"Defendants' application under Rules 19 and 52 of the Royal Court Civil Rules, 2007 for summary judgment and/or striking out of the Cause in a personal injury claim"

IN THE ROYAL COURT OF GUERNSEY
(ORDINARY DIVISION)
Civil No. 2511

[2026]GRC004

Between:

SUSAN COTTERILL **Plaintiff**

and

(1) THE MEDICAL SPECIALIST GROUP LLP
(2) MR RANJAN VHADRA **Defendants**

Judgment circulated under the Practice Direction on: 23 January 2026

Final Judgment handed down on: 5 February 2026

Before: Fionnuala A Connolly, Judge of the Royal Court

For the Plaintiff: Susan Cotterill, appeared in person

Counsel for the Defendants: Advocate R. Gist

Cases, texts & legislation referred to:

The Royal Court Civil Rules, 2007

Rawlinson & Hunter Trustees SA v Investec Trust (Guernsey) Limited and Bayeux Trustees Limited [2016] GLR 332
Easyair Ltd (t/a Openair) v Opal Telecom Ltd [2009] EWHC 339 (Ch)
JJW Hotels & Resorts Holdings Inc v Rhodes [2022] GLR 538
Tranquility Holdings Limited v Invista Real Estate Investment Management (C.I.) Limited 38/2015
Jakob International Inc -and- HSBC Private Bank (C.I.) Limited 26/2016
Boyle and Rice v The United Kingdom 9659/82 0658/82 – Chamber Judgment [1988] ECHR 3 (27 April 1988)
Maurice v France [GC], 2005 106
Right to an Effective Remedy, Guide on Article 13 of the European Convention on Human Rights (28 February 2025)
Laws of Guernsey, Dawes G (2003)

JUDGMENT

Introduction

1. By application made on 26 June 2025, the Defendants seek orders that they be given summary judgment on the Plaintiff's personal injury claim on the basis that there are no real prospects of success and there are no other compelling reasons why the claim should be disposed of at a trial and that certain parts of the Plaintiff's Cause tabled on 9 June 2023 ("the Cause") be struck out on the basis that they disclose no reasonable grounds for bringing the claim. The application was brought pursuant to Rules 52 and 19 of the Royal Court Civil Rules, 2007 ("the RCCR") and/or the inherent jurisdiction of the Court.

2. In short compass, the Defendants contend that the Plaintiff has no realistic prospect of success and that judgment should be awarded in their favour. The Defendants' position is that a joint supplemental expert report, prepared by the medical experts on behalf of both parties, has fundamentally undermined the Plaintiff's claim in that both experts have agreed on multiple points in favour of the Defendants. The evidence in support of the application is set out in the first affidavit of Ms Charlotte Olivia Tomlinson, Associate Solicitor at Ferbrache & Farrell LLP, sworn on 26 June 2025.

3. The Court had the benefit of written submissions from both parties and at hearing on 16 October 2025, the Court heard from Advocate Gist on behalf of the Defendants and Ms Cotterill who represented herself. The Court is grateful to Advocate Gist and Ms Cotterill for their submissions. In reaching my decision, I have given careful consideration to all of the evidence and the submissions.

Background

4. The Plaintiff commenced her claim against the Defendants by service of a summons on 10 March 2023. This is a personal injury claim by which the Plaintiff alleges negligence by the Defendants in respect of orthopaedic medical services provided to her for treatment of her left hip joint. The Cause was tabled on 9 June 2023.

5. The Cause asserts the following:

> *"1) The Defendants provided orthopaedic specialist medical records to the Plaintiff in relation to her left hip. The Second Defendant was a Consultant Orthopaedic Surgeon of the First Defendant.*
>
> *2) In July 2010, the Queen's Road Medical Practice ("The QRMP") referred the Plaintiff to the First Defendant and/or the Second Defendant, the Plaintiff having undergone x-ray on 27 April 2010 which showed, inter alia, osteoarthritic change within the left hip joint. The Plaintiff had a consultation with the Second Defendant in July 2010 in relation to her hip. The Plaintiff had very arthritic symptoms. The Second Defendant did not give the Plaintiff the option of having a total left hip operation and/or did not advise or adequately advise the Plaintiff to have that operation.*
>
> *3) In August 2012, further to the Plaintiff being in intolerable pain and feeling ready for a hip replacement, Dr Bill Barker of The QRMP referred her to the Second Defendant in August 2012 for a hip replacement.*
>
> *4) In July 2013, the Second Defendant wrote to the Plaintiff referring the Plaintiff for a course of physiotherapy.*
>
> *5) The Plaintiff was not seen by the Second Defendant or any other Orthopaedic Surgeon of the First Defendant until June 2014.*
>
> *6) At the Plaintiff's consultation with the Second Defendant in June 2014, the Second Defendant did not give the Plaintiff the option of having a total left hip operation and/or did not advise or adequately advise the Plaintiff to have that operation.*
>
> *7) An X-ray of the Plaintiff's left hip was taken in December 2017 showing, inter alia, severe osteo-arthritic change to the left hip; completely lost joint space, flattened femoral head, lateral subluxation and severe osteophyte formation.*
>
> *8) Neither the First Defendant nor the Second Defendant referred the Plaintiff for any updated radiography/x-rays in relation to her left hip from July 2010 to the referral of The QRMP to the First Defendant in December 2017 (by letter from the QRMP*

of 22 December 2017). Neither the First Defendant nor the Second Defendant made any arrangements to keep the Plaintiff under review in respect of her left hip during this time.

9) The QRMP referred the Plaintiff to the First Defendant on 22 December 2017 to discuss a joint replacement. The First Defendant did not see the Plaintiff in relation to this referral until 10 May 2018 when she had a consultation with Mr Ben Bradley of the First Defendant.

10) The Plaintiff did not undergo a total left hip replacement, performed by Mr Richard Hopcroft of the First Defendant, until 12 March 2020."

6. The Plaintiff's pleaded case is that the Defendants have been negligent. She alleges the following breaches of duty (para. 11 of the Cause):

"(a) Failing to advise or adequately advise the Plaintiff in relation to a total hip replacement in her left hip.

(b) Failing to refer the Plaintiff for any updated radiography / X-rays in relation to her left hip between July 2010 and December 2017.

(c) Failing in all of the circumstances to ensure that the Plaintiff received timely treatment.

(d) Failing in all of the circumstances to ensure that the Plaintiff received adequate treatment.

(e) Failing in all of the circumstances to adequately and appropriately manage the Plaintiff's condition.

(f) Failing to provide an acceptable standard of care to the Plaintiff."

7. At paragraph 12 of the Cause, the Plaintiff alleges:

"As a result of the negligence of the Defendants the Plaintiff has suffered pain, injury, loss and damage."

8. In their Defences tabled on 6 September 2023, the Defendants raised an exception de fond on the basis that the Plaintiff's claim is prescribed pursuant to Section 5 of the Law Reform (Tort) (Guernsey) Law, 1979 in that she failed to bring her claim within 3 years of the alleged negligence or knowledge of that negligence.

9. Further, and without prejudice to the exception de fond, the Defendants disputed the Plaintiff's claim in its entirety. They contend that at all material times, the Plaintiff was advised carefully and appropriately and the Defendants made informed decisions about her management and treatment as set out in the contemporaneous clinical records.

10. Directions were ordered for the progress of the personal injury claim. Disclosure was provided by the parties on 12 January 2024 and witness statements were filed and served by the parties on 15 March 2024.

11. At hearing, Ms Cotterill granted leave to amend paragraph 7 of the Répliques to reflect that she was eventually fully provided with medical reports in February 2023 (and not February 2024 as initially stated in the Répliques).

The Expert Medical Evidence

12. Directions were agreed for the exchange of expert reports and each of the parties filed and served expert evidence on 19 April 2024. The Plaintiff relied on an Orthopaedic Clinical Negligence report dated 17 May 2023 of Mr S. Venkat, Consultant Orthopaedic Surgeon ("Mr Venkat"). The Defendants relied on a report dated 6 April 2024 of Mr Paul B. Carter, Consultant Orthopaedic Surgeon ("Mr Carter").

