Neutral Citation Number: [2025] EWHC 1610 (KB)

Case No: KB-2022-000824

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice,
Strand,
London

Date: 26 June 2025

B e f o r e:

HER HONOUR JUDGE MELISSA CLARKE
Sitting as a Judge of the High Court

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B e t w e e n:

MS PHILIPA HODGSON

Claimant

- and -

(1) DR DANIEL HAMMOND
(2) DR ANDRE DIELEMAN

Defendants

- -
- -

Mr Conor Dufficy (instructed by Irwin Mitchell) for the **Claimant**
Mr Tom Gibson (instructed by Weightmans) for the **1st Defendant**
Ms Nicola Campbell-Clause (instructed by MDU Services) for the **2nd Defendant**
Trial dates: 12, 13, 14, 15, 16 and 20 May 2025
Judgment provided in draft on 22 May 2025

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JUDGMENT – Quantum

Her Honour Judge Melissa Clarke:

A. Introduction

1. This is my judgment in relation to quantum in a clinical negligence claim brought by the Claimant, Ms Philipa Hodgson, a patient at the Brighton Station Health Centre against two general practitioners, Dr Daniel Hammond and Dr Andre Dieleman. I handed down judgment on breach of duty on 20 May 2025 (*Hodgson v Hammond & Dieleman* [2025] UKHC 1261 (KB)) in which I found that each of the Defendants was liable in negligence (causation no longer being disputed) and this judgment should be read in conjunction with that. I will not repeat the matters which are set out in that judgment, save that I will expand on my summary of the experts' agreed position on causation as I consider it provides the background to understand condition and prognosis, and is relevant to my consideration of quantum.

2. The First Defendant refers to the judgment of Swift J in *Leo Whiten (A Protected Party) v St George's Healthcare NHS Trust* [2011] EWHC 2066 (QB) at [4]-[5], which in turn refers to the well-known guidance of Lord Woolf M.R. in *Heil v Rankin et al* [2001] 2 QB272 at [22], [23] and [27]. To paraphrase, full compensation should be provided; this must remain fair, reasonable and just to both claimant and defendant(s), and should not be "*out of accord with what society as a whole would perceive as being reasonable*".

B. Claimant's evidence

3. I have read the Claimant's witness evidence, and heard her oral evidence about the pain which she has suffered arising from her PID since August 2016, and the pain and her difficulties in recovery following her laparoscopy surgeries in January 2017 and in April 2018. I accept that evidence. For the January 2017 surgery she spent 5 days and 4 nights in hospital and was discharged on oral antibiotics. She stayed with her mother who looked after her. As past care is agreed I will not summarise the evidence of the care she received but I note it. She returned to work around 2 to 3 weeks after the surgery, but says she should have taken more time off. She travelled to Australia with her partner for six months between September 2017 and

February 2018. On her return to the UK, in April 2018, she was woken by severe abdominal pain and attended A&E. She had the second laparoscopy on 24 April 2018, and describes the post-operative pain as being not quite as severe as after the first surgery. She remained in the hospital until 26 April 2018, and again on discharge went to her mother's house to recover for the first week. She felt the recovery was easier and less painful than previously. She again went back to work after two weeks.

4. She had a further attendance in A&E due to right sided abdominal pain and fever in June 2019. A scan revealed a cystic mass on the right side of her uterus so she was admitted, placed on intravenous antibiotics, and offered a laparoscopy or continued medical management. She chose the latter.

5. Her son was born in July 2020 following emergency caesarean section. She describes that she initially refused to sign the consent form "*as I could not face the trauma of having to recover from yet another surgery and I was crying on the midwife saying I couldn't recover again and look after a baby this time*." She said she agreed because she was told she had to do it to save the baby.

6. The Claimant says that she has had pain when she opens her bowels, but not every day, and when it happens she knows it is the beginning of a flare up of her chronic PID. She says she gets very bloated and cannot exercise. She has provided a description of the pain of the dyschezia and also of her flare ups. She had one in July 2023 which brought her to hospital because of the pain, and had another in October 2023.

7. The Claimant says that has had pain on sexual intercourse since 2017, but the last time she had sex (as at the date of her witness statement in October 2023) was September 2022 when she became pregnant. She and her partner split up in April 2023 and she has been single since then. She says that she would love to have more children, as she has always wanted a large family. She is now 35 years old. In her witness statement she said that she would probably have them on her own if she was getting older and didn't have a partner, but in her oral evidence she said that what she really wanted was a partner and to have more

children with them as a family. She said, "*Having one more child would be amazing, but four is my ideal number*".

C. Expert Witnesses – Causation and Condition and Prognosis

8. The parties each had an expert gynaecologist to opine on matters of causation and condition & prognosis. Those were Mr Nicholas Raine-Fenning MBChB, FRCOG, PhD, MAE for the Claimant, who is a Consultant Gynaecologist and Reader in Reproductive Medicine and Surgery at the University of Nottingham School of Medicine; Mr Alexander Slack MBBS MRCOG for the First Defendant, who is a Consultant in Gynaecology with a sub specialty in Urogynaecology at the Maidstone and Tunbridge Wells NHS Trust and who is the lead for gynaecology and urogynaecology at that Trust; and Mr Adam Magos BSc, MB, BS, MD, FRCOG for the Second Defendant, who was a Consultant/Honorary Senior Lecturer in the University Department of Obstetrics and Gynaecology at the Royal Free Hospital, London, until he retired from that position in 2021. He stopped clinical practice on 1 January 2023 but remains on the GMC register.

