SHERIFFDOM OF GRAMPIAN, HIGHLANDS AND ISLANDS AT ABERDEEN

[2024] SC ABE 11

ABE-PD33-18

JUDGMENT OF SHERIFF MUNGO BOVEY KC

in the cause

DS

Pursuer

against

NHS GRAMPIAN

Defenders

Pursuer: Party
Defenders: McSporran KC, Dundas, Advocate; NHS Scotland

ABERDEEN, 9 NOVEMBER 2023

1. This judgment sets out the reasons for my decision to award the pursuer a sum of *solatium* in this case.

2. I heard evidence on 7 and 8 September, 28 and 29 November, 2, 16 and 19 December 2022, 24, 25, 26, 30 and 31 January 2023 and heard submissions on 13 and 14 February 2023.

3. All proceedings took place by Webex. Both parties lodged written submissions in good time for the hearing on the evidence. By interlocutor of 18 September 2023 I invite the parties to make written submissions on the quantum of my proposed award of *solatium*. On 17 October they both made written submissions on that issue and the issue of expenses.

4. The defenders lodged five inventories of productions without opposition. The pursuer lodged three inventories. The last of these, on the first day of the proof, was opposed but, other than 5/75, ultimately admitted without opposition. I refused to

allow 5/75 which related to PTSD, for which there was no record. During the proof, the pursuer tendered a fourth inventory in various forms all of which were opposed and rejected as being too late and unsupported by record and, where required, expert evidence.

5. There was no joint minute or other formal agreement of materials before me. However, medical records and academic articles were put to witnesses by both sides without objection. None of these witnesses suggested that the materials were not what they appeared to be. Senior counsel proposed that evidence that had been dealt with in this way should be admitted but that productions that had not been put to any witness were not evidence before me. The pursuer did not address this issue. I have, accordingly, proceeded in the pragmatic manner proposed, approaching documentary productions through the prism of the oral evidence.

6. On 29 November 2022, as she was nearing the end of her evidence in chief, the pursuer sought to move a motion for summary decree. I did not consider such a motion appropriate in the circumstances or at the stage we had reached.

7. In her closing submission, the pursuer sought anonymity for a number of reasons none of which seemed good to me. However, it seemed to me that she was in a vulnerable state that might justify such an order. I allowed her time while I had this case under consideration to lodge any supportive material in that regard.

8. She lodged both the original and a certified translation of a letter dated 28 February 2023 from a specialist psychiatrist in Wroclaw the whole terms of which were

> "Due to her mental health history and in order to avoid the exposure of [the pursuer] to additional mental strain it is highly advisable that the Court grants anonymity when publishing the result in her case."

9. By email dated 7 March 2023 the defenders' agent "... noted that the terms of the report are very brief and do not confirm whether the doctor has examined the pursuer

recently, or at all." However, beyond that, the defenders had further nothing to add to what had already been submitted regarding this matter both orally and in their written submissions (particularly the supplementary submissions lodged). They were content to rest on those submissions and leave the matter now to the court.

10. Despite the brevity and other faults of the letter provided by the pursuer, it corresponded to my own concerns and I have therefore anonymised this decision as regards the pursuer.

11. In this judgment:

- References in the form (P1 346/842) are to pages in the pursuer's inventories, this example being page 346 of 842 in her first inventory;
- References in the form (D3 112/123) are to pages in the defenders' inventories, this example being page 112 of 123 in their third inventory;
- ARI is a reference to the Aberdeen Royal Infirmary.

Findings in Fact

(a) Chronology

[1] The pursuer was born in Poland on 27 November 1986 and came to the UK as a young adult.

[2] On 10 April 2008 the pursuer was reviewed by her GP having previously been seen in the surgery on 25 March and antidepressant medication was continued. She was given a letter for her university where her course work was starting to suffer because of her mood which was not much improved (D1 68/677). On 20 May 2008, her mood was better in changed circumstances and she was continued on the same medication with a review planned in a couple of months.

[3] On 27 January 2010 the pursuer complained to her GP of dizziness and some nausea with some weeks of chest tightness. On 18 February 2010 she was

> "still feeling very tired. Headache generalised and feels very tight around head. Going home and sleeping +++. On 30 August 2010 the pursuer was admitted to Ninewells Hospital in Dundee with abdominal pain."

[4] On 9 June 2011 the pursuer was seen by her GP in connection with recurrent depression gradually worsening since splitting from her partner in January 2011 (D1 68/677).

[5] On 26 June 2011, the pursuer consulted NHS24 with a history of having hit her head two weeks earlier (P1 346/842)

> "Painful at the time but symptoms started next day. Ears feel blocked and from Friday eyesight has been affected – Can't concentrate for long looking at something. Has general feeling as if drunk. Confusion, sensitive to noise, headache 2 weeks … Headache, fever, dizziness, and unsteady on feet for three days and ears feel blocked with noise sensitivity."

[6] Seen by a doctor, she gave a history of headache for three days, difficulty concentrating, difficulty focussing, two weeks' back injury to head, not taking any pain relief, no weakness, numbness, no nausea or vomiting, ears feel blocked. Physical examination did not note any abnormality and she was diagnosed with headache.

2012

[7] On 22 April 2012 the pursuer completed an Out-Patient Physiotherapy Self-Referral Form (P1 703/842). She described her problem as "Headache all the time (was occasional) feeling of constant pressure in the head Hearing constant noise/ringing in the ears, Sensitivity to light and noise." She had had this problem for two months and that it was worsening. She had not had it before then. She had no on-going or previous problems with her health. A physiotherapy assessment on 10 May 2012 (P1 705/842) included the complaint that her speech and vision were affected after banging her head on a wall a

couple of months earlier but there was no pattern to the symptoms the document included a Clinical Risk Assessment of "Strange Symptom".

[8] In a letter to her GP dated 6 July 2012 (P1 616/842), the ARI Department of Otolaryngology/Head & Neck Surgery recorded that the pursuer had presented with a five month history of tinnitus in both sides with light-headedness, feeling of nausea with no vomiting:

> "She admits that it is not a spinning sensation and she feels that her vision is not as clear as it used to be despite wearing glasses. She admits that the noise and bright lights exacerbates her symptoms and for the last 5 months the symptoms have persisted associated with occasional headache, numbness and tingling. Nothing seems to be relieving her symptoms. On top of that she finds that despite a good sleep she still feels lethargic and almost fainting every morning when she wakes up. She is a non-smoker and otherwise fit and healthy and currently not taking any regular medication."

[9] On that occasion, a migraine was suspected. The doctor doubted she had any vestibular problem but thought it certainly worth while investigating further to rule out any central causes.

[10] The pursuer travelled to Wroclaw in Poland and underwent an EEG scan on about 28 August 2012. A report (P3 112/123) by a consultant neurologist and clinical neuro-physiologist recorded that carried out on the pursuer showed a "Small pathology requiring observation" and recommended a follow up visit in 3-4 months.

[11] On 5 October 2012, she was seen by an optician (P1 611/842) complaining of issues with focusing and finding it difficult to keep things stable and single:

> "Everything appear normal with her eyes. [the patient] is very distressed by her ongoing problems and the length of time they have been going on. She got some advice back home in Poland from a neurologist that suggested she should be considered for an MRI?"

[12] The optician also recorded complaint of ringing in her ears but that her hearing had been found fine by ENT:

> "Symptoms started with headache then got ringing and pressure in the ear. Now getting visual problem and tingling in arm and leg. Has some neck issues that were revealed by X-Ray."

[13] On 4 December 2012, the pursuer was assessed at the MSK Spinal Hub (P1 609/842) with a ten-month history of unchanging and constant tinnitus and vision issues and intermittent headache. A physiotherapist reported (P1 609/842) an impression of some clinical symptoms of cervical artery dysfunction. "We discussed the impact of stress on peripheral symptoms and headaches and she is going to take steps in regard to relaxation and pacing her activities more." A referral to physiotherapy was made.

[14] On 28 December 2012, Dr Callum Duncan, Consultant Neurologist at the ARI (P1 606/842) diagnosed the pursuer with Chronic migraine:

> "1 1 New persistent headache (onset February 2012)
> 1.2 Associated tinnitus and visual distortion
> 1.3 Past medical history of mild recurrent headaches"

[15] Dr Duncan's detailed account of her complaints in December 2012 (P1 606/842) records mild recurrent headaches since her teens with no associated migrainous features.

[16] On 28 December 2012 Dr Duncan wrote (P1 455/842) to Consultant Neuro-radiologist, MRI Scanning at ARI:

> "I would be grateful for an MRI brain and IAMs on this 26 year old who has had a sudden increase in her headaches since February. She has had continual distorted vision since then associated with bilateral tinnitus. I am looking for evidence of a structural cause for her headaches particularly within the brain stem."

2013

[17] On 18 January 2013 Dr Duncan reported to the pursuer's GP (P1 604/842) that the pursuer had provided him with a paper tracing of the Polish EEG. A neurophysiologist at ARI had reviewed this and felt it was within normal limits.

[18] On 23 January MSK Spinal Hub reported to the pursuer's GP a review following her x-ray and MRI of cervical spine that there was nothing there causing any of the headaches. The physiotherapist commented:

> "I understand from her that she has since had a neurology appointment relating to her headaches as well and she feels happier understanding the problems she is having."

[19] The pursuer underwent an MRI brain scan on 31 January 2013. On 1 February 2013 Dr Olive Robb reported (6/1/39 D1 42/677) (P1 518/842) on the MRI scan: "No intracranial abnormality is seen." By letter dated 13 February 2013 (P1 451/842) Dr Duncan reported to the pursuer that it was normal.

[20] By letter dated 6 February 2013 the pursuer was awarded a "spot award" by Shell UK Exploration and Production in recognition of her contribution over the course of the whole year to accurate forecasting of annual spending and cost focus (P3 41/123).

[21] The pursuer was employed by Cape Industrial Services as a Temporary Assistant Accountant between 1 April and 1 October 2013. This was on a contract for services basis with Thorpe Molloy recruitment (D2 159/221). On 10 March 2016 a nurse practitioner at the Unscheduled Care Service of the Adult Mental Health Directorate at the Royal Cornhill Hospital recorded (D1 188/677) having been told that she had a significantly heavier workload than anticipated and felt slightly overwhelmed by this and left this employment. The pursuer told me that she left this employment "partially" because of her health.

