Neutral Citation Number: [2024] EWHC 652 (KB)

Case No: G90CH330

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Manchester Civil Justice Centre,
1, Bridge Street West,
Manchester, M60 9DJ

Date: 26/03/2024

Before :

THE HONOURABLE MR JUSTICE TURNER

- -

Between :

(1) Ms Rebecca Thorp **(2) Ms Charlotte Melling** **(administrators of the estate of Ms Amanda Louise Thorp, deceased)**	**Claimants**
- and -	
Dr Harinder Mehta	**Fourth Defendant**
- and -	
The University Hospitals of Morecambe Bay NHS Foundation Trust	**Fifth Defendant**

- -
- -

Simon Cridland (instructed by **Hugh James**) for the **Claimants**
Michael Smith (instructed by **Hill Dickinson LLP**) for the **Defendants**

Hearing dates: 20, 21, 22, 23 and 27 February 2024

- -

Judgment Approved by the court for handing down

This judgment was handed down remotely at 10.30am on 26 March 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

The Hon Mr Justice Turner :

INTRODUCTION

1. Amanda Thorp died on 4 January 2018. She was only 42 years old. The cause of her death was a stroke in the form of a large right intra-cranial and subarachnoid haemorrhage.
2. This claim is brought by the administrators of her estate. They allege that her death was caused by the negligence of Dr Chua and Dr Mehta both of whom worked from the Ash Trees Surgery in Carnforth at which she had been registered as a patient since November 2011.
3. The central (but not the only) issue relating to breach of duty is as to whether the doctors ought to have prescribed antihypertensive drugs to control Amanda's high blood pressure.
4. The central (but not the only) issue on causation is as to whether, had such drugs been prescribed, the fatal stroke would have been avoided.
5. The issue of quantum falls to be determined at a later hearing in the event that I were to find that the claimants had succeeded on both liability and causation.

PRELIMINARY MATTERS

6. For convenience, I have set out a chronology of relevant extracts from the medical records in an appendix in order to avoid cluttering the main body of this judgment. I distributed a draft to counsel at the conclusion of the case and invited them to incorporate any further entries which they considered would be of particular relevance and to agree the final composite document. This they did and I am grateful to them for their respective contributions.
7. I have referred to the deceased throughout, both in the appendix and the body of this judgment, as Amanda in order to avoid any confusion with her daughter, Rebecca Thorp, who is a claimant in the action and who gave evidence at the hearing.

8. Both sides have raised a considerable number of arguments in support of their respective cases as to what secondary inferences

I ought to draw from the largely uncontentious but voluminous primary factual evidence. I have been provided with very detailed skeleton arguments and final written submissions which were developed in oral submissions. In the particular circumstances of this case, I make no complaint about the quantity of material produced. However, although I have carefully considered them all, I have not attempted to resolve every issue thus ventilated. The central conclusions I have reached and the reasons given are sufficient to determine the outcome of the claims and any questions not expressly adjudicated upon would have no impact upon my final decisions but would serve only to obscure the route I have taken to my conclusions. As the Court of Appeal held in ***Customs and Excise Commissioners v A and Another*** [2003] Fam 55:

> "82 A judge's task is not easy. One does often have to spend time absorbing arguments advanced by the parties which in the event turn out not to be central to the decision-making process…
>
> 83 However, judges should bear in mind that the primary function of a first instance judgment is to find facts and identify the crucial legal points and to advance reasons for deciding them in a particular way. The longer a judgment is and the more issues with which it deals the greater the likelihood that: (i) the losing party, the Court of Appeal and any future readers of the judgment will not be able to identify the crucial matters which swayed the judge; (ii) the judgment will contain something with which the unsuccessful party can legitimately take issue and attempt to launch an appeal; (iii) citation of the judgment in future cases will lengthen the hearing of those future cases because time will be taken sorting out the precise status of the judicial observation in question; (iv) reading the judgment will occupy a considerable amount of the time of legal advisers to other parties in future cases who again will have to sort out the status of the judicial observation in question. All this adds to the cost of obtaining legal advice.
>
> 84 Our system of full judgments has many advantages but one must also be conscious of the disadvantages."

THE BACKGROUND

9. Amanda’s blood pressure had been taken on six occasions at the surgery between November 2011 and September 2016. On each such occasion, her readings were elevated.
10. However, it forms no part of the claimants’ pleaded case that antihypertensive drugs ought to have been prescribed by any of the GPs then involved in contemporaneous response to these readings.
11. Amanda became pregnant in late 2016 and presented at about 21 weeks at the practice on 27 April 2017. Three blood pressure readings were taken. All were elevated. The highest reading was 180/90 mmHg. She was prescribed labetalol which is an antihypertensive drug often used to treat high blood pressure in pregnancy.
12. On the very next day, Amanda returned to the clinic where a GP took her blood pressure which was found to be gratifyingly normal at 119/83 mmHg. Her blood pressure was re-measured throughout the remainder of her pregnancy during the course of which the labetalol dosage was increased in response to some high readings.
13. After the baby was born, on 21 August 2017, Amanda had two weeks supply of labetalol left, assuming (which is not necessarily the case) that she had been taking the tablets as prescribed.
14. On 6 September 2017, she returned to the surgery where she was seen by Dr Chua and, subsequently, on 18 October 2017, by Dr Mehta. The central criticism directed towards these practitioners is that they ought immediately to have prescribed antihypertensive drugs and not wait upon the results of any further investigations before they did so. The course chosen was to await the results of ambulatory blood pressure monitoring (“ABPM”) before prescribing further medication.

