



Neutral Citation Number: [2025] EWHC 2576 (KB)

Case No: QB-2022-002633

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 29th October 2025

Before:

HIS HONOUR JUDGE SIMON
SITTING AS A JUDGE OF THE HIGH COURT

Between

MRS ALISON MARIE TARRANT

Claimant

- and -

MR SIMON MONKHOUSE

Defendant

Ms H Tibbitts (instructed by **RWK Goodman LLP**) for the **Claimant**
Ms A Hughes (instructed by **Clyde & Co LLP**) for the **Defendant**

Hearing dates: 23 – 25 June 2025

JUDGMENT

This judgment was handed down remotely at 10:30am on 29 October 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

HIS HONOUR JUDGE SIMON:**Introduction**

1. This is a claim in negligence arising out of complications following bariatric surgery. By an order dated 20 November 24, the trial before me was a liability only trial, dealing with breach of duty and causation.
2. The Claim initially encompassed issues relating directly to the performance of the sleeve gastrectomy procedure (the procedure). Shortly before the trial, leave was given for the claim to be amended. The parameters of the claim at trial are set out below at paragraph 15.
3. For ease, I set out in tabular form the identity of the witnesses in this case, their role and the abbreviation adopted to refer to them in the body of the judgment:

<i>Name</i>	<i>Role</i>	<i>Abbreviation</i>
Mrs Alison Tarrant	Claimant (patient)	C
Mr Simon Monkhouse	Defendant (surgeon, member MDT)	D
Lucy Jones	Bariatric dietitian (member of MDT)	LJ
Sarah Wigglesworth	Psychotherapist (member of MDT)	SW
Sarah Roche	Bariatric nurse (member of MDT)	SR
Mr Vittal Rao	Bariatric surgeon – C’s expert	Mr Rao
Mr Sackhawat Rahman	Bariatric surgeon – D’s expert	Mr Rahman

Background

4. C was born in 1983. Prior to the procedure, she was employed as a paramedic.
5. D was, at all material times, a Consultant Upper GI and Bariatric Surgeon. C was a private patient of the Defendant through his clinical practice at the Spire Hospital, Gatwick (the hospital).
6. In 2019, C contacted a company called Healthier Weight to explore the possibility of weight loss surgery, and a consultation was arranged for her to meet with D. C met with D in his clinic on 20 August 2019 to discuss her weight loss options, including surgical options. Following this consultation, C informed D that she wished to proceed with the proposed sleeve gastrectomy.
7. Prior to the procedure, C was reviewed by D’s team, including a specialist bariatric dietitian, a psychotherapist/counsellor and a bariatric nurse. She was found to be a suitable candidate for the planned procedure and underwent a thorough consenting process.
8. C proceeded with the sleeve gastrectomy surgery, under the care of D, on 24 September 2019.
9. C had regular contact with the bariatric nurse in the first week following her surgery, when she initially struggled with nausea and vomiting but gradually improved. At an appointment on 3 October 2019, she confirmed that she had transitioned from fluids to

slushy foods but was struggling with comfort when her food was going down. She was given advice by the bariatric nurse.

10. C was reviewed by the bariatric nurse on 29 October 2019, and complained of food getting stuck in her throat, even foods of a sloppy texture. The bariatric nurse sought advice from D. As a result, D arranged for C to undergo a barium swallow to investigate her symptoms further.
11. The barium swallow procedure took place on 13 November 2019. The radiological report noted that:

“There is intermittent mild delay or hold up of contrast at the GOJ (gastro-oesophageal junction) with transient pooling of contrast within the lower oesophagus for 10-30 seconds...no fixed stricture or stenosis is demonstrated...”.
12. On 27 November 2019 D initiated contact with C via Facebook Messenger, a medium used by patients for communication, to ascertain whether her symptoms were improving. C advised him that she was “*feeling quite weak at the moment as struggling to get enough food in*”. Later the same day, D performed a gastroscopy on C which then led to a balloon dilatation procedure. [For consistency, I have referred throughout to a ‘gastroscopy’ for the first of these procedures, although it is also referred to as an ‘endoscopy’ in some of the evidence.]
13. Subsequent to the gastroscopy and dilatation C suffered a sleeve leak. She underwent a laparoscopic conversion of the sleeve to a gastric bypass, adhesiolysis (release of adhesions in the abdomen) and the insertion of a drain to the left upper quadrant of the abdomen under the care of a different surgeon at St George’s Hospital on 7 December 2019. C was transferred to intensive care post-operatively and was subsequently discharged on 12 December 2019.
14. Following conversion to a gastric bypass C continued to experience pain and symptoms of restriction and vomiting with poor oral intake, malnutrition and an inability to tolerate solid food. In September 2022 she underwent insertion of a JEJ (jejunal) feeding tube for supplementary nutrition. C has spent prolonged periods in hospital receiving dedicated nutritional care. She continues to experience significant health issues.

Issues at trial

15. Following the amendment by consent of the claim, deleting the elements relating to consent and to performance of the gastrectomy procedure, the issues at the liability trial were:
 - (i) Whether there had been a breach of duty by D in failing to provide C with reasonable post-operative care following the sleeve gastrectomy;
 - (ii) Whether there had been a breach of duty in proceeding with the balloon dilatation;
 - (iii) Whether the breach(es) of duty caused injury or damage to C.

