakos reiterated his printed views. He told me that his practice was 50% clinical and 50% academic and that his PhD included a masters in epidemiology. He said that due to the rarity of HELLP, no randomised trial of that condition was possible which is why regard had to be had to the data on severe PE. He denied that the pathogenesis was different. He also denied that there were any 'secondary effects' of poor placentation. The only possible effect of Aspirin after 16 weeks would be for the very small number of women with thrombophilia.

48. He accepted that Cochrane studies were the 'gold standard' (and that Duley was a highly respected epidemiologist) but he said that they lack granularity and typically concluded that there was no outcome. He reiterated his reliance on *Roberge* which he said drove national clinical practice in the form of 'Saving Babies' Lives', which was 'following the evidence'.

49. He agreed that *Ebrashy* on which *Roberge* was based was not placebo controlled and therefore scored highly for one of the risks of bias. He also agreed that *Ebrashy* had excluded women like the Claimant with renal disease. He accepted that *Zhao* was only an extract and as such had an uncertain/unclear risk of bias. He claimed however that both these factors were also a feature of half the studies included in *Cochrane*.

50. He did not agree that IPD was superior to AD in all respects. He did however recognise that access to the source data allowed for a more sophisticated analysis. He also agreed that a greater number of participants lent greater power to a study. He accepted that *Meher* was better protected against publication bias and that *Cochrane* was up to date.

51. Professor Siassakos sought to emphasise the importance of adherence. He said that there were no factors in the Claimant's case to suggest that she would not have adhered to advice to take Aspirin. He also sought to draw assistance from *ASPRE* which he described as 'emerging evidence', although he recognised that the dosage was much higher and that there was a dose effect. He said that 50mg might work a bit, 60mg would have a small effect, 75mg would have a greater than 50% effect and 150mg would be even better.

52. He argued that Mr Tuffnell was using outdated evidence to counter what was generally agreed and appeared to suggest that to take any different view to his own was clinically improper. He was however compelled to agree that *Roberge* had also relied on older data. He also accepted that some of his criticisms of *Cochrane* in terms of 'all the fruits' also applied to *Roberge* in terms of adherence and pre-existing hypertension. As regards that latter factor, he said that *Poon* and *Richards* had established that Aspirin had no effect for hypertensive women. However, when taken to the literature he was compelled to agree that this was not the conclusion and that 'the jury is out' on this issue.

53. On the subject of heartburn, he agreed that a clinician would have a number of options including no further treatment, stopping Aspirin and prescribing Ranitidine. He did not however consider that the first two options were reasonable ones.

54. Mr Tuffnell told me that he had undertaken the Cochrane Reviews course and had authored three reviews. He had also authored various national guidelines including the RCOG Guidelines that recommended 75mg Aspirin at 12 weeks. He was unable to say why this did not appear in terms in his original report. He denied attempting to make light of the Claimant's PKD as a means of reducing the imperative for treatment. Asked about his knowledge, he said that he had a great deal of experience with systematic and other reviews but he was not an expert biomedical statistician.

55. It was for this reason that he had placed reliance on *Tong* as his conclusions made sense to him. He said that as an expert he was entitled to draw from available literature. He was unable to say whether *Tong* had revised his views in the light of *ASPRE*. He agreed that *ASPRE* demonstrated that dose was important. He said that there were reasons why a high dose would have a greater effect as at 150mg Aspirin 'paralysed' the synthesis of prostacyclin, whereas at lower doses this did not occur. He said that there was a paper which established this but he was unable to identify it there and then.

56. Asked about *Roberge*, he said that the challenge was that it analysed small trials, one of which was not placebo controlled and one of which had no data. It was 'hugely unsafe' to compare this with the reviews based on much larger trials which were based on IPD, were more robust and had less bias. He refuted the suggestion that the older trials were less valuable. He said that Aspirin was an old drug and pregnancy had not changed. Some of the earlier trials were 'gold standard' ones that had been publicly funded.

57. He said that it is always possible to find an individual trial that produces the evidence you want but this is cherry picking. The best approach was to look at all the evidence together in a large systematic review. This established that Aspirin 75mg at < 16 weeks had an effect but not one which crossed the line of balance of probability.

58. He agreed that in an ideal world you would for comparison purposes want to get as similar a population as possible to the Claimant and who took 75mg Aspirin at 12-14 weeks. He agreed that *Cochrane* included all women in the primary analysis regardless of dosage, adherence, hypertension etc. but these were then separated out in the secondary analysis using IPD. In *Meher* for example, women were separated out by reference to their start date. He had also analysed all women in *Meher* (1800) who had taken doses of 75mg or more and the outcome was still an RR of 0.90. He said that *Cochrane* demonstrated that AD tended to produce greater effect outcomes.

59. He agreed a lot of the trials in *Cochrane* involved doses of 50 – 60mg but there were also a number where the dose was higher than 75mg. He agreed that it was 'biologically plausible' that later administration might be less effective but this was not supported by the data, particularly in *Meher*. He did not agree that *Mendoza* proves that there is no effect later in pregnancy – that RCT had excluded women with an abnormal SPIIF IGF test but these were the very ones most likely to develop PE.

60. He agreed that adherence was an important issue but pointed out that there would need to be a non-compliance rate of 60% in order to move the data sufficiently to demonstrate an effect on a balance of probabilities. He agreed that there was some emerging evidence regarding a lack of effect for hypertensive women although this was surprising biologically.