BLOOD PRESSURE

15. Before turning to the detail of the allegations raised against the doctors, I will deal, in outline, with general matters not in issue relating to the diagnosis and treatment of hypertension. Much of what follows will already be very familiar to medical

practitioners and those who practise in the field of clinical negligence but, perhaps, less so to the more general reader.

16. Blood pressure is recorded with two numbers. The systolic pressure (higher number) is the force at which the heart pumps blood around the body. The diastolic pressure (lower number) is the resistance to the blood flow in the blood vessels between heartbeats when blood is pumped around the heart. Both are traditionally measured in millimetres of mercury (mmHg).
17. The ideal blood pressure for those under the age of 80 is usually considered to be between 90/60mmHg and 120/80mmHg. Variations within this range between different individuals and at different times are perfectly normal.
18. Elevation of blood pressure above these levels gives rise to potential risks to health. The higher the readings and the longer the period over which they persist, the greater the risks. They include: heart disease, heart attacks and, of particular relevance to this case, strokes.
19. The NICE guideline CG127 "Hypertension in adults: diagnosis and management" applied at all times relevant to this case. It defined levels of hypertension according to three categories:

> "***Definitions***
>
> In this guideline the following definitions are used.
>
> ***Stage 1 hypertension*** Clinic blood pressure is 140/90 mmHg or higher and subsequent ambulatory blood pressure monitoring (ABPM) daytime average or home blood pressure monitoring (HBPM) average blood pressure is 135/85 mmHg or higher.
>
> ***Stage 2 hypertension*** Clinic blood pressure is 160/100 mmHg or higher and subsequent ABPM daytime average or HBPM average blood pressure is 150/95 mmHg or higher.
>
> ***Severe hypertension*** Clinic systolic blood pressure is 180 mmHg or higher or clinic diastolic blood pressure is 110 mmHg or higher."

20. ABPM is a means by which blood pressure is measured as the patient moves around while living her normal daily life. It is measured for up to 24 hours. A small digital blood pressure monitor is attached to a belt around the patient's waist and

connected to a cuff around her upper arm. The monitor is fitted at a local hospital outpatients' department or at the GP's surgery.

21. The use of ABPM is to establish a diagnosis of high blood pressure and, in particular, to identify patients who have higher blood pressure readings when in the clinic (known as the 'white coat effect'). The results of ABPM are there to help the practitioner to decide if future blood pressure medication (or a change to existing medication) is required.
22. If medication is prescribed it is often effective in reducing high blood pressure to more normal levels over a period of four to six weeks. However, on the down side, antihypertensives are usually taken for life and are capable of giving rise to unwelcome side-effects of varying severity.

DR CHUA

23. Dr Chua gave evidence. He gave the distinct impression of being uncomfortable with the experience which, in the circumstances, is hardly surprising. I did, however, conclude that he was doing his best to give an accurate account of what he did and why notwithstanding the passage of time. In particular, he candidly accepted that, in some respects, his approach fell short of what could reasonably have been expected of him.
24. When he saw Amanda at the surgery on 6 September 2017, he took two blood pressure readings of 150/97 mmHg and 144/92 mmHg. He referred her for ABPM on the basis that results involving high readings could confirm that she was suffering from essential hypertension. Essential hypertension is high blood pressure which does not have an identifiable physiologic cause.
25. Dr Chua fell below the standard reasonably to be expected of him in two particular respects. He freely admitted this in the witness box.
26. Firstly, he did not access the blood pressure history screen on the computer system which would have revealed the six previous occasions between 9 November 2011 and 6 September 2016 upon which Amanda's blood pressure had been measured at the

surgery and found to have been high. The details of these readings are to be found in the chronology at 1-5 and 7.

27. Secondly, he could and should have realised that the reading of 119/83 mmHg taken at the surgery on 28 April 2017 was on the day after Amanda had been prescribed labetalol which would explain why it fell within a normal range at that time.

28. As a result of these two errors, Dr Chua, as his notes reveal, was in doubt as to whether Amanda's high readings were indicative of essential hypertension or gestational hypertension (i.e. related to her recent pregnancy). Had he been aware of the history of high readings over the years before Amanda was pregnant and that the normal reading on 28 April was likely to be attributable to the effects of labetalol, he would have realised that his suspicion of gestational hypertension was unfounded.