16. It was clear that the issue of causation remained live in respect of the alleged breach of duty relating to post-operative care (paragraph 15(i) above), but it was sensibly conceded by D that, if the Court found a breach of duty in respect of the balloon dilatation (paragraph 15(ii) above), then causation would obviously be established.
17. C's case in brief on the balloon dilatation was that there was no good evidence of stricture and conservative treatment measures should have been attempted and exhausted before embarking on the dilatation procedure.
18. D's case in brief was that C's presenting symptoms post-operatively were suggestive of some restriction at the GOJ, rather than an issue that might be susceptible to external (dietary and/or psychological) input. This was supported by the barium swallow and then by the gastroscopy, justifying the balloon dilatation procedure. Despite cautions applied, C developed a sleeve leak, but neither the dilatation procedure, as a response, nor its performance were negligent.
19. The evidence at trial of Mr Rao, C's expert witness, was that he had considered the written and oral evidence of C, D and D's witnesses and had formed the view that, if the Court were to accept the defence evidence about the accuracy of the medical notes post-operatively, then the care provided up to the point of the gastroscopy would be considered reasonable. Alternatively, if the Court accepted C's evidence about additional contact and/or further information of concern passed on by C then the failure to escalate the response from the bariatric nurse to the specialist dietitian and the psychotherapist would amount to a culpable failure and a breach of duty.
20. In the circumstances, the first consideration is resolution of the factual issues around the post-operative care and communication between C and D and his team.

Evidence

21. What follows is not intended to be an exhaustive and complete resume of the written and oral evidence of C, D and D's witnesses. In reaching my conclusions I have taken account of all the relevant evidence on the issues that require determination. Some evidence is referred to because it assists in the assessment of reliability.
22. C said that she recalled discussing types of food, textures and expected progression post-surgery with one or other of the MDT, although she could not recall if all of this was necessarily discussed before surgery. She agreed that LJ advised her about having a relatively high protein diet but did not recall the 'bariatric plate' including fruits/vegetables and carbohydrates. The importance of chewing well and not eating and drinking at the same time was made clear. C agreed that LJ had told her to be in touch with any problems with food post-surgery but denied there had been any reference to the potential for pain or vomiting or that this should not be tolerated and should be reported straightaway. She said if that information had been given to her, she would have been concerned about having surgery. C maintained her position that there had been more contact with the bariatric nurse than contained within the medical notes and that there were additional FBM communications between herself and D not contained in the pages of messages disclosed on both sides. As to the latter, she had disclosed into the proceedings all the messages that she could access.

23. Mr Rao placed some considerable reliance on one observation from the pre-operative assessment by SW of C, to the effect that C was “*not unsuitable for surgery but will likely need support*”. In her oral evidence, SW accepted that C had described experiencing depression and loss, but that these were not at levels greater than those seen in others in similar circumstances. SW rejected the suggestion that C was potentially vulnerable, which was not her presentation. SW could have been contacted directly by C but the indications post-operatively were that C was struggling with adjustment to the surgery, not that she was feeling unwell psychologically. If that had been said, then others in the MDT would have alerted SW.
24. Asked about SW’s note in respect of post-operative support, D said that the majority of his patients came with childhood trauma or traumatic life events, but there were no red flags that would stop C’s surgery. He saw C in hospital before discharge and he relied on two forms of communication thereafter: through the MDT, though primarily SR because she is the only member of the MDT permanently at the hospital and therefore available; and FBM which had become a medium for communication with patients and was one that C used. By the third day post-surgery, D had been made aware by SR that C was really struggling. It was most likely dehydration, and a bed was secured for her return for assessment. There was then no contact between 3 October and 29 October 19. Had there been a message from C that she was struggling there would have been advice to go back a stage in the reintroduction of different consistencies of food and then to seek to progress again, but there was no evidence that C contacted him.
25. By 29 October 19, D was aware of C complaining about food becoming stuck; the information came through SR. C’s difficulties were highly unusual in D’s experience at the six-week post-operative point, particularly because D had used the widest sleeve for the procedure (a 40 Fr bougie). To rule out a mechanical issue required a barium swallow. D did think at first that there may be some narrowing. The description given by C was a fairly ‘textbook’ description of narrowing, with the reports of vomiting being consistent with a mechanical obstruction. A normal barium swallow result would trigger psychological and dietetic support, but if the difficulty were mechanical, such support would not resolve it. D explained that it would be standard practice for him to sit with the radiologist and go through the barium swallow imaging, because the report alone does not provide the full picture. D accepted that this point was not covered in his statement.
26. D’s sitting with the radiologist would have been done after radiological reporting, with playback of the imaging. He said he did not rely solely on the radiological report, and it was his clinical opinion of the information as a whole that there was a GOJ stenosis. The pooling of liquid for as long as seen in the radio-imaging was abnormal and it cleared through a narrow segment. D concluded that something was preventing C’s oesophagus from opening normally. D denied ignoring evidence that weighed against narrowing, relying again on the visible abnormality in the context of a six-week history of suffering. The next diagnostic stage was gastroscopy with dilatation if appropriate. D had not set out with the intention of performing dilatation, which he would have avoided, if at all possible, but he could not leave a patient who was clearly suffering and struggling without investigating further and acting if necessary. He was clear that C was on the correct nutrition and hydration; no dietetic advice would have made a difference.