13. In his report dated 17 May 2023, Mr Venkat opined that on the balance of probability, the left total hip replacement should have been offered to Ms Cotterill and performed much earlier than 12 March 2020 and that this would have given a better outcome and avoided years of suffering with pain and difficulty with activities of daily living. In his opinion, the assessment and treatment of Ms Cotterill's left hip arthritis fell below the expected standards of care. He stated that the current position at that time was that Ms Cotterill had confirmed that the outcome of her left hip replacement performed on 12 March 2020 was excellent but that she had slight left limp due to leg length discrepancy and numbness in her left toes due to suspected neuropraxia. On his opinion on breach of duty and causation, Mr Venkat said this:

> *"In my opinion, Miss Cotterill should have been offered left hip replacement during 2010 when she reported significant pain, stiffness, and limitation of walking distance with restricted activities of daily living with moderate to severe radiological changes in the left hip.*
>
> *However, it was reasonable to delay the left total hip replacement for further few months if the symptoms and radiological changes were not severe enough to warrant the hip replacement surgery.*
>
> *It was reasonable for the consultant orthopedic (sic) surgeon to suggest weight reduction and conservative management until the symptoms become severe.*
> *But when the symptoms have deteriorated along with radiological advancement of the arthritic changes, she should have been offered a left hip replacement.*
>
> *When Miss. Cotterill reported deteriorating symptoms during 2011 and 2012, the GP or consultant orthopedic (sic) surgeon should have arranged an up-to-date x-ray of the left hip to assess the advancement of the arthritis. If symptoms reported by Miss. Cotterill was severe with evidence of deterioration of radiological changes, the left hip replacement should have been offered to her during 2011 or 2012.*
>
> *Her GP or the orthopedic (sic) department should have arranged regular review of her symptoms and arranged review x-rays for every 6 months from April 2010.*
> *In my opinion, I believe that there had been breach of duty by the MSG and Mr.Vhadra from December 2017 until her operation on 12 March 2020.*
> *In my opinion, the standard of follow up had fallen below the expected level of a reasonably competent orthopedic (sic) surgeon and his team.*
>
> *In my opinion and on the balance of probability, the standard of care provided to Miss. Cotterill fell below the reasonably competent orthopedic (sic) surgeon during the follow up between 2010 and 2020. If appropriate follow up and treatment provided in the form of non-operative or operative had been to the expected standard, Miss. Cotterill would have avoided suffering between this period and the outcome of the left total hip replacement would have been better than what has been achieved.*

> *In my opinion, if the left total hip replacement was performed at an early stage the leg length discrepancy could have been equalized and difficulty with her leisure activities, domestic chores and work could have been avoided*."

14. Mr Venkat's opinion was that the leg length discrepancy is likely to be permanent and the numbness in Ms Cotterill's left toes is likely to be permanent if it has not improved within 12-18 months after the operation.

15. In his expert report on behalf of the Defendants dated 6 April 2024, Mr Carter set out his review of records and imaging. He noted that Ms Cotterill had been reviewed by Mr Bradley, Consultant Orthopaedic Surgeon on 10 May 2018 and that she had a long history of worsening left groin and thigh pain. She had seen Mr Vhadra in 2014 and decided to proceed with conservative treatment. Things had deteriorated since then and she complained of constant pain. Mr Carter noted:

> "*Ms Cotterill wanted to consider surgical intervention. This was thought appropriate. She was (sic) consented and listed for total left hip replacement. She was noted to have a high BMI."*

16. Mr Carter also referred to a letter from Mr Hopcroft, Orthopaedic & Trauma Surgeon dated 18 February 2020 which recorded:

> *"This lady has been on the waiting list for an extraordinary length of time has had a couple of false starts in preparation for her total hip replacement on the left side. She has had previous urinary tract infections which we have treated. She has been proven also to be an MRSA positive carrier and has eradication therapy but remains a carrier. We now have a date for her surgery of 12 March, there will be of course a need for a side room to be available in order to proceed with the surgery due to her MRSA status but I would be grateful if you could see her in a fortnight or so beforehand as she will need her preoperative bloods checking again. Also arrange further urine sample checking and if this was to prove positive again it would not stop us but she would continued (sic) to have treatment with Trimethoprim at this stage. She will need providing with hibiscrub and nasal treatment for MRSA, which I will be grateful if you could instruct her to start a good week to 10 days prior to her admission. We will also need to stop her Clopidogrel in the week to 10 days before her surgery. It is only precautionary, so we should not need any intervening bridging therapy".*

17. Mr Carter set out his opinion on breach of duty:

> *"In my opinion, Ms Cotterill's treatment has been reasonable, logical and responsible from an orthopaedic perspective.* ***No breach of duty identified****.*
>
> *Mr Vhadra has documented the consultations on 19 07 2010 and 19 06 2014. He has clearly discussed conservative and operative treatment with Ms Cotterill. There is also evidence within the GP records that Ms Cotterill was not considering hip replacement surgery during this time. The documented evidence, therefore, does not confirm Ms Cotterill's account of events.*
>
> *In my opinion, Mr Vhadra has acted appropriately, within the same manner as a majority of Orthopaedic Surgeons. If a patient functions well with analgesia and conservative treatment, they should not be coerced into having a hip replacement. Once Ms Cotterill had exhausted conservative treatment, and had come to the conclusion she wanted hip replacement surgery i.e. in May 2018, she was appropriately listed for hip replacement surgery by Mr Bradley.*

Modern practice is not to continually follow up patients who have osteoarthritic change of their hips. Orthopaedic clinics would quickly become overwhelmed if this practice was adopted. Modern practice is to discharge patients who are not considering hip replacement surgery and request referral back when they need further discussion relating to surgery or indeed listing for surgery i.e. the treatment plan Mr Vhadra advised.

I accept there was an approximate 2 year delay between listing Ms Cotterill on 17 05 2018 and her left hip replacement surgery on 12 03 2020. However, this was due to the long waiting lists at the time and the multiple medical conditions which further delayed Ms Cotterill's surgery e.g. MRSA, urinary tract infections. I am led to believe that a 2 year wait at this time in Guernsey was not an unusual situation. I have seen no evidence of any negligence relating to the delay and indeed there is documented evidence that the medical professionals were trying their best to get Ms Cotterill's surgery done."

18. Mr Carter concluded that treatment had been reasonable and there had been no injury linked to the alleged negligence. He said this:

"The left hip x-ray osteoarthritic changes have progressed from April 2010 until the x-rays on 20 02 2020 - just before her left hip replacement surgery. However, there has been no significant shortening (in my opinion, less than 5mm change), there has been no significant bone loss or bony erosions, and alignment has remained essentially normal. In summary, the surgery for the left hip replacement performed on 12 03 2020 was not significantly more difficult than if left hip replacement had been performed in April 2010. Surgery on 12 03 2020 was a standard left cemented total hip replacement. No complications have been detailed within the operation notes. There is no evidence of significant bone loss or problems completing the left hip replacement surgery. Post operative x-rays from 14 03 2020 are satisfactory. I therefore conclude there has been no significant detrimental effect, relating to long term outcome, of any alleged delay in left hip surgery.

Although the post operative x-rays from 14 03 2020 are rotated (this is common in immediate post operative films) there is no obvious significant leg length discrepancy. I believe Ms Cotterill complains of some toe numbness. There are many causes for toe numbness. They do not usually relate to hip replacement surgery. Even if it is concluded that left toe numbness relates to the left hip replacement surgery, this is a recognized, and relatively minor, complication…"

19. The parties were then directed to file a joint supplemental expert medical report. A joint letter of instruction dated 17 March 2025 was addressed to both Mr Venkat and Mr Carter from Ferbrache and Farrell LLP. By that letter, the experts were instructed to prepare a joint supplemental report ("the Joint Report") further to the reports that they had already prepared for the Plaintiff and Defendant respectively. The experts were requested to confirm whether they were in agreement or dispute as to a series of points.

20. The Joint Report dated 19 March 2025 was filed on 15 April 2025. The experts set out the following responses to the questions identified in the joint letter of instruction:

"a) Did the x-ray of 27th April 2010 suggest that there had been healing of a previous femoral neck fracture?

Both experts are agreed that whether there was a previous femoral neck fracture or not is irrelevant. The x-rays from 27 April 2010 show moderate to severe degenerate change at Ms Cotterill's left hip. There is no evidence of femoral neck fracture seen on the images at that time.

b) Did Mr Vhadra fail to advise or adequately advise Ms Cotterill to have a total hip replacement at her consultation with him on 12 July 2010 and I or 12 June 2014?