29. The discharge summary of 25 August 2017 sent to the surgery from the Royal Lancaster Infirmary three days after the birth of Alex recorded: "To see GP for medication review 2 weeks postnatal as likely essential hypertension for onward management." Of course, the discharge summary must not be treated as if it were an instruction to the GPs working at the surgery. Each had to exercise an independent judgment as to the appropriate way forward.

30. Dr Lieberman, the expert in general practice called on behalf of the claimants, expressed the view that if Dr Chua had not fallen into error in these two respects, he would and should have prescribed antihypertensives for Amanda to be taken upon the conclusion of her course of labetalol without any delay awaiting the results of ABPM.

31. The question therefore arises as to what a responsible body of doctors (in the sense of the application of the well-known Bolam/Bolitho formulations[1]) in the position of Dr Chua might be expected to have done when equipped with these two pieces of information.

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[1] As laid down in the leading cases of Bolam v Friern Hospital Management Committee [1957] 1 W.L.R. 582 and Bolitho v City and Hackney Health Authority [1998] A.C. 232.

32. It is at this stage of the analysis that it is necessary to return to the NICE Guideline CG127. It provides:

> "1.2.3 If the clinic blood pressure is 140/90 mmHg or higher, offer ambulatory blood pressure monitoring (ABPM) to confirm the diagnosis of hypertension.
>
> 1.2.4 If a person is unable to tolerate ABPM, home blood pressure monitoring (HBPM) is a suitable alternative to confirm the diagnosis of hypertension.
>
> 1.2.5 If the person has severe hypertension, consider starting antihypertensive drug treatment immediately, without waiting for the results of ABPM or HBPM."

33. It will be recalled that the Guideline defines the threshold level of severe hypertension to be represented by clinic systolic blood pressure of 180 mmHg or higher or clinic diastolic blood pressure of 110 mmHg or higher.
34. It is to be noted that none of the historical readings of Amanda's blood pressure fell within this category.
35. By the application of the Guideline, therefore, the offer of ABPM would, at least at first blush, appear to have been appropriate even taking into account the additional information which would have been available to Dr Chua, had he looked for it. Although essential hypertension was likely to be the diagnosis and gestational hypertension could be effectively excluded there remained the chance that Amanda's blood pressure may have been elevated historically by the white coat effect which the results of ABPM would tend either to confirm or refute.
36. How, therefore, did Dr Lieberman seek to deal with the potential impact of the wording of the NICE Guideline?
37. In his report of October 2022, Dr Lieberman made no reference at all to the NICE Guideline in his analysis of Dr Chua's decision to proceed to ABPM. His conclusion was simply that there was "no logic" in waiting for ABPM measurements. He subsequently went on to criticise Dr Mehta for failing to prescribe antihypertensive tablets on 10 October 2017 when the blood pressure reading was 150/105 mmHg recording that:

> "At this point, treatment was necessary in line with the NICE Guidance on hypertension."

However, Dr Mehta's reading fell short of the immediate intervention threshold for either systolic or diastolic readings and Dr Lieberman did not explain how the wording of the NICE Guidance mandated the abandonment of the ABPM route.

38. The point was made on behalf of the claimants that the NICE Guidance provides:

> "**Your responsibility**
>
> The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian."

39. This passage confirms that the Guideline is not intended to be entirely prescriptive but should be taken "fully into account". It must follow, however, that cases in which practitioners are liable to be found negligent despite following the Guideline are likely to depend on particular circumstances.

40. Dr Lieberman contended that the history of elevated blood pressure readings available to Dr Chua were sufficient not merely to entitle him to depart from the recommendations in the Guideline but, in the Bolam/Bolitho sense, to mandate him so to do.

41. This approach, however, presented him with a problem which was exposed in cross-examination. If a recorded history of sufficiently high clinic blood pressure readings were sufficient to mandate immediate treatment with hypertensive drugs, why were the GPs who had been responsible for taking her blood pressure on 29 September 2015 and 6 September 2016 not also in breach of duty in failing to follow this course?

42. He exonerated Dr Woudenberg, who had examined Amanda on the second of these two occasions, on the basis that she did not have access to a relatively recent blood pressure reading. He accepted, however, that the position of Dr Wadeson, who had

examined Amanda on the first of these two occasions, could not be defended. He too was in breach of duty.

43. This was an entirely new allegation articulated for the first time in the witness box. It was not a mere detail. The relatively short period between Amanda's appointments with Dr Chua and Dr Mehta and her stroke had given rise to a hotly contested issue on causation and it would have been potentially very significant had the claimants been able to rewind the relevant period by up to two years.

44. The transcript of his response to cross examination on this point with reference to the 29 September 2015 appointment makes for uncomfortable reading:

> "Q. … what he did in fact was refer her for 24-hour blood pressure monitoring. Yes?
>
> A. Yes.
>
> Q. So he did exactly what Dr Chua did, didn't he?
>
> A. Yes.
>
> Q. You say this was the correct action?
>
> A. How many readings had he to go on at that point?
>
> Q. Well, let me show you. If we go back he had a reading two weeks earlier from Dr Trafford 154/102, so that's one. Further up that page we have a reading in July 2015, 160/98, so that's two. Yes?
>
> A. Yes.
>
> Q. Turning back, 14 February 2014, 170/107, so that's three. And then November 2011, 160/90, four. So he had four readings. He had four historic readings to go on, some of which were quite significantly higher. I mean, 170/107 is well in stage 2, isn't it, in February 2014?
>
> A. Yes.
>
> Q. So he had four readings to go on, he did exactly the same as Dr Chua, yet you say his was the correct action. Why?
>
> A. I think I was wrong. I think he should have also treated.

