Neutral Citation Number [2023] EWHC 156 (KB)

Case No: D90MA356

IN THE HIGH COURT OF JUSTICE

KING'S BENCH DIVISION

MANCHESTER DISTRICT REGISTRY

Before HHJ Sephton KC, sitting as a Judge of the High Court

- -

Between :

EDWARD GRAHAM (a child, by his Litigation Friend, Mrs Rebecca Graham)	Claimant
- and –	
DR SIMONE ALTAF	Defendant

- -

Judgment handed down on 27th January 2023.

Mr Stephen McNamara instructed by Slater & Gordon (UK) LLP, Liverpool for the Claimants

Mr Nicholas Peacock instructed by Blake Morgan LLP, Cardiff for the Defendant

JUDGMENT

1. In this action, the claimant seeks damages for negligence arising out of his treatment by the defendant on 14th – 16th June 2010. This was the trial of a preliminary issue pursuant to the order of DJ Davies dated 2 December 2019, namely, "whether or not the Defendant is liable to the Claimant by reason of the matters alleged in the Particulars of Claim and, if so, whether or not any of the injuries pleaded were caused thereby; if any such injuries were so caused, the extent of the same."

Breach of Duty

2. On Sunday 13th June 2010, Edward Graham, who was then aged 3 years and 4 months, fell ill. The following day, his parents took him to Orchard Surgery in Kegworth, to see the general practitioner. The doctor they saw was Dr Simone Altaf, who was a GP Registrar. Dr Altaf diagnosed tonsillitis and prescribed antibiotics for Edward. On 15th June 2010, Edward's mother, Rebecca Graham, had a telephone consultation with Dr Altaf about Edward's condition. By 16th June 2010, Edward's condition had deteriorated significantly. Mrs Graham again spoke to Dr Altaf by telephone. Dr Altaf had Edward admitted to Queen's Medical Centre in Nottingham. He had developed meningococcal meningitis. It is alleged that he has developed neuropsychological sequelae from his meningitis, in respect of which he now claims.

3. Paragraphs 3 and 4 of the Particulars of Claim summarise the claimant's case as follows:

> "3. The Claimant's case is that:
>
> (i) the Defendant was negligent on each occasion [i.e. on 14th, 15th and 16th June], but that;
>
> (ii) injury was caused to the Claimant specifically as a result of the Defendant's negligence on 15.06.10, and that;
>
> (iii) the Defendant's negligence on 15.06.10 caused there to be a delay in the suspicion, diagnosis and treatment of the Claimant's condition (which began as meningococcal bacteraemia but which progressed to meningococcal meningitis) which, in consequence;
>
> (iv) caused the Claimant to suffer from otherwise avoidable neurological sequelae or, alternatively, substantially contributed to their development.
>
> 4. Particulars of negligence in relation to 14.06.10 and 16.06.10 are included in this document because the Claimant avers that the fact of the Defendant's negligence on these 2 dates, whilst not causative of injury, is nevertheless probative of the likelihood of her having also been negligent on 15.06.10."

4. Paragraph 41 of the Particulars of Claim contains the allegations about 15th June 2010 which have causative relevance. There are 16 allegations of negligence in this paragraph, but in my view, they amount in substance to three allegations, that:

(1) Edward's condition had significantly deteriorated and consequently, Edward should have been seen in clinic as a matter of urgency and then referred to hospital. However Dr Altaf proceeded upon the basis that Edward was "slightly better today."

(2) Dr Altaf paid insufficient heed to the fact that Edward had not taken the antibiotics that had been prescribed.

(3) Dr Altaf paid insufficient heed to the finding she made on 14th June that Edward's capillary refill time exceeded 3 seconds.

The law

5. The standard of care required of Dr Altaf in this case is uncontroversial. The starting point is the well-known direction McNair J gave to the jury in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582:

> "The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art…he is not guilty of negligence if he has acted in accordance with practice accepted as proper by a responsible body of medical men skilled in that particular art….Putting it another way round, a man is not negligent if he is acting in accordance with such a practice merely because there is a body of opinion who would take a contrary view."

