Case No: B65YM427

IN THE NORWICH COUNTY COURT

Before HHJ WALDEN-SMITH:

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Between :

RACHEL MARIA DE ROEPER	**Claimant**
- and -	
(1) NHS COMMISSIONING BOARD	**Defendants**
(2) ANDREW RAMSAY	

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- -

SOPHIE MORTIMER (instructed by **Gotelee solicitors**) for the **Claimant**
SAM STEVENS (instructed by **Bevan Brittan LLP**) for the **First Defendant**
LIONEL STRIDE (instructed by **Browne Jacobson LLP)** for the **Second Defendant**
Hearing dates:

- -

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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HHJ KAREN WALDEN-SMITH SITTING AS A JUDGE OF THE HIGH COURT

HHJ WALDEN-SMITH:

Introduction

1. Ms Rachel Maria de Roeper brings this claim against both the NHS Commissioning Board and Mr Andrew Ramsay alleging clinical negligence with respect to ophthalmic examinations of Ms de Roeper conducted by Mr Ramsay on 29 August 2012 and 19 September 2012.

2. Ms de Roeper's complaint is that there was a failure on the part of Mr Ramsay to conduct detailed retinal examinations upon her so that there was a failure to identify at either the 29 August 2012 or the 19 September 2012 examination that she was suffering from an inferior retinal detachment (macular on) and had that been identified at that stage then she would not have sustained a sudden and profound deterioration in her visual acuity which resulted in an inferior retina detachment, involving the macular, on 30 October 2012.

3. The first examination on 29 August 2012 was a private consultation and the claim relates to the Second Defendant, Mr Ramsay, with respect to that examination. The second examination on 19 September 2012 was booked through the NHS Choose and Book scheme and was paid for by the West Suffolk Primary Care Trust. It is for this reason that the claim with respect to the second examination on 19 September 2012 is against the First Defendant, the NHS Commissioning Board ("NHS"). The claim is brought against the NHS on the basis that the NHS is vicariously liable for any acts or omissions on the part of Mr Ramsay at the appointment on 19 September 2012.

4. The NHS is therefore only concerned with the second examination and while Mr Ramsay rigorously denies being negligent in his examination at either consultation, the NHS have made limited admissions with respect to breach of duty at the second examination. Causation is, however, denied with respect to both examinations. The admission made by the NHS was an early admission and is contrary to Mr Ramsay's position and contrary to the expert evidence called on behalf of the defendants. However, the NHS has not sought to resile from that limited admission in the interests of saving costs. The admission has no affect upon the issue as to whether there was a breach of duty with respect to the first examination.

5. Both Mr Ramsay and the NHS dispute that there was a retinal detachment in existence at either the first examination on 29 August 2012 or at the second examination on 19 September 2012; that if there were such a retinal detachment at that time then it was not possible for a competent doctor to identify it at that early stage; and that, in any event, there would be no significant difference in outcome for Ms de Roeper.

Factual Background

6. In summary, Ms de Roeper has had a number of issues with respect to her eyes and sight. She is an artist and her sight and the difficulties that she has undergone has caused her particular anxiety and stress.

7. Prior to the matters that are of concern in this case, Ms de Roeper had a history of hereditary optic atrophy and myopia, together with atopic conjunctivitis and dermatitis. In or about July or August 2012 she developed a new floater in her left

eye together with flashes and she went to her optician who referred her on to Mr Ramsay who she first saw on 29 August 2012. As I will set out in further detail there is a substantial factual dispute with respect to that first examination. As a consequence of that examination Mr Ramsay recommended cataract surgery, subject to the optician being in a position to do something else to assist.

8. The optician concluded that there was nothing further she could do and at a further examination on 19 September 2012 it was concluded that Ms de Roeper should undergo cataract surgery – the first to her left eye.

9. The cataract surgery took place on 19 October 2012. At first there were no concerns expressed by Ms de Roeper but by approximately 26 October 2012, she was suffering from significant visual deterioration. An urgent referral was made by her optician to the West Suffolk Hospital and on 30 October 2012 she was diagnosed as having a left posterior vitreous detachment and an inferior bullous retinal detachment with an inferotemporal retinal tear with shallow fluid at the inferior macular.

10. A retinal detachment repair was undertaken by Mr Newman on 31 October 2012 at Addenbrookes. Ms de Roeper has made a recovery from that surgery. Her visual acuity returned but she alleges that she was left with a significant reduction of her colour vision in her left eye, an indication of damage to the macular, which impacts on her abilities as an artist. She also experiences anxiety, depression and PTSD.

Evidence

11. In addition to the evidence of Ms de Roeper herself and her two witnesses of fact, Paula Cornish and Samantha Spalding (now Green), Ms de Roeper relies upon the evidence of Mr Dominic McHugh, a Consultant Ophthalmic Surgeon, and Mr Christopher Fox, Consultant Psychiatrist.