27. As to the dilatation itself, the balloon used by D was very small, a 20 fr size (half the size of the sleeve) and it was applied very gently. D emphasised that it was used to dilate the oesophagus at the GOJ, not the sleeve itself of which the staple line is a margin of a centimetre from the GOJ. The decision to proceed to dilatation followed on from D's findings during the gastroscopy. The diameter of the GOJ is 13 millimetres and the scope used for the gastroscopy was 9 millimetres. D felt the endoscope was slightly gripped when going through the GOJ. D's operation note, including a question mark, means that it took a little bit of gentle pushing to get the endoscope through. The inflammation observed matched with the barium swallow findings and C's reported symptoms. The operation note was written on the day with the letter relating to it completed the same evening – this was not “concocted” as was suggested on C's behalf. Radiological evidence after the balloon dilatation showed an improvement.
28. LJ emphasised that, whilst there was a lot of dietetic information for a patient to consider in adjusting to life post-surgery, such information is not communicated during a one-off appointment with the dietitian, but rather it is standard advice given by all in the MDT consistently in the pre-operative stage and through support in the post-operative stage, as well as being provided in writing. In LJ's experience, the intervention and support of SR is sufficient in most cases, and it is rarely necessary to escalate matters to LJ. However, when required, naturally LJ would be available. LJ's personal experience of sitting in on SR's consultations gave her every confidence that she (SR) was giving accurate dietary advice. This was borne out by various references in SR's notes on which LJ commented, relating in particular to adequate hydration, nutritious fluids and energy levels. From a dietetic perspective, based on the records, SR's support was appropriate.
29. SR was taken through the relevant records, in particular the daily contact logs from the immediate post-discharge period. It was put to her that C complained of vomiting at the one-week post-operative stage, but SR said that if this had happened, there would be a note in the records as this would have been a red flag, and this would have been passed on. She could not see a way in which she would not have noted something so significant. SR also said that if there had been a telephone call, as C's evidence suggested, to say that she was extremely unwell and very weak, SR was sure that she would have acted on this and passed it on to D. It would not be unusual to feel weak ten days after surgery, but if C had communicated being very unwell, then SR would have acted differently. SR had daily contact with D. The quality of her record-keeping was challenged, but SR said she checked her work mobile and there were no messages from C asking for a call back. She considered herself a good practitioner, who does write things down, especially if patients are telling her that they are vomiting, for example. This would have been recorded and reported to D. SR would have been very concerned if she had ignored a report of vomiting; she would not have left that as an outstanding issue and would have acted at the time, not waiting for the next scheduled review. SR's communicated concerns to D led to the barium swallow procedure, because it sounded like a mechanical issue that needed input from a surgeon.

Findings of fact

30. In reaching determinations about the evidence, I introduce my findings with trite but nonetheless important general points. C bears the burden of proving any disputed fact to the civil standard, being on the balance of probabilities. The relevant evidence comes in the form of witness statements, oral evidence and documentary evidence. In respect

of the evaluation of witness evidence – written and oral – this can usefully be divided into two aspects. The first is credibility, which is in broad terms an assessment of motive; is the witness giving honest evidence, intending to assist the Court to the best of their ability? The second is reliability, being the extent to which that which the witness is saying can positively be accepted and used to form the basis of judicial findings, whether directly or by reasonable inference. There are many factors that can affect reliability, and the Court is cognisant of the generally accepted principles in the case law about the fallibility of memory in this regard as well as the impact of the passage of time. Reliability is also not an all or nothing commodity; a witness may be reliable on one topic, for example, but not on another. It follows that an entirely credible witness may yet be unreliable in relation to some or all of their evidence.

31. I begin with C's evidence. I note that her statement in the proceedings is dated 15 September 24, some five years after the events. Whilst it is likely that C was asked to recall various pieces of evidence much earlier than the date of her statement, the claim itself was issued some three years after the events. In the meantime, C unquestionably suffered the wide-ranging and serious consequences of the sleeve leak that she sets out in her evidence and that are described elsewhere in the papers. Those consequences have persisted since November 19 and it would be surprising if the panoply of difficulties were not to have had some detrimental impact on C's capacity to recall accurately the sequence of events and the nature, content and timing of every communication with D or a member of his team at what must have been a very distressing time, just as it was challenging in so many other respects. There is documentary evidence on which C can rely, for example FBM messages that she sent to D, which have been disclosed into the proceedings. C says that these are not complete and that the same is true of the records of interactions with the MDT, specifically SR, in the post-operative period.
32. It is not suggested by D that C is anything other than a credible witness, to use my terminology; that is, a witness who honestly believes that the evidence she has given is true and accurate. I agree; C said nothing during the course of her oral evidence that would give me any cause for concern about her credibility. However, and I emphasise without the slightest criticism of C, I cannot conclude that all her evidence is reliable. By way of example, C gave evidence that she was vomiting at the point of discharge post-procedure on 26 September 19. Leaving aside the inherent unlikelihood of any patient being discharged in that state, and perhaps especially in the case of a bariatric patient, SR's evidence on the point is clearly to be preferred. This was to the effect that C would certainly not have been discharged in circumstances where she was vomiting. There was documentary evidence in the discharge paperwork that went to support SR's evidence, rather than C's.
33. A further example is that whilst C recalled LJ telling her about the need for a high protein diet, she did not remember other aspects of dietary advice, which would have gone hand in hand with this advice when visualising a 'bariatric plate' of food, relating to fruits and vegetables and carbohydrates. I reiterate that I quote these examples not to embarrass or to criticise C in any way, but simply to illustrate that her memory of events is not as reliable as she genuinely believes. In answer to a direct question in cross-examination about the impact of events post-operatively, C accepted that they had affected her memory. That was a very honest and understandable concession.