9. Mr Raine-Fenning produced a causation report dated December 2023, a condition and prognosis report dated 30 March 2022 and an addendum condition and prognosis report dated 11 November 2023. The three gynaecologist experts met and produced a joint statement dated 10 November 2024. Mr Raine-Fenning attended Court and was cross-examined by Mr Gibson and Ms Campbell-Clause.

10. Mr Slack produced a causation report dated November 2023 and a condition and prognosis report dated July 2024 as well as the joint statement of 10 November 2024. He attended Court and was cross-examined by Mr Dufficy and Ms Campbell-Clause.

11. Mr Magos produced a causation report dated 23 November 2023 and a condition and prognosis report dated 24 April 2024 as well as the joint statement of 10 November 2024. He attended Court and was cross-examined by Mr Dufficy and Mr Gibson.

12. No criticisms have been made that any of these experts lack the experience or expertise to proffer their opinions to the Court as Part 35 experts in gynaecology, and I am satisfied they are well-qualified to do so. However, in their answer to question 4.3 of the agenda for the joint meeting, relating to in vitro fertilisation, and in their oral evidence, both Mr Magos and Mr Slack proffered their opinions but said they would defer to an expert in reproductive medicine, which each accepted they were not. I am satisfied that Mr Raine-Fenning is an expert in reproductive medicine, as Mr Slack accepted in cross-examination.

D. Experts' evidence

Causation

13. The experts are agreed in all material respects in relation to causation. They agree that if the Claimant had a pelvic examination by the First Defendant on 30 August 2016 or by the Second Defendant if he had called the Claimant into the practice on or shortly after 5 September 2016, on the balance of probabilities she would have been found to have mild pelvic tenderness (Mr Magos believes also possibly fullness in the left adnexa, Mr Raine-Fenning believes cervical excitation but on balance no fullness or mass). They are agreed that this would have led to a possible diagnosis of PID and had triple swabs taken and started immediately on broad-spectrum antibiotics aimed at treatment of PID in accordance with national guidelines of the Royal College of Obstetricians/British Association of Sexual Health and HIV, pending microbiology results.

14. They agree that the Claimant's tubo-ovarian abscess developed as a result of the PID, namely the ascending infection from the cervix spreading to the left fallopian tube, blocking it, which caused it to be filled with fluid which then formed the abscess. They were not agreed on what organism caused or may have caused the infection but that is not a dispute that I need to determine, in my judgment. They all agree that the results of the triple swabs taken at the time of the pelvic examination would have identified the organism and

discussion with a microbiologist would have ensured that appropriate antibiotic treatment was given or continued.

15. The experts agree that the Claimant's tubo-ovarian abscess most likely developed in or after late September 2016. As I summarised in my judgment on breach of duty, it was noted during her laparoscopies that the Claimant's Pouch of Douglas and both adnexa were "*obliterated*" such that the left ovary was buried and could not be seen, the uterus was covered by adhesions and the rectum was densely adherent to the uterus. It was also noted that the adhesions involve her right fallopian tube which appeared abnormal at the fimbral end, which was slightly clubbed. The experts agree that with treatment for PID following the consultations on either 30 August 2016 or 5 September 2016 she would have avoided the following:

    i) initial tubo-ovarian abscess

    ii) development of hydrosalpinx

    iii) loss of her left fallopian tube

    iv) laparoscopies on 5 January 2017 and 24 April 2018

    v) further abscess in July 2019

    vi) They agree that she would have developed adhesions, but less severe and extensive and these would have caused her to have a lower risk of developing chronic pelvic pain and dyspareunia.

16. Mr Raine-Fenning's opinion in relation to para 15(vi) above goes a little further than that of Mr Magos and Mr Slack in the joint report. He opines that on the balance of probabilities her uterus would not be densely adherent to her rectum and so she would not have suffered from dyschezia. In cross-examination by Mr Gibson he said that on balance, with earlier treatment, she would still have developed adhesions but these would have been limited to the left side and left fallopian tube, and would be very unlikely to have developed adhesions which (i) involved the uterus and obliterated the Pouch of Douglas; and (ii) caused the rectum to be adherent to the uterus, both of which he

described as unusual. He said, "*we don't see that often outside of endometriosis*". Mr Slack agreed with this in cross-examination by Mr Dufficy. He said that dyschezia and dyspareunia are different and should not be taken together, and he agreed with Mr Raine-Fenning's opinion that the dyschezia is likely caused by the fact that Claimant's rectum is adherent to the uterus and so would have been avoided with earlier treatment. Mr Magos did not appear to disagree in cross-examination, also distinguishing between dyschezia and dyspareunia, and noting that the dyspareunia pain could be caused both by inflamed tissue of chronic PID and adhesions, and it is difficult to assess what importance each of these problems plays in her current pain. On balance I find that timely treatment: (i) would have avoided the dyschezia entirely, and (ii) would have significantly reduced the dyspareunia as it would likely have avoided the PID becoming chronic at all, and reduced the severity and extent/density of adhesions.