[22] On 2 July 2013 (D1 38/677) Dr Duncan reported his latest review of the pursuer to her then GP. He said that she had obtained a selective serotonin reuptake enhancer from a GP in Poland which was reportedly better tolerated and as effective as SSRIs. She had told him there was emerging evidence for it in migraine:

> "She feels that her symptoms are about 50% better on this treatment. She can now 'cope'. Her headaches are still once weekly. Her daily mild headache is unchanged. Her continuous visual symptoms with tinnitus and balance difficulties are unchanged."

2014

[23] After a consultation on 9 July 2014, the pursuer's GP recorded:

> "Is presently on medication from Poland for 18 mths not available here was for headaches but is an SSRI enhancer … Not convinced depressed ? personality issue Agreed to refer to Cornhill? psychotherapy"

[24] By letter dated 14 August 2014 (P1 590/842) a Consultant Psychiatrist responded to a letter from the pursuer's GP that it did not seem to be describing any significant current mental health problems with features of depression, past traumas or personality disorder:

> "Our clinical psychologist did not feel that your patient's difficulties met the criteria for psychological input from the adult mental health service at present. They suggested instead that [the pursuer] may be more appropriately referred to the pain clinic and the psychologist …"

[25] The pursuer was employed by BP Exploration as a Temporary Cost Accountant between 18 August 2014 and 8 May 2015. This was on a contract for services basis with Thorpe Molloy recruitment (D2 159/221).

[26] On 25 September 2014 the pursuer's GP referred her to the Counselling Service at the Torry Neighbourhood Centre (P1 586/842) citing:

> "… mental health issues dating back to her early teens. She appears to [have] attempted suicide at the age of 13 and saw a psychologist at this point and subsequently been seen by the psychiatric services with long standing low mood. She describes bouts of apathy, poor motivation, recurring suicidal thoughts, can spend days on end in her flat doing very little, then seems to recover spontaneously and has episodes where she gets out and about and enjoys her dancing and photography. It would seem that there is however a background of low mood there pretty much all the time. She is unable to pin any specific issues in her childhood or adult essence, but does report that her mum has not enjoyed good health over the years and has suffered from depression. She has a university degree a 2.2 but thinks that this should have been a 2.1 and relates this to absences from course work, lateness and sickness all, which she feels, has impacted on her university career and

> subsequently now two jobs have been lost as a result of this. We referred her to the psychology services at Royal Cornhill Hospital but they did not believe she fitted the criteria for psychological psychotherapeutic interventions … this young lady is continuing to have ongoing problems with low mood, I suspect much of her physical symptoms are related to this. Her mood is however very variable and I was not convinced at the time that I saw her that the introduction of antidepressants would be of benefit."

[27] On 25 September 2014 the pursuer's GP referred her to the Respiratory Medicine AQ Sleep Clinic at ARI (P1 423/842). She recorded that she had seen the pursuer on a couple of occasions with issues relating to recurrent headaches, low mood and anxiety:

> "She was in for review today to discuss psychological referral but wanted to discuss in more detail her sleep problems. She described for many years having excessive daytime sleepiness … In theory this sounds very much as if it is relating to her low mood and mental health…"

2015

[28] On 12 February 2015, the Sleep Clinic replied (422/842) that the pursuer had been issued with an oximeter for a two night study:

> "On returning her study and the equipment there was a note left on her sleep diary on the bottom on the comments of night two saying 'I am tired, exhausted, I have had enough and I am suicidal, as I cannot live normally, cannot work and no income'. I am concerned about this lady's mental state of health. I have telephoned the Torry Medical Practice and spoke to the on-call doctor".

[29] Thorpe Molloy records show that she was paid Statutory Sick Pay between 19 February and 8 May 2015. In the week ending 13 March 2015 (week 50) the pursuer's gross year to date pay from Thorpe Molloy was £23,004 (5/2/18).

[30] On 6 March 2015 the Sleep Clinic proposed to offer the pursuer offer her a more sensitive sleep study (P1 420/842). On 22 May 2015 the clinic reported that this made sleep apnoea much less likely as a cause for her symptoms.

[31] On 31 March 2015 a radiology and imaging specialist in Wroclaw reported on a head MRI done in SE sequence, T1 and T2 dependent and FLAIR sequence carried out in relation to complaint of double vision, headaches:

> "There is a visible cluster of oval fluid lesions in pineal area of cystic characteristics on area of around 1.5 x 2 x 1.3cm. Size of cysts up to 0.9cm. Other than that cerebrum and intracranial cerebrospinal fluid spaces do not show any abnormalities in this MRI."

The clinician's conclusions were: "Further regular MRI to monitor the described pineal region lesions." (P1 735/842)

[32] On discharge from the Affidea Wroclaw Medical Centre 1 on 15 April 2015, after an MRI scan, the recommendations included to keep taking an anti-depressant (Venlafaxine) "as before" and to "Seek psychiatric consult". (P1 737/842)

[33] On 22 April 2015, Thorpe Molloy terminated her service with BP with a two week notice with the last payment of statutory sick pay on 6 May 2015 (5/2/33 P2 216/601).

[34] Pineal cyst resection in the absence of ventriculomegaly or Parinaud's syndrome: clinical outcomes and implications for patient selection by M. Yashar S. Kalani, MD and others was published in the *Journal of Neurosurgery* on 1 May 2015 (P2 335/601).

[35] On 2 May 2015 the Infectious Diseases department of a hospital in Wroctaw reported the pursuer's CSF negative for Lyme's Disease. The discharge recommendations included: "Repeat neurological consult; Seek psychiatric consult" (P1 727/842).

[36] On 6 May 2015 the pursuer wrote to Professor Schroeder "… looking for a Neurosurgeon who could operate (if that is the recommendation)". She also asked about a cross-border funding route. The reply asked her to send her MRI scan.

[37] By 15 May 2015 the pursuer had moved within Aberdeen and changed GP as a result. She found her new GPs less sympathetic.

[38] On 27 May 2015 Professor Schroeder wrote to the pursuer (P1 753/842) commenting that in the MR images she had provided he could see a relatively large pineal cyst already compressing the aqueduct:

> "The ventricles are not enlarged but this is not a prerequisite to be symptomatic for a pineal cyst. To see an indication for surgery I need to know your symptoms. Typical symptoms for a pineal cyst are headache, sometimes nausea and vomiting, sometimes visual problems. If the cyst is asymptomatic of course no intervention should be done. Then I would recommend MR imaging in one year."

[39] A patient de-registration report (P1 152/842) dated 2 June 2015 summarises appointments with a GP surgery from 14 August 2008 to that date with reference to a "depressive episode" in 2003. The last contact was a consultation on 1 June described by the GP as difficult. The pursuer took the observation that the doctor was unclear why she had not continued with her care in Poland as a racist invitation to return to her own country. Notwithstanding the de-registration process, the same GP referred the pursuer back to Dr Duncan on 8 June in light of the MRI scan from Poland.

[40] On 12 June 2015 the pursuer completed a request for the NHS to pay for her surgery for in Germany which was scheduled for 21 July 2015 (P1 444 to 446/842). In her application, she described the treatment as:

> "RESECTION OF MULTIPLE PINEAL REGION CYSTS COMPRESSING AQUEDUCT TO ALLEVIATE:
>
> 1. Headaches
> 2. Tinnitus
> 3. Nausea
> 4. Blurry vision
> 5. Fatigue
> 6. Sleep impairment
> 7. Minimize risk of hydrocephalus and further damages to health"

[41] On 19 June 2015 her GP recorded of the pursuer's forthcoming brain surgery in Germany: "She believes that this will cure all her problems." (D1 214/677).

[42] On 22 June 2015 (D1 119/677) Dr Duncan advised the GP that, as the pursuer had advised the MRI department that she was leaving the UK, perhaps permanently, he had cancelled the scan he had earlier asked for. On 23 June 2015 the pursuer's new GP expressed the gut feeling that the pursuer would not be free of symptoms once she had the operation (P1 441/842).

[43] On 14 July Dr Duncan commented (P1 432/842) that the pursuer had not been seen locally since 2013 and that, even if the local surgeon were prepared to carry out the proposed work, there would be a delay of at least three months. Efforts to contact Professor Schroeder had been unsuccessful. The funding was agreed on 15 July (P1 748/842). Because of the short time frame in the Summer of 2015, the pursuer was not seen in ARI before her surgery in Germany.

[44] A discharge letter dated 28 July 2015 from the Neurological Clinic at the Greifswald Medicine University in Germany indicates that the pursuer was a patient from 19 July and underwent a complete microsurgical resection of a pineal cyst through a gupracerebellar infratentorial approach on 21 July 2015:

> "The patient complained of headache associated with nausea, visual disturbances, ear noise as well as feeling of pressure in her head. Since 6 months she also experienced a general feeling of weakness and sleep disturbances. She sought medical advice for which an MRI was done and revealed the simple pineal cyst."

[45] On 10 September 2015, the pursuer's GP sought advice from Dr Duncan (P1 405/842):

> "[the patient] believes that she is making some form of recovery although still has some fatigue. Interestingly, she is now focusing on some gastrointestinal symptoms that she has and is seeking investigation for these. In addition, she has mentioned that she had been treated for Lyme Disease whilst in Poland and is also making some enquiries around these areas too."

[46] On 22 September 2015 a consultant in the Sleep Clinic reported to the pursuer's GP:

> "She was referred with significant daytime sleepiness. However, her symptoms seems to have almost completely resolved since she had surgery to excise a pineal gland cyst … since then her daytime sleepiness is much better … There is no evidence of sleep apnoea and I suspect her sleep symptoms may have been due to her pineal gland problems which seem to be a lot better … Given her recent history of bowel symptoms which I understand you are investigating a proton pump inhibitor may make the diarrhoea worse so I have not suggested this at the moment. No follow-up in the Sleep Clinic."

[47] On 7 November 2015, Dr Duncan recorded (D1 229/677) that the pursuer felt that her symptoms had essentially resolved following the operation and that she was aiming to return to work in the next few weeks. Her headaches had resolved along with the tinnitus and visual disturbances. The difficulty sleeping with fatigue and exhaustion had significantly improved and almost resolved.

