Neutral Citation Number: [2015] EWHC 298 (QB)

Case No: HQ12X03890

**IN THE HIGH COURT OF JUSTICE**
**QUEEN'S BENCH DIVISION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/02/15

**Before** :

**MR JUSTICE HICKINBOTTOM**

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**Between :**

**RADWAN HAMED**
**(a Protected Party through his Father and Litigation Friend RAYMON HAMED)**

**Claimant**

**- and -**

**(1) DR PETER GEORGE MILLS**
**(2) TOTTENHAM HOTSPUR FOOTBALL CLUB AND ATHLETIC LIMITED**

**Defendants**

**- and -**

**(1) DR CHARLOTTE MYONG COWIE**
**(2) DR MARK JOHN CURTIN**

**Third Parties**

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**William Featherby QC and David Kenny** (instructed by **Linder Myers LLP**) for the **Claimant**
**David Westcott QC** (instructed by **Brachers LLP**) for the **First Defendant**
**Neil Block QC** and **Michael de Navarro QC** (instructed by **Forbes Solicitors**) for the **Second Defendant**
**Michael de Navarro QC** (instructed by **Kennedys Law LLP**) for the **First and Second Third Parties**

Hearing dates: 3, 4, 5, 6 and 9 February 2015

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# 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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MR JUSTICE HICKINBOTTOM

**Mr Justice Hickinbottom :**

## Introduction

1. On 1 August 2006, the Claimant Radwan Hamed, then aged 17, signed on professional terms with the Second Defendant, Tottenham Hotspur Football Club ("the Club"). He was an extremely gifted and dedicated footballer, who had been associated with the Club since the age of 11. It was hoped – and, by many, expected – that he would become a successful professional footballer. However, three days later, whilst playing for the Club's youth team in Belgium, he suffered a cardiac arrest which resulted in catastrophic brain damage. On any view, this was tragedy writ large.

2. In this action, through his father as his litigation friend, the Claimant claims that the cardiac arrest and consequent brain damage resulted from the negligence of the First Defendant (Dr Peter Mills, a cardiologist who screened the Claimant in circumstances to which I shall shortly come); and of the Club through the First and Second Third Parties, Dr Charlotte Cowie and Dr Mark Curtin, who were specialist sports physicians employed by the Club. The Club is vicariously liable for their acts and omissions; although, by virtue of a Consent Order dated 4 February 2015, the Third Parties have agreed to indemnify the Club in respect of any damages etc it might be ordered to pay the Claimant.

3. The court directed that issues of liability (including causation) be tried first. At the start of that trial, it is no exaggeration to say that virtually everything was in dispute: Dr Mills challenged the proposition that he owed the Claimant any duty of care, both Defendants disputed breach of duty and causation, and there was at least the potential for issues between the Club and the Third Parties whom they employed. However, by the end of the trial, Dr Mills had accepted liability, the claims against the Club were restricted to those alleging negligence by the Third Parties (so that Michael de Navarro QC took over the Club's defence of the claim from Neil Block QC who left the trial), and the Club had accepted the Claimant's claim with regard to causation subject only to him proving a breach of duty against them. The Club had always accepted that they owed a duty of care to the Claimant as a result of both the doctor/patient and employer/employee relationships that existed between them. As I have indicated, by the end of the trial, in the CPR Part 20 proceedings between them, the Third Parties had agreed to indemnify the Club for any damages etc found due from the Club to the Claimant.

4. The only issues outstanding were consequently as to whether the Club breached the duty of care they owed to the Claimant; and, if so, the appropriate apportionment of liability between the Club and Dr Mills.

5. On these issues, in addition to the Claimant's family, and Dr Mills, Dr Cowie and Dr Curtin, I heard evidence from two expert sports physicians, Dr Mark Gillett (instructed on behalf of Dr Mills) and Dr Eric Widdowson (instructed on behalf of Dr Cowie and Dr Curtin). Further, although not called to give oral evidence, I had the benefit of evidence from three expert cardiologists (Dr David Wright, Professor William McKenna and Dr John Walsh), in the form of a joint statement dated 26 November 2014.

## The Medical Background

6. Some young athletes are prone to suffer from cardiac fibrillation (i.e. irregular and uncoordinated contractions of the heart muscles) which, unless treated very promptly, is usually fatal inducing what is known as sudden cardiac death ("SCD"). Even if not fatal, there is a serious risk of brain damage because, during the fibrillation, the brain is starved of oxygen because the heart does not pump oxygenated blood round the circulatory system.

7. Such fibrillations have a variety of causes. The most common in young athletes is a disorder known as hypertrophic cardiomyopathy ("HCM"); but there are other, rarer cardiac diseases which may cause fibrillation and consequent sudden death within that constituency. HCM, and most of the other diseases, have a genetic cause.

8. There are a number of markers for such heart diseases, two of which are relevant in this case:

    i) Abnormalities in the electrical activity of the heart, as recorded by an electrocardiogram ("ECG"). The heart beats as a result of small pulses of electricity. Each pulse causes contraction of, first, the atrial muscles (drawing blood into the heart), and then the ventricular muscles (to pump the blood out of the heart). The pulse then dissipates, repolarising the heart for the next beat. Each of those phases is recorded on an ECG, the last (repolarisation) in a part of the trace known as the T-wave. In a normal, healthy heart, the T-waves project above the axis. A marker of an abnormal heart is an ECG in which the T-waves dip below the axis (i.e. so-called "inverted" or "negative" T-waves).

    ii) Thickening of part of the muscle of the heart (the myocardium), notably the left ventricle ("left ventricular hypertrophy", or "LVH"). This morphological abnormality may be detected on an ultrasound-based echocardiogram ("ECHO") or a cardiac magnetic resonance image ("MRI") which show the structure of the heart.

9. HCM and these other heart diseases usually manifest themselves in a young athlete by the thickening of the left ventricle during the mid-teens to mid-twenties; and, although in most cases of actual cardiac arrest, the LVH is severe, it may be minimal[1]. Indeed, there are genetic mutations which have only mild LVH but have a high risk of death[2]; and there are cases reported in which a patient within the HCM spectrum has died without any left ventricular thickening at all[3]. The expert cardiologists in this case were in agreement that "changes seen on electrocardiogram may precede detectable morphological changes" (joint statement, paragraph 10(a)-(c)). Thus, a failure to detect structural abnormalities on imaging does not exclude T-wave inversion due to

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1 McKenna et al. The natural history of left ventricular hypertrophy. Circulation 1982; 66; 1233-1240.

2 Prasad K et al. Echocardiographic pitfalls in the diagnosis of hypertrophic cardiomyopathy. Heart 1999; III8-III15.

3 Ibid; and Marron BJ, Cecchi F, McKenna WJ. Risk factors and stratification for sudden cardiac death in patients with hypertrphioc cardiomyopathy. Br Heart J 1994; 72: S13-S18.

disease of the heart muscle, which may ultimately be associated with an adverse cardiac event[4].