17. The experts all consider that the Claimant's risk of infertility or sub-fertility and ectopic pregnancy would, however, still have been increased by the PID, even with appropriate and timely antibiotic treatment, whether this was provided on or shortly after 30 August 2016 or 5 September 2016. In relation to ectopic pregnancy, they agree that her risk of ectopic pregnancy would actually be higher with appropriate and timely antibiotic treatment, although the increased risk to her fertility would be lower. Mr Slack explains in the joint report that the effect on her fertility is related to the PID and its effect on the fallopian tube rather than the tubo-ovarian abscess, as is the risk of ectopic pregnancy. However, the delayed treatment resulted in the Claimant having her very damaged left fallopian tube removed entirely, leaving her at an overall lower risk of ectopic pregnancy albeit with a higher risk profile for infertility. Mr Magos relies on literature (Hillis et al, 1993) to support his opinion that the risk of infertility and ectopic pregnancy is increased with any woman diagnosed with PID where treatment is delayed even by a few days. I accept their evidence.

Condition

18. In relation to condition and prognosis there is also a large measure of agreement. The experts agree that she has severe and extensive pelvic adhesions as seen during the two laparoscopies. The experts agree that the Claimant currently experiences dyspareunia and dyschezia, and that she has reported chronic pelvic pain to Mr Slack and Mr Raine-Fenning. I am satisfied that she does have chronic pelvic pain. All agree that she does not suffer from painful periods, or at least periods which are any more painful than prior to the events of 2016. I accept Mr Raine-Fenning's opinion in cross-examination by Ms Campbell-Clause that this rules out the possibility of a co-morbidity with endometriosis.

19. The experts agree that the Claimant's current pain symptoms are related to the effect of the chronic PID, the development of a tubo-ovarian abscess with acute exacerbations, and associated adhesions. I accept their evidence.

Prognosis

20. The experts all agree that on the balance of probability, the Claimant will continue to experience these symptoms and they will not completely resolve as there are very few treatment options available to her. Mr Magos notes that earlier treatment would have reduced but not totally eliminated the risk of chronic PID and pain and superimposed acute infections. Mr Raine-Fenning agrees and opines that her pain symptoms are likely to become worse with further episodes of acute or chronic PID. This is supported by the BASHH 2018 Guideline for the Management of PID (the contents of which the experts agree were applicable in 2016, save in relation to recommended antibiotic regimens) which notes at internal page 10 that "*clinically more severe disease is associated with a greater risk of sequelae*". In cross-examination by Mr Gibson, Mr Raine-Fenning noted that once pain has been chronic for some time, say 15 or 20 years, it can become centralised and is known not to go away. I accept all of this evidence.

Surgical interventions

21. The experts agree that surgical interventions potentially open to the Claimant in the future are: (i) adhesiolysis which would likely be carried out

laparoscopically and (ii) hysterectomy/pelvic clearance once she has completed her family; however there is some disagreement about whether such surgeries are advised.

Adhesiolysis

22. Following cross-examination there appeared to be agreement between the experts that in the Claimant's case the surgery required was very complex because of the severity of the adhesions adhering her rectum to her uterus. Accordingly, there was a high risk of iatrogenic damage particularly to the bowel, which would likely be permanent, leading to a stoma.

23. There also was agreement between Mr Raine-Fenning and Mr Slack at least (the point not being explored with Mr Magos) that any such surgery would likely need to be carried out in a tertiary endometriosis centre, not because she has endometriosis (which there is no good evidence before me that she has), but because, as Mr Raine-Fenning explained, this meant it would be carried out by a team of experts including bowel surgeons, urologists and specialist radiographers as well as gynaecologists with advanced specialism in such complex surgeries. I am satisfied that is why the Claimant's treating gynaecologist, Mr Chan, referred her to such an endometriosis centre in September 2024. The Claimant's appointment there has had to be postponed as it fell during the trial. Mr Raine-Fenning told the Court that half his list on a Tuesday consisted of adhesiolysis surgery, but despite that expertise said "*Few people would do this surgery. I wouldn't."* I accept Mr Slack's evidence in cross-examination that the fact that Mr Chan had referred her for another opinion from a specialist centre does not mean that he himself considers the surgery to be appropriate and safe.

24. Mr Slack does not consider that adhesiolysis is recommended, as in his opinion there is no good evidence for benefit and it carries significant risk. In cross-examination by Mr Dufficy he describes it as being "*historically carried out a lot*". Mr Magos agrees and also would advise against such surgery on the grounds that it is unlikely to be effective and yet carries significant risk of organ injury. He said in oral evidence that if the Claimant was his patient he

would not advise her to undergo it. Both Mr Slack and Mr Magos made the point in oral evidence that having more surgery to remove adhesions may well cause new adhesions to form and so poses a risk that it causes no improvement, or even a deterioration, in pain symptoms.

25. Mr Slack relies on a paper *Surgical interventions for the management of chronic pelvic pain in women (Review)* Leonardi, Armour, Gibbons, Cave, et al: Cochrane Database of Systematic Reviews 2021, Issue 12) to support his opinion that there is no good evidence for benefit of adhesiolysis surgery, Mr Raine-Fenning said he was extremely familiar with the paper and its authors and had spoken at conferences about it, but it had limited relevance because the review team had excluded from the review studies with participants with "*pain due to active chronic PID*". I accept that they did. However, on reading the paper this appears to be for the reason set out in the plain language summary on internal page 2: "*When identifiable causes of chronic pelvic pain are present, …there may be different treatment strategies necessary than when there are no obvious problems. When no disease is identified at the time of a diagnostic surgery despite chronic pelvic pain, we may consider various surgical procedures to treat the chronic pelvic pain, including removing scar tissue originating from infection or previous operation (called adhesiolysis)…*". This seems to be for the reason that Mr Magos explained to the court as summarised in paragraph 16 above: because of the difficulties in assessing benefit of treating only one of several potential causes of chronic pelvic pain. However it still has value to this case, in my judgment, in its review of the benefit of adhesiolysis in treating pain arising from adhesions. The authors were left uncertain of the effect on pelvic pain scores post operatively at 3, 6 and 12 months post-operatively; they were uncertain of the safety of adhesiolysis compared to comparator groups due to low certainty evidence and lack of structured event reporting; they considered it may improve emotional wellbeing and social support but the evidence for this was also low-certainty; and there were no studies reported on psychological outcomes. Their conclusion was that "*there is currently little to support these interventions*" for patients with chronic pelvic pain.