34. C's evidence was that other FBM messages, beyond those disclosed by the parties, were exchanged between herself and D. Those messages that had been disclosed (by both parties) ran to many pages and covered a significant post-operative period. Ms Hughes invited me, during the trial, to take judicial notice of the FBM application-generated message just before the first printed message in time as indicative of there being no earlier messages, despite what C had said in her evidence. Whilst I refused the invitation for the reasons I gave at the time – which included simple technological and/or practical reasons for the appearance of such messages – in the absence of some supportive evidence for C's assertions, I am unable to find that she has discharged the burden of proving that such messaging took place, still less what it was likely to have said. Additionally, given C's then continuing difficulties with progressing through food types post-operatively in the staged manner of expected recovery, I find it improbable that a communication of relevance and importance from C would not have been documented by D or SR, whichever of them had been contacted.
35. It is important to subject the evidence of D and his witnesses to a similar assessment, particularly given the nature of the challenge to D's and SR's record-keeping. Whilst this evidence is based to a degree on independent memory, it is rooted in a combination of the medical records and other documentary evidence pertaining to C's interactions with each member of the MDT. It is then augmented by the established pattern of working of each member of the MDT individually, and of the MDT as a whole. By September 2019, the members of the MDT involved in C's case had been working closely together for some years. In the case of LJ and SR, they gave evidence about how they spent time additionally in direct observation of each other's clinics and clinical approach so that the skill set of one might be enhanced by exposure to that of the other. Given the particular specialist focus of the MDT, it seems to be that each member of it, when giving evidence, is able to draw and rely on their usual or standard practice as at the relevant time, alongside the documentary evidence, because they will have developed a process whereby they ensure that each patient receives, orally and in writing and in a consistent manner, all key information pre-operatively. A considerable amount of information was provided to C pre-operatively and, in the main, she accepted receiving it. I am satisfied that she will not only have received all the standard information, but also that she will have been taken through it and the associated advice in accordance with the evidence of D, LJ, SW and SR.
36. As far as the evidence of D, LJ, SW and SR generally is concerned, I found each of them to be a credible witness and that their evidence, despite the challenges advanced on C's behalf, was indeed reliable.

Factual findings

37. For the reasons set out above, I have concluded that the medical notes of C's interactions with SR post-operatively and the FBM messages form, on the balance of probabilities, a complete, accurate and reliable record.
38. Having reached that conclusion, I accept, as Mr Rao did, that considering each of SR's notes of contact with C post-operatively, any concerns raised by C were dealt with reasonably and appropriately.
39. The aspect of the claim relating to post-operative care is, therefore, dismissed, save to the extent that it still features at the point between gastroscopy and dilatation.

Revised issues

40. The remaining issues that the Court must resolve can now be reformulated as follows:
- (i) Whether there had been a breach of duty by D in failing to provide C with reasonable post-operative care from the point immediately following the gastroscopy and before the balloon dilatation;
 - (ii) Whether there had been a breach of duty in proceeding with the balloon dilatation;
 - (iii) Whether the breach(es) of duty caused injury or damage to C.
41. In practical terms, this reformulation rather blends the remaining breaches of duty together to form the two sides of the same decision by D. The question now is whether it was a breach of duty for D (i) not to pause immediately post-gastroscopy and set in motion a MDT approach involving the dietitian and psychotherapist and/or (ii) then to proceed with the balloon dilatation. The causation issue (iii) remains live and in dispute in respect of (i).

Expert evidence

42. From the Medical Literature Bundle, the following papers featured most prominently in the oral evidence of the experts:

<i>Title</i>	<i>Author (short format)</i>	<i>Reference in judgment</i>
Endoscopic balloon dilation for treatment of sleeve gastrectomy stenosis a systematic review and meta-analysis	Chang et al (2020)	Chang
Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children	NHS NICE Clinical Guidance (2006)	NHS Guidance
Guidelines for the follow-up of patients undergoing bariatric surgery	O’Kane et al (2016)	O’Kane
Oesophageal motility after laparoscopic sleeve gastrectomy	Sioka et al (2017)	Sioka
Gastric stenosis after laparoscopic sleeve gastrectomy	Rebibo et al (2015)	Rebibo

