EXPERT COURT REPORT

General Practice* | *Strictly Confidential

Claimant: Mr Adrian Green

Date of Birth: 20/04/1963

Instructing Solicitors: Cavendish Legal Services

Reference: 5820391

Date of Alleged Negligence: January 2023 to January 2024

Report Prepared By: Dr Anup Singh BSc MBChB DOccMed GP

Date of Report: 15 July 2026

GMC Number: 7135145

Report of Dr Anup Singh

Specialist field: General Practice

On behalf of: The Claimant

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1. Introduction

1.01 The Expert

I am Dr Anup Singh, my specialist field is General Practice. Full details of my qualifications and experience entitling me to give expert opinion in this case are in Appendix 1.

1.02 Summary Background to the Case

The Claimant, Mr Green, date of birth 20 April 1963, was registered at Oakfield Medical Practice, 58 Oakfield Road, Nottingham. From January 2023 he presented with persistent fatigue and was found on investigation to be iron-deficient and anaemic. Between January 2023 and January 2024 he attended his GP practice on multiple occasions with symptoms including rectal bleeding, abdominal discomfort and persisting, worsening anaemia. On 9 January 2024, following the onset of unintentional weight loss and a change in bowel habit, an urgent two-week wait referral for suspected colorectal cancer was made by Dr Farah Ashworth.

A diagnosis of colorectal adenocarcinoma was confirmed on 9 February 2024 following colonoscopy and biopsy. Staging computed tomography on 20 February 2024 showed a primary sigmoid tumour with mesenteric nodal involvement and multiple hepatic metastases, confirming Stage IV (T3N1M1) disease. The Claimant commenced palliative FOLFOX chemotherapy in March 2024 under the care of Dr Clarissa Bell, Consultant Clinical Oncologist, and remains under ongoing oncological care.

1.03 Summary of My Conclusions

I have been asked to consider whether the management of Mr Green's fatigue, anaemia, rectal bleeding and abdominal symptoms between January 2023 and January 2024 by the clinicians at Oakfield Medical Practice fell below the standard expected of a reasonably competent General Practitioner. Having carefully reviewed all of the

available records and applied the applicable clinical standards and the legal tests established in Bolam and Bolitho, it is my opinion that the initial investigation and management of Mr Green's fatigue and anaemia in January and April 2023 was defensible and consistent with the standard of a reasonably competent General Practitioner.

However, I have identified one breach of the duty of care: the failure at the consultation of 14 June 2023 to make an urgent referral for suspected colorectal cancer in accordance with NICE NG12 Recommendation 1.3.1, which requires an urgent (two-week wait) referral for any person aged 60 and over with unexplained iron-deficiency anaemia. By 14 June 2023 Mr Green was 60 years old, had unexplained iron-deficiency anaemia that had failed to respond to **some five months** of oral iron replacement, and had newly developed rectal bleeding. This finding is addressed in full at paragraphs **5.07 to 5.12**.

I reach that conclusion having considered the following matters: the clinical reasonableness of an initial trial of oral iron replacement pending further assessment in January 2023; the subsequent emergence of rectal bleeding and the persistence of anaemia despite treatment; and the specific clinical findings and documented reasoning at each consultation. I address each consultation and each question raised in my instructions fully in the opinion section below. Causation, being a matter of colorectal surgical and oncological medicine rather than General Practice, falls outside the scope of my expert opinion.

1.04 Technical Terms and Explanations

I have indicated technical medical terms in bold italic on first use and included a glossary at Appendix 2. Medical abbreviations are explained in brackets on first use. Direct quotations from the clinical records are reproduced in italic script. Superscripted numbers correspond to references at Appendix 3.

2. Issues Addressed and Statement of Instructions

2.01 Statement of Material Instructions

I have been instructed by Cavendish Legal Services pursuant to a letter of instruction dated 3 April 2026. In accordance with CPR Part 35, Practice Direction 35 paragraph 3.2(3), the substance of all material instructions, whether written or oral, upon which my opinions are based is set out in this section. No facts stated in this report are within my own knowledge. All facts have been derived from the documentary records listed at Section 3 below.

