Neutral Citation Number: [2024] EWHC 2338 (KB)

Case No: QB-2020-002905

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13/09/2024

Before :

DEXTER DIAS KC
(sitting as a Deputy High Court Judge)

- -

Between :

PHILIPPA CAROLINE DEAKIN-STEPHENSON **Claimant**

- and –

(1) NEBIL BEHAR

(2) CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST **Defendants**

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Sydney Chawatama (instructed by **Wellers Law Group LLP**) for the **Claimant**
Andrew Kennedy KC (instructed by **Medical and Dental Defence Union of Scotland**) for the **First defendant**
Claire Toogood KC (instructed by **Weightmans**) for the **Second defendant**

Hearing dates: 25-27 March, 4-5 and 20 June 2024

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APPROVED JUDGMENT

Deputy High Court Judge Dexter Dias KC :

1. This is the judgment of the court.

2. In this personal injury claim, the claimant is Ms Phillipa Deakin-Stephenson. Ms Deakin-Stephenson is represented by Mr Chawatama of counsel. The first defendant is Mr Nebil Behar, who is represented by Mr Kennedy KC. The second defendant is the Chelsea and Westminster NHS Foundation Trust ("the Trust"). The Trust is represented by Ms Toogood KC. The court is grateful to counsel for their invaluable submissions and advocacy.

3. To assist the parties and the public follow the court's line of reasoning, the text is divided into 19 sections, as set out in the table below.

B123: hearing bundle page number. Where documents cited contain spelling or other errors, they are reproduced in original form without correction.

§I. BRIEF FACTS

4. The key events took place in November 2016. There are eight days of great relevance to this case, from Wednesday 2 November ("Day 1") to Wednesday 9 November ("Day 8"), with three important days on either side of the weekend of 5-6 November. I include a detailed chronology at Section V to assist readers, since the order and timing of events is particularly important in this case.

5. On Wednesday 2 November 2016, the claimant Ms Deakin-Stephenson (also referred to by the family as "Pip" or "Pippa") went to a hairdresser's in Fulham, London, with her sister Joanna (Joanna Ingledow or "Jo"). Although both sisters lived in Hampshire at the time, they travelled to London for a day out as they both used to work in the capital and had used the same hairdresser's for years. Whilst there in the middle of the afternoon, the claimant collapsed with acute abdominal pain. She was with her son, who at the time was aged 10. An ambulance was called and Ms Deakin-Stephenson was taken to the Accident & Emergency Department of Chelsea and Westminster Hospital ("the Hospital"), operated by the second defendant. Doctors suspected she had a possible pyelonephritis, a type of urinary tract infection where one or both kidneys become infected. She was transferred to the Acute Assessment Unit ("AAU") for surgical review in the early hours of Thursday 3 November, where that morning she was examined by the first defendant Mr Behar, who is a consultant laparoscopic and emergency surgeon. It is at this point that the parties begin to differ about what happened. What can be agreed is that on 3 November, there was a CT scan that showed that Ms Deakin-Stephenson had developed a condition known as diverticulitis with a localised perforation. Diverticulitis is a condition that affects the large intestine and colon and is caused by the development of bulges called "diverticula". These pouches can sometimes cause severe abdominal pain and may enlarge to the extent that they perforate the intestinal wall. Mr Behar at first tried to treat the condition conservatively with intravenous antibiotics and fluids. But on Sunday 6 November, a second CT scan revealed a progression of the disease. On the morning of Monday 7 November, the claimant underwent a surgical procedure performed by Mr Behar called laparoscopic lavage, which involves puncturing a hole through the abdominal wall and washing out the infected area around the colon.

6. Ms Deakin-Stephenson's condition appeared to settle until about 23:00 hours on Tuesday 8 November (Day 7). She collapsed with severe abdominal pain. Mr Behar was called in and arranged emergency surgery. Very early on Wednesday 9 November, he performed a procedure called the Hartmann's procedure. The claimant was extremely unwell. She remained in the Intensive Care Unit ("ICU") until 17 November and was finally discharged home on 29 November 2016. To this day, she suffers from chronic abdominal pain and several other conditions, including PTSD.

7. It is no exaggeration to say that these events have been life-altering for Ms Deakin-Stephenson. She vividly described to the court how it had been the "most horrifically extraordinary event" of her life and she believed she was about to die. She experienced multiple organ failure and was, as she put it, on "life support". To save her life, she had to be placed in a medically induced coma and her family were advised that she may not survive.

§II. RIVAL CASES

Ms Deakin-Stephenson's case

8. The claimant case is that following her admission into the Hospital, she and her family repeatedly asked Mr Behar to refer her for a second opinion from a specialist colorectal surgeon, which Mr Behar failed to do, ignoring and obstructing their reasonable requests. Her case is that Mr Behar is principally an emergency surgeon and certainly not a specialist colorectal surgeon. If Mr Behar had referred her to a colorectal specialist, that surgeon is likely to have recommended the Hartmann's procedure following the second CT scan on the evening of Sunday 6 November when surgery was inevitable, and she is likely to have given her informed consent to this procedure, notwithstanding that this would result in her having a stoma, that is a hole in her abdomen through which the bowel is relocated to collect waste into a collection (colostomy) bag. The agreed expert evidence is that a Hartmann's procedure on that Sunday night is likely to have avoid the catastrophic deterioration Ms Deakin-Stephenson experienced late on the night of Tuesday 8 November which necessitated emergency life-saving surgery in the early hours of Wednesday 9 November. A prompt Hartmann's procedure would have avoided the adverse outcomes she experienced and continues to experience.

9. Ms Deakin-Stephenson says that Mr Behar did not consent her properly before the laparoscopic lavage on Monday 7 November because he did not tell her about the possibility of the reasonable alternative and variant treatment that is the Hartmann's procedure which she ultimately had to undergo in any event, but under emergency conditions when her life was at stake. If she had been told about the Hartmann's option on Sunday night, she would have chosen that surgical procedure and that would have avoided her collapse and the severe deterioration she experienced on Tuesday night. Further, Mr Behar delayed in performing the laparoscopic lavage from Sunday night to Monday morning unreasonably. She also says that during the time that she was an NHS patient (until the afternoon of Friday 4 November), the second defendant Trust was vicariously liable for the acts and omissions of Mr Behar. When Mr Behar first met her, he asked her if she had private health insurance and induced her move to the private wing of the Hospital. This was while he was caring for her under the NHS, and as her move to the private wing had been improperly induced, the Trust remained liable for Mr Behar's acts and omissions. In addition, the Trust was negligent in that it failed to have in place a safe and adequate system whereby the claimant could be managed by a surgical team led by a colorectal specialist surgeon, which Mr Behar was not, being an emergency surgeon.

Mr Behar's case

10. The first defendant states that he has no recollection of Ms Deakin-Stephenson or anyone else on her behalf asking for a referral to a colorectal surgeon. If such a request were made, Mr Behar would have assisted in the referral and had no reason not to and has never refused a referral. Further, Mr Behar has expertise and extensive experience in colorectal surgery. He did not induce her move to the private wing and had never done that with any patient. He properly consented the claimant, a process that began on the evening of Sunday 6 November and was completed on the morning of Monday 7 November. This was because Ms Deakin-Stephenson showed a great aversion to having a stoma (a constituent part of the Hartmann's procedure). Therefore, he gave her the

chance to think overnight about what she was wanted to consent to. She did this and was content to proceed with laparoscopic lavage with the possibility of converting that to a Hartmann's procedure if medically indicated during the procedure. There was no culpable delay in surgery between Sunday night and Monday morning. Upon surgical exploration on Monday 7 November, there was no faecal contamination and converting the "washout" (laparoscopic lavage) to a Hartmann's procedure was not medically mandated. The deterioration that Ms Deakin-Stephenson experienced 36 hours after this surgery could not have been reasonably foreseen. Therefore, there was no breach of duty and no causative breach of duty. The claim against Mr Behar should be dismissed.

The Trust's case

11. While broadly supporting Mr Behar's stance, the Trust specifically argues that there is no vicarious liability for any acts and omissions of Mr Behar following the claimant's transfer to the private wing of its hospital on Friday 4 November. The claimant was treated as a private patient from that point and not under the NHS. There is no evidence that the second defendant failed to have an appropriate policy in place to deal with cases such as Ms Deakin-Stephenson's. The claim against the Trust should be dismissed.

§III. ISSUES

12. There are eight prime issues for the court to determine; six in the case against Mr Behar and two in Ms Deakin-Stephenson's case against the Trust.

13. In respect of Mr Behar, the allegations can be further subdivided into issues of breach of duty (negligence, broadly) and causation. In respect of the Trust, there are issues of vicarious liability and policy failure.

The first defendant

Breach of duty

- Did the claimant and/or members of her family ask Mr Behar for a referral to a colorectal surgeon or a second opinion? [**Behar Issue 1 – "Referral"]**
- Did Mr Behar instigate and induce the claimant's transfer to private care? **[Behar Issue 2 – "Transfer"**]
- Did Mr Behar inform the claimant on 6 November 2016 that a Hartmann's procedure was a surgical option? **[Behar Issue 3 – "Hartmann's procedure"]**
- Did Mr Behar warn the claimant of the risks and benefits of a laparoscopic lavage and a Hartmann's procedure? **[Behar Issue 4 – "Risks"]**
- Did Mr Behar negligently delay surgery from the evening of Sunday 6 November to the morning of Monday 7 November 2016? **[Behar Issue 5 – "Delay"]**

Causation

- Did any breach of duty by Mr Behar cause injury to the claimant? **[Behar Issue 6 – "Causation"]**

The second defendant

- Is the second defendant vicariously liable for any negligent acts and omissions of Mr Behar after the claimant was transferred to the private wing of the Hospital? [**Trust Issue 1 – "Vicarious liability"**]
- Did the second defendant fail to possess or operate a policy to ensure that medical cases are referred to the appropriate specialist teams in good time? [**Trust Issue 2 – "Policy"**]

14. I make plain that my approach to the judgment text is heavily informed by the approach of the Court of Appeal in *Re B (A Child) (Adequacy of Reasons)* [2022] EWCA Civ. 407. The court stated at para 58:

> "... a judgment is not a summing-up in which every possible relevant piece of evidence must be mentioned."

15. Therefore, I focus on what has been essential to my determinations in this case. Numerous side issues were thrown up. I do not need to resolve them all. The critical issues are clear. I focus on those and make such findings of fact as are necessary to determine the prime identified issues here. While I do not set out all the evidence the court received, and it is extensive, I emphasise that as part of my review I considered or reconsidered it all. I reserved judgment for precisely that reason. I provide an assessment of each of the key witnesses and refer to the vital evidence that informed the court's decision on any specific issue within the dedicated section of the text.

§IV. MATERIALS

16. The chief materials before the court included:

(1) Trial bundle: 774 pp. and supplementary bundles

(2) Core medical records: 667 pp.

(3) Claimant's full medical records: 3774 pp.

17. The court also received helpful skeleton arguments from counsel before the trial and written submissions following the close of the evidence, which counsel spoke to and fleshed out orally.

§V. CHRONOLOGY

18. The key dates in the case can be divided into two categories. The first contains the eight vital days of Ms Deakin-Stephenson's admission and residency in the Hospital until her transfer to ICU following the emergency surgery in the early hours of Wednesday 9 November (Day 8). The second category consists of some notable dates in the unfolding chronology after Day 8 that will feature in the court's analysis.

2016

Day 1: Wednesday 2 November

19. On the afternoon of 2 November, the claimant was in London with her sister at a hairdresser's in Fulham. Ms Deakin-Stephenson was feeling unwell and her discomfort increased until she collapsed with abdominal pain. An ambulance took her to A&E at the Chelsea and Westminster Hospital. She arrived there in the early evening and was admitted at 18:18 hours.

20. On examination, Ms Deakin-Stephenson was found to have tenderness on the left side of the abdomen. The A&E team made a diagnosis of possible pyelonephritis (kidney infection) at 20:50 hours. (Note: at this point, she was not seen by Mr Behar.)

Day 2: Thursday 3 November

21. The claimant was transferred to the AAU in the early hours. At 08:30 hours, she was seen for the first time by Mr Behar acting in the capacity of Consultant Emergency Surgeon. Mr Behar was not satisfied with the pyelonephritis diagnosis of the admitting medical team and ordered an urgent CT scan, given his working diagnosis of diverticulitis. A "rapid" CT scan was arranged following Mr Behar's instructions, and took place at 09:30 hours on the morning of 3 November. The scan revealed diverticulitis within the sigmoid colon complicated by a localised perforation.

22. The surgical Specialist Registrar ("SpR") told the claimant about these findings. When the claimant saw Mr Behar at 14:45 hours, he confirmed a diagnosis of acute diverticulitis. His plan was for "conservative" management, with intravenous antibiotics and fluids.

Day 3: Friday 4 November

23. Mr Behar reviewed the claimant at 09:18 hours and her observations remained stable. He reviewed her again at 13:13 hours. Her abdomen remained painful and his plan was to continue the conservative management with a review the next day. Ms Deakin-Stephenson was having difficulty passing urine and Mr Behar suggested a catheter. The nursing notes indicate that the claimant was resistant to being catherised.

24. Around 16:30 hours, the claimant was formally transferred to the private Chelsea Wing of the Hospital (although it is possible that she physically moved beds later than this due to the lack of capacity). Mr Behar reviewed her at 18:00

hours and the plan for conservative treatment with antibiotics and fluids continued.

Day 4: Saturday 5 November

25. The claimant was reviewed by SpR Walsh. Her abdomen remained tender.

Day 5: Sunday 6 November

26. Mr Behar reviewed the claimant at 15:27 hours.

27. A second CT scan took place (how this came about is in dispute). The scan revealed a generalised large volume of free air within abdomen. There was a deterioration in regional inflammation. Mr Behar reviewed the claimant once more following the scan results. There was a discussion between Mr Behar and Ms Deakin-Stephenson about which surgical procedure should be performed as surgery of some kind was now inevitable. A consent form was signed by the claimant. The date on the form is "6/11/16". In the section entitled "Name of proposed procedure or course of treatment" Mr Behar wrote:

> "Laparoscopic washout of diverticulitis +/- sigmoid colectomy + stoma only if absolutely needed"

28. The intended benefits were "resolve sepsis". The "significant, unavoidable or frequently occurring risks" were listed as:

> "bleeding, infection, DVT, PE, chest infection"

29. Later that evening, the claimant's sister Mrs Ingledow sent a text message to her mother at 22:25 hours stating that she had identified a colorectal surgeon, Mr Oliver Warren. Mrs Ingledow also sent the claimant an email at 22:38 hours stating mentioning Mr Warren as someone she might want to "talk to".

Day 6: Monday 7 November

30. On the morning of 7 November, the claimant was taken to theatre around 10:45 hours, when Mr Behar performed a laparoscopic lavage. The operation note written by Mr Behar states:

> *"Operation:* "Laparoscopic washout of diverticular perforation with release of SB adhesion and bladder adhesion and Omental transposition. (5mm visiport entry and two further 5mm ports).
>
> *Findings:* "Proximal sigmoid diverticula phlegmon with adhesions to a loop of small bowel and bladder. Free Fluid with small amount of pus… No faeces seen. Colon not dilated.
>
> *Procedure:* "Free fluid washed first. Small bowel which could cause obstruction or fistulation was detached with wash. Dome of bladder freed of phlegmon sufficiently to avoid colovesical fistula (urinary frequency pre op). Area of perforation inspected; No faeces seen, no significant defect in bowel wall, but minimal amount of

> pus ooze on pressure. A tongue of Omental brought over from upper abdomen and sutured with vicryl to appendences epiploic of Sigmoid colon beyond the perforation so that the omentum now lies between perforation site and small-bowel. See photos. Further wash, drain Robinson 20ch to pelvis secured with silk ports out under vision. Haemostasis. 0 vicryl to umbilical defect. 3.0 Monocryl to skin and steristrips."

31. Therefore, while a small amount of pus was evident, there were no faeces and the colon was not dilated. Mr Behar found no clinical need to convert the surgery into a Hartmann's procedure as there was no clear hole or faeces. He took photographs that were subsequently provided to the claimant. The free fluid was washed out. The area of perforation was inspected. There was no significant defect in the bowel wall and a minimal amount of pus oozed from the area upon the application of pressure. Mr Behar placed a tongue of omentum (a fold of the abdomen lining, the peritoneum) from the upper abdomen and sutured it over the sigmoid colon to create a seal for the perforation. Following surgery, the plan was to continue with antibiotics.

32. At 11:30 hours on the same day, Mr Behar wrote a "retrospective" note, stating that the claimant was seen "last night" (Sunday 6 November) and was:

> "consented for lap washout with Hartmann's if needed am [in the morning]".

Day 7: Tuesday 8 November

33. At 08:36 hours, Mr Behar attended Ms Deakin-Stephenson and noted that her observations were stable. She was away from the bedside. Later that morning, he reviewed her again and she was well.

34. At around 23:00 hours the claimant experienced the onset of severe pain after she tried to move her bowels. Peritonitis (an inflammation of the abdomen lining) was diagnosed. This is often associated with a hole in the bowel. Ms Deakin-Stephenson was prepared for emergency surgery.

Day 8: Wednesday 9 November

35. The claimant was taken to theatre for surgery around 01:00 hours. On preliminary laparoscopy there was faecal peritonitis. Therefore, a midline laparotomy was performed. A 5 mm perforation in the proximal sigmoid colon was identified, contaminated with faeces along with peritonitis containing pus. Mr Behar converted the surgery to a Hartmann's procedure at around 03:00 hours, resulting in the claimant having a stoma.

36. Ms Deakin-Stephenson was transferred to the ICU experiencing septic shock from the contamination. She remained ventilated with a breathing tube and sedated. Ms Deakin-Stephenson required dialysis. Her family was informed that she may not survive.

Friday 11 November

37. The claimant's condition gradually improved and it was possible to take her off sedation.

Sunday 13 November

38. The claimant was extubated, the removal of the tube assisting her breathing.

17 November

39. The claimant was transferred from the ICU to the Chelsea Wing where she continued to make a steady recovery.

29 November

40. Ms Deakin-Stephenson was discharged from the Hospital and allowed to go home.

6 December

41. Mr Behar saw the claimant at this private clinic for follow-up review. He noted that she was making reasonable progress. Mr Behar referred her to Professor Tekkis to consider reversal of the Hartmann's procedure.

2017

1 January

42. Ms Deakin-Stephenson posted a positive online review of Mr Behar.

23 January

43. The claimant sent an email to Mr Behar about her condition and treatment.

13 March

44. The claimant sent an email (letter) of complaint to the Trust's complaints team.

26 April

45. Following the March complaint, the claimant and her sister met Mr Behar at the Hospital. The discussion was transcribed.

9 June

46. Ms Deakin-Stephenson made a formal complaint.

18 July

47. The claimant made a further complaint.

48. The procedural history of the claim then developed as follows:

- 2020, 3 August: claim form filed on behalf of Ms Deakin-Stephenson.
- 2021, 8 October: Amended particulars of claim filed.
- 2022, 10 March: Mr Behar's defence filed.
- 2022, 22 March: The Trust's defence filed.
- 2023, 31 January: Directions order of Master Sullivan (following costs and case management conference on 25 November 2022) setting down trial window for autumn 2023, ultimately varied for trial in March 2024.

§VI. LAW

49. The legal principles that govern the case are divided into three dominant themes, the contours of which can be simply stated (1) standard of care; (2) fact-finding; (3) conflict in expert evidence.

(1) Standard of care

50. In English law the standard of care expected is reflected in McNair J's direction to the jury in *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582, 586:

> "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.....in the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if he conforms with one of those proper standards, then he is not negligent. .....the real question .....is whether the defendants, in acting in the way they did, were acting in accordance with a practice of competent respected professional opinion..... 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."

51. When addressing the question of consent, the court will be guided by the Supreme Court's decision in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 at para 87:

> "The correct position, in relation to the risks of injury involved in treatment, can now be seen to be substantially that adopted in *Sidaway* by Lord Scarman, and by Lord Woolf MR in *Pearce* [1999] PIQR P53, subject to the refinement made by the High Court of Australia in Rogers v Whitaker 175 CLR 479, which we have discussed at paras 77—73. An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."

52. The reference to "reasonable alternative or variant treatments" needs to be read in light of the Supreme Court's decision in *McCullough and others v Forth Valley Health Board* [2023] UKSC 26 and the Court of Appeal's decision in *Bilal & Malik v St George's University Hospital NHS Foundation Trust* [2023] EWCA Civ 605 that the assessment of treatment options is to be determined by applying the test in *Bolam* (para 66). As the Supreme Court explained at para 56:

> "… the correct legal test to be applied to the question of what constitutes a reasonable alternative treatment is the professional practice test found in *Hunter v Hanley* 1955 SC 200 and *Bolam* [1957] 1 WLR 582."

(2) Fact-finding

53. This case involves fundamental disputes of facts between parties. Since they cannot agree, the court must step in and decide. There are numerous axioms of fact-finding, but here I identify those most pertinent to the determination of this case. There are 13 of them, starting from the most elementary, and borrowing from authority on the finding of facts across jurisdictions, where relevant.

(1) The burden of proof rests exclusively on the person making the claim (she or he who asserts must prove), who must prove the claim to the conventional civil standard of a balance of probabilities;

(2) Findings of fact must be based on evidence, including inferences that can properly (fairly and safely) be drawn from the evidence, but not mere speculation (*Re A (A child) (Fact Finding Hearing: Speculation)* [2011] EWCA Civ 12, per Munby LJ);

(3) The court must survey the "wide canvas" of the evidence (*Re U, Re B (Serious injuries: Standard of Proof)* [2004] EWCA Civ 567 at [26] per Dame Elizabeth Butler-Sloss P (as she then was)); the factual determination "must be based on all available materials" (*A County Council v A Mother and others* [2005] EWHC Fam. 31 at para 44, per Ryder J (as he then was));

(4) Evidence must not be evaluated "in separate compartments" (*Re T* [2004] EWCA Civ 558 at para 33, per Dame Elizabeth Butler-Sloss P), but must "consider each piece of evidence in the context of all the other evidence" (*Devon County Council v EB & Ors.* [2013] EWHC Fam. 968 at para 57, per Baker J (as then was)); such "context" includes an assessment of (a) inherent coherence, (b) internal consistency, (c) historical consistency, (d) external consistency/validity – testing it against "known and probable facts" (*Natwest Markets Plc v Bilta (UK) Ltd* [2021] EWCA Civ 680 at para 49, per Asplin, Andrews and Birss LJJ, jointly), since it is prudent "to test [witnesses'] veracity by reference to the objective facts proved independently of their testimony, in particular by reference to the documents in the case" (*The Ocean Frost* [1985] 1 Lloyd's Rep 1 at p.57, per Robert Goff LJ)[1];

(5) The process must be iterative, considering all the evidence recursively before reaching any final conclusion, but the court must start somewhere (*Re A (A Child)* [2022] EWCA Civ 1652 at para 34, per Peter Jackson J (as he then was)):

> "… the judge had to start somewhere and that was how the case had been pleaded. However, it should be acknowledged that she could equally have taken the allegations in a different order, perhaps chronological. What mattered was that she sufficiently analysed the evidence overall and correlated the main elements with each other before coming to her final conclusion."

(6) The court must decide whether the fact to be proved happened or not. Fence-sitting is not permitted (*In re B* [2008] UKSC 35 at para 32, per Lady Hale);

(7) The law invokes a binary system of truth values (*In re B* at para 2, per Lord Hoffmann):

> "If a legal rule requires a fact to be proved (a "fact in issue"), a judge or jury must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are 0 and 1. The fact either happened or it did not. If the tribunal is left in doubt, the doubt is resolved by a rule that one party or the other carries the burden of proof. If the party who bears the burden of proof fails to discharge it, a value of 0 is returned and the fact is treated as not having happened. If he does discharge it, a value of 1 is returned and the fact is treated as having happened."

[1] *Ocean Frost* was a fraud case, but Mostyn J is surely correct that the principle of external verification must be "of general application" (*Lachaux v Lachaux* [2017] EWHC 385 (Fam) at para 37).

(8) There are important and recognised limits on the reliability of human memory: (a) our memory is a notoriously imperfect and fallible recording device; (b) the more confident a witness appears does not necessarily translate to a correspondingly more accurate recollection; (c) the process of civil litigation subjects the memory to "powerful biases", particularly where a witness has a "tie of loyalty" to a party (*Gestmin SCPS S.A. v Credit Suisse (UK) Ltd* EWHC 3560 (Comm) at paras 15-22, per Leggatt J (as then was)); and the court should be wary of "story-creep", as memory fades and accounts are repeated over steadily elapsing time (*Lancashire County Council v C, M and F (Children – Fact-finding)* [2014] EWFC 3 at para 9, per Peter Jackson J ("*C, M and F*");[2]

(9) The court "takes account of any inherent probability or improbability of an event having occurred as part of the natural process of reasoning" (*Re BR (Proof of Facts)* [2015] EWFC 41 at para 7, per Peter Jackson J); "Common sense, not law, requires that … regard should be had, to whatever extent appropriate, to inherent probabilities" (*In re B* at para 15, per Lord Hoffmann);

(10) Contemporary documents are "always of the utmost importance" (*Onassis v Vergottis* [1968] 2 Lloyd's Rep. 403 at 431, per Lord Pearce ("*Onassis*")),[3] but in their absence, greater weight will be placed on inherent probability or improbability of witness's accounts:

> "It is necessary to bear in mind, however, that this is not one of those cases in which the accounts given by the witnesses can be tested by reference to a body of contemporaneous documents. As a result the judge was forced to rely heavily on his assessment of the witnesses and the inherent plausibility or implausibility of their accounts." (*Jafari-Fini v Skillglass Ltd* [2007] EWCA Civ 261 at [80], per Moore-Bick LJ);

And to same effect:

> "Faced with documentary lacunae of this nature, the judge has little choice but to fall back on considerations such as the overall plausibility of the evidence" (*Natwest Markets* at para 50).