Both experts agree that continuing conservative treatment on 12 July 2010 was appropriate and reasonable. The decision to offer total hip replacement is based on the patient's symptoms, examination findings and x-ray findings. Mr Vhadra has documented an appropriate assessment on 12 July 2010. The records detail that the decision, between the patient and the surgeon, was to continue with conservative i.e. non- operative, treatment:

"She is happy to continue as she is and will let me know in due course if she would like to be considered for a hip replacement"

Both experts agree that it was appropriate and reasonable for Mr Vhadra to advise and continue conservative treatment for Ms Cotterill on 12 June 2014. It is clearly documented that Ms Cotterill wanted to avoid an operation:

"She is quite happy at the moment and really does not want to consider a joint replacement as and when her symptoms dictate the necessity for joint replacement I would be grateful if you could organise an up to date x-ray and refer her back to me. I would be only too happy to see her again"

In summary, both experts agree Mr Vhadra's actions on the above dates were appropriate and reasonable. Total hip replacement was discussed but deemed unnecessary as conservative treatment was adequately controlling symptoms.

c) Taking into account Ms Cotterill's reported symptoms (noting any differences in the evidence regarding the same), the potential risks inherent in terms of conservative management (e.g. if there was avascular necrosis following an earlier fracture), the inevitability of increased symptoms, future potential poorer outcomes following delayed surgery and assuming that Ms Cotterill had indicated some reluctance to have surgery, as at the 12 June 2014 consultation

I) Was Mr Vhadra negligent in failing to advise I arrange x-rays at or around that time in order to determine the extent and severity of the osteoarthritis degeneration in the hip?

Both experts agree that, as Ms Cotterill was not considering surgery at the time, it was reasonable not to perform up to date x-rays. The clinical symptoms and signs were similar to those detailed in 2010.

Mr Carter notes that the hip x-rays taken on 13 December 2017 showed some progression of osteoarthritic change, but certainly not enough to alter surgical management. It therefore follows that any x-rays taken in 2014 would not have altered clinical judgement / management.

Mr Venkat is of the opinion that it would have been reasonable to arrange an up to date X ray of the pelvis and left hip on 12th June 2014 although it was not negligent.

II) Was Mr Vhadra in a position to (i.e. properly and safely - absent any recent x-rays) advise / counsel Mr Cotterill as to the advantages and disadvantages of hip replacement at that stage?

Both experts refer the reader to the above answer in (I).

The experts agree that Ms Cotterill was not considering hip replacement at that time and was managing with conservative treatment. This is the key information. An up to date x- ray at that point would not have altered Mr Vhadra's advice.

III) If Ms Cotterill did not want surgery at that stage, was she sufficiently advised to be able to properly consent to no surgery at that stage because she did not know the physical state of her hip (in the absence of an x-ray since 2010)?

We refer the reader to the above comments (I) and (II).
Both experts agree that Ms Cotterill's advice from Mr Vhadra was reasonable and appropriate. We are agreed that an x-ray at that stage would not have altered Mr Vhadra's advice or Ms Cotterill's decision to continue with conservative treatment. The physical state of her left hip, as seen on x-rays, is little different between 2010 and 2017.

IV) Is it likely, on the balance of probabilities that, as at 2014, x-rays would have revealed that Ms Cotterill's hip had collapsed and / or that degeneration was sufficiently advance (sic) at that stage so as to strongly indicate that surgery was appropriate?

There is only slight worsening of arthritis noted on the x-rays from 2017 as compared with those from 2010. Therefore, x-rays in 2014 would not have shown Ms Cotterill's hip had 'collapsed' or degeneration had become significantly more advanced. The decision to perform total hip replacement surgery was based on Ms Cotterill's symptoms and her satisfactory response to conservative treatment.

V) Would surgery at that stage have produced a better outcome than the 2020 procedure and / or would this have avoided the symptoms I restrictions suffered by Ms Cotterill during the intervening period?

Although there has been some progression of hip arthritis between the x-rays of 20 February 2020 (immediately prior to hip replacement surgery) and 27 April 2010, the progression of arthritis has not resulted in any changes that would make primary hip replacement surgery more difficult. The experts are agreed that the physical / bony outcome of the hip replacement surgery would have been the same whether performed in 2010 or 2020.

Both experts agree that a successful hip replacement would have improved Ms Cotterill's left hip symptoms. However, she was adequately managing her hip symptoms with analgesia and conservative methods between these two dates. Both experts are agreed it was appropriate and reasonable to manage her left hip symptoms with conservative treatment rather than take risks of hip replacement surgery. Not all hip replacements are successful.

Both experts are agreed that the hip replacement surgery performed in 2020 would have been the same type of surgery performed in 2010 (if a hip replacement had been undertaken at that time).

Mr Venkat is of the opinion that Ms Cotterill would have experienced pain, stiffness and limitation of walking distance during the intervening period but not severe or disabling.

d) Did Mr Vhadha and / or the MSG fail to adequately and appropriate (sic)manage Ms Cotterill's condition?

Both experts agree that Mr Vhadra / the MSG, based on the medical records, appropriately managed Ms Cotterill's condition. She was treated conservatively until conservative treatments stopped working for her. She was then appropriately listed, in May 2018, for left hip replacement surgery.

e) Was it appropriate for Mr Vhadra to discharge Ms Cotterill back to her GP between 2010 and 2017 or should there have been a plan made for a review? If there was a plan for a review, when would a further x-ray be warranted?

Both experts agree that it was reasonable and appropriate to discharge Ms Cotterill back to her GP between 2010 and 2017. Mr Vhadra has clearly detailed that when Ms Cotterill's symptoms dictated, and she wanted to proceed with left hip replacement surgery, she could be referred back for up to date x-rays and assessment for left hip replacement surgery.

Mr Venkat is of the opinion that Ms Cotterill could have been offered a patient initiated follow up if she anticipated delay through a GP re-referral.

f) Did Mr Vhadra and/ or the MSG fail to ensure Ms Cotterill received timely treatment?

Both experts agree that Ms Cotterill's treatment was appropriate and timely. She was listed at an appropriate stage. Both experts are aware there was some delay between listing on 10 May 2017 and operation on 12 March 2020. However, the delays were due to the long waiting times in Guernsey and several medical comorbidities which delayed Ms Cotterill's surgery. The 'medical' delays were necessary and appropriate i.e. UTI's, MRSA carrier status.

g) Did Mr Vhadra and / or the MSG fail to provide an acceptable standard of care

Both experts agree there was an acceptable standard of care.

h) Did the MSG fail to ensure Ms Cotterill received a timely operation after the x-ray of 13 December 2017?

Both experts note there was a delay between 13 December 2017 and operation on 12 March 2020. However, the delay related to long waiting times and medical comorbidities which required resolving before surgery.

i) Did the MSG fail to provide an acceptable standard of care to Ms Cotterill including after the x-ray of 13 December 2017?

Both experts agree there was an acceptable standard of care.

j) Where there any leg length discrepancies following the surgery in March 2020, and if so, to what extent can any such discrepancies be attributed to the timing of the referral of Ms Cotterill for surgery?

Neither expert is aware of any significant leg length discrepancy following surgery in March 2020.

Both experts are agreed that, even if there were any leg length discrepancies, they

are not attributable to the timing of Ms Cotterill's surgery.

Mr Carter notes he has reviewed the immediate postoperative pelvis x-rays from 14 March 2020. Although the film is rotated, the leg lengths appear satisfactory with no major leg length discrepancy.

Mr Venkat has not had sight of the postoperative x-rays from 14 March 2020. Neither expert has examined Ms Cotterill.

k) To what extent is the numbness in Ms Cotterill's toes attributable to the date the Plaintiff was referred for surgery?

Neither expert is aware of numbness in the toes. There are multiple causes for toe numbness. It is not necessarily attributable to hip replacement surgery. Both experts agree that any numbness in Ms Cotterill's toes is not attributable to the date of left hip replacement surgery.

I) Please comment on any or any other consequences to Ms Cotterill attributable to the timing of the surgery.