6. In *Bolitho v City and Hackney Health Authority* 1997 UKHL 46, the House of Lords made the clarification that the practice in question must be logically defensible. Lord Browne-Wilkinson said this:

> "In the Bolam case itself, McNair J stated…that the defendant had to have acted in accordance with the practice accepted as proper by a "responsible body of medical men". Later, he referred to "a standard practice recognised as proper by a competent reasonable body of opinion". Again, in the passage which I have cited from Maynard's cases, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives – responsible, reasonable and respectable – all show that the Court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts directed their minds to the question of comparative risks and benefit and have reached a defensible conclusion on the matter".

7. I was referred to the helpful remarks of Green J in *C v North Cumbria University Hospitals NHS Foundation Trust* [2014] EWHC 61 (QB). I have taken these remarks into account in my assessment of the expert evidence in this case.

Factual evidence

8. In the review of the evidence that follows, I have referred only to the salient matters that appear to me to have relevance to the issues I am required to decide.

9. Mrs Rebecca Graham explained to me that on Sunday, 13th June 2010 Edward had an episode of diarrhoea. He seemed hot and clammy. He was not himself and did not eat anything. He was drowsy on the way home from Derby, where the family had been shopping. He vomited in the night.

10. On Monday 14th June, Mrs Graham was sufficiently concerned about Edward that she arranged to see the doctor. She and Mr Graham took Edward to the clinic and Edward sat on his dad's knee. During the consultation, said Mrs Graham, Edward was lethargic and clammy. He was not himself at all. In cross-examination, Mrs Graham told me "He was not himself. He was awake and responding to his examination. He was reacting against what Dr Altaf was doing. I don't think he spoke to her." Mrs Graham could not recall if she had told Dr Altaf about the episode of diarrhoea. Mrs Graham accepted that Dr Altaf undertook some examination of Edward. She said that Dr Altaf checked Edward's throat, in his ears, his back and his tummy. She could not recall if Dr Altaf had squeezed Edward's fingers – the capillary refill test. She told me that Dr Altaf diagnosed tonsillitis and prescribed oral antibiotics for Edward to take. She said that Dr Altaf had told them to phone the surgery if they had any concerns. In cross-examination, she made clear that she could not really remember what follow-up advice had been given: she told me "She might have said if he gets worse let us know – what they always say at the end of every consultation." She told me that she could not remember a conversation in which Dr Altaf arranged to speak with her on 15th June.

11. Mrs Graham gave a vivid description of how Edward's condition deteriorated after they had visited the surgery. She referred to his condition as a "downward slope". Edward was just gazing at the television but not responding to the programme. In her witness statement, she said, "We tried to give Edward the medicine, but we had to fight to get it down him. It would take two of us, and he would either refuse the medication totally or if we did manage to get the medicine down him, he would immediately vomit it back up… He was refusing food totally. He would vomit fluids of any volume." She says that she phoned the clinic in the afternoon

because of her concern but could not remember who she spoke to. She denied that Edward's condition had only deteriorated much later.

12. On Tuesday 15th June, Mrs Graham said that Edward was worse again and still being sick. She was worried that he was not taking his medicine and had not eaten anything. In her witness statement, Mrs Graham stated that they brought him downstairs to watch TV but he only managed half an hour before falling asleep and so he was taken back to bed. He still had a temperature. In cross-examination, Mrs Graham explained to me that Mr Graham looked after Edward whilst she was at work. She telephoned the surgery when she came back from work and before Mr Graham left for his work, which was an afternoon shift. In the telephone call with Dr Altaf, she rang the GP surgery again in the afternoon and she explained to Dr Altaf that Edward had deteriorated, that he was either refusing his antibiotic medicine or vomiting the medicine back up. She said that Edward still had a temperature, that he was still not eating, and that he was asleep all the time. She says that Dr Altaf told her that Edward was probably dehydrated and that she should call again on Wednesday if there was no improvement. She told me that Dr Altaf's note of the conversation was incorrect; in particular, she had not said that Edward was gagging on his medicine, that he was watching the television, that he was slightly better; she was not given any choice about whether Edward was kept at home. She agreed that she had not made a note of the conversation.

13. Mrs Graham told me that the next morning, Edward was worse; he was semi-conscious. She phoned the surgery as soon as it opened at 8:30 and spoke to Dr Altaf. Dr Altaf arranged for him to be admitted to Queen's Medical Centre in Nottingham. Dr Altaf asked the Grahams to collect a letter from the surgery to take to hospital. Mrs Graham said that Edward was arching his neck whilst he was being placed in his car seat. Mrs Graham read the letter that Dr Altaf had prepared but did not think to correct inaccuracies in it because she was far more concerned about Edward's health.