Q. So that is a mistake on your part, is it?

A. Yes.

Q. Why? Why have you made a mistake like that in this report?

A. I hadn't considered all the previous readings. At that point I hadn't seen the historical print out. But it was a mistake. I think Dr --

Q. You just dealt with the readings on the previous two pages of your report.

A. Yes, but this is -- I'm talking about the list of the -- but I accept -- I accept that that is not consistent and I accept that -- Dr Wadeson, is it? My opinion wasn't correct on that."

45. The combination of Dr Leiberman's failure in his report to analyse the position of Dr Chua with any reference to the NICE guideline and his belated attempt in the witness box to salvage his conclusions by casting blame upon Dr Wadeson, whom he had earlier expressly exonerated, fatally undermined the plausibility of his conclusions. In my view, he had failed from the outset to take into adequate account the NICE recommendations as a result of which his subsequent analysis became incoherent. On this basis, I prefer the evidence of the defendant's expert, Dr Howe.

DR MEHTA

46. Dr Lieberman conceded that, if Dr Chua had been justified in deferring the prescription of antihypertensives pending the results of ABPM measurements, then Dr Mehta could not be criticised for continuing with this treatment plan. Cross-examination on this topic proceeded as follows:

"Q. Let's assume that His Lordship is against you and he concludes that Dr Chua's plan was a reasonable one. If that were the case, there can be no real criticism of Dr Mehta continuing the plan, given the information that was available to him, can there?

A. Correct. If the plan was reasonable in the first place, it was reasonable to continue with it."

47. It follows that the claim against Dr Mehta on the central issue cannot survive my findings in respect of Dr Chua.

STRONG ADVICE

48. A further freestanding pleaded allegation directed towards Dr Chua and Dr Mehta is that they failed to advise Amanda in clear and strong terms as to the importance of attending blood pressure reviews including any 24 hours ABPM appointment organised.
49. Dr Chua had no substantial reason to doubt that Amanda would follow his advice to proceed with ABPM. By the time Amanda attended upon Dr Mehta, she still had not attended for ABPM. However, it is to be noted that she volunteered to him that she had missed her hospital appointment for this purpose but had rebooked it. There is no evidence in the hospital records that she had actually re-booked the appointment but Dr Mehta was not to know this at the time of his examination. I have reached the conclusion that it would be a counsel of perfection to suggest that more emphatic advice was mandated. It is not suggested that Amanda was unaware of why ABPM had been recommended and of the doctors' plan to consider the results before contemplating her future treatment. It was obviously highly desirable that ABPM should be carried out sooner rather than later but it is important not to work backwards from the knowledge of what happened to Amanda later and thereby to confuse foresight with hindsight.
50. Furthermore, the decision as to how strongly to prompt any given patient into taking action may often be one of nuance. There is a risk that advice expressed over-emphatically may discourage a patient from re-attending for fear of admonishment. However, even though I would not criticise Dr Mehta for not reinforcing the ABPM message, it does not automatically follow that he was right at this stage not, at least, to draw Amanda's attention to the alternatives. It is to this element of the case to which I now turn.

TREATMENT OPTIONS

51. In a joint statement of the experts in general practice dated August 2023 the following appears:

> “17 As of 18 October 2017, to what extent, if at all, do you consider that a review of Ms Thorp’s medical records would have demonstrated a need for her to be prescribed antihypertensives…
>
> Dr Howe [the defendants’ expert] states that on 18.10.17 the blood pressure was 150/105 and was consistent with mild/moderate hypertension. It is known that a single reading in the GP Surgery is not representative of the reading over 24 hours. The blood pressure reading on 18.10.17 was not significantly raised. Therefore, two options could be considered:
>
> 1. Continue with the diagnostic assessment.
>
> 2. Prescribe treatment.
>
> Dr Howe states that both were reasonable.”

52. The claimants applied at trial to amend their pleadings to include an allegation that, on this basis, Dr Mehta should have presented Amanda with the two options from which it is likely, they say, that she would have chosen to take antihypertensives without waiting for the results of the ABPM.

53. I gave permission for the amendment to be made notwithstanding the delay in making the application and against the opposition of the defendants. My reasons were set out in an ex tempore judgment. There is no need for me to rehearse them here. I note that it was not alleged or pleaded that Dr Chua ought also to have presented Amanda with the two options and so I will restrict my analysis to the actions of Dr Mehta.

54. The legal basis for the new allegation was the decision of the Supreme Court in ***Montgomery v Lanarkshire Health Board*** [2015] A.C. 1430.