[48] On 11 November 2015 the pursuer underwent an MRI scan of her head (P1 728/842) which was compared with a scan from the day before her operation. The cyst was gone and the mass effect flattening the superior portion of the tectal plate had resolved.

[49] On 22 November 2015 Dr Duncan wrote to Professor Schroeder (P1 389/842) that the pursuer

> "… is doing well and feels that the majority of her symptoms have now resolved. She is headache free, tinnitus and facial distortions have resolved and her fatigue is improving."

2016

[50] On 28 February 2016 a gastroscopy and a colonoscopy were both reported as normal (D1 97/677) though the pursuer was recorded as having experienced extreme discomfort during the latter (P1 529/842). On 2 March 2016 the pursuer took an overdose of anti-depressant drugs in an acute stress reaction. On 7 March 2016, a liaison psychiatric nurse wrote to the pursuer's GP (D1 191/677) with her and her consultant psychiatrist's

assessment of the pursuer which was uninformed by access to psychiatric records. This account of the pursuer's suicide attempt did not mention the failure to report the 2013 scan correctly but seems to have focussed on conflict with a neighbour and having broken up with a boyfriend a couple of weeks earlier. The pursuer was not very hopeful of her continuing contact with Dr Duncan "... as she disagrees with the neurological opinion."

[51] On 10 March 2016 a nurse practitioner at the Unscheduled Care Service of the Adult Mental Health Directorate at the Royal Cornhill Hospital (D1 185/677) made no diagnosis with possible traits of emotional instability. He recorded that she had told him that she had tried to end her life as a result of a chronic fatigue type illness. Although her symptoms had greatly improved after her surgery in July 2015, they had been gradually returning since around October 2015. She had continually had to increase the temperature of her showers. Her reduction in sexual feelings and sensations since then had had a negative impact on her romantic relationships. She had bowel problems and lost ten kilograms over six months. At the age of 15 she had bowel issues perhaps related to stress in her academic life. She attempted suicide at the age of 13 and had psychiatric contact at the age of 15 and antidepressant medication for a time.

[52] On 29 April 2016 Dr Duncan discussed the facts of the pursuer's case at a Scottish Headache Interest Group of which he was a member (D1 177/677). None of the other professional witnesses were present.

[53] On 10 May 2016 Dr Duncan reviewed the pursuer in his Headache Clinic (D1 177/677). He apologised to her for the delay in treatment but they both acknowledged that what to do about a pineal cyst is controversial. The pursuer reported minor headaches but nothing significant. Her focus and her mental flexibility was better and she was much less clumsy. However, the difficulty in differentiating hot and cold

which had resolved with surgery, had recently recurred. Dr Duncan agreed to arrange a further MRI brain and cervical scan.

[54] On 21 June 2016, a nurse practitioner saw the pursuer at the Royal Cornhill when the break-up with her partner took up a lot of the consultation (D1 161/677). It was concluded the pursuer

> "... remains quite a complex case with multi faceted physical health concerns and further neurological assessment to be continued. She continues to exhibit traits of emotional instability..."

[55] On 28 August 2016 (P1 154/677) Dr Duncan wrote to the pursuer's GP:

> "She has previously had multiple neurological symptoms and while there has been a very clear improvement following her pineal cyst surgery I think a large amount of her symptoms will remain unexplained."

[56] By letter dated 15 November 2016 (P3 106/123) a Primary Care Mental Health Worker confirmed that he had been treating the pursuer for severe anxiety and depression since August 2016; assessment had shown that she had been experiencing severe anxiety and severe depression following an operation on her brain and the loss of her career and a close personal relationship: "This has improved very slightly but you are still experiencing a significant level of both anxiety and depression." The author supported Employment and Support Allowance for a further six months.

2017

[57] On 27 January 2017 Professor Schroeder wrote to Dr Duncan (D1 128/677) commenting on a new MRI scan he had sent earlier that month.

[58] On 15 May 2017 (D1 120/677) Dr Duncan reported to the pursuer's GP that she had had two periods of predominantly right-sided constant headache in December to February

and March to April. These had resolved and she was now symptom-free. There was some nausea but no clear migrainous features, despite which, were likely migrainous.

[59] In March to June 2017 the pursuer attended Cognitive Behavioural Therapy sessions (D1 93/677) having been referred on 9 February 2017. Her presenting problems included symptoms of depression, irritable bowel problems and chronic fatigue. The therapist recorded it being "... challenging to stay with the agreed agenda for each session as [the pursuer] would often wish to speak about her past relationships." She disclosed that she had recently twice tried an alternative treatment using injection of frog poison which causes nausea and vomiting which had helped her digestive problems. Fatigue prevented her from engaging in helpful coping structures. The therapist noted self-defeating patterns of behaviour and thought it may be that her longstanding difficulties are unlikely to respond to a short term 6-12 session model of CBT for depression.

[60] A discharge letter by a psychological therapist (D1 115/677) recorded that she had been discharged on 29 June 2017 after failing to continue her engagement.

Since 2017

[61] On 24 July 2020, the pursuer told Mr Kirkpatrick she was fit and well prior to the index illness in 2011 with no relevant past medical history:

> "She did inform me of some mild depression requiring some medicinal treatment periodically ... she was in a relationship and was very active socially and ... fit and well to carry out her domestic and leisurely activities without interruption."

[62] The pursuer described to Mr Kirkpatrick immediate relief from her headaches after the operation. Her tinnitus also improved but more gradually. Her eye symptoms likewise subsided. A year after surgery she still had some fatigue and tinnitus but everything else was more or less resolved. After two years of fatigue she improved further and the tinnitus

disappeared. Following the operation she did not return to her former work as she had also developed some gastrointestinal problems for which she was diagnosed as harbouring lamblia. Her gastrointestinal symptoms pre-dated the surgery when she was diagnosed as having irritable bowel syndrome. After the diagnosis was made there was a gradual improvement with treatment and this fully resolved in 2019.

[63] During her consultation by videolink on 25 April 2022 with Professor Carson, the pursuer began to go into the scientific literature and her understanding of it. He explained to her it was inappropriate for them to be discussing this and essentially arguing the merits of her case. She was unable to desist from doing this after a number of requests not to engage in a legal discussion or talk about the scientific literature on pineal cysts and he terminated the interview for this reason (D2 18/221).

[64] In the year to 5 April 2021, the pursuer received state benefits of £5,417.39 (P2 599/601). In the year of 5 April 2022, she received £5,443.21 (P2 600/601). By letter dated 26 June 2022, the DWP advised in light of a compliance interview with a Job Centre that her benefit award would not change at that time (P2 601/601).

(b) General

[65] In failing to report the presence of a large pineal cyst on the MRI scan of 31 January 2013, Dr Robb fell below the standard expected of a neuro-radiologist of ordinary competence.

[66] In the period of 2013 to 2015, surgery would almost never be indicated for a pineal cyst in the UK. Surgeons would only operate on pineal cysts with one or other of two symptoms: Parinaud's Syndrome (visual problems) or compression blocking the aqueduct

also referred to as ventriculomegal – enlargement of the ventricles. Neither of these were present in the pursuer's case.

[67] In the mid to late 1990s, the first papers appeared from doctors, largely in Europe, who had operated in the absence of these symptoms in cases of headaches and other symptoms. On 1 May 2015 (P2 335/601) Pineal cyst resection in the absence of ventriculomegaly or Parinaud's syndrome: clinical outcomes and implications for patient selection by M Yashar S Kalani, MD and others was published in the *Journal of Neurosurgery*.

[68] This dealt with 18 patients who underwent cyst resection in the absence of ventriculomegaly or Parinaud's syndrome. Presenting symptoms included headache (17 patients) and visual disturbances (10 patients). At a mean clinical follow-up of 19.1 months, 17 (94%) patients had resolution or improvement of their presenting symptoms. The authors suggested that ventriculomegaly and Parinaud's syndrome are not absolute requisites for a pineal cyst to be symptomatic and that a select cohort of patients with pineal cysts may benefit from surgery despite a lack of hydrocephalus or other obvious compressive pathology.

[69] In 2021 Professor Schroeder who performed the surgery on the pursuer was one of the authors of Surgical treatment of symptomatic pineal cysts without hydrocephalus – meta-analysis of the published literature by Riccardo Masina and others published in *Acta Neurochirugica* (2022) (P2 453/601). This article examined 26 published reports data as to the efficacy of surgical management of symptomatic pineal cysts without hydrocephalus (nhSPC), and assessed evidence relating to safety. 96% of 294 patients had been managed by cyst resection. Headache was the commonest symptom (87%), followed by visual (54%), nausea/vomit (34%) and vertigo/dizziness (31%). Other symptoms included focal neurology (25%), sleep disturbance (17%), cognitive impairment (16%), loss of

consciousness (11%), gait disturbance (11%), fatigue (10%), "psychiatric" (2%) and seizures (1%). Improvement rate was 93%. The study concluded that although the results support the role of surgery in the management of nhSPCs, they have to be interpreted with a great deal of caution as the current evidence is limited.

[70] In 2022 Professor Schroeder was one of the authors of Pineal cysts without hydrocephalus; microsurgical resection via an infratentorial-supracerebellar approach – surgical strategies, complications, and their avoidance (*Neurosurgical Review* June 2022 P2 192/601) based on the authors' experience of 73 patients with pineal cysts treated surgically between 2003 and 2020. These patients' symptoms included headache, blurred vision and tinnitus. 55 of 62 (89%) patients improved after surgery with good or even excellent results:

> "The high percentage of postoperative resolution of quality-of-life impairing symptoms … seems to justify surgery. Preoperatively, other causes of the leading symptoms have to be excluded."

[71] In undergoing her operation under Professor Schroeder, the pursuer was taking advantage of a growing practice in Europe of operating in circumstances in which UK surgeons would not have.

[72] On 28 December 2012 Dr Duncan asked for a scan because the pursuer's symptoms of visual distortion and tinnitus made him want to rule out a structural cause. Had the cyst been reported, he would have looked the scan at a meeting with radiology and repeated the scan in a year's time. Good practice would have included a recommendation for such follow up to exclude sinister pathology. Any such follow-up would have disclosed the existence of the cyst to the patient.