14. Mr Stephen Graham confirmed that Edward had fallen ill on Sunday 13th June. He had a bout of diarrhoea. He had a temperature, though Mr Graham could not remember what it was. He was not eating at all and was not drinking enough.

15. Mr Graham went with Mrs Graham and Edward to see Dr Altaf on 14th June. He confirmed that Dr Altaf examined Edward; this included checking his throat "using a lollipop." In cross-examination, he agreed that Dr Altaf had squeezed Edward's finger. He said that there was a discussion with Dr Altaf about whether Edward had a rash or was flushed. Mr Graham thought that Edward had a rash. He said that Edward was not himself; he was very quiet and subdued.

However, he conceded in cross-examination that Edward had reacted when Dr Altaf was examining him. He confirmed that Dr Altaf had diagnosed tonsillitis and had prescribed antibiotics. He said that Dr Altaf advised them to call the clinic if they had any concerns about Edward. In cross-examination, he amplified this comment: "She did mention that it might be her ringing us or us ringing her. She might ring us in the morning and if we were concerned to ring her."

16. Mr Graham explained that they had tried to give Edward some water and some Calpol, but "nothing seemed to stay down him." He went to work and, on his return from work at 10:30 pm, gave Edward some sips of water.

17. On 15th June, Mr Graham looked after Edward while Mrs Graham went to work. Edward was refusing food. He vomited if he was given medicine. He was brought down to watch TV but he was not responding to it and went to sleep. When Mrs Graham came back from work, she decided to phone the clinic. In cross-examination, Mr Graham was asked whether Edward's condition had been better on the Tuesday than the Monday. He replied, after a long pause, "I would say no." He accepted that Mrs Graham had told Dr Altaf that Edward was "slightly better" than he had been the day before. Mr Graham went to work after the phone call.

18. Mr Graham confirmed that they had taken Edward to the Queen's Medical Centre the following day, having collected a letter from Dr Altaf on the way.

19. Dr Altaf admitted that her account of these events depended upon the notes that she made and upon her usual practice. She made notes of the consultations on 14th, 15th and 16th June. She told me that her normal practice during face-to-face consultations is to make a few notes during the consultation, but the main note would be made at the end of the consultation. She would normally record telephone discussions contemporaneously. Dr Altaf also prepared a letter of referral on 16th June and made an entry relating to Edward's case in her learning log dated 29 June 2010. She told me about her normal practice when enquiring about symptoms.

20. The note of the consultation on 14th June is as follows:

> "14 June 2010 13:11
>
> History: Tonsillitis (Xa710) been unwell over night temperatures and very sleepy overnight as well. temps responded to calpol. no rash, drinking small amounts but not eating. not complaining of anything specific. vomited once this morning.
>
> Examination: temp 37.8, no rash well hydrated ears clear chest clear good air entry bilateral no crackles. abdo soft, bs normal, passing urine and BNO as yet. thraot red and inflammed with pus. CRT >3

Diagnosis: Tonsillitis (Xa710)

Phenoxymethylpenicillin 125mg/5ml oral solution - 100 millilitres - 1x5ml spoon 4 times/day

ETP FP10 Printed On Mon 14 Jun 2010 13:18 By Dr Simone Altaf"

21. Dr Altaf explained that "Tonsillitis (Xa710)" is a read code generated by the software used in the clinic. Dr Altaf explained that she had undertaken a capillary refill test. The result ought to have been recorded as "CRT < 3 sec." She told me she occasionally gets mixed up between a "greater than" sign and a "less than" sign. She points out that in her learning log, she recorded the refill time accurately as "<3 sec".

22. Dr Altaf did not record Edward's heart rate or his respiration. Her assumption is that, consistently with her normal practice, she assessed his heart rate and his respiration rate. She told me that if these had been abnormal, she would have recorded them. She agreed that she had not recorded Edward's level of alertness and conceded that she ought to have done so. She would normally have checked whether the patient's neck was stiff. In the defence, it is alleged that she made arrangements to speak to Mrs Graham the following day by way of follow-up. However, in her witness statement, she said this: "I would have said that if Mrs Graham was concerned about anything she should contact the surgery. I would have said if the surgery is closed you should contact out of hours or the hospital. I would have said that if he is no better within 24 hours she should bring him in again."