55. ***Montgomery*** marks, if not the final destination, at least the most recent resting point on a long journey away from a predominantly paternalistic approach to the relationship between doctor and patient as evidenced by the opinion of the majority in

the House of Lords' decision in ***Sidaway v Bopard of Governors of the Royal Bethlehem Hospital*** [1985] A.C. 87.

56. In ***Montgomery*** Lords Kerr and Reid observed:

> "75… One development which is particularly significant in the present context is that patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession."

57. They thereafter concluded that "the correct position" is:

> "87… 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."

58. It is clear that Dr Mehta did not engage with Amanda as to the option of starting antihypertensives rather than to continue with pursuing the ABPM route in the light of his blood pressure reading of 150/105 mmHg and the fact that she had, to his knowledge, earlier failed to attend certain other medical appointments. I can see the attraction of his simply continuing the treatment plan alighted upon by Dr Chua. However, the fact that there was, as I have found, a reasonable body of practitioners who would have considered this to be the more appropriate course from a Bolam perspective does not, of itself, absolve Dr Mehta from the obligation to discuss the alternatives with Amanda, so long as a reasonable person in her position would be likely to attach significance to the risk of further delay.

59. Dr Mehta was asked in cross examination why he did not explore the alternative with Amanda. He responded:

> "I did not, purely because there was a plan agreed for diagnostic assessment."

60. The evidence as to the scale of the risk of delay was, inevitably, lacking in precision even where it came from the cardiologists

who gave evidence in this case. Furthermore, I must assess the level of risk from the perspective of the awareness of a general practitioner and not a consultant cardiologist. Nevertheless, the whole purpose of prescribing antihypertensive drugs is to reduce, over time, the levels of the well-known risks of, inter alia, stroke.

61. Dr Howe expressly conceded, in my view correctly, that it would have been a reasonable option for Dr Mehta to consider the immediate prescription of hypertensives. On the particular facts of this case, Dr Mehta's decision not to ventilate the issue with Amanda is an example of the more paternalistic approach to the doctor patient relationship which would almost certainly have survived the ***Sidaway*** threshold of breach of duty but is vulnerable to the more patient-centred ***Montgomery*** analysis. As Lady Hale pointed out:

> "109… it is not possible to consider a particular medical procedure in isolation from its alternatives. Most decisions about medical care are not simple yes/no answers. There are choices to be made, arguments for and against each of the options to be considered, and sufficient information must be given so that this can be done…"

62. I am satisfied that, in the light of what he knew or ought to have known about Amanda's medical history and her recent patchy attendance record, Dr Mehta should, at least, have raised with her the alternative of an immediate prescription of antihypertensives. This would not, of course, have precluded him from recommending that, on balance, she should continue to follow the ABPM plan as the medically preferred route. This was a breach of duty.

MONTGOMERY CAUSATION

63. Save for the Montgomery issue relating to Dr Mehta, my findings are that neither doctor fell below the standard to be expected of a reasonable general practitioner in following the NICE guideline and awaiting the results of ABPM. Nor were they in breach of duty by not being more emphatic with Amanda

as to the advisability of her co-operating with the ABPM approach.

64. It remains necessary for me now to resolve the causation issue relating to the Montgomery breach. The first hurdle which the claimants must surmount in this context is to establish, on the balance of probabilities, that if Amanda had been informed of the option to take antihypertensives without waiting for the results of the ABPM then she would have taken the former course.

65. In this regard, they point out that Amanda had experienced difficulties in attending earlier appointments. She had responded fairly well to the earlier prescription of labetalol. She was clearly concerned about her elevated levels as evidenced by her face book posts at items 41-3 in the chronology. Perhaps if Dr Mehta had thought about drawing her attention to the option of prescribing tablets he would have steered Amanda towards this course.

66. On the other hand, Amanda had expressly articulated a continuing commitment to following the ABPM route at her appointment with Dr Mehta. Her trouble in attending appointments must be seen in the context of a woman with very heavy domestic responsibilities towards, in particular, a disabled son and young baby. When discussing the option of taking tablets she would have to be informed that this was likely to involve a lifetime commitment and there would be the potential for her to suffer adverse side effects. The risk of a stroke or other serious consequence of a modest delay would be identified to have been very small and the deployment of the ABPM was in accordance with NICE guidance.

67. The causation evidence in ***Montgomery*** was very clear:

> "101. That particular piece of evidence did not however stand alone. It was consistent with the evidence given by Dr McLellan to the effect that diabetic women in general would request an elective caesarean section if made aware of the risk of shoulder dystocia. Her position was that it was precisely because most women would elect to have a caesarean section if informed of the risk of shoulder dystocia (contrary, in her view, to their best interests), that she withheld that information from them. That was also consistent with the evidence of the Board's

expert witness, Dr Gerald Mason, that if doctors were to warn women at risk of shoulder dystocia, "you would actually make most women simply request caesarean section".