Mr Carter notes that Ms Cotterill was 62 years old at the time of left hip replacement surgery. The average life expectancy for a female in the UK is around 83 years. A majority of hip replacements last 25 years before revision surgery is necessary.
Therefore, Ms Cotterill will probably not require any revision hip surgery in her lifetime. If, for instance, she had undergone left hip replacement surgery 10 years earlier in 2010, she probably would have required revision of her hip replacement within her lifetime. This is why orthopaedic surgeons only advise hip replacement surgery when a patient cannot adequately control their symptoms with conservative measures i.e. analgesia and activity modification.

m) Any other areas of dispute?

No."

21. The Plaintiff sought to rely on a further supplementary report of Mr Venkat dated 1 July 2025. In his supplementary report, Mr Venkat, responded to a series of supplemental questions on the instruction of the Plaintiff. The Defendants did not agree that Mr Venkat's supplementary report should be allowed in evidence as the parties had filed the Joint Report. The Defendants accepted, however, that the supplementary report of Mr Venkat should be before the Court for the purpose of the summary judgment/ strike out application and it was included in the bundle before the Court accordingly.

22. Mr Venkat prefaced his supplementary report by indicating that it should be read in conjunction with his report dated 17 May 2023 and the Joint Report. In response to the questions put to him on behalf of the Plaintiff, Mr Venkat set out his response to the 11 questions put to him on behalf of the Plaintiff grounded on the standard of care expected of a reasonably competent orthopaedic surgeon:

"Question 1 *Would a reasonably competent Orthopaedic Surgeon have offered Ms Cotterill the option of having a left hip replacement at the consultation she had with Mr Vhadra on 12 July 2010?*

Response: *Yes. Given that the April 2010 x-ray showed moderate to severe degenerative changes, and the Claimant was reportedly experiencing significant symptoms (pain,*

stiffness, reduced function), it would have been appropriate and in keeping with the standard of care for a reasonably competent orthopaedic surgeon to discuss and offer total hip replacement (THR) as an option at the July 2010 consultation.

This does not mean that THR must have been recommended outright, but it should have been part of shared decision-making and clearly documented.
However, Mr Vhadra has documented an appropriate assessment on 12 July 2010. The records detail that the decision between the patient and the surgeon was to continue with conservative, i.e. non-operative, treatment:

> *"She is happy to continue as she is and will let me know in due course if she would like to be considered for a hip replacement"*

Question 2 *Would a reasonably competent Orthopaedic Surgeon have offered Ms Cotterill the option of having a left hip replacement at the consultation she had with Mr Vhadra on 12 June 2014?*

Response: *Yes. By 2014, the Claimant had reported intolerable pain (per the 2012 GP letter) and further difficulty with activities. Even though the Claimant appeared reluctant, the severity of symptoms and natural progression of hip osteoarthritis warranted renewed discussion of surgical options.*

Although she was not requesting surgery, it would still be expected that a competent surgeon would ensure the Claimant was fully informed of her options, including surgery, especially given the known trajectory of severe OA.

However, it is clearly documented that Ms Cotterill wanted to avoid an operation:

> *"She is quite happy at the moment and really does not want to consider a joint replacement ..... as and when her symptoms dictate the necessity for joint replacement, I would be grateful if you could organise an up-to-date x-ray and refer her back to me. I would be only too happy to see her again"*

Question 3 *Would a reasonably competent Orthopaedic Surgeon have explained to Ms Cotterill the benefits/advantages and risks/ disadvantages of having a left hip replacement and/or provided a recommendation as to whether Ms Cotterill should have surgery as at 12 July 2010? If so, please set out what the explanation and /or recommendation should have included, as a minimum.*

Response: *Yes. The expected standard includes providing a clear explanation of both non-operative and operative options. As a minimum, this should have included:*

<u>Benefits of THR:</u>

- *Significant relief of pain.*
- *Improved mobility and function.*
- *Improvement in sleep, gait, and overall quality of life.*

<u>Risks/Disadvantages:</u>

- *Surgical risks (infection, bleeding, DVT/PE).*
- *Prosthesis-related issues (loosening, wear, dislocation).*
- *Potential for leg length discrepancy or nerve injury.*
- *Lifespan of prosthesis (possibly requiring revision in future).*

<u>Recommendation:</u>

If the Claimant's symptoms were impacting her daily life and the x-rays showed moderate

to severe degeneration, it would be reasonable to recommend considering THR or at least ensuring the Claimant understood that it would become necessary when symptoms worsened.

Question 4 *Would a reasonably competent Orthopaedic Surgeon have explained to Ms Cotterill the benefits/advantages and risks/ disadvantages of having a left hip replacement and/or provided a recommendation as to whether Ms Cotterill should have surgery as at 12 July 2010? If so, please set out what the explanation and/or recommendation should have included, as a minimum if different to above.*

Response: *Yes. The explanation above remains valid and applicable. By this time, the Claimant had longstanding symptoms with possible radiological progression (though x-rays were not repeated). The threshold for counselling regarding surgery would have been even more pressing.*
Again, the minimum standard would be to ensure that the Claimant was fully aware of the future inevitability of surgery and its risks and benefits, even if she opted to delay.

Question 5 *Would Mr Vhadra have failed to provide an acceptable standard of care to Ms Cotterill if he did not provide the said minimum explanation and/or recommendation at the 12 July 2010 consultation?*

Response: *Yes, it would. Failure to provide this level of explanation and counselling, especially in the context of moderate to severe OA and functional limitation, would fall below the standard expected of a reasonably competent orthopaedic surgeon. This would compromise informed consent and patient autonomy in decision-making.*

However, Mr Vhadra has documented an appropriate assessment on 12 July 2010. The records detail that the decision between the patient and the surgeon was to continue with conservative, i.e. non-operative, treatment:

> *"She is happy to continue as she is and will let me know in due course if she would like to be considered for a hip replacement"*

Question 6 *Would Mr Vhadra have failed to provide an acceptable standard of care to Ms Cotterill if he did not provide the said minimum explanation and/or recommendation at the 12 June 2014 consultation?*

Response: *Yes, it would. Despite the Claimant's reported reluctance, it would still be expected that the surgeon would revisit the discussion of THR, especially after several years of conservative management and worsening symptoms. Not providing this information would again fall below the standard of reasonable orthopaedic care.*

> *However, it is clearly documented that Ms Cotterill wanted to avoid an operation:*
>
> *"She is quite happy at the moment and really does not want to consider a joint replacement ..... as and when her symptoms dictate the necessity for joint replacement, I would be grateful if you could organise an up-to-date x-ray and refer her back to me. I would be only too happy to see her again"*

Question 7 *If Mr Vhadra did not explain the benefits/advantages and risks/disadvantages of surgery and/or provide a recommendation, if needed, as to whether Ms Cotterill should have surgery adequately or at all at the said consultations, would Ms Cotterill have been able to give informed consent to having conservative treatment rather than surgery at each of those consultations?*

Response: *No. Without adequate counselling on the benefits and risks of THR, the Claimant would not have been in a position to make an informed decision about continuing conservative management. This would mean valid consent was not obtained, undermining shared decision-making and clinical autonomy.*

Question 8 *Did Mr Vhadra fail to provide an acceptable standard of care to Ms Cotterill by not offering or providing her with hip injection(s) at or after the 12 July 2010 consultation?*

Response: *No, but with qualification.*

Intra-articular hip injections (usually corticosteroids) are not a mainstay for managing advanced OA. They are occasionally used for diagnostic purposes or temporary symptom relief. Most surgeons do not routinely recommend them in the setting of advanced disease unless surgery is contraindicated.
Therefore, not offering an injection at that time does not constitute a breach of duty, although if pain was severe and the Claimant was not yet ready for surgery, a short-term injection could have been discussed.

Question 9 *Did Mr Vhadra fail to provide an acceptable standard of care to Ms Cotterill by not offering or providing her with hip injection(s) at or after the 12 June 2014 consultation (taking into account Dr Machin's suggestion of this in her referral letter)?*

Response: *Possibly, but not definitively.*

This is a more nuanced situation. The GP specifically suggested a hip injection, which should have at least prompted a discussion. While the orthopaedic surgeon may have reasonably considered injections to be of limited value, the standard of care would likely require acknowledging and explaining this position to the Claimant and GP, not simply ignoring the request.