10. However, in determining whether a young athlete suffers from one of these pathological conditions, there is another complication. The heart is a muscle. Intense training by a young athlete works that muscle and so may result in an enlarged heart and, in particular, thickening of the left ventricle. Far from being pathological, this phenomenon (known as "athlete's heart") is a healthy physiological condition; but it may result in similar abnormalities in an ECG, namely inverted T-waves.

11. Differential diagnosis between potential cardiac pathologies such as HCM, and the physiological consequences of intense training, is obviously crucial – particularly as the pathologies are life-threatening[5]. Where there is an abnormal ECG, disease may be distinguished from a benign condition in a number of ways. First, an ECHO or MRI scan may reveal sinister morphological changes in the heart. Whilst imaging alone can never rule out cardiac disease all together – because, as I have described, some diseases may not immediately manifest themselves in such changes – they may confirm a particular pathology. Second, the individual may cease training (i.e. "detrain"). If the enlargement of the heart is due to intense training, it is likely that the abnormalities reflected in the ECG will cease after a period of (say) three months without training, as the heart enlargement wanes; but they are likely to continue despite cessation of training if they result from disease.

12. Genetic heart disease which may lead to sudden cardiac arrest and death in young athletes has been recognised for some years, fatalities including David Longhurst (who died whilst playing for York City in 1990), Daniel Yorath (Leeds United 1992), John Marshall (Everton 1995), and Ian Bell (Hartlepool United 2001). Marc-Vivien Foé, a Manchester City player, had a cardiac arrest and died whilst playing for Cameroon against Colombia in the semi-final of the 2003 FIFA Confederation Cup at the Stade de Gerland, Lyons. More recently, in March 2012, Fabrice Muamba had a cardiac arrest whilst playing for Bolton Wanderers against Tottenham Hotspur in an FA Cup tie at Tottenham, with the result that his heart stopped for a considerable time. Remarkably and happily, he appears to have suffered no serious long term sequelae; although, after taking medical advice, he never played professional football again.

13. Organisations responsible for young athletes – including the Football Association ("the FA"), which is responsible for football in England – are well aware of this risk, and they promote and usually require procedures to be in place to screen for conditions which might give rise to an adverse cardiac event. The FA's protocol in 2005 was "Football Academies – Medical Screening Programme – Cardiological Screening – Policy on Entry" (April 2000), which required all new entrants to any football academy to be referred to a Regional Consultant Cardiologist familiar with the programme. The expert cardiologists in this case agreed – indeed, it is entirely uncontroversial – that "the purpose of the FA cardiological screening programme is to

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[4] See Corrado D et al. 12-lead ECG in the athlete: physiological versus pathological abnormalities. Br J Sports Med 2009; 43: 669-676 at page 1390.

[5] Maron et al. Cardiac Disease in Young Trained Athletes. Am Heart Assoc Current Perspectives; 1995: 91; 1596-1601 at page 1598.

identify those who are or may be at risk or potential risk of SCD" (joint statement, paragraph 1(a)).

14. **The protocol** required the relevant football club to send a standard screening advisory letter to the player (or parents, if the player was under 16) together with a family history medical questionnaire for completion and sending on to the cardiologist. The screening comprised an ECG and ECHO performed by a technician, the results of which were then assessed by the cardiologist who completed a standard form, which included a section for "Recommendations for further investigation". The form was sent to both the FA Medical Centre, and copied to the football club doctor. It is uncontroversial that, if recommendations were made, then it was for the football club to take matters forward. The cardiologist could not do so off his own bat: the club were responsible for the follow-up, although of course they might request the cardiologist who has assessed the ECG and ECHO to play a part in any further investigations. An FA panel of cardiologists was made available to support football clubs' medical staff, although access to that panel was usually on the recommendation of the cardiologist involved with the scan and any follow-up.

## The Factual Background

15. In 2005, both Dr Cowie and Dr Curtin were specialist sports physicians employed by the Club.

16. Dr Curtin was the sole doctor at the Club for some years until 2004. However, he wished to return to general practice; and so, in January 2004, Dr Cowie joined the Club as Head of Medical Services, a new role which included responsibility for the existing medical and sports science team ("the Medical Services Department"). She was an experienced sports physician, having previously been the club doctor at Millwall Football Club and Fulham Football Club, and with the England Women's Football Squad. In that role at the Club, she readily accepted that she was responsible for what went on in the Medical Services Department: in her phrase, the buck stopped with her.

17. When she first joined the Club, Dr Cowie did so on a part-time basis, because of child care obligations; and so Dr Curtin agreed to stay on for a while, also part time, amounting to perhaps a half a day per week together with matchdays (when he looked after the first team) and tours. His duties included some responsibility for the Club's Academy players, i.e. the players aged 16-18 years of age. Dr Cowie also recruited Dr Nick Krasner as Academy Doctor; and Henna Horth (with whom she had worked at Fulham) as a physiotherapist with special responsibility for the youths up to the age of 16. As was apparently common in football clubs, as a full-time employed physiotherapist, although the Medical Services Department had an administrator, Ms Horth also performed some administrative tasks, e.g. fixing up medical and screening appointments for the players. As we shall see, Ms Horth played an important part in the events relevant to this claim; but she has subsequently moved to Australia and, unfortunately, she did not give evidence at the trial.

18. The Claimant was born on 19 December 1988. As a boy, his focus was more on sport than on his academic studies. He was always talented at football. At the age of 11, he was scouted by and signed for the Club as a youth; and, after his GCSEs, in March 2005 he joined the Club's Youth Training Scheme and Football Academy as an

apprentice. This was full-time, involving attendance at the Club from 9am to 4pm, five days per week, with competitive matches on Saturdays and occasional light training on Sundays.

19. As I have indicated, under the FA protocol, new entrants to any football academy had to be the subject of cardiac screening. At the Club, this took place in close season, when the new players were sent together to have an ECG and ECHO performed by a technician, the results of which were then referred to an FA Regional Cardiologist. In 2005, Dr Mills was the FA Regional Cardiologist for South East England.

20. The Claimant went for his ECG and ECHO on 21 July 2005. He was asymptomatic; but the ECG trace showed inverted T-waves. The expert cardiologists agree that the ECG was "unequivocally abnormal", and "well beyond an athlete's heart expected in a 16 years old" such that "a diagnosis of athlete's heart was unlikely", the ECG being "indicative of the Claimant suffering from an underlying heart muscle disease" (joint statement, paragraphs 5(d), 15(a) and 16). With regard to the ECHO, they agree that "the image quality was inadequate for accurate measurement or diagnosis" and "the findings of the [ECHO] do not explain the abnormalities on the [ECG]" (paragraphs 12 and 14(a)). So, the ECG was abnormal and, at that stage, there was no unequivocal benign explanation for the abnormality. Indeed, it was more likely than not that it resulted from heart disease.