61. On the subject of heartburn, he pointed out that the Claimant was receiving the treatment recommended in the NICE guidelines – Gaviscon. If something more was required, then at 27 weeks (when the Claimant is first recorded as reporting heartburn) the preferred course would be to recommend stopping Aspirin, rather than prescribing another drug to counter the effects of the first.

Pain

62. There was in the end a relatively narrow difference between the pain experts. The Claimant relies on the evidence of Dr Munglani, a consultant in pain medicine. He examined her in 2021 remotely and again in person in 2023. On the latter occasion, he noted that the Claimant appeared to have deteriorated further. Indeed he records that *"We went through her history again and it does seem that from the period of diagnosis of HELLP in 2016 until the hepatectomy in 2018 she had the presence of some fatigue, also pains but things have progressed [deteriorated] since then".* He noted pain at various sites and was particularly concerned to exclude a local biomedical cause for the reported pain in the right shoulder.

63. He confirms a diagnosis of FM or, as he would prefer, chronic pain syndrome with possible aspects of a functional neurological disorder. He says that research supports the proposition that patients who experience multiple medical comorbidities are more likely to develop FM, especially when in conjunction with depression. The Claimant's medical history (and her general experience of pregnancy) would only have disposed her to a 10% risk of FM.

64. He considers that the Claimant's FM is due to the significant traumatic events (including the HELLP and her liver resection) that she has experienced. Absent the liver resection, he considered that she would still have developed FM but at a lesser degree of severity. His prognosis was for the FM to be enduring; *"…she is becoming entrenched in a chronic pain syndrome pain which may be being magnified by her mental state with possible Somatoform/FND (the latter being subject to psychiatric opinion)"*.

65. The Defendant relied upon the evidence of Dr Armstrong, a consultant Rheumatologist. Like Dr Munglani, he noted the Claimant to exhibit low mood and to report multi-site pain. It was his opinion that the Claimant's medical history, and particularly her Irritable Bowel Syndrome, made it more likely than not that she would develop FM.

66. He agreed that she was properly diagnosable with FM in 2020 but queried whether, after the lapse of time since the birth, an association could be made between them. Cases of FM brought on by trauma were unusual and in order for a plausible link to be established, the onset should generally occur within 6 months. He described the liver resection and associated pain as being a likely significant contributor to her condition, which he considered might resolve in part with the conclusion of the litigation.

67. In the joint statement, the experts agreed on the diagnosis of FM and that FM could result from trauma, albeit in a minority of cases. They also agreed that the Claimant was vulnerable to the development of FM given her medical history. Dr Armstrong maintained his view that in this case there was too great a gap between the birth and the diagnosis of FM to enable a causative link to be made between them. Rather, the birth trauma was simply another 'predisposing factor' and the liver resection was more likely to have been the trigger.

68. Dr Munglani was however of the view that there was (provided the Claimant's evidence of fatigue was accepted) a 'continuous timeline' between the trauma of the birth and the diagnosis of FM. Any delay in diagnosis (which itself was not unusual) was due to her FM symptoms being masked by other biomedical issues. He placed considerable weight in answering questions 11 and 12 on the significance of PTSD. He did not consider that, by itself, the liver resection would have triggered FM but he did agree that it had made at least a material contribution to it.

69. In evidence, Dr Munglani was subject to some criticism for not having examined the Claimant's medical records after November 2018 (including details of her treatment by Dr Jarrett) and agreed that with hindsight it was important to investigate the full history of symptoms. He agreed that it was appropriate to diagnose the Claimant with FM in 2020 but not in 2019. He recognised that this was long lapse of time since the birth and that the only symptom in the interim was fatigue, but he said that in 20% of cases fatigue is the primary symptom.

70. He accepted that there were other potential causes for the Claimant's fatigue, including her liver condition and PTSD/depression. He went on to agree (in a significant shift of position) that the Claimant's liver condition was in itself a significant trigger for her FM but this would not have been as severe in the absence of PTSD, which would have rendered the Claimant vulnerable to any further trauma. Cross examined further on the significance of PTSD (and the medical literature relating to the link with FM), he concluded by saying that in effect the continuing PTSD needed to be shown to be significant enough (although he could not define this) to enable the link to be made.

71. Dr Armstrong maintained that there was no good evidence of symptoms dating back to the birth to establish a link with FM. Whilst it was important to consider fatigue, it would need to have been accompanied by widespread pain. Fatigue by itself was of limited significance. Taken to extracts from the Claimant's witness statement and those of her witnesses referring to fatigue and to leg (and some hand) pain, he conceded that a persistence of similar symptoms might lead to a consideration of FM but intermittent leg pain would not be enough – it needed to be chronic and widespread for a period of more than three months.

72. He agreed that there was a progression or continuum of some symptoms, based on the Claimant's evidence, but not such as to establish a connection with her FM. He maintained that the interval between the birth and diagnosis was implausibly long to enable causation to be established. He agreed that it can be difficult to diagnose FM when there are other concurrent issues and that there could be 'masking' but concurrent biomedical pain did not otherwise inhibit a diagnosis where the pain experienced was out of proportion.

73. Asked about the significance of PTSD, he agreed that it was possible that PTSD could aggravate FM. He said that in this case it was unlikely to have contributed to the development of FM as it was improving or had resolved. Mild PTSD would have little or no effect. He did however go on to concede that if the Claimant did have continuing PTSD then this would have contributed to her development of FM and that, had she not had PTSD, she would have been in a better position when she underwent the liver resection. In answer to a question by me, he again stated that continuing mild PTSD would not have had a contributory effect.