2.02 Questions Raised

I have been asked to address the following questions:

- Please advise whether the treatment and care provided by GPs to the Claimant in relation to his fatigue, anaemia and bowel symptoms from January 2023 onwards to January 2024 was appropriate.
- Whether there was any breach of duty of care in that GPs failed to refer the Claimant for further investigation when his rectal bleeding in June 2023 was attributed to haemorrhoids without addressing his ongoing, unresponsive anaemia.
- Whether the Claimant's age, persistent unexplained iron-deficiency anaemia and subsequent rectal bleeding should have triggered an earlier urgent referral for suspected colorectal cancer.
- Whether the delay in diagnosing the Claimant's cancer in February 2024 was caused or contributed to by any breach of duty on the part of the GPs.
- Please advise on all other breaches of duty of care which you may identify within your expertise.
- Please advise what defence may be raised in the Claimant's claim.
- We defer to your opinion as an expert and there may be other issues which you wish to raise; if so, we would ask you to consider these as well.

3. Documents Reviewed

3.01

In preparing this report I have reviewed the following documents:

- Oakfield Medical Practice GP records (94 pages)
- Nottingham University Hospitals NHS Trust records (63 pages)
- Further bundle of medical records (112 pages)

3.02

I have not examined the Claimant in person. This report is based entirely upon the documents listed above.

4. Summary of Relevant Facts

4.01 The following is a summary of the key clinical events as they appear from my review of the records. This summary is an aide to reading the report and is not an exhaustive account of the medical notes.

4.02 October 2018. Type 2 diabetes mellitus diagnosed, well controlled on metformin. No other significant past medical history. The Claimant is a lifelong non-smoker and drinks alcohol occasionally.

4.03 9 January 2023. Telephone consultation. The Claimant complained of fatigue for approximately six weeks. He denied weight loss, denied any change in bowel habit and denied rectal bleeding when specifically asked. A full blood count and ferritin were arranged together with routine bloods (U&E, LFT, TFT, HbA1c).

4.04 16 January 2023. Results reviewed and filed with the comment: *“Iron deficiency anaemia — Hb 10.1, ferritin 8. Start ferrous fumarate 210mg BD, recheck bloods in 8 weeks.”*

4.05 20 January 2023. Telephone follow-up. Ferrous fumarate was commenced as planned. No physical examination was performed and no further gastrointestinal history was taken beyond the questions asked on 9 January 2023.

4.06 14 April 2023. Repeat bloods: Hb 10.3 g/dL, ferritin 11 µg/L. Noted as *“slight improvement, continue iron, routine review.”* No safety-netting advice regarding red flag symptoms was documented.

4.07 14 June 2023 — Dr Farah Ashworth. Face-to-face consultation. The clinical notes record the following history: intermittent rectal bleeding for approximately three weeks, described as bright red blood on toilet paper and occasionally seen in the pan; no abdominal pain; no weight loss; bowels opening normally; ongoing fatigue. On examination: abdomen soft and non-tender with no masses palpated; digital rectal examination with chaperone revealed internal haemorrhoids; no other masses palpated. A diagnosis of haemorrhoidal bleeding was made.

The plan documented: *“continue iron, topical haemorrhoid cream, review if worsens.”* The persistent, treatment-unresponsive anaemia recorded **five months** earlier and confirmed again that day (Hb 10.0 g/dL) was not separately addressed in the plan.

4.08 3 October 2023 — Dr Farah Ashworth. The Claimant presented with intermittent lower abdominal discomfort for approximately four weeks and ongoing intermittent rectal bleeding. Fatigue persisted. Weight loss was not volunteered and was not specifically asked about. Repeat bloods were arranged: Hb 9.8 g/dL, ferritin 9 µg/L, confirming the anaemia had in fact worsened despite nine months of oral iron replacement. A diagnosis of irritable bowel syndrome, likely compounded by haemorrhoids, was recorded. Dietary advice was given and conservative management continued.

4.09 5 December 2023 — Practice nurse, routine diabetes annual review. An incidental note records: *“patient reports ongoing tiredness, declined further GP review for now, wants to wait and see.”*

4.10 9 January 2024 — Dr Farah Ashworth. The Claimant presented with approximately two stone (12.7kg) of unintentional weight loss over the preceding four months, worsening abdominal pain, ongoing intermittent rectal bleeding, and a new alteration in bowel habit with looser and more frequent stools. An urgent two-week wait referral for suspected colorectal cancer was made that day.

4.11 2 February 2024. Colonoscopy at Nottingham University Hospitals NHS Trust identified a large ulcerated mass in the sigmoid colon. Biopsies were taken.

4.12 9 February 2024. Histology confirmed moderately differentiated adenocarcinoma of the colon.

