OUTER HOUSE, COURT OF SESSION

[2021] CSOH 15

A288/18

OPINION OF LADY WISE

In the cause

FIONA SUSAN MACPHIE or WIDDOWSON AND OTHERS

Pursuers

against

(FIRST) LIBERTY INSURANCE LIMITED, (SECOND) NHS GRAMPIAN AND (THIRD) NHS HIGHLAND

Defenders

Pursuer: Sutherland QC, Waugh; Balfour + Manson LLP
First Defender: Stuart QC, Nicholson; Kennedys Scotland
Second Defender: Stephenson QC, Watts; Central Legal Office
Third Defender: P Reid; Central Legal Office

4 February 2021

[1] The first pursuer is the widow and executrix of the late John (known as Ian) Timothy Place Widdowson ("Mr Widdowson"). The other pursuers are Mr Widdowson's sons (one of whom sues also as legal guardian of his own children), brother and sister respectively. On 1 January 2016 in the circumstances described below, Mr Widdowson, then aged 59 was seriously injured in a road traffic accident. He subsequently died of his injuries on 11 January 2016. The first defenders are the motor insurers of the late Daniel Thomson Gordon ("Mr Gordon") who died at the locus and whose negligent driving had caused the

accident and the consequential injuries to Mr Widdowson. The second defenders, NHS Grampian, are a health board with responsibility for Dr Gray's Hospital in Elgin, and for the actions and omissions of staff employed at that hospital who were responsible for Mr Widdowson's care shortly after the road traffic accident. The third defenders, NHS Highland are a health board with responsibility for Raigmore Hospital in Inverness and for the actions and omissions of staff employed at that hospital who were responsible for Mr Widdowson's care from 3 January 2016. All three defenders admit liability (at least to some extent) and summary decree was granted against all three on 24 October 2020. The quantification of damages was agreed thereafter and so the contentious issue about which I heard proof and submissions over three days was the apportionment of liability between the three defenders. Accordingly, counsel for the pursuers played no part in the eliciting of oral evidence and made only a very brief submission thereafter. There was a large measure of agreement in relation to the factual background. Evidence was led only from expert witnesses.

Undisputed facts

[2] The following summary of the undisputed facts is taken primarily from (i) the Police Scotland Road Policing Collision Investigation Report ("the Police Report") (number 6/47 of process) the terms of which were agreed by all parties, (ii) the medical records of Dr Gray's Hospital, Elgin and Raigmore Hospital, Inverness and (iii) certain agreed expert reports (of John O'Neill, consultant surgeon number 6/1 of process and Mr Simon Paterson- Brown number 6/3 of process) together with (iv) the undisputed sections of Mr Neil Nichol's first report (number 7/17 of process). The Police Report referred to was prepared by two experienced police officers trained in attending and investigating serious road traffic

collisions and was verified by a third officer. It records that at about 1200 hours on Friday 1 January 2016 a grey Volkswagen Polo car was being driven westwards on the B9089 near Kinloss, Moray by Mr Gordon who was alone in his vehicle. At the same time a red Volkswagen Polo driven by the deceased's mother-in law (Elizabeth McPhee) with Mr Widdowson as a front seat passenger was travelling eastwards on the same road. The grey Volkswagen Polo, when negotiating a left hand bend, crossed the road from the west to the east bound lane into the path of the red Volkswagen Polo causing it to collide with the front nearside of the grey VW Polo and both vehicles to rotate. The red VW Polo came to rest facing north, remaining partially on the carriageway, with the front of the vehicle near to the roof area of the grey VW Polo. The red VW Polo thereafter burst into flames. As a result of the collision the deceased Mr Gordon was trapped within his motor car but the occupants of the red VW Polo, including Mr Widdowson, were extracted from their vehicle by eye witnesses before it combusted. Mr Gordon was pronounced dead at the locus and Mr Widdowson and his driver were conveyed separately to hospital for treatment for their injuries.

[3] At the time of the collision it was daylight and overcast with good visibility. The road surface was damp and free from contamination. The deceased Mr Gordon was found by the police within his motor vehicle within the driver's seat, lying on his back, with his feet trapped beneath the peddles. His seatbelt was found to be stowed with no evidence of it having been worn at the time of the collision. No pre-collision defects were found on either of the vehicles which would have contributed to the collision. The locus of the accident consisted of a long straight section, the bend directly involved in the accident and then a further long straight section of road. The left hand bend negotiated by Mr Gordon where he lost control was not a sharp bend, with the radius being calculated as a little over 189 metres.

The calculated maximum speed at which the bend could be negotiated safely was 35.83 metres per second or 80 miles per hour (mph), plus or minus 10%. Accordingly, a vehicle should have been be able to safely negotiate the bend involved in the accident at an upper limit of between 72 and 88 mph. Mr Gordon did not safely negotiate the bend and it is therefore likely that he was travelling at a speed well in excess of the speed limit and probably in excess of 80 mph.

[4] Elizabeth McPhee, who was driving the red VW Polo stated that she had seen a car coming round the bend ahead towards them. She told police that "the other car appeared to be travelling quickly. As the car came out of the bend I saw it begin to weave and cross over onto my side of the road when it was only three or four car lengths away from my car". Mr Widdowson told the police that the deceased Mr Gordon "…was obviously out of control and moving from side to side". Elizabeth McPhee was driving normally and there was no basis to infer that she could have avoided the collision. The unchallenged conclusion of the collision investigators was that the accident was caused by loss of control by Mr Gordon of his motor vehicle, which he was driving at excessive speed for the road and conditions. Toxicology results had shown a very minimal amount of diazepam within the deceased's blood but this was unlikely to have had an effect on his driving. Mr Gordon's driving was the sole cause of the accident.

[5] Mr Widdowson sustained injuries in the accident and was taken by ambulance to Dr Gray's Hospital in Elgin while Mrs McPhee was conveyed to Aberdeen Royal Infirmary. The ambulance crew noted that he was at the side of the road on arrival and suffering from left lower quadrant pain. He was removed from the verge using an orthopaedic stretcher. A secondary survey showed a graze to his arm and leg and abdominal pain. He was fully conscious (15 on the Glasgow Coma Scale) throughout. His pulse rate was 66 and his

respiratory rate varied from 15-22, his pain score was measured at 6/10 on two occasions. The ambulance crew arrived at the hospital at 1338 hours and on admission the receiving nurse inserted an intravenous line, sent off blood tests and started intravenous fluids. The initial nursing note recorded that the patient had pain in his left pelvis and abdomen and that he was hypotensive and cold. Mr Widdowson was seen by Dr S Dar ("Dr Dar") at Dr Gray's Hospital. Dr Dar noted the history of a road traffic collision where Mr Widdowson had been in the car with his mother-in-law driving. He then noted on examination "…no concerns. Patient stated pain in left hip area. C. spine - no neck pain, no c spine tenderness. Full pain free movements". Observations on breathing, chest sounds, breath sounds and circulation were all noted as being normal, although the patient's blood pressure was 90/60. On examination of the pelvis Dr Dar detected nothing abnormal (NAD). He found the abdomen to be soft with no concerns about intraperitoneal bleeding. A minor injury to the left lower leg was noted, together with some seatbelt tattooing to the lower abdomen.

[6] A FAST (Focused Assessment for Stenography in Trauma) scan was performed at 1345 hours and reported by Dr Dar as showing "no evidence of pneumothorax or intraperitoneal bleeding". X-rays for the chest and pelvis were ordered and pain and bruising in the left lower abdomen and pelvis was then noted. At 1500 hours Dr Dar noted that the patient felt completely well and was asymptomatic. Mr Widdowson informed Dr Dar that he suffered from sleep apnoea and required a PP mask at home. Dr Dar queried the cause of the decreased blood pressure which was still only 93/55. He instructed a repeat FAST scan. That FAST scan was negative although the patient remained hypotensive and intravenous paracetamol was commenced for his pain. Various other observations were made by the nursing staff. At 1800 hours on 1 January Dr Dar noted

> "patient remains well. Family concerned about how he looks and confusion. Patient shows no signs of confusion… No chest pain. No abdo. pain. Abdomen soft non tender. BP noted. BP measured at calf 1100/60… No clinical evidence of haemorrhage. Continue to observe. Plan IV fluid. Keep overnight. CT abdo not indicated."

Later that evening on 2030 hours Dr Dar noted that the patient "remains well. No new complaints. Last BP readings OK. Plan - observe overnight. Review in the morning". On 2 January 2016 at 10.00am Dr Dar noted that the patient had been well through the night, that his blood pressure remained stable and his other observations were "ok". A plan was made to discharge Mr Widdowson home to his family and that was done on 2 January 2016.