68. There can be no suggestion in this case that Dr Mehta deliberately failed to mention the option of starting on tablets immediately because he thought, if she were presented with this choice, then Amanda would, contrary to his view as to what would be in her best interests, have taken it. I find that, if presented with the choice, Amanda would probably have continued to opt for ABPM to the extent that it would have provided an opportunity to exclude the white coat effect and may have allowed her to avoid a lifetime on drugs. She would have been told that there was no room for compromise between the two options because, once she started on antihypertensives, the value of the ABPM readings would be contaminated by the effect of the tablets.

69. The suggestion that Dr Mehta may, had he introduced Amanda to the option of resorting immediately to prescribing tablets, have positively encouraged her to make this choice is speculative and, in my view, far less likely than not.

70. I conclude, therefore, that the claimants have not proved that the ***Montgomery*** breach was causative of Amanda's stroke.

COUNTERFACTUAL CAUSATION

71. The findings I have now made are such as to mandate the conclusion that, unhappily, this claim must fail. The relevance of the remaining issues are now rendered hypothetical. I will, however, deal with one further issue relating to causation which the claimant would have to have surmounted in order to succeed in this case.

72. Dr Khan and Dr Challenor gave expert cardiology evidence on behalf of the claimants and defendants respectively.

73. In many respects, they were in agreement. It was likely that Amanda was suffering from essential hypertension at the time she was seen by Dr Chua and Dr Mehta. Following the prescription of antihypertensives, her blood pressure would

probably have been controlled within four to six weeks. The cause of her stroke was severe uncontrolled hypertension.

74. Two central issues, however, gave rise to a difference of opinion between them.

75. The first was whether Amanda's stroke was caused by an acute event or chronic hypertension. The second was whether or not the immediate prescription of antihypertensives by either Dr Chua or Dr Mehta would have prevented her stroke.

76. With respect to the first issue, Dr Khan conceded that it is only if the claimant were chronically hypertensive in the period leading up to her stroke that her death can be attributed to her not taking hypertensives. In this regard, the claimants rely, in particular, upon the readings taken by Amanda on a home blood pressure monitor and published on Facebook. I reproduce these entries in full for the sake of convenience:

> "19 December 2017
>
> Facebook post "Wat a frickin night that a was never again". Amanda at Alder Hey overnight with Kevin Jr. "My bp yesterday was 189/118 now that stress"
>
> 24 December 2017
>
> Facebook post: my bp reading last night not good. Photo of bp monitor reading 191/119
>
> 3 January 2018
>
> Facebook post. Image of bp reading of 175/116"

77. There is no record of when Amanda started using the home monitor nor where she had got it from. It is, however, agreed that it was a reliable make and the accuracy of the readings is not in dispute.

78. The defendants point out that the first two Facebook entries report blood pressure readings from the previous day and do not indicate that these levels of hypertension had remained similarly elevated at the time the posts were made. The first refers to an overnight hospital stay with Amanda's son, which was clearly very stressful. The second, just before Christmas, depicts the monitor resting on a document from Alder Hey Children's

hospital. There is no evidence as to the circumstances in which the third reading was taken.

79. More generally, they point out that the readings were spread out over a period of about a fortnight and it may well be that Amanda chose to post these particular entries on Facebook for the very reason that they were salient rather than that they were indicative of the general level of elevation of her blood pressure over the relevant timescale.

80. Regard must also be had in this context to earlier blood pressure readings recorded in the medical notes in the period of weeks after Amanda's supply of labetalol is likely to have run out. These were:

1. 7 September	2. 153/90 Hg/mm
3. 9 September	4. 140/82 Hg/mm
5. 10 September	6. 140/82 Hg/mm
7. 15 September	8. 150/90 Hg/mm
9. 18 October	10. 150/105 Hg/mm
11. 19 October	12. 160/100 Hg/mm

None of these readings, although elevated, fall within the range of severe hypertension as categorised in the NICE Guideline.

81. I am satisfied, taking into account the matters relied upon by the defendants, that the three very high readings, even when considered together do not establish on the balance of probabilities that her hypertension was chronically at these levels at the time of her stroke. From this it follows that, even on the evidence of Dr Khan, the failure to prescribe antihypertensive drugs on 6 September 2017 or later was not causative of Amanda's stroke.

82. In the light of these conclusions, I consider that it would be disproportionate for me to go on to consider what my conclusions would have been had I been wrong not only on the issues of breach of duty but also on this first threshold condition of causation. I will not, therefore, proceed to address the doubly hypothetical issue of causation on the assumptions that antihypertensive ought to have been prescribed in September or

October 2017 *and* Amanda was suffering from chronic levels of severe hypertension (as opposed to spikes) in the period leading up to her stroke. Suffice it to say that the issue was by no means straightforward and it would be inappropriate for me to give even a tentative indication of how this issue may have been resolved.

83. Finally, I would add that, whatever conclusions I may otherwise have reached on the issues of liability and quantum, this is not a case in which I would have found any contributory fault on the part of Amanda.