21. The ECG and ECHO were forwarded to Dr Mills for consideration. The Club did not complete the questionnaire as they ought to have done, and so Dr Mills did not have the benefit of that. But he considered the scans, and completed the FA form, indicating that the ECG was "Abnormal" and setting out the T-wave abnormalities. In terms of "LV [i.e. left ventricle] function", he marked that as "Abnormal", specifying "Marked LVH? apical HCM". In terms of "Diagnosis based on ECG and Echo study", that too he marked "Abnormal", specifying: "LVH vs apical HCM". In terms of recommendations, he commented: "Suggest Cardiac MR scan & clinical review". Despite the use of the word "suggest", he intended those recommendations to be carried out – and Dr Cowie and Dr Curtin said that they took those recommendations to be, in effect, mandated requirements. Neither they nor Dr Mills knew of a case in which a football club had not followed such a "suggestion" of a cardiologist, in these circumstances. That is in line with the agreed expert cardiologists' evidence, that the ECG trace mandated both further investigation and clinical review (joint statement, paragraph 20(h).

22. There was also common ground between the parties as to what a clinical review by a cardiologist in this context would entail. First, given that HCM and some of the other myopathies are genetic, the cardiologist would take a family medical history. Second, he would explain to the Claimant and his parents the level and nature of the risk involved, particularly to enable them to take an informed decision as to whether that risk should be borne. Such a full explanation would only have been sensible once the MRI scan was available, because, although that scan could not have ruled out all sinister pathologies, it might have shown that the Claimant was at a greater or lesser degree of risk.

23. Dr Mills sent the completed form to the FA, with a copy to the Club, as required by the protocol. However, the FA also sent a copy on to the club, with a covering letter

dated 28 July 2005 and addressed to "Club Doctor", which drew attention to "the findings/comments/recommendations on the form", and saying:

> "As Club Doctor you may wish to discuss the findings and recommendations with the Regional Cardiologist".

24. The letter was seen by Dr Curtin, who endorsed it:

> "Arranged Cardiac MR + review Dr Mills".

In his evidence – which I accept – Dr Curtin said that he saw Dr Mills' recommendations, and instructed Ms Horth, "in line with previous cases", to arrange for Dr Mills to see the Claimant (with his parents) for a clinical review; and, before that took place, to arrange through Dr Mills for an MRI scan of the Claimant. This was the first case in which either Dr Curtin or Dr Cowie had been involved in which a cardiologist had recommended an MRI scan in these circumstances. Dr Curtin endorsed the letter as he did, to confirm that he had actioned both recommendations. He expected that, in line with his instructions, the Claimant would be subject to both an MRI scan and a clinical review by Dr Mills.

25. There is a gap in the evidence here. As I have said, Ms Horth did not give evidence. Dr Mills was not personally involved in making appointments: his secretary did that, but neither did she give evidence. Nevertheless, it seems clear that Ms Horth did contact Dr Mills' secretary with a request for Dr Mills to arrange an MRI scan; that was Dr Mills's recollection, and the MRI scan was in fact arranged by his office. However, there is no evidence at all that Ms Horth arranged – or sought to arrange – a clinical review between Dr Mills on the one hand and the Claimant and his parents on the other. Certainly, no such review took place or was arranged. As (i) it was for the Club to arrange such a review, (ii) Dr Curtin instructed Ms Horth to arrange a review, (iii) there is no evidence that Ms Horth attempted to arrange a review, (iv) there is no evidence that Dr Mills would not have been available to conduct such a review (he said, clearly, that he would have been available), (v) Dr Mills said that, had his secretary been asked to arrange a clinical review, she would have done so as a matter of routine, and (vi) Dr Curtin carried forward the understanding that a clinical review had been arranged and had in fact been performed by Dr Mills, I find that, despite the requirement of Dr Mills and the instructions given to her by Dr Curtin, Ms Horth simply failed to arrange or attempt to arrange for a clinical review to take place.

26. In the meantime, Dr Cowie had both spoken to the Claimant himself and also telephoned the Claimant's father. Mr Hamed said that Dr Cowie told him that his son had an enlarged heart, but this was common in athletes and nothing to worry about. She told him that they were arranging a scan "to make sure there is nothing more than that".

27. The MRI scan was performed on 12 August 2005 by Dr Raad Mohiaddin, a Consultant in Cardiovascular Imaging at the London Imaging Centre. Mr Hamed drove his son to the appointment and was told, at the end of it, that "it was OK and that the doctor at the Club would talk to [the Claimant and him] about it".

28. In a letter of 15 August 2005, Dr Mohiaddin sent Dr Mills the relevant images and a report which concluded:

> "1. Mild concentric LVH with normal LV volumes and good systolic function. Absolute and normalized LV volumes and mass are provided on a separate sheet to this report.
>
> 2. No obvious imaging features of HCM but this can't be completely excluded from imaging alone.
>
> 3. No significant LVOTO or aortic valve stenosis.
>
> 4. No obvious myocardial fibrosis or previous myocardial infarction.
>
> 5. The overall findings are in keeping with an athlete's heart."

In other words, the MRI image did not disclose any positive structural features of the heart muscle which suggested HCM, and indeed, the morphological findings were consistent with a healthy athlete's heart; but, as Dr Mohiaddin emphasised, a cardiac pathology could not be excluded by images alone.

29. Dr Mills had one query about this report. The report said that the Claimant's left ventricular mass was 204g, but it was unclear as to whether this was within the normal range. He therefore wrote to Dr Mohiaddin to clarify that issue.

30. In the meantime, on 17 August 2005 he wrote to the Club – in fact, addressed to Dr Curtin, to whom he was used to writing. He did not include a copy of Dr Mohiaddin's letter, but rather wrote as follows:

> "I now have the MR scan on the sixteen year old. This confirms the presence of mild concentric ventricular hypertrophy.
>
> The absolute values of his septal thickness of posterior left ventricular wall thickness on the [ECHO] are not unduly great at 11 and 10 mm respectively. The worrying feature is his [ECG] which shows T wave inversion in the 2, 3 and AVF and V3-V6. I have written back to [Dr Mohiaddin] to ask [him] to clarify [his] report which gives an absolute value for Radwan's left ventricular mass but doesn't provide us with a range of normal for that measurement and once I have that information I will write to you again. Basically there are no features of [HCM]. "

That noted Dr Mills' only query with Dr Mohiaddin: was the Claimant's left ventricular mass within normal limits? The letter made clear that, despite the otherwise normal MRI scan, Dr Mills was still "worried" about the abnormal ECG. Given that imaging cannot exclude disease, and the ECG abnormality remained unexplained, that was understandable.

31. Dr Mills explained in his evidence that when he said he still considered the ECG trace as "worrying", that was as an escalation in concern from "abnormal". The MRI scan results had not assuaged his concern. Given the ECG trace, Dr Mills still did not

consider athlete's heart was likely; but, after the MRI scan, he did not believe that the Claimant had HCM either. He said he considered that there was still a risk of a cardiac event and, as a result, a risk that the Claimant might die. That risk was, he said, "very low" – but not zero.

32. Dr Curtin saw that letter from Dr Mills, and endorsed it:

> "Await further letter – then need to copy in FA."