If there was no evidence of this being discussed or documented, it may be argued that care fell slightly below standard, not because injections were indicated, but because communication and patient engagement were lacking.

However, within Mr Vhadra's letter to Dr Machin of 19 June 2024, he stated that hip injections were not an ideal way to manage Ms Cotterill's symptoms and that hip injections are only performed for diagnostic purposes, not maintenance therapy.

Question 10 *If it was appropriate to offer or provide hip injections to Ms Cotterill, how often should these have been offered/ provided and by whom (eg GP or Consultant Orthopaedic Surgeon) and should Mr Vhadra and or the MSG have kept Ms Cotterill under review for this treatment?*

Response: *If corticosteroid injections were deemed appropriate:*
They should not be repeated frequently, perhaps once or twice per year, ideally not more than three times in a joint due to risk of infection and accelerating cartilage degeneration. They are generally administered by the consultant orthopaedic surgeon, or radiologist under image guidance.

GPs do not typically offer hip joint injections due to technical demands.
If this route had been chosen, the Claimant should have been reviewed 6–12 weeks post- injection to assess efficacy and consider the next steps, including THR.

Question 11 *How effective would hip injections have been in alleviating Ms Cotterill's symptoms?*

Response: *Modestly effective and temporary.*

In the context of moderate to severe OA, corticosteroid injections:

- *likely provide short-term relief (typically 4–12 weeks).*
- *do not halt progression of the disease.*
- *are less effective as the arthritis becomes severe or bone-on-bone.*
- *would not have significantly changed the overall need for THR.*

Therefore, at best, they would, on balance, have offered transient relief, buying time if surgery was delayed, but not a definitive or reliable solution."

Relevant Legal Principles

The Law on Summary Judgment

23. Rule 19 of Part IV of the RCCR provides for the power to give summary judgment:

> *"19. (1) The Court may, at any time after inscription of the action on the Rôle des Causes à Plaider, on the application of a party to the action, give summary judgment against any other party on the whole of the claim or on a particular issue.*
>
> *(2) The grounds of the application for summary judgment shall be that –*
>
> *(a) the plaintiff has no real prospect of succeeding on the claim or issue, or*
>
> *(b) the defendant has no real prospect of successfully defending the claim or issue,*
>
> *and there is no other compelling reason why the claim or issue should be disposed of at a trial."*

24. The leading authority on summary judgment in Guernsey is ***Rawlinson & Hunter Trustees SA v Investec Trust (Guernsey) Limited and Bayeux Trustees Limited*** [2016] GLR 332. In its judgment, the Court of Appeal of Guernsey referred to the following guidance set out by Lewison J in ***Easyair Ltd (t/a Openair) v Opal Telecom Ltd*** [2009] EWHC 339 (Ch) (para. 100):

> *"(1) Does the claim have a realistic as opposed to a fanciful prospect of success?*
>
> *(2) A realistic claim is one which is more than merely arguable and must carry some degree of conviction.*
>
> *(3) The court must not conduct a mini trial.*
>
> *(4) That said, the court may appraise and analyse what is said by a claimant as it may be clear, perhaps from contemporaneous documentation, that the factual assertions have not real substance.*
>
> *(5) The court's conclusions may be instructed both by evidence actually placed before it and evidence that can reasonably be expected to be available at trial.*
>
> *(6) Where reasonable grounds exist for believing that a fuller investigation into facts would add to or alter the evidence available, a court is entitled to hesitate about making a final decision without a trial.*
>
> *(7) It may be important to identify that important material in the form of documents or oral evidence is likely to exist and can be expected to be available at trial. However, it is not enough simply to argue that the case should be allowed to go to trial because something may turn up which would have a bearing on the issues at trial.*

(8) Short points of law or construction which may be determinative should be dealt with sooner rather than later."

25. These principles were affirmed by the Court of Appeal of Guernsey in ***JJW Hotels & Resorts Holdings Inc v Rhodes*** [2022] GLR 538. Citing ***Tranquility Holdings Inc v Invista Real Estate Inv. Management (C.I.) Ltd*** 38/2015, the Court held that the overall burden of proof is on the applicant to establish that there are grounds to believe that the respondent has no real prospect of success and that there is no reason for a trial. Once an applicant for summary judgment has adduced credible evidence in support of their application, the evidential burden will pass to the respondent to prove that there is some real prospect of success or other reason for trial. This was said to not be a high standard of proof and it is sufficient for the respondent to merely rebut the applicant's statement of belief.

The Law on Strike Out

26. Rule 10(2), Part III of the RCCR provides that a Cause must contain:

> *"a statement of the material facts on which the plaintiff relies for his claim, but not the evidence by which those facts are to be proved."*

27. Part IX of the RCCR provides for the Conduct of Proceedings. Rule 52 provides for the power to strike out a pleading:

> *"(2) The Court may strike out a pleading if it appears to the Court –*
>
> *(a) that the pleading discloses no reasonable grounds for bringing or defending an action,*
> *(b) that the pleading is an abuse of the Court's process or is otherwise likely to obstruct the just disposal of the proceedings, or*
> *(c) that there has been a failure to comply with a rule, practice direction or Court order.*
>
> *(3) The Court may also order a pleading to be struck out for want of prosecution."*

28. The principles governing an application for strike out in Guernsey on the basis of the pleadings disclosing no reasonable grounds for bringing or defending an action are set out in ***Tranquility Holdings Limited v Invista Real Estate Investment Management (CI) Limited***. Bailiff Collas held (para 47):

> *"a) Claims which are suitable for striking out on ground (a) include those which raise an unwinnable case where continuance of the proceedings is without any possible benefit to the respondent and would waste resources on both sides (Harris v Bolt Burdon [2000] L.T.L., February 2, 2000, CA).*
>
> *b) The principal test is whether the party's case is "bound to fail", which creates a high threshold before a pleading, or a part thereof, will be struck out. Simply because a case might be weak is not sufficient to justify striking out.*
>
> *c) A statement of case is not suitable for striking out if it raises a serious issue of fact which can only be properly determined by hearing oral evidence (Bridgeman v McAlpine-Brown January 19, 2000, unrep, CA).*
>
> *d) Where a statement of case is found to be defective, the court should consider whether that defect might be cured by amendment and, if it might be, the court should refrain from striking it out without first giving the party concerned an opportunity to amend (In Soo-Kim v Youg [2011] EWHC 1781 (QB)).*

e) The court may strike out, as an abuse of the court's process, particulars of claim which are so badly drafted that they fail to reveal to the defendant, or to the court, the case the defendant can expect to meet at trial. However, proof of bad drafting is not, by itself, sufficient. The court should not strike out the particulars without first giving the claimant an opportunity to amend (see In Soo-Kim v Youg [2011] EWHC 1781 (QB)).

f) The purpose of the particulars of claim were explained by Moore-Bick LJ in Credit Suisse AG v Arabian Aircraft & Equipment Leasing Co [2014] CP Rep 4: "Particulars of claim are intended to define the claim being made. They are a formal document prepared for the purposes of legal proceedings and can be expected to identify with care and precision the case the claimant is putting forward. They must set out the essential allegations of fact on which the claimant relies and which he will seek to prove at trial, but they should also state the nature of the case that is to be made in order to inform the defendant and the court of the basis on which it is said the facts give rise to a right to the remedy being claimed."

g) It is not appropriate to strike out a claim in an area of developing jurisprudence, since, in such areas, decisions as to novel points of law should be based on actual findings of fact (Farah v British Airways, The Times, January 26, 2000, CA referring to Barrett v Enfield BC [1989] 3 W.L.R. 83, HL)."

29. In ***Jakob International Inc -and- HSBC Private Bank (C.I.) Limited*** 26/2016, Deputy Bailiff McMahon (as he then was) held that the onus is on the Defendant to show that the claim is unarguable or otherwise bound to fail.

Summary of the Submissions

30. The core position of the Defendants was that in light of the multiple areas of agreement reached between Mr Venkat and Mr Carter in the Joint Report, the allegations relied on in the Plaintiff's Cause have been fundamentally undermined.