43. Mr Rao was called as the expert witness for C.

44. He is a Consultant Upper Gastrointestinal, Laparoscopic and Bariatric Surgeon and he provided two reports as well as contributing to the joint expert statement. During the course of cross-examination, he accepted various propositions put to him on behalf of D that provided a somewhat clearer context for his opinions than may have been obvious from his reports. For example, he had referred in his main report to the difficulties experienced by C in week three post-operatively. Although his report said he had drawn the information from the medical records, he accepted that this was not correct, there being no recorded contact between C and any of the MDT between 3 and 29 October. He could not pinpoint the source of the information but accepted that it may have come from C's written evidence. By reference to O'Kane paper, Mr Rao advanced the view that the private sector ought to mirror the NHS in terms of best practice. He agreed that SR was the most readily accessible member of the MDT and that she was giving advice in line with what might be expected of a dietitian up to 3 October, but when things seemed to be going wrong thereafter, he stated that a full reassessment by a dietitian was required.
45. Mr Rao agreed with Ms Hughes that, if the Court were to accept the evidence in the contemporaneous medical records as a complete record of interactions, then the post-operative care of C was reasonable up to and including the performance of the gastroscopy on 27 November 19. It was from that point in the chronology, he opined, that there should have been a MDT review to consider what, if any, action should be taken and by whom. He took the view that dietetic and psychological input was required, given C's presentation of difficulties and given the pre-operative psychotherapeutic assessment.
46. Mr Rao did not accept that performing a balloon dilatation or do nothing (in the context of D's finding of a possible narrowing, coupled with the barium swallow result) were the only options because of his view about the need for a MDT review. Nevertheless, he was candid that he could not say what dietetic or psychological interventions might be suggested as these were outside his field of qualifications. He also accepted that the barium swallow was a reasonable investigation because usually in clinical practice one would investigate the physical before the psychological. As to whether a barium swallow could miss a functional stenosis, Mr Rao said it could not but relented when taken to the Rebibo paper.
47. Mr Rao was strongly of the view that a balloon dilatation was only to be conducted in the presence of confirmed stricture and equally strongly of the view, it seemed, that such stricture would only be expected at the distal end of the sleeve (the incisura angularis) usually as a result of twisting. He would not countenance stricture at the proximal end, at the GOJ. However, Mr Rao's use of the term's 'stricture', 'stenosis' and 'narrowing' was to say the least difficult to follow and, from a careful review of his evidence, seemed to shift depending on the context in which he wished to use it, particularly regarding the term 'stenosis'. At times, Mr Rao appeared to be using it as a synonym for narrowing, but at other times he sought to distinguish the two. He referred to D's opinion of there being narrowing at the GOJ as "his subjective interpretation". In Mr Rao's view there had to be "definite evidence of organic or functional stricture" before considering balloon dilatation.
48. Mr Rao's general opinion was that one would expect the bariatric dietitian to be the point of contact post-operatively and he referred to guidance issued for the NHS. He

did accept that the established MDT in this case worked closely together and there appeared to be good practice in the way in which it operated.

49. As part of his evidence, Mr Rao also accepted that C's symptoms were indicative of narrowing but added dysmotility as an alternative explanation. Despite this, he acknowledged that it was reasonable to view narrowing as top of the list of possibilities. However, he expressed the opinion that once the barium swallow and gastroscopy had ruled out mechanical stricture there was "nothing to treat" and a practitioner would then look at other problems that C might have. He added that he would have engaged the dietitian and psychotherapist/counsellor alongside the investigative measures but conceded that it was reasonable to address possible physical causes first and input from the other members of the MDT subsequently. He referred back a number of times to SW's assessment of C as potentially needing post-operative support, even when it was put to him that there was no evidence that C was in fact having difficulties coming to terms with the changes to diet and lifestyle.
50. Mr Rao provided an anatomical description of why he suggested dysmotility was another possible explanation and which should have been considered immediately following the gastroscopy, taking a "step back" as he described it.
51. Mr Rao was asked by Ms Hughes to explain his understanding of the *Bolam* test, which he had mentioned by name in his report. The answer he gave did not disclose an accurate understanding and/or an ability to explain the test applicable in cases of alleged clinical negligence.
52. Mr Rahman was called as the expert witness for D.
53. He is a Consultant General Surgeon with a special interest in Pancreaticobiliary, Upper Gastrointestinal and Bariatric Surgery. Although his academic interest is in matters related to the pancreas, his clinical practice, both NHS and private, is 50% bariatric-related. He had relied on the contemporaneous medical notes for his assessment of the case, because factual disputes between the parties' witnesses were for the Court to resolve.
54. He accepted that there was a risk of perforation from balloon dilatation (noting that such risk existed just from the gastroscopy) but pointed out that in the paper by Chang the risk was assessed as 2/432. The risk was also related to the size and type of balloon used. Mr Rahman noted that none of the papers actually dealt with use of a small balloon, as was used by D. He said, in his opinion, the risk was tiny and probably well below 1/500 or 1/600. The presentation of C's symptoms, where food was getting stuck, together with the findings of the oral contrast swallow, suggested an abnormality. It was then reasonable to perform a gastroscopy followed by a dilatation if narrowing was found – and such a finding would correlate with the radiological findings and the history given by C.
55. Mr Rahman agreed that there were multiple potential causes for the symptoms described by C, but he rejected Mr Rao's suggestion that the intermittent holdup of contrast in the barium swallow was consistent with dysmotility. He referred to the Sioka paper which looked specifically at changes in pressure, comparing results before and after sleeve gastrectomy operations. Although Mr Rao was correct about the

reduction in length of lower oesophageal sphincter, pressure readings were in fact lower post-operatively in such cases and not higher as Mr Rao described.