4.13 20 February 2024. Staging CT of the chest, abdomen and pelvis showed the primary sigmoid tumour with mesenteric lymph node involvement and multiple hepatic metastases. Staging T3N1M1, confirming Stage IV metastatic colorectal cancer.

4.14 Treatment and current status. Following MDT discussion on 27 February 2024, the Claimant commenced FOLFOX chemotherapy in March 2024 under Dr Clarissa Bell, Consultant Clinical Oncologist. CT imaging in July 2024 after six cycles showed a partial response in the hepatic metastases. The Claimant remains under ongoing oncological review with treatment of palliative intent.

4.15 12 March 2024 — Practice significant event review. Dr Ashworth reviewed the case at the request of the practice manager following a complaint from the Claimant’s family. The note records that Dr Ashworth acknowledged the persistent, treatment-unresponsive anaemia and subsequent rectal bleeding had not resulted in a referral prior to January 2024, and agreed the matter would be the subject of a formal significant event analysis.

4.16 Blood Test Results. The following haemoglobin, ferritin and mean corpuscular volume (MCV) results are recorded in the medical records and are relevant to the opinion at paragraphs **5.07 to 5.12** below:

Date	Haemoglobin (Hb)	Ferritin	MCV
16 January 2023	10.1 g/dL	8 µg/L	78 fL
14 April 2023	10.3 g/dL	11 µg/L	79 fL
14 June 2023	10.0 g/dL	10 µg/L	77 fL
3 October 2023	9.8 g/dL	9 µg/L	74 fL

The normal reference ranges applied by the laboratory were: haemoglobin 13.0–17.0 g/dL (adult male); ferritin 20–250 µg/L; MCV 80–96 fL. Every result from 16 January 2023 onwards was below the lower reference limit for haemoglobin, ferritin and MCV, confirming a persistent, worsening, microcytic iron-deficiency anaemia that did not respond to nine months of oral iron replacement.

Relevant legal tests applied

In forming my opinion on breach of duty, I have applied the test in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, as qualified by *Bolitho v City and Hackney Health Authority* [1998] AC 232 (also cited as [1997] UKHL 46). I have not asked whether I would personally have managed the patient differently. The question I have asked, for each attendance, is whether the care given accorded with a practice accepted as proper by a responsible body of practitioners exercising ordinary skill in that field, at the time the care was given.

Where I have found that a responsible body of opinion would support the care given, I have gone on, in accordance with *Bolitho*, to ask whether that opinion is itself capable of withstanding logical analysis, that is, whether it is a defensible conclusion reached with

proper regard to the comparative risks and benefits in play. I have applied this second stage to every conclusion that a particular course involved no breach of duty.

I have judged each attendance by what was known, or ought reasonably to have been known, to the practitioner at that time, not by what is now known following the eventual diagnosis. Where a symptom was genuinely non-specific and was reasonably attributed at the time to a sensible alternative explanation, I have not treated the fact that it later proved to be something else as turning that earlier, reasonable judgement into a breach of duty

5. My Opinion

5.02 My opinion on each question raised in my instructions is set out below. I have applied the standard of the reasonably competent General Practitioner as established in Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, as refined by the House of Lords in Bolitho v City and Hackney Health Authority [1998] AC 232. The Bolam test asks whether a responsible body of General Practitioners of ordinary skill would have acted in the same way. The Bolitho refinement requires that the body of opinion relied upon must be capable of withstanding logical analysis having proper regard to the balance of risks and benefits. I have applied both tests rigorously and my conclusions reflect genuine and considered clinical judgement. Where there is a range of opinion among General Practitioners I identify it and state my own position with reasons.

Applicable Guideline Framework

5.03 The primary applicable standard throughout this period is NICE Guideline NG12 (Suspected Cancer: Recognition and Referral), first published in June 2015. The colorectal cancer recommendations are found at Recommendation 1.3. Recommendation 1.3.1 requires an urgent (two-week wait) referral for suspected colorectal cancer in adults who are aged 40 and over with unexplained weight loss and abdominal pain; aged 50 and over with unexplained rectal bleeding; aged 60 and over with iron-deficiency anaemia or a change in bowel habit; or who have tested positive for

occult blood in their faeces. The age-60 iron-deficiency anaemia criterion under Recommendation 1.3.1 is a standalone trigger: it does not depend on the presence of rectal bleeding, abdominal pain or any other symptom. Recommendation 1.3.2 separately provides for referral to be considered in adults with a rectal or abdominal mass, and Recommendation 1.3.3 provides for referral to be considered in adults under 50 with rectal bleeding together with other unexplained symptoms such as abdominal pain or change in bowel habit. Recommendation 1.3.4 provides that a quantitative faecal immunochemical test (FIT) should be offered in primary care to adults with unexplained symptoms who do not otherwise meet the criteria for direct urgent referral under 1.3.1.