[2] The *Gestmin* principles approved variously (but see next footnote), including *R (Bancoult No.3) v Secretary of State for Foreign and Commonwealth Affairs* [2018] UKSC 3 – see Lord Kerr at para 103, where they were said to have "much to commend them"; however, the Court of Appeal subsequently stated that *Gestmin* is "not to be taken as laying down any general principle for the assessment of evidence … [instead] It is one of a line of distinguished judicial observations that emphasise the fallibility of human memory" (*Kogan v Martin* [2019] EWCA Civ 1645 at paras 88-89, per Floyd LJ).
[3] It must be remembered that *Onassis*, like *Gestmin*, was a dispute about recollection of business conversations, where typically there will commercial documentation. Ryder LJ sounds a necessary warning note about "simply harvesting obiter dicta expressed in one context and seeking to transplant them into another" (*Re B-M (Children: Findings of Fact)* [2021] EWCA Civ 1371 at para 23).

(11) The judge can use findings or provisional findings affecting the credibility of a witness on one issue in respect of another (*Bank St Petersburg PJSC v Arkhangelsky* [2020] EWCA Civ 408 ("*Arkhangelsky*").[4]

(12) However, the court must be vigilant to avoid the fallacy that adverse credibility conclusions/findings on one issue are determinative of another and/or render the witness's evidence worthless. They are simply relevant:

> "If a court concludes that a witness has lied about a matter, it does not follow that he has lied about everything." (*R v Lucas* [1981] QB 720, per Lord Lane CJ);

Similarly, Charles J:

> "a conclusion that a person is lying or telling the truth about point A does not mean that he is lying or telling the truth about point B..." (*A Local Authority v K, D and L* [2005] EWHC 144 (Fam) at [28]).

What is necessary is (a) a self-direction about possible "innocent" reasons/explanations for the lies (if that they be); and (b) a recognition that a witness may lie about some things and yet be truthful "on the essentials … the underlying realities" (*Re A (A Child) (No.2)* [2011] EWCA Civ 12 at para 104, per Munby LJ).

(13) Decisions should not be based "solely" on demeanour (*Re M (Children)* [2013] EWCA Civ 1147 at para 12, per Macur LJ); but demeanour, fairly assessed in context, retains a place in the overall evaluation of credibility: see *Re B-M (Children: Findings of Fact)* [2021] EWCA Civ 1371, per Ryder LJ:

> "a witness's demeanour may offer important information to the court about what sort of a person the witness truly is, and consequently whether an account of past events or future intentions is likely to be reliable" (at para 23); so long as "due allowance [is] made for the pressures that may arise from the process of giving evidence" (at para 25).

But ultimately, demeanour alone is rarely likely to be decisive. Atkin LJ said it almost 100 years ago (*Societe d'Avances Commerciales (SA Egyptienne) v Merchans' Marine Insurance Co (The "Palitana")* (1924) 20 Ll. L. Rep. 140 at 152):

[4] At para 120, per Males LJ, "once other findings of dishonesty have been made against a party, or he is shown to have given dishonest evidence, the inherent improbability of his having acted dishonestly in the particular respect alleged may be much diminished and will need to be reassessed." A dishonesty case, but I discern no valid reason a different kind of impairment to credibility, such as unreliability or inaccuracy, is not capable of the same approach. It is an application of the principle of judging evidence in the context of all other evidence.

> "… an ounce of intrinsic merit or demerit in the evidence, that is to say, the value of the comparison of evidence with known facts, is worth pounds of demeanour."

(3) Conflict in expert evidence

54. Expert evidence can be of immense value to the court. However, we do not have trial by experts. Where experts disagree, the proper legal approach has been identified by the court in several cases. In *Flannery v Halifax Estate Agencies Ltd* [2000] 1 WLR 377, Henry LJ said:

> "where the dispute involves something in the nature of an intellectual exchange, with reasons and analysis advanced on either side, the judge must enter into the issues canvassed before him and explain why he prefers one case over the other. This is likely to apply particularly in litigation where as here there is disputed expert evidence" (proposition 3)

55. This approach was affirmed in *English v Emery Reimbold & Strick Ltd* [2002] EWCA Civ 605. Further guidance was provided by Lord Phillips MR at para 19:

> "This does not mean that every factor which weighed with the judge in his appraisal of the evidence has to be identified and explained. But the issues the resolution of which were vital to the judge's conclusion should be identified and the manner in which he resolved them explained. It is not possible to provide a template for this process."

§VII. ASSESSMENT OF MS DEAKIN-STEPHENSON

Approach to assessments

56. There are irreconcilable and highly significant factual disputes between the lay witnesses. An important body of contemporaneous or near-contemporaneous documentation exists along with the filed and oral witness evidence. I have found the contemporaneous evidence of use in assessing the reliability, accuracy and credibility of the rival witnesses (*Onassis* principle). My approach has been grounded in the axioms of fact-finding that I have set out in the preceding Law section. I have considered the "wide canvas" and in many key instances reconsidered the evidence carefully to permit analysis in the context of all the other evidence (*Re T* principle). This was one of the reasons for reserving judgment. I have taken a global and holistic approach to evidence evaluation. One of the consequences of the discipline of setting down a judgment is that to promote comprehensibility, issues are recorded in linear order. Such structure is designed to aid intelligibility. But I emphasise that the task of evidential analysis and evaluation has been a recursive and iterative process, without hiving discrete areas off into forensic silos. This is how the factual findings in this case should be understood. Each finding is to the requisite civil standard.

Ms Deakin-Stephenson

57. An assessment of Ms Deakin-Stephenson's evidence is fundamental to this case. I emphasise that my approach has been to assess it in the context of all the other evidence, including that of Mr Behar, the contemporaneous records, and the body of evidence provided by the three members of her family and close circle. In this section, I examine a number of topics across the range of disputed issues to show how I have formed an overall assessment of the claimant's credibility and have not simply analysed Ms Deakin-Stephenson's evidence in artificial compartments.

58. Overall, I found Ms Deakin-Stephenson to be an extremely affable, polite and engaging person. She is articulate, confident and intelligent. She had been professionally involved in nursery care and had been the principal of a nursery. This is unsurprising from the way she came across: someone with a measure of inner steel and self-confidence, able to be articulate and firm under pressure. She clearly has leadership qualities. She set up three nursery schools and was the principal. There were 550 children aged 1 between 5 at different times. She was the named "responsible person" for Ofsted and regulatory purposes. As she put it, "it was a big responsibility - huge". Ms Deakin-Stephenson is plainly a person of substance. She is well able to get her point across fluently, ask intelligent, relevant questions, argue a point and argue back. She did all of this when being cross-examined by two very able counsel, both King's Counsel of great professional skill. Due to the strain on her and recognising at all times her continuing medical difficulties, the court adapted its process and ensured that Ms Deakin-Stephenson could have all the breaks she needed. The court arranged that a courtroom was selected for the trial to ensure easy access to facilities to assist her and ensure, to the extent it was possible, that she was comfortable. The court regularly checked on how she was faring and whether she needed a break. Once, for example, when it appeared to the court that she was very distressed, something not spotted by counsel (no criticism), the court asked if she would like a break, which she accepted and time was granted.

59. In the intervening period between the events of 2016 and trial, the claimant read in depth into the medical literature about her disease and the available treatments. This most certainly stated in a critical way. She was trying to understand what had happened to her. However, the consequence is that at times instead of answering counsel's questions, she sought to respond by putting detail from the literature and the technicalities of medical procedure and then asked counsel questions instead of answering directly. She had developed an encyclopaedic knowledge of the details and dates within the trial bundles, which was impressive.

60. It must never be forgotten that between 2 and 9 November 2016, the eight days the court is particularly concerned with, Ms Deakin-Stephenson was ill and in hospital, but there were times when she was doing better. Her evidence is that throughout the period, save for Saturday 5 November (Day 4) when she says that Mr Behar was not at the hospital, a matter he disputes, she asked him repeatedly for a referral to a specialist colorectal surgeon. This is a vital and central dispute between the parties that the court must resolve and will be Issue 1 in the allegations made against Mr Behar.

61. The court places limited weight on demeanour as a reliable guide to where the truth lies, but I recognise that, in line with authorities, this factor is not entirely irrelevant. The forensic limitation is all the more poignant in this case since Ms Deakin-Stephenson has been deeply affected by the medical situation in 2016 and thereafter and this impacted her composure during testifying. I do not hold that against her. Few issues could be more deeply personal in nature.

62. However, her conduct in the witness box was variable. Sometimes she could be responsive and engaging, whereas at others her assertiveness tipped into being argumentative and even abrasive with counsel. For example, when Ms Toogood was cross-examining her about what she would have chosen from the various surgical interventions, Ms Deakin-Stephenson said, "I would have chosen a stoma and that's all I have to say about it, Ms Toogood", expressed in a strident way to shut off any further investigation of the topic. Therefore, any surface impressions must be put into the context of Ms Deakin-Stephenson's continuing trauma. Nevertheless, it was possible for the court to discern when she was prepared to answer directly and a genuine desire to assist the court existed and when there was a reluctance to answer to a particular question that dented her case. This is one of the clear advantages of watching evidence unfold live in the witness box.

63. At various times the claimant did not answer the carefully framed direct question asked of her by counsel, but chose to embark on speeches by way of long answers that did not address the point. On several occasions the court had to ask counsel to repeat the question as the claimant had deviated greatly from the tight focus of the question. It is understandable that because Ms Deakin-Stephenson feels very strongly about her case that she was eager to make all the points she believed important, even though they did not address the question asked by counsel, but when she was confronted by evidence that did not assist her, she sometimes struggled and was uncooperative. At times, I judged that this was in an attempt to avoid answers that she had the insight to recognise were unhelpful to her case. She is certainly intelligent enough to understand the difficulties of her case and sometimes she sought to avoid them. For example, when Mr Kennedy was asking her about whether she had previously mentioned allegations that are now central to her case – for example, asking Mr Behar for a colorectal surgeon referral - instead of simply saying that they were not mentioned, she sought to give extended disquisitions that were ultimately not a direct answer. The court found that this acted to impair her credibility because she recognised evidence and answers that were not helpful to her case and tried to avoid them.

64. She was asked by Ms Toogood if she had heard about a colostomy bag. It was an entirely straightforward question and capable of a direct answer. Instead, the claimant's response was, "I had not heard of a colostomy bag. You can't ask for five colostomy bags in Boot's." The answer, aside from being unhelpfully sarcastic, is implausible for a person of her intelligence and life-experience. The claimant had seen the thrust of counsel's question and chose to give an answer that did not ring true and responded in an unnecessarily sarcastic way. She is a mature, educated and smart person who has made a significant contribution to her communities through her professional work. She has been closely

connected to surgery and the medical investigation of her body for years. Her sister her undergone serious bowel surgery, including a colectomy. Mrs Ingledow was referred to a nurse for support and advice about an ileostomy which may result in a stoma (a hole in the abdomen), but for the small intestine (ileum) rather than a colostomy where it is the colon that is rerouted to an external hole. Both procedures require a bag over the hole to collect waste products. Ms Deakin-Stephenson is plainly very close indeed to her sister, who attended the Hospital with her on admission and was named as next-of-kin. Mrs Ingledow was deeply involved in supporting her sister both during the claimant's time in hospital and then in the aftermath, as her attending the April 2017 meeting with Mr Behar makes clear. In that context, Ms Deakin-Stephenson's suggestion of never having heard of colostomy bag is not credible, and is more likely a response given with the purpose of blunting counsel's line of questioning.

65. The court found that her evidence at points was confused and contradictory. She said on oath that during the 26 April 2017 meeting with Mr Behar at the Hospital she could remember mentioning that she had requested that Mr Behar refer her to a colorectal surgeon. But the record shows that she did not raise this this concern with Mr Behar once during the meeting. A variation of this point arises about whether during the April meeting she suggested that it was Mr Behar who first made the suggestion of private care or private insurance and thereafter induced her to move to the private wing of the hospital. Her answer about this was unconvincing. She stated:

> "How could I ask those questions, there was no time, when I got a chance to ask the questions, the meeting was over."

66. The reason this was an unconvincing answer is that the meeting lasted 71 minutes. The court has carefully read and re-read the transcript. It was certainly open to Ms Deakin-Stephenson, and indeed her sister, to raise this concern with Mr Behar and yet neither did. Ms Deakin-Stephenson's explanation for failing to do so that "there was no time" is unconvincing. A comparable issue arises with the question of what happened on the crucial Sunday night (6 November). At paragraph 233 of the transcript, Mr Behar gives a long and detailed account during the meeting. This narrative runs contrary to the claimant's case. During the April meeting, she does not seek to query or challenge his account, and nor does her sister. To understand why that may be the case, one must look at what she had said in the month before the meeting, evidenced by her email on 9 March 2017:

> "I said I had no complaint and that you had been amazing looking after me and saving my life."

67. Therefore, in March 2017, that is several months after her discharge, she remained very grateful to Mr Behar for saving her life and had "no complaint" about him. That extends not only to "saving her life", which might be a reference to the emergency operation, but to "looking after her". Yet she said in evidence that she believed "at the time" – that is, as at March 2017 - that if she had been referred to the colorectal surgeon she would not have had the life-endangering collapse. That meant that at the time of the March email and the

April meeting in the Hospital with Mr Behar, she was aware of the significance of the referral to a colorectal surgeon. But in neither the March email nor the April meeting did she or her sister raise the fundamental point about how she could have avoided her medical deterioration and collapse because of Mr Behar's obstructiveness or inaction. This is at the very heart of her criticism of Mr Behar and yet she did not mention it in the January 2017 online review, the January email (after she had been discharged home for over a month and had opportunity to speak to her family), the March email to the complaints team and the April face-to-face meeting with Mr Behar.

68. Another weakness in her evidence is the question of the colorectal surgeon Mr Oliver Warren. She said in evidence that she had directly asked Mr Behar on the Sunday night to refer her to Mr Warren. But after the very unsatisfactory meeting with Professor Tekkis on 9 March 2017, which she considered "a total waste of time", she emailed Mr Behar. She said that the Professor would write letters to two doctors, one of whom was Oliver Warren. Ms Deakin-Stephenson then says in terms, "I have never heard of these other doctors". This is a curious answer indeed if she had asked Mr Behar directly to refer her to Mr Warren on Sunday 6 November 2016. The only possible explanation would be if by the time of her 9 March 2017 email, she had either forgotten – or not recovered the memory – that she had asked Mr Behar to refer to Oliver Warren. But she agreed in evidence that as of the meeting with Mr Behar on 26 April 2017, she had a recollection of "a couple of occasions" during which she had asked Mr Behar for a referral. Thus, her memory had returned or cleared enough to permit that. Yet neither her request for a referral to Mr Warren, nor any of her other requests for a referral, nor the requests by her family members, were mentioned in the 9 March email to Mr Behar, nor the meeting on 26 April 2017.

69. Her evidence on oath also undermines her case on this point. She told the court that on the night of Sunday 6 November, when her mother received the message from the claimant's sister, Ms Deakin-Stephenson read out the name Oliver Warren to Mr Behar and asked if he could make a referral to him. If this were true, is unlikely that in the claimant's 9 March email to Mr Behar she could have said that she had never heard of Mr Warren – on the contrary, on her trial evidence she had specifically mentioned his name to Mr Behar in requesting a referral. To say as she did in the email of 9 March that she "had never heard of" Mr Warren suggests that Mr Warren was not a prominent matter in the family's conversations with her. It is more consistent with her sister Mrs Ingledow having done some internet Googling or search engine research and having identified Mr Warren as a possible candidate for a second opinion on Sunday 6 November 2016 or around then. That, however, is very different from the claimant or anyone else having specifically asked Mr Behar directly to refer Ms Deakin-Stephenson to Oliver Warren.

70. On 9 June, the claimant sent an email to the Chelsea and Westminster "complaints team". The email stated:

> "Following the meeting at c& w hospital on 26 April I am sadly and with regret raising a formal complaint as questions were not answered in relation to my letter and care, or medication and why I was not operated on immediately."

71. Therefore, she was in the email making a "formal complaint". That is clear from the next sentence in which she states that "The complaint is as follows". She sets out in a series of paragraphs the nature of her complaint. For example, in the first paragraph she says:

> "1) on examination of the blood results from the time of my admission to being operated on as an Emergency on Monday 7 November 2016, including the first CT scan showing a perforated colon, it is clear that I had sepsis and therefore the " conservative" approach not to operate until the Monday 7 November 2016 was inappropriate treatment. I should have been operated on within 24 or mac 48 hours from admission."

72. In cross-examination, Mr Kennedy put paragraph 4 of the complaint to her in an attempt to find the content closest to any complaint about the various matters that ended up pleaded in the particulars of claim. This paragraph states:

> "4) please provide me with the consultants treatment plan after admission into the hospital and who was making the decisions on me between admission and the first operation as to what medication of antibiotics I was to receive."

73. The point Mr Kennedy makes, and with force, is that in this letter of complaint there is no complaint about how she ended up in private care, nor the request for a referral to a colorectal surgeon being refused (nor that she had to "beg" Mr Behar for a second CT scan on the Sunday). These are matters essential to her claim. It is puzzling why none of these matters that now are of such prime concern to the claimant were mentioned in the 9 June letter of complaint. The claimant's response to this is that the 9 June letter was superseded by the letter of 18 July. There are two points about this remark. First, the terms of the 9 June email indicate clearly that it is a letter of complaint. It ends in this way:

> "I am now raising this as a formal complaint to the chief executive of Chelsea & Westminster Hospital and for the subsequent consequences that led to the 1st operation not taking place until Monday 7th which then failed 36 hours later, resulting in the Hartmann procedure and septic shock on 9 November 2016 and the life threatening critical illness in ICU thereafter which include multiple organ failure and full life support."

74. Second, the 18 July letter once more fails to make the complaint that Mr Behar was asked to make a referral to Mr Warren. There is no mention of having to "beg" Mr Behar on Sunday 6 November for a second CT scan. This is despite in this letter of complaint stating that her complaint is "SEVERE" (original emphasis), and that she is instructing lawyers "for a law suit". Given the great seriousness of the situation that had been reached by 18 July 2017, it is surprising indeed that the allegation of asking Mr Behar on "multiple" occasions for a referral to a colorectal surgeon did not find its way into this "severe" complaint. It is a central allegation made against Mr Behar in these proceedings and this trial. The fact that this vital allegation was not mentioned in the 18 July 2017 complaint, nor the 9 June complaint, nor the 26 April meeting, nor the claimant's email to Mr Behar on 9 March 2017, undermines the core credibility of the allegation.

75. In Ms Deakin-Stephenson's statement at para 83 she refers in detail to the visit on Saturday 5 November by "SpR Walsh", that is, a Specialist Registrar. She states that she asked the SpR for a referral to a colorectal surgeon. She states refers to this doctor on eight occasions as "he" or "him". It is an undisputed fact that Specialist Registrar Walsh is a woman. However, in common with her former partner Mr Stephenson, Ms Deakin-Stephenson has said in her statement that the doctor is male. This indicates that the statements were produced in collaboration as both the claimant and Mr Stephenson have made the identical error. I deal with the unsatisfactory way that Mr Stephenson attempted to explain the error when I come to an assessment of his evidence. The claimant sought to justify this glaring factual inaccuracy in cross-examination by stating, "I cannot tell what all the doctors' race or gender is." This is an unsatisfactory answer. Her case is that she specifically asked the Specialist Registrar who visited her on the Saturday for a colorectal surgeon referral. She is able to recount in her statement that Mr Stephenson and her son were present. She gives a very detailed account of what was spoken between her and the doctor:

> "I remember being very tearful explaining to him how my abdomen and tummy felt and the pain in my bladder. I recall telling him I felt that something felt really not quite right, and it was different, but worse than yesterday. I told him I was clearly getting worse, not better. I asked the doctor where Mr Behar was, but he said he was not on duty I asked again to see a colorectal surgeon and he said he would pass the message on to Mr Behar."

76. I find that the mistake about the gender of the doctor, along with the clear collaboration with Mr Stephenson about the incident in preparing their statements, adversely affect the reliability of her account on the Saturday referral point. Another plausibility issue about Ms Deakin-Stephenson's claim that she asked Mr Behar for a referral is about how, on her case, he reacted to her requests. On oath, Ms Deakin-Stephenson said that she personally asked Mr Behar "8, 9 or 10 times" for a referral to a colorectal surgeon. In all those times when she was speaking directly to him and he to her, her case is that he never once said that he was a colorectal surgeon himself. One must add to this the allegations that Mrs Ingledow also allegedly asked him for a colorectal surgeon referral, or was present when such a request was made. Mrs Ingledow does not suggest that Mr Behar ever mentioned that he was such a surgeon. The claimant's evidence is that except when Mr Behar said on Friday that no colorectal surgeon would be on duty, his response to her was that "it was unnecessary". He never said, on her case, you are asking for referral to a colorectal surgeon but I am a colorectal surgeon. It is unlikely that Mr Behar would not have simply stated that he was a colorectal surgeon. This issue was explored with the two experts, and I will deal with it in due course. The experts agree that Mr Behar was competent to undertake colorectal surgery. Indeed, Mr Behar's unchallenged evidence is that at Chelsea and Westminster Hospital in the relevant period, he had performed the large majority of Hartmann's procedures, one type of colorectal surgery and the type of colorectal surgery Ms Deakin-Stephenson would shortly undergo.

77. The claimant states that her concern was the issue of a perforation. Her sister, who had undergone significant surgery for her bowel by way of colectomy, did not have a perforation, and it was this issue that made the claimant worried. Yet the claimant never asked Mr Behar whether he had the surgical skill to correct or remove the perforation surgically. She said in evidence that she was "not happy" with his answer that a perforation sometimes would "heal itself". Yet she never asked him if he was able to surgically deal with that. If she had asked him, his immediate answer, given that he was very experienced in colorectal surgery, would have been to say that he had the skill and experience to do so. Indeed, on Day 9, Wednesday 8 November, that is precisely what he did.

78. The claimant's case is that up until Sunday night (Day 5), she was asking him for a colorectal surgeon referral. Then she seems to agree, putting aside for now whether the options he offered her amounted to a Hartmann's procedure, he did mention "colectomy" and "stoma". Therefore, he was telling her on Sunday night that he could perform colorectal surgery on her. There is no suggestion in her evidence that she was surprised at what would have been a revelation to her: that Mr Behar was indeed able to perform colorectal surgery after all. On her case she had been asking him for a referral to a colorectal surgeon since Day 2, Thursday 3 November. Now on Day 5 he was suggesting that he would perform colorectal surgery. If she had previously been asking him for a referral to a colorectal surgeon, she is likely to have asked him why he had never mentioned in the previous days and discussions that he was a colorectal surgeon himself. This points to the fact that she did not make the referral request, an issue that is analysed in detail at Behar Issue 1. Indeed, in evidence when asked when she first found out that Mr Behar was also a colorectal surgeon, she said it was between the meeting with Mr Behar on 26 April 2017 and the summer of 2017, possibly July. This simply cannot have been the case as the consent form documents that the "proposed procedures" for surgical intervention included colorectal surgery and Mr Behar performed colorectal surgery on Ms Deakin-Stephenson by way of a Hartmann's procedure on Day 8, Wednesday 9 November.

79. One of the central disputes between the parties is whether the consent form contains the elements of a Hartmann's procedure. It should be remembered that the consent form lists a sigmoid colectomy and a stoma. Ms Deakin-Stephenson's denial that it did is not credible. Her filed statement (at B69) contains this account of what she overheard her sister telling Mr Behar:

> "My sister, Joanna explained to Mr Behar that she was extremely concerned about the diagnosis and therefore the proposed treatment plan, as she herself had had previous episodes of diverticulitis that had resulted in her own hospital admission. She had consequently been referred and seen a colorectal surgeon and upon reviewing her, made a recommendation for her to have a Colectomy, so to avoid further diverticulitis episodes and to reduce and remove the risk of a perforation, which her Colorectal consultant had said, could end up being a significant medical emergency. She told Mr Behar this and informed him that she had some personal knowledge; therefore, she told Mr Behar that upon the advice of her Colorectal surgeon, she underwent the elective surgery two

> years earlier and the diverticular area of her colon was removed and her colon was then reattached back together; consequently, her elective surgery had been successful."

80. The claimant stated in cross-examination that she understood that a colectomy is the cut out of parts of the colon and stitching the severed ends together. She also maintained that she did not understand what Mr Behar was advising her about during the consenting process and she told him so. This seems unlikely. She agrees that he had been conducting himself towards her previously as a "nice kind professional". It makes little sense that he turned when asked to explain the procedures and ignored her or failed to explain what each of the two principal elements of a Hartmann's procedure he had listed on the consent form meant. The experts agree that what Mr Behar listed on the consent form amounted to a Hartmann's procedure: sigmoid colectomy and stoma. That is a Hartmann's.

81. A likely explanation of what happened is that Ms Deakin-Stephenson did feel, as she says, "overwhelmed". This is likely to be attributed to both the news of need for surgery following the second CT scan on Sunday, but also the fact that she may need a stoma if a Hartmann's proved necessary. She wanted to avoid a stoma if at all possible. Her deep aversion to a stoma, which is entirely understandable, can be gleaned from the graphic terms in which she described her understanding of it to the court:

> "a live organ that would sit outside my body."

82. This is likely why Mr Behar took the course he did of not completing the consenting process on the Sunday night, but gave her the opportunity to think about what she was prepared to consent to and then confirm her consent on Monday morning before the surgical procedure. As will be detailed later, Ms Deakin-Stephenson took a similar approach of wishing to have time to think about a medical recommendation when on Friday 4 November Mr Behar recommended that she have a catheter. She declined the advice and asked for time to think.

83. Ms Deakin-Stephenson's evidence that the consent form in fact describes three surgical procedures and not two does not make sense. A stoma, the siting an end of a bowel outside the body, cannot exist in isolation. This is why the consent form mentions "colectomy". It is the cutting out of the diseased segment of the bowel. Then something has to be done with it. This is why the note combines accurately a "+" sign, the cutting out (colectomy), with the stoma – the stoma explains what happens to the severed end of the colon in a Hartmann's procedure. The claimant gave evidence that Mr Behar said he would start with a laparoscopic wash and then "see what happened". This supports Mr Behar's case that he would proceed on the basis of an attempt to do the laparoscopic wash and then take it from there, that is, he would make decisions intra-operatively, and that might include a Hartmann's procedure if medically indicated as necessary due surgery.

84. Ms Deakin-Stephenson said, "I believe I would have asked him what a laparoscopic washout for diverticulitis is." If this is the case, and given her

intellectually inquisitive nature, it is likely that she did ask about other procedures listed on the consent form. It is improbable if she asked about one element of the listed "proposed procedure[s]" (the consent form box heading), that would she not have asked about what is listed immediately after, unless for some reason Mr Behar arbitrarily mentioned one but deliberately chose to remain silent about another. Indeed, she accepts that she asked him what a stoma is and that Mr Behar "probably did mention the removal of the diseased part of the colon", which is the colectomy part of the Hartmann's procedure, the stoma formation being the other.