12. The NHS and Mr Ramsay rely upon Mr Ramsay's own evidence and Professor Simon Taylor, Consultant Ophthalmic Surgeon, on behalf of the NHS and Mr Robert Cooling, Honorary Consulting Ophthalmologist, who gave evidence on behalf of Mr Ramsay. Dr Latcham, Consultant Psychiatrist, gave evidence on behalf of the defendants.

13. Ms de Roeper is now aged 49. As mentioned above, she is an artist and, in addition to a number of other employment roles, including in marketing and account management and business development, she has worked as an artist during her adult life. That is plainly her vocation. Any interference with her ability to see clearly and sharply causes her considerable distress.

14. She had a history of optic atrophy which appears to have been a genetic disorder that she inherited from her father. As a consequence, Ms de Roeper has had to wear glasses and contact lenses at a prescription of between 2.5 and 3.75. The corrective lenses enable her to drive and read and, most importantly to her, carry out her art work without any difficulty. She also has a history of atopic conjunctivitis and dermatitis which was being dealt with through the department of dermatology at the West Suffolk Hospital through 2011 and 2012.

15. Her evidence was that in August 2012 she developed a problem with her vision, particularly in her left eye, where she describes herself as having:

> "Cloudy, misty vision and I was seeing flashes and spots in my eye and appeared to have a shroud over the top of the part of the vision in my left eye. In the very early stages the shroud started in the right hand corner of my left eye but then settled over the top of my left eye. I recall the shroud got in the way of my vision and I would try opening my left eyelid by hand in the hope that it was something to do with my left eyelid dropping down but this made no difference and the shroud was still there. I also had a 'wave' effect across my vision."

In her first statement, Ms de Roeper describes "the shroud "in these terms:

> "In the very early stages the shroud started in the right hand corner of my left eye but then settled over the top of my left eye"

16. Ms de Roeper said that she visited her optician, Patricia Callear, on 30 July 2012 and on 17 August 2012. It was Patricia Callear who referred Ms de Roeper to Mr Ramsay for a private consultation by letter dated 17 August 2012. In that letter of referral, Ms Callear sets out that Ms de Roeper had been diagnosed with optic atrophy and that "she is an artist and is almost paranoid about her vision, understandably I think". Ms de Roeper said that she was worried about losing her sight and told Ms Callear that she was seeing the "shroud" and using that word to describe what she was experiencing. I will turn to the expert evidence in more detail in due course but it is clear that the experts all understand that, while the word "shroud" is an unusual description, it refers to an obstruction or fixed area of defective vision. Mr McHugh describes it as being a description of a partial obstruction of the visual field. Mr Cooling and Professor Taylor describe it in their joint statement as follows:

> "Her description ranges from shrouded vision to a "shroud". She does importantly localise the "shroud" in her field of vision. We therefore interpret her use of the term "shroud" as meaning a fixed or constant area of missing or defective vision extending to the far periphery of the visual field above. This would be synonymous with seeing a shadow or a curtain in the field of vision."

17. The experts are agreed that, given her description, if she did report a shroud at either of the consultations then it is likely, on the balance of probabilities, that she was suffering a retinal detachment and that it would have been identifiable at that time.

18. The letter of referral from Ms Callear does not refer to Ms de Roeper complaining that she was seeing a shroud but does say that her vision is poor, that she had new floaters and an occasional flash. The letter set out that it was a complex case and that was the reason why it was a private referral as being the best way to help Ms de Roeper. Nowhere in the list of difficulties – including the reference to facial eczema with the need to take steroids topically and orally, the myopia and changes to vision, and the new floaters and flashes – is there any reference to a shroud. In her written

witness statement, Ms de Roeper refers to having "developed" a problem in August 2012. In her oral evidence to the court she said that she had told Patricia Callear of her shroud in July 2012 and that it got worse in August 2012. Ms de Roeper said that the referral letter was not inaccurate but that it failed to include everything, including any reference to her description of the shroud

19. Mr Ramsay was recommended to Ms de Roeper by her optician as being "one of the best and an expert in his field". He has been a Consultant Ophthalmologist since 1 February 2001 and therefore had more than 11 years' experience as a consultant when he examined Ms de Roeper in August 2012. He provided details to the court of his training and experience.

20. Ms de Roeper says that she told Mr Ramsay at the consultation on 29 August 2012 that her "vision was cloudy, that I could see flashes and spots in my eye and there appeared to be a shroud over the top part of my left eye which interfered with my sight." It is accepted by Mr Robert Cooling, the Consultant Ophthalmologist called on behalf of the Second Defendant, that had Ms de Roeper been complaining of a shroud in July or August 2012 then that was evidence of the existence of a retinal detachment which would have been identifiable upon examination at that time. Mr Ramsay's account refers to her complaining about intense ocular and facial discomfort, smearing of her already hazy vision, photophobia, dryness and glare, as well as symptoms of floaters in her left eye. There was no reference to a shroud. Ms de Roeper says that Mr Ramsay did not appear to be paying any attention to what she was saying about the flashes and spots and that she had a 'shroud' and that he was much more concerned with the fact that she had cataracts and that they needed to be dealt with by being operated upon and that she would be able to see far better after the cataract operation. Ms de Roeper alleges that Mr Ramsey barely examined her putting her in front of "a normal optic lens" that she put her chin on. What Mr Ramsay says he did was perform an indirect ophthalmoscopy as well as a 3-mirror examination on the slit lamp microscope and that was what Ms de Roeper was describing. He says he examined her in this way because she was not able to tolerate scleral indentation and that while the equipment would look materially different to a patient compared to what would be seen at a teaching hospital, what he did was to dilate the pupils in order to examine her retina and that he did not find any detachment. He denies absolutely that there was a macula-on inferior retinal detachment at the time of his examination in August 2012.