Psychiatry

74. In her report, Dr Moore reviews various aspects of the Claimant's history and the information gathered from her in interview before turning to her medical records. This includes the Claimant's CBT records where Dr Moore provided the IES-R scores for 14 March 2017 (74), 17 July 2017 (72) and 14 December 2017 only. In the latter case, she gave the score as 50 when it was in fact 15. Her conclusion was that the Claimant had developed PTSD as a result of the circumstances of the birth which was *"…resolving after treatment with therapy"* and moderate clinical depression that was being partially ameliorated by anti-depressants. In paragraph 12.8 she states that *"Mrs De Francisci's IES scores further support a diagnosis of PTSD, this is a diagnostic tool used to assess for PTSD. She scored 74 on the 14th of March 2017, 72 in July 2017 and 50 in December 2017. These scores are all diagnostic of a severe clinical episode of PTSD."* It was her opinion that the 2018 surgery retraumatised the Claimant and prolonged her symptoms although she also states that her *"…ongoing severe pain and fatigue is significantly correlated…"* with it.

75. Dr Briscoe in his report accepts that the Claimant suffered from PTSD following from, and as a result of, the traumatic birth together with a mild to moderate depressive episode. He considers however that she no longer fulfilled the diagnostic criteria for these conditions by the completion of the CBT (when her IES-R scores for PTSD and her PHQ-9 scores for depression were below the level of clinical significance). He considers that the liver resection was probably responsible for what he differentially diagnoses as a subsequent Bodily Distress Disorder accompanied by an acute stress reaction to redundancy in October 2020 against the context of a vulnerability to somatisation (the manifestation of psychological distress in a physical symptom(s)).

76. In the joint report, Dr Moore and Dr Briscoe maintained their positions. They agreed that the cut off for PTSD using the IES-R measure was 33 but that this had to considered alongside a clinical assessment. Dr Moore acknowledged her error with the December 2017 IES-R score but maintained that the evidence suggested ongoing mild or fluctuating PTSD in accordance with a typical 36-month recovery timeframe.

77. Dr Briscoe considered that the IES-R scores (and the notes of the CBT sessions) demonstrated a typical progression to recovery with nothing in the PHQ-9 (or GAD-7) to indicate anything more than mild anxiety. Having occasional symptoms of PTSD was not the same as having PTSD. It was also important to separate out symptoms that may be attributable to other conditions or events. None of the symptoms described by the Claimant to Dr Moore or to himself in interview met the requirements of ICD-11 for *"…strong or overwhelming emotions, such as fear or horror, and strong physical sensations…"*.

78. Dr Briscoe also maintained that the Claimant's depression was mild to moderate in degree, basing himself on the clinical notes. Dr Moore asserted that such notes were often based on underreporting or under-identification by clinicians and did not undermine her assessment of moderate depression which she said persisted. Dr Briscoe relied on the progression on PQH-9 scores as establishing that the Claimant's depression had resolved, particularly given that there had been no relapse when she ceased to take anti-depressants. Such symptoms as she may have had could be attributed elsewhere and she did not have the pervasive low mood that is the hallmark of depression.

79. Dr Moore agreed that the PHQ-9 scores had fallen as expected but maintained that they did not show a recovery and maintained the opinion that the Claimant's depression had continued and had been prolonged by the events of 2018. She rejects Dr Briscoe's differential diagnosis of Bodily Distress Disorder.

80. In cross examination Dr Moore was asked about the IES-R scores. She confirmed her error in respect of the December 2017 score but said that this did not affect her analysis. She agreed that she had omitted the other scores below clinical significance from her report. She said that this was an omission rather than a conscious exclusion and denied that this impacted on her opinion, which was based on the Claimant's account. She said that the scores were a useful diagnostic tool but not an absolute measurement. She agreed that the IES-R and PHQ-9 scores were sub-clinical at the completion of treatment but said that this was just at that particular moment in time. Asked by me at the conclusion of her evidence to explain the basis for the selection of IES-R and PQH-9 scores in her report, she was unable to do so.

81. More generally she acknowledged that she had not reviewed parts of the Claimant's medical records. In particular, she acknowledged having not considered the medical records between 2018 and 2021, including the review by the pain clinic and Dr Jarrett's assessment. In re-examination she said that having seen them her opinion was unchanged. She accepted that it was possible to display sub-clinical symptoms of PTSD without having it. Taken to paragraph 2.5 of her report, she said that the Claimant is reminded every day of her trauma and a memory can be a 'replay'. She maintained that the Claimant had ongoing replaying, flashbacks and nightmares. She agreed that the ICD criteria for depression required pervasive low mood or reduced ability to participate in activities, albeit in the same mood component. She was taken to paragraph 10.4 of her mental state examination where she states that the Claimant 'has no pervasive low mood'. She acknowledged that this was a 'mismatch' but maintained that the Claimant met the diagnostic criteria having regard to other factors including replaying, nightmares, avoidance and hyper-arousal/hyper-avoidance.

82. Taken to the medical records, she was asked about the assessment (not considered by her at the time of writing her reports) by Dr Harmer (a clinical Psychologist) on 23 October 2019. She dismissed this as being only a brief account lacking in detail. Similarly, she dismissed the significance of the GP record of 14 July 2017 recording the Claimant as saying that she was better and the record showing that she had declined a depression review in July 2018 as it had 'resolved'. They lacked detail and absence of reporting of mental health difficulties did not mean they did not exist.