85. By November 2016, was very experienced in being a patient, and had a substantial track record of surgical procedures. It is not credible being the type of person she is, which is very assertive and curious, that she would not have asked about the significant risks and benefits of the proposed operations. One only has to review the nursing notes to get a sense of Ms Deakin-Stephenson's ability to be complain and act in an assertive way towards hospital staff. The nursing notes detail the following:

> **"3 November 2016**
>
> The patient (claimant) had asked for a TED stocking and pointed out to the nurse that 'you have not given it to me'.
>
> The patient 'insisted' on receiving the stocking 'immediately'.
>
> The patient stated 'why didn't I give the right medication before when she asked me'. When the nurse apologised and explained, the patient 'complained that I have been very rude to her'.
>
> **4 November 2016**
>
> The patient wants to go down and 'have a fag and fresh air' before doing the catheter. Afterwards, although encouraged by nursing staff to be catherised, 'patient still refused and said she will have it later'.
>
> [**later on 4th**]
>
> The patient 'still refusing to have her urinary catheter inserted, she said she's changing her mind.' [A member of staff] 'tried to explain to the patient about the urinary catheter but still the patient wants to think about it'."

86. I can readily accept that Ms Deakin-Stephenson was shocked and traumatised from the moment on Sunday when she found out that the conservative treatment plan had failed and she may need very significant surgery. I found her evidence about her stance towards a stoma unpersuasive. She said at first that "anyone would be horrified" by a stoma. She then said that if the option of a Hartmann's procedure was offered to her as a discrete choice, with the certainly that she would have ended up with a stoma, she would have opted for it, rather than the more conservative step-by-step approach with trying to resolve the situation with a laparoscopic washout first.

87. Ms Deakin-Stephenson's medical history was significant in respect of another disputed issue: whether she knew any alternative surgeons she could contact. Prior to her admission in 2016, the last time a possible diagnosis of diverticulitis was suspected was in 2013. She had seen four different surgeons: Messrs Pain, Cohen, Crosby and Akle. It was for this reason that the following question and answer arose in her cross-examination.

> "Q: You said you did not know any colorectal surgeons, but had been seen by four surgeons?
>
> A: I did not know any in November 2016."

88. Her answer that she did not know whom to contact as a colorectal surgeon when she was admitted as an NHS patient makes little sense. She had had contact with four colorectal surgeons. Even if she did not feel well enough to try to contact any of these surgeons herself, she had a loving and concerned family, any member of which could have readily done so for her. Further, there is no independent evidence that anyone tried to contact Mr Khan, her sister's colorectal surgeon, the inference being that the asserted (but otherwise unevidenced) attempt to call or contact him was ignored. I find that the claimant's evidence about not knowing any colorectal surgeons to contact by 2016 lacks credibility, and her statements were misleading when she said:

> "I had never before had any bowel or intestine issues, which made it [the diagnosis of need for surgery on Sunday 6 November] even more shocking."

89. When this answer was challenged, her answer was also unconvincing, that she had in fact meant, "I had never had anything significant before." It was misleading for her to have said that she had "never" had "any" bowel or intestinal issues. She had. Her answer was consistent with her assertion in her statement at para 19:

> "I asked Mr Behar about the diverticulitis and how had that happened, as I had never before had any problems with my bowels or colon."

90. As to her experience of private health treatment, she was asked whether between 2007 and 2016, the period for which her full medical records are available, she spent "a single night" in an NHS hospital ward. She agreed she was likely to have been in private hospitals receiving private treatment during at various points during that period. This supports the fact that she was very familiar with how to use the BUPA system. The fact that she had not used the NHS in the nine years previously when she had significant amount of medical treatment in hospital, increases the likelihood that she or her sister asked Mr Behar if she could be transferred to a private room. This question is fully examined in Behar Issue 2. However, having looked at all the evidence, I prefer Mr Behar's evidence to the claimant's on this, given Ms Deakin-Stephenson's near-decade history of using private healthcare and being in private hospitals. It is clear why the claimant wished to transfer to the private wing within Chelsea and Westminster. As she put it, the medical treatment is the same, but you are not

on a ward, instead being in a private room away from the "busy area of an AAU".

91. A connected issue about the transfer to the Chelsea Wing is whether the medical treatment was under Mr Behar as a private patient (the case of both defendants) or under the NHS, for which the second defendant was vicariously liable (the claimant's case). In her statement at para 42, the claimant states:

> "BUPA had asked me to confirm to them what surgery was proposed by Mr Behar. On asking Mr Behar who was near the nurses' station; he stated it would be a Laparoscopic washout, possibly in the morning. I then called BUPA back, as requested and told them."

92. She was challenged about her continuing belief that her treatment was under the NHS in light of this evidence, as it made little sense for BUPA to need to know the proposed surgery if the medical treatment remained under the NHS. Her response was:

> "I don't have an answer to the question, it's a good point you make. I agree one way of looking at it is that I knew BUPA were covering the costs."

93. I will in due course detail the invoicing which indicates how BUPA paid sums under Ms Deakin-Stephenson's private healthcare insurance to Chelsea and Westminster Hospital and Mr Behar. Ms Deakin-Stephenson's continuing insistence that her medical treatment was under the NHS in light of the contemporaneous records is another matter that has adversely affected the court's assessment of her credibility.

Conclusion on Ms Deakin-Stephenson

94. There can be no question but that the claimant has been deeply affected by the events of November 2016 and their consequences. Her narration at times manifested the undoubted trauma she has suffered. This inevitably is an intensely personal matter for Ms Deakin-Stephenson, and in describing surgical procedures she spoke about how they had been performed on "my body", which should never be forgotten.

95. I judge that what has happened is that in Ms Deakin-Stephenson's quest to make sense of what has happened to her, with all its dire life-changing consequences, she has not accurately remembered what happened at certain critical junctures during those critical days between 3 (her first contact with Mr Behar) and 7 November 2016. Instead, she has misremembered events in accordance with a narrative that lays the blame for the severe impact of her deterioration on Mr Behar in an unwarranted and factually inaccurate way. She has convinced herself that she repeatedly asked for a referral to a colorectal surgeon when the balance of evidence fails to prove to the civil standard that it is likely that she did (Behar Issue 1).

96. She denies that Mr Behar mentioned the alternative surgical treatment of a Hartmann's procedure when the balance of evidence is that he did (Behar Issue 3). It is simply not credible that she did not have the two surgical options of

laparoscopic lavage and Hartmann's procedure, with its components of sigmoid colectomy and stoma, presented to her and explained along with the risks attending this and a laparoscopic lavage (Behar Issue 4). Ms Deakin-Stephenson has sought to muddy the waters by claiming that the consent form in fact presents three and not two options. That suggestion is not credible. The fact that Hartmann's procedure is not mentioned in terms on the consent form does not assist her. In many ways, the breaking down of the Hartmann's into the two critical component parts may be of greater use to a patient since it provides more information about what is involved in the option: both a colectomy of the sigmoid colon (the part of the large intestine leading to the rectum) and a stoma (a hole in the abdomen for the colon to exit).

97. I found Ms Deakin-Stephenson to be a highly intelligent person, someone who has been an autonomous highly responsible professional person, a leader, who is inquisitive, with the ability to be assertive and challenging, and possessing a history of surgical interventions and private healthcare. If she did not understand the nature of the options that Mr Behar laid out to her, given her character traits as I found them, it is unlikely that in the prolonged discussions between her and Mr Behar on Sunday 6 November that she would not have asked what each option entailed. Ms Deakin-Stephenson is precisely the type of person, as was absolutely clear from her oral testimony, who would have pressed and probed and asked about important details should she not understand them. Allowance must be made for the fact that she was feeling unwell, although Mr Behar found her to be relatively stable which was why he felt able to delay surgery until Monday morning. I accept that the news that she would now needed surgery came as a "shock". But that "shocking" development would have meant she would have been all the more insistent on ensuring she knew and understood what the options in front of her involved. There remains little doubt, as will be clear when I survey the evidence in more detail, that her deep aversion to a stoma resulted in Mr Behar giving her more time to think about what she wished to consent to, just as two days previously she had wished for more time to think about the catheter, despite medical advice.

98. Upon issuing proceedings on 3 August 2020, and in pleadings and evidence up to and during the trial, Ms Deakin-Stephenson seriously criticised Mr Behar. Yet on 1 January 2017, that is, just over a month after her discharge home from the Hospital, she posted a review on the internet about the treatment she had received from Mr Behar.

> "1st January 2017
>
> I was admitted in c&w by ambulance on 2nd November 2015 with severe abdominal pain. While I have no recollection due to amnesia for the following two and half weeks, Mr Behar operated on me twice and literally saved my life from perithinitus and sceptis after suffering from severe divictilitus. Mr Behar and the extra ordinary nursing and medical team who cared for me 24/7 when I was transferred into I the intensive care department after suffering apparently multiple organ failour and being on life support, literally saved my life. My family were able to speak personally to Mr Behar about my illness even when I was on life support. When eventually I came round I remember meeting him (I

> thought it was the first time I had met him) and he very kindly explained to me over the following days what had happened. While it is still very shocking that I was so very ill, mr Behar did not give up on me at anytime or indeed any of the increasingly nursing and medical staff and the micro biologists and to them all, I thank them from the bottom of my heart for giving me my life again and to be back home recovering with my family for Christmas. Mr Behar, thank you for saving my life and being so unbelievably amazing. To you all at C&W and the NHS you are all amazing, and thank you does not seem to be enough, but it is from the bottom of my heart."

99. There is then an option to give a star rating in three categories. Ms Deakin-Stephenson awarded Mr Behar as follows:

> "Recommend 5 stars
>
> Listen 5 stars
>
> Trust 5 stars"

100. Therefore, the claimant cannot have given Mr Behar a higher rating in terms of trust and listening. She recommended him as highly as she could. It is a strong and contemporaneous indication of her true response to Mr Behar's treatment. There is no hint that she was badly or negligently treated or forced into surgery that she did not want or consent to. The clear message provided by Ms Deakin-Stephenson's review of Mr Behar as her surgeon is the opposite.

101. What appears to have happened is that as time went on, the claimant, entirely understandably, reflected time and again about what had happened to her and how she had nearly died. The process evolved from a quest for answers into finding someone to blame. Mr Behar became the chosen target of the claimant's unhappiness and trauma and the iterative process of visiting and revisiting these profoundly distressing events led to her misremembering her exchanges with Mr Behar in a way that resulted in a narrative that implicated him in serious breaches of professional duty. However, the narrative is inaccurate. It did not reflect what happened at Chelsea and Westminster Hospital between Ms Deakin-Stephenson and Mr Behar in November 2016 as supported by the contemporaneous documentation and the clear probabilities. Over time, and especially given that she initially had virtually no memory of events, the claimant has persuaded herself of a factually false narrative that directs the blame for her deterioration and near-death experience towards Mr Behar. The claimant has come to sincerely believe it, which has greatly deepened her distress.

102. Therefore, without adopting a totalising or inflexible approach, the court generally prefers Mr Behar's evidence to Ms Deakin-Stephenson's, emphasising as I do that although this is a sequential setting down of the judgment, the evidential analysis and evaluation was iterative and holistic and I have carefully considered the discrete issues separately and together. No issue is determinative of any other; credibility problems on one issue, while potentially cross-relevant, are not and cannot be determinative of credibility on

another issue. Nevertheless, for all the reasons here provided and developed in the issue-by-issue analysis, the court has serious concerns about the accuracy, reliability and inherent probability of the claimant's account on most of her key criticisms of Mr Behar. The court has found her evidence at vital junctures to be inaccurate, unreliable and improbable. The specific weaknesses of the claimant's evidence will be identified within the sections to come. This has been an overview of the court's assessment, fleshed out in greater detail than may be customary because it is so important to all parties and the issues are complex and in places connected.

§VIII. ASSESSMENT OF CLAIMANT'S WITNESSES

Mr Stephenson (former partner)

103. Paul Stephenson is the claimant's former partner, with whom he shares a son. Mr Stephenson works for the Ministry of Defence, having previously served in the Royal Engineers for 27 years. He made a statement dated 7 February 2023. When he began his evidence in chief, he adopted his statement while wishing to make a correction.

104. The correction related to an account he gave in his statement of an event on Saturday 5 November. In his witness statement he states that he saw "Pippa", that is, Ms Deakin-Stephenson, ask a male doctor for a referral to a colorectal surgeon. Mr Stephenson also spoke to the male doctor and made the same request. However, it is now agreed evidence between the parties that the doctor who attended on the Saturday was Dr Walsh, a female Specialist Registrar. When Mr Stephenson gave evidence in chief, he changed his account and stated that in fact the requests for a colorectal surgeon on the Saturday were made to a female whom he believed to be a doctor. When he was then challenged about his change of account, he stated that he cannot recall whether the doctor he spoke to was a man. Then he said he was "sure it was a she".

105. This was unimpressive evidence. It had all the hallmarks of a witness trying to tailor his account to assist the claimant rather than respecting the truth. He appeared to be altering his narrative once the evidence revealed that his original account was wrong. As noted, it is significant that Mr Stephenson's error in his original witness statement is mirrored by the identical error about the gender of the doctor in Ms Deakin-Stephenson's original evidence. This is not the only evidence of the collusion between Mr Stephenson and Ms Deakin-Stephenson and then between Mr Stephenson and Mrs Deakin (senior), the claimant's mother. There are strikingly similar spelling errors in both sets of statements:

Example 1

Ms Deakin-Stephenson

"Everything Mr Behar had said appeared very **contractionary**"

Mr Stephenson:

"None of it made any sense to me and appeared to be **contractionary** to common sense"

Example 2

Mr Stephenson:
"it was **defiantly** understood by us, that Pippa would remain an NHS patient"

Mrs Deakin:
"I don't recall who told us this, but it was **defiantly** not Mr Behar"

106. These spelling errors are so distinctive that they cannot sensibly be explained except through consultation and collaboration between the claimants' witnesses. In both instances, Mr Stephenson was involved. I cannot accept Mr Stephenson's answer that the error about "defiantly" was just "a coincidence". As unsatisfactory is the account that "contractionary" was a simple spelling error, meaning that he and Ms Deakin-Stephenson made the same highly unusual error independently.

107. In his original statement, Mr Stephenson stated that Mr Behar was refusing to refer the claimant to a colorectal surgeon for his own reasons. He said that Mr Behar's "determination" was based "entirely on his own position and reputation". Mr Stephenson said that he based this conclusion on his role as a "military officer". He made an allegation of gross professional misconduct against Mr Behar, with Mr Behar allegedly prioritising his personal interests over that of a patient. Mr Stephenson felt in 2016 that the surgeon dealing with Ms Deakin-Stephenson "hoped for her demise", and yet he took no steps to get his former partner and mother of his son an alternative surgeon. The "demise" comment expresses the depth of Mr Stephenson's feelings about Mr Behar. There is a loss of balance and an unmistakable partiality in favour of the claimant. His evidence contained puzzling improbabilities. He felt on the night of Sunday 6 November that there was a sense of urgency to contact a colorectal surgeon due to Mr Behar's lack of professionalism and intransigence, yet he took no steps try to arrange an alternative colorectal surgeon.

108. When the claimant came out of the ICU and went back to the Chelsea Wing, she was again under Mr Behar, the doctor who had "hoped" for her demise, and yet no one, including Mr Stephenson, took any steps to find a different consultant. His explanation that other people were looking at that issue is unsatisfactory. There is no evidence that anyone was taking such steps. Despite the fact that the intimate relationship between Mr Stephenson and the claimant no longer subsists, they share a son and Mr Stephenson lives with the claimant when he is not, as he puts it, "in barracks".

109. I cannot accept that Mr Chawatama's description of the claimant's witnesses applies to Mr Stephenson, that is as someone providing "clear, straightforward and consistent" evidence. Mr Kennedy was more accurate in submitting that the court should be "particularly circumspect" about Mr Stephenson's evidence. It is understandable that Mr Stephenson was concerned about the medical condition of the claimant and the great distress she was in. However, I found him to be an unsatisfactory witness. His evidence was inconsistent and implausible in several key respects. I did not find him a reliable narrator or to

be sufficiently credible on disputed matters to place any significant weight on his testimony.

Mrs Deakin (mother)

110. Mrs Joyce Deakin is the claimant's mother. She made two witness statements. The first on 8 February 2023; the second is dated 14 March 2024, and deals with an email from her daughter Joanna. No one hearing Mrs Deakin's evidence could fail to be struck by the very serious and traumatising impact that the events of the claimant's surgery had on both the claimant and her family. They were concerned, upset, shocked and looking for answers. Mrs Deakin supported her daughter's case in several material respects. However, there were several flaws in her evidence.

111. As to the Sunday night, the actions of Mrs Deakin and the other family members were puzzling. If it were true that the situation was urgent and they wanted a referral to a colorectal surgeon, they had a telephone number for Mr Warren and did not call it at any point or send a message. They had Mr Warren's secretary's number and at no point called it or sent a text message.

112. On the next morning, Monday 7 November, they did not ask anyone if they could go and see Mr Warren. Mrs Deakin's answer when asked about this was not convincing. She said, "We assumed it was impossible." I cannot accept that such intelligent people would have each have made this unlikely assumption. What Mrs Deakin did confirm was that "Pippa" (the claimant) "was very frightened". That answer supports Mr Behar's case that the claimant was very concerned about a stoma. Mrs Deakin also confirmed that she recalled Mr Behar saying:

> "that he would not know how to treat her until he got her into surgery and the treatment would depend on what he found in the surgical procedure. My husband might have asked him what the other thing that could have happened aside from the washout. The discussion was quite a long time."

113. She added that she probably did ask Mr Behar what the consent form meant because she did not understand. If the claimant's father asked what the "other thing" – the further surgical procedure beyond the lavage (washout) – might be, it is unlikely that Mr Behar would not have simply mentioned the Hartmann's procedure. This would, of course, explain Ms Deakin-Stephenson's concern about ending up with a stoma, something she wished to avoid if at all possible. Mrs Deakin stated in evidence that the discussion went on "quite a long time", which increases the likelihood that the matters were not being skated over, but talked about in detail, increasing the likelihood that Mr Behar would have mentioned the Hartmann's procedure (or its constituent elements), as he says. Indeed, Mrs Deakin's evidence is that Mr Behar repeated "a number of times" that what he did depended on what he found when he was doing the surgery, which is consistent with the "+/-" notation that Mr Behar wrote on the consent form. Mrs Deakin testified that her daughter "probably did ask Mr Behar what the form meant because she did not understand". There can be little credible reason that Mr Behar would not have explained the main elements of the Hartmann's alternative. It is difficult to understand why an experienced surgeon

would be deliberately keeping such details from an intelligent patient and her concerned family, also of intelligent people.

114. As to whether her husband (the claimant's father, now deceased, sadly) had asked Mr Behar for a referral to a colorectal surgeon, she stated it was a possibility that he might have done so, but she was looking after her daughter. The consequence is that she cannot provide the evidence with confidence. This should be contrasted with her filed statement where she says that Mr Behar "had refused on multiple occasions since Pippa was diagnosed to refer Pippa to a colorectal surgeon". However, she was unable to provide the court with clear details to support this passage in her statement. At one point in her oral evidence she stated:

> "I repeated what my daughter said to get a second opinion. Mr Behar's response was that there was no one else in the hospital and they could not do that."

115. But when she was challenged in cross-examination by Mr Kennedy and counsel squarely put to her that she was wrong about the requests for a colorectal surgeon, her answer was revealing. It was to repeat that "it's possible" that her husband "might have asked", but that she "would not have necessarily have heard it all as she was looking after my daughter". This was the opportunity for her to say that she (Mrs Deakin) asked Mr Behar herself for a referral, in line with an answer she gave earlier. She did not. She ended her cross-examination on behalf of the first defendant by saying that if the request happened, the "possibility" is that it came from her husband. Thus, the court can place little weight on her evidence that she had directly asked Mr Behar for a referral.

116. A clear inference is that the part of her statement referring to refusals "on multiple occasions" was part of a common line that the family was advancing. That there was collaboration with other members of the family can be seen with the identical spelling error that is contained in both her statement and Mr Stephenson's ("definitely" being spelled as "defiantly"). She stated on oath that she made her statement "independently" and without the assistance of any family member. This is highly unlikely to be the case.

117. When the claimant returned from the ICU to the Chelsea Wing, Ms Deakin-Stephenson was again under the care of Mr Behar. Mrs Deakin testified that she was "frightened" by what had happened to her daughter and how she had ended up in ICU and there were concerns about the conduct of Mr Behar who had been refusing to refer the claimant to a colorectal surgeon. If it was correct that Mrs Deakin and the family had such concerns about the competence and lack of professionalism of Mr Behar, it is difficult to understand how no attempt was made by Mrs Deakin or anyone else to move the claimant's care to another doctor.

118. I found that through her evidence Mrs Deakin sought to support her daughter through the her understandably very strong ties of loyalty. Mrs Deakin very memorably said in oral evidence:

> "I think a mistake was made in her treatment and having seen what my daughter has had to live for a number of years is heart-breaking."

119. This is bound to deeply affect almost any parent. This is the best explanation for why in Mrs Deakin's statement she says that she and her husband "understood that Pippa would remain an NHS patient and that she was only having a private bedroom and bathroom". If this were truly the case, it makes no sense that a treatment code was being sought. As Mrs Deakin wrote in her statement at para 7, BUPA "wanted verification from the admitting surgeon as to what operation Pippa was to have." Indeed, in her statement, Mrs Deakin proceeds to say that BUPA "had authorised the treatment". Having a private room is not a "treatment". Equally, the suggestion that Mr Behar was stubbornly refusing a referral, that he had as Mrs Deakin put it, "blatantly disregarded" their requests, sits uneasily alongside her comment that he was "charming and very polite".

120. In her statement, Mrs Deakin stated:

> "At no time on Monday 7th November either before or after the surgery, did we see Mr Behar despite being in Pippa's room."

121. Therefore, Mrs Deakin stated that she was in her daughter's room, having got up early to get to the Hospital and getting there around 8am, but did not see Mr Behar. She added to this filed evidence by stating on oath, "I was not impressed by that." Mrs Deakin said in her statement:

> "I note that the doctor daily notes also confirm Mr Behar did not see Pippa prior to surgery in her room and there was no ward round, which I find extremely unusual."

122. This evidence is difficult to reconcile with the contemporaneous record of a ward round visit to Ms Deakin-Stephenson by Mr Behar. Therefore, either Mrs Deakin was not in her daughter's room when Mr Behar visited, or her account is part of the common narrative that has been developed with the claimant. The tone and implication of Mrs Deakin's statement is that Mr Behar visited her daughter "at no time" and thus it did not happen. If she or her husband had momentarily been out of the claimant's room when the undoubted ward visit by Mr Behar took place, the claimant or the remaining parent could have told the missing person. Mrs Deakin doubles down on the lack of pre-operative visit by stating:

> "Pippa was taken down to surgery and we still had no idea what surgery was going to be performed or by whom."

123. Since Mr Behar visited the claimant before surgery, as contemporaneously evidenced by the medical record, on this question, Mrs Deakin's evidence points firmly to being part of a common narrative that has been developed.

124. I found Mrs Deakin, while advanced in years, to be a formidable, acute and intelligent person. However, the court must assess the cogency and reliability of the evidence. I found that there was little in Mrs Deakin's evidence that could

reliably advance the claimant's case on the crucial disputed issues, and her evidence was affected and adversely shaped by her strong ties of loyalty to her daughter.

Mrs Joanne Ingledow (sister)

125. Mrs Ingledow is the claimant's sister. She lives in Hampshire. She made one witness statement which is dated 3 February 2023. She prepared the draft of her statement in August 2022, approaching six years after the key events at the Hospital and stated, "I made the statement on my own". She exhibited a screenshot of relevant text messages she sent to her mother on Sunday 6 November 2016. The first is timed at 17:42 hours. It asks her parents to return to London as the claimant had to have an operation.

126. The second SMS is at 22:25 hours and contains details of Mr Oliver Warren and his secretary. There has been much discussion about this message, and so it merits setting out in full:

> "Hi mummy
>
> You and daddy have been so wonderful reassuring [to] Pip, so good that you have been with her today, it will have meant so much to her. I've found out that Dr Oliver Warren is also at Chelsea and Westminster and a very senior Colorectal surgeon with amazing reviews. He also practices at the London clinic and he is definitely the man for an extra opinion or discussion … Maybe he's already involved in Pip's case? But worth talking to. His secretaries tel number is 07XXXXXX. I'll email his details to you & daddy. Try to sleep I'm sure she's going to make a full recovery and will soon be bouncing around again!
>
> [signed affectionately] Joanna."

127. Despite having Mr Warren's secretary's direct mobile number, Ms Ingledow not once calls or messages the secretary about her sister's case. If there was the grave concern about how Mr Behar was treating her sister, it is difficult to understand how such a simple step was not taken given the alleged repeated flat refusals to refer by Mr Behar and the great urgency. Mrs Ingledow's lack of action is inconsistent with her trial evidence that "We really did not want to leave my sister in Mr Behar's care."

128. It is clear that reviews were important to the family. Joanne looked at Mr Warren's "amazing reviews". As noted, on 1 January 2017, Ms Deakin-Stephenson posted a 5 Star and very effusive review of Mr Behar. It is curious that if there was genuine concern about Mr Behar's conduct and judgements at the time while the claimant was in hospital that no one checked his online reviews or sought to see what his surgical experience and track record are. It is not disputed that Mrs Ingledow, due to her own health challenges, had significant experience of being a patient. As she put it, "I am the family history of diverticulitis", and had been admitted to hospital as a result.

129. The text messaging about Mr Warren also suggests that the prevailing attitude of the family was significantly different to that which was maintained at trial. This exchange occurred during Mrs Ingledow's cross-examination:

> "Q: The text is a strange way of framing it that he may be already involved in her care when you had been crying out for a colorectal surgeon
>
> A: I don't know why I said a colorectal surgeon may be involved in our care."