56. In response to the various papers relied on by Mr Rao, Mr Rahman disagreed with the suggestion that they clearly supported dilatation only with a confirmed stricture or stenosis. He first provided a careful and intelligible explanation of what was encompassed medically and physically by each of the three terms in contention: stricture, stenosis and narrowing. He then provided commentary on the various papers to explain why they were not as supportive of Mr Rao's position as might appear superficially. This included, for example, why distal gastric stenosis would often be the result of twisting, whereas this would not be the case at the proximal end, the GOJ, as in C's case. It was therefore understandable that papers defining stenosis as twisting would not include stenosis at the proximal end. He opined that functional stenosis at the proximal end is harder to detect and is more likely to be the result of inflammation or distortion at the top of the gastric sleeve. He did not disagree that functional stenosis at the GOJ was less likely than at the incisura angularis, but many of the papers had either not looked for such cases or such cases were under-reported. Many of the papers also involved a relatively small number of cases and this had an impact on their wider applicability.
57. Whether functional or mechanical stenosis, Mr Rahman was clear that in his opinion it was reasonable for D to perform the dilatation. This was especially so bearing in mind the size of the balloon and the limited duration of its use. The fact that a perforation occurred from the use of the small-sized balloon, was itself strong support for the presence of stenosis or narrowing. Mr Rahman also explained that D's query as to tightness on the gastroscopy, contained in the surgical note, was when D was using a 9mm scope. It would have been even more obvious if a regular 9.6mm scope had been used. Taking the preoperative findings and the post-operative outcomes as a whole led him to conclude that the balloon dilatation was "absolutely reasonable".

Submissions

58. Having reached the factual findings about the lay evidence in this case, which incorporated the central submissions of both counsel on that evidence, I summarise here only the submissions made in respect of the expert evidence.
59. Ms Hughes' primary point was that Mr Rao's evidence simply did not support a conclusion that there was no body of reasonable and responsible bariatric surgeons who would have performed a balloon dilatation in the circumstances presenting to D at the point of the gastroscopy. D considered C's symptoms to be 'textbook' indications of narrowing and Mr Rao agreed narrowing would be top of the list of potential causes. The gastroscopy findings of possible tightness or inflammation were consistent with all other information available to D. Mr Rahman had been consistent in his written and oral evidence and remained of the view that the balloon dilatation was reasonable, despite fair but robust cross-examination. There was an improvement post-procedure which also suggested that it was reasonable to treat the narrowing that was suspected and then demonstrated on the gastroscopy. The small size of balloon compared to the sleeve size, together with the site of its use and the limited duration and strength of its use all combined to make the balloon dilatation not only reasonable, but the correct treatment. Ms Hughes noted that there was no evidential basis for the assertion that it

would have made a difference to refer to the dietitian and psychologist immediately post-gastroscopy.

60. Ms Tibbitts acknowledged the significant criticism made of Mr Rao's evidence, but she emphasised that he had been doing his best to assist the court, had made fair concessions, gave evidence in a measured way and was very clear about the definitions he was using in relation to narrowing or stricture. She criticised Mr Rahman's evidence for failing to take into account C's evidence regarding post-operative follow-up. She accepted the limitations to the evidence about what might have come out of a reference back to members of the MDT but submitted that Mr Rao had been very clear and consistent that there was no role for balloon dilatation in the absence of confirmed stricture or stenosis. She repeated Mr Rao's evidence about how an experienced dietitian can be more thorough than a surgeon and engaging the MDT might have yielded a different approach. There was, she contended, a gap in the evidence, she said, as to whether functional stenosis can occur at the GOJ; only Mr Rahman says it can. Ms Tibbitts also highlighted aspects of D's evidence which she contended were unsatisfactory, such as omitting details about reviewing the radiological findings of the barium swallow or describing the narrowing that he relied on as his key finding.

The Law – Bolam et al

61. The applicable law in respect of claims of clinical negligence is well-traversed territory, beginning with the written directions to the jury (subsequently sometimes referred to as the judgment) of McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583. Having explained at page 586 what 'negligence' was in law in an "ordinary case", that is one not involving any special skills, the judge then defined the different test to be applied in a case, such as Mr Bolam's, which involved some special skill or competence on the part of the Defendant or an individual acting on their behalf:

"But where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art."

62. At page 587, McNair J directed the jury further in these terms:

"I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. ... Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion."

63. The Appellate Committee of the House of Lords considered the applicable test in *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634. The judge at first instance had found in favour of Mrs Maynard, but this was reversed on appeal by the Court of Appeal. Lord Scarman gave the lead judgment, with which the other Law Lords agreed. At 638E, Lord Scarman said this:

“A case which is based on an allegation that a fully considered decision of two consultants in the field of their specialist skill was negligent clearly presents certain difficulties of proof. It is not enough to show that there is a body of competent professional opinion which considers that theirs was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. It is not enough to show that subsequent events show the operation never need have been performed, if at the time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper. I do not think the words of Lord President Clyde in *Hunter v Hanley* 155 SLT 213, 217 can be bettered:

“...in the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men ... The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care ...”