33. Dr Mohiaddin's response to the query, dated 22 August 2005, was to the effect that the published normal range for left ventricle mass index is for subject at least 20 years of age. Whilst the Claimant's left ventricular mass was within normal limits on that basis, Dr Mohiaddin said that, with adjustments he considered appropriate for the Claimant's age based on the trend of the mass index graph, "this patient's [left ventricular] mass index is above what is expected for his age…". Dr Mills wrote to Dr Mohiaddin on 2 September 2005 to confirm that he understood that the MRI scan and left ventricle mass index chart together suggested that the Claimant did have a degree of LVH. He also wrote to the Club on 2 September indicating that the Claimant's left valve mass appeared to be larger than expected at his age; but, in the meantime, there was an important telephone conversation with which I must deal, before I continue dealing with the correspondence.

34. Dr Cowie explained that the Medical Services Department was transferring from written to computerised medical records. In the event, there are virtually no written records in respect of the Claimant relevant to the matters in this case, except the letters and endorsements on those letters. There is only one such computerised record, dated 24 August 2005, and written by Dr Cowie. Dr Curtin faintly suggested that, at some stage, there may have been more records; but there is no evidence that other records, computerised or manual, had been made and lost. Insofar as Dr Curtin suggested otherwise, I do not accept that evidence.

35. Dr Cowie said that she wrote the single electronic record after a discussion between Dr Curtin, Ms Horth and her, following a telephone conversation on or about that day (24 August 2005) between Ms Horth and Dr Mills' secretary. The record reads:

| | |
|---|---|
| Subjective | Asymptomatic |
| Objective | Routine cardiac screening showed some local thickening of R ventricle. Reviewed by Dr Mills after cardiac MRI. He does not believe that this is HCM and is happy for Rad to continue training as before |
| Analysis | No current risk, able to continue training and playing |
| Rx | Await further confirmation in writing from Dr Mills |
| Plan | No further action required |

36. The circumstances of the telephone conversation that gave rise to this note are unclear – neither Ms Horth or Dr Mills' secretary gave evidence, and Dr Mills knew nothing of it. However, I accept that there must have been some telephone conversation during which Dr Mills' secretary gave Ms Horth some information about the Claimant's case. The note suggests that the section headed "Objective" was largely the content of the call. Perhaps unsurprisingly (given anything Dr Mills may have said had been communicated through his secretary and Ms Horth, neither of whom were doctors), it contains a number of mistakes. The routine screening had shown some generalised (not local) thickening of the left (not the right) ventricle; and, insofar as the note suggests that Dr Mills had clinically reviewed the Claimant (which, on its face, it does suggest), it would be again wrong. But the substance of the message as received and understood by Dr Cowie was that Dr Mills did not believe that the Claimant had HCM, and was "happy" for him to continue training and playing football.

37. Following consideration of the MRI scan results, Dr Mills did indeed consider that the Claimant did not have HCM; but he was still "worried" about the abnormal ECG, and understood that there was still a risk that the Claimant had some heart disease albeit without yet any detected morphological signs. However, although "happy" is perhaps not the right word, balancing the very small risk of an adverse event and the potential benefits for this young man of continuing his footballing career, in his judgment as a cardiologist he considered that it would be reasonable for the Claimant to continue training and playing.

38. Subject to checking the Claimant's family medical history, that professional judgment was generally in line with international recommendations. The recognised consensus for athletes with "isolated abnormal ECGs" such as the Claimant was as follows[6]:

> "Special attention should be paid to athletes with ECG abnormalities (such as… diffuse T wave inversion…) suggestive for HCM, in the absence of familial incidence of HCM and in the absence of LV hypertrophy. Evaluation of these athletes should include complete family screening, personal history, echocardiography, and 24h Holster ECG monitoring. When SCD or HCM in the family are excluded, and in the absence of symptoms, arrhythmias and LV hypertrophy, and with normal diastolic filling/relaxation, there is no reason for restricting athletes from competitive sports, but periodical and diagnostic follow up is recommended."

39. However, from the third-hand telephone message, Dr Cowie said she drew a conclusion – crucial, in the event – that the Claimant would be at no risk of an adverse cardiac event if he continued to train and play football. I use the term "drew a conclusion" (rather than "made an assumption") advisedly, because, as I understood her evidence, she said that she positively considered the matter. I accept that she did

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[6] Pellicia A et al. Recommendations for competitive sports participation in athletes with cardiovascular disease: A consensus document from the Study Group of Sports Cardiology of the Working Group od Cardiac Rehabilitation and Exercise Physiology and the Working Group of Myocardial and Pericardial Diseases of the European Society of Cardiology. Eur Heart J 2005; 26: 1422-45. The expert cardiologists agreed that these were appropriate recommendations: joint statement, paragraph 30.

so. It is vital to note that "No current risk" was Dr Cowie's assessment on the basis of what she had been told, not an assessment by Dr Mills.

40. Dr Cowie's analysis was as follows. Dr Mills appeared satisfied that the Claimant did not suffer from HCM; and she considered HCM and LVH (which she assumed referred to only the benign form of athlete's heart) were differential diagnoses, binary in the sense that they covered all possibilities. Therefore, by eliminating HCM, the only explanation left for the abnormal ECG was athlete's heart. That was a healthy condition, not a pathology. Hence, her conclusion that there was no risk. That, she thought, explained why Dr Mills was "happy" for the Claimant to continue to exert himself. It of course explains why, subject to getting confirmation of the telephone message, she considered "No further action required".

41. The entry in the computerised record of 24 August 2005 is crucial in this claim, and Dr Cowie made clear that she regarded it as such – because, although Dr Cowie awaited confirmation of the message she had received from Dr Mills through Dr Mills' secretary and Ms Horth, her conclusion that there was no risk in the Claimant continuing to train and play was thereafter maintained. It was an important conclusion, because Dr Cowie readily accepted that, if she had considered that the Claimant was at some – any – cardiac risk, she would have arranged for him (and his parents) to be told of it, so that they could have made an informed decision as to whether to take that risk or not. That would have been done through a clinical review by a cardiologist, almost certainly Dr Mills. He said that, at such a review, he would have given the Claimant and his parents all of the clinical results and the correspondence in relation to them, including Dr Mills's own letter indicating that he was still "worried" by the ECG trace; so that, despite the risk of an adverse event being very small and (as a cardiologist) he would have advised it was reasonable for the Claimant to have borne that risk and carried on playing, Radwan and his parents could have made an informed decision as to whether to do so. There is nothing surprising in any of that: it is standard medical practice.

42. Dr Cowie accepted that any such discussion would have taken place in the context of a clinical review meeting between Dr Mills and the Claimant and his parents, Dr Mills being best able to explain what the various scan results showed and the nature and extent of the risk they disclosed. She said that no such discussion took place because, until 24 August 2005, she considered that investigations were proceeding and she did not wish to concern the Claimant and his parents in the meantime, as the eventual results may have disclosed that the Claimant's heart was normal and there was nothing to worry about; and, after 24 August, she considered there to have been no cardiac risk, and so there was nothing for Dr Mills and the Claimant to discuss. It was on that basis that, shortly after 24 August, Dr Cowie spoke to the Claimant's father and told him it was fine for the Claimant to continue training but that "they would keep an eye on him". Although there was evidence that this conversation took place shortly after 24 August, the reference to "keeping an eye on him" suggests it may have been after Dr Cowie had seen Dr Mills' letter of 2 September (see paragraph 44 below). The precise date of the conversation is of no matter.