26. Mr Raine-Fenning in the joint statement generally agrees with the view of Mr Magos and Mr Slack, accepting that the evidence for adhesiolysis is unclear and that there is a high risk that adhesions will reform, but he notes that: (i) some women do experience a reduction in pain, even if this is temporary; and (ii) the formation of new adhesions can be reduced by meticulous surgery and the use of anti-adhesion agents. In oral evidence he said that he would not carry out so many adhesiolysis surgeries if there was no benefit to them, but of course each case will have its own risk/reward profile for each patient to consider and decide whether to consent to surgery. Mr Raine-Fenning also sees potential value in such surgery providing an opportunity to assess her right fallopian tube and divide any adhesions that impact it, which could improve her chances of natural conception and reduce the risk of ectopic surgery. Mr Magos accepted that could improve her chances, but noted his view that she had a reasonable chance as she is, having conceived twice previously.

Pelvic clearance/hysterectomy

27. All of the experts agree in the joint statement that that hysterectomy/pelvic clearance can be beneficial for pelvic pain associated with chronic pelvic inflammatory disease (Mr Magos describing this as "*the treatment which is likely to be the most effective in chronic PID*") and that on balance the Claimant will likely have this surgery. Mr Slack injects a note of caution in the joint statement, opining that there is little evidence to support its use in the management of adhesion-related pain.

28. The picture was perhaps slightly less clear following oral evidence. In cross-examination by Mr Gibson, Mr Raine-Fenning said that it was not probable, but possible that she would have such surgery, but was unable to provide a percentage chance. He accepted that pelvic clearance does not necessarily clear pain, and the fact that it would necessarily be done after the Claimant's family was complete meant that there was a risk that her pain would be centralised by this time and not go away. In cross-examination by Mr Dufficy, Mr Slack said that the surgery had potential to resolve that element of her pain which was related to the chronic PID, but much of her pain was due to pelvic

adhesions. It was unlikely that surgery would remove all of them, and might cause new adhesions to form. I accept this evidence.

In vitro fertilisation (IVF) treatment

29. The experts agree that the Claimant is not infertile, as she has conceived twice since the events of 2016 which shows that her remaining right fallopian tube is functional for the purposes of conception. However both Mr Magos and Mr Slack consider that the failure to provide timely diagnosis and treatment will not, on balance, mean that she will require IVF treatment if she wishes to add to her family in the future, whereas Mr Raine-Fenning considers that it likely she will.

30. Mr Raine-Fenning's opinion is that 80-90% of couples conceive within one year of trying, and 50% of those who do not, conceive the following year. For that reason, he explained in oral evidence, IVF is generally recommended, under NICE guidelines, after two years of trying for those with no known explanation for fertility problems, and after one year for those, like the Claimant, who are sub-fertile for a known reason. He notes that it is unclear how long the Claimant took to conceive both previous pregnancies, as she was taking the contraceptive pill for some of the time, but estimates that from a review of the records that was at least two years on the first occasion and over 12 months up to 18 months on the second occasion.

31. However, he notes that the loss of one fallopian tube reduces conception rates to about 60-70%, but only if the one remaining tube is normal, and there is a normal pelvis. In this case, there is a damaged fallopian tube and adhesions with an obliterated Pouch of Douglas, into which the egg is often released. His evidence is that a fallopian tube not only needs to be patent, but also functional, so it has a normal relationship with the ovary and can pick up the egg at ovulation. He explains that a fallopian tube is lined by cilia which aid the passage of sperm, the egg and, if fertilisation occurs, the embryo. His evidence is that these cilia are likely to have been damaged by the extensive infection and inflammation that was present because of the delayed diagnosis of the PID.

32. Mr Raine-Fenning also notes that the Claimant's dyspareunia is also likely to reduce how often she has sex. For all these reasons he considers that "*all reproductive medicine experts would agree that she has a < 50% chance of conceiving naturally and so it is more likely than not that she will require IVF*". He further noted that IVF will reduce her risk of ectopic pregnancy which all the experts agree has been increased by the PID. Mr Raine-Fenning's opinion is that this risk is 2% with IVF, but the Claimant's risk of ectopic pregnancy if she conceives naturally is much higher and probably around 20-25%. In fact there is literature before me (*Pelvic Inflammatory Disease*: Medscape 2019, Tough DeSapri, Karjane et al, 2019) which states that the risk of ectopic pregnancy is increased 15-50% in women with a history of PID. Mr Slack accepted Mr Raine-Fenning's analysis both of the chances of conception and of the risks of ectopic pregnancy in cross-examination saying "*Of course I do. I'm not an expert in IVF or fertility and I accept he is*".