“I would only add that a doctor who professes to exercise a special skill must exercise the ordinary skill of his speciality. Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other: but that is no basis for a conclusion of negligence.”

64. At page 639, having noted that the two consultants, against whom the negligence claim was directed, were legitimately counted among the “formidable number of distinguished experts” called for the Defendants, Lord Scarman said this:

“My Lords, even before considering the reasons given by the majority of the Court of Appeal for reversing the findings of negligence, I have to say that a judge's "preference" for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his

judgment he stated the law correctly. For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate speciality, if he be a specialist) is necessary.”

65. In *Bolitho v City and Hackney Health Authority* [1998] AC 232, the House of Lords was called upon to consider the applicability of the Bolam test to causation, where the breach of duty consisted of an omission to act. Lord Browne-Wilkinson, with whom the other members of the Appellate Committee agreed, said this at 241F:

“ ... I agree with these submissions to the extent that in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant’s treatment or diagnosis accorded with sound medical practice. In the Bolam case itself, McNair J stated that ... the defendant had to have acted in accordance with the practice accepted as proper by a “responsible body of medical men”. Later ... he referred to “a standard of practice recognised as proper by a competent reasonable body of opinion”. Again, in the passage which I have cited from Maynard’s case ... Lord Scarman refers to a “respectable” body of professional opinion. The use of these adjectives – responsible, reasonable and respectable – all show that the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.”

66. At 243B, Lord Browne-Wilkinson said this:

“These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But

if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

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

67. As to the test for causation generally, the court was reminded of the words of Lord Bingham in *Fairchild v Glenhaven Funeral Services Ltd & ors* [2003] 1 AC 32, a case in fact dealing with an exception to the usual test. At 44A Lord Bingham said:

“In the generality of personal injury actions, it is of course true that the claimant is required to discharge the burden of showing that the breach of which he complains caused the damage for which he claims and to do so by showing that but for the breach he would not have suffered the damage.”

The Law - approach to expert evidence

68. The centrality of the dispute between the experts in this case requires the Court to be very mindful of the guidance in *C v North Cumbria University Hospitals NHS Trust* [2014] EWHC 61 (QB). In that case, Green J set out a number of principles that he applied when analysing expert evidence in clinical negligence cases. I set them out in full due to their applicability to the assessment in this case. Those principles appear at [25] and I gratefully adopt them:

“i) Where a body of appropriate expert opinion considers that an act or omission alleged to be negligent is reasonable a Court will attach substantial weight to that opinion.

ii) This is so even if there is another body of appropriate opinion which condemns the same act or omission as negligent.

iii) The Court in making this assessment must not however delegate the task of deciding the issue to the expert. It is ultimately an issue that the Court, taking account of that expert evidence, must decide for itself.

iv) In making an assessment of whether to accept an expert's opinion the Court should take account of a variety of factors including (but not limited to): whether the evidence is tendered in good faith; whether the expert is "responsible", "competent" and/or "respectable"; and whether the opinion is reasonable and logical.

v) Good faith: A sine qua non for treating an expert's opinion as valid and relevant is that it is tendered in good faith. However, the mere fact that one or more expert opinions are tendered in good faith is not per se sufficient for a conclusion that a defendant's conduct, endorsed by expert opinion tendered in good faith, necessarily accords with sound medical practice.

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. In the course of my discussions with Counsel, both of whom are hugely experienced in matters of clinical negligence, I queried the sorts of matters that might fall within these headings. The following are illustrations which arose from that discussion. "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. Such a person expressing an opinion about normal clinical conditions will be doing so with first hand knowledge of the environment that medical professionals work under within the NHS and with a broad range of experience of the issue in dispute. 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. "Respectability" is also a matter to be taken into account. Its absence might be a rare occurrence, but many judges and litigators have come across so called experts who can "talk the talk" but who veer towards the eccentric or unacceptable end of the spectrum. Regrettably there are, in many fields of law, individuals who profess expertise but who, on true analysis, must be categorised as "fringe". A "responsible" expert is one who does not adopt 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. For example, a judge will consider whether the expert opinion accords with the inferences properly to be drawn from the Clinical Notes or the CTG. A judge will ask whether the expert has addressed all the relevant considerations which applied at the time of the alleged negligent act or omission. If there are manufacturer's or clinical guidelines, a Court will consider whether the expert has addressed these and placed the defendant's conduct in their context. 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, a further issue arising in the present case emerges from the trenchant criticisms that Mr Spencer QC, for the Claimant, made of the Defendant's two experts due to the incomplete and sometimes inaccurate nature of the summaries of the relevant facts (and in particular the Clinical Notes) that were contained within their reports. It seems to me that it is good practice for experts to ensure that when they are reciting critical matters, such as Clinical Notes, they do so with precision. These notes represent short documents (in the present case two sides only) but form the basis for an important part of the analytical task of the Court. If an expert is giving a précis then that should be expressly stated in the body of the opinion and, ideally, the Notes should be annexed and accurately cross-referred to by the expert. If, however, the account from within the body of the expert opinion is intended to constitute the bedrock for the subsequent opinion then accuracy is a virtue. 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.”