43. Of course, the conclusion that Dr Cowie drew – that the Claimant faced no cardiac risk – reflects, at least, a quite shocking failure of communication; because, as I have explained (see paragraph 37 above), Dr Mills considered the Claimant *did* still bear a risk of an adverse cardiac event which would be potentially fatal; and, if Dr Cowie

had understood that to have been the case, she would have ensured that the Claimant and his parents were aware of it by way of a clinical review. Dr Cowie said in evidence that she was well aware that the Claimant had not had a clinical review, but considered that the 24 August message overrode that earlier requirement – because there was now, she thought, no risk.

44. As I have indicated, Dr Mills wrote to the Club on 2 September 2005, enclosing a copy of Dr Mohiaddin's latest letter, and saying:

> "As you see Radwan's ventricular mass is increased taking into account his body weight. I imagine there is no other comparable data for males of his age. Given his abnormal [ECG] I think we should keep a closer eye on him than usual. I would suggest that he is screened on an annual basis."

That did not suggest that the MRI scan was in any way sinisterly abnormal; and the expert cardiologists are agreed that it was not abnormal, showing no diagnostic or early features of HCM or any other cardiomyopathy (joint statement, paragraph 19(b)).

45. However, that letter was not sufficient confirmation for Dr Cowie, who telephoned Dr Mills' office and spoke to his secretary who made a short note of that conversation, for Dr Mills, as follows:

> "Dr Cowie rang – they need a letter from you confirming that you are happy for Radwan to continue training. They've had it verbally but need it documented."

There is then a reference to Dr Krasner, but that seems to have no relevance. This note reflects the 24 August 2005 record, and fits in with Dr Cowie's version of events, i.e. from Dr Mills telephone message that he did not consider the Claimant to suffer from HCM and was "happy" for his to continue training, she concluded that the Claimant faced no cardiac risk, and she simply wanted those premises, upon which her conclusion was based, confirmed.

46. Dr Mills wrote on 9 September 2005:

> "Further to my recent letters about Radwan Hamed's MR scan I think it would be reasonable for him to continue to train as a professional footballer but I would suggest that he has an annual review with an ECG and an [ECHO]."

Dr Cowie took this as the confirmation she sought. That letter was filed. No further action was taken on it. However, Dr Cowie gave a copy of the 9 September letter to the Claimant to take home to his parents, which he did. For them, it effectively confirmed the conversation that they had had with Dr Cowie earlier. They thought that that the Claimant had been given a "green light" to carry on as a professional footballer, on the basis that he had been shown to have no cardiac risk in doing so. That understanding was unsurprising, as that was what Dr Cowie believed.

47. There is no further relevant medical activity before August 2006; except, oddly, on 18 November 2005, Dr Krasner completed a medical screening questionnaire for the Claimant. It is not known whether Dr Krasner saw the Claimant in order to do so. The form contains nothing of substantive interest, although it contains some errors, e.g. it suggests that the Claimant performed an exercise ECG in 2005 (he did not) and that he "saw cardiologist Dr Mills 17th August 05 re hypertrophy". The Claimant of course never saw Dr Mills: the only source of that misunderstanding (which could not have come from the Claimant himself, even if Dr Krasner did see him) appears to be the computerised record of 24 August 2005 which suggests that Dr Mills did conduct a clinical review with the Claimant (see paragraphs 35-36 above).

48. Although Dr Mills recommended an annual review in his letter of 9 September 2005, by August 2006 no ECG or ECHO had been arranged.

49. On 4 August 2006, whilst playing in Belgium for the Club's youth team against Cercle Brugge Football Club, the Claimant collapsed. Bystanders could not resuscitate him. After about a quarter of an hour an ambulance arrived with a defibrillator, and he was taken to hospital where he was diagnosed as having suffered brain damage as a result of anoxia. Another Club physiotherapist (Rory Brown, who was responsible for the 17-18 year olds) was at the match, and he telephoned Dr Cowie who met the Claimant's parents at the Club from where they all drove immediately to Belgium.

50. On 30 August 2006, before the Claimant's return to London, there was a meeting attended by, at least, Dr Cowie, Dr Mills, John McDermott (the Manager of the Club's Academy) and the Claimant's parents. Handwritten notes of the meeting are available. It is not known who prepared them, but none of the witnesses who gave evidence suggested that they were in any way materially wrong as a record.

51. It is clear from these notes that the issue of "balancing career against risks" was discussed; and that Mr Hamed was concerned that the Claimant and his parents had been kept out of the information about the risk to which the medics had been privy – and had been denied the opportunity to decide whether the Claimant should take that risk. The notes say, close to the reference to the risk-benefit balance: "Missing link is not communicated to parents". It is also clear from the notes that Mr Hamed was concerned that his son had not been treated properly, as a patient, by the medics.

52. Dr Mills said that, at the meeting, Dr Cowie appeared to have been under the misapprehension that a clinical review had taken place. In her evidence, Dr Cowie said that Dr Mills had blamed the Club for not having arranged a clinical review, as he had recommended in July 2005. Mr Hamed's evidence as to this – which I accept – was that he (Mr Hamed) specifically asked Dr Mills why he had given his son "the all clear", and Dr Mills said he had recommended to the Club that the Claimant be seen by a cardiologist. At this point, Mr Hamed said, Dr Cowie intervened and said:

> "Dr Mills you did not ask for Radwan to be reviewed clinically. There is not a single shred of evidence to support that. We did not get any further letters from you."

53. That suggests that Dr Mills had never recommended a clinical review – which, of course, he had, in the form he completed in July 2005 after the ECG and ECHO. In

her evidence, Dr Cowie conceded that she was mistaken in that regard, but, she said, she had not looked at the Claimant's medical records before attending that meeting. But in any event, it seems to me that what Dr Cowie said is compelling evidence that, rather than thinking that a clinical review had taken place, she was aware that it had not – and wished to make clear her view as to why it had not.

54. Dr Mills thereafter performed tests on the Claimant's family. When Mrs Hamed attended him for that purpose, she said he asked him why he had not advised about the risk that the Claimant might have a cardiac condition, to which he replied:

> "I couldn't take away a young boy's dream"

Dr Mills accepted that he might have responded thus; but it was in the context of a risk-benefit balance that he understood he was being asked to opine upon as a cardiologist.

## Breach of Duty: Introduction

55. During the course of the trial, Dr Mills conceded – on the evidence, in my view, quite properly – that, when writing his letters on 2 and 9 September 2005, he owed a duty of care to the Claimant which he breached, by failing to make specific reference to the clinical review which he had recommended on 21 July 2005.