33. Mr Magos's oral evidence was that IVF is both stressful and not very successful, and he would advise the Claimant to try to conceive naturally. He said that she is of proven fertility, that women who have had a pregnancy have an almost doubled chance of conception than someone who has never been pregnant, and an even better chance if they have conceived twice. He considers that the prognosis is good, even if it may take a little longer than someone without a single fallopian tube and adhesions. In relation to the damaged remaining fallopian tube, he says the best test of tubal function is pregnancy, and she has become pregnant twice. In cross-examination he criticised Mr Raine-Fenning's evidence that the fact that the Claimant has been pregnant twice does not alter his percentage chance of a natural conception saying "*logically, she is in a much better prognostic category*" and "*her pregnancies are strong evidence that [the right ovary and right fallopian tube] are not totally caught up in adhesions*", but accepted that he had no experience in IVF and would defer to a fertility expert. I am satisfied that Mr Raine-Fenning is such a fertility expert.

Alternative therapies

34. In relation to alternative therapies which the Claimant has tried in the past (yoga, acupuncture, abdominal massage therapy, raspberry tea and "apothecary"), Mr Slack says he is unable to comment, Mr Magos notes that there is no scientifically valid evidence that any of these treatments are beneficial and so he cannot recommend that she should continue with them, and Mr Raine-Fenning agrees. However he notes that many women describe benefit from alternative therapies and as such he finds these reasonable.

E. Determination of Quantum

General Damages

35. The Claimant's Updated Schedule of Loss served in April 2024, drafted by the Claimant's solicitors, remains "tbc" in relation to general damages. It is only in Mr Dufficy's skeleton argument filed shortly before trial that the Defendants learned that she seeks an award in the region of £110,000. Mr Gibson for the First Defendant comments adversely on that in his skeleton argument for trial, entirely correctly and justifiably in my judgment. This approach leaves the Defendants unclear of what their potential liability is, prevents them from answering the head of claim in their counter-schedules, and stifles any meaningful opportunity for settlement. As Yip J put it in *Wright v Satellite Information Services Limited* [2018] EWHC 812 (QB) at [29], to which he refers, "…*schedules and counter-schedules are an essential part of the advocacy in a case. In my view they need to be drafted by lawyers with sufficient experience and skill to properly present the claim as it will be presented at trial, particularly in a contentious case such as this*". I make clear that I have no reason to, and do not, question the Claimant's solicitors' experience and skill but the updated schedule must in fairness properly present the claim as it will be presented at trial, and the Claimant's does not do that in respect of general damages.

36. Mr Dufficy for the Claimant directs me to the Judicial College Guidelines 17th Edition, Chapter 6, Injuries to Internal Organs (F) Reproductive System: Female. In the preamble to this Chapter, it notes that "*level of awards in this area will typically depend on (i) effect on fertility; (ii) pain and sexual*

dysfunction; (iii) hormonal effects; (iv) whether or not the affected person already has children and/or whether the intended family was complete; (v) scarring; (vi) psychological reaction; (vii) medical complications…".

37. Mr Dufficy submits the appropriate category in which to place the award is (b). I set out below (a) to (c), being the first three of seven categories in this section, for reference:

> "(a) Infertility whether by reason of injury or disease, with sexual dysfunction, severe depression and anxiety, pain and scarring. The upper end will be in cases with significant medical complications, e.g. following failure to diagnose ectopic pregnancy, and in a younger person. (£140,210 to £207,260)
>
> (b) Sexual dysfunction, which is likely to be permanent in the case of a person with children or who would not have had children in any event. The upper end will include cases with significant medical complications, e.g. ectopic pregnancies or multiple surgeries. (£52,490 to £124,620)
>
> (c) Infertility with no aggravating features and no sexual dysfunction in a young person without children. (£68,440 to £87,070)
>
> …".

38. The Claimant relies on two comparable cases. One is *X v Dartford and Gravesham NHS Trust* (2018) (settlement, £80,000, liability not admitted) and the other is *P v Salford Royal Hospitals NHS Trust* (2002) (£129,500 after trial and a further £26,000 afterwards to settle an appeal, being £155,000 in total).

39. The First Defendant submits that Chapter 6(F) discusses infertility in several of the brackets in absolute terms, and the Claimant is not infertile, but sub-fertile, as the experts agree. He submits that as Mr Slack noted in the joint statement, this is really a case about chronic pain – chronic pelvic pain, dyschezia and dyspareunia. Accordingly he relies on Chapter 9(B) (Other Pain Disorders) of the Judicial Guidelines and submits that the appropriate award is £30,000, within the bracket (b) Moderate (with (a) Severe set below in addition, for reference):

> "(a) **Severe**. In these cases, significant symptoms will be ongoing despite treatment and will be expected to persist, resulting in adverse impact on ability to work and the need for some care assistance. Most cases of fibromyalgia with serious persisting symptoms will fall within this range. £51,410 to £76,870.
>
> (b) **Moderate**. At the top end of this bracket are cases where symptoms are ongoing, albeit of lesser degree than in (i) above and the impact on ability to work/function in daily life is less marked. At the bottom end are cases where full, or near complete recovery has been made (or is anticipated) after symptoms have persisted for a number of years. Cases involving significant symptoms but where the claimant was vulnerable to the development of a pain disorder within a few years (or 'acceleration' cases) will also fall within this bracket. £25,710 to £46,970."

40. The First Defendant accepts that the Claimant has significant ongoing issues which demand compensation, but submits that she is not disabled in Equality Act terms, and is able to work, parent, do yoga and high intensity interval training classes, manage her pain with analgesia as required, and live her life independently without the need for care or assistance. He submits that an award in the "(a) Severe" category is therefore not appropriate.