5.031 I note for completeness that NG12 has been amended on several occasions since 2015, including a substantive amendment in **August 2023** that placed greater emphasis on quantitative FIT testing within the wider colorectal referral pathway, and further amendments since. In accordance with the ordinary approach to expert evidence in clinical negligence claims, I have applied Recommendation 1.3.1 as it stood at the time of the relevant consultations, which — consistent with NICE's own guidance on iron-deficiency anaemia current at that time — required a direct urgent referral, without a prerequisite FIT test, for a patient aged 60 or over with unexplained iron-deficiency anaemia. That direct-referral pathway for this specific patient cohort was unaffected by the August 2023 amendment (which concerned the separate FIT pathway for patients who do not otherwise meet the 1.3.1 criteria) and has been maintained throughout the subsequent evolution of NG12. In any event, the consultation at which I find a breach — 14 June 2023 — predates the August 2023 amendment, so the amendment has no bearing on the standard applicable at the material time.

Question 1 — The standard of care in January and April 2023

5.04 At the telephone consultation of 9 January 2023 the Claimant reported fatigue of approximately six weeks' duration with no other symptoms volunteered, and specifically denied rectal bleeding, weight loss and change in bowel habit when asked. A full blood count and ferritin were arranged. On 16 January 2023 these confirmed iron-deficiency

anaemia. Oral iron replacement was commenced and a repeat blood test arranged for eight weeks later, in accordance with standard first-line management of newly identified iron-deficiency anaemia in primary care.

5.05 I have considered whether commencing an empirical trial of oral iron replacement, without an immediate referral, fell below the standard expected of a reasonably competent General Practitioner at this stage. In my opinion it did not. At the point of diagnosis in January 2023 there was no rectal bleeding, no weight loss and no change in bowel habit, and the Claimant was 59 years old, so the standalone age-60 anaemia criterion under NG12 Recommendation 1.3.1 was not yet engaged in any event. A trial of oral iron with a planned early review of both symptomatic and haematological response is a recognised and defensible first step in the management of newly identified iron-deficiency anaemia in a patient below that threshold, provided — as was the case here — a clear plan for timely reassessment is documented. I do not identify a breach of the duty of care at the consultations of 9 or 20 January 2023.

5.06 At the review of 14 April 2023 the anaemia had shown only marginal improvement (Hb rising from 10.1 to 10.3 g/dL; ferritin from 8 to 11 µg/L) after twelve weeks of oral iron. The Claimant remained 59 at this review, six days short of his sixtieth birthday. This was recorded as “slight improvement” and the plan was to continue iron with routine review. I have considered whether this consultation should have prompted referral. In my opinion, while the failure to respond meaningfully to iron replacement was a finding that should have prompted closer safety-netting and an explicit plan to refer if the next review remained unsatisfactory , not least because the Claimant was, on any view, about to reach an age at which the anaemia alone would engage the guideline — a single early review showing a marginal haematological trend, without the benefit of hindsight, was capable of falling within the range of reasonable practice for a further short period of monitoring. I do not characterise the 14 April 2023 consultation, taken in isolation, as a breach of the duty of care, although I return to its significance as part of the cumulative picture at paragraphs 5.07 to 5.12 below.

Question 2 — The 14 June 2023 consultation and the attribution of bleeding to haemorrhoids

5.07 By 14 June 2023 the clinical picture had materially changed. The Claimant, then aged 60, had unexplained iron-deficiency anaemia that had failed to improve meaningfully over five months of treatment, and had newly developed intermittent rectal bleeding. Examination identified internal haemorrhoids, and the bleeding was attributed to this finding. Haemorrhoids are a common and frequently correct explanation for rectal bleeding, and I accept that their identification on examination was a reasonable clinical finding in itself.