83. Dr Briscoe said in cross examination that in his opinion the relevant trauma was the Claimant being told that she would have to undergo a caesarean section. He was asked about his mental state examination of the Claimant. He acknowledged that he had described her as 'somewhat flat with a mild depressive affect' but this did not amount to depression. Equally, the fact that the Claimant had issues of trust/wariness/anxiety regarding leaving Mia with other people did not amount to hypervigilance. Whilst poor memory and fatigue can be symptoms of depression, it was necessary to consider the context of her FM and Bodily Distress Disorder. Fluctuations in mood do not add up to a diagnosis of depression. The Claimant had denied being depressed when interviewed by him.

84. He said that some of the things described by the Claimant, such a reliving experience and avoidance, could be symptoms of PTSD but did not justify a diagnosis. There was an overlap in symptoms between FM and PTSD. He agreed that, whilst IES-R scores obtained in a clinical setting by a trained therapist were valid, they had to be considered with all the evidence. However, equally the Claimant's subjective account needed to be considered against her Health Visitor and iTalk records. References in the medical records to 'flashbacks' had to be regarded with caution as this had a specific meaning in psychiatry and there was no reference to these in the iTalk records.

85. He agreed that whilst the Claimant had improved during therapy this did not mean that she did not have some continuing symptoms or that she was not vulnerable to another episode. He agreed that someone who has had depression is more vulnerable to further episodes, albeit that the Claimant had other predisposing factors. He did not accept that the Claimant did have depression after the surgery in 2018 but if she did, then the impact of the depression following birth had to be balanced against the techniques learned during CBT.

Submissions.

Liability

86. It is impossible to do justice to the full depth of the written and oral submissions that I received on the issue of liability. In her printed case, Ms Power submits that it is impossible to demonstrate on the medical literature that taking Aspirin at 12 or 14 weeks, as opposed to at 23 weeks, would have reduced the risk of HELLP and all its consequences by more than 50%. In this respect, she urged upon me the conclusions of the larger *Meher* and *Duley/Cochrane* studies demonstrating an effect of only 10-20% overall as opposed to the sub-group analysis by *Roberge*.

87. In relation to FM, she urges upon me the conclusion of Dr Armstrong that the gap in time was simply too great to enable a link to be made to the birth. Similarly, she invites me to prefer the evidence of Dr Briscoe in the context of the IES-R/PHQ-9 scores. She contends that stopping Aspirin (as was done) was an appropriate response to the Claimant's complaints of heartburn and a prescription of Ranitidine was not mandated.

88. In oral submissions she acknowledged that Professor Siassakos was ‘passionate’ but he had allowed his strongly held beliefs to colour his opinion. He had rejected other ‘gold standard’ evidence that ran contrary to it even though it had more power, less bias and better quality. She suggested that he was prone to making sweeping statements and that some of the criticisms levelled by him at *Meher* etc. (e.g. age of study) also applied equally to *Roberge*. She contrasted that approach with that of Mr Tuffnell who declined to rely on small studies (e.g. as regards HELLP) that might otherwise have supported his conclusions on the grounds that it would be incorrect to do so.

89. On the subject of heartburn, this was in the first instance a question of fact. Ms Power reminded me that there was no contemporaneous record of the reports that the Claimant now asserts she made. In any event nowhere in the Claimant’s evidence does she say when she made these reports. She submits that Professor Siassakos had accepted that prescription of Ranitidine was not mandated, nor is it mandated in the NICE guidelines. There is no evidence that it would have been efficacious; it did not relieve her epigastric pain in January 2018 and (according to the birth reflections recording) had no effect when administered during the delivery.

90. She reminded me that Dr Munglani has accepted that the liver resection was a ‘trigger’ for the Claimant’s FM, that there had been a significant deterioration thereafter, and that it was not appropriate to diagnose FM before November 2020. There were other explanations for the Claimant’s fatigue in the intervening period. If the liver resection was the trigger, then no question of contribution arose.

91. She submitted that Dr Munglani had accepted that there was no link between the birth trauma and FM if the Claimant's PTSD was mild and that this was how Dr Moore categorised it in the joint report. She further submitted that FM was plainly a divisible injury as it was dose related and at its highest (and in the alternative), the birth trauma had only contributed to severity.

92. She described the omissions from Dr Moore's report as both astounding and concerning, particularly in relation to the IES-R scores. She reminded me of the significant errors as regards the recording of those scores and otherwise. She submitted that Dr Moore dismissed out of hand any other assessment (including those made by the GP, the therapist, the health visitor and Dr Harmer) where it did not fit with her opinion. She simply attributed all symptoms (even where they might overlap) to PTSD/depression.

93. Ms Edwards was critical in her opening note of Mr Tuffnell's failure to recite the NICE guidelines regarding Aspirin in his report and suggested that he had 'made light' of the Claimant's PKD. She suggested that this called into question his impartiality. She was also critical of what she described as Mr Tuffnell's delegation of his analysis to *Tong*. She suggested that by contrast Professor Siassakos' opinions on timing and dose were supported by both the biological mechanism of placentation and by those studies that were closest to the Claimant's circumstances i.e. *Roberge*. She adopts Professor Siassakos' 'apples and pears' and age criticisms of the larger *Meher* and *Duley/Cochrane* studies.