21. In his contemporaneous note of the consultation on 29 August 2012, Mr Ramsay does not make any note that Ms de Roeper had complained of the existence of a shroud although he does refer to new floaters in the left eye. Mr Ramsay said that by examining Ms de Roeper's retina by using a slit lamp microscope he could see that the vitreous had shifted which could be the same as a posterior vitreous detachment (PVD). He did not make a note of that finding in his notes and he did not inform Ms de Roeper or refer to it in his letter to Dr J Masters of Angel Hill Surgery, Bury St Edmunds. He said that the reason he did not record PVD at that time was because there was insufficient evidence at the time of the 29 August 2012 examination to do so, and having previously been criticised for recording a PVD when there was not sufficient evidence, he is wary of recording a PVD without better evidence. Mr Cooling set out that diagnosing PVD can sometimes be difficult and if a clinician is not sure there is PVD then there is no requirement to record it or to inform the GP.

22. In his manuscript note of the examination he refers to Ms de Roeper's visual acuities, the optic disc pallor on fundoscopy, and the bilateral cataracts which were more marked on the left. He also refers to atopy, atrophic conjunctivitis, ocular surface disease and a new left floater. His record and his letter to Ms de Roeper both refer to the new floaters but have no reference to either a shroud or a shadow, the reason for that being that he says that Ms de Roeper did not mention any such interference with her eyesight at the examination on 29 August 2012. His plan was for cataract surgery if matters did not improve and Ms de Roeper described how pleased she was that this surgery was, according to Mr Ramsay, going to provide a marked improvement in her eyesight and that she would see far better than she had ever seen before. She said that she felt thrilled and very relieved. Mr Ramsay did not record his negative findings but Mr Cooling said that he would not expect him to do so. He said that it would not be usual to record that there was no finding of pigment cells.

23. Ms de Roeper was given a lift home from that first consultation by her long-standing good friend Paula Cornish. Ms Cornish gave evidence to say that she recalls that at this time she was handing in her own dissertation and so it was a time she recalled well and that Ms de Roeper was talking about a shroud. It is important to note that Ms de Roeper was telling her friend that Mr Ramsay had advised her that it was all due to cataracts and that everything would be alright after the operation. Ms Cornish says that her own brother is an optician and told her about retinal detachment. It is difficult to believe that Ms Cornish would not have mentioned her brother's view to Ms de Roeper, who was apparently "banging on about the shroud all the time", if in fact at that time Ms de Roeper was informing her that Mr Ramsay had said it was all due to the cataracts which he would operate upon.

24. I am in no doubt that both Ms de Roeper and Ms Cornish are doing their very best to recall what happened when. However, there is always a difficulty in pinpointing when things happened and when there is a passage of time memories can become clouded and it is genuinely difficult to know what was the situation at the time and what has been coloured or over laid by information received at a later date.

25. I am satisfied that when Mr Ramsey saw Ms de Roeper in August 2012 she did not say anything to him about seeing a shroud and that she did not mention a shroud to her optician, Patricia Callear, either in July or August. Had she been talking about a shroud, it is accepted that this would be evidence of an interference with her field of vision. In my judgment, Ms de Roeper was neither experiencing interference to her vision through the existence of a shroud nor was she telling anyone of the existence of a shroud. I am satisfied that she was not reporting seeing a shroud and she was not experiencing the effects of the shrouded vision as a consequence of retinal detachment at that time.

26. Both Mr Ramsay and Ms Callear were very detailed in their reports about Ms de Roeper and the various difficulties that she was suffering at that time. While Ms de Roeper is adamant that she mentioned shrouded vision at the time and that it was a difficulty that she says she was suffering from since July 2012, I do not accept that to be the case. There is no suggestion that Ms de Roeper is being dishonest and I accept that she genuinely and honestly believes that she was suffering from a visual field defect from July and August 2012 and that she told Mr Ramsay of this vision field defect by describing it as a "shroud". That is such an unusual description to use

that there is even more reason for it to have been noted in the examination record had it been mentioned by her. As it is such a graphic description, it would have alerted Mr Ramsay to there being a serious issue with her eyesight.

27. Despite Ms de Roeper's certainty, supported by the evidence of her friend Paula Cornish, I am satisfied on the evidence before me that there was no mention of the "shroud" or vision field defect by Ms de Roeper before or at the consultation on 29 August 2012.