CONCLUSION

84. For the reasons I have given, this claim must fail. It would, however, be wrong of me to conclude this judgment without paying tribute to the courage and dignity shown by the members of Amanda's family during the course of the hearing. I appreciate that they are bound to be bitterly disappointed by the outcome. I can only hope that, despite this setback, they are able to continue together as family providing mutual support, both practical and emotional.

THORP CHRONOLOGY

1. **9 November 2011**
   Amanda undergoes a new patient screen at the Ash Trees Surgery performed by the practice nurse. As part of the screen, her blood pressure is measured and recorded as being 160/90 mmHg.
2. **14 February 2014**
   Amanda is seen by a fifth-year medical student at the practice. She is complaining of chest pain. Her blood pressure is recorded as 170/107 mmHg with it being noted "patient rushed here today".
3. **13 July 2015**
   Amanda is seen at the Surgery by the practice nurse. Her blood pressure is recorded as 160/98 mmHg.
4. **16 September 2015**
   Amanda is seen by one of the GPs at the practice who notes a complaint of left elbow pain. On this occasion her blood pressure is recorded as 154/102 mmHg.
5. **29 September 2015**
   Amanda is seen by one of the GPs at the practice. On examination, her blood pressure is recorded as being 160/100 mmHg and she is referred for 24 hours ambulatory blood pressure monitoring.
6. **10 November 2015**
   It is noted that Amanda did not attend the blood pressure monitoring appointment.
7. **6 September 2016**
   Amanda is seen by a GP at the surgery about her conjunctivitis. It is noted "O/E – blood pressure reading 170/100 mmHg" and "comment": "Note raised BP. TCI [to come in] to see nurse in a week for check."
8. **27 April 2017**
   Amanda, who is now about 21 weeks pregnant, is seen by a midwife at the practice. Her blood pressure is recorded as 180/90 mmHg. She is sent to the DAU [day assessment unit] where a history of essential hypertension is queried. At

1.15pm her blood pressure is recorded as 162/94 mmHg and it is noted "? Essential hypertension declined investigations via GP [no] medication." At 2pm, the blood pressure reading is recorded as161/95 mmHg. Amanda is started on labetalol 100mg tds [there times a day].

9. 28 April 2017

Amanda is seen by a GP at the Surgery where her blood pressure is recorded as 119/83 mmHg. She is referred for consultant led antenatal care.

10. 11 May 2017

Amanda is seen at the surgery where her blood pressure is recorded as 130/80 mmHg.

11. 25 May 2017

Amanda is reviewed in the antenatal clinic. Her blood pressure is recorded as 150/120 mmHg. Her labetalol dosage is increased to 200mg bd [twice a day]. Following the administration of the labetalol, her recorded blood pressure drops over several readings to 111/71 mmHg. She is booked in for weekly blood pressure tests. By this stage, according to the hospital records the diagnosis is "essential hypertension".

12. 2 June 2017

Amanda's blood pressure is recorded as 120/78 mmHg.

13. 8 June 2017,

At a consultant review, Amanda's blood pressure is recorded as 138/72 mmHg.

14. 3 July 2017

When seen by the midwives at home, Amanda's blood pressure is recorded as 130/70 mmHg.

15. 7 July 2017

Amanda's blood pressure is recorded as 128/70 mmHg.

16. 12 July 2017

Amanda's blood pressure is recorded as 140/85 mmHg, and it is noted she had not yet taken the labetalol.

17. 13 July 2017

Amanda’s blood pressure is recorded as 160/90 mmHg. She had not taken her labetalol and was stressed. The midwife noted she was advised to take the medication.

18. 15 July 2017

Amanda’s blood pressure measured by the midwife is recorded as *130/80* mmHg.

19. 17 July 2017

Amanda’s blood pressure measured by the midwife is recorded at 120/60 mmHg.

20. 4 August 2017

Amanda’s blood pressure measured by the community midwife is recorded as 140/80 and it was noted “not taken Labetalol”. *She was advised to take it.*

21. 5 August 2017

Amanda’s blood pressure measured by the community midwife is recorded as 140/84.

22. 6 August 2017

Amanda’s blood pressure measured by the community midwife is recorded as 138/78.

23. ***8 August 2017***

Advised to attend DAU but reluctant. DAU contacted and agree review indicated. Will consider.

24. 22 August 2017

Amanda gives birth to Alex.

25. 25 August 2017

Amanda is discharged on a 2 weeks’ course of labetalol.
It was noted by the discharging doctor in the hospital records:
“Daily BP [with] CMW [community midwife]. See GP 2/52 for meds review as likely essential hypertension.”

The discharge summary received by the Ash Trees Surgery provides:
“CMW to monitor BP daily for 5 days then alternate days until discharge. If BP > 150/100 please refer to obstetrics/GP.
To see GP for medication review 2 weeks postnatal as likely essential hypertension for onward management”

26. 25 August 2017

following receipt of the discharge summary, it is noted in Amanda's GP records:-

"likely Essential Hypertension – needs post natal monitoring."

27. **26 August 2017**

when measured by the community midwives, Amanda's blood pressure is 140/72 mmHg.