[7] On 3 January 2016 at 2019 hours a call was made to NHS 24 from Mr Widdowson's home reporting that his condition was worsening, that he was vomiting, had a fever and was very sleepy/drowsy. A 999 call was made and an ambulance attended at Mr Widdowson's home and transferred him to Raigmore Hospital in Inverness. The ambulance report included notes that the patient's blood pressure lying down was 110/65 and sitting up was 79/47. They were unable to cannulate as the patient was "very shut down". His abdomen was tender and distended. On arrival at Raigmore Hospital at about 2210 hours Mr Widdowson was seen by the duty Emergency Department doctor. Blood samples were taken, intravenous, fluids commenced and a chest x-ray was arranged. That x-ray was reported as showing "right pulmonary contusions". The doctor then arranged for a CT scan of the chest, abdomen and pelvis and referred Mr Widdowson to the surgical team. The blood results showed acute renal failure and an elevated lactate (a form of lactic acid). The haemoglobin had dropped to 109. The surgical registrar at Raigmore had noted the relevant history including that in the RTA Mr Widdowson had been a front seat passenger, that the driver of the other vehicle had died at the scene and that airbags had been deployed. The examination of the patient showed bruising of the left side of the

abdomen extending down into the groin with tenderness of the left and right upper quadrants.

[8] The report of the CT scan performed at Raigmore illustrated a number of abnormalities including rib fractures, an undisplaced fracture of the sternum, biliary gas in the left lobe of the liver, a defect in the abdominal wall with herniation (abnormal protrusion) of the descending colon, gas and fluid filled diluted loops of the small bowel with a transition point anteriorly in the pelvis to the left of the midline and patchy basal and lingular consolidation consistent with pulmonary contusion (bruising of the lung). There was also a note in the addendum of a small volume of high density fluid in the pelvis and left abdomen consistent with haemoperitoneum (blood in the peritoneal cavity). This finding suggested mesenteric injury (the mesentery being an organ that attaches the intestines to the abdominal wall) with resultant bowel ischaemia and obstruction.

[9] The CT scan findings were made by a Dr Brodie who reported them to the consultant, Mr M Walker, by telephone. A decision to employ a course of conservative management was taken. Mr Widdowson's conditions deteriorated further and on 7 January 2016 a decision was taken to perform surgery. A laparotomy was performed the following day. During the procedure a mesenteric tear was identified with ischemic perforation of the jejunum (one of the sections of the small intestine). The non-viable bowel was resected and Mr Widdowson was admitted to the ITU at Raigmore for close monitoring. On 9 January 2016 he pulled out his naso gastric tube. His temperature was raised and his white cell count elevated. On 11 January at 0045 hours the patient had a large bilious vomit which caused him to aspirate and then suffer a cardiac arrest. He died later that day. A post mortem was carried out on 13 January 2016, the report of which (number 6/46 of process) concluded that Mr Widdowson's death was a direct consequence of the abdominal trauma

sustained in the motor vehicle collision. Dr Dar was referred to the General Medical Council in relation to his treatment of Mr Widdowson.

Evidence led at proof

[10] In the first defender's case, evidence was led from Mr Neil MacPherson Nichol, consultant in emergency medicine at Ninewells Hospital in Dundee since 1999. Mr Nichol is a member of both the Royal College of General Practitioners and the Royal College of Surgeons although has primarily worked as an emergency medicine physician. He had prepared numerous reports on medico-legal matters and has given evidence as an expert witness previously. He was asked to give an opinion in this case in relation to the actings and omissions of first, Dr Dar and of Dr Gray's Hospital and secondly, the surgical team at Raigmore Hospital. He spoke to his first report (number 7/17 of process) and was taken to some of the undisputed background to Mr Widdowson's injury and death. Mr Nichol confirmed that eliciting a history from a patient forms the foundation stone of patient assessment, particularly in the field of emergency medicine. He had paid particular attention to the history as recorded by Dr Dar, a review he had made himself of the nursing charts, a narration of the events subsequent to Mr Widdowson's hospital admission, the post mortem report and the radiology findings. He considered that it was important to look at those findings and consider how they might reasonably have been interpreted had a CT scan been carried out on 1 January 2016. He felt able to assess what a doctor acting with ordinary skill and care would have seen at that time. In reaching his overall opinion that Dr Dar had not acted with ordinary skill and care in the management of Mr Widdowson at Dr Gray's Hospital, Mr Nichol relied on a number of factors. He considered that Dr Dar had failed to establish key points in the relevant history that would have assisted with patient

management, including the severity of the head-on collision which had caused a fatality in the driver of the other vehicle. A high-speed impact of that nature would indicate a very high level of energy transfer such that a clinician acting with ordinary skill and care would have had a low threshold for requesting a CT scan of the chest, abdomen and pelvis. Further, Dr Dar had noted seatbelt tattooing over the lower abdomen which was a physical sign of a significant deceleration force, associated with intra-abdominal injury. The patient had been given intravenous paracetamol for pain at 15.00 and then stronger and additional painkillers later in the evening of 1 January. While Dr Dar had said that Mr Widdowson had felt completely well that coincided with a time where his pain was being relieved by intravenous medication. Taking all the information available to him at the time, if acting with ordinary skill and care Dr Dar would have arranged an urgent CT scan. Dr Gray's Hospital had a CT scanner which was available at any time of the day or night, so albeit that 1 January was a public holiday, additional staff could have been mobilised to perform the CT scan.

[11] Mr Nichol was critical of Dr Dar having undertaken a FAST scan on two occasions and relying on the findings to exclude any intra-abdominal bleeding. A FAST scan uses ultrasound to check for blood in the abdominal cavity. It was popular from about 2004 in emergency medicine and its use is a core competency that practitioners in emergency medicine require to attain. Doctors in that field require to perform a sufficient number of FAST scans to ensure they are interpreting them properly. By using the scan machine to look for blood in the abdominal cavity, Dr Dar clearly understood the possibility that the patient was bleeding. His error was in using the FAST scan to exclude that. While the purpose of a FAST scan was to document the presence of fluid, the absence of free fluid does not exclude serious intra-abdominal injuries. In as many as 50% of cases scanning of that

sort will not accurately identify blood in the abdomen. In any event, FAST is not used to identify any injury to organs. Computed Tomography (CT) remained the gold standard approved by the Royal College of Emergency Medicine to identify abdominal injuries. All consultants in emergency medicine would be familiar with CT scanning and know that a FAST scan cannot rule out abdominal bleeding. All doctors are required to be trained in FAST scans before being able to carry them out and Mr Nichol had, subsequent to his first report, been provided with documents confirming Dr Dar's level of experience.

[12] Mr Nichol was also critical of Dr Dar's interpretation of the x-rays taken. He had failed to identify a broken rib. While there were three other fractured ribs these were subtle and might be missed. A significantly displaced fracture of one of the upper ribs indicates substantial force and again this should have prompted Dr Dar to instruct a CT scan. Further, Dr Dar appeared to have ignored abnormal blood results including the elevated lactate at 3.7 and an elevated amylase at 203. These were significant findings and Dr Dar appeared to have circled them in the record but had not taken any action. A normal lactate reading was 1.4 and this would confirm how well the patient's circulation was working. If it is elevated, that is indicative of either a shock state (such as blood volume loss) or confirms that a part of the body has had its blood supply disrupted. A reading of 3.7 would certainly indicate a circulatory problem. So far as the amylase was concerned a reading of 203 was way in excess of a normal result of 90. On any view it indicated a definite injury and on its own mandated the instruction of a CT scan. It was also relevant that from 13.25 on 1 January 2016 until his discharge from hospital the following day, Mr Widdowson had received a total of 3.5 litres of intravenous fluids. This was not a trivial amount of fluid and if there was no clinical need for it then it should not have been given because it could be masking internal bleeding. When Mr Widdowson tried to get up on the morning of 2 January he had

a "dizzy" turn which was indicative of low blood volume. Accordingly, after inputting a few litres of fluid the patient had a low blood volume which could only be due to abnormal fluid loss. Pulling the various factors together, they all supported that a CT scan ought to have been performed on the afternoon of 1 January 2016. Had that been done, it would have shown the bone injuries, pulmonary contusion and the traumatic abdominal wall hernia. It would probably also have shown up the small bowel abnormality at that early stage although it was difficult to conclude confidently whether or not that would have been seen.

[13] When Mr Nichol prepared his first report he had been unaware that there was a surgical team at Dr Gray's but regardless of that, normal and usual practice in a situation of this sort would require early discussion with a surgical team. If that had been done then Mr Nichol was in no doubt that the Dr Gray's surgical team would have organised a CT scan. However, the results of that scan, had it been carried out, would illustrate that the situation was beyond the capacity of the Dr Gray's team and a transfer to a major trauma centre would have occurred, almost certainly to Aberdeen Royal Infirmary.