41. The Second Defendant adopts the First Defendant's submissions, agreeing that this should be viewed as a pain disorder case and compensated in the JC Chapter 9(B)(b) Moderate range, but Ms Campbell-Clause for the Second Defendant places it higher within that range and submits that £45,000 is the appropriate award, taking into account that further surgery may be required. She also submits that Chapter 6(F) relied on by the Claimant is not particularly helpful as the Claimant is not infertile, and so it provides the incorrect starting point. I will return to that. She further submits that the Claimant's comparables are also not helpful as *X v Dartford* is a settlement and *P v Salford* is quite different on the facts and can easily be distinguished. I accept those submissions.

42. In my judgment awarding general damages as if this was a chronic pain case would undercompensate the Claimant. It would not take into account the pain and suffering arising from her two laparoscopic surgeries and likely future pelvic clearance surgery, the risk the damage to her fertility and pain arising out of future IVF cycles, and raised risk of ectopic pregnancy. I accept Chapter 9(B) is useful as a guide to damages for chronic pain, however.

43. I do not agree that Chapter 6(F) is inappropriate because some of the categories refer to infertility. Four of the seven categories do, but three do not, and these and the preamble make clear that it is intended to cover cases both where there is infertility and where there is some or no effect on fertility. For example, category (f) applies where there is a delay in diagnosing ectopic pregnancy but fertility is not affected. The range is from £4,140 to £24,930 and the award is said to be dependent on the extent of pain, suffering, bleeding whether blood transfusion was required, anxiety and adjustment disorder, and whether there is resultant removal of one of the fallopian tubes. The Claimant did not have an ectopic pregnancy but had pain, lasting much longer than an ectopic pregnancy, and removal of a fallopian tube, and on top of this had damage to the other fallopian tube, a second surgery, possible further surgery, chronic pain and sexual dysfunction, all at a young age.

44. In fairness to all parties, I have used all of these categories as a guide to reach a figure which achieves full compensation to the Claimant, rather than placing this within one of them. **I award the Claimant £94,000 in general damages in pain, suffering and loss of amenity.**

45. **I award interest on general damages at 2% from the date of service of proceedings to trial**, being £5,358.00.

Past Losses

Past Care and Assistance

46. **This has been agreed at £260** which I believe includes interest.

Past Travel Expenses

47. The Claimant has in submissions revised the sum sought under this head from £773.03 to £500. The Defendants submit that the original sum claimed was too high as, inter alia: it includes travel costs to the GP on the index date of 30 August 2016 when the Claimant says she should have been diagnosed, and also on 5 September which was a telephone consultation; it provides travel to therapies which I should not allow as recoverable (and to a large extent have not allowed – see "Past Therapies" below); that it allows for travel of the Claimant's partner to visit her in hospital when her evidence is that he did not provide care ("*He didn't help me much*"); the mileage is charged at 45p per mile instead of the usual 25p per mile; and the sums claimed do not give credit for the fact that the Claimant would have required investigation, treatment, possible surgery, follow up and review even if not misdiagnosed. I accept all these submissions. The First Defendant offers £150 for past travel and the Second Defendant £314.69. Doing the best that I can I come to a figure very close to that of the Second Defendant. I award £315 plus interest of £23.23.

Past Medical costs

48. **This has been agreed at £146.39** which I believe includes interest.

Past Therapies

49. The Claimant seeks £1,418.21. These relate to:

    i) yoga sessions in 2019 and 2020. The Claimant says these helped her become more flexible, less inflamed and calmer;

    ii) acupuncture session in 2019, to help with management of her ongoing symptoms and anxiety;

    iii) abdominal massage to help with management of her ongoing symptoms of abdominal pain.

50. As noted, none are recommended by the experts. There is no evidence that the yoga assisted with inflammation, or that the acupuncture or abdominal massage assisted with her symptoms, although I accept that the Claimant believes the massage did. She said that the acupuncture made her feel worse.

The Second Defendant submits that yoga is a commonly undertaken exercise to maintain general fitness and wellbeing and notes that the acupuncture does not appear to help, but offers £130 plus interest for the abdominal massage, accepting it was reasonable for her to trial this alternative therapy. I am afraid I do not adopt that admission. The First Defendant denies this head on the basis of lack of clinical benefit and lack of recommendation by treating clinicians or the experts. I am with the First Defendant. **I make no award under this head.**

Past Miscellaneous Expenses

51. The Claimant seeks £350.69 for raspberry leaf tea which she drank as she read that it was good for her uterus, "apothecary" (undefined) which tried for one month and bio-oil and castor oil to help improve the appearance of her laparoscopy scars.

52. I do not consider that there is any evidence of benefit to the raspberry leaf tea or the "apothecary" nor that it is reasonable to require the Defendants to pay for them. **I allow £25 for the bio oil and castor oil** plus interest at half rate of £1.71, it being unclear when this was purchased.

Future Losses

Future Medical Treatment

53. The Claimant seeks £82,456.50 being £9,500 for adhesiolysis to treat chronic pain, £8,000 for a pelvic clearance and associated medical care aged 51 and £66,795.00 for IVF treatment plus associated costs to complete her family.