31. On the application for summary judgment, it was submitted that the medical evidence upon which the personal injury claim could be based is before the Court. The Court was urged to appraise the medical evidence and compare it to the Plaintiff's pleaded case without the need for a mini trial. Advocate Gist carefully referred the Court to the initiating medical reports of Mr Venkat and Mr Carter and in particular to the Joint Report. In Advocate Gist's submissions, the Joint Report highlights a number of points on which the experts are in agreement contrary to the allegations advanced in the Plaintiff's Cause.

32. It was contended that in light of the evidence provided by the experts in the Joint Report, the Plaintiff cannot demonstrate a case with a realistic prospect of success and the claim ought not be allowed to proceed. To permit otherwise, in Advocate Gist's submission, would be disproportionate and would lead to an inappropriate allocation of the share of the Court's resources, contrary to the overriding objective as set out in Rule 1 of the RCCR.

33. It was submitted that should the Court be satisfied that the Defendants had adduced credible evidence in support of their application, the Plaintiff had failed to prove that there is some real prospect of success or other reason for trial. Mr Venkat's supplementary report did not indicate a shift in Mr Venkat's opinion from the Joint Report and did not alter the Defendants' position.

34. In Advocate Gist's contention, it was abundantly clear that the cause of action as pleaded and any cause of action that could arise even if an amendment was made, was substantively time barred. Advocate Gist referred the Court to the exceptions de fond in the Defences by which the Defendants submitted that pursuant to Section 5 of the Law Reform (Tort) (Guernsey) Law

1979, the Plaintiff was obliged to bring her claim within 3 years from the date of the alleged negligence or knowledge of that negligence. The Defendants contended that in May or June 2019, the Plaintiff was offered surgery in Jersey which she chose not to undertake. By no later than June 2019, the Plaintiff knew that she required surgery and well before 10 March 2020 being 3 years before the date of her summons. The Plaintiff, it was submitted, had been in a position for many years to bring her claim but had elected not to do so.

35. However, Advocate Gist submitted that the time-barring argument was a much less attractive argument in light of the content of the medical evidence, including the supplementary report of Mr Venkat which, it was submitted, discloses that the factual assertions have no substance. It was submitted that in the Joint Report, the experts agreed in essence that there is no breach of duty and that the treatment throughout the relevant period was reasonable in all of the circumstances for an appropriately qualified expert. Advocate Gist submitted that it is difficult to envisage how that position could change.

36. On the strike out application, Advocate Gist helpfully clarified that the Defendants relied on one of the specified grounds under Rule 52(2) of the RCCR, namely that the pleading discloses no reasonable grounds for bringing or defending an action (Rule 52(2)(a)). Advocate Gist robustly submitted that parts of the Cause should be struck out, namely paragraphs 2, 6, 11 and 12 as they were bound to fail in light of the conclusions reached by the experts in the Joint Report.

37. It was submitted that given the extent to which the Joint Report had undermined the claim, paragraphs 2, 6, 11 and 12 of the Cause were incapable of being cured by amendment. Further, none of those paragraphs relate to an area of developing jurisprudence and should be struck out. It was further submitted that on the basis that paragraphs 2, 6, 11 and 12 of the Cause should be struck out, the remaining paragraphs do not contain a statement of material facts such as to define a claim being made. On striking out those paragraphs, the particulars of claim fall away and the remaining paragraphs of the Cause should therefore be struck out also.

38. On the Plaintiff's reliance on Article 13 ECHR, relying on the published guide of the European Court of Human Rights entitled *Guide on Article 13 of the European Convention on Human Rights, Right to an effective remedy* (28 February 2025) and on ***Boyle and Rice v the United Kingdom*** [1988] ECHR 3, Advocate Gist submitted that Article 13 ECHR is available solely in respect of arguable claims. Further, it was submitted that Article 13 has no independent existence and is about the right to an effective remedy in respect of *another* Convention right. It was submitted that in the present case, the Plaintiff had not asserted any other Convention right.

39. In summary, the Defendants submitted that the Plaintiff's case has no realistic prospect of success nor is there any other compelling reason for a trial and as such the Plaintiff's claim should be dismissed. In the alternative, the Joint Report substantially undermines part of the Plaintiff's Cause to such an extent that these parts should be struck out and as a result, the Cause should be struck out in its entirety.

40. Ms Cotterill submitted that the strike out application appeared to be an attempt to avoid trial and was made in desperation. She submitted that there was a procedural error when hard copy documents were sent to the court for her to collect on 27 June 2025. This required her to take time off work to collect the documents from H.M. Sheriff's Office and deliver them to her former Advocate's office. She had emailed Advocate Gist to query why he hadn't sent the documents to her former Advocate or informed her that he was making an application for strike out. Advocate Gist was aware that additional questions were being put to my expert and were imminent, as this was the reason an adjournment was sought from a previous hearing. The report from Mr Venkat was sent to Ferbrache and Farrell on 1 July 2025, after the request for strike out was filed, which could have led to Ferbrache Farrell withdrawing their application,

but they did not. It was submitted that as Mr Venkat's supplementary report was wholly in favour of her claim and that she was not informed of the content of the strike out application until 10:34 on 3 July 2025, less than 24 hours before the court hearing on 4 July 2025.

41. Ms Cotterill submitted that if granted by the Court, strike out would deny her of her right to a fair hearing and her right to an effective remedy under Article 13 of the European Convention on Human Rights ("ECHR"). Ms Cotterill submitted that as court action was the only available avenue to her, an effective remedy to the neglect that she considered she had endured by Mr Vhadra and Mr Bradley was a Court trial. At hearing, Ms Cotterill confirmed that she relied on Article 13 ECHR.

42. Ms Cotterill submitted that she had very reasonably offered the Defendants' Advocates the alternative of continuing the negotiations started by Advocate Breckon at Ferbrache and Farrell at the end of 2023. Ms Cotterill said that the only voice that she has is through the courts.

43. In Ms Cotterill's submission, the Joint Report was prepared using her medical records but it did not refer to her witness statement and other witness statements and the issues of fact were not addressed. She took issue with the content of the Joint Report.

44. Ms Cotterill submitted that she needed to be compensated for the years of pain and suffering because of the Defendants' negligence. It was submitted that the prospects of success are high and that the further questions put to Mr Venkat in his supplementary report are wholly in favour of her claim. Far from frivolous, the impact of the Defendants' neglect has had a huge impact on her life and mobility and was likely to continue into the future. Ms Cotterill submitted that she needed to be compensated for the alleged negligence.

45. It was submitted that Ms Cotterill was never given a choice regarding a total hip replacement ("THR") by Mr. Vhadra during the 2010 or 2014 consultations. She felt bullied into not having surgery on both occasions. She said that had the benefits and disadvantages been explained to her, she would have had the operation much earlier. She said that she did not receive information about the meaning of conservative treatment and was not sufficiently advised and that as such she was unable to give informed consent.

46. Ms Cotterill submitted that osteoarthritis is a known degenerative disease. It was submitted that the Defendants' incompetence kept her waiting longer than necessary. It took time to obtain full medical records because of the coronavirus lockdown with many people working from home. Ms Cotterill referred to a letter from Number 10 Advocates which confirmed that the records were not provided in full until February 2023. It was just after this that the summons was issued. Ms Cotterill referred the Court to an extract from *Laws of Guernsey*, Dawes, G (2003) on *Personal Injury Claims* which relates to the time limit for bringing a personal injury claim.

47. It was further submitted that the prospects of success in Ms Cotterill's claim are high. Mr Venkat's supplementary report was wholly in favour of her claim and she set out the following summary with her comments on Mr Venkat's supplementary report as follows:

> *"**Q. 1 Treatment Options in 2010**:*
>
> *Mr. Venkat states that a reasonably competent surgeon would have offered me a THR in 2010 as one of the treatment options. I was not informed of my options or the benefits and disadvantages at that time, so I could not consent to a delay in the operation. Had I been offered one, I would have taken it.*
>
> *Q2 **Increased Pain and Daily Life Impact in 2014**:*
>
> *By 2014, Mr. Venkat states that I should have been offered a THR due to increased pain and the effects on my daily life. I was not offered a THR at that consultation. Had I been offered THR, I would have accepted it.*

Q3 ***Explanation of Benefits and Disadvantages****:*

Mr. Venkat explains the benefits and disadvantages of a THR, which Mr. Vhadra never did.