28. I am also satisfied that Mr Ramsay undertook an appropriate examination of Ms de Roeper when he saw her at that first consultation on 29 August 2012. I accept his evidence that he undertook an examination of the retina with an indirect ophthalmoscope together with a condensing lens and a Goldman three-mirror contact lens in order to obtain an overall picture of the state of the retina. Ms de Roeper was intolerant of scleral indentation as a consequence of her eczema and that was the reason for the use of the indirect ophthalmoscope.

29. In looking for a vitreal detachment, Mr Ramsay says that he looked for the presence of pigment cells but that he would not record a negative if there were no pigment cells present. Mr Cooling and Professor Taylor, called on behalf of Mr Ramsay and the NHS, accept his method of examination on 29 August 2012 as being entirely appropriate. Mr McHugh, the Consultant Ophthalmic Surgeon called on behalf of Ms de Roeper, accepts that if (as I have found) Mr Ramsay had undertaken the examination in the way he described then that would not be a breach of duty. He does criticise Mr Ramsay for his failure to record all his findings – including negative ones – as it "only takes a matter of seconds" to do so. While it would have been of great assistance to Mr Ramsay to have been able to point to a more detailed record of the examinations undertaken, as that would have avoided a great deal of the argument, it does not amount to a breach of duty. Mr Ramsay had recorded "nil else fundus" which is consistent with his stated practice of not recording specific negative findings.

30. In order to establish that Mr Ramsay was in breach of his duty of care it is necessary for Ms de Roeper to establish that he acted in a manner which is not accepted as proper for an ordinarily competent medical practitioner by a responsible body of medical opinion (see *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118). Given the opinions of the experts in this case and my finding that Mr Ramsay carried out the examination as he describes, that breach of duty cannot be made out with respect to the examination on 29 August 2012.

31. It may well be that, quite understandably, Ms de Roeper did not appreciate the nature of the examination which was being undertaken. Ms de Roeper was extremely, and understandably, anxious. She was also upset that Mr Ramsay appeared to her to be talking over her and that he had come to a firm view that the difficulties with her eyesight related to her cataracts and that he was not listening to other concerns. However, with respect to the allegation that he had ignored her reference to suffering from a shroud, there is no suggestion of such a complaint contained within Ms de Roeper's initial letter of claim dated 20 April 2015. The first occasion when Ms de Roeper complained that she had referred to a shroud at the first examination was not until her statement dated 12 April 2017. While not conclusive, that is supportive of

my conclusion that she did not mention a shroud in August 2012 but, in looking back at events, she is genuinely misremembering what happened.

32. In summary, therefore, with respect to the first examination on August 2012 I find that there was an appropriate examination and that there was no breach of duty. I further find that Ms de Roeper did not inform Mr Ramsay at the first examination, and had not previously informed her optician Ms Callear, that she was suffering the effects of a shroud to her vision.

33. While I have found that there was no breach of duty with respect to the first examination on 29 August 2012, as mentioned above, there has been an admission of a breach of duty by the NHS with respect to the second examination on 19 September 2012. On 25 August 2015, in response to the letter of claim dated 20 April 2015, the NHS wrote as follows:

> "It is accepted [that] the examination carried out by Mr Ramsay on 19 September 2012 fell below a reasonable standard of care. Due to the Claimant's symptoms of new onset flashes and floaters in the left eye a full examination of the posterior segment of the eye would be expected.
>
> However it is not accepted a full examination would have revealed a detached retina. This allegation is denied and the Claimant is put to strict proof.
>
> It is denied the Claimant was suffering from retinal and/or macula detachment prior to 26 October 2012…"

34. The NHS have not resiled from that admission in the defence, stating at paragraph 8 :

> "… the First Defendant (the NHS) repeats its admission of breach of duty in respect of the examination on 19 September 2012 in the terms set out in its Letter of Response dated 25 August 2015. The First Defendant does not seek to resile from that admission."

although it is acknowledged by the NHS in its reply to Part 18 requests that the admission was made without any input from Mr Ramsay. For his part, Mr Ramsay does not accept that there was a breach of duty at the second consultation.

35. Mr Ramsay saw Ms de Roeper for a second time on 19 September 2012, having been referred by her GP on 3 September 2012. This appointment was funded by the NHS pursuant to the "Choose and Book" scheme as Ms de Roeper was not in a financial position to pay for the cataract operation. At that appointment, Ms de Roeper says that she explained to Mr Ramsay that she was suffering from cloudy and misty vision, that she was still suffering from floaters and flashes and that they had not improved. She also says that she felt her vision was deteriorating and that the "shroud" or shadow had settled in the upper part of her left eye. She said that during this period her vision was getting worse, everything was looking grey and "the shroud had lowered to cover more of my left eye" with the flashes becoming more frequent. She said that overall the symptoms were becoming more intense and that she was

distressed about the potential consequences with her eyesight. Mr Ramsay denies any reference to a shroud being made by Ms de Roeper and contends that he carried out an appropriate examination.