5.08 However, the presence of a plausible local cause for rectal bleeding does not, in my opinion, discharge the separate and standalone obligation arising under NG12 Recommendation 1.3.1 in respect of the Claimant's iron-deficiency anaemia. Mr Green was 60 years old and had persistent, unexplained, treatment-resistant iron-deficiency anaemia. This finding alone — irrespective of the haemorrhoids or any other symptom — met the age-60 threshold under NG12 1.3.1 for an urgent two-week wait referral. The addition of rectal bleeding, itself independently capable of triggering referral in a patient over 50 under NG12 1.3.1, reinforced rather than diminished the case for referral. Haemorrhoids can coexist with colorectal malignancy, and a diagnosis of haemorrhoidal bleeding does not exclude a proximal colonic lesion as the cause, or a contributing cause, of the anaemia.

The Breach — Failure to Refer at 14 June 2023

5.09 The clinical notes of 14 June 2023 record no consideration of NG12 Recommendation 1.3.1, no discussion of the persistent, unresponsive anaemia in the context of the newly presenting rectal bleeding, and no clinical reasoning to explain why referral was not made despite the guideline being unambiguously engaged on the anaemia criterion alone. The plan was limited to continuing iron and providing topical haemorrhoid treatment, with review only if symptoms worsened.

5.10 In my opinion, the failure to make an urgent referral for suspected colorectal cancer at the 14 June 2023 consultation was a breach of the duty of care. This satisfies the Bolam test: no responsible body of General Practitioners, presented with a 60-year-old man with persistent, unexplained, treatment-resistant iron-deficiency anaemia and new rectal bleeding, would attribute the entirety of the clinical picture to haemorrhoids without at least considering, and documenting consideration of, an urgent referral under NG12 1.3.1.

5.11 3 October 2023 — Compounding failure. By the consultation of 3 October 2023 the anaemia had demonstrably worsened (Hb falling to 9.8 g/dL, ferritin to 9 µg/L) despite nine months of oral iron, and the Claimant continued to report intermittent rectal bleeding together with new lower abdominal discomfort. A diagnosis of irritable bowel syndrome was recorded and conservative management continued. In my opinion this consultation represented a further, compounding failure to act upon findings that by this stage were even more strongly indicative of the need for urgent referral than they had been in June. The guideline obligation identified at paragraph 5.10 above applied with at least equal, and in my view greater, force at this consultation.

5.12 I do not identify the 3 October 2023 consultation as a free-standing, separate breach, but rather as a compounding failure that reinforces my conclusion regarding the 14 June 2023 breach and demonstrates that the missed opportunity to refer was not an isolated lapse but part of a sustained pattern of under-investigation of a persistent and worsening anaemia.

Question 3 — Whether age, anaemia and rectal bleeding should have triggered earlier referral

5.13 As set out at paragraph 5.03 above, NG12 Recommendation 1.3.1 applies a standalone age-60 threshold for iron-deficiency anaemia that does not depend on the presence of any other symptom. Mr Green was 59 years old at the time of his initial anaemia diagnosis in January 2023 and remained 59 at the 14 April 2023 review, turning 60 on 20 April 2023 — shortly afterwards, and well before the 14 June 2023 consultation. By 14 June 2023 he had therefore both reached the qualifying age and

had anaemia that had been present, confirmed and treatment-resistant for five months, with rectal bleeding newly developed. In my opinion the combination of the Claimant's age, the persistent unexplained iron-deficiency anaemia and the subsequent rectal bleeding meant that the NG12 1.3.1 threshold for urgent referral was clearly and unambiguously engaged from 14 June 2023 onwards, for the reasons given at paragraphs 5.07 to 5.10 above.

Question 4 — Whether the delay in diagnosis caused or contributed to harm

5.14 The question of whether an earlier referral in June or October 2023 would have resulted in an earlier diagnosis at a less advanced stage, and whether this would have altered the Claimant's treatment options or prognosis, is a matter of colorectal surgical and oncological medicine. It requires expert assessment of the likely rate of tumour progression over the relevant period, the stage at which the disease was likely to have been detectable on colonoscopy in mid-to-late 2023, and whether curative treatment would have been possible at that stage. These questions fall outside my expertise as a General Practitioner and I am not in a position to express an opinion on them.

5.15 Summary — Question 4: A breach of the duty of care has been identified in this report, namely the failure to refer at the 14 June 2023 consultation in accordance with NICE NG12 Recommendation 1.3.1, addressed at paragraphs 5.07 to 5.12. The question of whether that breach caused or contributed to the Claimant's current stage of disease and prognosis is a matter of causation falling outside my expertise. Expert evidence from a Consultant Colorectal Surgeon and a Consultant Clinical Oncologist will be required to address this aspect of the claim.