56. The Club accept that they owed a duty of care to the Claimant, as a result of both their doctor/patient relationship and their employer/employee relationship. The scope of each duty is well-established. In respect of the former, a doctor is only negligent is he fails to act to the standard of any contemporaneous responsible body of medical opinion (Bolam v Friern Hospital Management Committee [1957] 1 WLR 582). On the other hand, an employer owes an employee a duty to take all reasonable steps to safeguard him from all reasonably foreseeable risk of injury during the course of his employment (see, e.g., Wilsons and Clyde Coal Co v English [1938] AC 57 and Harris v Brights Asphalt Contractors [1953] 1 QB 617). An employer must thus take all reasonable steps to ensure that his employee is fit to do the work for which he is employed without reasonably foreseeable injury. Of course, in assessing what is reasonable, the more serious the potential injury, the greater the burden upon the employer to respond proportionately to it. If the risk is of death or a catastrophic injury, then the employer must take commensurately meticulous steps.

57. Although the Club accept they owed a duty of care to the Claimant as both doctor and employer, they deny any breach. The Claimant's claim against the Club is now restricted to allegations of negligence by Dr Cowie and/or Dr Curtin (for whom the Club are vicariously liable); but, as Dr Cowie was the Head of the Medical Services Department at the Club, they accept that she – and therefore, vicariously, the Club – are liable for, not only her own individual acts of negligence, but any systemic failure that amounts to negligence.

58. Mr Featherby put the Claimant's case on breach as against the Club on a number of bases. However, his primary focus was set out in paragraph C1 of the allegations of negligence, within paragraph 8 of the Amended Particulars of Claim:

> **"Failing to arrange for the Claimant to be clinically reviewed by [Dr Mills] (or another Consultant Cardiologist) as suggested by [Dr Mills] and/or subsequently failing to ascertain/check that the Claimant had undergone a clinical review and having ascertained that the Claimant had not been clinically reviewed by [Dr Mills] (or another Consultant Cardiologist) failing to ensure that the Claimant was clinically reviewed…".**

59. Following the evidence, his focus was even more specific; because, on the basis of Dr Cowie's evidence, it seemed that a clinical review was not arranged because of her conclusion on 24 August 2005 (and maintained thereafter) that the Claimant was at no risk of an adverse cardiac event. The primary issue was therefore whether Dr Cowie was negligent in drawing that conclusion.

**Breach of Duty: The Primary Breach alleged against the Football Club**

60. The expert cardiologists agreed the following, which is again uncontroversial as between the parties.

    i) The Claimant's ECG of 21 July 2005 was unequivocally abnormal and well beyond an athlete's heart changes expected in a 16 year old. It was suggestive of HCM or other heart muscle disease.

    ii) The ECHO image quality was inadequate for the purposes of measurement or firm diagnosis. The later cardiac MRI scan showed a morphologically normal heart. However, whilst a normal MRI excludes manifest HCM, it cannot exclude the possibility that the subject (a) is suffering from some other myocardial abnormality such as inherited arrhythmia, or (b) has a gene mutation which makes him prone to HCM which, although not yet manifest, may become manifest in the future.

    iii) Thus, even after the MRI scan, the Claimant was left with an abnormal ECG but without any firm diagnosis as to its cause. It was likely that it was benign, but there was a risk that it was not. That risk was very small; but, if the Claimant were suffering from a pathology, it would be a very small risk of death or catastrophic injury.

61. It is also uncontroversial that, if there were a cardiac risk in the Claimant continuing to train and play:

    i) it would be mandatory to communicate this to the Claimant and his family, usually through the cardiologist (see expert cardiologists' expert report, paragraph 31(a));

    ii) it would be for the Claimant (or, as he was a minor, his parents) to make an informed decision as to whether he should continue or not; but

    iii) if they decided that they wished him to continue, the Club would then effectively have a veto: the Club would have to take an informed decision of

their own as to whether they wished to employ a player who bore a risk of death or serious injury if he continued to play.

62. Dr Mills was aware of the above. He was aware of the very small risk; but, if asked whether the Club was justified in allowing the Claimant to continue to train and play, considered that, balancing that risk against the benefits to the Claimant and Club of him continuing to play, it would be reasonable for the Club to allow him to continue. That is what he meant by saying, in his letter of 9 September 2005 to the Club, that it was "reasonable" for him to continue. "Reasonable" implies that a judgment has been made by balancing various factors.

63. In her evidence, Dr Cowie accepted that, at the relevant time, she was aware that, although HCM was the most common cardiac disease in young athletes manifesting in LVH, there were other pathologies. She also accepted that, had she considered the Claimant to have been at risk from an adverse cardiac event, then, once the 2005 investigations were complete, she would have ensured that he (and his parents) were aware of that risk, and were enabled to take an informed decision as to whether to take such a risk by continuing to train and play football. One would not expect any doctor to have taken a different view. In conceding the Claimant's case on causation, the Club accept (as does Dr Mills) that, if the Claimant and his parents had been aware of the cardiac risk borne by the Claimant, they would have decided that the Claimant would not continue as a professional footballer.

64. Mr de Navarro submitted that, in concluding on 24 August 2005 that the Claimant was at no risk of an adverse cardiac event, Dr Cowie acted reasonably; and, in any event, it would be entirely inappropriate to find her and thus the Club negligent on such a basis.

65. That submission was boldly made; but it is unmaintainable. Dr Widdowson (the expert sports physician instructed on behalf of Dr Cowie) conceded that Dr Cowie's conclusion on 24 August 2005 that the Claimant was at no cardiac risk was not a conclusion she, as a sports physician, could properly draw. That was said in the context of a series of question about what a reasonably competent sports practitioner might do. Dr Widdowson's view (which mirrored that of Dr Gillett) was, clearly, that no reasonably competent sports practitioner would have come to the conclusion that there was no cardiac risk in the circumstances and on the basis of the information that Dr Cowie had at hand then. He made that concession on the basis that any reasonably competent sports physician would know that:

i) Cardiac screening of young athletes is designed to detect all cardiomyopathies including, but not restricted to, HCM.

ii) LVH may be a manifestation of a physiologically healthy athlete's heart; but it can be caused by potentially inherited cardiomyopathies including, but not restricted to, HCM.

iii) The gene mutation which causes HCM when fully expressed, may be present before it is full or indeed any manifestation in the form of heart wall thickening.

Dr Cowie accepted that she was in fact aware of, at least, (i) and (ii).

66. Mr de Navarro's contention requires me to disagree with the experts, including the expert that he called, in the absence of any evidence that they might be wrong. But, in fact, the experts are clearly right. The ECG showed an abnormality which suggested that the Claimant had a risk from a cardiomyopathy. In suggesting a differential diagnosis of HCM or LVH, Dr Mills was not suggesting that, if the condition were not HCM, then it was necessarily benign: a reasonably competent sports physician would know (and Dr Cowie in fact knew) that there was a small chance of the Claimant suffering from some other pathology. The MRI scan was capable of confirming, one way or the other, whether the Claimant suffered from manifest HCM; but it could not exclude other pathologies. By stating that he did not believe the Claimant was suffering from HCM, Dr Mills did not mean (and could not have been understood by any reasonably competent sports physician to have meant) that he was excluding all other pathologies.