130. She said of the FaceTime call on Sunday night that, "I was very upset why [Mr Behar] did not arrange the second opinion with a colorectal surgeon". Yet by this point the contact details for Mr Warren were available. Mrs Ingledow did not try to contact him. No one else did. Her explanation that they "ran out of time" cannot be right. This was an emergency situation, according to the family, and yet Mrs Ingledow took no step to contact a colorectal surgeon whose contact details were available to her. In her statement as para 29, she says "I suggested to my parents to ask Mr Behar to involve Mr Warren." But the text she sent her mother does not say that. It is not a suggestion that the parents should ask Mr Behar to involve Mr Warren. It suggests he may already be involved. So the statement must be wrong.

131. Further, if there were the depth of concern about Mr Behar's competency and advice, it is curious that the email on Sunday night from Mrs Ingledow to her sister at 22:38 hours provides the link to Mr Warren's profile "If you want someone else to talk to." This is not consistent with the determined and repeated attempts by the family for Mr Behar to refer the claimant to a colorectal surgeon. Here was a specialist consultant who met that specification. Mrs Ingledow does not say anything like this is the person we have been wanting to find. The framing of this email runs contrary to the claimed urgency of the situation by Sunday night on the claimant's case, supported by the family witnesses, including Mrs Ingledow.

132. She states that she asked Mr Behar for a referral to a colorectal surgeon twice: in the mid-afternoon on Thursday, and on Friday at 6pm. She stated that she had obtained Mr Behar's number on Friday, yet she did not try to contact him to ask him to reconsider his refusal to refer to a colorectal surgeon.

133. At the meeting on 26 April 2017, there is no mention by Mrs Ingledow that she asked Mr Behar twice, or even at all, for a specialist referral. This is a curious omission if this were truly the position. By the time of the trial, she was very exercised about the fact that Mr Behar had not acceded to the requests, including two made directly to him by her, for a referral. As at April 2017, this was all much fresher, and the anger was likely to be raw. The lack of questions about requesting a referral undermines the credibility of her evidence on this point. Having watched her evidence carefully, it is clear that Mrs Ingledow is a forthright person, intelligent and well able to stand up for herself and was undaunted by the court setting. If she really was troubled in April 2017 about the lack of referral, it is likely that she would have asked Mr Behar about one of the most important criticisms made by the family of him. I found her

explanation for its omission inadequate. She stated, "It was not a complaints meeting." Yet by April 2017, her sister had already sent an email to the "complaints team". Further, Mrs Ingledow also accepted that "part of my task was to voice the family concerns." No concern was voiced by her about Mr Behar's alleged refusal to make a referral. This is more unsatisfactory because she said that in the meeting, "I set the record straight because I had a clear memory of the sequence of events on the dates."

134. Her loss of balance and perspective is evident from her statement at para 32 in which she stated:

> "… we were all taken for a complete ride, lied to and manipulated and that is because of [Mr Behar's] 'ego' and desire to undertake what we now know to be his own 'research' surgery … Pippa could have died."

135. These are very serious allegations of gross professional misconduct, potentially risking her sister's life for Mr Behar's research interests. Once more, after the claimant was returned to the Chelsea Wing from the ICU, Mrs Ingledow stated that "it didn't occur to us to refer [my sister] to another surgeon." The complete lack of effort to transfer the claimant's care away from a reckless risk-taking and manipulative surgeon remains inexplicable. Her response to this improbability was unsatisfactory: "Perhaps it was a thing like Stockholm Syndrome." This will not do. This is an educated, articulate and forthright family, full of strong characters. The more likely explanation is that until the unforeseen catastrophic deterioration of Ms Deakin-Stephenson on the night of Tuesday 8 into Wednesday 9 November, there was not a complaint about Mr Behar's management of Ms Deakin-Stephenson's case.

136. Mrs Ingledow's strong ties of loyalty coloured her summary of the April 2017 meeting, which she described as "one big cover-up" and an "utter disgrace". These extreme characterisations have affected the weight the court can place on this witness's evidence, which gave every indication of being highly partial. She stated that her statement was "produced from memory" and she did not talk to her sister in compiling it. Yet she stated that her sister "begged" Mr Behar for a second scan, replicating precisely the way in which Ms Deakin-Stephenson has described it, despite her stating that her "best recall" was unaffected by conversations with other family members.

137. Mrs Ingledow was asked in cross-examination about her sister's email dated 13 March 2017 to the complaints team. In that email, Ms Deakin-Stephenson stated that Mrs Ingledow had confirmed to her that she had signed a consent form for "both types of operation". Mrs Ingledow stated that the two types of operation were a laparoscopic washout and a sigmoid colectomy.

138. Mrs Ingledow denied that there was any mention of a stoma. This is hard to accept given that the consent form has stoma written on it in terms in the box for "proposed procedure[s]". On the question of stoma, there are credibility issues with Mrs Ingledow's evidence. She claimed, as did her mother and her sister, that she had by that point never heard of the word stoma. This is unlikely given that Mrs Ingledow had previously had an appointment with an ileostomy

(stoma) nurse. This related to a surgical intervention in 2014. Mrs Ingledow stated:

> "Mr Khan also said I might need an ileostomy for a few months and I was given the opportunity to see a stoma nurse, I use the word now, but no one used that word. It was explained to me that it involved a bag attached to my skin to catch the fluids and it would be repaired in future."

139. It seems unlikely that the word stoma was not used in 2014 at any point. This was two years before the surgery on Ms Deakin-Stephenson. Mrs Ingledow added in evidence that:

> "The nurse showed me the bag and lots of literature to read about the ileostomy."

140. Given the nature of Mrs Ingledow, it is implausible that she would not have asked about what was being proposed and why she was seeing the nurse; it is unlikely that she did not look at the literature that she was given about such a major surgical intervention in her life. As explained, an ileostomy for the small intestine performs the same function as a Hartmann's procedure does for the colon, both resulting in a hole in the abdomen for the collection of waste products – a stoma. The necessity to deny Mrs Ingledow's likely familiarity with the term comes from the need to support Ms Deakin-Stephenson's case that a stoma was not discussed during the consenting process, and to attribute the delay from Sunday night to Monday morning to Mr Behar's professional incompetence rather than a judged sensitivity to Ms Deakin-Stephenson's strong aversion to a stoma (Behar Issue 5, Delay).

141. Mrs Ingledow is an intelligent and forthright person. She is perfectly able to make her views and concerns known. She exhibits understandably strong ties of loyalty to her sister. However, these proved stronger than her affinity for a truthfully accurate account of events in November 2016. The court felt unable to place much weight on her evidence.

Conclusion on claimant's witnesses

142. I have found that there was significant factual coordination among the claimant's family members during the settling of their witness statements. This is understandable. It was powerfully summarised in evidence by the claimant's mother:

> "I was appalled by the state of her body when she was discharged as she had an open wound right down her body, she was so traumatised as we were all were, as a family we were so traumatised by what had gone on and sitting in ICU, we could not understand what had happened."

143. This is the context to view the claim that these statements were the product of independent recollection and the statements were written by each witness "on my own" (variously formulated). It is undermined by telling clues on a close analysis of the statements. By way of further example, when each of the claimant's three witnesses recalled the night of 8 November 2016 (Day 7), they

all independently claimed to recall precisely the same detail. It should be remembered that these statements were all finalised in February 2023, that is, over six years after the night in question:

> Mrs Ingledow: "I invited [Mr Stephenson] and [his son] … for supper to have roast chicken with me and my parents."
>
> Mr Stephenson: "Pippa called on facetime while we were eating Roast Chicken."
>
> Mrs Deakin: "we were all having supper in the kitchen. We were eating roast chicken."

144. The inconsequential and irrelevant detail of the roast chicken, replicated in all statements, points to an element of coordination and collusion, especially taken together with other otherwise inexplicable similarities such as the mentioned common spelling errors ("defiantly", "contractionary"). Another example of unaccountable similarity comes from the comments in the statements of Mrs Deakin and Mr Stephenson about what BUPA had been requesting in conversations that these two witnesses were not party to. This is significant to the issue of whether Mr Behar initiated the transfer to private care and whether once the claimant did transfer to the Chelsea Wing it was under the NHS or private medical treatment. The claimant's case, supported by her witnesses, is that BUPA was only paying for accommodation ("hotel") fees.

> Mrs Deakin: "My daughter was told to contact BUPA who wanted verification from the admitting surgeon as to what operation Pippa was to have"
>
> Mr Stephenson: "apparently BUPA wanted more information from Mr Behar and asked Pippa to find out what was the exact treatment plan for her from Mr Behar was (sic), and what surgery he was planning to perform."

145. If these witnesses were not party to the conversations, it is difficult to understand why it was necessary to include the BUPA conversation that did not involve them in their statements. This suggests, as does other identified evidence such as the spelling errors, that there has been coordination in the preparation of statements that undermines the claim that they were made independently. They claim to be "independently" reporting six years later a conversation they were not party to and that did little to advance their testimony. Mrs Deakin said in cross-examination that she could not recall the conversation at all. Mr Stephenson accepted that he had no idea why BUPA would need to know about the proposed "treatment" (surgical procedure) if BUPA was not paying. In similar vein, when providing his narrative in his statement, Mr Stephenson goes out of his way to state:

> "Pippa and Joanna had no knowledge of the Chelsea Wing which they discovered much later was apparently a private wing in the main hospital …"

146. Mr Stephenson was not present at the Hospital when the alleged conversations with Mr Behar about private health insurance took place. This provision of information about the state of mind of Ms Deakin-Stephenson and Mrs Ingledow when Mr Stephenson was not present relating to a conversation he was not party to again points to a degree of coordination in the construction of the witness statements. In her evidence to the court Ms Deakin-Stephenson stated that she knew no colorectal surgeons. In his statement, Mr Stephenson provided evidence that capable of supporting her assertion when he stated:

> "she had never had any previous problems with her colon."

147. This is not factually true. The claimant's medical records show that she was diagnosed as suffering with diverticular disease in 2011, having been seen by Mr Payne, a colorectal surgeon, between 2005 and 2011; she saw Mr Akle another colorectal surgeon in 2008, and he organised a colonoscopy in September 2008; in 2013, she saw two further colorectal surgeons, Mr Cohen and Mr Crosbie. Yet as Mr Stephenson documents in his witness statement, he has known the claimant since 2005 and their son was born in May 2006. He was in a relationship with her, which ended in a way he explained in his witness statement:

> "Due to the medical situation that developed following [her] November 2016 admission to hospital, Pippa withdrew from our relationship."

148. It is hard to understand how Mr Stephenson, in such a close relationship with the claimant at material times and sharing a son, could assert her lack of previous colon problems, unless it is to provide support for her case.

149. Humans look for explanations when catastrophic things happen. What is likely to have happened is that a common narrative evolved within the claimant's family that in looking to explain the disastrous consequences suffered by Ms Deakin-Stephenson, placed the blame on Mr Behar. This is a variation of "story-creep" identified by Peter Jackson J in *C, M and F*. It is a variation because Ms Deakin-Stephenson appears to have lost her memory of events of her hospital admission. Then as it returned and she attempted to reconstruct events in her head, it is likely on the evidence before the court that a false narrative developed. This has been adopted by those close to her and who wish to support her through their ties of loyalty and deep affection. The submission on behalf of Mr Behar has force: the weight of evidence is not necessarily judged by "head count".

150. Ms Deakin-Stephenson's desire to account for what happened to her and her near-death experience is understandable. But the reconstructed and coordinated account that developed in important respects did not accurately reflect events.

§IX. ASSESSMENT OF MR BEHAR

151. Mr Nabil Behar is a highly qualified medical professional. By 2016 when he encountered the claimant, he had gained very extensive experience of dealing

with colorectal problems surgically, and using laparoscopic lavage as an intervention to treat one type of colorectal problem, that is (acute) diverticulitis. Of the patients he saw as emergency admissions, typically one in four needs surgery. Of the surgical group, more than 50 per cent received colorectal surgeries. This involved a wider range of medical conditions than just diverticulitis, which numbered around 5 per cent of the surgical group. That means of all the emergency surgeries Mr Behar performed, around 2 to 3 per cent were for diverticulitis. This may be explained by the fact that in many cases diverticulitis resolves without surgery, which is very much the exceptional intervention for the condition. Nevertheless, due to his focus on emergency medicine, treating patients with diverticulitis was a substantial part of Mr Behar's professional practice on a regular basis.

152. During his time at Chelsea, Mr Behar became concerned about the standard of surgical care that patients who were emergency admissions were receiving. Therefore, he helped develop and operationally lead what he believes to be the country's first emergency surgery standing team. His ambition was to provide emergency surgical patients with the same level of care as those who opt for elective surgery. To do this he had to downgrade his private practice, reducing it to around 20 per cent of his professional work. The success of this new type of emergency arrangement was such that it has been replicated across the country. This is an important context in which to view the allegation made against him that he unethically subverted the claimant, then an NHS patient, into the private wing of Chelsea under his care. His evidence is that this is something he would not do. Beyond that, such a course, for this particular doctor, runs contrary to the personal and professional sacrifices he has made to ensure better treatment for emergency patients. Having considered the evidence as a whole, including the weaknesses and improbabilities in the evidence of Ms Deakin-Stephenson, along with the issues identified in the evidence of Mrs Ingledow, the court finds it unlikely that Mr Behar behaved in the unethical way alleged by suggesting a transfer to the private wing on the Hospital (analysed in detail in Behar Issue 2). In burden of proof terms, the claimant has failed to prove the allegation to the civil standard (note: each allegation is analysed in its dedicated section.

153. That said, Mr Behar did concede that there is no record of his initial consultation with the claimant when she had transferred to the private wing. He comments on this consultation in his witness statement and accepted in oral evidence that the absence of a record is a breach of professional good practice. This is not the only breach of good practice he accepts, as will be seen. For example, he recognises that after 15:27 hours on Sunday 6 November 2016, he made no notes. He accepts that not noting the result of the CT scan on Sunday and the discussion of the treatment plan after that is a "serious failure". That answer needs to be qualified by evidence that emerged later in his testimony, which must be examined. However, he did accept that the record-keeping at the Chelsea and Westminster Hospital at the time, and his recordings of interactions with the claimant, were both "poor".

154. It was put to him that he did not see the claimant on the Monday morning before the surgery later that morning. He appeared genuinely mystified by the

suggestion as he emphasised that it was his invariable practice to see a patient he was about to operate on. On Monday 7 November 2016, the claimant fell into that category because he was due to operate on her. It was put to Mr Behar that there was no meeting with the claimant on the Monday morning and no record of a meeting with her. While the documents were put to him, Mr Behar explained two records that were entered electronically on Monday 7 November.

> "Written in retrospect Behar
> seen last night with second CT result suggestive of further spread of sepsis with now free air and pelvic
> fluid
> patient remains well
> dw patient need for surgery
> consented for lap washout with Hartmans if needed am"

155. Mr Behar was able to identify this entry as being written by himself because he signs it "Behar" at the end of the first line, his practice. This was a retrospective record he entered on Monday about what had happened on Sunday night. It was the next entry that became of importance in the case. Mr Behar confirmed that it was written by one of his trainees, not him. This is because the first line states that it was a review by "Behar".

> "11.31am
>
> Behar Wr review
>
> well
>
> bowels opened twice
>
> for wash today"

156. The nature of the "review" is vital to the truth of what happened. "Wr" means "ward round". This supports Mr Behar's evidence that he did go on a ward round. I flesh out this point further shortly. This near-contemporaneous record, written on the morning of the Mr Behar's pre-operation visit to the claimant, significantly undermines Ms Deakin-Stephenson's evidence that Mr Behar did not visit her on Monday morning. It calls into question the evidence of her mother, who said that she did not see Mr Behar, an account the court finds was likely provided to support her daughter's case. The "for wash" indicates that this was before the operation and not after, because it is correct that the claimant was "for" an impending "wash" (laparoscopic lavage) "today".

157. The next question is whether Mr Behar spoke to the claimant during the ward round. What is noticeable are the two details that the claimant is "well" and that her "bowels opened twice today". This supports that there was a meeting between Mr Behar and the claimant – a "review" – at which information was passed on by Ms Deakin-Stephenson. Viewed as a whole, the entry points to Mr Behar having told the truth about seeing Ms Deakin-Stephenson on Monday morning before the first operation. Here was a record made on the day of the

first operation that casts light on what in fact happened. It supports Mr Behar's account; it importantly contradicts the claimant's and her mother's.

158. This part of the evidence reveals with clarity a fundamental problem with Mr Behar's evidence. As he accepted when questioned, his recordkeeping was "poor". One of the benefits of contemporaneous records is that they provide insight into events that is not susceptible to the degrading of memory or after-the-fact agendas on either side. At several critical moments in events, the record is blank. Mr Behar's explanation is that at the time the hospital was struggling with documenting systems. They were moving from paper-based recording to electronic systems, but the infrastructure was not in place. This might have been the generally prevalent picture, but I cannot see how that would have materially prevented Mr Behar from making adequate records of his interactions with Ms Deakin-Stephenson. At various points he did not.

159. Thus he did accept that not recording the result of the CT scan on Sunday and the nature of his consequent discussion with the claimant was a "serious failure". The fact that there are no records made by Mr Behar after 15:27 hours on Sunday 7 November is also, I judge, a further serious failure. Mr Behar emphasised that consenting is a "process" and it was not complete on Sunday night. In that case, it is puzzling that he provided no record of his discussions with Ms Deakin-Stephenson on Monday morning. It could have been added "retrospectively", as he added the account of the Sunday evening discussions retrospectively. The absence of a record of the encounter on Monday morning is a clear departure from good practice. He is fortunate indeed that his trainee recorded his ward round on Monday 7 November, a fact that the parties right until near the end of the trial appeared to have missed.

160. The result is that by Mr Behar's own evidence the consent form for the first operation could have been "more detailed"; the retrospective note made at 11:30 hours on Monday morning about Sunday night was "poor"; there was no record of the discussions on Monday morning. This is an imperfect and highly unfortunate situation. However, this is not the same thing as doubting the veracity and reliability of his evidence. This is because, and perhaps this is the moral of it, where there are records, they support Mr Behar's account. The consent form supports his account of the surgical options he discussed with the claimant: laparoscopic lavage and what amounts to a Hartmann's, in the form of its two prime constituent parts. The addition on the consent form of the words about "stoma" and "only if absolutely needed" reflected Ms Deakin-Stephenson's high degree of aversion towards having a stoma as she made clear to Mr Behar. The adverb "absolutely", modifying the verb "needed", indicates Mr Behar's sensitivity towards his patient's anxieties. Rather than ignoring them, he took the trouble to document them on the consent form – if he was indifferent to Ms Deakin-Stephenson's wishes, it is mystifying why he would have done this.

161. That said, as previously stated, there are sound criticisms of Mr Behar's record-keeping. The claimant relies, correctly, on his failure to make a record of the initial private consultation he had with her and for which BUPA paid him £143. His failure to make a note of his advice during the consenting process was a

serious record-keeping failure. Mr Chawatama has accurately characterised Mr Behar's recording failures as "multiple".

162. A further criticism of Mr Behar comes from events leading to the second CT performed on the claimant, which took place ultimately on Sunday 6 November (Day 5), following the initial scan on Day 2, Thursday 3 November. I do not understand the allegation to amount to a breach of duty, and it is difficult to conceive how it could, but it is said to be a further dent to Mr Behar's professional conduct and a lack of concern about the claimant, with attendant credibility implications. It is alleged that Mr Behar "vacillated" about ordering a second scan until Ms Deakin-Stephenson's was forced to "beg" him to arrange one. Mr Behar denies this.

163. Mr Behar's evidence about this is that when he examined the claimant on Sunday he felt another scan would be useful. However, Ms Deakin-Stephenson was not in considerable pain at the time and he felt it was not justified to treat the situation as it presented itself to him as an emergency and for there to be a scan immediately. As his contemporaneous note at 15:27 hours records (B234):

> "Plan: tomorrow morning CT Abdomen and pelvis to check progress as agreed by radiology."

164. Mr Behar faces a difficulty about the suggestion that he was "begged" by the claimant for a second scan. He makes no notes (leaving aside the consent form) from this note around at 15:27 hours until a retrospective note after the operation on Monday 7th. On oath, his response to the suggestion that he was begged for a scan was "That is not how I recall it". One indication about the truth of this is that the claimant's evidence is that she was alternatively begging Mr Behar for a second scan or to contact a colorectal surgeon. As indicated, the court has ruled that Ms Deakin-Stephenson's claim that she requested a colorectal surgeon has not been proved by her and the court has concerns about her credibility on this point.

165. About this dispute, there is a nursing note from 6 November at 14:11 hours that states:

> "Radiologist called regarding CT abdo for patient, they said its too soon for patient to have the CT scan today, asked if we could liaise with the consultant looking after the patient to discuss regarding the matter. Spoken with Mr Behar regarding the radiologist's suggestion that the scan is too soon as patient had a previous one last thursday. Dr Behar said he will speak with the radiologist; gave him the radiologist phone number."

166. There is a further nursing note that accords with Mr Behar's note of 15:27 hours that "tomorrow morning CT abdomen and pelvis as agreed by radiology". The next nursing note is at 16:55 hours:

> "Received a call from Radiology requesting for patient to come down for CT verified with radiology as plan was to have her CT tomorrow; On-call

> radiologist said that consultants changed their mind and for patient to have CT this afternoon."

167. As is submitted by Mr Kennedy, the "changed their mind" does not necessarily indicate that it was Mr Behar who changed his position as opposed to the radiology department. While it may be that Ms Deakin-Stephenson's requests for a scan on the Sunday prompted further discussions between consultants, it is difficult to see how this adversely affects Mr Behar's professionalism. A second scan did take place. He did not block or refuse it. Once more, it is important to see this evidence in context and to compare it with Mr Behar's previous conduct. It should not be forgotten that on Thursday 3 November, Mr Behar was not satisfied with the diagnosis of the previous medical team and ordered an urgent CT scan of the claimant's abdomen, ensuring Ms Deakin-Stephenson was scanned within the hour (from 08:30 to 09:30 hours). Further, Mr Behar's working diagnosis of diverticulitis proved correct. He was concerned about Ms Deakin-Stephenson's condition; he took immediate action; he reached an independent conclusion at variance to that of his colleagues and his clinical judgement was subsequently vindicated. All that goes to supporting his professionalism and credibility.

168. It is not known what time the CT in fact took place. It had to be before 20:12 hours due to another record, so is likely to be before that. Nothing in the contemporaneous recordings points clearly supports the proposition that Mr Behar pressed for a CT scan due to the claimant "begging" him for one. The two experts agree that up until the results of the scan later that day, Mr Behar's management of the case was reasonable. It is more likely that what happened was that the radiologist department at first refused the scan and it was as a result of Mr Behar's intervention that it was brought forward from Monday to Sunday. The court has found in key respects, such as in relation to the dispute about referral requests, the origins of her transfer to private care and Monday pre-operatively visit, the claimant's account has proved unreliable and/or unconvincing.

169. In closing submissions, it was submitted on behalf of the claimant that an illustration of Mr Behar's poor decision-making is the "vacillation" about a second scan. The second scan took place only at the instigation of the claimant who had to "beg" him to arrange one and Mr Behar was "pushed into it". That is why the nursing records say "consultant changes their minds". Mr Behar, the claimant submits, "gives no plausible reason why he changes his mind" and this is a relevant factor for the court drawing its overall conclusion about his credibility. On this issue, the court is not persuaded to the civil standard that the claimant "begged" Mr Behar for a second CT scan. For understandable reasons, the claimant has been highly emotional about what happened during this time, had lost her memory of it, has tried to reconstruct what occurred, and has not proved to be a reliable historian.

170. I do not find that the issue of the second scan materially affects Mr Behar's overall credibility. The court finds no lack of care or concern in Mr Behar's conduct around the second scan.

171. Therefore, the evidential picture before the court has been complicated by the lack of adequate contemporaneous records. When Mr Behar met with Ms Deakin-Stephenson on 26 April 2017, he attended with no notes. It is a fair criticism of him, as made by Mr Chawatama, that on the facts and sequence of events he "had to be corrected several times" during the April meeting in the Hospital. Mr Behar's record-keeping failures have made him vulnerable to a number of allegations made by the claimant. Despite the evidentiary gaps, I have no hesitation in concluding that the truth about events emerged during the course of the trial with clarity. Overall, while Mr Behar's recordkeeping has been "poor", the court found him to be an honest witness whose evidence at critical points is supported by the contemporaneous records, such as they exist, and the canons of probability and improbability. I have found the contemporaneous records, in line with authority, "of the utmost importance" (*Onassis* principle). This has included the consent form, Mr Behar's retrospective note, his trainee's note, the private care invoices, the claimant's emails of complaint, Mr Behar's reply, the transcript of the 26 April 2017 meeting and Ms Deakin-Stephenson's online "review" of Mr Behar written by her for the benefit of other patients. There are other documents, but this provides a sense of the body of contemporaneous documentation that has assisted the court.

172. Mr Chawatama's submission that Mr Behar "has not called a single colleague to support his actions" on 6 November 2016, comes perilously close to seeking to reverse the burden of proof. Mr Behar does not have to prove his actions. The claimant brings this case. She must prove the - often serious - allegations made against Mr Behar. The court rejects the claimant's submission that the factual evidence "is heavily in favour of the claimant". While demeanour is not a significant or determinative factor, it is of forensic value in the assessment of witnesses, and the court in reaching its conclusions on where the truth lies has been able over an extended period to observe each of the witnesses carefully as they testified and that has added to the overall factual picture, kept always in its proper proportion. Generally, on disputed matters about the events during the claimant's stay in the Hospital until the surgery on Monday 7 November 2017 (Day 6), the court preferred Mr Behar's evidence to that of the claimant and her witnesses. Mr Behar was an honest witness who gave his evidence fluently, acknowledging fairly his shortcomings and where he had made errors, for example by the lack of record-keeping. However, I emphasise that the court's determination on each of the disputed issues is based on the entirety of the evidence before the court and is not simply a "credibility contest" between Mr Behar and Ms Deakin-Stephenson individually or between him and any of her witnesses, important though that is. It has been an iterative composite exercise, fitting the oral and filed written evidence together with the contemporaneous records, the evidence from the experts and the dictates of common sense and probability. It is precisely for that reason that reserving judgment has proved invaluable to assess and evaluate what emerges from the global picture holistically.