[14] Mr Nichol recognised that Dr Gray's Hospital in Elgin would not see a large number of patients, far less trauma patients. However, as the hospital has an emergency department, general standards of care required to be met. If Mr Widdowson had been appropriately managed he would have received a CT scan regardless of Dr Gray's being a minor unit and not a major hospital. Mr Nichol also considered that, despite Mr Widdowson being admitted to the CDU with advice to keep a close eye on him there was a gap of over 9 hours with no nursing observations recorded.

[15] Mr Nichol spoke to his second report which took the form of a letter to the agents for the first defenders (number 7/18 of process). Prior to writing that letter, Mr Nichol had seen the report of Dr Dilip Patel who had confirmed that the accuracy of a FAST scan depended

on the scale and experience of the operator. Mr Nichol noted that Dr Dar had apparently been advised not to perform such scans as he had not maintained the necessary level of competence for relevant accreditation in that. To have carried out and relied on the FAST scans in those circumstances when not competent to do them was a major deficit in Dr Dar's care of the patient. Mr Nichol was aware that all the other experts in the case agreed that a CT scan should have been performed at Dr Gray's Hospital. His conclusion remained that the results of the scan would have mandated a transfer to Aberdeen Royal Infirmary on 1 January 2016. The major trauma centres in Scotland were Aberdeen, Dundee, Edinburgh and Glasgow. Aberdeen was the closest major trauma centre to Dr Gray's and had greater experience and expertise in the management of trauma cases than other hospitals in the area.

[16] Mr Nichol had prepared a third report after he had seen the report of Dr Donald in relation to what had occurred at Raigmore Hospital. Mr Nichol had then been asked to make an assessment of how far outside normal practice Dr Dar had been acting. He disagreed strongly with the comments in a report by Dr M Donald (number 14/1 of process) that Dr Dar had conducted a thorough clinical examination on Mr Widdowson when he arrived at Dr Gray's Hospital. (Dr Donald did not give oral evidence). Mr Nichol considered that had there been such a thorough examination Dr Dar would have noted both reports that Mr Widdowson had been in severe pain in the ambulance and the abnormal physiology indicative of abdominal injury. The combination of factors that had been ignored by Dr Dar had resulted in very poor management of the patient and each failure should have led to a different decision or investigation.

[17] Counsel for the second defender objected to the parts of Mr Nichol's evidence where he was asked to draw a distinction between a single act or omission and several acts or omissions in concluding there was a deviation from normal and usual practice. Counsel for

the third defender associated himself with that objection and what follows was heard under reservation of competency and relevancy. Mr Nichol stated that in his view Dr Dar made a very significant departure from normal and usual practice "in multiple elements". He ignored significant abnormalities, failed to identify significant injuries, failed to note concerns of nurses and other professionals and undertook an inappropriate test (the FAST scan) and repeated it. He had clearly been advised not to use that technique in that setting. Each of these acts or omissions was outwith normal and usual practice and in arriving at the ultimate position of not performing a CT scan, Dr Dar had ignored a number of factors.

[18] Under cross-examination by Mr Stephenson, Mr Nichol confirmed that he had retired from his post as a consultant in emergency medicine in April 2019. His special interest had been, amongst other things, in the treatment of trauma. Ninewells is a major Scottish teaching hospital with a specialist unit. Mr Nichol agreed that Dr Gray's Hospital, in contrast, was not a teaching hospital but was a very small district general hospital. The witness agreed also that different health boards have different methods and means of working and that he had not worked in the Grampian Health Board area. He had not visited Dr Gray's Hospital in the last 10-15 years. He did not know what the arrangements were in that hospital in 2016 or the workloads of the specific unit in which Dr Dar worked. He would expect the number of trauma cases a doctor would see at Dr Gray's Hospital in any given year to be small. Unlike a hospital like Ninewells where patients admitted following trauma would likely remain there for treatment, at a hospital like Dr Gray's there was a much greater chance that they would be transferred onto another hospital for that treatment. It was fair to infer that the doctors at Dr Gray's would have less opportunity to develop skills in trauma management, that they would see fewer patients and that they would treat a much smaller proportion of them. Since 2016, the delivery of trauma services

in Scotland has been reorganised following a recognition that outcomes were better if care was focused in the larger centres in the major cities. As a result, from the point of a 999 call, an assessment is made and where there are likely to be serious injuries a specific trauma team response will be initiated very early on so that patients can be directed to the four main trauma centres. That system was not yet in place in January 2016 when Mr Widdowson had his accident but there had been a growing recognition that doctors in small hospitals could not be as experienced or regard themselves as trauma experts.

[19] Mr Nichol agreed that he had assumed that the paramedics who arrived at Dr Gray's Hospital had been at the scene of the accident and would have been able to report what had happened in general terms to the senior nurse or doctor receiving the patient. There would then be an "E-Pacer" report which would give more detailed information about the patient's condition on transfer. The witness was shown the Grampian Health Board investigation report (number 7/23 of process) where findings were made (and agreed as accurate in these proceedings) that the patient had arrived at Dr Gray's at 13.14 and had been assessed by Dr Dar and a colleague at 13.30. The report recorded that the doctors were not aware that the patient had suffered trauma until the patient confirmed that. It stated also that the road traffic report was not immediately available to the medical team. Mr Nichol thought that he had noted from the Police Report that the collision had taken place on an A-class road and agreed that could be an error although the speed limit on both roads would be the same. His note about a head-on collision had also been taken from the Police Report and so not from the records of Dr Gray's Hospital. There was, however, a note in the records that by 13:54 it was known that there had been a head-on collision. Mr Nicol had made an assumption that the impact had been at a speed of 120 mph based on both vehicles travelling at the speed limit of 60 mph. It was a notional calculation only.

[20] The witness was taken through the ambulance crew's E Pacer report which made no mention of the accident involving a fatality but did describe a multiple response to the accident indicative of a major incident. Mr Nicol accepted that there was no reference in the E Pacer report to the driver of Mr Widdowson's vehicle being taken by ambulance to Aberdeen Royal Infirmary, having sustained multiple injuries. He considered that it was the responsibility of the receiving doctor to make appropriate enquiries of the ambulance crew about such matters. He accepted that such handovers would sometimes take place with a nurse and not the responsible physician. He doubted the accuracy of the E Pacer report where it stated that the crew had been at the scene for only 2 minutes between 12.56 and 12.58 on 1 January 2016, despite those times being within the agreed investigation report.

[21] The records of Mr Widdowson's complaints of pain or lack of pain were put to the witness who concluded that, notwithstanding Dr Dar's notes it was more likely than not that Mr Widdowson had significant abdominal and chest pain. A factor in his conclusion was that pain medication had been given by the time Mr Widdowson stopped complaining of pain. He accepted that a clinician relies to some extent on subjective reports from the patient although there could also be physical signs of pain. Mr Nichol accepted Dr Dar's notes that the first assessment of the patient had recorded that there was nothing abnormal diagnosed and that the abdomen was soft indicating an absence of pain as the patient will guard or tense their muscles when touched if they are in pain. Under references to Dr Dar's subsequent notes taken at 1500 and 1800 Mr Nichol accepted that the report from the patient appeared to be of chest pain before an X-Ray was taken which showed no obvious rib fracture and subsequently no chest pain, no abdominal pain and a soft and tender abdomen on examination. The area of the abdomen examined would have included that where there was later found to be an abdominal hernia at Raigmore. In relation to the blood test results

Mr Nichol had assumed that Dr Dar had circled the unusual results as these were his notes. At 1810 on 1 January Dr Dar had recorded normal chest and breath sounds in the patient and noted that he remained well with no new complaints. The entries for 2 January illustrated that apart from a dizzy/sweaty period in the morning the patient had no complaints and was well when the decision to discharge was taken at 1230. If one relied on Dr Dar's records there was no indication from mid-afternoon on 1 January that the patient was complaining of pain.

[22] Mr Nichol had not referred in his report to the "news score chart", a form normally filled in by nursing staff in relation to pain scores. The chart at Dr Gray's in relation to Mr Widdowson had a scale of 0-4 for pain scores. At 1510 on 1 January the patient had reported a pain score of 2-3 out of a maximum of 4, reducing to 1 at 1630 and then at 0 for all subsequent reports until 9.00pm when it was 1. On the morning of 2 January the pain was recorded at 2 at 6.30am and was subsequently 0 or 1 until discharge. Again, Mr Nichol considered the absence of pain was probably attributable to the administration of painkillers. He accepted that the chart would have been taken into account when those looking after Mr Widdowson were considering whether he was complaining of significant pain.