94. She argues that a prescription of Ranitidine was the only logical response to the Claimant's reported problems with heartburn. On the issue of FM, she adopts Dr Munglani's continuum and says that it is unsurprising that FM went undiagnosed given the concurrent biomedical and psychiatric issues. As regards PTSD and depression, she challenges Dr Briscoe's expertise in perinatal trauma and criticises his reliance on the IES-R/PHQ-9 scores over the other evidence.

95. In oral submissions I invited Ms Edwards to address me on the precise timing regarding Aspirin. She said that the advice should have been given at 12 weeks with a 'backstop' of 14 weeks. If advised, the Claimant would have taken it. She submitted that it was misleading to characterise this case as one of 7, 9 or 11 weeks' delay without recognising that Aspirin has a different effect at different times.

96. She repeated her criticisms of Mr Tuffnell as 'tainting' his evidence. She noted that he did not suggest that there was a difference between severe pre-eclampsia and HELLP until the joint report and that in cross-examination he had accepted that the histopathological mechanism was the same. She suggested that Mr Tuffnell had failed to draw attention to the fact that *Duley/Cochrane* was a 'whole fruit bowl' containing predominantly later start times and lower doses. She urged upon me Professor Siassakos' statistical expertise and described Mr Tuffnell's reliance on *Tong* as troubling. She submitted that Mr Tuffnell had 'made up' his evidence regarding timing in the witness box.

97. She rejected Ms Power's criticisms of Professor Siassakos and suggested that he had made appropriate concessions, for example as regards the significance of *Duley/Cochrane*. She said that rather than 'cherry picking', Professor Siassakos was legitimately seeking data that most closely matched the Claimant's circumstances. *Roberge* and the trials therein considered prove the Claimant's case to the requisite standard, particularly as the Claimant's adherence would be higher than the average levels used there.

98. Ms Edwards acknowledged that the issue of causation of FM was complicated by the liver resection. However, whilst Dr Munglani had accepted that this was a trigger, he had also described the birth trauma as a potent cause. There was in this case a continuum and it did not matter that there may have been a fluctuation in symptoms. She submitted that there could be a prodromal phase for FM.

99. On the issue of PTSD/depression, she said that Dr Moore had the more relevant expertise. Ms Edwards did not shy away from the difficulties with her report but said that she was an honest witness who had made a mistake rather than having made deliberate omissions. She said that the IES-R scores had to be looked at in the context of all the evidence. It did not matter that they were sub-clinical for diagnostic purposes. It was agreed that the Claimant had had PTSD and accordingly she was entitled to recover for all the ongoing consequences.

100. The fact that the Claimant had reported herself as not suffering from depression did not mean that she was not. The best evidence that she had had PTSD since the birth was that she still had it in April 2020, albeit that it may have fluctuated in severity in the interim. She submitted that I also had the Claimant's own evidence (and that of her witnesses which had not been challenged); her description of her symptoms fell within the definition of PTSD.

Quantum

101. At the conclusion of the hearing, and in order to accommodate the additional scenario advanced by Ms Edwards, I gave both Counsel an opportunity to make further written submissions on quantum. Ms Edwards adopted the current (17th) edition of the Judicial College Guidelines for the Assessment of Damages in Personal Injury Cases ('the Guidelines') for the purposes of her submissions. Ms Power contends that, given that that version had not been published when this case was heard, the appropriate set for use was the previous 16th edition. By way of a short response, Ms Edwards reminded me that the current version of Guidelines reflected in large part the very significant inflation that had taken place since the 16th edition.

102. Ms Edwards submits that:

(1) In either scenarios B or C, the Claimant is entitled to recover damages of £10,500 for having to undergo an unnecessary caesarean section, based on the current Judicial College Guidelines for an exploratory laparotomy.

(2) In either scenarios B or C, the Claimant is entitled to recover damages of £50,000 - £55,000 in respect of her inability from a psychological perspective to have further children. This is Ms Edwards argues a reasonable decision forced upon her by her traumatic experience, her fear of recurrence and her lack of trust in medical professionals. It is indistinguishable from cases of a physical inability to have children and on that basis the appropriate award falls between 6(F)(c) and (d) in the Guidelines.

(3) In scenario B, the Claimant is (having regard to sections 4(A) and (B) of the Guidelines) entitled to recover damages of £30,000 - £35,000 for psychiatric injury, resulting in an overall award (after allowing for overlap) of £75,000 plus £2,800 for the cost of further CBT. She submits that the Claimant is entitled to recover for ongoing symptoms of PTSD/depression (dreams and reliving experiences, mood changes, anxiety, avoidance etc.) even if she was not diagnosable as such and she is now more vulnerable to further bouts of depression.

(4) In scenario C, the Claimant is entitled to recover damages of £40,000 - £45,000 for psychiatric injury based on ongoing PTSD at a mild level and depression at a moderately severe level, resulting in an overall award (after allowing for overlap) of £85,000 - £90,000 plus £16,875 for the cost of further CBT. She submits that account must be taken of the Claimant's loss of enjoyment of life, self-confidence and self-esteem, reduced concentration, the impact on her social life and on her relationship with her husband and Mia. She submits that useful comparators can be found in the Lawtel summaries for *AL v Royal Cornwall Hospitals NHS Trust*, *SW v Kettering General Hospital NHS Foundation Trust* and *GM v Royal Cornwall Hospitals NHS Trust.*

(5) For a simple failure to prescribe Ranitidine, the appropriate award is £3,000.

103. Ms Power's response, using the same numbering, is as follows:

(1) Ms Power rejects Ms Edwards' analogy with laparotomies, not least because a vaginal birth carries with it its own significant pain and discomfort, risk of complications and recovery period. She suggests that one can infer from the combined award in the unreported case of *ES v Hywel DDA University Health Board* that the element for a caesarean section was probably in the region of £2,000.