§X. EXPERT EVIDENCE

173. It was submitted on behalf of the defendants that in light of the evolving evidence, there was no need for the court to receive any live expert evidence. The court permitted all parties to make submissions about this and ultimately ruled in favour of the claimant. Accordingly, two experts were called to give live evidence in the trial. Mr Hartley was instructed on behalf of the claimant. Mr Meleagros was instructed by the second defendant. The expert instructed on behalf of Mr Behar was Professor Winslet. Sadly, Professor Winslet passed away between filing his report and the trial. Mr Behar wished to rely on Professor Winslet's evidence, to the extent that it remained relevant and had not been overtaken by developments in the case.

174. After some movement between the parties about issues, ultimately the two expert witnesses gave evidence at trial about four issues:

> (1) Whether Mr Behar can be considered a colorectal surgeon;
>
> (2) Whether Mr Behar's delaying of surgery from the evening of Sunday 6 November to Monday 7 November 2016 was in breach of duty;
>
> (3) Whether, if a referral had been made to a colorectal surgeon, the surgeon would have given a second opinion or taken over the care of the claimant;
>
> (4) What were the reasonable alternative or variant treatments in light of the CT scan results obtained on Sunday 6 November 2016.

Mr Hartley

175. Mr Hartley is a consultant surgeon at the Hull University Teaching Hospitals NHS Trust. He was instructed on behalf of the claimant. Mr Hartley prepared a liability report dated October 2022, then contributed to two joint reports, the first dated 4 September 2023, and the second based on the defendants' joint agenda also dated 4 September 2023.

176. **Issue 1**. On whether Mr Behar can be considered a specialist colorectal surgeon, Mr Hartley's opinion is that while Mr Behar is employed as an emergency general surgeon, there is a difference between Mr Behar and a specialist colorectal surgeon. Mr Behar will have been examined on "exit" (of training) in colorectal surgery, but there is a "world of difference", as Mr Hartley puts it, between that and someone who takes on the (specialised) role as a colorectal surgeon. They would usually have a higher degree, an MD or PhD in colorectal surgery and have research postings and fellowship in such surgery. Those are not essential criteria for the post, but in Mr Hartley's experience this is a common profile, and Mr Behar lacks these.

177. Against this, the statement of Mr Jason Smith, a consultant surgeon, and former Divisional Medical Director (Planned Care) of the defendant Trust was put to Mr Hartley. Mr Smith's statement is dated 1 December 2022 and states:

> "Most emergency surgery is gastrointestinal surgery, Diverticular disease is a very common emergency; I would estimate that gastrointestinal cases

> account for around 60% of all emergency cases. Accordingly, Mr Behar would be considered to have the relevant experience and training to treat the claimant."

178. This is evidence from a witness whose statement the parties have agreed can be read. The court can take it as accepted. Mr Hartley did not dissent from the statement as put to him in cross-examination. Mr Hartley said:

> "The emergency surgeon is expected to deal with acute presentations for a full range of GI conditions, that is what an emergency surgeon would be employed for."

179. He then added that diverticulitis is a common problem, and patients with it:

> "come in most days of the week. Most patients will be treated with non-operative antibiotics. It is a small number, perhaps one in ten of diverticulitis cases require surgery. It seems like more than two per year I have to deal with surgery for diverticulitis. The main part of my practice is dealing with elective colorectal surgery, including bowel and cancer surgery."

180. The joint experts' report at B602-03 was put to Mr Hartley where Mr Meleagros' opinion is given:

> "LM will say that the role of a general/emergency surgeons is not as a triage/emergency admission service tasked with managing the patients initially but transferring them to other 'specialist surgeons' for definitive care. Emergency consultant surgeons are consultants with equivalent status to 'specialist' surgeons. They manage all aspects of the care of emergency patients from admission through to discharge."

181. Mr Hartley agreed that he "cannot see the point in employing someone to triage patients." He confirmed that up to Sunday 6 November, that is, until the second CT scan, a specialist colorectal surgeon's treatment and care management would have been "identical" to that of Mr Behar. He agreed that the consent form note written by Mr Behar of "sigmoid colectomy + stoma" in fact "amounts to a Hartmann's procedure". He stated about the words on the form "only if absolutely needed" that "I've not seen this expression on the consent form written by any other surgeon." The question then becomes that if it is an exceptional or unique entry, why Mr Behar wrote it on the form and what reasonable inference can be drawn from its appearance on the form. Mr Hartley said in re-examination that it could be evidence of "surgical bias". I will return to this question.

182. As to the risks detailed on the form, he stated that they are "generic risks you can apply to general surgery/procedure." He felt that:

> "There should have been failure of treatment and the requirement for further emergency surgery. I would say that consent form is not evidence of adequate warning of risks."

183. **Issue 2**. On the second issue of delaying the surgery from Sunday evening to Monday morning, Mr Hartley could not "see any reason to delay surgery on clinical grounds that evening". The chances of the condition settling were minimal, and the problem with delay is that the claimant was at risk of the kind of catastrophic deterioration that did happen. Thus, he could detect no clinical reason to delay the surgery. Further, as someone on the emergency rota, Mr Behar would not know which further cases or emergencies were coming in. Mr Hartley told the court how "When we book an operation we categorise its priority. The standards are for audit. But in real terms you would not delay." He agreed that there is a category and a patient, and these are just guidelines.

184. He was asked whether in general it is safer to operate "in hours" rather than out of hours due to the availability of back-up. He said, "People are at their best in normal working hours and more people are around." As to whether on Sunday afternoon Ms Deakin-Stephenson was clinically stable as far as can be seen from medical notes, he stated that there is no evidence of a deterioration from the medical records (clinically), "but radiologically she was worse, and she said she felt worse." He continued:

> "I do not think doubts in patient's mind about surgery is a reason to delay surgery. I agree Mr Behar appears to spend quite some time with claimant on Sunday. I would have been extremely uncomfortable at deferring surgery at that time. I do not accept it was reasonable to defer to the following day."

185. Mr Meleagros also provided evidence about delay, dealt with below.

186. **Issue 3**. On whether a colorectal surgeon would have taken over the care or offer a second opinion, Mr Hartley said, "I would have taken over as a colorectal surgeon myself, that is more likely." He says that in 2016, a colorectal surgeon was very likely to say get on and do a Hartmann's, as that was the proven and established way of dealing with the claimant's problem. The "vast majority" of colorectal surgeons would have done so, he told the court. When he was challenged about this assertion, he acknowledged that laparoscopic lavage was in the NICE guidance. He accepted that in 2016 there was a responsible body of surgeons that would have followed lavage given an appropriate consenting process and thus it was a reasonable alternative or variant treatment. Nevertheless, "a Hartmann's was and remains the standard way of dealing with it." Mr Hartley went further and stated that although laparoscopic lavage was reasonable alternative or variant treatment:

> "In 2016, I would not have offered a laparoscopic lavage. As a bowel surgeon I did not see how washing out the abdomen would deal with the hole in the bowel. The safest thing to do is take out the diseased section. The colon behaves in a different way than a duodenal ulcer. The risks of a colonic perforation are life-threatening through sepsis and septic shock. The colon does not behave like other organs. We try to respect that and try to remove the problem rather than patch it up in some way."

187. Therefore, laparoscopic lavage was never part of his practice and he never saw the rationale for doing it. He would not offer it to patients, even though it was

a reasonable or alternative variant treatment. The NICE guidance was put to him. It stated:

> "Offer either laparoscopic lavage or resectional surgery (see recommendation 1.3.27) to people with diverticular perforation with generalised peritonitis after discussing the risks and benefits of the 2 options with them (see table 3)."

188. He stated that he "recognised" the national guidance. However, he continued:

> "But I did not follow it with a large body of colleagues and the professional body has subsequently come down against using lavage."

189. Therefore, despite laparoscopic lavage being a NICE-approved alternative treatment, Mr Hartley still would not have offered it to patients. He agreed that the "bifurcation", that is surgical procedure options, offered by Mr Behar was reasonable in 2016.

190. **Issue 4**. After the CT scan on Sunday 6 November, the likely recommendation of a colorectal surgeon would have been a Hartmann's as it is the safest way of dealing with the problem, and was how colorectal surgeons dealt with problem in 2016 and do now. Mr Hartley said:

> "If [the claimant] is well and settled, that is a good time to deal with the problem rather than wait for a deterioration. Surgery was inevitable. I would have dealt with it that night. I accept that colorectal surgeons would be less experienced in lavage. If it had been suggested that lavage would be done on claimant, I would have taken charge and ensure the correct thing was done – which was a Hartmann's."

191. Mr Hartley stated that he would perform about 8-10 Hartmann's per year, and his hospital would have between 50-100. He accepted that of the Hartmann's he performed, not all of them would be for acute diverticulitis, and these numbered between 4-5 per year.

192. As to the consenting process, the email from Mr Behar to the claimant was put to Mr Hartley (B256):

> "I explained to you that there were 2 options to proceed with; both surgical. One was washing out the infection laparoscopically to allow infection to settle without removing the colon and sparing you a colostomy (I have warned you that this procedure may, during surgery or afterwards, necessitate colectomy nevertheless if the contamination was extensive). The other was an outright removal of colon with Hartmans Procedure and colostomy. You have opted for the laparoscopic washout of the infection wanting to avoid a stoma. At the time of laparoscopy the contamination proved to be minimal and the washout was sufficient without proceeding to Hartmans Procedure."

193. Mr Hartley was asked, if these extracts represent the consenting process, would it be a *Montgomery*-compliant process? He said it would. He was then asked if it was consistent with what is written on the consent form. His answer was:

> "This form is a consent form for a laparoscopic lavage and Hartmann's if required, but does not tell us if a Hartmann's was offered as an alternative. It is consistent with one limb of the approach, but does not tell us whether Hartmann's was discussed as an alternative."

194. Therefore, Mr Hartley was making the point that the consent form does not "tell us" whether a "straight" or stand-alone Hartmann's procedure was offered to Ms Deakin-Stephenson on the evening of 6 November 2016 as a self-contained alternative to a laparoscopic lavage with a Hartmann's procedure if medically indicated during surgery.

Mr Meleagros

195. Mr Meleagros is a retired consultant surgeon. He retired on 31 March 2023 from North Middlesex Hospital. He was a general and colorectal surgeon. His practice was primarily in colorectal surgery. Until 2005-07 he was the only colorectal surgeon at North Middlesex. That kept him busy. He wrote a report in March 2023 for this case. His oral evidence to the court did not follow the strict structure that Mr Hartley's did, but nevertheless was once more of value.

196. As to the risks that Mr Behar recorded on the consent form, he agreed with Mr Hartley, that this was "inadequate about the procedures and their risks". However, his opinion was that the consent form did reflect the offering of a Hartmann's procedure as a stand-alone choice for the claimant. The two procedures could not have been listed on the consent form without both being explained. This consent form does not say that the Hartmann's is conditional on laparoscopic lavage. The alternative was to have two consent forms signed. The lavage cannot be offered without the "get out" of the Hartmann's. A reasonable surgeon would have advised that you can have a Hartmann's with 100 per cent certainty of stoma or lavage with 0 per cent chance of stoma, but the risk of a second operation. There would be a 10-20 per cent possibility that you would have a second operation with a stoma.

197. His professional experience of the practice of surgeons in 2016 was different to that of Mr Hartley. Mr Meleagros stated that his "emergency colleagues favoured laparoscopic lavage but towards the end of my career I did Hartmann's." That said, he agreed with Mr Hartley that the majority of surgeons after the Sunday CT scan would have performed a Hartmann's, but that is because they lack the experience of using laparoscopic lavage. He referred the court to the "Gregory" research paper that states that surgeons are "not familiar" with lavage and "practice defensive medicine". He then continued:

> "Most of my colleagues are reluctant to proceed with lavage, and there is no accreditation for lavage. But I would say Mr Behar was accredited and developed a sub-specialism in it. The Hartmann's procedure is not done by specialist colorectal surgeons. The guidelines are for everyone who performs Hartmann's. Therefore, the majority of Hartmann's is carried out

> by non-specialist colorectal surgeons. In my hospital, the emergency surgeons eventually took over virtually all the Hartmann's. Hartmann's is such a drastic thing because of the stoma and because of the distressing experience this produces for the patient."

198. Mr Meleagros gave vivid evidence about the potentially severe impact on a patient that having a stoma can result in. He explained how the literature documents that patients with stomas fare far worse than those with the surgery the claimant's sister underwent, whereby the organs remain within the body. Indeed, patients who were struggling with stomas reverted to the same level of outcomes and prospects once the stoma was reversed, such is its effect and the distress it causes to the patients. The significance of this is that Mr Behar's case is that Ms Deakin-Stephenson expressed great reluctance to agree to surgery resulting in a stoma. Given the evidence of Mr Meleagros, such alleged reluctance by Ms Deakin-Stephenson becomes a completely reasonable and, one might add, rational response to the prospect of one of her organs being placed outside her body, as she viscerally termed it. It is not for the experts to make a judgment about where the truth lies in the dispute between Mr Behar and Ms Deakin-Stephenson. However, the evidence of Mr Meleagros does provide support for why Ms Deakin-Stephenson may have been very reluctant to live with a stoma, with the distress she exhibited at the prospect reflecting the distress of patients found in the literature and Mr Meleagros's professional experience. It is, as Mr Meleagros agreed, a "drastic" intervention in someone's life, and a very "distressing experience".

Conclusion: expert evidence

199. The court greatly benefited from the expertise and thoughtful consideration of two eminent consultant surgeons, Mr Hartley and Mr Meleagros. It was undoubtedly the right decision to grant permission for their testifying. They were rather different personalities, but each possessed intellect and were articulate, frank and forthright – precisely what the court would expect of high-quality experts. The court is grateful to them both. Given the importance placed on the issue of the medical management following the CT scan on Sunday 6 November, it is necessary to pull together the strands of the experts' evidence about it.

200. First, the experts are agreed that while a Hartmann's procedure should have been offered as part of an appropriate consenting process, as one of the options, the other reasonable alternative or variant treatment option was laparoscopic lavage.

201. For reasons developed in Behar Issue 3, the court finds that the claimant was offered two options. First, a Hartmann's procedure, the option that Mr Behar had a mild preference for in an otherwise evenly balanced ("50-50") clinical situation, in his estimation. Second, a laparoscopic lavage with the possibility of converting it to a Hartmann's procedure. Thus, the options Mr Behar discussed with the claimant were in accordance with what the experts agreed should be done. It is for the court and not the experts to make findings of fact about what in fact happened, a proposition both experts agreed.

202. As to whether a laparoscopic lavage was reasonable as at the evening of Sunday 6 November 2016, Mr Hartley stated in the joint report that "he accepts the evidence base for a lavage". Mr Meleagros stated:

> "LM agrees that laparoscopic lavage was reasonable and would be supported by responsible body of surgeons, based on some of the relevant scientific literature available in 2016. The WSES guideline was published in 2016 but it is not known whether this was before or after the index event in November 2016. LM defers to the Court in the matter. In his view the 1st Defendant would have been aware of the articles published prior to the WSES guideline (2013-2015) and which are analysed in the guideline. LM will say that the plan was reasonable given the 1st Defendant's experience with laparoscopic lavage, in his capacity as a consultant emergency and colorectal surgeon."

203. When asked whether Mr Behar's "management plan" (following the second CT scan) was reasonable, Mr Hartley added:

> "JH will say that the Claimant needed surgery. In his view a Hartmann's procedure was the standard of care in 2016 and remains so today. However in light of the NICE guidance and other guidelines he accepts that a responsible body of surgeons would have offered lavage as an alternative."

204. Therefore, it must follow that notwithstanding Mr Hartley's personal practice, a laparoscopic lavage was a reasonable alternative or variant treatment.

205. Second, the experts are agreed that a majority of responsible specialist colorectal surgeons would have advised a Hartmann's procedure. The fact that the majority of responsible specialist colorectal surgeons would have made this recommendation is only of causative relevance if by the time of the consenting process on Sunday night a specialist colorectal surgeon should have taken over Ms Deakin-Stephenson's care. There is no evidential basis to reach that position. Mr Hartley does not suggest that Mr Behar lacked the competence, skill or experience to perform either a laparoscopic lavage or a Hartmann's procedure. Indeed, Mr Behar performed the lavage on the morning of Monday 7 November and the emergency Hartmann's procedure in the early hours of Wednesday 9 November. I do not understand the claimant's case to be that Mr Behar was not competent to perform either surgical procedure. As Mr Meleagros said on oath:

> "The Hartmann's procedure is not done by specialist colorectal surgeons. The guidelines are for everyone who performs Hartmann's. Hartmann's are carried out by non-specialist colorectal surgeons and the majority of Hartmann's are performed by non-specialist surgeons."

206. He added that in his hospital, the emergency surgeons eventually took over virtually all the Hartmann's procedures. Therefore, for the approach of a "majority" of colorectal surgeons to be of causative relevance, the court would have to find that Mr Behar had been requested to make a referral to a colorectal surgeon which he refused. As explained in Behar Issue 1, the court finds that

allegation unproven to the civil standard that governs this case. Thus, what the majority of colorectal surgeons are likely to have done lacks the factual basis to be causatively relevant.

207. As to what the claimant should have been told, Mr Hartley further stated in the joint report that:

> "He takes the view that adequate consent would involve presenting Hartmann's procedure as a safer and more definitive procedure."

208. Mr Hartley stated on oath:

> "A Hartmann's was and remains the standard way of dealing with it. In 2016, I would not have offered a laparoscopic lavage. As a bowel surgeon I did not see how washing out the abdomen would deal with the hole in the bowel. The safest thing to do is take out the diseased section. The colon behaves in a different way than a duodenal ulcer. The risks of a colonic perforation is life-threatening through sepsis and septic shock. The colon does not behave like other organs. We try to respect that and try to remove the problem than patch it up in some way."

209. Mr Hartley continued in the joint report:

> "JH will add that both ACPGBI and ASCRS guidelines (the professional bodies of specialist colorectal surgeons in the UK and USA) specifically recommend against relying upon laparoscopic lavage in this scenario."

210. In the joint report, Mr Meleagros addressed these guidelines:

> "LM is familiar with the ASCRS and the ACPGBI guidelines, which were published after the index event in 2020 and 2021 respectively. He has already alluded to the discrepancies between, on the one hand, these guidelines and, on the other hand, the NICE guidelines which were published in November 2019 and the ESCP guidelines published in 2020. He does not have an explanation why four sets of guidelines, presumably based on analysis of the same scientific literature, arrived at different conclusions. However, as set out in his expert report and elsewhere in this Joint Statement, both ASCRS and ACPGBI provide a more nuanced opinion regarding laparoscopic lavage (see paragraph 5.40 in LM's expert report and LM's answer to question 28 above). Furthermore, the more recent article reporting on long-term results of the randomised SCANDIV trial (2021) concludes that the outcomes of laparoscopic lavage are not unfavourable compared to Hartmann's procedure (see article and conclusions -reference in LM's expert report)."

211. The difficulty with Mr Hartley's position is that the guidelines he relies on were published after Ms Deakin-Stephenson's surgery in 2016. Given the divergence between the two experts in approach to laparoscopic lavage, the court cannot find to the requisite civil standard that Mr Behar should have "presented" or advised Ms Deakin-Stephenson that a Hartmann's procedure is a "safer and more definitive procedure". On this issue, the court prefers the evidence of Mr

Meleagros. Mr Hartley's evidence relies on guidelines that were not in existence at the time of the consenting process in this case. So I turn to the four issues identified at the outset of this section.

212. **On Issue 1**, the question of whether Mr Behar can be considered "a colorectal surgeon", I conclude that the issue must be further disaggregated. If the question is whether Mr Behar is experienced in colorectal surgery, then the answer is plainly yes. He has very considerable experience in it. If the question is whether he was sufficiently competent to perform colorectal surgery, then the court has the evidence of Mr Smith that is not disputed. It is that "Mr Behar would be considered to have the relevant experience and training to treat the claimant." The claimant's expert Mr Hartley did not dissent from this conclusion. While Mr Behar did not have all the further qualifications that Mr Hartley stated were part of the "common profile" of a colorectal surgeon, Mr Hartley agreed that up to the Sunday CT scan, the medical management provided by Mr Behar was identical to what would have been provided by a specialist colorectal surgeon. It is significant that both at Chelsea and Westminster Hospital and at Mr Meleagros's hospital, the great majority of Hartmann's procedures are performed by surgeons who not hold themselves out to be "specialist" colorectal surgeons, while being able to call themselves colorectal surgeons. Therefore, Mr Behar can accurately call himself a colorectal surgeon. The court was not asked to consider whether he can call himself a "specialist" colorectal surgeon. As will be seen in Behar Issue 1, and as has been touched upon in the witness assessments, a clear flaw in Ms Deakin-Stephenson's claim that she sought a referral to a colorectal surgeon is that undoubtedly Mr Behar is so qualified. As he said in his statement at para 8:

> "I am a qualified colorectal surgeon and the management of diverticulitis was a large part of my day-to-day practice."

213. It cannot sensibly be suggested that he is not a colorectal surgeon. The highpoint of the claimant's case on this point is in Mr Hartley's comment that specialist colorectal surgeons "usually" have a higher degree in colorectal surgery. But he recognised that such a degree and colorectal surgery fellowships "not essential criteria" for the post. Therefore, it must follow that there are specialist colorectal surgeons who lack those further qualifications (usually cannot mean always). Thus there must be on Mr Hartley's logic specialist colorectal surgeons whose qualifications are little different to Mr Behar's.

214. **On Issue 2**, delay, it is important to emphasise that the issue of whether Mr Behar should have performed the first operation on the Sunday night rather than on the Monday morning is not now alleged by the claimant to be a causative breach of duty. As such, it cannot go to liability. Nevertheless, the court granted permission for the issue to be explored with the experts because it has the capacity to affect Mr Behar's credibility. It for that purpose that the claimant now relies on it, there being no necessary causal liability link.

215. Mr Hartley's evidence is that there was no clinical reason to delay surgery once the results of the CT scan had been obtained.

216. Mr Meleagros's evidence is that clinically the claimant was stable. There was no worsening in abdominal pain or in abdominal tenderness, according to the clinical records. CRP had decreased compared to the previous day. NEWS was 1 in the afternoon of 6 November and 0 in the early hours of 7 November. The CT scan showed that antibiotic treatment alone was not effective and therefore surgery was required. According to WSES guidelines, distant air on CT is a predictor of failure of non-operative treatment. However, in haemodynamically stable patients, with certain caveats (see WSES guidelines), they may be treated non-surgically, at least initially but with the knowledge that failure rate of such treatment is high. Furthermore, ASGBI guidelines on emergency general surgery (2014, set out in Mr Meleagros's expert report) state that patients with sepsis but without organ compromise may be operated on within 18 hours. The timing of the claimant's surgery was therefore in accordance with published guidelines. He agrees that lengthy delay in performing surgery in the presence of colonic perforation is not appropriate because of risks of worsening sepsis. However, the claimant avoided this risk by the time she came to surgery in the morning of 7 November.

217. Mr Meleagros notes that Mr Behar recognised the claimant's very serious concerns about a stoma and they agreed to revisit the consenting process on Monday morning after she had had the opportunity to think about it. If this were factually true (and the court has now made these findings of fact), and given that there was not a life-saving emergency situation where it was imperative to get to theatre within an hour (a Category 1 case), Mr Meleagros's opinion is that it was not unreasonable to delay.

218. Part of the rationale for Mr Hartley's conclusion about the unreasonableness of delay is that very serious potential consequences attend a colon perforation, such as faecal leakage and possible sepsis or septic shock. Against this, Mr Meleagros emphasises that nowhere in the literature does it say that the deterioration Ms Deakin-Stephenson experienced is a common or even an outcome that occurs albeit rarely; nowhere does the literature refer to the events that the claimant experienced. Put another way: no one could have warned her that this would have happened or could have included it in the "counselling" (discussion) or included it in the consent form. It is important to put the risks that Mr Hartley speaks of into their proper context. I am not persuaded that it was unreasonable to delay non-emergency surgery from Sunday night to Monday morning if Ms Deakin-Stephenson needed further time to think about what she was prepared to consent to given her great anxieties and since it was not an "emergency" situation. For the reasons given in my assessments of the claimant and Mr Behar, I prefer his evidence about Ms Deakin-Stephenson's aversion to a stoma to her evidence on the issue. I was unconvinced by her explanations and her evidence about events about both the alleged requests for referrals to a colorectal surgeon and the consenting process has proved unreliable.

219. For example, her case is that Mr Behar did not visit her pre-operatively on Monday morning. His case is that such a meeting is his invariable practice. As it turned out, the record of his trainee points strongly to his having seen the claimant on his ward round ("W/r") on Monday morning before surgery. His

evidence is that the claimant confirmed the approach documented on the consent form at that encounter. Ms Deakin-Stephenson has no evidence to put against what he says happened at this ward round meeting as she said the pre-operation meeting did not happen. The evidence as a whole, including the contemporaneous evidence, suggests that it is likely to the civil standard to have happened. These are recursive matters and the court must look at the wide canvas of the evidence. The ward round visit supports Mr Behar's credibility. His supported credibility about this issue supports his account of a reluctance on the claimant's part for a stoma and hence in part the non-emergency delay. Mr Behar's approach is further supported by the claimant's conduct in the Hospital following admission. The nursing notes show that she had been reacting in an assertive way at points by complaining and criticising nursing staff. That is not held against her, naturally. What is of significance to the issue of delay is her declining to accept the medical recommendation on Friday 4 November (Day 3) that she have a catheter inserted. This was two days before her lengthy discussion with Mr Behar on Sunday (Day 5), which led to the consenting process not being completed until Monday on his case (Day 6). Mr Behar's evidence is that she was highly anxious about a stoma, and this accounts for the "only if absolutely needed" entry on the consent form. In relation to the catheter, Ms Deakin-Stephenson wished to think about the medical recommendation. Mr Behar faced a similar wish from her on the Sunday to think about the medical options. He was sensitive to this. I prefer Mr Meleagros' assessment of the question of delay to Mr Hartley's. Mr Meleagros was assessing the matter in the context of the indicators that Ms Deakin-Stephenson was medically "stable" and although lengthy delay was not justified, she came to surgery the next morning, which he deemed reasonable.

220. Taking all this into account, I judge that Mr Behar's approach to delay was reasonable. The claimant has failed to prove that it was unreasonable. Therefore, I do not assess the delay in surgery from Sunday night to Monday morning as adversely affecting Mr Behar's credibility, which was the remaining significance of the issue, the causative link having gone.