[23] In relation to FAST scans, the witness confirmed that these had been used at Ninewells although he had not been trained in them and had not used them. He was aware from trainee reports that FAST scans were part of the overall training for junior emergency doctors. Ninewells had taken a decision as a unit that FAST scans would not be used as a diagnostic tool of choice from about 2004. Other departments still use FAST scans in trauma cases. An ultrasound scan of that type was invariably followed by a CT scan and so added nothing to trauma management. The witness accepted that there was a difference of opinion

between those hospitals who continued to use FAST scans in trauma assessment and those such as Ninewells who did not. Those who used FAST scanning would have to appreciate its limitations but would still use it as the machine can be brought to the patient's bedside and was an easy and convenient first step. However, in a good trauma unit there would be no real delay in calling on a radiologist to perform a CT scan. Mr Nichol accepted that in 2016 FAST scans continued to be in use depending on the opinion of the treating physician. There was a respectable body of opinion that they should continue to be used now.

[24] On what a CT scan would have shown had one been carried out on 1 January 2016, Mr Nichol accepted that it was difficult to say whether the small bowel abnormality would have been able to be seen on a CT scan on 1 January. A specialist radiologist or surgeon might be able to comment further. The tear in the mesentery ultimately found could have developed over time in the sense that a perforation may take some days to appear but that was for expert radiologist comment. The correct surgical management would have been to transfer the patient to a major trauma centre following a CT scan. In re-examination Mr Nichol confirmed that he did not consider Dr Dar's statement about the patient not being in pain to be consistent with some of the other evidence, including that a nurse had recorded that he was in significant pain before a range of painkillers was administered. On the use of FAST scans Mr Nichol acknowledged that Tayside was an outlier in having decided not to use these in trauma assessment and he offered that Tayside had been open to criticism for not doing so. His comments in this case were restricted to how Dr Dar had used the FAST scan as a diagnostic tool.

[25] Professor Edwin Van Beek, a professor of radiology at Edinburgh University and an eminent practitioner in his field, was also called in the first defender's case. Professor Van Beek had prepared two reports numbers 7/19 and 7/20 of process, the latter

taking the form of a letter to the first defender's agent. In his first report Professor Van Beek had been asked whether a CT scan ought to have been undertaken at Dr Gray's hospital and he concluded that it should have been. His evidence to the court focussed primarily on what a full body CT scan was likely to have shown had it been undertaken on 1 January 2016. He had concluded that it was highly likely that all the findings detected on the CT scan images at Raigmore on 3 January would have been similarly detected had a scan been performed immediately after the accident on 1 January. The witness was asked about the use of FAST scans in looking for major damage to the abdomen. He explained that these ultrasound scans had been developed many years ago, initially for pregnancies, but were increasingly used in other areas including emergency medicine. Their use requires additional training but the basics can be taught in a couple of days to a week. Professor Van Beek considered that the benefit of using FAST scans in trauma patients was that they assisted as a quick look when building up an overall clinical picture. For example, if one sees blood in the abdomen during such an ultrasound that might confirm a suspicion of other injuries but the use of FAST scans were limited as part of the overall clinical picture. The main use in trauma patients was to detect fluid or blood in the abdomen.

[26] In relation to his opinion that all of the findings on the CT scan later performed at Raigmore would have been detected on 1 January, the witness had been made aware since issuing his report that another expert, Dr Dilip Patel, had offered a slightly different opinion. Professor Van Beek was clear that most of the injuries would have shown up on 1 January. The only issue was whether one would have noticed the poor enhancement of small bowel loops compatible with mesenteric vascular injury with small bowel ischaemia on a first scan. The report of Dr Dilip Patel (number 6/2 of process) was put to Professor Van Beek and in particular a statement (at paragraph 8.4) that it was "…highly unlikely that the abnormal

small bowel and portal venous gas would have been present on the scan…" on 1 January. Professor Van Beek accepted that the injury to the small bowel would have developed over time and would probably not have been seen on an initial scan. However, he considered that the abnormal enhancement of the small bowel, the vascular problem, could have been seen although it would have become more obvious after 3 to 4 days. Dr Patel had not mentioned this and Professor Van Beek did not consider that they were in real disagreement. He explained that if the blood vessels that supply the small bowel are interrupted one will see less brightness on the bowel wall on a CT scan. This is a sign of vascular injury and if one waits 3 to 4 days you then see the gas, but before that the enhancement can be detected. Only once the bowel is actually dying off do you get the gas. Professor Van Beek could not be 100% sure that the abnormal enhancement of the small bowel would have been visible on 1 January but he had experience of detecting such an abnormality. On balance he expected that he would have been able to see abnormal enhancement on the small bowel following a CT scan on Mr Widdowson on 1 January, especially given the other injuries present and signs such as the amalyse readings. There was available evidence that a lot more had gone wrong than a little free fluid.

[27] Usual practice in such a situation would be that there would be an immediate interpretation by a radiologist after the scan had been carried out and then a final report within an hour. A system of double reporting took place so that another radiologist would have a second look and report any additional findings. It was not uncommon to miss some findings the first time, due to the stress of such situations. In a large trauma hospital second reporting was normal practice.

[28] The witness explained that the bowel has multiple vessels running in a tree like structure. In blunt trauma one can get a tear in the mesentery which can then run right

through the blood vessels. On a CT scan the tear might not be visible but blood loss into the abdomen will show up and will contrast with the blood going out of the abdomen. Blood in the abdomen is a red flag sign in trauma cases and a patient would be taken to theatre regardless of what else is visible. While in Professor Van Beek's view one would have expected an exploratory laparotomy on the CT findings he had confirmed would have showed up on 1 January that was ultimately a decision for a surgeon. He was aware that there may be reasons why a surgeon would decide to wait before performing surgery depending on the condition of the patient and he would defer to their view on that.

[29] Under reference to his second report, the witness agreed that the lack of a CT scan had significantly contributed to a major delay in making the correct diagnosis of Mr Widdowson's multiple internal injuries. He reiterated that the limitation of a FAST scan as a diagnostic tool was that the patient's body habitus can result in things being missed and that it was helpful really only for major findings like lots of fluid and perhaps renal injury. It could be used to rule in or identify major findings but could not be used to rule out life threatening injuries. There was clear guidance from the Royal College of Radiologists not to hold up a CT scan by carrying out FAST scans.

[30] Under cross-examination by Mr Stephenson, Professor Van Beek agreed that he had considerable interest and expertise in vascular imaging and cardio imaging. He described himself as a clinical radiologist with academic interests including the science of imaging. His department was a renowned centre of excellence but it was next door to Edinburgh Royal Infirmary and he still performed more routine CT imaging. His awareness of the facilities at Dr Gray's was based on his having looked it up when he was preparing his report and saw that there was a CT scanner there. He had done so on 14 January 2019 and had assumed that the same facilities had been available in 2016 there. He could not say

whether contrast imaging would be routine in a small district general hospital like Dr Gray's in 2016. In Lothian it had certainly been available from 2010 and possibly earlier. The witness confirmed his view that while the notional CT scan that should have been carried out on 1 January probably would not have shown an ischemic bowel he thought it would have shown the poorer enhancement as already described. That would have assisted in a possible diagnosis of a developing tear. Under reference to the first CT report from Raigmore of 3 January 2016 Professor Van Beek agreed that the initial findings had no report of small bowel enhancement or ischemia and so even on 3 January this was not apparent to the first radiologist. However, two people can look and see different things and that findings were not mentioned in the initial report from Raigmore but were seen when reviewed with the surgeon. He acknowledged that it was difficult to say why it would have been picked up on the CT scan on 1 January other than that with double reporting there was particular focus on looking for abnormalities in the area where the trauma was received. It was now clear that the enhancement was there to be seen on 3 January and to that extent the first radiologist at Raigmore could be criticised. However, in the "heat of the moment" it was not uncommon for these things to be missed. The 3 January scan did not show small bowel enhancement as such because the visible gas illustrated that it was now beyond the initial moment of injury and rotting was starting to take place.

[31] Under cross-examination by Mr Reid the witness accepted that the mesenteric tear was an injury attributable to the road traffic accident and that while he thought signs of it would have been seen on 1 January it would have been much more subtle than some days later. There was always an element of human error where such things can be missed although on taking a second look it becomes clearer. As abdominal injury occurs regularly in trauma cases there is always an "index of suspicion".

[32] In re-examination the witness explained that although there may have been no sign of mesenteric injury on 1 January there were still a lot of other injuries which would definitely been seen on a scan. In that situation it might be that the course that would have been taken was to wait and see how things developed with the patient remaining in hospital. If his condition worsened the CT scan would have been repeated. This is a different approach from immediate surgery. If the patient had been scanned at regular intervals he would have been in surgery much quicker. In a vascular injury there will be a lack of blood flow to the relevant organ and so ischemia. If you restore the blood flow the organ will survive and so the more this is delayed the worse it gets and the organ dies. In this case it was by day four that the gas in the liver and damage to the abdominal wall was detected and by then "the whole thing was falling apart".