[73] By 2012 the pursuer was already seeking medical care on the continent, notably the EEG in Poland. After the negative report from the MRI scan in 2013 the pursuer continued

to pursue the European option, culminating in the surgery by Professor Schroeder in July 2015. That surgery took place four months after the cyst was detected in the Polish MRI scan on 31 March 2015.

[74] The pursuer would have pursued in 2013 the course she ultimately pursued, namely the operation by Professor Schroeder. The circumstances were not materially different from those pertaining in 2015; Schroeder and others were then carrying out such operations. The operation would have been available to her in 2013.

[75] Since the operation, the pursuer has not mentioned as a current complaint visual distortion or tinnitus or difficulty sleeping (insomnia). There is a link between lesions in the pineal cyst and disruption in sleep; the gland produces melatonin and so has to do with modulating sleep. Tinnitus and visual distortion are associated with the gland and unusual in migraine.

[76] Had Dr Robb's report of 1 February 2013 included the pineal cyst the pursuer would have arranged an operation about four months from that date. The pursuer's loss and damage occurred in the two year period between 2013 and the pursuer's operation in July 2015. During this period, she continued to suffer symptoms that would have been resolved by an earlier operation namely insomnia, visual distortion and tinnitus

[77] The improvement of these symptoms after the surgery is improvement of symptoms that the surgery was undertaken to resolve. There is no clear alternative explanation for the improvement.

Findings in fact and law

1. The pursuer has suffered loss and damage through the fault and negligence of a radiologist for whose actings the defenders are vicariously liable and is entitled to reparation therefor from the defenders.

2. The sum awarded is a reasonable estimate of reasonable reparation for the pursuer.

The evidence

The pursuer

1. The pursuer told me she was born in Poland and had a happy childhood there with normal development. She had a short stay in hospital when at school by reason of constipation and this had a knock-on effect on her school performance. The school psychologist recommended one-to-one tuition. She was prescribed a mild anti-depressant by a psychiatrist and transferred to a private high school where she was educated to a high standard. The pursuer came to the UK to visit a relative after finishing school. She found a basic labour job. In 2006 she applied for university places in the UK and was accepted by Leeds and Aberdeen. She formed her first serious relationship as a couple and lived with a partner. From January 2007 she was in temporary administrative work with the Halifax in Leeds through an employment agency. Between January and June she was in increasingly responsible roles, finally dealing with the complaints that needed more investigation. She was encouraged to go to university by the team and received a standing ovation on her last day. Later in 2007 she moved to Aberdeen to start a course at Robert Gordon's University. She chose this course because it offered sandwich placement in workplaces. She got good grades in first year and a student bursary. After the first semester she also engaged in the Citibank business challenge. This raised concerns that her partner was quite a few years

older than her and working as a painter and decorator. She decided that they were not the best match for interests, personality or ambitions in life and she decided to break up and asked him to leave. This was quite a stressful time as it was her first cohabitation with a partner and she felt a little low and it created a little emotional difficulty to deal with. She went to her GP and got the lowest dose of anti-depressant which she took for four months.

2. The financial downturn in 2009 worried the pursuer in relation to the reduction in employment prospects. She was interviewed by Shell through the Carlton Recruitment Agency and accepted a placement along with three other students. She worked full time with a salary. Shell recognised her previous experience and she was assigned to a project migrating work within the company to another country. This was from a team of analysts from the UK to India. She worked with analysts from India and attended some of their training. After that she was transferred to the financial business department supporting a senior cost analyst. She was quite highly regarded as a good employee. Towards the end of the placement which was supposed to end in May/June 2010, she was continued over the Summer to September. During that third year she also got good grades in the three course works she had to submit. Her health was unremarkable, perhaps one or two minor influenzas. She continued to take exercise.

3. She continued part-time with Shell during her fourth year at university, working more independently on smaller projects. Her managers were happy to accommodate her academic needs. Her part-time work continued until she graduated in 2011. She was offered a full time position in a team of ten analysts. She was allocated to the health and safety department and another department dealing with corporate capacity. Her salary progression was facilitated by a recruitment agency. Towards the end of 2011, she was able

to swap roles with another analyst to one supporting the operational management of three floating platforms. Her daily pay in January 2012 was £168.

4. From 2011 she was connected with the Thorpe Molloy, a very highly regarded recruitment agency in the oil sector. 5/2/61 is her contract with them from July 2011. Operators like Shell are the top employers in the sector. Having worked for them is an asset on her CV in terms of prestige in the labour market. 5/2/61 is an agency worker contract pertaining to the pursuer. She was a desirable candidate.

5. After this she was unemployed for some months. From August 2014 she worked as a joint venture control advisor for BP in relation to a gas terminal on Shetland. This involved reviewing monthly figures and making sure there was compliance with contracts and financial regulations. She was involved in creating a budget and with presenting that budget to joint venture partners. The pursuer's three month contract was extended to the end of 2014 and it was made very clear that it would be renewed to at least June 2015. 5/27 of process is the Thorpe Molloy Agency Worker Pack she received, showing that she was employed as a Temporary Cost Analyst from 18 August 2014 to the end of the year at a daily rate of pay of £211.74.

6. The pursuer adopted 5/64 of process, a document of her own headed Witness Statement – Employment. She started to experience neurological symptoms around June 2011. Between then and January 2013, her symptoms gradually got worse, especially headaches. She often had to take days off - 1 to 2 a month on average. She struggled with sleep and tiredness. By the end of 2012 she was unable to attend the daily Offshore-Onshore Operations Meeting at 8am. Rather, she was starting work around 9.30. Although her concentration deteriorated and she struggled with tasks, she still had high achievements and received spot awards for her performance.

7. Her headaches were of two types; in 2011 she gradually noticed mild sensation of pressure inside which was "somewhat horrible". Also, once or twice a week, more seriously, she had pain from the back of her head towards the front. Some days this prompted her to stay in bed. On 26 June 2011, the pursuer consulted NHS24 with a history of having hit her head two weeks earlier (P1 346/842) complaining of headaches.

8. The pursuer narrated a chronology of events by reference to medical records included in her first inventory which I have incorporated, as far as material, in the first section of my findings in fact.

9. The pursuer travelled to Wroclaw in Poland and underwent an EEG scan on about 28 August 2012. A report (P3 112/123) by a consultant neurologist and clinical neuro-physiologist recorded that carried out on the pursuer showed a "Small pathology requiring observation" and recommended a follow up visit in 3-4 months.

10. The pursuer underwent an MRI brain scan on 31 January 2013. By letter dated 13 February 2013 (P1 451/842) Dr Duncan reported to her that it was normal.

11. At this stage, the pursuer was looking to be properly informed about surgery. She had read of patients who had "… died relating deaths to pineal cysts. It was a risk to consider." She was concerned that features of her cyst were atypical, including the multiloculation, the internal division of the cyst. The pursuer should have been told of her cyst in 2013 which she assumes would have prompted a multi-disciplinary team review of the treatment options. It was her right as a patient to have had the various possible treatment options explained, specifically the conservative and the surgical. Sudden death is a grave risk and, if conservative treatment was proposed, this risk should have been mentioned. The pursuer became emotional as she maintained it would have been her right to consider the various risks of each type of treatment in light of her health, financial

situation, spiritual and emotional state, family and social considerations. Given her circumstances in 2013, the pursuer believed that she would have followed the same route then as she ultimately did in 2015. She could have done so in a couple of months.

12. Counsel for the defender objected that the pursuer was reading out the test in *Montgomery* v *Lanarkshire Health Board* [2015] UKSC 11 (11 March 2015) 2015 SC (UKSC) 63.

13. In 2013 she was negotiating terms for a permanent job with Shell when she got an offer from another company. In February, she received a diagnosis of migraine which she had the impression was not serious, especially in light of the MRI scan reported to her as normal. Following prolonged discussions that year, the pursuer applied in December 2012 for a position on Shell's staff created specifically for her at a salary of £40,000 a year with a £3,000 bonus but she was "… swayed to take a contract with Cape instead, as at that time it was a different role that gave a little more variation to my experience …"

14. Had the pursuer known her full medical condition, that there were lesions in the brain she would have decided to stay with Shell, on a permanent staff basis because of the security of the job.

15. After interview she was employed from April to October 2013 as a commercial coordinator with Cape. In that role she was responsible for the commercial and financial contract worth about twenty-five million pounds. She got to travel to a gas terminal run by Total on the north-east coast.

16. She started with Cape PLC in March/April 2013 in the role of Commercial Coordinator, being promoted after a month or two to Commercial Manager. Her health issues caused her to start late – often 9.30 or 10am – so that she had to stay late. She had to take days off for headaches and growing tiredness. She gave her notice in September 2013

as her condition continued to deteriorate, difficulty in concentrating adding extra stress so that she felt she could not cope with this very responsible role.

17. She decided to take time off and pursue artistic endeavours for a while. Early in 2014, then needing a wage, she applied for Job Seeker's Allowance but when she failed to keep an appointment, this was stopped in May. In August 014 she started as a financial analyst with BP supporting Sullum Voe Gas Terminal in Shetland. Although she had to take a day off in the first month, her three-month contract was extended in December 2014 to June 2016.

18. She went to her GP in February 2015 and was signed off sick in March, very tired and unable to work. She was prescribed anti-depressants but felt that this did not address the nature of her concerns so, still signed off, she went to Poland for private tests. Thorpe Molloy terminated her service with BP with a two week notice with the last payment of statutory sick pay on 6 May 2015.

19. On 25 September 2014 the pursuer's GP referred her to the Respiratory Medicine AQ Sleep Clinic at ARI. The GP made reference to the pursuer's mental health – her general mood was deteriorating because of her ongoing problems; she was getting frustrated at not getting better despite all the investigations. On 12 February 2015, the Sleep Clinic replied (P1 422/842) that the pursuer had been issued with an oximeter for a two night study: On returning her study and the equipment there was a note left on her sleep diary on the bottom on the comments of night two saying "I am tired, exhausted, I have had enough and I am suicidal, as I cannot live normally, cannot work and no income". I am concerned about this lady's mental state of health. I have telephoned the Torry Medical Practice and spoke to the on-call doctor."