221. **On Issue 3**, whether a colorectal surgeon would have provided a second opinion or taken over the care of Ms Deakin-Stephenson, while it is correct that Mr Hartley would have taken over the care of Ms Deakin-Stephenson, he did not give evidence that all colorectal surgeons would have done so or indeed a majority would have done so. But in any event, even if that were the case, the essential evidential foundation for this to be relevant is absent: the court has rejected the claim that there was a request for a colorectal surgeon referral.

222. **On Issue 4**, based on the joint expert evidence, laparoscopic lavage was a reasonable alternative or variant treatment following the CT scan on Sunday 6 November 2024. There is no evidence to indicate otherwise.

§XI. BEHAR ISSUE 1

(Referral)

- **Did the claimant and/or members of her family ask Mr Behar for a referral to a colorectal surgeon or a second opinion?**

223. The claimant relies on the following list of requests:

- 3 November 14:45 hours: the claimant and her sister directly to Mr Behar
- 4 November 09:18 hours: the claimant and her sister directly to Mr Behar
- 5 November: the claimant directly to SpR Walsh
- 5 November: the claimant's former partner Mr Stephenson directly to SpR Walsh
- 6 November 15:00 hours: the claimant directly to Mr Behar in presence of parents
- 6 November 15:40 hours: the claimant's late father to Mr Behar
- 6 November 21.30 hours: the claimant directly to Mr Behar
- 6 November 22.30 hours: the claimant asking Mr Behar to call Mr Oliver, following text from sister
- 6 November 22:50 hours: the claimant directly to Mr Behar in presence of parents, asking to speak to Mr Oliver Warren that night.

224. In addition, the claimant's trial evidence is that she asked Mr Behar repeatedly for a referral, as she put it, "8, 9 or 10 times". On Sunday evening alone, she asked him "several times" for a colorectal surgeon referral. The court has received written and oral evidence from the claimant, her mother Mrs Deakin, her sister Mrs Ingledow, and her former partner Mr Stephenson, all of whom said that at various points requests were made to Mr Behar for a referral to a colorectal surgeon.

225. In terms of contemporaneous evidence, there is evidence of two messages that Mrs Ingledow sent on the night of Sunday 6 November. First, she sent a text message to her parents at 22:25 hours. She states that Mr Oliver Warren is "definitely the man for an extra opinion or discussion". She added that "Maybe he's already involved in Pips [the claimant's]". The excerpted message ends there. But the sense is clear.

226. Second, an email to her sister at 22:38 hours. In it, Mrs Ingledow stated:

> "If you want someone else to talk to I think he's the man!! … I'm sure he and Dr Behar Work [sic] must work together!"

227. These two messages provide support for the proposition that the question of an "extra" or second opinion arose amongst family members on the evening of 6 November by the very latest. It is submitted on behalf of the claimant that the evidence is "overwhelming" that "multiple requests were made directly to Mr Behar by the claimant, her sister and her parents". In evidence, Ms Deakin-Stephenson, Mrs Ingledow, Mrs Deakin and Mr Stephenson all confirmed that they made requests for a referral (Mr Stephenson to SpR Walsh, and the claimant also once to SpR Walsh). Mr Chawatama submits that the evidence shows that attempts were made to contact the Ms Deakin-Stephenson's GP and

a colorectal surgeon Mr Khan, who had treated Mrs Ingledow for diverticulitis by way of sigmoid colectomy.

228. Mr Behar's case, supported by the second defendant, is that there was never a request made for him to refer the claimant to a specialist colorectal surgeon.

Discussion

229. The statements from Ms Deakin-Stephenson and her witnesses are dated 2023, and therefore over six years after the events, although they may have been prepared in draft, or partially, in 2022 (or at least some of them were). There is no contemporaneous medical record of any request for a referral, despite the allegedly numerous requests. The claimant or any member of her family could have asked any member of the nursing staff if they could assist or complain to the nurses that Mr Behar was refusing repeatedly to make a referral. The nursing records are substantial and in places detailed. They document Ms Deakin-Stephenson's ability to express her wishes and voices her concerns, a matter consistent with the court's assessment of the claimant's evidence. The nursing records document several issues that were of concern to Ms Deakin-Stephenson, including TED stockings, pain medication, catheterisation, stoma care and continuity of nursing care. Yet there is no recorded complaint from the first alleged request on 3 November until discharge on 29 November that Mr Behar did not refer the claimant for a second opinion, nor a single request that nurses ask another doctor to assist. Indeed, the court received no evidence from the claimant or her witnesses that any of them asked the nursing staff for a referral or told nurses the family's concern that Mr Behar was refusing to make a referral despite numerous requests. If this were a true concern, it is puzzling that this assertive family would have said nothing whatsoever over several days until the first surgery and then over several weeks until discharge home at the end of November.

230. In evidence, Mr Behar recalls a conversation with Mrs Ingledow about colorectal surgery. Mr Chawatama submits that this "supports the contention that a request for a referral was made." It is important to be clear what Mr Behar said in his statement (para 8):

> "I do recall having a conversation with the Claimant and/or her sister regarding her treatment plan and a course of treatment the Claimant's sister previously underwent (elective laparoscopic resection of the colon), however I advised that this would not be a realistic option for the Claimant given her presentation and that she was not an elective case."

231. It is plain that the discussion was about treatment plans and not the nature of the doctor advising Ms Deakin-Stephenson. The claimant's submission on this is misconceived. The further submission is that it is "inherently probable" that requests were made given that there was a perforation to the claimant's bowel. Against this, and undermining the reliance of probabilities here, is the fact that the claimant had several important opportunities to raise this complaint in the first half of 2017 and up until the July 2017 complaint and failed to do so. In the 18 July 2017 complaint, the claimant stated that Mr Behar should have passed her care on to a specialist colorectal surgeon, but did not allege that she

and others had made numerous requests that he do precisely that. As Mr Behar stated in his statement (ibid.):

> "I am a qualified colorectal surgeon and the management of diverticulitis was a large part of my day-to-day practice. Had the Claimant requested for another colorectal surgeon to assess her I would have not denied her this request."

232. This is an important context in which to view the two contemporaneous messages of Mrs Ingledow on the Sunday night. It will be noted that there is no reference to referral requests having been made to Mr Behar or anyone else. Significantly, the email to Ms Deakin-Stephenson states "if" you want someone else to talk to. This is very far from there having been by this point numerous direct requests made to Mr Behar. Indeed, in the text message to her parents, Mrs Ingledow states that Mr Warren is the man for "an extra opinion or discussion." I cannot accept the submission that this provides "powerful evidence in support of requests for a referral to a specialist colorectal surgeon". Indeed, proper analysis of this text message and the email viewed in context makes it less likely that there had been repeated and urgent requests that Mr Behar refer the claimant to a specialist colorectal surgeon. The suggestion that Mr Behar "must work with him [Mr Warren]" and that "maybe" Mr Warren "is already involved" is not consistent with the intense criticism the claimant and her family claim they had for Mr Behar's conduct by Sunday night. In neither message from Mrs Ingledow is there any criticism of Mr Behar. There is no hint of anger or frustration. The content and tone of these two messages run contrary to Mrs Ingledow's evidence and are inconsistent with the claimant's overall narrative on this issue. Further, if there had been numerous requests for a colorectal surgeon by the evening of Sunday 6 November, it is inexplicable why there had not been any search for colorectal surgeon before Mrs Ingledow's identifying of Mr Warren on the Sunday (Day 5). Equally, if as the evidence relied on by Ms Deakin-Stephenson claims there were numerous telephone calls for assistance made to Dr Street, the claimant's GP, it is puzzling that not a single one of them was returned. It also appears that the message for the colorectal surgeon Mr Khan was also never responded to. It seems implausible that all these calls were met with a complete silence from independent medical professionals. Although it is alleged by the claimant and Mr Stephenson that they attempted to contact Dr Street, Ms Deakin-Stephenson's GP, there is no record or contemporaneous evidence to support this. There is no record or independent evidence to support the claim that they tried to contact Mr Khan. It was open to the claimant to provide such material to the court. There is no evidence that she tried to obtain it and failed.

233. The claimant emailed Mr Behar on 23 January 2017 asking about her condition and the need for treatment. She made no mention of any concern over the way in which she had been treated by him and at the beginning of the month had written a glowing online review of him for other members of the public, having had the opportunity to speak to her family about concerns about his conduct between discharge and the review. As someone who has held positions of public responsibility as Ms Deakin-Stephenson had in education, it is inconceivable that she would have done this if she truly believed that Mr Behar's medical

management of her case was as unprofessional as she alleges and had led to her near-death experience. She would have undoubtedly spoken repeatedly with her family members both in the latter stages of her hospitalisation when she neared discharge and then in the month of December following discharge and before she wrote the review on 1 January 2017. Indeed, Ms Deakin-Stephenson wrote in the review " mr Behar did not give up on me at anytime" and she thanked him from the "bottom of [her] heart".

234. On 9 March 2017, after the claimant had seen Professor Tekkis, she emailed the Mr Behar. She was deeply dissatisfied with the consultation with the Professor which she called "a total waste of time" and "energy" and "money". She was "very upset"; her sister was "extremely shocked". Professor Tekkis told her that he would write letters to a number of doctors, including Mr Oliver Warren. Ms Deakin-Stephenson wrote to Mr Behar that "I have never heard of these other doctors". This is of relevance because if the family had been so intent on seeking a referral to Mr Warren from Mr Behar in November 2016, it is puzzling that Ms Deakin-Stephenson had "never heard" of him. Indeed, Ms Deakin-Stephenson's evidence is that she directly asked Mr Behar for a referral to Mr Warren on the Sunday night. The claimant's trial evidence was:

> "I said please can I have a referral for a second opinion with a colorectal surgeon for all the treatments. I asked if he knew Oliver Warren but he was not on duty on Sunday night."

235. Further, it is significant that if she was so critical of the medical treatment she received from Mr Behar that she would write to him to receive his assistance. She continues in her email to him that she would like his suggestion for a surgeon that Mr Behar "would personally recommend." This request is inconsistent with the grievance she claims she felt towards Mr Behar. Mr Behar's evidence is that:

> "I understand from the medical records that the Claimant attended Professor Tekkis on 8 March 2017 and the consultation did not go well according to her email to me on 9 March 2017, which I responded to same day and arranged a referral to another Colorectal Surgeon, Mr Oliver Warren at the suggestion of Professor Tekkis. The Claimant was a memorable patient and we had good rapport, as she referred to me as her saviour at that time and wrote a very nice review of my care online."

236. Ms Deakin-Stephenson wrote back to Mr Behar, "thank you for your email and for being so kind as to reply so supportively, I appreciate it very much". Here is evidence that upon being asked to make a referral to Mr Warren, Mr Behar did so the same day. This speaks to the point that there is no credible reason why Mr Behar, an experienced and senior medical professional, would refuse or obstruct the claimant's wishes for a referral. Mr Hartley states that he has no experience of a surgeon declining to arrange for a second opinion when one was requested, which makes sense as there is not a plausible reason for refusal. Further, with regard to Mr Warren specifically, at no point in her March 2017 email does the claimant say to Mr Behar that Mr Warren is exactly the surgeon he was asked to refer her to and that he had refused.

237. Ms Deakin-Stephenson's email undermines any credible suggestion that Mr Behar refused a referral to Mr Warren. I have dealt with the weakness of the evidence of the claimant and Mr Stephenson about the request to SpR Walsh, with both of them at first stating that the doctor was male. This is another sub-issue on which the credibility of the claimant's allegation is weakened. It was of course open to the claimant's family to approach Mr Warren or any other expert they found through the consultant surgeon's secretary, but they did not. Ms Deakin-Stephenson was covered by BUPA throughout, yet no attempt was made to seek a second opinion through BUPA or ask BUPA to assist given Mr Behar's alleged obstructiveness.

238. On 13 March 2017, Ms Deakin-Stephenson wrote a comprehensive letter of complaint. She posed detailed questions about her treatment. She does not make any complaint about requests and refusal of requests for a second opinion or referral, nor express any frustration or distress about the way she was treated by Mr Behar. Instead, she states in a way entirely consistent with her online review from January, and following further time for discussion with her family about her treatment by Mr Behar:

> "please note, I am unbelievably and very sincerely grateful to Mr Behar as well as the entire medical team at Chelsea and Westminster for saving my life"

239. On 26 April 2017, there was the meeting at the Hospital, attended by Mr Behar, the claimant and her sister. There was no mention of requests for a referral.

240. The formal complaint letter is dated 9 June 2017. There was no complaint about being refused a colorectal surgeon referral and no mention of the multiple requests or indeed any.

241. On 18 July 2017, Ms Deakin-Stephenson made a further complaint. The terms are instructive. First, that Mr Behar did not liaise or consult "anyone of the colonoscopy team". Then that:

> "I should have been operated on immediately and if Mr Behar, while he is I am sure an excellent general emergency surgeon, he failed to pass me over as a patient to a colonoscopy specialist who should have performed the first operation and immediately".

242. However, once more there was no mention of the requests for a referral. The focus of the complaint, as it developed by July 2017, now eight months after the surgery, was a failure to hand over the care to "colonoscopy" specialist and to operate immediately. If referral requests had been made, it is unlikely that they would not be mentioned in this very detailed July complaint (following the communications in March and June).

243. All this raises wider questions. The first alleged referral requests were made on 3 and 4 November, while the claimant was still being treated conservatively. There can be little reason why such a request would be refused at this early "conservative" stage. Further, there is little reason, taking 3 November as a starting-point, why the claimant at that point would need or wish to seek a

second opinion, and why Mr Behar would not simply reply that he is a qualified colorectal surgeon.

Conclusion: Behar Issue 1

244. Stepping back, and looking at the evidence as a whole, I find that the claimant has not proved to the civil standard that any of the requests alleged were made. On the balance of the evidence, it is likely that they were not. This is because the evidence is not cogent or credible based on the weaknesses identified in the assessment of their individual credibility and above, and having carefully viewed each witness in the witness box for an extended period of time, taking all the evidence together. Each of the claimant's witnesses and including the claimant herself, and in slightly different ways, provided unconvincing evidence about the alleged requests. I am not persuaded that any of these witnesses are reliable narrators about these requests for the reasons given. Up to 18 July 2017, there were repeated opportunities to complain about Mr Behar's obstructiveness. It defies logic and common sense that no such complaint or criticism was made, especially given the high prominence of this serious criticism in the list of allegations that are now directed at Mr Behar. I am quite satisfied that this series of alleged requests is an afterthought and has become part of the narrative advanced by the claimant and supported by those with close ties of loyalty to her whose evidence has been coloured by powerful biases. I reject the submission that the evidence relied upon by the claimant is "coherent and consistent." On the contrary, it contains clear flaws and there are obvious identified improbabilities. Seeing the witnesses testifying has been of additional, but not decisive, benefit to the court in reaching that conclusion. It is not just a question of demeanour, which is of limited relevance, but the fluency of the evidence, the way in which a witness was prepared to answer the question or was obstructive, unnecessarily argumentative, evasive or uncooperative. There is no credible reason for Mr Behar to have refused any of the referral requests, let alone every one of them, and if the claimant's case were correct, then SpR Walsh again either ignored the request or passed it on without there being any record of it. It is accepted by the claimant's expert Mr Hartley that up until the second CT scan his management of Ms Deakin-Stephenson's case was in accordance with medical practice and was reasonable. I accept Mr Behar's evidence that if a second opinion was requested, he would have facilitated it and prefer Mr Behar's evidence to the claimant and her witnesses on this dispute.

245. Therefore, the claimant has failed to prove to the civil standard that there was any request made to Mr Behar or anyone else from the claimant or any person on her behalf for a referral to a colorectal surgeon, specialist or otherwise. It is unnecessary for the court to rule in the opposite direction, but if that had been necessary, I would have had no hesitation, having reviewed all the evidence and having seen all the witnesses on this issue over a lengthy period, in ruling that the court is satisfied to the civil standard that there was no request for a referral to a colorectal surgeon.

§XII. BEHAR ISSUE 2

(Transfer)

- **Did Mr Behar instigate and induce the claimant's transfer to private care?**

246. The significance of this issue is two-fold. First, it affects the professionalism and credibility of Mr Behar. Second, the claimant relies on the improper way that transfer was instigated and induced by Mr Behar as a foundation for her vicarious liability claim against the second defendant Trust. The argument on both bases is grounded in the agreement by both experts that it is not good medical practice for Mr Behar in his initial role as an NHS consultant to suggest or recommend that Ms Deakin-Stephenson transfer to the private sector, a general principle of professional conduct that Mr Behar does not dispute.

247. The detail of the allegation by the claimant is that shortly after the consultation at 14:45 hours on Thursday 3 November (Day 2), Mr Behar asked her if she had private medical insurance. If it was, as the claimant alleges, Mr Behar who instigated her transfer to the private Chelsea Wing of the Hospital, the Trust remains liable after such transfer for Mr Behar's medical treatment of Ms Deakin-Stephenson. Mr Behar denies that he initiated a discussion about private care in any way. The Trust denies vicarious liability, an issue that will be considered separately in due course. In this section, therefore, the court determines the merits of the factual dispute around the claimant's transfer.

248. The claimant's case on this issue relies on the following elements (as styled by Mr Chawatama):

(1) The claimant's evidence that she was not aware of the Chelsea Wing;
(2) In consequence such knowledge could only have come from a suggestion by Mr Behar;
(3) There is no note by Mr Behar of his further interaction with the claimant after the 14:45 hours consultation;
(4) The fact that such interaction took place is evidenced by the Patient Request for Transfer dated 3 November and timed at 15:30 hours. This handwritten form was not completed by or signed by the claimant. The clinical information in that form can only have been provided by Mr Behar;
(5) The Healthcare invoice dated 3 November 2016 was created by or on behalf of Mr Behar. This is an invoice charging BUPA for an initial / pre-operative consultation. There is no note of such a private consultation on 3 November. In his oral evidence Mr Behar was unable to say when this private consultation took place and the contents of that consultation;
(6) That initial private consultation, if it took place, must have taken place before BUPA authorisation as evidenced by the patient transfer form timed at 15:30 hours. BUPA authorisation for private treatment was given at 16:14 hours.
(7) In his witness statement, Mr Behar omits to make any reference to all this activity on 3 November concerning private treatment or transfer;

(8) In the CW journal, Mr Behar actively advertises the provision of private treatment through a dedicated service for adult emergency general surgery for patients with medical insurance.

249. The claimant's evidence that she was unaware of the Chelsea Wing save for its maternity services must be put into context. Ms Deakin-Stephenson had been what Mr Kennedy called a "preferential user" of private healthcare. As Mr Kennedy submitted in his written submissions, "all of [the claimant's] previous colorectal consultations were on a private basis." One does not need to know about a specific wing or know its name. It is not credible, as submitted on behalf of the claimant, that the "only" source of information about the Hospital's private wing could be Mr Behar. A person with the long history use of private healthcare like Ms Deakin-Stephenson can discover the existence of private care on the Chelsea Wing very simply as it is in the public domain and there is no reason for it not to be. Any member of the claimant's family, including Ms Deakin-Stephenson's sister who was soon to use the internet to find the name of Mr Warren, could have discovered the information equally easily on the internet or by asking members of staff. To this must be added that in the claimant's core medical records, there is a letter from Dr Singh dated July 2015, that is, the year before these events. The letter states that the claimant undertakes to pay the Trust for

> "accommodation and/or services provided as a private patient at the Chelsea and Westminster Hospital"

250. As Mr Kennedy graphically put it, the claimant "had not spent a night" in a hospital under NHS care for years. She has a strong established history of preferring to be a private patient, which is her right, but runs against the suggestion that Mr Behar could be the "only" source of information about the Chelsea Wing.

251. It is true that the Patient Request for Transfer was not written or signed by the claimant. But the clinical information on it does not imply that it was Mr Behar who initiated the discussion of private healthcare. Mr Behar stated in cross-examination that he did not write the patient transfer form. The handwriting, he stated, was that of the administrator in the private wing. This was not disputed by the claimant when she testified, and the court can accept Mr Behar's evidence on this point in the absence of challenge. Mr Behar continued that the details on the form did not have to come from him, but could come from "the trainee, the nurses or the patient". However, he qualified that answer by fairly recognising that since the medical trainees do not work on the private wing, it is unlikely that any of them would have provided the information. Nevertheless, it simply cannot be the case that the only source of the information on the form was Mr Behar.

252. The fact that there is no note made by Mr Behar of the private consultation is undoubtedly an error by him and a further example of poor recording. However, this does very little to support the disputed proposition that Mr Behar suggested the transfer. The timings around the private consultation and the patient transfer form do not assist the claimant as BUPA is unlikely to accept a charge for a private consultation before authorisation.

253. As to the invoice, Mr Behar stated the document was created on his behalf. He would have raised it with the accounts team that he had seen a patient privately. He stated that the date of the invoice is "wrong" as the patient was transferred later – on Friday 4 November in the afternoon, not Thursday 3 November. One weakness in Mr Behar's evidence is that he cannot recollect independently when the private consultation did take place. He certainly arranged for the administration to invoice for the private meeting he had had with Ms Deakin-Stephenson. Further, he erred in not making a note of what was discussed and what advice he gave. That said, he stated that the substance of his meeting "would not be different from what I discussed before". On this, I do not understand the claimant's evidence to be that Mr Behar's advice was any different. No such suggestion was put to him.

254. I find little significance in the fact that in his statement Mr Behar does not refer to private healthcare transfer. First, the relevant material was only provided after he had signed his statement. Second, his case is that he did not instigate any discussions about such a move. It is notable that in a similar way to the referral request issue, in all the contemporaneous documentation and the post-discharge correspondence and exchanges up to the further complaint on 18 July 2017, there is no suggestion that it was Mr Behar who first asked whether the claimant had private health insurance and thus should consider a private transfer. If this allegation were soundly based, it is unlikely that there would be no mention of it during the several key opportunities from early 2017 until the July 2017 complaint. Mr Kennedy's careful closing submission is correct that at most the relevant passage in the 26 April 2017 meeting is "neutral" on this point. It is in fact Mrs Ingledow who mentions the transfer and in terms that are significant:

> "181. Joanna: Yeah, on Thursday. She was put on nil by mouth, and she was told that she'd almost certainly be having open surgery. I was very shocked because I knew exactly what that meant, having had issues myself. Trying to reassure her, of course she remembers nothing of this. So, she then went from acute assessment ward on the Friday, into the Chelsea wing, because it was thought that she'd be more comfortable there, sort of thing.
>
> 182. [Over speaking]
>
> 183. Joanna: Yeah, because you were covered by BUPA"

255. Here was a perfect opportunity for Mrs Ingledow to state what she would later assert in witness statement and trial evidence that it was Mr Behar who initiated discussion about the transfer to private care. She does not. The silence on the topic over an extended period when Ms Deakin-Stephenson, no doubt assisted by her sister, had numerous opportunities to raise this criticism explicitly, and in light of the fact that she raised other criticisms (such as why there was no immediate operation) powerfully undermines the cogency of her complaint about transfer.

256. The credibility of the allegation against Mr Behar is further undermined by the suggestion, maintained until trial, that BUPA was only paying for the accommodation in the private wing ("hotel fees"). This claim is not consistent with the contemporaneous invoicing. It plainly was not the case. Ms Deakin-Stephenson's persistence in adhering to that claim in the face of the clear contemporaneous invoicing evidence further undermines her credibility. She must have known very well from her previous colorectal consultations which were all within private healthcare and her history of healthcare more generally that BUPA paid more than simply bed-and-breakfast fees on a private wing.

257. The arguments detailed in the claimant's closing written submissions about the second defendant "directly benefit[ting]" from the transfer by "wrongly charging the claimant for treatment" do nothing to settle the issue about whether Mr Behar instigated Ms Deakin-Stephenson's transfer. Indeed, in her 13 March 2017 email, the claimant stated that after (her sister's) activation of the claimant's private healthcare insurance, "all treatment thereafter was covered by BUPA" – plainly, "treatment" extends beyond "hotel fees".

258. The court cannot accept the claimant's explanation in cross-examination that her letter of complaint was not designed to detail her complaints. I found it an unconvincing attempt to deal with obvious weaknesses in her case on this question. It makes little sense that two of the chief and central allegations against Mr Behar - the refusal to make a colorectal surgeon referral and his initiation of her transfer to private healthcare - were not mentioned during the written and verbal opportunities she had to raise them in terms in 2017. She did not. These omissions make it more unlikely that these complaints are well-founded and true.

259. As to the claimant's reliance on Mr Behar's advertising of his private treatment services, there is nothing unlawful or improper in this. Should the suggestion be that Mr Behar was prepared to depart from good medical practice for his own enrichment, this is a very serious allegation that the court has already considered in the assessment of witnesses. What further undermines the credibility of the suggestion in terms of private transfer is that Mr Behar gave evidence that he was so concerned about the treatment that patients received under the NHS that he altered the profile of his professional work:

> "I believe I was the first full-time emergency surgeon in the UK. The post was set up because we were doing very badly. Chelsea had the foresight that emergency [surgery] should have more dedicated care without the distraction of elective. I thought emergency patients were getting a rough deal. I gave up elective work and dedicated my care to emergency."

260. As he stated in his statement at para 2, his emergency work amounted to approximately 80 per cent of his professional activity. On oath, Mr Behar told the court:

> "I never try to persuade patients to move to private. It's unethical because the patient is entitled to free NHS care. And to remove the patient from that environment is completely unethical."

261. The court accepts his evidence as truthful. Mr Behar has shown through the shaping of his career priorities evidence of a clear commitment to achieving the best outcomes for patients. The central allegation was put very fairly by Mr Chawatama, that Mr Behar had "led the claimant and her sister to move to the private wing". He answered:

> "The patient asked me what the difference with private was. I said they are more likely to be private room. The care would be the same and they would get my services out of NHS hours, so I would keep [her case] after 5pm and not the on-call consultant. The nurses could call me at all hours from the private wing and the same consultant would continue to care."

262. In other words, he explained that once she had asked him about the difference in nature of care between the sectors, that there would be a continuity of care. This account by Mr Behar was provided fluently and without hesitation and had, to my mind, the ring of truth. I accept it as being likely to be true. I prefer Mr Behar's evidence on this issue to the claimant's. I found him to be an honest and sincere witness, deeply concerned about the needs of patients. Not only has he been integral to providing better care at Chelsea for emergency patients, but he demonstrated his commitment to the claimant by spending a very significant amount of time with her on Sunday 6 November to explain the medical options to her. None of this is consistent with the allegation of self-centred enrichment by her improper transfer to private care. I find it unlikely to be true.