[33] The final witness in the first defender's case was Euan John Dickson a consultant surgeon at Glasgow Royal Infirmary, a post he has held since 2007. Mr Dickson is a specialist pancreatic surgeon and in addition has significant experience in trauma, being recently appointed to the post of Trauma Unit Lead Consultant with the Scottish Trauma Network. Details of his qualifications and experience are provided within his report, number 7/4 of process, which he adopted in evidence. Mr Dickson was instructed to consider this case and give an opinion on whether the injuries suffered by Mr Widdowson in the accident were survivable had he been treated appropriately from the outset and to examine the nature and extent of the acts and omissions of those involved at Dr Gray's Hospital and at Raigmore. Since the preparation of his report Mr Dickson had been made aware of the second and third defenders' admissions in relation to the failure to instruct a CT scan and the subsequent delay in surgery respectively.

[34] Mr Dickson reiterated the accepted view that had a CT scan been undertaken at Dr Gray's Hospital Mr Widdowson's clinical management would have followed a different course. The likely abnormal findings from such a scan would have provoked either further investigations or surgery after discussion with the relevant team. An exploratory laparotomy would likely have been performed and this would have included looking for injuries not apparent on a CT scan. The witness was clear that the surgical team should have been involved from the outset of Mr Widdowson's treatment rather than his being admitted for observation and subsequent discharge. So far as the treatment at Raigmore was concerned Mr Dickson viewed the key consideration as the decision regarding conservative management versus early surgical intervention. He spoke of a management algorithm based largely on index of suspicion, patient physiology, patient trajectory and radiology with the last of these being contextualised by the preceding three factors. At paragraphs 6.3.3-6.3.7 of his report Mr Dickson had set out how each of these key factors should have been approached. He explained that one of the most challenging aspects of clinical practice is decision making without having all of the information that one would like. However, there were a sufficient number of known factors in this case that should have led to a very high index of suspicion including the known facts of the accident, the CRP reading indicative of a massive inflammatory response and the other findings. It was clear that Mr Widdowson had a negative trajectory and so while a CT scan would never be used in isolation and had to be considered in combination with clinical signs, there were sufficient features of Mr Widdowson's situation to have raised a need for urgent intervention. Urgent surgical intervention was accepted practice for acute small bowel ischemia.

[35] Mr Dickson also gave evidence under reservation that in his opinion the departure from normal and usual practice at Raigmore in treating the patient conservatively rather

than heading straight for surgery was very significant for the reasons he had given after the CT scan findings and coupled with the high index of suspicion resulting from the patient's deteriorating pathology he ought to have been sent for urgent surgery.

[36] Under cross-examination by Mr Stephenson Mr Dickson agreed that after the surgery at Raigmore. Mr Widdowson had died after aspirating his gastric contents and suffering a cardiac arrest. The causes of that included the initial trauma in the road traffic accident, the perforation in the small bowel identified after the CT scan at Raigmore and the subsequent surgery. The perforation in the small bowel resulted in inflammation of the abdomen and consequential impact on the patient's general physiology. The defining event in what occurred to Mr Widdowson was the ischemic injury to the bowel. The witness thought it hard to answer whether Mr Widdowson would have died if there had been no perforation but the perforation certainly reduced his chances of survival. He had provided a step by step analysis of the likely sequence of events leading to death in his report (at paragraph 6.1.3) but it was a multifactorial situation that included the post-operative ileus which was the failure of the bowel to revitalise after surgery. By the time surgery was performed Mr Widdowson was significantly unwell with a medium to high chance of dying. Accordingly, while the aspiration at the end contributed to his death on balance he already had a high chance of death before that final event.

[37] In relation to events at Dr Gray's hospital, Elgin, it was put to the witness that at paragraph 6.2.7 of his report he had concluded only that "on balance" a whole body CT scan would have been appropriate when Mr Widdowson was a patient there. Mr Dickson said that on reflection he would drop the expression "on balance". He agreed that the NICE guidelines published in February 2016 referred to in his report post-dated the events under scrutiny. He agreed also that it could take longer for guidelines to be adopted in local

hospitals although did not consider that they were irrelevant. Against a background of his experience as a surgeon working on trauma cases in a team, Mr Dickson felt able to comment that the injury to the mesentery and small bowel might not have been visible at Dr Gray's on 1 January but he was not sure. However, there were two components. First, the mesenteric vascular injury was acute and he thought it might well have been visible but the ischemic bowel was a consequence and so an evolving injury that would probably not have been visible had Mr Widdowson been scanned by CT scanner on 1 January.

[38] Under cross-examination by Mr Reid, Mr Dickson agreed that by the time Mr Widdowson arrived at Dr Gray's he was already significantly injured and that his death 10 days after the accident was as a result of a progression of the injuries sustained in the road traffic accident. While there was no doubt that all threads of enquiry trailed back to the index road traffic accident, Mr Dickson considered it false and unhelpful to look at any polytrauma in isolation. Mr Widdowson had fractured ribs and when added to the hernia and vascular injury all sustained in the car crash the totality pushed the patient into ultimate death. Mr Dickson agreed that there were no risk free options when taking decisions about abdominal trauma and that in certain circumstances it may be managed conservatively. If so, the obligation was to observe the patient carefully and monitor him so that the situation could be reappraised quickly if the information changed. He agreed that Mr Widdowson's situation was one of a patient in a complex clinical scenario and that while on balance he would have survived the injuries had surgery been performed, he needed urgent treatment to have that chance of surviving. Mr Dickson agreed also that it was easier to determine the appropriate course (as between conservative management or surgery) in retrospect. He agreed that Mr Widdowson was subject to frequent review and observation at Raigmore hospital. While the decisions taken there had been a continuation down the same wrong

pathway, there was no question of the patient having been ignored or not reviewed frequently. The documentation from Raigmore confirmed that he was managed properly post-operatively and that the team there had considered all options that might have enhanced his survival, other than the insertion of the nasal gastric tube as he had noted at paragraph 6.3.13 of his report. Ultimately, any one of (i) the initial injury (ii) the laparotomy or (iii) the perforation of an ischemic small bowel could cause ileus. All three contributed to that final disruption of the propulsive ability and he could not say precisely the extent to which each contributed. On any view the initiating factor was the motor vehicle accident without which none of the subsequent events would have happened.

[39] In re-examination Mr Dickson agreed that none of the initial injuries sustained in the accident were immediately life threatening. The injuries sustained in the accident had been acute and potentially evolving. On the issue of what a scan on 1 January would have shown, (in addition to the agreed list of injuries) Mr Dickson said that if all that was seen was the vascular enhancement and no ischemic signs then continued observation would be reasonable but only with input from and discussion with a surgical team.

Evidence in the second defender's case

[40] Dr Dilip Patel, a consultant radiologist in Edinburgh since 1999, gave evidence in the second defender's case. Dr Patel had initially been instructed on behalf of the pursuers and had produced a report (number 6/2 of process) dated 16 April 2019. Dr Patel adopted that report which confirmed his areas of expertise including CT, MRI and radionuclide imaging (INC. PET/CT). Dr Patel is the lead radiologist in one of the multi-disciplinary teams for NHS Lothian. He explained that the bulk of his work involved carrying out and analysing the findings of CT scans of the abdomen including the small bowel and small bowel

mesentery. A routine part of his work, including on-call work, involves emergency scanning following trauma. He had been asked initially to address whether a CT scan should have been performed at Dr Gray's hospital on 1 January 2016 which he understood was now admitted. He had also been asked to assess whether, had such a scan been performed on 1 January 2016 it would have demonstrated the same findings as the scan ultimately carried out on 3 January. In his report (paragraph 5.5) Dr Patel had summarised the findings of that CT scan. At paragraph 5.6 he had noted the addendum to the report added by Dr Brodie (consultant radiologist) who had reviewed it the following day. Dr Brodie had interpreted the scan as including mesenteric injury and resultant small bowel ischemia and obstruction. Dr Patel agreed that the first radiologist on 3 January 2016 had not seen or noted that finding.