(2) Ms Power submits that the Claimant is not medically prevented from becoming pregnant again. Ongoing treatment for FM and the conclusion of this litigation (which both psychiatric experts agree will benefit the Claimant) may lead to a change of heart. However, on the basis that the Court finds that she will not now have further children, Ms Power submits that this case lies below the bottom of the bracket for section 6(F)(d) of the guidelines at £18,000.

(3) Ms Power submits that, on the basis of Dr Briscoe's evidence, the facts of this matter fall within sections 4(A)(d) (less severe psychiatric damage) and 4(B)(d) (less severe PTSD). She reminds me that the Claimant felt able to return to work even before CBT had begun. On this basis, an appropriate award would be an additional £6,000 plus £2,450 for future CBT. The figures are not adjusted further for overlap.

(4) Ms Power submits that any ongoing symptoms of PTSD/depression are mild, do not impact significantly on the Claimant's functioning and may improve. All or many of the Claimant's symptoms and such loss of function as there is would have resulted from FM in any event. On this basis, when placed correctly in the brackets for sections 4(A)(c) and 4(B)(c) of the Guidelines, the right figure would be £18,500, giving a total of £36,000 (£20,000 if it is found that the Claimant may change her mind about a future pregnancy). She rejects the comparators relied upon by Ms Edwards, primarily on the basis that the mothers in those cases had not returned to work either full time or at all. She concedes a further £13,125 for future treatment based on the possibility of two further depressive episodes.

(5) Ms Power describes this injury as a *de minimis* but in any event as one falling well within the minor injuries category of the Guidelines. On the Claimant's best case, Ranitidine would only have ameliorated her symptoms and she had other ongoing pain in any event.

Presumably, all of these figures would require some adjustment if the 17th edition of the Guidelines were to be the correct benchmark.

Conclusions.

Facts

104. The starting point for any consideration of liability and causation in this matter is of course the determination of the factual matrix. In this respect Ms Edwards is right to submit that the evidence of fact called by the Claimant went either largely (in the case of the Claimant and her husband) or entirely (in the case of Ms Walton and Mrs Fuller) unchallenged. Given that the Defendant's witnesses were not called to give evidence, little if any weight can attach to their written statements.

105. However, it does not follow that because the Claimant's evidence has gone unchallenged, it must be accepted uncritically. The Claimant must still satisfy me that it is more likely than not that her account is accurate. The Claimant clearly found the task of giving (and listening to) the evidence distressing and I make allowance for this. I also have to recognise that the Claimant is speaking of events that occurred over 7 years ago and that her recollection will inevitably be conditioned to some degree by the trauma of her experiences in both 2016 and 2018 and the undoubted impact on her mental health.

106. I have to weigh the risk that her recollection may be affected by her status as claimant in this litigation and by her obvious belief (manifested in her evidence) that she has been the victim of the medical profession, both in 2016 and in the lead up to the surgery in 2018. I must for these reasons measure her evidence against such contemporaneous records as exist.

107. In terms of the chronology, the first matter where findings of fact are required is in relation to compliance. When advised to take Aspirin at 23 weeks, the Claimant's evidence is that her husband bought her some gastro-resistant tablets. She later says that she ceased taking them on medical advice shortly before the birth. The clear inference is therefore that she was taking Aspirin throughout this period, although nowhere does she state her level of adherence.

108. I conclude that had the Claimant been recommended to take Aspirin at 12 (or 14) weeks, then she would have accepted that advice. I also find that in general terms she would have adhered to it, but not necessarily rigidly so. I have to bear in mind that she was suffering from gastric symptoms that can be a side effect of Aspirin use and that it therefore cannot be said that there were no factors contraindicating compliance.

109. The second issue upon which findings of fact are required is that of heartburn. It is as Ms Power submits very difficult to identify from the Claimant's witness statements when precisely she began to suffer from significant heartburn. Other than the clinical note for 15 July 2016 (at 27 weeks), all we have is her statement that she obtained a prescription for Gaviscon from her GP in late July/early August. Although in her witness statement she speaks of consuming 600ml of Gaviscon every two to three days, in her complaint to the Defendant made in December 2016 and therefore relatively contemporaneously with events, she states it at 600ml a week which is somewhat less remarkable.

110. In my judgment, the only report of heartburn that can be proved on a balance of probabilities is that recorded on 15 July when I am satisfied that it was at a sufficiently unpleasant level that merited a recommendation that she seek a prescription from a GP i.e. it was something more than intermittent or routine. 'Severe' should be understood in this more limited context.

111. The third and perhaps most substantial issue is that of the level of the Claimant's symptoms in the period between birth and the liver resection in April 2018. The Claimant describes feeling tired and fatigued following the birth. She is also clear that she was suffering significant pain from her liver cyst which progressed to unusual bruising and ultimately severe shoulder pain. It is common ground that she was suffering from PTSD and some degree of depression. All of this inevitably clouds the picture that emerges from the evidence.

112. The conclusion that I have reached on all of the evidence is that the Claimant did suffer from fatigue immediately after the birth (inevitably and understandably so at that stage) and then on a continuing basis thereafter. However, I also find as a fact that by April 2018 there had been a substantial improvement in both her fatigue and in her general mental health, as demonstrated by her IES-R/PHQ-9 scores, her CBT summaries and other clinical records, including for example the record of her depression being 'resolved' in July 2018.