54. I have considered all the evidence relating to adhesiolysis very carefully, and in particular the evidence that the benefit of adhesiolysis to reduce pelvic pain is uncertain, that the evidence that it is safe even in patients without the Claimant's complexity is also uncertain, and although there is some evidence it may improve emotional wellbeing falling short of psychological benefit, the evidence base of that is also low-certainty. I do note Mr Raine-Fenning's evidence that he would not carry out so many adhesiolysis operations if it did

not provide benefit to his patients. However, it seems to me that the very much higher risk profile of the Claimant compared to his own patients (which I feel safe in inferring, as Mr Raine-Fenning says he would not operate on a patient with the Claimant's complex issues) means that the risk/reward analysis tips decisively away from adhesiolysis, in my judgment.

55. Of course, it will be for the Claimant to obtain further advice from treating specialists, and it will be a matter for her to decide whether, if she is offered adhesiolysis, the potential benefits are such that she considers those risks worth taking, but I do note that she did not accept a laparoscopy when she was offered it in June 2019, and also resisted a caesarean section because she was concerned about adhesions when her son was born. The First Defendant correctly notes in its counter-schedule that Dr Raine-Fenning acknowledges in his updated condition and prognosis report that "*Miss Hodgson can just rely on analgesia. Her pains typically settle fairly quickly and she seems to cope without any treatment. However, she needed to take codeine during the recent flare in July – September 2023*". I consider that it is very unlikely that she will have adhesiolysis treatment, and that in any event if she does, that it will be reasonable to have such treatment privately. She has been referred to, and will in my judgment be best served in, the NHS at a tertiary endometriosis centre where she will be under the care of a specialist multidisciplinary team as described by Mr Raine-Fenning. **I make no award for adhesiolysis**.

56. In relation to infertility treatment, I accept that the Claimant is sub-fertile, not infertile, and her fertility has been successfully tested by two natural conceptions. I also accept the Claimant's revised evidence at trial that she wishes to find a partner before undertaking IVF. Of course that is not certain, and if she does find a partner, it is not certain that he will want to have children. But life is not certain and both these things are entirely possible and I would go so far as to say probable. I also hope that if she does find a partner and decide together to add children to the family, that conception will occur naturally. However I do accept Mr Raine-Fenning's evidence, and I prefer it to that of Mr Magos and Mr Slack as he is the fertility expert and they are not, that as a result of the breach of duty it is more likely that not that she will not

conceive naturally in the first year of trying, and so she will be advised to try IVF and it would be reasonable for her to do so.

57. The Claimant's written evidence is that she would like four children in total. She currently has one son. She estimates that each cycle of IVF will cost her £7,000 and that three cycles will be needed for each live birth. She claims 3 x £21,000 plus additional costs of £1265 for each birth.

58. I do not think that the timescales are in her favour to have four children with assisted conception. She needs to find a partner and agree to start a family with him, which may take several years. Three cycles of IVF per live birth will also take considerable time, if that is what is needed. Both the First and Second Defendants submit that there is too much uncertainty for any award to be made. I disagree. I think it is reasonable and realistic to assume on the balance of probabilities that she will be able to undergo one full treatment of three cycles of IVF. The First Defendant in his counter-schedule agrees that if I am to find that she will undertake private IVF at all, this is the most likely scenario. However he submits that I should further discount it by a 67% to reflect the possibilities that she may not find a new partner who wishes to have children, that she conceives naturally, etc. I consider that I have reflected these possibilities in my assessment of the likely timescales available to her, by awarding for one full treatment not three, and if I were to further discount as suggested this would, in effect, be double-counting. Accordingly, in my judgment the award which is fair to both parties is the cost of three cycles of IVF to achieve a single live birth, plus associated costs. If the Claimant conceives more quickly, using only a single cycle for example, the remaining award could fund one or two more cycles to achieve a third child, if she remains of the age where this remains open to her. I award the sum of £22,265.00 for future IVF to which a multiplier of 0.9851 must be applied (the appropriate multiplier for advance receipt given the likely timescale which in my judgment is for such treatment to start in 3 years' time). Accordingly the sum awarded is £21,933.25.

59. In relation to pelvic clearance, I am satisfied that the Claimant is likely to undertake this surgery once she has completed her family in order to treat the

chronic PID, although it may not give entire relief from pain because of remaining adhesions. **I award the sum of £8,000 for pelvic clearance, to which the agreed multiplier of 0.91 must be applied.**

Future Therapies

60. The Claimant seeks £18,195.72 for abdominal massage at £65 per session once every 3 weeks, from now until her pelvic clearance operation at age 51.

61. I do not consider that this claim is reasonable or recoverable. She says that she had 4 sessions from August 2022 and that she stopped them, although they were helpful, because her partner was paying for them and he ceased to do so when they split up. Despite that, as the First Defendant notes in its counter-schedule, the Claimant's pelvic pains do not prevent her from working, looking after her son, and remaining independent with all her day to day care and household needs, they do not stop her from engaging in regular and strenuous HIIT and cardio exercise classes, and the gynaecology expert evidence does not support any abdominal massage. I do not consider that she has proven any medical benefit, and I consider that if they provided her with any material wellbeing benefit she would have paid for such massages even after her partner ceased paying for them, as she has paid for exercise classes. **I make no award for future therapies.**

Future Care and Assistance

62. The Claimant seeks £20,415.40.

63. To the extent the claim under this head relates to care following future adhesiolysis, this falls away.

64. In relation to future care following future pelvic clearance surgery, which is likely to be laparoscopic but may be open, the Claimant claims for an agency carer at 20 hours per week for 9 weeks, and a nanny for 8 hours per day for 9 weeks. Mr Raine-Fenning's evidence is that she will require 5-7 days in hospital and then take 8 – 10 weeks to recover after pelvic clearance. Mr Magos says she is likely to be in hospital for no more than 5 days and fully

recovered within 6-8 weeks. Of course the recovery will be easier if it is laparoscopic rather than open. I note that the Claimant had 16 hours of care per week for a week to 11 days, and returned to work after two weeks, for each of her previous laparoscopies, although for the first one she felt that was too early.