[41] Dr Patel had reviewed the CT scan performed on 3 January for himself and his interpretation listed everything he had seen. He was asked about his finding that there was "intrahepatic gas within the left lobe of the liver typical of portal venous gas in distribution". Dr Patel explained that intrahepatic gas can be divided into intrabiliary gas and portal venous gas, the latter being typical of bowel infarction. The two types can be difficult to distinguish but in essence the portal venous gas can be associated with small bowel infarction. This is because the small bowel has a rich blood supply and should show enhancement on a scan. The reduced enhancement on the scan taken of Mr Widdowson on 3 January was indicative of ischemia or infarction. Dr Patel explained that peristalsis was the rhythmical moment or muscular action which did not function when the smooth muscle was infarcted. Ischemia occurred when there was a reduction in blood supply and infarction was the ultimate death of the organ or its tissue as a consequence. Dr Patel agreed that ischemic bowel injuries typically evolve over time and that when the blood supply to an

organ was reduced initially this would not show on a scan as ischemia because it takes time to cause tissue damage and ultimately death of that tissue. For that reason the first scan taken can often look normal.

[42] When asked about FAST scanning, Dr Patel confirmed that this can be used to triage patients. If a FAST scan showed fluid or blood in the abdomen there should be an immediate CT scan. If not and the patient is stable a CT scan can wait although if a patient is clinically very unstable they are often taken for immediate surgery without imaging. Overall, Dr Patel did not consider it unreasonable that a FAST scan was performed on initial assessment. That did not detract, however, that it was in line with current practice that a CT scan should have been undertaken despite the negative FAST scan result.

[43] In Dr Patel's opinion, had a CT scan been carried out at Dr Gray's hospital on 1 January it was highly unlikely that the abnormal small bowel and portal venous gas in the liver would have been present and visible. It was unlikely also that the key finding of poorly enhancing small bowel loops would have been seen because a CT scan would not have been sensitive enough to pick that up. Dr Patel had seen cases where the CT scan was normal on this even on review and the patient ultimately was found to have small bowel ischemia. The closer to the trauma event the scan is performed the less likely it is that the small bowel enhancement would have shown up.

[44] Dr Patel was not cross-examined and no evidence was led on behalf of the third defenders.

Discussion

[45] This case concerns the relative contributions that should be made by three defenders, each of whom has either admitted liability or in the case of the first defenders had summary

decree awarded against them. Section 3 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1940, section 3(1) provides that in such a situation the defenders *"… shall be liable inter se to contribute to such damages or expenses in such proportions as the jury or the court, as the case may be, may deem just …"*. Counsel were not in dispute in relation to the correct approach to be taken to such an issue. In *Downs* v *Chappell and Stephenson Smart & Co (a Firm)* [1997] 1 WLR 426, the Court of Appeal gave guidance on the application of a similar English provision, with Hobhouse LJ stating (at p 445) that:

> "The extent of a person's responsibility involves both the degree of his fault and the degree to which it contributed to the damage in question. It is just and equitable to take into account both the seriousness of the respective parties' faults and their causative relevance."

In that particular case the court found that, while the fault of one defender in making fraudulent representations was greater than the other defender whose fault had been that of making negligent representations, the causative force of the second defendant's representation had been greater. The approach in *Downs* v *Chappell* was cited with approval by Lord Woolman in the case of *McKenzie and others* v *Asda Group Limited and DHL Services Limited* [2018] CSOH 102.

[45] Counsel for the first defenders submitted that the decision of the UK Supreme Court in *Jackson* v *Murray* [2015] UKSC 5 was also of some assistance, albeit that the case involved contributory negligence rather than apportionment of liability between defenders. A distinction was there drawn (at para 27) between someone who acts in breach of a duty and someone who acts with a want of regard for their own interests. In my view it is clear that the nature of the court's exercise in assessing contributory negligence is a little different from that involved in this case. It is instructive to note, however, that the approach of relative blameworthiness and causative potency in assessing apportionment was followed

both by the Inner House and the UK Supreme Court in *Jackson.* In the present case it is not in dispute that each of the three defenders owed a duty of care to Mr Widdowson and that each breached that duty. Accordingly, in contrast with *Jackson* (see para 27) the present case does involve more of a "like with like" comparison.

[46] While a number of examples from case law were cited by counsel, ultimately it is indisputable that issues of relative blameworthiness and causal effect are essentially matters of fact, direct or inferred. All of the relevant evidence in relation to the circumstances of the road traffic accident in this case and the subsequent medical treatment is essential to the determination of the central issue. The oral evidence concentrated on the actings of the medical professionals involved at Dr Gray's Hospital and at Raigmore Hospital against a background of admissions of liability having been made. Accordingly, the extent of the dispute in that evidence was relatively small. With the exception of a short passage of evidence heard under reservation, which I will deal with shortly, the arguments presented to me in submissions dealt not so much with disputes as to fact but to the inferences that should be drawn from established fact. The task for the court is to consider all of the facts carefully and apply the test of relative blameworthiness and causal potency. If the court finds itself unable to apportion with reasonable precision, it has been said that the burden should then be shared equally (*Drew* v *Western SMT* 1947 CS 222, per Lord Mackay at 236). Mr Stuart QC on behalf of the first defender submitted that in the present case, whatever moral blameworthiness could be attributed to the deceased's driver Mr Gordon, the causative potency in terms of Mr Widdowson's death was "almost nil" on his part. He relied on the case of *Webb* v *Barclays Bank Plc* 2001 EWCA (Civ) 1141 where, at paragraph 57, the court concluded that the doctor's negligence in advising the plaintiff wrongly on amputation of her left leg did not eclipse the original wrongdoing of the defendants which

had caused the pursuer to fall over a protruding stone in their forecourt. In that particular case liability had been apportioned 75% to the doctor and 25% to the bank defendant. I note that the court also took the opportunity to reiterate the position that where an initial injury is exacerbated by medical treatment any medical negligence involved will normally be regarded as a foreseeable consequence for which the initial wrongdoer is liable. Only medical treatment so grossly negligent as to be a completely inappropriate response to the injury might break the chain of causation. While that is no longer a live issue in this case, an assessment of the nature and extent of the fault on the part of the medical professionals falls squarely within the task of apportionment of liability. The first defender's position was that the causative potency of the action of the first defenders' insured was very considerably diluted by the two subsequent separate and significant medical failings first at Dr Gray's Hospital and then at Raigmore. Mr Stuart submitted that the first defender's liability should be limited to no more than 10% of the total damages and expenses awarded.

[47] For the second defenders Mr Stephenson QC referred to a number of cases in which the courts had been seen to proceed on the basis that a car is a potentially dangerous weapon under the control of its driver - *Lunt* v *Khelifa* [2002] EWCA Civ 801 at paragraph 20 and *Eagle* v *Chambers* [2003] EWCA Civ 1107 (which had been cited in *Jackson* at para 25). Senior counsel submitted that it is in the public interest that negligent drivers are held responsible for their actions and consistent with that, the courts had consistently attributed the bulk of the responsibility for the consequences of car accidents to the driver of the car. Accordingly in contributory negligence cases, it tended to be the negligent driver who bore the majority of the responsibility even where the contributory negligence of the pursuer or claimant was reasonably substantial. For example in *Eagle* v *Chambers* [2003] EWCA Civ 1107 the Court of Appeal had reduced a finding that the claimant

was 60% contributorily negligent and substituted a finding of 40% contributory negligence in circumstances where the claimant had been drunk and walking down the middle of a dual carriageway when she was struck by the defendant's car. Reference was also made to cases involving failure to wear a seatbelt where a discount of no more than 25% tended to be applied even if wearing a seatbelt would have avoided injury. Attempts to overturn this longstanding approach, set out in *Froom* v *Butcher* [1976] QB 286 had failed, the case of Pearson v Mohammed [2014] 10 WL UK 396 being one example.

[48] Under references to *Hughes* v *Williams* [2013] PIQR P17 and *J (a child)* v *Wilkins* [2001] RTR 19 and *EMS (a child)* v *ES* [2018] NIQB 36 it was submitted that a similar approach has been taken in cases where a third party's fault has contributed to the injuries. Mr Stephenson submitted that where the third party at fault is a treating doctor there is no reason to depart from the established practice of attributing the majority of the responsibility for the harm to the driver who negligently caused the accident. In *Commonwealth of Australia* v *Martin and others* (1985) 59 ALR 439 the Federal Court of Australia had not disturbed the decision of the trial judge on appeal which had been to apportion 20% of the blame for a car accident to the deceased (who had been contributorily negligent) and of the remaining 80%, 75% to the driver of the vehicle that struck the deceased and a 25% contribution by the hospital which had been negligent in its care of the deceased. As with the present case, the deceased in *Martin* had suffered abdominal injuries in the car accident which would have inevitably led to his death in the absence of effective intervening medical treatment which he did not ultimately receive. The higher degree of blameworthiness to the negligent motorist as opposed to the omissions of busy hospital staff was also mentioned in the case of *ZZZ* v *Yeovil District Hospital NHS Foundation Trust* [2019] EWHC 1642 (QB). Mr Stephenson also adopted the part of the third defender's submissions that sought to draw a distinction

between negligent omissions and positive acts. The second defender's suggestion was that the first defenders should be responsible for something between 75 and 85% of the total award of damages with the remainder being split between the second and third defenders.