36. Again, there is nothing in the contemporaneous note of the examination in September 2012 which supports Ms de Roeper's contention that she was complaining of experiencing the effects of a "shroud" at that time. She describes the shroud as *"like looking through a window where the view is framed by the size of the window but when someone pulls down a blind it either partially or completely blocks out the view."* If Ms de Roeper had said at that time that she had the effects of a "shroud" over her eyes then this would have indicated a visual field defect. Mr Ramsay said that people often refer to a shadow or curtain or black patch. As I have already set out above with respect to the August 2012 examination, the description of a shroud is sufficiently unusual that it would be expected for both Mr Ramsay and Ms Callear to have remarked upon it in the contemporaneous records, had it been mentioned by Ms de Roeper.

37. It is clear from Ms de Roeper's evidence that she is convinced that she was suffering from a visual field defect both at the time of her first examination by Mr Ramsey in August 2012 and at the time of the second examination in September 2012.

38. Mr Ramsay does not deny the reference to floaters and flashes. He relies on his note of his examination on 19 September 2012 which records the existence of a posterior vitreous detachment but which does not make any reference to shrouded vision. He states that his examination and management plan was formulated in the context of a patient with known atopic lens opacities, optic atrophy, high myopia and atopic conjunctivitis or ocular service disease. He noted no peripheral retinal abnormalities and he drew a diagram of the retina with a tick beside it. He did record PVD. There is no reference to a visual field defect in that note. I am satisfied that Ms de Roeper did not inform Mr Ramsay at the second examination that she was suffering from a shroud impacting on her vision.

39. In the letter dated 20 September 2012 sent to Ms Callear, Mr Ramsay sets out that his diagnosis was that she had (1) atopic conjunctivitis and ocular surface disease and cataract; (2) New left floater which is visually intrusive [information that Mr Ramsay says he had to ask directly about and not something Ms de Roeper volunteered to give]; (3) Long standing optic atrophy limiting vision to 6/12; and (4) moderate myopia. Both in that letter and in the note of the examination, Mr Ramsay notes that the cataract surgery would not alter the existence of the floaters. Again, there is no reference to a visual field defect.

40. The letter dated 20 September 2012 was dictated in front of Ms de Roeper and, while it would be unfair to suggest that she ought to have had a full understanding of all that was being said by Mr Ramsay, it would be surprising for the one thing that she says was causing the greatest concern to her, namely the existence of the shroud, not to have been mentioned and for her not to raise that with Mr Ramsay. What is clear from the contents of the letter and the note of the examination is that Ms de Roeper was concerned to ensure that she could continue to drive. The cataracts were impacting on her ability to do so but, before undertaking surgery, Mr Ramsay wished to ensure that it was not possible to improve her vision with the use of spectacles so as

to avoid the need for surgery. It is also clear from the letter and the note of the examination for 19 September 2012 that Mr Ramsay was not attributing all her problems to her cataracts. It is apparent from the manuscript note and the letter dated 20 September 2012 that there was an issue with Ms de Roeper being atopic and suffering from eczema. Mr Ramsay said that she had "problems at the front, middle and back of the eye."

41. In response to the request from Mr Ramsay to ensure that there was nothing else that could be done to correct the vision so as to avoid the need for cataract surgery, Patricia Callear confirmed on 21 September 2012 that there was nothing further she could do and she referred her for cataract surgery with Mr Ramsay as her surgeon. Ms de Roeper also telephoned herself to say that she was anxious as she needed surgery as soon as possible and suggesting the 19 October, which Mr Ramsay agreed to. There is then a further post it note which provides that Ms de Roeper was "very depressed, needs surgery as soon as possible."

42. Ms de Roeper was in contact with her former school friend Sam Spalding (now Green) throughout this period and she records that Ms de Roeper told her that she was unhappy at the time that Mr Ramsay was not properly listening to her and hearing her concerns. If that is correct, Ms de Roeper was still content to use the "Choose and Book" scheme to request Mr Ramsay to undertake the cataract surgery, which took place on 19 October 2012.

43. Mr Ramsay says that the cataract surgery was unremarkable and the post-operative notes dated 20 October 2012 do not identify any issues. There was an issue that is recorded by both Ms de Roeper and by Mrs Green which is that the eye that required cataract surgery first was the left eye, whereas Mr Ramsey had obtained her consent to surgery on the right eye. Mrs Green describes in her witness statement that Ms de Roeper was asking Mr Ramsay exactly what he was going to be doing and on which eye and that *"… as she was asking these questions Mr Ramsay was talking over her and did not appear to me to be listening to what she was saying or answering her questions…I went through the paperwork that Rachel [de Roeper] had given me and to my surprise it did refer to the right eye and not to the left eye which was the one she was due to have operated on."* Mrs Green managed to resolve that issue by talking to one of the nursing staff. This appears to have been an error on the part of Mr Ramsay, although he says that he was obtaining consent for both eyes as the right eye would also have needed to be operated on at some point. If he did identify the incorrect eye, it gives support to Ms de Roeper's case that Mr Ramsay would talk over her but it does not impact upon whether there has been negligence in the alleged failure to identify a detached retina at that stage. There is no finding of a retinal detachment during the course of the cataract surgery.