28. **28 August 2017**

when measured by the community midwives, Amanda's blood pressure is 150/78 mmHg.

29. **30 August 2017**

when measured by the community midwives, Amanda's blood pressure is 140/90 mmHg.

30. **31 August 2017**

when measured by the community midwives, Amanda's blood pressure is 150/80 mmHg.

31. **1 September 2017**

when measured by the community midwives, Amanda's blood pressure is 144/88 mmHg.

32. **3 September 2017**

when measured by the community midwives, Amanda's blood pressure is 150/90 mmHg. It is noted she was "advised to get GP appt to review meds as per plan made on 25/8/17".

33. **4 September 2017**

when measured by the community midwives, Amanda's blood pressure is 122/85 mmHg and 149/86 mmHg.

34. **6 September 2017**

Amanda attends upon Dr Chua who notes:

"Problem Blood pressure monitoring (review)

History Blood pressure was elevated while patient was pregnant

Difficult delivery about 2 weeks ago (forceps delivery), had post-partum haemorrhage after – 1500mls

Has been treated with 200mg Labetelol BD in hospital, unable to find any blood pressure readings from hospital to compare to

Asymptomatic for high blood pressure, no other physical symptoms of note other than bilateral leg swelling up to mid calves
Smokes approx. 5 pack years
Dad had heart attack when he was very young <50 years old, can't remember exact age
Rarely drinks alcohol
Examination O/E – blood pressure reading 150/97 mmHg O/E blood pressure reading 144/92 mmHg
Previous blood pressure in April 2017 showed to be normal 119/83
HS I+II+0
Pulse 88, regular, good volume
Urine dip negative for protein, positive erythrocytes (noted she has kidney stone that is going to be removed in – 4 weeks' time)
Comment Referral for ambulatory blood pressure monitoring in a few weeks' time as it could be pregnancy induced hypertension
If still remains high, treat as essential hypertension
Review bloods on indigo from hospital
Medication Paracetamol…"

35. **6 September 2017**
referral for blood pressure monitoring.

36. **7 September 2017**
referral for blood pressure monitoring. When measured by the community midwife, Amanda's blood pressure is recorded as 155/90 mmHg. The community midwife noted "Saw GP on 5.9.17 [sic] who did BP x 2 & spoke of needing to change hypertensives & will refer to hospital ? who…. Checked with GP surgery – plan to refer to hospital for ambulatory BP monitoring in a few weeks if still high. Phoned surgery and asked for GP appt next week".

37. **9 September 2017**
when measured by the community midwife, Amanda's blood pressure is noted to be 140/82.

38. **15 September 2017**

when measured by the community midwife, Amanda's blood pressure is 150/90 mmHg. The community midwife notes inter alia "Missed GP review mane for BP and review of Rt groin/upper thigh pain – will rearrange. …. GP phoned and will ring Mandy back."
The computerised GP records contain the following entry:-
"had telephone appointment booked … re BP CNR 17.25hrs VM left"

39. 18 October 2017

Amanda attends the Surgery and is seen by Mehta who records:
"Problem Maternal P/N 6 week exam
History 8w1d post partum – 36w6d forceps delivery. Had PPH
Nil periods since
Partner 60 yrs age
Cigarette smoker 5/day alcohol consumption 0 U/week
Chat re contraceptive options – keen for mirena. PIL given – will book with GP for same
Missed 24 hr BP appt -has relisted for same with RLI
Depression screening using questions – normal
Mentions poor diet – on fortisips and managing well continue same but informed NOT long term option and may involve dietician next if req regularly
Examination O/E – blood pressure reading 150/105 mmHg O/E weight 97.5kg
Comment Chat rpt bloods but mentions difficult to get samples
History Smoking cessation advice"
This is the last entry concerning Amanda's blood pressure.

40. 19 October 2017

Amanda attends hospital for endoscopy. Procedure not tolerated and withdrew consent. Pt quite distressed. Repeat procedure booked with sedation. BP 104/53 during the procedure and 160/100 prior to discharge. It is noted under "further relevant information": "pt aware of chronic high bp, was high on admission, she is seeing her GP for treatment

regarding this currently. Pt sleepy in recovery, has new baby and disabled son at home and reports to be very tired, I feel she is back to her normal baseline today prior to discharge."

41. **19 December 2017**
Facebook post "Wat a frickin night that a was never again". Amanda at Alder Hey overnight with Kevin Jr. "My bp yesterday was 189/118 now that stress"

42. **24 December 2017**
Facebook post: my bp reading last night not good. Photo of bp monitor reading 191/119

43. **3 January 2018**
Facebook post. Image of bp reading of 175/116

44. **4 January 2018**
Amanda suffers a large right intra-cerebral and subarachnoid haemorrhage. Four readings of blood pressure were taken before her death: 192/128 mmHg at 14.30 hours; 198/140 mmHg (untimed); and then following Ms Thorp's decline, 122/84 mmHg (untimed) and 85/54 mmHg at 18.55 hours.