65. The First Defendant allows for 14 hours personal care per week for three weeks, but at gratuitous, not commercial, rates with a 25% discount against contingencies. He denies the claim for post-operative commercial childcare, but submits that if the Court finds she may undergo future surgery as a result of the Defendants' negligence, and she does so at a time when she is likely to have children who remain dependent on her and need childcare, the First Defendant will allow 4 hours per day of gratuitous care per day for three weeks, with a 25% discount for contingencies.

66. The Second Defendant allows for 2.5 hours of personal care per day at commercial rates (although he reduces those to the East Sussex County Council's self-funded home care costs of around £21 per hour which I think is less realistic than the Claimant's agency costs of £25.27) for the first two weeks of recovery, then 1.5 hours per day for a further 2 weeks, then 7 hours a week for a further 2 weeks, and 3.5 hours per week for the final, 7th, week of recovery. He allows nothing for childcare, submitting that no assistance will be required as the Claimant is unlikely to undergo this procedure whilst her children are young enough to need it.

67. I am satisfied on the evidence that I have heard about the Claimant's mother's health that she will not be providing gratuitous personal care or childcare in 16 years' time.

68. The Claimant's son is now 5 years old and in education, and so will be c. 21 by the time of the pelvic clearance. It seems to me to be more likely than not that whether he is at university or working, the surgery can be scheduled so that he is available to provide some gratuitous personal care and assistance with younger siblings, although possibly not for the full recovery period. It is more likely than not, in my judgment, that any following children who may be

born would be at the youngest 8 years old (if they were born when the Claimant was 43) and the oldest 14 years old (if they were born in 2 years from now). I do not consider that any child over the age of 11 will require childcare, and nor do I consider that any child under 11 will need anything more than wraparound care for a few hours per day, say 1 hour in the morning and three in the afternoon.

69. Taking all of this into account, **I will allow personal care for the Claimant (i) from an agency carer at 16 hours per week for the first three weeks at £25.27 per hour as sought, and (ii) gratuitous care at 10 hours a week for the following 2 weeks and 7 hours a week for the following 2 weeks, at a rate of £12.87 per hour less 25% being £9.65. I do not attach a contingency discount to this. I will allow gratuitous childcare at 4 hours per day at £12.87 less 25% being £9.65, but I will apply a 50% discount to this to account for the contingency that no childcare is required.** I understand that the parties have agreed that this totals £2,262.95.

70. The Claimant also seeks the costs of childcare assistance during future flare-ups of her chronic PID at 8 hours per day for three days per year. Her evidence is that she has 2-4 episodes of acute pain per year, but in cross-examination she said that she had never needed to arrange for emergency care for her son during flare ups in the five years since he was born. It was put to her that if she did have difficulties with a school pick up etc, she would be more likely to call in a favour from a friend rather than arrange paid childcare and she did not disagree that was a possibility, but said "It would all depend on if they were working". I do not consider that the Claimant has satisfied me on the balance of probabilities that she will need paid childcare assistance for three days per years in the future, if she has not needed it in the first five years of her son's life. She is likely to have more secure friendship groups and support to call on with a second child than with the first, not less in my judgment. **I make no award under this head.**

Future Travel Expenses

71. The Claimant seeks £4,085.65. The majority relates to travel to abdominal massage therapy, and this falls away. The remainder of £516.60 is for travel to hospital once a year for life at £8.91 each time, arising from flare ups of the Claimant's chronic PID. I note, as does the First Defendant in his counter-schedule, that the Claimant has only attended A&E once since 2019 for this reason. I agree with both Defendants that this level of attendance is wholly speculative, and that the flare ups of chronic PID will cease after pelvic clearance. The First Defendant allows a lump sum of £50 to cover travel, the Second Defendant allows £4.95 per year until age 51 amounting to £75.44 which averages an A&E visit every two years on the Claimant's mileage. This seems logical and reasonable. **I award £75.44** under this head.

F. Summary

72. I have made the following awards:

General Damages	Damages for PSLA £94,000 plus interest at 2% being £5,358.00	Para 44 and 45
Special Damages - Past		
Past care and assistance	£260 (inclusive of £35.18 interest)	agreed
Past travel	£315 plus interest at £23.23	Para 47
Past medical costs	£146.39 (inclusive of £10.90 interest)	agreed
Past therapies	£0	Para 50
Past miscellaneous	£25 plus interest at £1.71	Para 52
Special Damages - Future		
Future medical treatment	£21,933.25	Para 58

	£7,280 (£8,000 x 0.91) pelvic clearance	Para 59
Future therapies	£0	
Future care and assistance	£2,262.95	Para 69
Future travel	£75.44	Para 71

73. The total damages award excluding interest is therefore £126,251.95. I will hear submissions on costs and consequentials at the handing down.

74. I am very sorry to have heard all that the Claimant has been through since 2016, and to learn that she will still be dealing with the results of the missed diagnosis of PID for many years into the future. I hope the determination of this claim will let her move forward. I wish her and her family all the very best for the future.