[49] Mr Reid for the third defenders submitted that a distinction between acts and omissions had long been recognised by the law. As Lord Reed had articulated it recently in *Poole BC* v *GN* [2019] UKSC 25 at paragraph 28, the law draws *"… a distinction between causing harm (making things worse) and failing to confer a benefit (not making things better).* Applied to the facts of the present case, this meant that the culpability of the first defender was far worse, albeit that the third defenders' omission meant that they could not avoid liability. Failing to take positive action that would have saved someone's life was not the same as committing an act that caused death - *Thompson* v *Toorenburgh* (1973) 50 DLR (3d) 717 at 721. Counsel for the third defenders also emphasised the approach taken to contributory negligence in road traffic accident cases under reference to the authorities referred to by Mr Stephenson. The central point was that in this case nothing that the second and third defenders could have done would have avoided the deceased sustaining the significant and extensive injuries that were ultimately detected because the first defenders' insured caused all of those. It might be different if the negligence of the medical professionals would have avoided those injuries. So far as the involvement of two different health boards in this case was concerned, that was a matter of happenstance and should not be used to allow the first defenders to reduce their liability. The appropriate course, Mr Reid submitted, was for the court to assess liability as between the driver and the medical profession (ie as between the first defenders on the one hand and the second and third defenders on the other) and then to assess apportionment as between the two health boards after that. To do otherwise would risk over-discounting the first defender's liability.

There was clearly a broad discretion and the court had to decide what apportionment was just.

[50] Turning to the evidence, then, I will deal first with the passages in the evidence of both Mr Nichol and Mr Dickson that were heard under reservation. In essence, these related to the question of how significant or material the departures from normal and usual practice were on the part of both Dr Dar and the team at Raigmore Hospital. Counsel were all agreed that the matter of admissibility of expert evidence is usefully summarised at paragraphs 45 to 49 of the decision of the Supreme Court in the case of *Kennedy* v *Cordia Services* [2016] UKSC 6. There the court reiterated that it is for the first instance court to decide whether expert evidence is needed when the admissibility of such evidence is challenged. The test is whether any skilled evidence of fact offered would be likely to assist efficient termination of the case. If so, the judge should admit it. At paragraph 48 the court referred to the case of *Dingley* v *Chief Constable of Strathclyde Police* 1998 SC 548 where it was stated that *"as with judicial or other opinions, what carries weight is the reasoning, not the conclusion."* The court also emphasised in *Kennedy* v *Cordia* that *"expert assistance does not extend to supplanting the court as the decision maker"* (paragraph 49). Mr Stuart submitted that when the court is engaging in an exercise of apportionment that inevitably required a relative assessment of the failures of each of the joint wrongdoers. Where there were three defenders that assessment was more complicated and the court might accordingly find it of assistance to hear expert evidence on the extent of the departure from normal or usual practice. The importance of the evidence was in the witnesses' explanations of why they were each of the opinion that the departures from normal and usual practice had been significant.

[51] For the second defenders Mr Stephenson pointed out that the purpose of the objectionable evidence appeared to be directed at blameworthiness which was one of the principal matters for the court to decide in this case. Accordingly the matter was not one for expert evidence but for the court. The opinions of witnesses on the matters of the perceived extent of the departure from normal and usual practice were neither necessary to allow the court to make a decision nor would they assist with that decision. For the third defenders, Mr Reid also submitted that any question of how significant the departure from normal practice omissions of the third defenders may have been was not something on which the court required assistance. The proper approach was for the court to make its own assessment of the issue armed with the material provided. Further, while there was largely unchallenged material about relevant matters in this regard in relation to Dr Dar, such as the training requirements and professional guidance in relation to FAST scanners, so far as the third defenders were concerned the first defenders had led no similar factual evidence upon which any opinion of significant departure from normal practice could be based. The first defenders could not be allowed to short circuit matters by simply asking Mr Dickson for his view. Mr Dickson's answer in this respect was a bare *ipse dixit* and thus of no value to the court (*Kennedy* v *Cordia* at paragraph 48).

[52] I have decided that the submissions of the second and third defenders on this matter are to be preferred. The central question in these proceedings relates to the relative culpability and causative potency of the acts and omissions of the three defenders. Insofar as the objectionable evidence was led, as I understood it to have been, with a view to establishing greater blameworthiness on the part of the second and third defenders, it offends against the rule that expert evidence cannot be used to usurp the function of the court. I have found the expert evidence in this case reasonably useful in putting into context

what happened at the two hospitals in question and to explain from a medical perspective the admissions about what should have been done in the particular circumstances with which each hospital was presented. It was useful also to assist my understanding of the progression of the injuries sustained in the road traffic accident and how they led ultimately to Mr Widdowson's death. However, against a background of the admissions of failure on the part of both the second and third defenders on record, there was no basis on which the expert witnesses could properly be asked about the extent of that fault. Their evidence could go little further than providing skilled evidence on the complexities of a trauma case and how to deal with it. That evidence has been of some assistance but Mr Nichol and Mr Dickson's views on the extent of fault, being one aspect of the central issue for determination, were not. I consider also that there is some force in the third defender's argument that so far as Mr Dickson was concerned there was insufficient primary evidence led upon which he could be asked to express a view on the significance of the departure from normal practice at Raigmore. In any event, what I am concerned with is the relative blameworthiness of the three defenders. Even had I considered that the evidence on the significance of the fault on the part of Dr Dar and the surgical team at Raigmore was competent and relevant, it would have been of little assistance to the issue of how their blameworthiness compared with that of the deceased driver who caused the injuries. For all these reasons I have not considered it necessary to rely on the evidence heard under reservation.

[53] Turning then to the central assessment of (i) relative blameworthiness and (ii) causative potency, I will deal with those each in turn. So far as fault is concerned, the undisputed facts of the case are eloquent of the high degree of blameworthiness of the first defenders' insured. In a long straight section of a B road there was a bend which ought to

have been easy to manoeuvre with a radius for drivers travelling in the direction Mr Gordon had been of a little over 189 metres. Critically, the undisputed evidence is that the bend could have been negotiated safely at 80 miles per hour plus or minus 10%. As Mr Gordon did not negotiate the bend safely, the accepted evidence is that on balance that he must have been travelling at a speed of at about 80 miles per hour. Mr Widdowson and his mother-in-law confirmed that the car seemed to be out of control and the evidence indicates that Mr Gordon was not wearing a seatbelt. In the absence of any other explanation for the loss of control, the indisputable conclusion is that Mr Gordon was driving both at a speed very considerably in excess of the speed limit and recklessly. I accept the submission of the second defenders that had he survived it is likely that he would have been prosecuted for that. There is no suggestion that there was any other cause of the road traffic accident.

[54] It will have served only to add to the anguish of the pursuers that, absent the negligent omissions of the second and third defenders, Mr Widdowson would on balance have survived his serious injuries. That is a matter that I will examine closely in dealing with causative potency. However, there is no suggestion that either Dr Dar or the surgical team at Raigmore Hospital failed to do their best to treat the patient. A number of individual shortcomings in Dr Dar's approach were identified by Mr Nichol but it seemed to me that these were all part of the exercise of diagnosis and all culminated in the negligent act admitted namely, to fail to perform a CT scan. Dr Dar proceeded down the wrong route in trying to identify whether this patient had suffered an abdominal injury. He performed two FAST scans and while there is an issue about whether he should have done so at all given his out of date accreditation, the expert evidence supports a conclusion that such scans can be a convenient first stage assessment tool. However, when the FAST scans showed no blood in the abdominal cavity Dr Dar was wrong to be reassured by that, even coupled with

his examination of the patient which had not detected anything abnormal with the abdomen. Mr Nichol was clear in his evidence that FAST scanning can be used to identify free fluid in the abdomen which would mandate immediate surgery but it could never rule it out and Dr Dar ought not to have placed the emphasis on its findings in the way he had. Ultimately, there were a number of clinical features and test results that mandated the instruction of a CT scan. Dr Dar's conclusion that there were insufficient indications of abdominal injury to merit such a scan was simply wrong. He appears to have allowed himself to be comforted by the lack of confirmed abdominal bleeding, the patient's own lack of complaints and his seemingly stable condition. As indicated, however, in my view all of that is subsumed within the admission made by the second defenders prior to proof. While Mr Nichol identified a number of features that he said should all have led to a different decision or investigation, I conclude that the only relevant investigation that would have led to a different outcome was a CT scan. It was undisputed that Dr Gray's hospital would have had to transfer Mr Widdowson elsewhere for any surgery and so Dr Dar would never have been responsible for any subsequent delay with surgical intervention.