113. This is not of course to say that she did not have continuing symptoms. PTSD and depression, in common with many other mental health difficulties, are not conditions that are capable of empirical cure in the way that, for example, a fracture can heal. She could properly be described as 'recovering' even after her symptoms fell below the diagnostic level. I do not doubt that the Claimant continued to have occasional nightmares and episodes of anxiety etc. I do however find that by April 2018 this was at what might be described as a 'mild' or residual level following successful treatment.

114. In making this finding, I am acutely conscious that this is one area where the Claimant's recollection, given the extent and duration of her suffering, might be vulnerable to hindsight. I am satisfied that the surgery in 2018, and its aftermath, were responsible for a significant escalation or resumption of her symptoms. This is particularly supported by the careful and comprehensive note and subsequent letter written by Dr Harmer on 23 October 2019 but also by the evidence of Ms Troy.

Ranitidine

115. It is common ground that heartburn is not an unusual feature of pregnancy. I have found as a fact that the Claimant was complaining of heartburn that, as she perceived it, went beyond what might be regarded as usual. The question however is whether a report of this kind mandated a referral to a consultant and a prescription of Ranitidine. I am not on a balance of probabilities persuaded that it did mandate an obstetrics referral and accordingly the recommendation made by Ms Stonock was a legitimate one.

116. Even were the position to be otherwise, Professor Siassakos rightly conceded that an obstetrics referral for 'severe' heartburn could have generated a number of possible outcomes, including no action, a recommendation for further or other 'white medicine', termination of Aspirin or Ranitidine. He has not persuaded me that only one of these options was *Bolam* available. There does in particular seem to me to be a disconnect between his clear evidence that Aspirin after 16 or at the latest 20 weeks has no effect on the one hand, and his refusal to accept that ceasing Aspirin at what I have found to have been 27 weeks at the earliest would have been an available and reasonable response and an alternative to the prescription of medication which was recommended for use in pregnancy only when necessary. Ceasing Aspirin was in fact the course taken (without criticism) on 1 September.

117. On this issue (and for some of the reasons given in the next section of this judgment) I accept the evidence of Mr Tuffnell that a referral to a consultant was not mandated. A recommendation for white medicine (as was made) or alternatively termination of Aspirin would have been reasonable alternative responses to the report made by the Claimant. I conclude that it cannot be shown that no reasonable, responsible and respectable body of opinion would have done anything other than prescribe Ranitidine. It is unnecessary in these circumstances to go on to consider any issues of causation in this respect.

Aspirin.

118. It is I think common ground that the mere fact that clinical guidelines mandated Aspirin at 75mg does not by itself assist in establishing causation to the requisite standard. This is because even the literature relied upon by the Defendant establishes that Aspirin at this dose has some modest benefits. Given that Aspirin is generally regarded as a safe drug with limited side effects, the risk reward balance is clearly in favour of administration.

119. Professor Siassakos is clearly well qualified to express an opinion on the issues arising in this matter, although he is primarily a professor in Obstetrics rather than a Consultant Epidemiologist. He gave his evidence with an obvious passion and struck me as sincere in his belief in the effect of Aspirin at 75mg administered before 16 weeks but not later.

120. I do however fear there is force in Ms Power's submissions that this passion affected his impartiality, not in the sense of advancing the case of his instructing party but in the sense of being unwilling to recognise and balance countervailing evidence; the 'flexibility of mind' referred to in *Loveday v. Renton*. He was unwilling save in very limited respects to make any concessions. He was also in my judgment prone to making sweeping statements.

121. One example was his evidence that *Poon* and *Richards* established that Aspirin had no effect for women with pre-existing hypertension when, as he eventually conceded, those papers merely concluded that the 'jury was still out' on this issue. I was particularly struck by his suggestion, made more than once, that to take a different view to his own was verging on being clinically improper. His contention that *Meher* was 'the outlier' was patently unsupportable having regard to the broad sweep of research outcomes. If there is an outlier, and I am far from sure that it is appropriate to categorise analysis in this way, then it is *Roberge*. Finally, I noted his readiness to criticise *Meher* as relying on 'old data' whilst being willing to ignore the fact that a similar criticism could be made of *Roberge*. The issue is in my judgment in any event not age but quality.

122. Mr Tuffnell is not free from criticism. Ms Edwards' criticisms for example of his reluctance to categorise the Claimant as at high risk and his omission to mention the NICE guidelines in his report were well made. There is also some force in her contention that Mr Tuffnell's reliance on *Tong* suggested a relatively lesser expertise in statistical analysis. It cannot however I think be contended that Mr Tuffnell does not have an appropriate level of expertise given his professional history and in particular his authoring of Cochrane reviews. Overall, he struck me as more measured, more willing to make concessions and recognise contrary arguments whilst at the same time providing a coherent basis for his opinion.

123. The outcome cannot of course depend simply on a subjective assessment of the experts. Their conclusions have to be tested against the biomedical context and against the literature itself. So far as the former is concerned, and given that poor placentation is currently considered to be the primary cause of pre-eclampsia, it is right to recognise that there are some good reasons why Aspirin might be more effective if administered before the point at which placentation is complete. I do however accept Mr Tuffnell's evidence that there are also reasons to believe that Aspirin administered after that time may have some continuing benefit. He provided a coherent explanation for why that might be so and I was not impressed by the fact that professor Siassakos dismissed this out of hand.