Q4 Threshold for Surgery in 2010:

According to Mr. Venkat, with long-standing symptoms in 2010, the threshold for surgery was even more pressing.

Q5 Standard of Care:

Mr. Venkat's response indicates that Mr. Vhadra failed to provide an acceptable standard of care.

Q6 ***Below Minimum Expected Standard****:*

This further demonstrates that the standard of care was below the minimum expected.

Q7 ***Informed Consent****:*

I was not able to give informed consent as I was not properly informed about my options.

Q8,9,10&11 Injections for Pain Relief:

Regarding injections, I did not receive a full explanation about the benefits and disadvantages of having injections to help with pain relief, so I could not make an informed decision."

48. Ms Cotterill drew the Court's attention in particular to Mr Venkat's response to question 6 in his supplementary report, namely *"Would Mr Vhadra have failed to provide an acceptable standard of care to Ms Cotterill if he did not provide the said minimum explanation and/or recommendation at the 12 June 2014 consultation?"*. Ms Cotterill submitted that in his response, Mr Venkat stated that Mr Vhadra would have failed to provide an acceptable standard of care to Ms Cotterill and that not providing this information would fall below the standard of reasonable orthopaedic care.

49. The Plaintiff took issue with the content of the Joint Report and submitted that she had suggested mediation as a way forward. She sought to amend the Cause to make more precise allegations regarding the failure of the Defendants to counsel or adequately counsel her and the consequent failure to obtain her valid consent to conservative treatment and contended that this was supported by Mr Venkat particularly but not exclusively in his latest report dated 1st July 2025.

Discussion

50. The application for summary judgment and/or strike out before the Court plainly engages the overriding objective as contained in Rule 1 of the RCCR which provides:

" 1. (1) The overriding objective of these Rules is to enable the Court to deal with cases justly.

(2) Dealing with cases justly includes, so far as is practicable –

(a) ensuring that the parties are on an equal footing,
(b) saving expense,
(c) dealing with the case in ways which are proportionate –

(i) to the amount of money involved,

(ii) to the importance of the case,
(iii) to the complexity of the issues, and
(iv) to the financial position of each party,

(d) ensuring that it is dealt with expeditiously and fairly, and
(e) allotting to it an appropriate share of the Court's resources, while taking into account the need to allot resources to other cases."

51. I turn to consider the application for summary judgment. In essence, as I set out earlier, it is the Defendant's contention that the Plaintiff has no real prospect of succeeding on the personal injury claim. As the Court of Appeal held in ***Rawlinson***, a realistic claim is one which is more than merely arguable and must carry some degree of conviction. Without conducting a mini-trial, I have carefully appraised and analysed the evidence in its totality, including in particular, the expert medical evidence that would be before the trial. I have also taken into account the supplementary report of Mr Venkat dated 1 July 2025, which was properly, in my opinion, accepted by Advocate Gist to be relevant for the purpose of the summary application in light of the high bar for an application for summary judgment and strike out.

52. Whereas Mr Venkat and Mr Carter differed in their conclusions in their initial reports, they have reached a significant level of agreement in the Joint Report across multiple core areas. Those agreed points are central to the merits of the Plaintiff's claim and must be examined by the Court against the Plaintiff's pleaded case.

53. Both experts agree that continuing conservative treatment on 12 July 2010 was appropriate and reasonable. They agree that it was not reasonable to perform up-to-date x-rays in 2014. They agree that the Plaintiff was not considering a hip replacement in 2014 and that it was appropriate to continue with conservative management and that the Defendants' advice to the Plaintiff at this stage was both reasonable and appropriate. The experts agree that the physical/bony outcome of the hip replacement surgery would have been the same whether performed in 2010 or 2020 and that it was appropriate and reasonable to manage Ms Cotterill's left hip symptoms with conservative treatment rather than take risks of hip replacement surgery. The experts agree that based on the medical records, the Defendants appropriately managed Ms Cotterill's condition. Further, the experts agree that it was reasonable and appropriate to discharge Ms Cotterill back to her General Practitioner between 2010 and 2017. They agree that Ms Cotterill's treatment was appropriate and timely and that she was listed for an operation at an appropriate stage. Crucially, the experts agree that the Defendants provided an acceptable standard of care and they confirm that there was no other area of disagreement between them.

54. These are compelling medical conclusions but I must also take into consideration the supplementary report of Mr Venkat dated 1 July 2025. Ms Cotterill drew particular attention to Mr Venkat's response to question 6, namely whether Mr Vhadra would have failed to provide an acceptable standard of care to Ms Cotterill if he did not provide the said minimum explanation and/or recommendation at the consultation on 12 June 2014. Mr Venkat's response to this question must be considered in its entirety. Whereas Mr Venkat opined that Mr Vhadra would have failed to provide an acceptable standard of care to Ms Cotterill if he did not provide the said minimum explanation and/or recommendation at the consultation on 12 June 2014, he went on to say that it was however clearly documented that Ms Cotterill wanted to avoid an operation and he cited the medical notes that recorded that Ms Cotterill "*is quite happy at the moment and really does not want to consider a joint replacement ….as and when her symptoms dictate the necessity for joint replacement, I would be grateful if you could organise an up-to-date x-ray and refer her back to me. I would be only too happy to see her again.*" Similarly, I find that Ms Cotterill's summary of Mr Venkat's answers to the other questions does not fully reflect the entirety of Mr Venkat's conclusions. I agree with Advocate Gist that Mr Venkat's supplementary report does not substantively change the position as set out in the Joint Report.

55. Ms Cotterill complained that the joint experts had not referred to the witness evidence provided to them. However, it is clear from paragraph 2.3 of the Joint letter of instruction from Ferbrache and Farrell LLP dated 17 March 2025 that both experts were provided with the witness statements on behalf of the Plaintiff and Defendants and indeed, those witness statements are expressly acknowledged in the introduction to the Joint Report. I am satisfied that whereas the experts do not refer expressly to those witness statements, they were taken into account by them in reaching their conclusions.

56. Having examined the medical evidence in its entirety against the Plaintiff's pleaded case, I am satisfied that the claim does not have a realistic prospect of success. I do not consider on the basis of the submissions before me that any further medical evidence would be expected to be available at trial and in any event, there was no specific application before me seeking time to adduce further medical evidence. As I set out above, Mr Venkat's report does not in my opinion change the position in relation to the findings of the joint experts. The Defendant has shown that there is clear and compelling agreed medical evidence before the Court on multiple core areas that manifestly undermine the Plaintiff's claim.

57. I must turn to consider the questions as to whether the Plaintiff has discharged the evidential burden of proving that there is some real prospect of success or other reason for trial. This is not a high standard of proof. The Plaintiff's reliance on Mr Venkat's supplementary report does not show that there is some real prospect of success for the reasons I set out above and neither do I find there is other reason for a trial.

58. I have considered Ms Cotterill's submission that she wished to amend the Cause to make more precise allegations regarding the failure of the Defendants to counsel or adequately counsel her and the consequent failure to obtain her valid consent to conservative treatment as supported by Mr Venkat's expert evidence. Ms Cotterill did not draw the Court's attention to particular extracts from Mr Venkat's reports in support of this particular submission.

59. I have nonetheless examined Mr Venkat's medical evidence and I assume that Ms Cotterill relies on the response to question 7 in Mr Venkat's supplementary report. There, Mr Venkat speaks to the subject of informed consent. He opines that Ms Cotterill would not have been able to give informed consent to having conservative treatment rather than surgery at each of the consultations if Mr Vhadra had not explained the benefits/advantages and risks/disadvantages of surgery and/or provide a recommendation, if needed, as to whether Ms Cotterill should have surgery adequately or at all at the said consultations. He further states that without adequate counselling on the benefits and risks of THR, the Plaintiff would not have been in a position to make an informed decision about continuing conservative management and this would mean that valid consent was not obtained, undermining shared decision-making and clinical autonomy.

60. I consider that properly analysed, question 7 in Mr Venkat's supplementary report is at heart a hypothetical question and that Mr Venkat does not opine in his response that there was a failure to provide adequate counselling to the Plaintiff by the Defendants. Viewed in the round with the other medical evidence and in particular the Joint Report, which must be read in conjunction with the supplementary report, I find that there is no basis for Ms Cotterill's submission in relation to an intended application to amend the Cause. I am satisfied that the Plaintiff has not discharged the evidential burden to prove that there is some prospect real prospect of success or other reason for trial.