20. On 20 March 2015 the pursuer consulted Dr Barowski in Poland. He made a thorough examination of her vision, carried out ultrasound checks and received the outcome of an MRI scan of her brain. A couple of days later she consulted a professor of infectious diseases and had blood tests including Lyme's disease. She underwent a lumbar puncture to check cerebral spine fluid and may have stayed overnight in hospital though she did not recall exactly.

21. The pursuer consulted a number of specialists on the continent including Professors Zub and Schroeder. She also researched publications by doctors from around the world including Europe and the UK. A recurring theme emerged that there were both specific and non-specific symptoms. Her symptoms of headache, nausea and fatigue were in the latter category. She also had some mood problems. She was quite distressed at the time by the years of migraine diagnosis and the lack of progress in resolving her symptoms. On 6 May 2015 the pursuer wrote to Professor Schroeder "… looking for a Neurosurgeon who could operate (if that is the recommendation)". She also asked about a cross-border funding route. The reply asked her to send her MRI scan.

22. By 15 May 2015 the pursuer had moved within Aberdeen and changed GP as a result. She found her new GPs less sympathetic.

23. Professor Schroeder's discharge letter dated 28 July 2015 (P1 407/842) indicates that the pursuer underwent a complete microsurgical resection of a pineal cyst on 21 July 2015 at the Neurological Clinic at the Greifswald Medicine University in Germany. However, the letter is incorrect because her sleep disturbances had been occurring for more than the six months stated. It was confirmed to her that a single large pineal cyst was removed.

24. As Dr Duncan reported to Professor Schroeder on 22 November 2015 (P1 389/842), the pursuer did well after the operation and the majority of her symptoms resolved. Her sleep improved and her energy level increased.

25. In April/May 2016 she suffered from pain and a problem feeling the temperature of hot water. She does not know if it was related to having lain in bed for long periods. She had a decline in health because she lost her job with the associated financial consequences and spent long periods in bed with extreme fatigue. All these factors contributed to a decline in well-being and were related to cramps and pain in her abdomen. She was quite weak after the brain surgery and had tests for a parasite infection organised by her GP who also prescribed antibiotics for her bowel problems. She had not problems with her bowels before 2015

26. On 19 June 2015 her GP recorded of the pursuer's forthcoming brain surgery in Germany: "She believes that this will cure all her problems." (D1 214/677). Professor Carson records that as far as the pursuer was concerned, all her health problems were related to negligence. (D2 24/221). In cross-examination the pursuer did not recall saying either of these things and doubted whether she had said what Professor Carson had noted.

27. Professor Carson records that during her consultation by videolink with him on 25 April 2022, the pursuer began to go into the scientific literature and her understanding of it. He explained to her it was inappropriate for them to be discussing this and essentially arguing the merits of her case. She was unable to desist from doing this after a number of requests not to engage in a legal discussion or talk about the scientific literature on pineal cysts and he terminated the interview for this reason (D2 18/221). Asked about this in cross-

examination, the pursuer said that she had mentioned it once or twice and he said it was unethical for him to discuss it.

28. In February 2015 she went to her GP and in March she was off sick

29. Because of difficulties with her bowel, bloating and a diagnosis of IBS, the pursuer tried different diets, including a vegetarian diet for quite some time. After two weeks on a ketogenic (a high fat) diet, her headaches resolved and she found it anti-inflammatory. This was one of the things she said to the defenders' experts at interviewed which was simply ignored by them.

30. The pursuer underwent a gastroscopy and a colonoscopy which were both reported as normal on 28 February 2016 (D1 97/677) but the pursuer suffered tremendous pain during the latter procedure. She was crying from the pain despite the drugs intended to make it bearable. She did not feel the same person and three days later made a suicide attempt. She has continued to have symptoms since then, a lot of time related to the stressful situation of paying for this process and the experts. She lost her job and career and had to deal with the mental health impact of that and the consequences of not reporting the MRI scan. She wrote a suicide note mentioning hopelessness, pain in her abdomen and the loss of opportunity to enjoy life and hobbies. These misfortunes would not have developed to this level if told of the cyst. She contrasted the life she was leading – working and enjoying swimming, dancing and rock-climbing with a cyst that could burst at any moment, fatigued and staying in bed most of the time in 2013 and the months leading up to the surgery. Things were better after the surgery; she started a business project and, while still fatigued, her sleep was restful.

31. On 25 September 2014 the pursuer's GP referred her (P1 589/842) citing "... mental health issues dating back to her early teens …" These were a reference to teenage arguments with her mother.

Krzysztof S

32. The pursuer's father gave evidence from Poland with the aid of a Polish interpreter.

33. Mr S spoke of his daughter's early life in rosy terms similar to the evidence of the pursuer. Like her, he was much less forthcoming in cross-examination. He had played a significant role in obtaining medical treatment and reports on the continent but had very little direct experience of his daughter's condition when living outwith Poland.

Professor Alan Jackson

34. Professor Jackson (65) is emeritus professor of radiology at Manchester University. He now gives expert evidence on neuro-radiology. Although they were both drafts, he was happy to adopt reports he prepared on 3 September 2018 and 18 March 2020.

35. The pineal mass lesion was clearly visible on the scan of 31 January 2013. This should have been included in the report, which is entirely inaccurate. This standard of reporting is outside what would be expected of a qualified neuroradiologist.

36. The witness measured the cyst at 12 by 20 by 13 millimetres. The cyst on the 2015 scan was measured at 17.25 by 13 by 16 millimetres. He would regard the difference as being within the measurement error. It is extraordinarily difficult to assess whether cysts have grown. The best way is to put the images side by side and compare them visually.

37. The reason it was important to identify the cyst in the report is the risk that such lesions are malignant. Good practice would have included a recommendation for follow up

to exclude sinister pathology; Professor Jackson would have proposed a colour-enhanced scan. Any such follow-up would have disclosed the existence of the cyst to the patient.

38. The witness did not criticise the failure to disclose the cyst on the basis that the failure prevented the pursuer from having surgery at any stage. Surgeons will classically only operate on pineal cysts with one or other of two symptoms: Parinaud's Syndrome (visual problems) or compression blocking the aqueduct. Neither of these were present in the pursuer's case. The operation used to be very hazardous. In the mid to late 1990s, the first papers appeared from people who operated in the absence of these symptoms in cases of headaches and other symptoms and 2016 a survey of neuro-surgeons was published. A majority had not operated in such circumstances, but everyone who had said the patient had improved. So this raised the issue of revising the treatment guideline. Before 2016 this surgery was mainly in Poland, Czech Republic and Germany. As early as 2008 a Polish group reported two cases in which benign pineal cysts responded to surgery. So in 2013 there might have been a surgical intervention on the Continent but not in the UK. Professor Jackson did not see such a case until 2018. The lack of the likelihood of surgery in the UK in 2013 is re-enforced by the lack of surgery in 2015 when it was still not accepted practice.

39. If malignant, the cyst would have been so from the start. In 2019 Professor Schroder who performed the surgery on the pursuer published the largest series of cases ever presented "to try and clarify the indications and clinical course of patients after resections of pineal cysts without ventriculomegaly". This series appears six years after the original MR investigation in this case and starts with the sentence:

> "surgical indications for patients with pineal cysts are controversial. There are absolute indications such as hydro catalysts or technical compression; otherwise it is

> difficult to decide whether surgery would be beneficial when symptoms are not distinct."

40. The study concludes that presentation with headache or visual disturbances are an indication for surgery when other causes have been excluded. However, this information was clearly not available in 2013. In addition, even though outcome in this cohort was good the authors conclude "we must admit that there is still no evidence to recommend this technique as a treatment of headache in these patients."

41. Professor Jackson spoke with great authority and clarity and I am happy to accept his evidence.

Peter Kirkpatrick

42. Mr Kirkpatrick adopted his reports of 1 September 2020 (5/19 P2 /601) and 15 November 2021 (5/69). He is a consultant neurosurgeon based at the University of Cambridge Hospital Trust having been appointed in 1995. He has over 24 years of experience at Consultant level in all aspects of general cranial and spinal Neurosurgery.

43. In addition to medical records and Professor Jackson's reports and the pleadings, Mr Kirkpatrick conducted a zoom meeting with the pursuer on 24 July 2020. On 24 July 2020, the pursuer told Mr Kirkpatrick she was fit and well prior to the index illness in 2011 with no relevant past medical history:

> "She did inform me of some mild depression requiring some medicinal treatment periodically ... she was in a relationship and was very active socially and ... fit and well to carry out her domestic and leisurely activities without interruption."

44. The pursuer told Mr Kirkpatrick that following her surgery in July 2015 and an inpatient stay of ten days, she returned to the UK. She described immediate relief from her headaches after the operation. Her tinnitus also improved but more gradually. Her eye

symptoms likewise subsided. A year after surgery she still had some fatigue and tinnitus but everything else was more or less resolved. After two years of fatigue she improved further and the tinnitus disappeared. On 24 July 2020, her current situation was that she had little fatigue but considered her energy levels to be around 80% of her normal. Before the surgery she quantified her energy levels to be around 5%. Following the operation she did not return to her former work as she had also developed some gastrointestinal problems for which she was diagnosed as harbouring lamblia. Her gastrointestinal symptoms pre-dated the surgery when she was diagnosed as having irritable bowel syndrome. After the diagnosis was made there was a gradual improvement with treatment and this fully resolved in 2019.

45. Some conditions can be diagnosed from the symptoms of which the patient complains but the symptoms of a pineal cyst are very nebulous; they usually include headaches which are the most common cause of enquiry. Pressure on the adjacent neural structures can disrupt vision and lead to dizziness. There is also a link to poor sleep pattern and general apathy and fatigue. No neurologist could diagnose from these symptoms. The approach is always "We don't know what's wrong – let's do a scan."

46. The witness was unable to identify any particular psychological feature. He was not aware of "frank" psychiatric symptoms – they were all secondary. The most major concern was a sudden and abrupt disruption to the brain fluid. Pineal cysts are highly unpredictable as to how they behave. It is not known how they are formed – it may be genetic. Nor do we have a great handle on how they progress. There are a whole range of ways in which to treat them including observation. A lot are operated on but it is not easy surgery and there are risks associated to that it is possible to make a patient considerably worse.