124. So far as the literature is concerned, there is an obvious attraction to professor Siassakos' argument that if he was picking cherries, then this was because this was the right fruit. I am however persuaded that the bowl of cherries he has used is just too small, and too uncertain in quality, to support the conclusions that he draws. There is in my judgment an obvious danger (identified in *Roberge* itself) in taking two relatively small RCTs and over-extrapolating outcomes from the data. This is all the more so when there are genuine question marks over the reliability and relevancy of the data in *Ebrashy* for the reasons identified by Ms Power and where so little is known about *Zhao*.

125. More generally, there appears to be considerable force in the suggestion that studies based on AD seem to observe greater effects than those based on IPD. As the authors of *Duley/Cochrane* observe, *"...It is not plausible that treatment effects really are bigger if IPD were not available."* Given the broad (but not unqualified) agreement that AD is at risk of publication bias and that IPD is more precise and allows for more sophisticated analysis, this is a further reason to exercise caution in respect of the outcome of a small AD review where the confidence interval cannot, with respect to Professor Siassakos, be categorised as narrow. Considerable weight must instead attach to the outcome of a large, 'gold standard' review with narrow confidence intervals, whilst of course recognising the impact (to some degree) of the mixing of fruit and factors such as adherence and hypertension.

126. Finally in this respect, Professor Siassakos drew great comfort from *ASPRE* as supporting his opinion. Given however that he was clear that there was a very significant dose response relationship, it was unclear to me exactly why that should be. I accept Mr Tuffnell's explanation for why 150mg Aspirin might have a particular effect. I merely note in passing that although *ASPRE* did not specifically consider outcomes for severe pre-eclampsia, the observed effect of 150mg dose on pre-eclampsia (with good adherence) is only marginally greater than that reported in *Roberge* for 75mg, suggesting an underestimation in the former or an overestimation in the latter.

127. I return to my essential task which is to weigh the expert evidence and to give the statistics such weight as I deem appropriate reminding myself in the process in particular of what is said in paragraph 28 of *Gregg v. Scott*. I have in mind all of the arguments and I have weighed in the balance the possible effect of adherence on the one hand, and the fact that we are considering HELLP rather than general severe pre-eclampsia on the other. Having done so, I recognise the possibility that further RCTs and analyses will more conclusively establish both the dose and timing effect of Aspirin. However, taking all the current evidence together, it is in my judgment simply not possible to find that on a balance of probabilities this Claimant would have avoided developing HELLP had she been advised to take 75mg Aspirin at 12 (or 14) weeks instead of at 23.

Pain

128. In the light of my findings in relation to Aspirin, it is technically unnecessary to go further. However, in deference to the arguments put to me it is right that I should make findings in relation to the remaining elements of causation, albeit in relatively short form.

129. In relation to FM, the factual findings that I have made above are of obvious importance. There is an attraction to Dr Armstrong's central and simple contention that there was in this case too long a gap between the Claimant's birth trauma and the onset of diagnosed FM to make the link, even allowing for any element of 'masking' by other issues. This is all the more so given that there was an intervening trauma in the form of the liver resection which on the evidence had significant consequences for the Claimant's state of mental health.

130. By way of balance, I found Dr Munglani to be an impressive expert who was willing to be flexible of mind and whose evidence did evolve over the course of his journey from report to witness box. However, his conclusions depend ultimately on his asserted continuum, both in respect of the Claimant's fatigue and perhaps ultimately more significantly, on the continuing severity of her PTSD. Given the numerous other competing possible causes, I am not persuaded that fatigue by itself provides the necessary prodromal link. In the light of the conclusions drawn in the next section of this judgment (that the Claimant no longer suffered from clinical PTSD by April 2018 and that therefore it cannot be described as 'significant), even on Dr Munglani's evidence the link cannot be made.

Psychiatry

131. It was in this respect that the difference between the experts called by the parties was most stark. I found Dr Moore's omission of the full set of IES-R and PHQ-9 scores from her report to be extraordinary for an expert who should be weighing all the evidence. The error in the December score might have been a genuine mistake but it is troubling that it is largely the lower scores that were omitted. This is damaging by itself but it was unfortunately consistent with the tenor of the remainder of her evidence. She struck me as being invested in the Claimant's perception and completely unwilling to recognise the possibility of any alternative diagnosis or cause for the various symptoms reported by her. I was unimpressed by her simple dismissal of any clinical record that suggested a contrary view.

132. By contrast, I found Dr Briscoe to be an impressive expert who gave his evidence confidently, authoritatively but even-handedly. I accept his evidence that displaying symptoms of PTSD or depression is not the same as having those conditions. I find that following the birth the Claimant did have PTSD and mild to moderate depression but that these conditions responded well to CBT as shown by the scores and that she was no longer diagnosable by early 2018. I do not doubt that, but for the liver resection in April 2018, she would have continued thereafter to have some symptoms at a sub-clinical level which would have further resolved with time. However, the recurrence and continuing level of her mental health difficulties after April 2018 (whatever their level and whatever the correct label might be) was a result of the events at that time.

Quantum

133. It is neither necessary nor appropriate to address the issue of quantum in the light of my findings on liability and causation, save in two respects. First, FM is plainly (even on Dr Munglani's evidence) a divisible condition as its severity is dose sensitive. Secondly, Ms Edwards is quite right to adopt the current edition of the Guidelines for the purposes of considering quantum. Inflation is the principal (although not the only) driver of the revision in the brackets for awards and it would be wholly artificial to ignore it for the purposes of assessment simply on a publication date basis.