263. I find that here, as in other respects, the supporting evidence from Mrs Ingledow is animated through ties of loyalty to her sister and little weight can be placed on it. Mrs Ingledow's evidence on other topics (see specific assessment of her evidence) has been shown to be unreliable and skewed in favour of her sister. One must look at the credibility of witnesses in the round (*Arkhangelsky* principle), although I emphasise Charles J's Fact A/Fact B principle of one credibility failing not being determinative of another.

Conclusion: Behar Issue 2

264. The claimant has not proved to the requisite civil standard that Mr Behar instigated or induced Ms Deakin-Stephenson's transfer to private care.

§XIII. BEHAR ISSUE 3

(Hartmann's procedure)

- **Did Mr Behar inform the claimant on 6 November 2016 that a Hartmann's procedure was a surgical option?**

265. The claimant's core case on this issue, as detailed in Mr Chawatama's written closing submissions, is that the "consent process was flawed": she was not offered the option of "lavage or a Hartmann's, as she should have been"; the risks and benefits of the procedures were not explained; and the consent form was largely pre-filled and defective. In this section, the court examines the

dispute between the parties about whether a Hartmann's procedure was offered and, if so, in what way. The question of risk is addressed in the next section (Behar Issue 4).

266. The claimant submits that the mere presence of the word "stoma" on the consent form does not amount to an offer of a Hartmann's procedure, and that must be correct as a stoma is not synonymous with a Hartmann's procedure. The claimant submits she should have been offered a "straight", Hartmann's procedure, without a lavage as a precursor with the Hartmann's being a fall-back position if medically indicated intra-operatively. In other words, a Hartmann's procedure should have been offered to Ms Deakin-Stephenson as a "stand-alone" option.

267. Although the matter was put in various ways in opening, in cross-examination, in written and then oral closing submissions, the claimant's case on this issue can be summarised as being (1) a Hartmann's procedure was never offered at all; (2) even, contrary to (1) it was offered, it was not offered on a "stand-alone" basis; (3) laparoscopic lavage was offered in a privileged and surgically "biased" way.

Sub-issue (1)

268. The first sub-issue can be resolved quickly. On the consent form, Mr Behar has written "sigmoid colectomy + stoma". The claimant's expert Mr Hartley accepts that this amounts to a Hartmann's procedure as these are the two surgical elements of a Hartmann's. The court does not accept the claimant's evidence that this was not presented to her. Indeed, the reason for the delay in completing the consenting process until Monday morning, as previously found by the court, was because of the claimant's strong aversion to ending up with a stoma. One must examine the possible outcomes for the claimant as at Sunday night. Surgery was inevitable following the second CT scan. Indeed, her sister's text message to their parents on 6 November at 17:42 hours told them:

> "pips got to have an operation you need to go back to london [crying emoji]"

269. If Ms Deakin-Stephenson had a "straight" Hartmann's, as her counsel termed it, it would be a certainty that she would have a stoma. The only way to avoid a stoma was a successful laparoscopic lavage. However, even then, as the consent form makes plain, a stoma by way of a Hartmann's procedure may still result but "only if absolutely needed". It is clear on the expert evidence and the evidence of Mr Behar that a Hartmann's procedure was offered to the claimant. Implicit in Ms Deakin-Stephenson's wish to avoid a stoma is that the claimant knew what a stoma was. The court rejects her evidence to the contrary. It is difficult to understand how someone could be averse to something one did not know existed. It is implausible that Ms Deakin-Stephenson did not know that she may end up with a hole in her abdomen. Indeed, that is what she wished to avoid.

270. Great emphasis has been placed on Mr Behar's alleged failure to see Ms Deakin-Stephenson on Monday morning before the surgery. I have dealt with this in the

witness assessment section. However, it is of such importance that it bears restating here. This is because central to the impugning of Mr Behar around consenting is his failure to visit the claimant pre-operatively. It is put in this way on behalf of the claimant:

> "If the court accepts the evidence of the Claimant and her mother that she was not seen by Mr Behar on the morning of 7 November before her surgery, then by his own account he did not complete the consenting process."

271. This was how the trial was conducted until Mr Behar pointed out very late in the trial that in fact the contemporaneous medical records documented that he reviewed Ms Deakin-Stephenson on a pre-operative ward round. As indicated previously, this adversely impacts the credibility of Ms Deakin-Stephenson's serious criticisms around the consenting process and supports Mr Behar's credibility.

Sub-issue (2)

272. As to the question of whether a Hartmann's procedure was offered as a stand-alone option, there is evidence contrary to the claimant's case from several sources.

273. First, the 26 April 2017 meeting between the claimant and Mr Behar addressed the question of options. It is highly revealing that Mr Behar expressed during the meeting that his preferred option was a Hartmann's procedure. The transcript records his comment as follows:

> "233. Nebil Behar: Sunday night, that's right, the Sunday. We had a chat about the options at that point. We said, it's probably not a good idea to keep insisting on antibiotics, even though you were only slightly worse, you're not generalised peritonitis, or septic shock or anything like that. You had some pain and we said, we'd better do something now. We discussed two options at that point. We said, either we can do a laparoscopy keyhole, wash off the area and we'll only find out if that's possible at the time of surgery, or we remove the bowel and give you a stoma. I said, perhaps on this occasion, we should even remove the bowel straight out and not worry about the wash, but wash is something I'm happy to do, because that's what I do, and I see it work a lot."

274. Therefore, Mr Behar told Ms Deakin-Stephenson that he had been suggesting to her that "perhaps" they should "remove the bowel" – a sigmoid colectomy, one constituent element of a Hartmann's procedure and "give you a stoma", the second of the constituent elements. This was not disputed or queried in any way by either the claimant or her sister in the April meeting, where even on her case, she wanted clarification of what had happened.

275. Second, Mr Behar stated in evidence that the medical situation as at Sunday night was "50-50" and "a Hartmann's would have been as good as a washout". But "one is always guided by the patients a bit."

276. Third, in his email to the claimant on 18 June 2017, and thus some weeks after the April meeting, Mr Behar again states that two options were presented to the claimant. This supports his trial evidence, being comparatively, but not perfectly, contemporaneous. The concerns raised by the claimant in the contemporaneous documentation relate not to the choices she was presented with during the consenting process but with a complaint that she was not operated on immediately, that is, in the first days of her hospital admission. In her email of 13 March 2017, Ms Deakin-Stephenson accepts in terms on two occasions that she consented by signing the consent form to two types of surgical intervention. This is a five-page document written by Ms Deakin-Stephenson (B770-74). She states through bracketed comments pasted into Mr Tekkis's Discharge Summary Report:

> "(My sister confirms that I signed for both types of operation)"

277. And then:

> "(note please: I have no memory of any of this)"

278. And:

> "(My sister confirms that I signed consent for emergency surgery for both types of operations on 6th November 2016 when apparently my parents were visiting me, following a 2nd CT scan earlier in the day: I apparently consented to both types of operation – again I have no memory of this.)"

279. Fourth, Mr Behar's original filed witness statement explains the following:

> "The scan showed a progression of disease with free air in the peritoneum. I explained to the Claimant that that same day, who was still reasonably well with a soft abdomen at this stage, that an operation would now be needed to treat the infection. I gave her the two options of a laparoscopic approach, which could end with a simple wash and drain, giving her a lower risk of mortality and morbidity and no stoma, or straight to laparotomy and Hartman's Procedure which would entail removing the diseased sigmoid colon and forming and end colostomy if frank perforation was to be encountered. I recall the Claimant being very distressed at the idea of surgery, and especially the stoma. We involved her family in the discussions; however, the Claimant still struggled to come to a decision as to what surgery route to go down. As she was relatively well, I did not want to rush her into a decision she would not be content with and I gave her time to think overnight. I did not feel it was necessary to take her to theatre that same night. The consent process began at this time"

280. Mr Behar's statement notes that when he reviewed the claimant on the day after the laparoscopic lavage, on Tuesday 8 November, she was "grateful for having avoided a stoma". This body of evidence cumulatively provides significant material support for the proposition that a "stand-alone" Hartmann's procedure was offered to Ms Deakin-Stephenson and that Mr Behar's preference was for

a Hartmann's, but he was respectful and cognisant of Ms Deakin-Stephenson's wish to avoid a stoma if at all possible.

281. It should be emphasised that the fact that the consent form does not appear to document the offer of a Hartmann's procedure as stand-alone surgery should not be confused with the fact that it was offered by Mr Behar as he said in the April meeting and his June 2017 email to Ms Deakin-Stephenson. The claimant wished to avoid a stoma. She consented to a laparoscopic lavage which would only be converted to a Hartmann's if absolutely needed clinically.

Sub-issue (3)

282. This leads to the third sub-issue, that of surgical bias. On this, there is some evidence from Professor Winslet. It is fairly and reasonably accepted by Mr Kennedy on behalf of the first defendant that the Professor's evidence has not been tested in cross-examination because of his passing. Thus, it carries less weight and a conclusion should not be based on it exclusively, especially if there is evidence pointing in the opposite direction. It is with that caveat that Professor Winslet's evidence at para 8.18 of his report should be viewed:

> "It would be for a Court to decide why the addendum of 'only if absolutely needed' was added to the Hartmann's procedure as this is not standard surgical practice. It would be for a Court to decide whether this was surgical bias, or the patients request."

283. Professor Winslet's evidence is supported by the evidence of Mr Hartley to this extent: he had never seen the "absolutely needed" words on a consent form before. The unusual nature of these words written by Mr Behar supports his evidence that they were written in response to Ms Deakin-Stephenson's wishes. They are not consistent with a surgeon exhibiting surgical bias and dictating the course of surgical procedures to a patient. A further criticism of Mr Behar on this theme is that he had "pre-filled" the consent form, thereby evidencing his closed mind and surgical bias. Mr Chawatama submits that this was "an astonishing admission". It is important to be clear what the evidence from Mr Behar on oath actually was. He testified:

> "I do not remember when I started filling the form. Sometimes for expediency you start writing. It is not unusual for doctors to write things in advance so you can have a free discussion with the patient. It's possible that I wrote the form in advance at the nurses station. [That is] I would have written the first 1.5 lines, but I think the '+ stoma only if absolutely needed' is likely from her wishes because she was averse to the stoma. It might have been "+ stoma" [already written] and all I needed to add was 'if absolutely needed' was added because of her wishes."

284. Mr Hartley gave evidence that he never fills in a consent form in advance and it "implies you are not approaching a patient with an open mind". However, I do not understand his evidence to say that it is improper to begin filling the form in advance in all circumstances. The court has accepted Mr Behar's evidence that his preference was for a Hartmann's procedure, as he indicated to the claimant and her sister at the April 2017 meeting. Mr Behar did not say on oath

that he did in fact fill out the consent form in advance. His evidence is that it is possible. Therefore, it remains a possibility that the consent form was not filled in before Mr Behar met with the claimant and the evidence remains unclear. What is significant, as indicated, is the addition of the words "only if absolutely needed". This non-standard phrase was, the court accepts, added to reflect the strength of Ms Deakin-Stephenson's aversion to a stoma. If, which is not clear, part of the consent form was filled in before the Sunday meeting with Ms Deakin-Stephenson, that does not mean that Mr Behar was tone deaf to the claimant's wishes. Plainly he was not, and he added medically unusual words to the form to reflect them.

285. I have considered all the evidence, including the fact that there was a delay in completing the consenting until the visit by Mr Behar on Monday morning as he has said in written and oral evidence. His suggestion is supported by the contemporaneous record that he in fact conducted a ward round that morning and reviewed Ms Deakin-Stephenson before the operation. The ward round note does not provide explicit support that the consenting process was completed on the Monday morning. However, it does confirm Mr Behar's evidence that there was such a review. It thus documents the opportunity for the second part of the consenting process to occur without explicitly documenting it. That Mr Behar's review was before the operation can be in little doubt since it says "for wash" – thus it anticipates the laparoscopic lavage yet to happen.

286. The fact that Mr Behar contemporaneously recounted in the meeting in April 2017 his preference for a Hartmann's procedure is consistent with his approach not being one of surgical bias, but a sympathetic and responsible reflection of his patient's abiding and profound anxieties about ending up with a stoma. It is regrettable that Mr Behar's sensitivity to the claimant's wishes has been seized upon and used to criticise him. This criticism is without merit or substance. The words were written by Mr Behar, the court is satisfied, to reflect Ms Deakin-Stephenson's true wishes and after the protracted discussions that took place on Sunday 6 November between Mr Behar and the claimant. When Ms Deakin-Stephenson emailed Mr Behar in March 2017, she was could have detailed any relevant criticisms of him about the consenting process. Instead, she accepted that she consented to two surgical interventions, as Mr Behar has said. It was Mr Meleagros's opinion at para 48 of his report that:

> "the Claimant was appropriately consented with respect to the surgical options listed as the proposed procedure, in the consent form. She was not fully consented with regards to the risks and complications of laparoscopic lavage, namely failure to control sepsis and need for a secondary procedure in the form of Hartmann's resection."

287. Naturally, the ultimate decision on the appropriateness of the consenting process is a matter for the court. This is not trial by experts. It is for the court to decide whether Mr Behar in fact offered the claimant the option of a Hartmann's procedure and the risk of a Hartmann's procedure in any event if a laparoscopic lavage did not work or Hartmann's was indicated intra-operatively. Based on all the evidence, the court finds that both these things happened. However, the court concurs with Mr Meleagros that there was a recording failure on the

consent form about the failure to detail the risk of sepsis and the need for a Hartmann's procedure as a "secondary procedure" in that event. A Hartmann's procedure was listed (in its constituent elements) in the "proposed procedure" part of the form, but not in the risk section below. That was a recording failure. I can accept the claimant's submission that the accounts that Mr Behar gave of the consenting process at the April 2017 meeting and in his June 2017 email "do not exculpate" him from his admitted "serious failure" to make contemporaneous notes of the consenting process. However, there is the consent form that he filled in. His account of a pre-operative Monday visit to Ms Deakin-Stephenson, advanced in pleadings and his statement, was made in the absence of knowing about the contemporaneous record which has subsequently proved his account to be true. While the April and June 2017 accounts from Mr Behar do not refer to a two-stage consenting process, there is an account of the discussions with Ms Deakin-Stephenson that has proved reliable. Further, it should not be forgotten that Mr Behar made a retrospective note of the consenting process at 11:30 hours on 7 November 2016 in which he documents that Ms Deakin-Stephenson was consented for a laparoscopic lavage ("washout") with a "Hartman's if needed". That is consistent with the consent form and Mr Behar's statement and trial evidence.

288. However, I am satisfied that the evidence shows that Mr Behar carefully explained to Ms Deakin-Stephenson the reasonable alternative or variant treatments of a stand-alone Hartmann's procedure (his preference) and laparoscopic lavage with the possibility of a Hartmann's procedure if medically indicated intra-operatively. The fact that Ms Deakin-Stephenson had these options presented to her on 6 November 2016 is supported by the lack of complaint about the failure to offer them during the April 2017 meeting and in correspondence and complaints up to July 2017.

Conclusion: Behar Issue 3

289. The claimant has not proved to the requisite civil standard that (1) the claimant failed to offer a Hartmann's procedure; (2) failed to offer a Hartmann's procedure as a stand-alone surgical alternative; (3) laparoscopic lavage was offered in a surgically biased or privileged way.

290. Put alternatively, and on the totality of evidence, the court finds that (1) the claimant was offered a Hartmann's procedure; (2) a Hartmann's procedure was offered as a stand-alone surgical intervention; (3) Mr Behar did not present the options in a way that exhibited a surgical or other bias towards laparoscopic lavage – indeed, his preference was for a Hartmann's procedure, but Ms Deakin-Stephenson was strongly averse to a stoma and so the reasonable alternative or variant treatment of laparoscopic lavage was consented to in the hope that a stoma could be avoided unless "absolutely needed". The surgery that Mr Behar performed on Monday morning was consistent with this plan, consented to by the claimant. This is also captured in the email that Mr Behar wrote to the claimant on 19 June 2017:

> "Subsequently your attack of diverticulitis failed to settle as evidenced by increased pain and rise in inflammatory markers. This is uncommon and unfortunate but was picked up without significant deterioration in your

> health, early. At that point I reviewed you and discussed surgery. I explained to you that there were 2 options to proceed with; both surgical. One was washing out the infection laparoscopically to allow infection to settle without removing the colon and sparing you a colostomy (I have warned you that this procedure may, during surgery or afterwards, necessitate colectomy nevertheless if the contamination was extensive). The other was an outright removal of colon with Hartmans Procedure and colostomy. You have opted for the laparoscopic washout of the infection wanting to avoid a stoma. At the time of laparoscopy the contamination proved to be minimal and the washout was sufficient without proceeding to Hartmans Procedure."

291. Mr Behar's trial evidence is that "this is my recollection of what I remember [happened]". The court accepts this evidence. The court finds him an honest witness and can rely on his testimony on this topic. The court finds that this relatively contemporaneous account from June 2017 accords closely with what in fact happened in November 2016. The court finds that the claimant consented in accordance with the consent form. This was ultimately a two-part process beginning Sunday night and being completed on Monday morning at Mr Behar's pre-operative ward round visit was that Ms Deakin-Stephenson, having thought things through.

§XIV. BEHAR ISSUE 4

(Risk)

- **Did Mr Behar warn the claimant of the risks and benefits of a laparoscopic lavage and a Hartmann's procedure?**

292. The claimant's allegation is that Mr Behar did not explain the risks and benefits either of a laparoscopic lavage or a Hartmann's procedure. Mr Chawatama began his closing submissions to the court by emphasising that this case "is about risk and benefits" and the risks had not been adequately explained to Ms Deakin-Stephenson. The discussion of the risks "should be reflected in the consent form", but the form is "defective" as the risks recorded are only those of general surgery. However, there are specific risks "peculiar" to the surgical interventions in this case and these are not recorded on the consent form. The essence of the allegation comes in the next submission which is that had Mr Behar warned the claimant about these risks, he would have recorded them on the form and the inference from the lack of recording is that the risks were not discussed and therefore Ms Deakin-Stephenson was not properly consented.

Discussion

293. Mr Chawatama is correct that in terms of risk, the consent form provides "nothing to help the court". I have no hesitation in concluding that the recording of risk on the consent form was inadequate, as the experts agree. The question is whether the court can infer from that failure that Mr Behar did not warn Ms Deakin-Stephenson about the material risks.

294. In my judgment, that is a step too far. What is clear is that Mr Behar's recording in matters beyond the question of risk has been poor. Mr Behar himself accepts that. But as has been seen elsewhere, for example with the failure by Mr Behar to record himself that he visited the claimant on Monday morning prior to the operation. Therefore, documenting failure does not necessarily map across to a failure of care or treatment. The starting-point must be that there were lengthy discussions between Mr Behar and the claimant on Sunday after the CT scan results. No one now disputes this. It will be noted that in her email (letter) to the complaints team, the claimant states that she has no memory herself of her stay in the Hospital and so her memory has been reconstructed or recovered following more or less complete loss about the relevant times.

295. Mr Meleagros put it this way in the joint report:

> "LM She was not fully consented with regards to the risks and complications of laparoscopic lavage, namely failure to control sepsis and need for a secondary procedure in the form of Hartmann's resection. She was not fully consented with regards to the risks and complications of Hartmann's procedure. If the Court accepts that the Claimant was anxious regarding the surgery (see nursing entry 07/11/2016 at 03:41 hours), the 1st Defendant was acting according to the so-called therapeutic exemption in Montgomery by not disclosing information that would be detrimental to the Claimant's health, in this case her mental health."

296. Once more, it is for the court and not the expert to make determinations about factual events that are disputed and to reach consequent conclusions. This approach was properly recognised by Mr Hartley, when asked in the joint report whether the claimant was appropriately consented:

> "JH will defer to the Court for a finding of fact. If the Claimant was simply consented for a lavage with a plan to proceed to a Hartmann's only if faeces were found then his opinion would be that the consent process was not appropriate."

297. The key word is "if". It is for the court to determine what happened, not the experts. In a similar way, when answering about counselling in relation to a possible stoma, the experts stated:

> "JH will say that he cannot answer this question from the records. He will defer to the Court for a finding of fact.
>
> LM will say that there are no details in the record regarding how the 1st Defendant counselled the Claimant, other than the mention of a stoma in the consent form."

298. Therefore, to assess whether the claimant was informed about the risks advised upon, the court must examine all the evidence put before it. Mr Behar stated on oath:

> "I haven't recorded further surgery as a further risk on the consent form, but we discussed it."

299. I have no doubt that Mr Behar is correct and the possibility of further surgery by way of a Hartmann's procedure if indicated during the laparoscopic lavage was discussed with Ms Deakin-Stephenson. Naturally, if Ms Deakin-Stephenson would have consented to a stand-alone Hartmann's procedure (her case), she would have logically consented to the further surgery necessary for its reversal when medically appropriate. Her case is that she would have consented to a Hartmann's procedure despite its risks. Mr Behar agreed in evidence that the consent form "should have been more detailed". I find that the documentation of risks on the consent form was not sufficiently detailed, but that this was a recording failure by Mr Behar. It would have undoubtedly been in accordance with professional practice for him to have recorded this possibility of further surgery as a risk. But I am completely satisfied that in the very lengthy discussions that Mr Behar had with Ms Deakin-Stephenson, he informed her of the risk that the laparoscopic lavage may not be successful and the risk of advancing sepsis may necessitate a Hartmann's procedure nevertheless, ultimately resulting in her having a stoma, which in due course would fall to be reversed if appropriate. At that point, the only way to avoid a stoma was to attempt a laparoscopic lavage first and examine the situation intra-operatively. That is what Mr Behar did. During the lavage, the Hartmann's procedure was not indicated medically at that point. It would later become necessary. However, he performed the laparoscopic lavage and, as Mr Tekkis put it, "the area of perforation was patched with omentum and sutured." (It is recorded in the operation records as "Omental transposition", but it is the same thing, a transferring "of a piece of fat", as Mr Behar put it, over the perforation.) There was no clear hole or faeces, which precipitated conversion to laparotomy and Hartman's procedure apparent during surgery on Monday morning. It was 36 hours later that Ms Deakin-Stephenson suddenly became very ill just before midnight on 8 November (Day 7) and emergency life-saving surgery was necessitated early on 9 November, when a Hartmann's procedure was performed by Mr Behar.

300. In these circumstances, I accept Mr Kennedy's submission that the failure by Mr Behar in terms of risk was one of recording and not of substance. I accept Mr Behar's evidence that "I have spent way more time with the patient than I have written, but I could not have done more in terms of caring." The recording on the consent form was inadequate. But the claimant has not proved to the civil standard that Mr Behar's failed to advise her about the material risks of the two surgical interventions listed as "proposed procedures" on the consent form. As Mr Kennedy submitted in closing, there was no complaint about consenting in the 26 April 2017 meeting, nor in the email to the complaints team.

301. Significantly, Mr Behar's account at the April meeting was not contradicted in any respect by either the claimant or her sister. Both of them are temperamentally well able to contest something they disagree with and provided many examples of that ability during trial testimony. Further, the nursing notes show how Ms Deakin-Stephenson is able to contest and challenge medical staff. It is correct, as Mr Chawatama submits, that Mr Behar's April account does not mention the completion of the consenting process on Monday 7 November. However, the trainee's contemporaneous note made on Monday morning supports that there was a review prior to the operation. Further, it is significant

regarding the delay in the consenting process from 6 November that two days earlier, Ms Deakin-Stephenson had declined to accept medical advice for a catheter and wanted to think about it. It is very similar to what happened on the Sunday night when the claimant wished to think about the advice that Mr Behar had given her. Therefore, the contemporaneous recording of Ms Deakin-Stephenson's ability to assert herself and have time to think before accepting a medical recommendation on 4 November provides support for her wish to think things over on the evening of 6 November. Ms Deakin-Stephenson's faith in Mr Behar's judgement and advice continued after her discharge from hospital, when in January 2017 she emailed him in these terms:

> "I will be guided by your judgment if you believe and think he [another surgeon] is the best for me, then I will be guided by you."

Conclusion: Behar Issue 4

302. The claimant has failed to prove to the requisite civil standard that she was not advised about the material risks attending the surgical procedures listed on the consent form.

Conclusion on consent overall

303. Putting issues 3 and 4 together, the court is satisfied that Ms Deakin-Stephenson provided her informed consent for the surgery performed on 7 November 2016, having wanted to think over Mr Behar's advice on the Sunday night. She consented to laparoscopic lavage with further consent for a Hartmann's procedure that if clinically indicated intra-operatively, but only if absolutely needed. Ms Deakin-Stephenson was resolute in her wish to avoid a stoma if at all possible.

§XV. BEHAR ISSUE 5

(Delay)

- **Did Mr Behar negligently delay surgery from the evening of Sunday 6 November to the morning of Monday 7 November 2016?**

304. The court has dealt with the issue of surgery delay from Sunday night to Monday morning in the section on the expert evidence. The analysis needs no repetition.

Conclusion: Behar Issue 5

305. The claimant has not proved that the delay in surgery from Sunday 6 November to Monday 7 November 2016 was unreasonable.

§XVI. BEHAR ISSUE 6

(Causation)

- **Did any breach of duty by Mr Behar cause injury to the claimant?**

306. The court has found that the claimant has not proved to requisite civil standard that Mr Behar was requested, either by Ms Deakin-Stephenson or anyone associated with her, to make a referral to a specialist colorectal surgeon.

307. In any event, even if the court had ruled in the claimant's favour on this issue, it would not have assisted her because Mr Hartley accepted two matters of causative significance. First, that from her admission up until the CT scan results on Sunday 6 November, Mr Behar's medical management of the claimant's case is identical to that of a colorectal surgical "specialist". It was reasonable for Mr Behar to have tried to treat the diverticulitis conservatively from admission until the Sunday CT scan. At that point, it became clear that surgery was needed. The question is what surgical procedures were reasonable alternative or variant treatments at that point. Mr Hartley stated that "the majority" of specialists would have recommended a Hartmann's procedure on Sunday night. Mr Meleagros agreed. In his closing submissions, Mr Chawatama adopted this evidence to support his submission that factual causation has been proved. He fleshed out his submission by stating that such an approach is in accordance with the national NICE guidelines and those of the American Institute. He asked rhetorically, why would you not follow their guidance?