47. A neurologist/neurosurgeon who had been presented with a patient with the pursuer's symptoms together with an MRI scan showing a complex pineal cyst formation with resulting mass-effect on the MRI scan, would have considered the pineal cyst to be potentially relevant. In these circumstances, rare that they are, a consideration for surgery would have been discussed and offered to the patient. The decision would have involved a multidisciplinary team discussion, and a clinical review by a neurologist who would be asked to determine whether the cyst could be responsible for her symptoms. He would not operate on a pineal cyst in the absence of a helpful comment from a neurology colleague.

48. Mr Kirkpatrick thought that, given the pursuer's "spectacular" response to surgery, the offered diagnosis of functional neurological disorder went against clinical common sense.

49. Cross-examined, Mr Kirkpatrick agreed that pineal cysts are unpredictable but mostly benign. They are mostly an incidental finding in an MRI scan. They very often do not grow. He did not dispute that some shrink though he had never seen this. He disagreed with the proposition that in 2013 in the UK there was no practice of operating in the absence of hydrocephalus or Parinaud's Syndrome; he thought we were getting into a grey area. However, he agreed that in 2018 and, even today, surgery in the absence of these specific symptoms remains controversial.

50. His view that the pursuer's minor head injury had rendered the cyst symptomatic was on the basis of the chronology.

51. I do not think that the pursuer's account of her condition before the event in June 2011 that Mr Kirkpatrick thinks triggered her symptoms is a sound foundation for his opinion evidence. More significantly, he attributes her stomach symptoms soon after the operation to an organic cause (giardiasis) for which there is no support in her medical

records. The account he attributes to her, that her gastrointestinal symptoms pre-dated the surgery when she was diagnosed as having irritable bowel syndrome likewise do not accord with the records before me.

52. In his closing submissions, counsel for the defenders made criticisms of this witness based upon comments in judgments in other cases. As these were not put to the witness, I have not used them against him.

Dr Olive Robb

53. Dr Robb retired in 2014 having spent almost all her career in Aberdeen, latterly as consultant neuro-radiologist from 1992. She had not done any medical work since retirement. She interpreted the MRI scan of the pursuer and reported the day after it was taken on 31 January 2013. She did not meet the pursuer and had no active memory of the case. Pineal cysts were something they began to see with the improvement of scanning. In her view pineal tumours arose in the pineal region and some of them can behave aggressively. Pineal cysts are benign. They are usually found where a scan was being carried out for some other purpose.

54. Dr Robb was shown the letter from Dr Duncan of 28 December 2012 (D1 510/677) requesting an MRI scan. The expression "structural cause" was a phrase routinely used in requests and meant no more than something identifiable as a cause. It was almost redundant to add a requirement that it be visible since that was the nature of the radiologist's task.

55. Dr Robb would have carried out her task on a system of dual monitors. She would not have met the patient or had any of her medical records.

56. Dr Robb accepted retrospectively, that there was an abnormality. It was difficult to answer whether it should have been reported as an abnormality; she would prefer if she had but it was not the most obvious lesion. It was difficult to have a neutral attitude to the images once she had seen the Polish scan.

57. In cross-examination, Dr Robb accepted that she was aware of the potential negative consequences of non-reporting of lesions but also of the dangers of over-reporting. Had she identified the lesion, she would have described it. Her feeling was that she analysed it but came to the wrong conclusion. She would have reached the conclusion it did not constitute an abnormality. The machine available was perhaps older than the one in Poland but it was the available one.

58. Dr Robb addressed the issues of how she now thought she had misinterpreted the scan but, as she had no actual recollection of what she did, I have some hesitation with regard to the competence of her opinion evidence albeit it was led without objection by both parties.

Dr Callum Duncan

59. Dr Duncan has been a consultant neurologist at the Aberdeen Royal Infirmary since 2008. He adopted his CV of March 2022 (6/27). He is a general neurologist with a special interest in headache. He had an active recollection of his dealings with the pursuer. He was first involved in 2012. His first letter in that regard was on 28 December 2012 (D1 46/677; P1 606/842)). Tinnitus and visual distortion are unusual in migraine and Dr Duncan wanted to be sure there was not an underlying structural cause. A persistent aura is always unusual. This is a disturbance of neurological activity. Referred to his letter of referral to radiology of the same date (D1 510/677) he said he did not have a specific place

in mind to be concentrated upon. On 2 July 2013 (D1 38/677) Dr Duncan recorded an improvement in the pursuer's condition. As regard the unlicensed medication she was using, he did not have safety concerns but could not recommend it: "I suppose I was being pragmatic". The fifty percent improvement in headache was a reasonable one; he assumed before me that it was her medication.

60. The pursuer was referred back to Dr Duncan by letter of 24 September 2013 (D1 456/677).

61. He recorded after her surgery in a letter of 7 November 2015 (D1 229/677) that she had reported that her symptoms of headache, bilateral tinnitus and visual distortions had all resolved. Her difficulty sleeping with fatigue and exhaustion had significantly resolved and almost resolved.

62. Dr Duncan had been involved in the decision to fund her operation in Germany although he felt that the cyst was not connected to her symptoms. The pursuer thought it was symptomatic.

63. On 29 April 2016 Dr Duncan discussed the facts of the pursuer's case at a Scottish Headache Interest Group of which he was a member (D1 177/677). At that meeting the participants were uncertain whether the cyst would be symptomatic. Dr Duncan's colleagues were not able to identify the abnormality on the image presented until pointed out but, once pointed out, it was obvious. None of the other professional witnesses were present.

64. On 28 August 2016 (D1 154/677) Dr Duncan wrote to the pursuer's GP:

> "She has previously had multiple neurological symptoms and while there has been a very clear improvement following her pineal cyst surgery I think a large amount of her symptoms will remain unexplained."

65. On 15 May 2017 (D1 120/677) Dr Duncan reported to the pursuer's GP that she had had two periods of predominantly right-sided constant headache in December to February and March to April. These had resolved and she was now symptom-free. There was some nausea but no clear migrainous features, despite which, were likely migrainous. Dr Duncan thought they were the same headaches as before the operation. The visual distortion and the tinnitus were the symptoms associated with the pineal gland and there was no recurrence of these. The pursuer told him the tinnitus had resolved after the operation.

66. Cross-examined, Dr Duncan denied feeling affected in his dealings with the pursuer by the threat of litigation. Referred to Pineal cyst resection in the absence of ventriculomegaly or Parinaud's syndrome: clinical outcomes and implications for patient selection by M Yashar S Kalani, MD and others published in the *Journal of Neurosurgery* on 1 May 2015 (P2 535/601) Dr Duncan considered the article controversial; the decision to fund the pursuer's operation in Germany had been made because it was to be undertaken by a reputable expert in the field and a reassessment of the patient's condition would have caused a delay in the operation. He acknowledged that one of the criteria for not funding was if the procedure carried excessive risk but, the German surgeon was of international renown and known to do a lot of this kind of work so that the risks were acceptable. The ultimate decision was made by the medical director. Asked if he felt the surgery should not have happened, he replied that he was uncertain and again referred to the delay further assessment would have caused.

67. Dr Duncan had asked for a scan because the symptoms of visual distortion and tinnitus made him want to rule out a structural cause. Had the cyst been reported, he would have looked the scan at a meeting with radiology and repeated the scan in a year's time.

68. Dr Duncan acknowledged the link between lesions in the pineal cyst and disruption in sleep; the gland produces melatonin and so has to do with modulating sleep. But it did not make him link the cyst to the pursuer's symptoms like headaches and disrupted sleep; there was a lot of uncertainty about these symptoms. Taking them as a group the cyst was an incidental finding.

69. Re-examined, Dr Duncan agreed that surgery would have been available in Aberdeen if clinically indicated, the decision being for a surgeon.

70. Time and again when reviewing the evidence in preparing this judgment I have found it useful to return to Dr Duncan's contemporaneous records and oral evidence both of which I value for their fairness and moderation.

Dr Myles Connor

71. Dr Connor adopted his reports of 25 March 2019 (6/3 D1 647/677) and 27 July 2022 (6/7 D2 41/221). He is a consultant neurologist with the Borders General Hospital. He has a special interest in functional neurological disorders (FND).

72. Dr Connor's principal report concluded that because the symptoms of which the pursuer complained did not fall within the established symptoms of a symptomatic pineal cyst, they originated elsewhere. He did not acknowledge the validity of the basis on which Professor Schroeder undertook surgery on the pursuer. In his oral evidence he was clear that he would not have supported surgery.

73. In relation to tinnitus, Dr Connor recognised an interaction between the tectal plate and the auditory networks. The news that on 24 July 2020, the pursuer told Mr Kirkpatrick that a year after surgery she still had some fatigue and tinnitus but everything else was more or less resolved and that after two years of fatigue she improved further and the tinnitus

disappeared added weight to his view that favoured migraine. He would not expect visual symptoms from a pineal cyst. They are very clearly compatible with migraine. Similarly, migraine and other things cause fatigue. It is not a symptom of a pineal cyst even given the link to melatonin.

74. Functional neurological disorders include a wide range of symptoms which are often considered unexplained. The structure of the nervous system in people with FND is normal but it does not function normally. It spans the boundary between neurology and psychiatry. People with FND often have a range of associated symptoms with a high representation of IBS and unexplained pain. He accepted that there was no reference to FND in the pursuer's medical records but both the GPs and Dr Duncan had made reference to unexplained symptoms and that is what they were alluding to. Psychiatrists may use the term somatic disorder.

75. Dr Connor thought the recurrence of some (though not all) of the pursuer's symptoms relatively soon after surgery supported the diagnosis of migraine and otherwise a placebo effect, the assumption that improvement in the patient's condition was caused by a medical intervention.

76. I found Dr Connor wedded to the concept of functional neurological disorders in a manner that contrasts with other practitioners and closed to the basis on which the pursuer's surgery had taken place. These features of his evidence very much limited the weight I was able to place on his evidence.

Dr Peter Keston

77. Dr Keston adopted his CV (6/29 D5 16) and his reports of July 2022 (6/4 D2 3/221) and imaging and comments (6/5 D2 11/221). Dr Keston is a consultant Interventional Neuroradiologist.

78. Informed by informal polling of relevant professional colleagues, Dr Keston thought that up to a quarter of ordinarily competent neuro-radiologists would have failed to spot the pineal cyst in the 2013 scan. Asked whether the failure of Dr Robb to report the pineal cyst in 2013 reflected a difference of view or practice or a mistake understandable in the circumstances, Dr Keston was clear that it was the latter, an error of observation many of us would make.