44. While Mr Ramsay rigorously denies there having been any breach of duty and there is nothing in the evidence which would suggest that the second examination was not carried out in accordance with Mr Ramsay's duty of care, the limited admission of the NHS (given when no instructions had been obtained from Mr Ramsay) with respect to that second examination means that it is not necessary to consider further whether there was in fact a breach of duty.

45. Both Mr Ramsay and the NHS strongly argue that, even with a breach of duty in the second examination, Ms de Roeper is unable to establish causation. It is argued on behalf of Mr Ramsay and the NHS that there was no retinal detachment in either August or September 2012 and that the retinal detachment developed later so that, whatever examination had been undertaken in August and September 2012, it would not have identified a detachment requiring immediate surgery.

46. Ms de Roeper contends that, even without a finding that she was experiencing and reporting a "shroud" indicating the existence of a retinal detachment at the time of the examinations, the symptoms of flashes and floaters at that time, was indicative of a retinal detachment. She relies on the evidence of Mr McHugh that the type of retinal detachment diagnosed at the end of October 2012 is indicative of a relatively lengthy period of development of the detachment over a period of weeks to months rather than days. The evidence of Mr Cooling and Professor Taylor, on behalf of Mr Ramsay and the NHS, is that the detachment was acute and progressive and developed subsequent to the consultations and possibly brought on by the cataract surgery.

47. Subsequent to the cataract surgery on the left eye, Ms de Roeper's optician, Patricia Callear, recorded on the "Post-Operative Cataract Information Form" dated 26 October 2012 that the outcome of the surgery was "satisfactory". The note of the examination on 26 October 2012 contains a request for the second eye to be referred for cataract surgery.

48. However, it appears from the contemporaneous documentation, that things had changed by 28 October 2012 as there is a record on the Ophthalmology and Eyecare Multi-Purpose Referral Form that visual acuity had dropped over the previous 3 days and that the eye is painful. The form is marked as urgent and the request is made that Ms de Roeper be seen as soon as possible. The experts are agreed that on the basis of the reported symptoms and the subsequent diagnosis of an interior retinal detachment with macular involvement it is probable that the detachment involved the macula on 28 October 2012.

49. On 30 October 2012, Ms de Roeper was seen at Ophthalmic Outpatients at West Suffolk NHS Trust where reference was made to her "feeling awful" and that she was suffering from a "bleed shadow" for 6 weeks, "nasally initially" and that she had flashes for the past 6 weeks which had calmed. Ms de Roeper was described as being "very anxious". A letter to her GP from Dr Thomas of the Ophthalmology department dated 30 October 2012 set out the following

> "This lady was referred with symptoms following recent left cataract extraction. The most salient one seems to be a spreading show starting nasally in the left eye some six weeks ago and spreading to involve a superior visual field. There were flashes at the onset.
>
> Examination shows left pseudophakia with some expected level of inflammation. There is a PVD on the left and a[n] inferior and temporal retinal detachment that is just involving the inferior macular"

50. In the letter of referral to the Eye Treatment Centre at Addenbrookes, Dr Thomas sets out the following on the same date:

> "She describes many symptoms 10 days following LE cataract surgery including a foreign body sensation, a dull ache, wavy lines, headaches, generally feeling awful, and a black shadow. On pressing, the black shadow was first noticed nasally 6 weeks ago, and has gradually spread to involve the superior visual field on the left. Flashes were seen at onset but have settled. These symptoms certainly predate the cataract surgery."

51. The record taken at Addenbrookes on 30 October 2012 refers to the shadow during the past 2 – 3 weeks moving from left through to a central position. The Addenbrookes notes refer to the shadow or shroud first being noticed 6 weeks before. This evidence is consistent with the finding that there was no mention of a shroud and no retinal detachment at the time of the August 2012 examination. 6 weeks would have been approximately the same time as the second examination on 19 September 2012. However, it was only 2 to 3 weeks before the history being taken then that would have been approximately 9 to 16 October 2012 and therefore after the second examination.

52. Retinal repair surgery was undertaken at Addenbrookes on 31 October 2012. It is agreed by the experts that Ms de Roeper was found to be suffering from a bullous inferior rhegmatogenous retinal detachment secondary to a previous posterior vitreous detachment and retinal break formation that at the time of diagnosis on 30 October 2012 had extended to involve the macular. The surgical notes did not record the existence of any scarring or other indications of a chronic detachment.

Retinal Detachment

53. The experts have considered the outcome of the intervention on 31 October 2012 to assess the evolution of the retinal detachment and, as a consequence, whether Mr Ramsay had failed to identify the detachment when he undertook his examinations in August and September 2012.