Questions 5 and 7 — Additional observations

5.16 The breach identified in this report is addressed at paragraphs 5.07 to 5.12 and relates to the failure to refer at the 14 June 2023 consultation, compounded by the further missed opportunity on 3 October 2023. Beyond this, I have considered whether any further breach arises from the January and April 2023 consultations and have found none, for the reasons given at paragraphs 5.04 to 5.06.

Question 6 — The Defendant's position

5.17 For the purposes of completeness I set out below the principal matters that arise in the Defendant's favour, together with the area where, in my opinion, the Defendant faces a significant difficulty.

5.18 On the initial management in January 2023: The Defendant will correctly argue that a trial of oral iron replacement, with a planned review, is a recognised and standard first step in managing newly identified iron-deficiency anaemia in primary care, and that there was no rectal bleeding or other red flag symptom at that point to mandate immediate referral. I agree, for the reasons given at paragraph 5.05.

5.19 On the haemorrhoids found on 14 June 2023: The Defendant will argue that a genuine local cause of bleeding was identified on examination and that haemorrhoidal bleeding is a common and usually benign finding. This is correct so far as it goes. However, this argument does not address the separate and standalone obligation arising from the persistent, unexplained, treatment-resistant iron-deficiency anaemia, which independently met the NG12 1.3.1 threshold irrespective of the cause of the rectal bleeding. This is, in my opinion, the Defendant's most significant difficulty in this claim: there is no documented clinical reasoning addressing the anaemia at the 14 June 2023 consultation, and the guideline does not permit the anaemia trigger to be set aside because an alternative, non-exclusive local explanation for a separate symptom has been found.

5.195 On the availability of FIT testing as an alternative first step: The Defendant may point to the wider integration of quantitative FIT testing into the colorectal pathway from **August 2023** onwards and argue that a FIT test, rather than immediate referral, was an acceptable first step. I do not accept this argument in relation to the anaemia finding specifically. NICE's guidance on iron-deficiency anaemia, current at the material time, provided for direct urgent referral — without a prerequisite FIT test — for patients aged 60 and over with unexplained iron-deficiency anaemia, precisely because iron-deficiency anaemia is itself already a recognised marker of possible occult gastrointestinal blood loss and a FIT test adds little in that specific cohort. This is

consistent with recognised published concern that the general FIT-first pathway and the anaemia-specific direct-referral guidance can, if not carefully applied, pull in different directions; the appropriate and cautious course for a treating GP was to follow the direct-referral pathway for this cohort, as the anaemia guidance itself recommended. In any event, this argument does not assist the Defendant in relation to the 14 June 2023 consultation, which predates the August 2023 amendment.

5.20 On the October 2023 consultation: The Defendant may argue that a diagnosis of irritable bowel syndrome was a reasonable working diagnosis for intermittent abdominal discomfort in a patient with known haemorrhoids. I do not accept that this diagnosis, even if reasonable in isolation, provides an answer to the persistent and by then worsening anaemia, which by October 2023 had been present, confirmed and unresponsive to treatment for nine months.

5.21 On causation: The causation question — namely whether an earlier referral would have altered the Claimant's stage at diagnosis or his prognosis — falls outside my expertise as a General Practitioner. I am not in a position to express a view on the Defendant's likely causation arguments. Specialist evidence from a Consultant Colorectal Surgeon and a Consultant Clinical Oncologist will be required to address this aspect of the case.

6. Statements and Declarations

Statement of Compliance

6.01 I understand my duty as an expert witness is to the court. I have complied with that duty and will continue to comply with it. This report includes all matters relevant to the issues on which my expert evidence is given. I have given details in this report of any matters which might affect the validity of this report. I have addressed this report to the court.

Declaration of Awareness

6.02 I confirm that I am aware of the requirements of CPR Part 35, Practice Direction 35, and the Guidance for the Instruction of Experts in Civil Claims 2014.

Statement of Conflicts

6.03 I confirm that I have no conflict of interest of any kind, other than any which I have already set out in this report. I do not consider that any interest which I have disclosed affects my suitability to give expert evidence on any issue on which I have given evidence and I will advise the party by whom I am instructed if, between the date of this report and the trial, there is any change in circumstances which affects this statement.