67. Therefore, whilst I accept that the form of communication on 24 August 2005, and his letters of 2 and 9 September 2005, might have been made clearer by Dr Mills, I am driven to conclude (as her own expert clearly conceded) that Dr Cowie's conclusion made on 24 August 2005 and maintained thereafter until the catastrophic event on 4 August 2006, was not a conclusion to which any reasonably competent sport physician could have come.

68. In coming to that conclusion, Dr Cowie was thus negligent, whether as the Claimant's employer or under the stricter Bolam test. Indeed, following Dr Widdowson's concession, the contrary ceased to be arguable.

69. Had Dr Cowie appreciated, as she ought to have done, that the Claimant bore this risk, she understandably accepted that she would have ensured that he (and his parents) were made aware of the risk. That in practice would have been done by a clinical review being arranged with a cardiologist – almost certainly Dr Mills. Dr Mills said – and I accept – that, at such a review, he would have made clear the risk faced, including sharing with the Claimant and his parents the various scan results he had received and his correspondence including the latter he sent to the Club after the MRI scan was available to the effect that he was still "worried" about the ECG scan. In any event, both he and the Club accept that, had the Claimant and his parents been properly informed of the risk, the Claimant would have stopped training and playing football – and the catastrophic event on 4 August 2006 would not have occurred.

## Breach of Duty: Other Breaches alleged against the Football Club

70. I can deal very shortly with the other breaches of duty alleged against the Club.

71. Of the other specific allegations of negligence set out in paragraph 8 of the Amended Particulars of Claim extant at the end of the trial, I need only deal with the following.

    i) Two of the allegations (that the Club failed to discuss the findings and recommendations with Dr Mills (paragraph C3); and, on 24 August 2005, failing to ascertain whether the Claimant had been clinically reviewed and/or erroneously believing he had been clinically reviewed (paragraph C8)) in the event add nothing of substance to the claim.

ii) It is alleged that the Club were negligent in failing to make a referral to the FA cardiologist panel (see paragraph 14 above). However, although it was open to the Club to make a reference, the evidence was that in practice referrals were only made on the recommendation of the Regional Cardiologist. In any event, in this case, there was no need for any second opinion, and the analysis of the various scans etc by Dr Mills is not now questioned. There was thus, in my view, no need to make a reference; and the Club were not negligent in failing to make one.

iii) It is alleged that the Club failed to ensure that, in line with Dr Mills' recommendation (i.e. mandated requirement) in his letter of 2 September 2005, the Claimant was screened on an annual basis. It is said that the screening considered by Dr Mills was performed on 21 July 2005, and so he should have been the subject of further scans by about 21 July 2006 and in any event before 4 August 2006. Whilst I understand the concerns of the Claimants' parents about the fact that, prior to 4 August 2006, no steps were taken by the Club to arrange for the Claimant to be screened again, (a) each of the sports physician experts accepted that it was implicit that the Club had some leeway in fixing the date for an annual review (their joint statement, paragraph 6), (b) 4 August 2006 was only 54 weeks after the 2005 scans, (c) Dr Cowie gave evidence that, whilst the new intake players were screened together in the close season, annual follow-up screening of players did not, (d) she said that appointments could be and were made at short notice, and (e) there is evidence that the follow-up screening for another player was not arranged until 1 September 2006 when it was fixed for 4 September. I am not persuaded that the Claimant's annual review had simply been forgotten; nor am I persuaded that the Club were in breach by failing to organise his follow-up screening by 4 August 2006.

72. There is no specific allegation that the Club breached its duty of care to the Claimant by failing to keep proper medical records for him; but the suggestion was made and, as it may affect apportionment, I should deal with it.

73. It is of course important not to expect too much of medical practitioners in terms of record taking and keeping – particularly where, as here, they must be judged by standards applicable some years ago – but Dr Cowie properly accepted that it was important for a patient's medical records to set out his medical history sufficiently to enable other medical practitioners who might become involved with his care to be able to make properly informed decisions. Again, one would not expect any different a view from a doctor.

74. In this case, as I have explained (see paragraph 34 above), the only medical records kept by the Medical Department at the Club concerning the Claimant's cardiac investigations were a single entry in their computerised system, and the correspondence to which I have referred including the notes endorsed on the letters by, mainly, Dr Curtin. It is important in this context to note that, from January 2004, Dr Curtin was not the only doctor employed at the Club, and the chances of more than one medic being involved in the treatment of a player/patient greatly increased. Indeed, as in this case, it was very likely that that more than one medic would be involved with any medical issue.

75. With regard to the clinical review, it is true that, had such a review taken place, one would have expected to have seen in the records a letter from the cardiologist who had performed it reporting back. There is no such letter in respect of the Claimant.

76. Neverthless, it is clear that many within the Club (including doctors within the Medical Services Department) understood that there had been such a review. Dr Curtin (who had been quite closely involved in this matter) confirmed in his oral evidence that that was his understanding. On 26 August 2006, Mr McDermott wrote a paper for the Club with a recommendation as to how to proceed with regard to the Claimant and his family – no doubt in preparation for the 30 August meeting with them – in which he indicated that Dr Mills had met the Claimant and his father, with a "recommendation" that he continue to play football. I have already mentioned Dr Krasner's note on the questionnaire he completed on 18 November 2005 (see paragraph 47 above).

77. Mr Featherby and, particularly, Mr Westcott submitted that, on all the evidence, I should find that Dr Cowie was under the misapprehension herself that a clinical review had taken place, the contemporary evidence overwhelmingly suggesting that Dr Cowie was told by Ms Horth that it had. Mr Westcott particularly relied upon the following:

    i) Dr Cowie said that she and Ms Horth had discussions about the Claimant's case (one such being recorded in the 24 August 2005 note);

    ii) the 24 August 2005 note, made by Dr Cowie, strongly suggests that a review had taken place:

    iii) on 5 August 2006, the day after the Claimant's cardiac arrest, Dr Cowie emailed a number of people (including Mr McDermott) suggesting that the Claimant had seen Dr Mills during the 2005 investigation;

    iv) Dr Cowie accepted that Mr McDermott would likely have obtained the necessary medical input for his 26 August 2006 report from her; and

    v) it was inherently unlikely (Mr Westcott submitted) that Dr Cowie and Dr Curtin would have different understandings on this important matter;

78. That was a forceful submission; but, after careful consideration, I am not satisfied that, in August 2005 through to August 2006 and beyond, Dr Cowie was under the misapprehension that the Claimant had been clinically reviewed by a cardiologist. On this issue, I find the evidence of the Claimant's parents as to the 30 August 2006 meeting (see paragraphs 51-52 above) particularly compelling. At that meeting, Dr Mills said that he had recommended to the Club that the Claimant be seen in a clinical review; and Dr Cowie immediately responded, not that such a review had been carried out, but that Dr Mills did not recommend such a review. Whilst of course her understanding might have changed, she said that (somewhat oddly) she had not looked at the Claimant's medical records in preparation for that meeting – that I accept, as it accounts for her mistake in saying that Dr Mills had not requested a clinical review. Indeed, in the evidence, there is no suggested prompt for such a change of apprehension. I find that, as she said in evidence, Dr Cowie was at all relevant times aware that the Claimant had not been clinically reviewed; and I accept

her evidence that a review was not pursued because she had concluded on 24 August 2005 (in the event, both wrongly and unreasonably) that the Claimant was at no cardiac risk.