[55] There was no reliable evidence to support a conclusion that Dr Dar's failings were more than honest mistakes by someone doing his best to care for a patient. The evidence of the move towards similar hospital admissions following road traffic accidents being dealt with in only four major trauma centres in Scotland quite soon after Mr Widdowson's accident was instructive. It tended to support the view that a doctor such as Dr Dar, working in a small general hospital in January 2016, would not have been able to gain or maintain the skillset required to deal with complex polytrauma, which was becoming an increasingly specialised area of medical practice. The second defenders' admission

acknowledges that such circumstances cannot exonerate Dr Dar, but they provide a context that is relevant in terms of relative blameworthiness.

[56] Dr Dar was included on both the first and second defenders' witness list but was not called to give evidence. Accordingly, I place little reliance on the bare agreed fact that he was referred to the GMC following the events of January 2016. I do not know whether the matter proceeded to a hearing and if so on what specific grounds, far less whether or not he was exonerated in relation to any conduct allegation. I take into account that his accreditation to perform FAST scans had lapsed, although as indicated, his actions in relying on the results of those scans was a subsidiary aspect of the overall decision not to instruct a CT scan. He is squarely to blame for the omission to undertake that procedure, but there is a complete absence of evidence of any reckless behaviour or an uncaring approach on his part.

[57] So far as the surgical team at Raigmore is concerned, the admitted fault is also one of omission. When Mr Widdowson was admitted to Raigmore on 3 January 2016 the necessary CT scan was carried out. While the original report of the 3 January scan missed the small bowel mesenteric injury and likely ischaemia, this was picked up in the revised report the following day. The decision making at Raigmore was flawed because the information available by 4 January all pointed to immediate surgery as the only reasonable action. By adopting a course of conservative management until 7 January, the team at Raigmore departed from the accepted practice of urgent surgical intervention for small bowel ischaemia. That was again admitted and surgery should have been performed by 4 January.

[58] The analysis in terms of blameworthiness on the part of the team at Raigmore is similar to that for Dr Dar and Dr Gray's hospital. There is no criticism at all levelled at Raigmore in terms of the effort employed, the determination to care for the patient, the note-keeping and so on. With one exception in relation to the nasogastric tube, the surgical

procedure and post-operative care cannot be faulted. In essence the team made the wrong decision on 4 January in what was undoubtedly an anxious case with the worst possible consequences. There is no question of there being criticisms of conduct, as opposed to breach of duty, on the part of Raigmore. Again that hospital has not become a major trauma centre since the 2016 re-organisation and the number of polytrauma patients received at the material time will have been far lower than in Aberdeen or Dundee. Mr Dickson explained just how complex cases of this type were and how finely balanced the decision making could be for the medical professional involved.

[59] On the undisputed facts of this case, then, three separate defenders were at fault, but the first defenders' insured acted in a way that was by far the most culpable and which I categorise as extremely reckless. It was his deliberate act in taking a bend in the road at a speed of 80 miles per hour or so with the inevitable consequence of losing control of his vehicle that stands out as being morally reprehensible. The omissions of the medical teams who tried but failed to save him following that are far less blameworthy. An approach that acknowledges the significant difference between the driver's positive act on the one hand and the omissions, well intended, of the medical professionals in the context of a complex decision making process on the other, is in my view the correct one. I conclude that on the facts of this case, the first defenders must bear by far the greatest share of the blame for what occurred.

[60] Turning to causative potency, the primary argument for the first defenders was that, while Mr Widdowson was seriously injured in the accident, it was the second and third defenders' failure to save his life that had the greatest causative connection. In my view, matters are not as straightforward as that. It was the initial reckless act on the part of the first defender's insured that put Mr Widdowson in a position where, absent surgical intervention

he was going to die, albeit not immediately. While his chances of survival lessened with each day of delay, his serious injuries, including the life threatening abdominal injury, were attributable solely to the first defenders' insured's actions. Of course, the second and third defenders' omissions increased very significantly the risk that he would die from those injuries and ultimately death became inevitable, but they did not cause any injuries. All of the medical witnesses agreed that the relevant sequence of events started with the injuries sustained in the road traffic accident and that those injuries worsened over time causing disruption to the small bowel leading to ischaemia, perforation and ultimately Mr Widdowson's death. I accept the submission made on behalf of the third defenders that the medical negligence chapter of events can be taken together in the sense that it occurred simply by chance that the period of inaction involved two hospitals. In short, the life threatening injuries having been caused by the first defenders' insured, there were opportunities to remedy that and save Mr Widdowson's life that were not grasped. It is agreed that had surgery been performed by 4 January on balance Mr Widdowson would have survived.

[61] The evidence relating to CT scans and what would have shown on one performed on 1 January as compared with the one actually performed on 3 January is of some relevance to this issue. In short, as illustrated by the summary of the evidence above, there was ultimately little difference between the radiologists about what the findings of a scan taken on 1 January would have been. As the tear in the mesentery may have developed over time, the most one would have seen would be the abnormal or reduced small bowel enhancement. Professor Van Beek thought it likely that such a finding would have been made on 1 January but Dr Patel thought it would not. I prefer the unchallenged evidence of Dr Patel on this point. The first CT report from Raigmore two days later than the hypothetical 1 January scan

made no mention of small bowel enhancement, despite the progress to ischaemia by that date. Professor Van Beek was clear that in these complex and stressful cases findings are often missed, hence the system of double reporting. As the eventual tear was developing over time, it can be inferred that any abnormality would be less visible, if visible at all, on 1 January than two days later. Dr Patel stated in terms that in cases of ischaemic bowel injury the first scan taken can often look normal. His particular area of experience and expertise is the radiology of the abdomen. On balance I do not find it established that a CT scan on 1 January would have identified the developing injury to the small bowel.

[62] The significance of that is that Mr Dickson confirmed that a decision about conservative management as opposed to surgical intention would depend upon the CT scan findings. In the absence of a scan pointing to a developing small bowel perforation, conservative management for a day or two would be one of the available options, albeit coupled with the patient remaining in hospital and repeat scanning. The accepted findings would have been sufficient to proceed immediately to an exploratory laparotomy but a delay of a day or two would have been unlikely to be fatal. By 4 January, however, the findings of the re-reported scan were sufficiently clear that surgery was the only reasonable course. The causative potency of the earlier failings of the medical professionals involved centres on the undisputed fact that with every day of delay increased the likelihood of Mr Widdowson being unable to survive his injuries. I have concluded that the second and third defenders are equally responsible for that downward spiral. Even leaving aside the developing small bowel injury that would probably not have been identified on 1 January, the other injuries and fluid in the abdomen would have been seen and the transfer to a centre of trauma care excellence (Aberdeen) would have taken place. For that reason, the

causative potency of Dr Dar's omission is in my view not manifestly less than that of the surgical team at Raigmore.

[63] The issue then is how to balance the very significant proportion of fault that attaches to the actions of the first defenders' insured against the easily identifiable causal potency of all three defenders' negligence in relation to Mr Widdowson's death. Such a balance is not simply an arithmetical exercise albeit that fractional or percentage proportions will be the result. Having considered all of the evidence and the submissions made, I have reached the view that it would be just for the first defenders to contribute by far the greatest proportion of the damages due to the pursuers. The actions of their insured triggered everything that followed and only the driver of the grey VW Polo acted without any care for the ultimate consequences of his actions. As against that, the failures to act on the part of the medical professionals, honest mistakes though they were, had the effect of denying to Mr Widdowson any chance of interrupting the fatal sequence of events and so the causative potency of their omissions was not insubstantial. Accordingly, while the causal potency of the actions of the first defenders' insured was also greater than that of the medical professionals' omissions, the disparity is not so overwhelming as to justify quite such a small proportion of liability in damages being attributed to them as their Counsel suggested. In all the circumstances and for the reasons set out above I have decided that a just apportionment would be to find the first defenders liable for 70% of the damages to be awarded and the second and third defenders each liable for 15%, such that between them they will meet 30% of the total damages awarded.

[64] The principal sums agreed as damages (with interest to the start of proof) and still to be paid in this case amount to a total of £741,361 divided as follows; £500,000 to the first pursuer as individual and £34,861 as executrix, £47,500 for each of the second third and

fourth pursuers as individuals, £31,500 to the second pursuer as legal guardian for his two children (£15,750 each) and £32,500 to the sixth pursuer. However, senior counsel for the pursuers advised the court at the conclusion of the evidence that there remained a dispute with at least one of the defenders in relation to questions of ongoing interest. Accordingly, I will have the case put out for a By Order Roll hearing so that I can be addressed on that matter before making the substantive awards that will include up to date interest. The question of expenses also requires to be addressed and I will reserve that issue meantime.