308. This leads to the second significant matter. The difficulty for the claimant is that there is no convincing evidence that Mr Behar was not competent to conduct either the laparoscopic lavage or a Hartmann's procedure. There is no credible or convincing evidence to prove that he should have passed on Ms Deakin-Stephenson's care to a "specialist" colorectal surgeon for lack of skills or medical competence reasons. The court has rejected her claim that Mr Behar ever asked to make such a referral. Therefore, the basis for making the causative argument that the claimant seeks to advance does not evidentially or factually exist. Mr Hartley agreed that a laparoscopic lavage with the possibility of converting it to a Hartmann's procedure if intraoperatively indicated was a reasonable alternative or variant treatment approach. The expert evidence is that the course taken by Mr Behar when he finally performed the surgery on Monday 7 November 2016 was a reasonable alternative, even if Mr Hartley himself would have performed a Hartmann's. Indeed, even though in Mr Hartley's opinion a "majority" of colorectal surgeons would have recommended and performed a Hartmann's procedure following the Sunday CT scan, there remained a responsible and respectable body of skilled surgeons who would taken the course that Mr Behar did. Mr Meleagros confirmed this.

309. While Mr Hartley stated that he personally would have not offered laparoscopic lavage, he accepted that his personal stance not in accordance with what should have been offered, as laparoscopic lavage was a reasonable alternative or variant treatment. I judge that responsible surgeons are likely to have offered Ms Deakin-Stephenson the reasonable alternative or variant treatments. That would have included laparoscopic lavage. I do not understand Mr Hartley's evidence to say that the majority of competent and skilled surgeons on the evening of Sunday 6 November would not have informed Ms Deakin-Stephenson that laparoscopic lavage was a reasonable alternative or variant treatment. It was.

310. There was no need to refer Ms Deakin-Stephenson to a specialist colorectal surgeon given Mr Behar's proficiency, competence and experience. Both experts agree that Mr Behar was competent to perform a Hartmann's procedure. Indeed, Mr Behar had performed the vast preponderance of Hartmann's procedures at the Trust hospital over the immediately preceding years. No one has suggested that this was something he was not competent to do. The true significance of Mr Hartley's evidence about what a majority of specialist colorectal surgeons would have recommended lies in the question of whether there should have been a referral to such a surgeon. The court has rejected Ms Deakin-Stephenson's claim that such requests were made.

311. Therefore, in accordance with NICE guidelines, it is likely that responsible and competent surgeons would have advised Ms Deakin-Stephenson of the reasonable alternative or variant treatments. She likely would have been advised of the possibility of laparoscopic lavage along with a Hartmann's procedure, just as Mr Behar did. I prefer the evidence of Mr Meleagros to that of Mr Hartley on this. Further, and crucially, the court is satisfied that if Ms Deakin-Stephenson had been advised of a laparoscopic lavage as an alternative surgical option, she is likely to have consented to a lavage in the hope of avoiding a stoma if at all possible, along with avoiding the need for further surgery for reversal of the stoma.

312. I find that the concerns that the claimant has emphasised about septic shock and that "sepsis can kill you", are more likely to be the product of a retrospective attempt to claim she would have opted for a Hartmann's procedure if offered. The fact is that the evidence clearly shows she was offered a Hartmann's, which in fact on balance was Mr Behar's preferred alternative, but she wished to try laparoscopic lavage first to avoid a stoma. Seeing whether the laparoscopic lavage would remedy the medical situation post-scan was the only chance she would have had to avoid a stoma. I am perfectly satisfied that Ms Deakin-Stephenson would have opted for that choice. This is supported by the evidence from the framing of the consent form by Mr Behar and his adding of the words "only if absolutely needed".

313. The claimant submits that the GMC guidance is that medical records should be clear, but nothing could be "more unclear and muddy" than the words "absolutely necessary". I reject the submission. The step taken by Mr Behar to include these words reflected the depth of Ms Deakin-Stephenson's aversion to a stoma and accurately reflected her wishes. There is nothing "muddy" about them. With clarity they convey Ms Deakin-Stephenson's position. The words "only" and "absolutely" indicate that Ms Deakin-Stephenson did not simply have a mild preference or that it was a marginal thing. She was very firmly against having a stoma. This is also supported by her vivid descriptions of what she perceived a stoma to be, one of her "living organs outside her body". I cannot accept Mr Chawatama's submission that "there is no evidence that the claimant was stoma-averse". There is no rational or logic explanation for the entry on the consent form and its distinctive framing and I strongly prefer Mr Behar's evidence about this rather than the claimant's. Thus, on causation, I am satisfied that should a competent and skilled colorectal surgeon have offered

both a Hartmann's procedure and a laparoscopic lavage, that the claimant would have tried to avoid the certainly of a stoma through a laparoscopic lavage.

314. I note that there is a degree of artificiality in this analysis since the court has not found proved that Ms Deakin-Stephenson or anyone else on her behalf requested a referral to a colorectal surgeon from Mr Behar. Therefore, I cannot accept Mr Chawatama's submission (closing skeleton, para 54) that one of the factors supporting factual causation being proved is that the claimant and her family members had repeatedly "actively and repeatedly asking for a referral". The court has ruled against the claimant on that issue. Nevertheless, to continue the analysis, Mr Kennedy is correct in his submission that the proper approach is to return to the position the claimant was in on 6 November 2016. Her choices and preferences cannot be altered or skewed by knowledge of the subsequent and unforeseeable disastrous deterioration she was to experience 36 hours later, which was not reasonably predictable. Mr Chawatama is at risk of being prey to this fallacy when he submits that by choosing a Hartmann's procedure over a laparoscopic lavage:

> "She would have avoided the catastrophic events that befell her on the night of 08.11.16, admission to ICU, multiple organ failure, near-death and discharge with an open wound and sepsis and her injuries that continue to this day as a result."

315. As Mr Meleagros explained in unchallenged evidence, this outcome was not reasonably foreseeable. Mr Chawatama's submission does not use the right frame. It does not compare like with like. If one adopts the correct approach, the court finds that Ms Deakin-Stephenson, even if recommended a Hartmann's procedure on the night of Sunday 6 November 2016 but offered along with the option of a laparoscopic lavage, would have strongly chosen the lavage. Put in burden of proof terms, the claimant has not proved to the requisite civil standard that she would have chosen a Hartmann's procedure, even on this conjectural hypothetical.

Conclusion: Behar Issue 6

316. The claimant has not proved factual causation to the civil standard.

§XVII. TRUST ISSUE 1

(Vicarious liability)

- **Is the second defendant vicariously liable for any negligent acts and omissions of Mr Behar after the claimant was transferred to the private wing of the Hospital?**

317. On the afternoon of Friday 4 November 2016, at around 16:30 hours, Ms Deakin-Stephenson was formally transferred from the NHS part of the hospital to the Chelsea Wing in the hospital's private wing. The claimant submits that the second defendant is vicariously liable for the Mr Behar's alleged negligence

after that transfer. The procedural history is important as the parties dispute whether the issue of vicarious liability was withdrawn by the claimant. It is necessary to examine the pleadings.

318. The claim form was issued on 3 August 2020. The particulars of claim are dated 30 November 2020. The particulars were amended on 8 October 2021, and are settled by Mr Chawatama. The claimant submitted in closing argument that the second defendant is vicariously liable for the acts or omissions of Mr Behar "after transfer to the private wing" (claimant closing skeleton, paras 10-16). This caused consternation and protest from Ms Toogood on behalf of the Trust. She objected to the claimant adopting such a stance at the end of the trial since she submitted this was not how the case was pleaded, opened or conducted.

319. By way of background, the Trust has relied on the legal principle set out succinctly in *Clerk and Lindsell on Torts*, 24th edition at para 9-113:

> "not everyone involved in patient care falls necessarily to be treated as an employee of the hospital or health authority. In the absence of a relationship closely akin to employment as described above, there is no general vicarious liability in hospitals or similar organisations for independent contractors. Again, a fortiori a private patient may well have selected the consultant to care for him, contracted directly with that consultant for the necessary treatment or surgery, and then contracted separately with the hospital or clinic for nursing and ancillary care. In such a case there can be no vicarious liability for any negligence of his."

320. The Trust further relies on the encapsulation of this principle in *Charlesworth and Percy on Negligence*, 15th edition, at para 10-174:

> "In a private hospital, the consulting physicians and surgeons are generally not employed by the hospital, so it is not liable for their negligence."

321. On Monday 25 March 2024, the first morning of the trial, as part of the court's duty to identify (and if possible narrow) issues, the claimant was invited to explain the basis of any continuing vicarious liability claim against the second defendant. In part this was because in the claimant's opening skeleton dated 18 March 2024 - that is, one week before the trial started - there is no mention of vicarious liability of the second defendant in the "Issues for the Court" section of the document (para 9). In response, Mr Chawatama explained that the claimant put this aspect of the case on the basis that the second defendant should have had a "system" in place to treat "complex diverticulitis" since Mr Behar was "not a specialist colorectal surgeon". Thus, the complaint was a systemic one, claiming that the second defendant did not have adequate caring or referral arrangements in pace. This approach was supported by the claimant's pleaded case. It states at para 22 of the particulars of claim:

> "Failed to institute and / or implement a standard operating policy, procedure or guideline to ensure that appropriate cases, as in the Claimant's case, are referred timeously to appropriate teams. In the

> Claimant's case the appropriate team would have been a surgical team led by a specialist colorectal surgeon."

322. In Ms Toogood's closing skeleton, she immediately confronts what happened in court. She notes at para 2:

> "Following the Claimant's opening submissions and discussions with the Judge, it was the Second Defendant's understanding that the Claimant agreed that the Second Defendant was not vicariously liable for Mr Behar after the Claimant became his private patient."

323. It is entirely understandable why Ms Toogood made that submission. However, in his closing submissions, Mr Chawatama stated that vicarious liability after the private wing transfer on the afternoon of 4 November "does remain an issue". He submitted that it would be unconscionable for the Trust to "rely on the independent contractor exception" identified in *Clerk and Lindsell*. In other words, even if, which the claimant did not accept, Ms Deakin-Stephenson had contracted separately for medical care from Mr Behar, because her transfer to private medical care had been improperly induced by Mr Behar while he was employed by and working for the Trust, the second defendant could not avoid liability. In his closing submissions, Mr Chawatama conceded that nowhere in the pleadings is it alleged that "Mr Behar continued to provide medical treatment under the NHS". Counsel put the case on the basis that "Ms Deakin-Stephenson's oral evidence supersedes her pleadings."

324. The complicating factor of this dispute derives from the nature of the amended particulars of claim. At para 37, it states:

> "37 Further or alternatively, the Second Defendant, its servants or agents, was negligent.
>
> PARTICULARS OF NEGLIGENCE OF THE SECOND DEFENDANT
>
> (i) The Second Defendant is vicariously liable for the negligent acts and omissions of
>
> the First Defendant and the allegations against the First Defendant pleaded at paragraph 34 (i) to (viii) above are each repeated against the Second Defendant."

325. The numbering may be wrong and the reference should be to paragraph 36 (i) to (viii). It matters not; the sense is clear, and I resolve the confusion in the documents in favour of the claimant. The significance is that the particulars of negligence pleaded against Mr Behar include alleged breaches of duty after the transfer to the private wing. The situation is further complicated by the fact that no doubt as a result of the concession Mr Chawatama made, it was never put to Mr Behar that he treated Ms Deakin-Stephenson throughout as an NHS patient. If this remained the claimant's case, it should have been put to Mr Behar to give him the opportunity to deal with the point. If that had happened, Ms Toogood on behalf of the second defendant would be able to ask him questions about the true position, either fleshing it out or challenging it. She was deprived of that

opportunity to test or amplify the evidence. Therefore, there is no evidence from Mr Behar about this point because it was not pursued during the trial as an issue.

326. However, the observation in Mr Chawatama's closing submissions about Ms Deakin-Stephenson's evidence needs explanation. In her oral evidence, the claimant stated that "her understanding", as Mr Chawatama put it, was that although the accommodation in the private wing was supplied under her health insurance policy, the medical treatment remained under the NHS. It is difficult to reconcile this with further parts of her amended pleadings. At para 19, it is alleged on behalf of the claimant that:

> "At around 18.00 hours on 4 November 2016 the Claimant was reviewed by the First Defendant in the presence of her sister and her sister's son, The Claimant (**now a private patient**) and her sister again asked for a second opinion and referral to a specialist colorectal surgeon, which the First Defendant declined."
>
> (emphasis provided)

327. The significance of this for the moment is not about the alleged request, an issue already dealt with, but that the claimant has pleaded that she was "now a private patient". Indeed, in Mr Behar's filed Defence, he accepts that:

> "3 It is admitted and/or averred that:
>
> (a) Between her admission to the Hospital on 2 November 2016 and about 1600-1630 on 4 November the Claimant was an NHS patient.
>
> (b) Between about 1600-1630 on 4 November 2016 and her admission to the Intensive Care Unit at the Hospital on 9 November 2016 the Claimant **was a private patient**."
>
> (emphasis provided)

328. It is clear why Ms Toogood forcefully submitted in closing submissions that vicarious liability issue "was abandoned on the first day of the trial", and further that "the claimant has not referred to any law", nor agreed any legal principles around vicarious liability in the agreed note of law jointly provided by counsel to the court. Ms Toogood further submits that from all the invoices and documentation that "Mr Behar treated the claimant on the usual basis after her care was transferred into the private sector".

329. Even if one were to put to one side the pleading and concession problems – and they are fundamental – the claimant still faces significant evidential difficulties. The subjective belief of the claimant that she was being treated under the NHS is of very little persuasive value when it is not supported by other evidence. Indeed, it is flatly contradicted by the independent evidence. At B687, there is an invoice from BUPA. It documents the various sums paid by BUPA in respect of Ms Deakin-Stephenson's policy. It runs from just after her admission to Chelsea and Westminster on 2 November 2016 right up to December 2023.

There are numerous different recipients of disbursements paid out by BUPA, as Ms Deakin-Stephenson has received medical advice, support and treatment from different private suppliers, including the Princess Grace Hospital, the Royal Brompton and the London Clinic and a range of private consultants. Once more it is clear that Ms Deakin-Stephenson has continued to heavily rely on her BUPA policy to receive private healthcare.

330. The invoice documents that BUPA paid Chelsea & Westminster Hospital £32,776.50. The relevant dates are listed as between 3 and 28 November. It is noteworthy that this is the day before the transfer in fact took place, but is plainly for medical treatment following Ms Deakin-Stephenson's transfer on the next day, Friday 4 November. It makes no sense whatsoever if Ms Deakin-Stephenson were being treated under the NHS that BUPA would have paid such significant sums.

331. As Ms Toogood puts it, the BUPA invoice is simply documenting the claimant being treated in the private sector "on the usual basis". Further, there is no logical reason why BUPA was seeking a treatment code if all BUPA was going to pay for were accommodation fees. It was important to have a code for the treatment as BUPA would be footing the bill as after transfer Ms Deakin-Stephenson would receive medical treatment as a private patient. Of course, as very frequently happens, NHS facilities would be used, such as the operating theatre, but BUPA would pay the NHS Trust for that facility. In addition, there are payments made to Mr Behar, including for an "initial" consultation in the sum of £143. If he were treating Ms Deakin-Stephenson under the NHS, such a fee would make no sense.

332. On 13 March 2017, Ms Deakin-Stephenson wrote a letter of complaint to the "complaints team". She stated since she had only a vague memory or none at all, and she stated that therefore "from what I have understood, this is what happened":

> "Later I was moved into the Chelsea Wing, after my sister activated my BUPA insurance policy and all treatment thereafter was covered by BUPA, so is my understanding."

333. This account, although pieced together from others, is in direct contradiction to the claim of vicarious liability in closing the case. If Ms Deakin-Stephenson still lacked memory of these key events as at March 2017, the court must treat carefully claims of being able to recollect events at a later point. It is not impossible for that to happen and for her to recover memory (although the claimant has provided no memory loss/recovery expert evidence). Here, however, the independent evidence from the BUPA invoicing seriously undermines the claim of vicarious liability against the second defendant. Ms Toogood is correct that it is not for Trust to "make a positive case".

334. The claimant relies on her evidence that she was not aware of a private wing at the Hospital until, she claims, she was asked if she had medical insurance and the idea of a transfer was suggested by Mr Behar. I have found the claimant's evidence on this point unconvincing. She is a person who, regrettably, has experienced frequent healthcare problems and she has a long history of using

private healthcare before her admission in this case and very substantially again after it, as recorded in the BUPA invoice.

335. Recalling without here replicating the letter from Dr Singh about the claimant in July 2015 with a reference to Chelsea and Westminster private care, it is difficult to understand how the claimant can credibly maintain that by November 2016 she was unaware of private treatment as a possibility at the Chelsea and Westminster Hospital. This is another example of her credibility being called into question by reference to independent contemporaneous records. Further, all of the claimant's earlier colorectal consultations were on a private basis. This is evident from the consultants, as is professional practice, writing to Ms Deakin-Stephenson's General Practitioner. The claimant accepted in cross-examination that she had "not spent a night" in an NHS hospital for a number of years.

336. On this point, I also reject the purported supporting evidence of Mrs Ingledow about her sister continuing to receive medical treatment under the NHS throughout. Plainly this was not the case, and Mrs Ingledow has sought to support her sister's account.

337. I return briefly to the question of proper legal procedure. Mr Chawatama did not challenge Mr Behar about his pleaded Defence that he contracted directly with the claimant and between the Friday transfer and her admission to the Intensive Care Unit, she was a "private patient" (para 2(d)). If this argument were maintained, it is procedurally incumbent upon the claimant to challenge Mr Behar about this. This did not happen. The prejudice to the second defendant is obvious and already explained. The burden of proof is on the claimant to make out her claim of vicarious liability. For the reasons given, I find that she has not come close to reaching civil standard. Rather, it is clear to me that Ms Deakin-Stephenson understandably preferred to be more comfortably accommodated in a private room on a private wing. Further, she had prior to the instant hospital admission, and then subsequently, consistently relied on private treatment. All this supports the fact that she was receiving medical treatment as a private patient after transfer to the Chelsea Wing and not under the NHS until her admission to ICU. This is no doubt why the skeleton argument filed on her behalf immediately before the trial started stated at para 2 that she

> "was a patient under the care of Mr Nebil Behar at the Chelsea and Westminster Hospital in November 2016, initially as an NHS patient and subsequently as a private patient."

338. Therefore, Ms Deakin-Stephenson has not proved to the necessary civil standard that following transfer to the Chelsea Wing on the afternoon of Friday 4 November 2016 that the second defendant is vicariously liable for the acts and omissions of Mr Behar. I reject the submission that it would be "unconscionable and unjust" for the second defendant to "evade liability" for the acts and omissions of Mr Behar after transfer. Further, the fact that the experts agree that there is "no clinical justification" for Mr Behar to recommend private treatment is beside the point. The claimant has not proved that he did.

Conclusion: Trust Issue 1

339. Vicarious liability has not been proved by the claimant on a balance of probabilities. The consequence is that any liability for medical treatment must end upon transfer to the private wing when the claimant fell under the care of Mr Behar as a private patient and no longer the second defendant Trust.

§XVIII. TRUST ISSUE 2

(Policy)

- **Did the second defendant fail to possess or operate a policy to ensure that medical cases are referred to the appropriate specialist teams in good time?**

340. The question of systemic or operating policy failure is pleaded in the amended particulars of claim. It is alleged that the second defendant:

> "failed to institute and/or implement a standard operating policy, procedure or guidelines to ensure that appropriate cases, as in the Claimant's case, are referred timeously to appropriate teams. In the Claimant's case the appropriate team would have been a surgical team led by a specialist colorectal surgeon."

341. It is of significance that in the claimant's written closing submissions there is no argument whatsoever about the second defendant's systemic or institutional failure. In oral argument during closing submissions, Mr Chawatama again failed to address the question of operating policy failure. It is difficult to discern from the claimant's case as it has developed how the allegation against the second defendant as pleaded can be maintained.

342. The most that remains to the claimant is the suggestion that Mr Behar is not a "specialist colorectal surgeon" and thus it was negligent on the part of the second defendant to entrust Mr Behar with treating the claimant. The question of Mr Behar's competence to treat the claimant in the early stages of admission to the Hospital were considered with the medical experts. Mr Hartley, the expert instructed on behalf of the claimant, stated in evidence that the management of the claimant's medical case came within the medical competence of Mr Behar. Further, Mr Hartley agreed that the conservative treatment plan formulated by Mr Behar after admission was reasonable. As significantly, Mr Hartley stated that the Mr Behar's management of the claimant in that initial phase was indistinguishable from the treatment that a "specialist" colorectal surgeon would have instituted up to the point of the consenting process on the night of Sunday 6 November. This means even beyond the point of transfer into the private medical care of Mr Behar, the claimant's expert agrees that the care she received is, as Mr Hartley puts it, "identical" to that she would have received from a "specialist" colorectal surgeon – at least until the advice during the Sunday night consenting process, a separate matter. Mr Behar was the most experienced of the doctors at the Chelsea and Westminster Hospital in treating

diverticulitis. Mr Behar's hands-on day-to-day experience of the condition was deep and constant. Mr Hartley accepted that the "higher degree" in colorectal surgery that a "specialist" would "usually" have, and Mr Behar lacks, are "not essential criteria for the post" that Mr Behar was performing. The statement of Mr Smith (B258) a consultant at Chelsea and Westminster Hospital was put to Mr Hartley. It is an agreed statement and Mr Smith has not been asked by the claimant to attend trial for cross-examination. Cited in full previously, it bears repeating that Mr Smith concluded that "Mr Behar would be considered to have the relevant experience and training to treat the claimant." Mr Hartley did not dispute the statement. He did not suggest that Ms Deakin-Stephenson should have been referred to a different surgeon or medical team after her admission.

343. In his evidence, Mr Behar stated that he treated the great majority of acute diverticulitis cases presented by patients at the Trust, save for those after hours or at weekends when he was not on call. He therefore has gained great experience of dealing with this condition. He had performed this role for six years by the time of Ms Deakin-Stephenson's arrival. He estimated that he treated 95 per cent of the Trust's acute diverticulitis cases. To return to the question: the focus in this section of the judgment is the liability of the second defendant for its policy and operational system. I find no or no sufficient evidence to support the proposition that the second defendant's institutional arrangements were defective or in breach of a duty of care. Indeed, by the conclusion of the trial, the claimant advanced no contrary argument.

344. There is no evidence before the court from the experts that the second defendant should have had a different system in place for the assessment and treatment of cases such as Ms Deakin-Stephenson's where acute diverticulitis is presented. Mr Chawatama has not identified any such evidence.

Conclusion: Trust Issue 2

345. The allegation against the second defendant of policy or systemic failure is not proved.

§XIX. DISPOSAL

346. These have been long and complex proceedings. The court's judgment must necessarily be detailed and delve into significant detail to do justice to the issues and the rival cases of the parties. However, the most vital features of the court's decision on each issue are clear.

347. An introduction to what has happened in this case comes from the succinct summary of the expert Mr Meleagros:

> "Nowhere in the literature does it say that the deterioration is a common or even a rare outcome, nowhere does it refer to the events that Ms Deakin-Stephenson suffered. No one could have warned her that this would have happened or could have included it in the counselling (discussion) or included it in the consent form."

348. This is a vital insight. It must be combined with what subsequently happened to Ms Deakin-Stephenson, as she explained in her email of 13 March 2017 (B770-74). In that she stated that she experienced "nightmares and flashbacks" and along with a "loss of memory" of what happened to her between admission to the Chelsea and Westminster Hospital on 2 November 2016 and discharge on 29 November 2016, resulted in her not being able to "ascertain" whether what she was recalling was "reality or fiction". That Ms Deakin-Stephenson subsequently then "desperately" tried to "piece together" what had happened is entirely understandable and a natural human response. Regrettably what has transpired is that a narrative has been developed that sought to blame Mr Behar for the outcome that the expert Mr Meleagros, without contradiction from any party, told the court was unforeseeable and not previously documented in the medical literature. That has entailed the evolving reconstruction of the facts into an account that is substantially undermined both by the contemporaneous documentation and the canons of probability and logic. When Ms Deakin-Stephenson wrote to the Trust's Complaints Team on 13 March 2017, that is, some four months after her discharge, she wrote:

> "Please note, I am unbelievably and very sincerely grateful to Mr Behar as well as the entire medical team at Chelsea and Westminster for saving my life …"

349. This is likely to be far closer to the truth. That said, it is difficult to criticise Ms Deakin-Stephenson when she has suffered so much in what became a life-threatening medical emergency. But the court takes no sides and cannot. It must be fair to all parties, including Mr Behar and the Trust. The court's ultimate allegiance is to the search for truth, as understood within the discipline of civil proceedings, and the furtherance of the overriding objective, which encapsulates several of our most important legal principles. No one can or should take any satisfaction in the dismissal of Ms Deakin-Stephenson's claims, which is what must follow, and the sensitive and responsible way in which this trial has been conducted by all parties tells me that everyone involved cannot but applaud her daily resilience and fortitude. It does her, and those who rally round and constantly support her, great credit.

350. To conclude, I summarise the court's answers to the questions posed:

The first defendant

Breach of duty

(1) Did the claimant and/or members of her family ask Mr Behar for a referral to a colorectal surgeon or a second opinion? **NO.**
(2) Did Mr Behar instigate and induce the claimant's transfer to private care? **NO.**
(3) Did Mr Behar inform the claimant on 6 November 2016 that a Hartmann's procedure was a surgical option? **YES.**
(4) Did Mr Behar warn the claimant of the risks and benefits of a laparoscopic lavage and a Hartmann's procedure? **YES.**
(5) Did Mr Behar negligently delay surgery from the evening of Sunday 6 November to the morning of Monday 7 November 2016? **NO.**

Causation

(6) Did any breach of duty by Mr Behar cause injury to the claimant? **NO.**

The second defendant

(1) Is the second defendant vicariously liable for any negligent acts and omissions of Mr Behar after the claimant was transferred to the private wing of the Hospital? **NO.**

(2) Did the second defendant fail to possess or operate a policy to ensure that medical cases are referred to the appropriate specialist teams in good time? **NO.**

351. There is no causative breach of duty proved against Mr Behar. The claim against him is dismissed.

352. There is no breach of duty proved against the second defendant. The claim against the Trust is dismissed.