79. In my view, the fact that many people within the Club considered the Claimant had had the benefit of a clinical review was not a result of a misapprehension by Dr Cowie, but the result of the very poor state of the Claimant's medical records. The only relevant records were (i) Dr Mills original recommendation of 21 July 2005 that there should be a review, and (ii) the computerised record of 24 August 2005 which suggested that there had been a review. This was in respect of a case which, both Dr Cowie and Dr Curtin said, was the first at the Club where a cardiologist having considered the ECG and ECHO had recommended an MRI scan. It appears to me to speak volumes about the expectation of medical records in the Medical Services Department of the Club at that time that those thin documents appear to have persuaded the doctors who referred to them that there had been a review, even in the absence of a clinical review report from a cardiologist. It is no answer to say, as Dr Cowie suggested, that the medics discussed individual players on a regular basis and therefore they each knew what was going on; because, in this case, whereas Dr Cowie correctly understood that there had been no clinical review, others within the team (including Dr Curtin) had the opposite understanding.

80. The records were quite evidently not adequate for their purpose. Had they been reasonably adequate, it would have been apparent from them that there had been no such clinical review; and a high likelihood that another medic within the department – Dr Curtin or Dr Krasner, for example – would have concluded from them that such a review was necessary and sought to have arranged it. It is unlikely that anyone reviewing the records would have fallen into the same error as that committed by Dr Cowie in considering there was no cardiac risk for the Claimant; and they would have seen that that risk had not been conveyed to the Claimant and his parents. As it was, the evidence of Dr Curtin was simply that he understood that Dr Cowie was dealing with the matter of the Claimant's cardiac issue; but that understanding did not come from the medical records.

## Breach of Duty: Conclusion

81. For the reasons I have given, both Dr Mills and the Club are in breach of their respective duties to the Claimant.

## Apportionment

82. Causation has been conceded by each Defendant. I therefore have to proceed to apportion liability between them.

83. Again, the relevant principles are well-established: as between defendants inter se, the proportions of liability have to be just and equitable taking into account blameworthiness and causative potency (see, e.g., Downs v Chappell [1997] 1 WLR 426 at page 445).

84. Mr Westcott submitted that, in all the circumstances, the Club should bear the major proportion of the liability. I agree. In coming to that conclusion, I have taken into

account all of the matters to which I have referred above in relation to the claims against each of them, but of particular note are the following.

i) I do not accept that Dr Cowie (or the Club through any of their other employees) treated the Claimant as simply an "asset" of the Club, rather than a patient, as Mr Westcott contended and Mr Hamed clearly thought might have been the case. I do not consider that Dr Cowie in any way deliberately shut her eyes to the risk. In concluding that the Claimant bore no risk of an adverse cardiac event, Dr Cowie made a simple negligent error of judgment.

ii) But it was serious error of judgment. The Club owed a duty of care to the Claimant as a result of both the doctor/patient and employer/employee relationship. With regard to the former, the Club doctors were not only in effect the Claimant's general practitioners, but specialist sports physicians who were (or should have been) well-acquainted with the cardiac risk faced by young athletes. In addition to the usual obligations of a doctor to a patient, the FA protocol placed an obligation upon them to ensure that the Claimant and his parents were made aware of any risk that the Claimant faced. It was their responsibility, as specialist physicians and employers, to ensure that relevant risks were identified and communicated to the Claimant and his parents to enable them to make an informed decision as to whether to bear them. In this, they singularly failed.

iii) Following Dr Mills' report in July 2005, it was the Club's job to organise the follow-up (including the clinical review). The FA made clear – and Dr Cowie well-understood – that cardiologists had been instructed not to carry out any investigations unless requested by a football club's medical team to do so. In this case, despite the July 2005 recommendation by Dr Mills and the understanding of Dr Curtin that a review was required, the Club never requested any such review of Dr Mills or any other cardiologist.

iv) Whilst Dr Cowie said that she did not wish unduly to concern the Claimant's parents before the investigations were complete, she was the Claimant's medical practitioner; and she unfortunately but unreasonably gave them false assurance that the Claimant's heart was normal (on any view, it was not) and there was nothing to worry about (when, even after the MRI scan, the cardiologist had specifically indicated to the Club that he was worried by the ECG). Whilst my firm finding is that the conclusion upon which that assurance was given was one which she could not properly have made, had there been any ambiguity then the proper course would have been for her to have contacted Dr Mills himself for clarification. Although she said he was sometimes busy and difficult to get hold of, given that she was dealing with a risk of a potentially fatal condition, in the event of any doubt she was obliged to obtain any necessary clarification from him.

v) As a result of Dr Cowie wrongly concluding that the Claimant was at no cardiac risk, she did not consider it necessary to pursue a clinical review. Had she considered that he was at such a risk, as she ought to have done, she would have ensured that he had been clinically reviewed by a cardiologist, almost certainly Dr Mills. At such a review, a family history would have been taken (which we now know would have been negative) and, vitally, the level and

nature of the risk explained to the Claimant and his parents. In those circumstances, the Claimant would have ceased playing professional football, and he would have avoided the cardiac arrest from which he suffered on 4 August 2006.

vi) Furthermore, the record keeping at the Club's Medical Services Department fell far short of the acceptable. Had it been adequate, then it is likely that a member of the department would have spotted that there had not been a clinical review circumstances in which there ought to have been a review.

vii) On the other hand, I accept Mr Westcott's submission that, until at least 24 August 2005, Dr Mills had complied with all of his obligations: he had properly construed and reported upon the various scans that had been performed and done all that had been required of him. His professional judgment that it would be reasonable for the Claimant to continue as a professional footballer was, subject to the taking of a family medical history, generally in accordance with recognised recommendations. It was accepted by Dr Widdowson that, when Dr Mills wrote his September 2005 letters, he was reasonably entitled to assume that the Claimant and his family had been apprised of the thrust of his concerns about the Claimant's cardiac function. Although Dr Mills owed the Claimant a duty of care, he was not in a doctor/patient relationship with him. He had not been asked to clinically review the Claimant. Had he been asked, he would have done so. His only breach of duty to the Claimant was in failing to make clear to the Club from (at the earliest) 24 August 2005, and notably through his September 2005 letters, that it was still a mandated requirement for there to be a clinical review conducted by a cardiologist. Dr Mills' letters of 2 and 9 September 2005 used language that was, at best, very loose. I accept that, had he made that continuing requirement clear, the Club would in all likelihood have arranged such a review, at which a family history (which we now know would have been negative) would have been taken and, vitally, the level and nature of the risk explained to them. In those circumstances too, for the reasons I have set out above, the Claimant would have ceased being a professional footballer and his adverse cardiac event on 4 August 2006 would not have happened.

85. In all of the circumstances, I consider the appropriate apportionment as between the defendants to be the First Defendant Dr Mills 30%, the Second Defendant the Football Club 70%.