61. I gave careful consideration to the Plaintiff's human rights claim and specifically her reliance on Article 13 ECHR. Article 13 of the ECHR provides for the right to an effective remedy:

"Everyone whose rights and freedoms as set forth in [the] Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity."

62. The European Court of Human Rights' publication entitled *Guide on Article 13 of the European Convention on Human Rights, Right to an Effective Remedy* provides the following analysis:

"1. An arguable claim

10. Article 13 cannot reasonably be interpreted so as to require a remedy in domestic law in respect of every supposed grievance under the Convention that an individual may have, no matter how unmeritorious his complaint may be: the grievance must be an "arguable" one in terms of the Convention (Boyle and Rice v. the United Kingdom, 1988, § 52; Maurice v. France [GC], 2005, § 106).

11. Article 13 guarantees the availability at national level of a remedy to enforce the substance of the Convention rights and freedoms in whatever form they might happen to be secured in the domestic legal order (Rotaru v. Romania [GC], 2000, § 67). Article 13 has no independent existence; it merely complements the other substantive clauses of the Convention and its Protocols (Zavoloka v. Latvia, 2009, § 35 (a)). It can only be applied in combination with, or in the light of, one or more Articles of the Convention or the Protocols thereto of which a violation has been alleged. To rely on Article 13 the applicant must also have an arguable claim under another Convention provision."

63. In ***Boyle and Rice v the United Kingdom***, 1988, the Court (plenary) held (para 52):

"The stopping of one of Mr Boyle's letters has been found by the Court to constitute a breach of Article 8 (art. 8) ….All the remaining claims of violation forming the basis of the applicant's complaints under Article 13 (art 13) were rejected by the Commission at the admissibility stage on the ground of being manifestly ill-founded…

Notwithstanding the terms of Article 13…read literally, the existence of an actual breach of another provision of the Convention (a "substantive" provision) is not a prerequisite for the application of the Article (art. 13) (see the Klass and Others judgment of 6 September 1978, Series A no 28, pg. 29, 64). Article 13 ..guarantees the availability of a remedy at national level to enforce – and hence to allege non-compliance with – the substance of the Convention rights and freedoms in whatever form they may happen to be secured in the domestic legal order (see the Lithgow and Others judgment of 8 July 1986, Series A no 102, p. 74, 205 and the authorities cited there).

However, Article 13 ..cannot reasonably be interpreted so as to require a remedy in domestic law in respect of any supposed grievance under the Convention that an individual may have, no matter how unmeritorious his complaint may be: the grievance must be an arguable one in terms of the Convention (see, as the most recent authority, the Leander judgment of 26 March 1987, Series A no 116, pg 29, 77(a)."

64. In ***Maurice v France*** [GC], 2005 106, the Court said this:

"106. The Court reiterates that Article 13 of the Convention guarantees the availability at national level of a remedy to enforce the substance of the Convention rights and freedoms in whatever form they might happen to be secured in the domestic legal order. The effect of this Article is thus to require the provision of a domestic remedy allowing the competent national authority both to deal with the substance of an "arguable" complaint under the Convention and to grant appropriate relief (see, among other

authorities, Aksoy v Turkey, judgment of 18 December 1996, Reports 1996 VI p. 2286, § 95).”

65. I agree with the Defendants' submission that the human rights claim must fail as in the present case as the Plaintiff did not assert another Convention right. Whereas there was reference to a right to a fair hearing in her written submission, the latter point was not expanded on in any detail by Ms Cotterill and at hearing, she confirmed to the Court that she solely relied on Article 13 ECHR.

66. On application of the relevant authorities, I am satisfied for the reasons set out above that summary judgment is appropriate and I grant the application on that basis alone.

67. It is not necessary to consider the Defendants' submission that the cause of action was substantively time-barred, but for completion, I would have agreed with the Defendants on this point. I accept that the Plaintiff was offered surgery in Jersey in May or June 2019 and that by no later than June 2019, the Plaintiff knew that she required surgery. This was indeed well before 10 March 2020 being 3 years before the date of her summons. The Plaintiff's lack of access to the full medical reports until February 2023 would not have precluded her from bringing her claim on an earlier date.

68. Had I not been satisfied that summary judgment was appropriate, I would have granted the Defendants' strike out application under Rule 52(2)(a) of the RCCR, namely that the pleading discloses no reasonable grounds for bringing or defending an action, for the following reasons.

69. I accept that the Joint Report has established that a total hip replacement was discussed in 2010 and that the Defendants did adequately advise the Plaintiff at this time. I consider therefore that the assertion set out at paragraph 2 of the Cause, namely that the Second Defendant did not give the Plaintiff the option of a having a total left hip operation and/or did not advise or adequately advise the Plaintiff to have that operation is unarguable and bound to fail. I accept the submission on behalf of the Defendants that paragraph 2 of the Cause does not raise a serious issue of fact which can only be properly determined by hearing oral evidence in that the issue of fact has been determined by the Joint Report.

70. In my consideration, the Joint Report has established that the Plaintiff was not considering a hip replacement in 2014 and that the key information is that the Plaintiff was managing with conservative treatment at this time. Further, the Joint Report establishes that the Defendants provided an acceptable standard of care. I therefore consider that paragraph 6 of the Cause, which alleges that at the Plaintiff's consultation with the Second Defendant in June 2014, the Second Defendant did not give the Plaintiff the option of having a total left hip operation and/or did not advise or adequately advise the Plaintiff to have that operation, is unarguable and bound to fail. This paragraph does not raise a serious issue of fact which can only be properly determined by hearing oral evidence in that the issue of fact has already been determined by the Joint Report.

71. I accept that paragraph 11 of the Cause, which provides for the particulars of negligence, should be struck out on the basis that the particulars of negligence have been substantially undermined by the Joint Report such that the Plaintiff's claim is unarguable and bound to fail. Further, I am satisfied that there are no serious issues of fact raised within the particulars of negligence that can only be properly determined by hearing oral evidence as these issues of fact have been determined by the Joint Report.

72. I am also of the opinion that paragraph 12 of the Cause, which asserts that as a result of the negligence of the Defendants, the Plaintiff has suffered pain, injury, loss and damage, should be struck out on the basis that the findings of the Joint Report are such that such an assertion of negligence on the part of the Defendants is unarguable and bound to fail. I agree with the

Defendants that paragraph 12 does not raise a serious issue fact which can only be properly determined by hearing oral evidence in that the issue of fact has already been determined by the Joint Report.

73. I therefore would have concluded that paragraphs 2, 6, 11 and 12 of the Cause should be struck out for the reasons set out above. In reaching this conclusion, I would have also given consideration to the question as to whether the defects in the pleadings may be cured by amendment. On this point, I accept that in light of the extent to which the Joint Report has undermined the claim, paragraphs 2, 6, 11 and 12 of the Cause are incapable of being cured by amendment. I am further satisfied that the relevant paragraphs of Cause do not relate to an area of developing jurisprudence.

74. I agree with Advocate Gist that had paragraphs 2, 6, 11 and 12 of the Cause been struck out, the remaining paragraphs in the Cause would not contain a statement of material facts such as to define a claim being made. As such, the particulars of claim would fall and the remaining paragraphs would also be struck out.

75. Finally, in relation to Ms Cotterill's complaint about her late notification of the present application, I am satisfied that Ms Cotterill had sufficient time to consider the papers as the summary judgment and strike out hearing did not proceed on 4 July 2025 but rather on 16 October 2025. There was therefore ample time available to allow Ms Cotterill to prepare her hearing.

76. In reaching my conclusions, I have taken into account that dealing with the case justly in accordance with the overriding objective includes in particular saving expense and allotting to it an appropriate share of the Court's resources, while taking into account the need to allot resources to other cases. Those factors are indisputably relevant considerations in giving effect to the overriding objective contained in Rule 1 of the RCCR.

Conclusion

77. In conclusion, after careful consideration and for the reasons set out above, I grant the Defendants' application for summary judgment pursuant to Rule 19 of the RCCR. Although it was not necessary to give consideration to the strike out application, for the reasons set out above, I would have granted the strike out application. I shall hear from the parties on costs.