Discussion

69. The working model of D’s MDT is that the bariatric nurse is the primary point of contact. This was based on practical and patient-focussed considerations, because SR was the only member of the team permanently based at the hospital. There was, in my judgment, a perfectly proper system for sharing knowledge and expertise and the ‘up-skilling’ particularly of the specialist dietitian and specialist nurse in relation to each other’s work. In any event, patients could, and did, contact D directly through FBM. Any guidance document prepared for the NHS remains both guidance – not a statement of required practice – and of less direct applicability in the private sector as long as there is a reasonable equivalent. I have not been persuaded that what was on offer from the MDT in terms of patient support at the hospital was anything other than a reasonable equivalent.
70. Mr Rao set much store by the observation in SW’s pre-operative assessment of C that she may need psychological support post-operatively. He relied on this in particular when expressing the opinion that D should have paused after the gastroscopy and engaged dietetic and psychological input and not proceeded to the dilatation, although he was unable to make any suggestion as to what such input might have entailed, because, he explained, it was outside his field of expertise.
71. I find Mr Rao’s reliance on SW’s observation to be surprising and misplaced. C’s presentation to SW was objectively unremarkable, as SW made clear in her evidence. It would be surprising if a patient seeking out radical bariatric surgery were not to have some degree of psychological history to note. I reject the contention that SW’s observation had any greater significance in C’s circumstances or that it provides support for the case relating to psychological input post-gastroscopy. There was nothing in C’s presentation or from any of the investigations to suggest that the root cause of her difficulties was related to anything susceptible to counselling/psychological resolution. I find that the same applies to dietetic input. C had not progressed as expected (by her and by SR), she had moved back a stage in the reintroduction of textures and restarted her progression. There is no evidence that C was doing anything other than following the careful guidance as to diet and therefore no evidence that all the presenting information immediately after the gastroscopy indicated difficulties that might be resolved by dietetic input. I accept D’s evidence and that of Mr Rahman (and even Mr Rao’s general view) that the holistic picture was highly suggestive of some form of narrowing in the area of the GOJ.
72. Mr Rao’s suggestion that C’s difficulties might be explained by dysmotility, which seemed superficially attractive when he explained the mechanics, was roundly undermined by Mr Rahman’s evidence explaining the findings of the Sioka paper, which addressed this point.
73. The inability of an expert witness to recite the Bolam test by heart is in no way determinative of the quality of their opinion. However, in this case it was simply not clear to me that Mr Rao had at least the basic understanding of the legal parameters within which he was being asked to express his opinion.

74. As characterised above in paragraph 47, Mr Rao's evidence was both difficult to understand, due to his inconsistent use of terminology, and was lacking a coherent basis for the position he adopted. This position was that balloon dilatation should only be performed in the presence of what he called 'confirmed stricture'. However, he might have been more able to consider objectively and respond to points put in cross-examination if he had adopted a consistent rather than fluctuating approach to the central terminology engaged in the expert reports and the medical literature. I was simply left with the impression from Mr Rao that (a) confirmed stricture (whatever this strictly meant in his lexicon) was required before considering balloon dilatation; (b) confirmed stricture is not to be found at the GOJ; ergo, (c) balloon dilatation as performed by D should not have been done and could not be justified. I would interpret this as the basis on which Mr Rao asserted that D's actions failed the Bolam test.
75. Mr Rao was not able to respond adequately to points put forward in cross-examination from Mr Rahman's evidence that supported a different opinion. This was to be contrasted with the evidence of Mr Rahman who explained his opinion in a coherent and comprehensible manner, backing up his opinion by reference to the medical literature – both in support of his evidence and explaining why the literature relied on by Mr Rao did not have the import or force ascribed to it by Mr Rao.
76. In all material respects, and applying the principles in *C v North Cumbria*, I have no hesitation in preferring the evidence of Mr Rahman to that of Mr Rao.
77. Of course, Mr Rahman's opinion is only as good, so to speak, as the factual basis upon which it is based. I acknowledge that some details of D's oral evidence were not contained in his written evidence. However, I have reminded myself of the context within which the written statements were prepared. At the stage that they were served, the claim was very much wider, encompassing a much more extensive set of alleged negligent acts, almost from the inception of the patient-doctor relationship. The claim was significantly truncated and reduced to a much more limited focus only the week before trial. In those circumstances, and from my general assessment of D's evidence, I am not persuaded that there is any potential unreliability to attach to his evidence as given at trial.
78. Addressing the revised issues in paragraph 40 above, I have concluded that there was no breach of duty as set out in (i), the pleaded failure to provide reasonable post-operative support by not involving other MDT members post-gastroscopy and pre-balloon dilatation. Even if that had been established as a breach, I would not have been persuaded that, on the balance of probabilities, such a failure caused injury or damage to C. Equally, I have concluded that C has not proved that on the balance of probabilities there was a breach of duty by D's performing the balloon dilatation in the particular circumstances of this case.

Conclusion

79. There is no doubting the extremely serious consequences that C has suffered as a result of the leak. The Court really does have every sympathy for her serious and continuing health challenges. The Court's decision will come as a real disappointment, but the claim against D is simply not made out even on the more limited basis advanced at trial before me.

80. The claim must be dismissed.