54. Mr McHugh, the Consultant Ophthalmic Surgeon instructed on behalf of Ms de Roeper, concludes that the inferior retinal detachment would have developed slowly and possibly been present at the examinations in August and September 2012. By stating that it is merely "possible" that the detachment would have been present at the examinations in August and September is not strong support for Ms de Roeper's claim. I have been invited to dismiss or place less weight upon Mr McHugh's evidence given the previous criticism in *McGovern v Sharkey & Belfast Health and Social Care Trust* (unrep. 23 October 2014). I do not consider that the earlier decision assists me in determining what weight should be placed upon the evidence in this case and I will deal with the evidence as presented in this case.

55. Mr McHugh's opinion is that the bullous retinal detachment implied the accumulation of sufficient sub retinal fluid to impart a grossly convex elevation of the retina. He is of the view that with an inferior detachment this implies a relatively lengthy period of evolution of the detachment of weeks to months rather than days

only as, due to the counteracting effect of gravity, sub retinal fluid will accumulate relatively slowly with an inferior detachment. In support of his opinion he refers to the causative break, through which the fluid has to pass from the vitreous cavity to the sub retinal space, and contends that as it was so small that it was not identifiable at surgery that supports there having been slow progression of the detachment to its bullous state and the involvement of the macula.

56. The joint statement of Mr Robert Cooling, Honorary Consulting Ophthalmologist instructed on behalf of the Second Defendant and Professor Simon Taylor, Consultant Ophthalmic Surgeon, instructed on behalf of the First Defendant provides that the retinal detachment was very likely to have developed in a matter of only days or weeks as its presentation is not consistent with a long-standing detachment given the lack of features of chronicity that would have only taken around 6 weeks to develop. Such features could include immobility of the retina, demarcation lines where the retinal detachment is arrested, areas of atrophic retina where the retina is thin and wasted, and the folding of the retina leading to scar tissue in the fold and surface. Mr Cooling estimated that those features would be seen after approximately 40 days or 6 weeks from detachment of the retina. The lack of that evidence is supportive of the opinion that the detachment was rapid and could not have been detected in August or September by Mr Ramsay. A further indication of the detachment being a recent detachment is the fact that Ms de Roeper made a good recovery. Long-standing detachments are usually associated with poor recoveries.

57. The joint opinion of Mr Cooling and Professor Taylor is that the inferior detachment is unlikely to have been diagnosed either on 29 August 2012 or 19 September 2012. They do not agree with Mr McHugh's interpretation of the evidence and the medical literature and their agreed opinion is that the bullous rhegmatogenous retinal detachment in the presence of a posterior vitreous detachment signifies that the vitreous has detached sufficiently to allow significant fluid to be recruited from the space in front of the retina through a retinal break to access the sub retinal space and that the retina is mobile and unaffected by the scarring frequently associated with chronic detachment. The drawings of Mr Chan and Mr Newman at Addenbrookes when preparing Ms de Roeper for the retinal surgery show the detachment to be "quite bullous" which supports their view that fluid is tracking down beneath the inferior retina under the influence of gravity with the break close to the meridian. Professor Taylor's opinion is that if the drawing on 30 October 2012 is accurate, which both he and Mr Cooling consider it would be, the pattern of the detachment indicates that the break is at or above the meridian and when compared with the drawing made on 31 October 2012, which Mr Cooling refers to as being the most reliable drawing, which shows a significant increase in the detachment over that previous day. That increase in the detachment over a short period of time is clear support for this being an acute progressive detachment. It is because detachments increase rapidly that they are operated upon swiftly once detected. "These detachments do not hang about, they progress".

58. In my judgment, the clearest evidence that this was not a slow detachment and had not been in existence for the weeks or months suggested by Mr McHugh is the lack of any signs of chronicity or scarring.

59. Mr Cooling and Professor Taylor could not agree with Mr McHugh's assessment that an inferior detachment with slow rising fluid was consistent with the surgical findings of Mr Newman and Mr Chan. This was, in both their opinions, a recent retinal detachment. In their opinion, which I prefer, Ms de Roeper would have presented long before with macular on retinal detachment if there had been a retinal detachment present at the time of the examinations in August and September 2012.

60. I am satisfied that the evidence from the retinal attachment operation on 31 October 2012 is consistent with this being a short-lived detachment that developed subsequent to the examination which took place on 19 September 2012 and, while flashes and floaters pre-dated the cataract surgery, that is not sufficient to establish the existence of a retinal detachment at that stage. The nature of the cataract surgery with the disturbance to the lens and the vitreous could, in the opinion of Mr Cooling and Professor Taylor, have been the cause of the detachment as cataract surgery has a risk of retinal detachment.

61. For all the reasons set out herein, I do not find that Ms de Roeper had a clinically diagnosable detachment at the time of the examination on 29 August 2012 or on 19 September 2012 and the claim must therefore fail. I understand the distress that this conclusion will cause to Ms de Roeper who genuinely, and understandably, believes that the issues with her eyesight was caused by the failure of Mr Ramsay to detect the retinal detachment at his examinations. However, the evidence from the contemporaneous records and the findings of the surgeons who carried out the attachment surgery on 31 October 2012 do not support a finding that the retinal detachment was present at the time of Mr Ramsay's involvement.