Statement of Truth

6.04 I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

6.05 I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: 

Dr Anup Singh

GMC 7135145

MBChB BSc GP

15 July 2026

Appendix 1 — Experience and Qualifications

I am a highly experienced and versatile General Practitioner with a broad clinical, medico-legal and governance portfolio. I am a portfolio sessional GP averaging six sessions per week and have worked across more than 150 NHS GP practices, predominantly in the East Midlands. I qualified as a GP in 2011. I currently hold judicial appointments as a Medical Tribunal Member with both the Medical Practitioners Tribunal Service and the First-tier Tribunal (Social Entitlement Chamber). I am a Bond Solon CUBS Certified GP Expert Medical Witness. I have completed the diploma in occupational health medicine. I have served as Medical Director of the Nottinghamshire COVID-19 Vaccination Programme, as a GMC PLAB Examiner, as an NEMS Out-of-Hours GP and GP Registrar Trainer, and as a GP in HMP prisons, immigration removal centres and private medicine. I have completed medico-legal reports on the Vaccine Damage Payment Scheme.

With reference to this case, as a practising GP I regularly assess patients presenting with bowel symptoms, apply the NICE NG12 suspected cancer criteria, manage patients with rectal bleeding and abdominal pain and regularly make two-week wait referrals for suspected bowel cancer in primary care.

Qualifications: • **BSc (Hons) Biomedical Sciences**, Queen Mary University of London, 2006. • **MBChB**, University of Manchester (Keele Campus), 2011, Distinction in OSCE, Donald Kemp Prize. • **GMC number:** 7135145. • **Tel:** 07356 265030. • **Email:** expertwitness.anupsingh@zohomail.eu.

Appendix 2 — Glossary of Technical Terms

Adenocarcinoma: A malignant tumour arising from glandular epithelial tissue; the most common histological type of colorectal cancer.

Bolam test: The legal test from Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, asking whether a responsible body of medical opinion of the relevant specialty would have acted in the same way.

Bolitho refinement: The refinement of the Bolam test in Bolitho v City and Hackney Health Authority [1998] AC 232, requiring that a body of medical opinion relied upon be capable of withstanding logical analysis.

Colonoscopy: An endoscopic examination of the large bowel using a flexible camera, allowing direct visualisation and biopsy of the bowel lining.

FBC: Full Blood Count — a blood test measuring, among other things, haemoglobin and red cell indices such as MCV.

Ferritin: A blood protein that reflects the body's iron stores; a low ferritin is a specific marker of iron deficiency.

FIT: Faecal Immunochemical Test — a stool test that detects trace amounts of human blood, used to help identify patients at higher risk of colorectal cancer.

Hb: Haemoglobin — the oxygen-carrying protein in red blood cells; a low level indicates anaemia.

Iron-deficiency anaemia (IDA): Anaemia caused by insufficient iron to support normal red blood cell production, confirmed by a low haemoglobin together with a low ferritin and typically a low MCV.

MCV: Mean Corpuscular Volume — the average size of red blood cells; a low MCV (microcytosis) is characteristic of iron-deficiency anaemia.

Metastasis: The spread of cancer cells from the primary site to other organs via the bloodstream or lymphatic system.

NICE NG12: NICE Guideline NG12, Suspected Cancer: Recognition and Referral, first published June 2015 and amended on several occasions since, including a substantive amendment in August 2023 concerning faecal immunochemical testing (FIT) within the colorectal referral pathway.

PR examination: Per rectum (digital rectal) examination.

Two-week wait referral (2WW): An NHS urgent cancer referral pathway requiring specialist assessment within fourteen days, implementing NICE NG12.

T3N1M1: TNM staging notation representing a tumour invading through the muscularis propria into pericolic tissues, with regional lymph node involvement and distant metastasis. Stage IV disease.

Appendix 3 — Literature and Guidelines Relied Upon

1. NICE Guideline NG12: Suspected Cancer: Recognition and Referral. National Institute for Health and Care Excellence. Published June 2015, amended on several occasions since (including August 2023, in relation to faecal immunochemical testing). Colorectal cancer referral criteria at Recommendation 1.3. https://www.nice.org.uk/guidance/ng12

2. NICE Clinical Knowledge Summaries: Anaemia — Iron Deficiency. National Institute for Health and Care Excellence.

3. GMC Good Medical Practice (2024 edition). General Medical Council. https://www.gmc-uk.org/professional-standards/good-medical-practice-2024

4. Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.

5. Bolitho v City and Hackney Health Authority [1998] AC 232.

END OF REPORT