Patrick Statham

79. Mr Statham adopted his CV (6/30 D5) and his report from July 2022 (6/8 D2 57/221). He has been a consultant neurosurgeon since 1993.

80. Looking back to the period of 2013 to 2015, surgery would almost never be indicated for a pineal cyst. The only indication would be an enlarging cyst causing appropriate and significant symptoms. Hydrocephalus might produce appropriate symptoms. The two involved are raised intercranial pressure and Parinaud's syndrome. Other than acute hydrocephalus, a surgeon would want the involvement of a neurologist.

81. Removing these benign and otherwise harmless lesions can cause both physical harms, as in detectable neurological deficit and death, but also psychological harm in a number of ways. Firstly, the expectation that surgery will abolish symptoms, despite provisos from the surgeon that surgery may not always work, can lead to disappointment, and in the vulnerable patient, worse, precipitating depression or suicide. Secondly the

undermining of professional colleagues leads to a loss of trust between patient and medical professionals in future years. For instance, when the pursuer experienced further headache in 2017, she phrased her complaint as "was told in the past that headaches were from migraines, *then [told they were] from pineal cyst*", inferring incompetence on the part of the doctors diagnosing her headache. But time has shown that the wise approach to the pursuer was that of her GP, through psychological support rather than surgery, the latter having not done her any good, other than through an early placebo effect for three months after surgery. Add to this the whole business model of being Director of surgery in an academic institution in Germany, where the director decides on admissions and finances, encourages health tourism of patients, particularly those with unexplained symptoms but semi plausible lesions causing them. The preoperative assessment of the pursuer's symptoms in the German Neurosurgical unit, particularly headache, would be considered below a standard of care from a neurosurgeon in the UK. None of the prior psychological problems were acknowledged. There were no physical signs to support a diagnosis of raised intracranial pressure, and no tectal plate signs, suggesting local compression of the midbrain. Most importantly the natural history of the condition was never explained, nor the uncertainties about whether the pursuer's symptoms did or did not relate to the presence of a pineal cyst, which may be seen in 50% of the population. If neurosurgeons in the UK were to offer operation for all the cases of pineal cyst seen on an MR scan, who also had migrainous headache, we would see how ineffective the procedure is, and how much morbidity is produced from overtreatment of a harmless condition. Removal of the pineal cyst was not a reasonable option to offer the pursuer.

82. Having attended international meetings, Mr Statham was familiar with literature and, to some extent, practice in this regard on the continent. In 2013 to 2015 their threshold

for surgery was very different and much lower than that in the UK, demonstrating a willingness to operate on scan findings when surgeons in the UK would not. It was quite clear from his paper that Professor Schroeder was happy to consider treatment for pineal cysts causing a multitude of symptoms when we would not be happy with that at all.

83. Mr Statham was taken through a number of journal articles some of which he was familiar with.

84. Mr Statham was perhaps the high point in the culture clash between practice in the UK and the continent. His evidence would have been most in point had I had to choose between the two schools of thought. His disapproval of what he saw as a practice of undertaking surgery that carries serious risks on the hypothesis that it might do some good did not address the issue of whether the surgery actually undertaken had been beneficial.

Professor Alan Carson

85. Professor Carson adopted his CV (D5 23/52) which cites 254 published items. He has been a consultant neuropsychiatrist since 2000. He adopted his report of 19 July 2022 (D1 17/677) which substantially proceeds on a consultation by video link with him on 25 April 2022

86. By his reading of the records:

> "... the pursuer had periods of symptom remission when treatments were tried. A significant placebo response is commonplace in such a presentation and well-recognised. Certain interventions will be likely to have more placebo than others. I strongly suspect the initial very positive response to neurosurgery was largely mediated by placebo. My logic for saying this is that her disability in terms of the fatigue, in terms of the headache, and in terms of the bowel symptoms all returned, as did mood disturbance and indeed she ended up in a suicidal state. There is no long-term evidence that removal of the pineal cyst made a systematic difference to her symptoms."

87. Professor Carson records that as far as the pursuer is concerned, all her health problems were related to negligence. (D2 24/221) .

88. Professor Carson records that during the consultation, the pursuer began to go into the scientific literature and her understanding of it. He explained to her it was inappropriate for them to be discussing this and essentially arguing the merits of her case. She was unable to desist from doing this after a number of requests not to engage in a legal discussion or talk about the scientific literature on pineal cysts and he terminated the interview for this reason (D2 18/221).

89. Professor Carson made a convincing case for the pursuer's currently obsessional approach to the issues before me.

NOTE

The pursuer

[1] I regret that I do not consider that the pursuer is a reliable historian. There is a marked contrast between the way in which she presented her childhood to me and the manner in which she is recorded as having done so on previous occasions, notably when on 25 September 2014 the pursuer's GP referred her (P1 589/842) citing

> "... mental health issues dating back to her early teens. She appears to [have] attempted suicide at the age of 13 and saw a psychologist at this point and subsequently been seen by the psychiatric services with long standing low mood. … It would seem that there is however a background of low mood there pretty much all the time. She is unable to pin any specific issues in her childhood or adult essence, but does report that her mum has not enjoyed good health over the years and has suffered from depression."

[2] Similarly, on 10 March 2016 a nurse practitioner at the Unscheduled Care Service of the Adult Mental Health Directorate at the Royal Cornhill Hospital (D1 185/677) recorded:

> "She attempted suicide at the age of thirteen and had psychiatric contact at the age of fifteen and antidepressant medication for a time. She had bowel issues at the age of 15 perhaps related to stress in her academic life, linked to low self-esteem following a difficult first year at school where she had to repeat a year."

When this was put to her in cross-examination, she had nothing to say about it.

[3] I regret that I consider these reported accounts of her childhood and earlier years more accurate than the picture she sought to give me, given that she did not lodge any record earlier than 2008 and no significant record from the continent.

[4] I am afraid, her evidence as to more recent events was also less than satisfactory; Dr Duncan's detailed account of her complaints in December 2012 (P1 606/842) records mild recurrent headaches since her teens. The pursuer denied this but pressed as to whether she might have said this to Dr Duncan, could not recall. Referred to her GP records for 2008 to 2010 (D1 68/677), the pursuer could only vaguely recall the events narrated such as having been admitted to Ninewells Hospital in Dundee with abdominal pain on 30 August 2010. Nor did she recall having been depressed since splitting from her partner in January 2011, gradually worsening by the time she saw the GP on 9 June 2011.

[5] Despite having reported headaches to NHS24 in June 2011, she told physiotherapy in April 2012 that her headaches had only been happening for two months and that she had no on-going or previous problem with her health. On that occasion she said the headaches were all the time having been occasional whereas, by 6 July 2012, she complained to the ARI Department of Otolaryngology/Head & Neck Surgery only of five months' occasional headache. Her father's evidence did not materially assist.

[6] Dr Duncan's detailed account of her complaints in December 2012 (P1 606/842) records mild recurrent headaches since her teens with no associated migrainous features.

[7] On 19 June 2015 her GP recorded of the pursuer's forthcoming brain surgery in Germany: "She believes that this will cure all her problems." (D1 214/677). Professor Carson records that as far as the pursuer was concerned, all her health problems were related to negligence. (D2 24/221) In cross-examination, the pursuer did not recall saying either of these things but, having seen and heard her at length, I consider that they capture an essence of the pursuer's attitude to the matters before me. Some flavour of the pursuer's obsession with the case may be got from the fact that during her consultation by video link on 25 April 2022 with Professor Carson, the pursuer began to go into the scientific literature and her understanding of it. He explained to her it was inappropriate for them to be discussing this and essentially arguing the merits of her case. She was unable to desist from doing this after a number of requests not to engage in a legal discussion or talk about the scientific literature on pineal cysts and he terminated the interview for this reason (D2 18/221).

[8] In my view, the pursuer significantly over-stated her professional success; From August 2014 she worked for BP. In chief she said she was a joint venture control advisor in relation to Sullum Voe gas terminal on Shetland and that her three month contract was extended to the end of 2014. However, the document from the employment agency confirming her assignment details (P2 55/601) on which she relies describes the role as Temporary Cost Analyst and the likely duration as to the end of the year. She presented an email dated 16 October 2014 (P3 39/123) from Thorpe Molloy informing her of a cost analyst vacancy paying £200 to £230 a day as if it were a job offer which does not reflect my understanding of how recruitment agencies work.

[9] In the circumstances, I have largely based my findings on the medical records to which the parties made reference. To a significant extent these rely on what the pursuer said

at the time which I regard as a reasonable contemporaneous basis for judgments both for and against her.

A Was there negligence?

[10] I find that in failing to report the presence of a large pineal cyst on the MRI scan of 31 January 2013, Dr Robb fell below the standard expected of a neuro-radiologist of ordinary competence. She did not act in accordance with a practice accepted as proper by a responsible body of medical opinion.

[11] In this regard I accept the evidence of Dr Jackson.

[12] Dr Robb had no recollection of her assessment. In any event, she did not seek to justify her failure to report; rather, she sought to explain what might have happened.

[13] Dr Keston thought the failure to report understandable but, asked to characterise it between a decision made by a body of opinion and a mistake, chose the latter without hesitation.

[14] Contrary, therefore, to the view urged by Mr MacSporran, there is no opposing school of thought among the relevant group of responsible medical practitioners between which I am asked to choose.

[15] At this stage, I comment on the evidence of Dr Duncan as to what was said when he discussed the facts of the pursuer's case at a meeting of the Scottish Headache Interest Group on 29 April 2016 (D1 177/677) and of informal polling of relevant professional colleagues by Dr Keston. I do not consider such evidence helpful; the opinions expressed are not to be compared with those of a skilled professional engaged to learn about a case and give expert opinion.

[16] While I accept Dr Duncan's evidence that none of the other professional witnesses were present at the Scottish Headache Interest Group meeting, I do not consider that the level of engagement in such an exercise would in any event have justified the fears of the pursuer of a conspiracy of professionals against her.

B What would have happened if the pursuer had been told of the pineal cyst in early 2013?

[17] I accept that Dr Duncan would have proposed a conservative approach to the cyst with a review in a number of months.