Alternative treatment

62. For completeness, it is important that I deal with the additional issues that have been raised with respect to what the likely treatment would have been had there, contrary to my findings, been a clinically diagnosable retinal detachment that Mr Ramsay ought to have detected in August or September 2012. I will do so relatively succinctly given my finding that Ms de Roeper did not suffer a retinal detachment that could be diagnosed clinically on or before 19 September 2012.

63. First, all the experts are agreed that there would have been surgery to repair the detachment within 24 hours of it being discovered so that any visual field defect until the corrective surgery on 31 October 2012 would have been avoided. Ms de Roeper would also have avoided the acute loss of visual acuity which was complained about from in the days leading up to the corrective surgery on 31 October 2012.

64. In the course of the surgery on 31 October 2012, Mr Newman used a silicone oil to repair the retinal break together with a scleral buckle. Mr McHugh contends that had there been earlier surgery then Ms de Roeper would have avoided the use of the silicon oil, which requires a further operation for the purpose of removal, and that a gas tamponading agent would have been used instead. Mr Cooling agreed that it is better to use gas if possible as it is absorbed naturally, whereas oil has to be removed and blobs of oil can be left behind but all the experts agreed that it is a matter for the operating surgeon to decide whether to use gas or oil. In this particular case it is likely that the surgeon used silicon oil as it was difficult to find the tear. As Mr

Cooling explained, it is essential to find the break or tear as it is necessary for that to be repaired or the retina will detach again. By using the silicone oil it is possible to successfully deal with the attachment successfully at the first surgery rather than run the risk of further surgery.

65. Ms de Roeper states that she continues to suffer ongoing visual field defects and loss of colour saturation in her left eye. While Mr Cooling set out how he found the results of the colour testing to not be entirely reliable, in my judgment there is sufficient evidence to establish that there is some deterioration in colour vision in the left eye which is likely to have been caused by reason of damage to the macular. Consequently, had there been a retinal detachment which ought to have been detected at the time of Mr Ramsay's examinations (which is contrary to my findings) then that colour desaturation is likely to have been avoided. While such colour desaturation might not have any notable functional impact on most people, because of Ms de Roeper's vocation as an artist her perception of colour in the left eye would have an impact.

Psychiatric Impact

66. Ms de Roeper relied on the evidence of Mr Fox and the defendants relied upon the evidence of Mr Latcham. The experts agree that Ms de Roeper has suffered a recognisable psychiatric condition.

67. On the basis of the psychiatrists' evidence, I am satisfied that Ms de Roeper would have suffered an adjustment disorder of mild severity in the absence of any of her ophthalmic problems.

68. I am also satisfied that from October 2012 and the operation to correct the detached retina, Ms de Roeper suffered moderate PTSD with associated anxiety and depression, including flashbacks, until 2016. I cannot accept Mr Latcham's contention that she was not suffering PTSD given that she was suffering flashbacks. Had Ms de Roeper been able to avoid the sudden loss of vision in late October 2012, by virtue of earlier surgery, or if she had undergone the cataract operation and the reattachment of the retina in the same surgical procedure, the experts are agreed that *"if she developed an Adjustment Disorder" this would have been of mild severity and she would not have had symptoms of PTSD."*

69. There are a multitude of complex interlinking reasons for Ms de Roeper's depression and the attempts on her own life. In the circumstances where I have found that Ms de Roeper's claim does not succeed, it does not seem to me to be at all helpful to deal with this issue further as I do not wish this judgment to be the unnecessary cause of any further distress.

Conclusions

70. For the reasons set out in detail in this judgment, I do not accept the basis of the claim brought against the NHS and Mr Ramsay in this matter. I do not accept that Ms de Roeper was either suffering a retinal detachment in August or September 2012 or that she was reporting the symptoms of such a detachment by describing a shroud. The contemporaneous written evidence of the examinations and referrals in August and September 2012 do not contain any reference to a shroud and when a history is taken

at the end of October 2012 as to her symptoms, she initially talks about the shadow being present for 2-3 weeks before that time and then 6 weeks. Had it been 6 weeks before the examination on 30 October 2012 then that may have taken it before the examination on 19 September 2012, but only just before. If there had been a visual field defect at that time then I have no doubt it would have been mentioned as it was a recent development. However, there is no reference to it either in the notes of Mr Ramsay or in the notes of Ms Callear, the optician.

71. The evidence of Mr Cooling and Professor Taylor is in my judgment compelling and supports a conclusion that this was a short-lived detachment. No scarring or other signs of chronicity were detected at the operation on 31 October 2012, which are highly likely to have been present if this had been retinal detachment which had progressed slowly over a period of time.

72. Ms de Roeper did not, in my judgment, suffer a retinal detachment that was capable of clinical diagnosis at the examination on 29 August 2012 or 19 September 2012 and this claim must therefore be dismissed. Even with the admission of a breach of duty on 19 September 2012, Ms de Roeper is unable to establish any causative link between that and the retinal detachment.