[18] In this regard, I am accepting the evidence of those with more immediate knowledge of practice in Aberdeen than Mr Kirkpatrick.

[19] However, by 2012 the pursuer was already seeking medical care on the continent, notably the EEG in Poland. The department of Otolaryngology/Head & Neck Surgery, physiotherapy and the optician had all been pursued without relief. It was noted at the Spinal Hub that she felt happier with a neurology appointment relating to her headaches.

[20] After the negative report from the MRI scan in 2013 the pursuer continued to pursue the European option, culminating in the surgery by Professor Schroeder in July 2015. That surgery took place four months after the cyst was detected in the Polish MRI scan on 31 March 2015.

[21] In the circumstances, I accept the pursuer's evidence that she would have pursued in 2013 the course she ultimately pursued, namely the operation by Professor Schroeder.

[22] I also accept that the operation would have been available to her in 2013. This is not because the ARI would have assisted in this regard; the impression that the traditional approach of not operating would have prevailed is very strong. But the Kalani and more

recent articles indicate that Schroeder and others were carrying out operations on the basis set out in that article at the relevant time. The circumstances were not materially different from those pertaining in 2015.

C What was the consequence of the operation in Germany?

[23] The symptoms on the basis of which the pursuer sought to have the defenders pay for her operation were

1. Headaches
2. Tinnitus
3. Nausea
4. Blurry vision
5. Fatigue
6. Sleep impairment

[24] On 10 September 2015, the pursuer's GP sought advice from Dr Duncan (P1 405/842): "[the patient] believes that she is making some form of recovery although still has some fatigue. Interestingly, she is now focusing on some gastrointestinal symptoms that she has and is seeking investigation for these."

[25] On 22 September 2015 a consultant in the Sleep Clinic reported to the pursuer's GP:

> "She was referred with significant daytime sleepiness. However, her symptoms seems to have almost completely resolved since she had surgery to excise a pineal gland cyst … since then her daytime sleepiness is much better …"

[26] In his letter of 7 November 2015 (D1 229/677) Dr Duncan records "...very clear improvement following surgery". He lists the existing complaints:

- Headache
- tinnitus

- visual disturbance
- difficulty sleeping (insomnia)
- fatigue/exhaustion

[27] Dr Duncan records the pursuer's information that the first three had resolved by then and that the other two had significantly improved and almost resolved.

[28] On 22 November 2015 Dr Duncan wrote to Professor Schroeder (P1 389/842) that the pursuer:

> "… is doing well and feels that the majority of her symptoms have now resolved. She is headache free, tinnitus and facial distortions have resolved and her fatigue is improving."

[29] On 10 March 2016 a nurse practitioner at the Unscheduled Care Service of the Adult Mental Health Directorate at the Royal Cornhill Hospital (D1 185/677) recorded a complaint of a chronic fatigue type illness.

[30] On 10 May 2016 (D1 177/677) the pursuer reported minor headaches but nothing significant.

[31] On 15 May 2017 (D1 120/677) Dr Duncan reported to the pursuer's GP that she had had two periods of predominantly right-sided constant headache in December to February and March to April. These had resolved and she was now symptom-free. There was some nausea but no clear migrainous features, despite which, were likely migrainous.

[32] Mr Kirkpatrick records of her interview with him on 24 July 2020 (P2 9/601):

> "14) After the operation, she described immediate relief from her headaches. Her tinnitus also improved but more gradually. Her eye symptoms likewise subsided.
>
> 15) A year after surgery she still had some fatigue and tinnitus but everything else was more or less resolved. After two years of fatigue she improved further and the tinnitus disappeared.

> 16) The current situation for [the pursuer] is that she has little fatigue but considers her energy levels to be around 80% of her normal. Before the surgery she quantified her energy levels to be around 5%"

[33] This was presented by the defenders as evidence of the return of the symptoms but, against the background of her general unreliability as a historian, I do not so view it. Rather, it is clear that of the pre-operation complaints, in 2020, she only had the fatigue. This is consistent with the other evidence that supports the conclusion that fatigue was never entirely resolved after the operation.

[34] Viewing the individual complaints, it seems that since the operation, the pursuer has not mentioned as a current complaint visual distortion or tinnitus or difficulty sleeping (insomnia). Dr Duncan acknowledged the link between lesions in the pineal cyst and disruption in sleep; the gland produces melatonin and so has to do with modulating sleep. Dr Duncan asked for a scan because the pursuer's symptoms of visual distortion and tinnitus made him want to rule out a structural cause. Tinnitus and visual distortion are unusual in migraine and the link with the gland seems to be stronger.

[35] Headache is more problematic given the substantial body of opinion diagnosing her headaches and associated symptoms as migraine. Moreover, the pursuer complained of two periods of predominantly right-sided constant headache in December 2016 to February and March to April 017 which Dr Duncan thought in May 2017 were likely migraine.

D Did the failure to report the 2013 scan correctly cause the pursuer loss and damage?

[36] One of the key features of this case is the proper treatment of pineal cysts in the absence of the two known effects (Parinaud's Syndrome (visual problems) and compression

blocking the aqueduct also referred to as ventriculomegaly – enlargement of the ventricles). Neither of these were present in the pursuer's case.

[37] The traditional view espoused by Dr Connor and Dr Duncan regards cysts lacking these signs as asymptomatic and, as pineal cysts do not generally grow or become cancerous, they do not support surgery. They look for other explanations of symptoms such as headaches. Migraine is a very broad term capable of including a wide range of symptoms – Dr Connor's evidence left tinnitus as a potential symptom of both pineal cyst and migraine.

[38] Much of the defenders' evidence was directed at the unwisdom of undertaking surgery in the circumstances of the pursuer; much less at the proposition that the improvement she demonstrated was not caused by the surgery. Insofar as the defenders did undertake this, it was by reference to a number of diagnoses including migraine, functional neurological disorder and placebo. I consider it significant that there is no clear alternative diagnosis to the proposition that the pursuer's condition was improved by the operation in Germany.

[39] The placebo effect performs a cautionary role against the presumption that improvement after medical intervention is objectively caused by that intervention. However, I do not consider that the view that resolution after surgery of symptoms that the surgery was designed to resolve is caused by the surgery falls into this error in the same way.

[40] The defenders also relied on the fact that the pursuer moved quite quickly after her operation to a number of complaints associated with FND. More than one GP in more than one GP practice took the view that there was "an underlying psychological distress". The pursuer also has a history of potentially relevant symptoms before the 2013 scan. However,

much of the opinion evidence that any improvement must be regarded as placebo was given against a frank disbelief in the appropriateness of the surgery that was undertaken. Given a suspension of that disbelief, what we have is the fact is that since the operation, the pursuer has not complained of significant insomnia or visual distortion or tinnitus. In this regard, I distinguish between complaint and her recollections of when these symptoms abated.

[41] The defenders called Professor Carson to propone that any benefit from the operation was placebo on the logic that her disability in terms of the fatigue, in terms of the headache, and in terms of the bowel symptoms returned, as did mood disturbance and indeed she ended up in a suicidal state.

[42] The same logic applies in my view to the symptoms that did not return. The fact that the pursuer has complained of a number of symptoms supportive of functional overlay does not affect this conclusion.

[43] It is a sound principle that where a person has, by breach of a duty of care, created a risk, and injury occurs within the area of that risk, the loss should be borne by him unless he shows that it had some other cause. In my view, Dr Robb's breach of duty of care created a risk to the health of the pursuer from the cyst remaining untreated. The symptoms that the pursuer suffered during the period of two years after the scan are injury within that area of the risk. No other cause has been shown.

E If so, what was the extent of that loss and damage?

[44] On the foregoing basis, had Dr Robb's report of 1 February 2013 included the pineal cyst the pursuer would have arranged an operation about four months from that date. This is generous to the pursuer because it may well be that exhausting the Aberdeen route would have taken longer in those circumstances than it took in 2015 but, taking a very broad brush,

it seems to me that the pursuer's loss and damage occurred in the two year period between 2013 and the operation in July 2015.

[45] For the avoidance of doubt, I reject suggestions made by the pursuer in various contexts of a harm from the 2013 omission outlasting the 2015 operation. There was no coherent evidence to that effect.

[46] Nor do I accept that the pursuer has proved any link between the failure to identify the cyst in 2013 and any loss of earned income. The pursuer has a complex psychological set of issues and I accept the view attributed to her GP that, to the extent that the operation in 2015 resolved them, they were replaced by further problems rendering her unfit for meaningful work. She has, in any event, failed to produce any acceptable evidence of an earning capacity in her current chosen profession as a therapist or otherwise.

[47] So during the two years to July 2015, the symptoms that the pursuer suffered that were alleviated by the operation were insomnia, visual distortion and tinnitus.

[48] This is not a conclusion that either party wanted and neither addressed me on it. It gives rise in my view to a modest award of *solatium* in respect of the delay in the operation occasioned by the failure to detect the cyst in 2013.

[49] In the circumstances, I issued an invitation to the parties in an interlocutor dated 18 September 2023 indicating in general terms my findings and inviting submissions in writing as to how much that *solatium* should be. Both responded in writing. The defenders cited a number of damages cases and submitted that the award should be £5,000. The pursuer sought to go behind the basis on which she had been invited to make submissions and did not propose a figure and cited a case that did not address the issue I had identified[1].

[1] *John* v *Central Manchester and Manchester Children's University Hospitals NHS Foundation Trust* [2016] EWHC 407 (QB) (2 March 2016)

[50] The pursuer but not the defenders sought an oral hearing on this issue. I do not consider an oral hearing necessary.

[51] Although the defenders properly set the issue in the context of the fact that the pursuer was suffering from what they termed "a constellation of varying symptoms … in respect of the majority of which the pursuer is not entitled to damages", the cases they cite seem to involve shorter periods than I have found. In all the circumstances, I consider the appropriate award of *solatium* to be £7,500.

[52] That sum will carry interest at the judicial rate from the end of the month in which the operation finally took place – July 2015.

[53] I was not addressed on expenses and invited the parties to agree the outcome in that regard or, failing agreement, to enrol the relevant motion. Both parties made written submissions seeking an award of expenses. This time both parties sought a hearing once they had seen the final judgment. As I am proposing to hold such a hearing, I will not decide the issues raised now.