23. Dr Altaf's finding that Edward's throat was "red and inflamed with pus" was not challenged.

24. The note of the telephone consultation on 15th June was as follows:

"15 Jun 2010 14:53

History: telephone consultation with edward's mum.

mum struggling to get antibiotics down edward, as gags every time he has them.

still sleepy, but watching TV down stairs in day, and goes up to bed at night.

mum feels he is slightly better today. no worse. drinking fluids but sips only as if has large amounts vomits it back up.

still not hungry. wet nappies still happening.

mum happy to keep him at home, will call tomorrow for review.

still having temperatures but not needing any paracetamol to bring them down at present."

25. Under cross-examination, Dr Altaf accepted that she was aware that Mrs Graham was concerned that Edward was not keeping down the antibiotics he had been prescribed. However, she remained firm that she had recorded that Mrs Graham felt he was slightly

better and not worse because this is what Mrs Graham had told her. She thought that there must have been a discussion with Mrs Graham about whether she was happy to keep Edward at home. She explained that she wanted Mrs Graham to phone the next day because she needed to be sure that Edward was getting better. She denied that Mrs Graham had told her that though Edward was sitting in front of the television, he was paying it no heed.

26. Dr Altaf's record of the consultation on 16th June was as follows:

> "16 Jun 2010 08:41
>
> History: Telephone conversation with a 3rd party: mum. edward still very sleepy, not wanting to eat or drink anything since yesterday, no wet nappies over night. temp still present refusing calpol and antibiotics.
>
> very drowsy still, mum can wake him but falls asleep straight away again.
>
> mum just getting worried as thought he was getting better yesterday but now thinks he is worse.
>
> plan to send him into to childrens admission unit for assessment.
>
> spoke with SHO on call at QMC happy to see edward this morning.
>
> letter done for mum to collect at surgery before goes into hospital.
>
> Choose And Book Referral to Mr. Edward Graham."

27. Dr Altaf's witness statement raises the possibility that on this occasion, she phoned Mrs Graham rather than being called by her. Dr Altaf told me that she was concerned that Edward was very sleepy. It was obvious to her that he was unwell and she wanted a second opinion. She contacted the SHO and arranged for the admission. She had been taught that it was common courtesy to write a letter of referral to acquaint the hospital doctors with the history and presentation.

28. Dr Altaf's referral letter is dated 16 June 2010. It states:

> "I would be grateful if you could see this 3 years and 4 month little boy, who I saw on Monday with high temperatures and being generally unwell.
>
> On examination that day his temp was high 38, which were responding to calpol, refusing to eat but still drinking and having wet nappies. No rash to note, ears were clear, no lymph nodes felt, chest clear and abdomen soft with no masses. The positive feature was that he has a sore throat with a few pustules on his right tonsil. Therefore he was treated with penicillin for tonsillitis.
>
> Over the last few days mum has been struggling to get any medication down him due to him refusing or him vomiting the medication straight back. Yesterday he was still drinking but ate no food.

But overnight he has stopped eating and drinking and no wet nappies have been produced.

Mum also feels that yesterday she thought he was improving but now she feels he is drowsier and no better.

In view of no improvement in Edwards's condition over the last 48 hours I would be grateful for your assessment, and whether he requires IV fluids with IV antibiotics."

29. The following relevant information appears in the notes taken by practitioners at QMC when Edward was admitted to hospital on 16th June:

(a) Dr Samanta recorded a history that Edward's problems started with a cough; he was sounding wheezy. His temperature increased and he was complaining of a sore throat. There was no diarrhoea.

(b) When Dr Samanta examined Edward, there was no neck stiffness. His tonsils were large and not inflamed. There was no purulent exudate.

(c) Dr Adabi recorded "no diarrhoea… no cough but sounded chesty this am."

(d) When Dr Samanta clerked Edward, his respiration rate, his heart rate and his capillary refill time were all unremarkable.

(e) The C-reactive protein ("CRP") reading taken in the morning or early afternoon of 16 June was 225.

(f) Edward would not tolerate a lumbar puncture. Accordingly, no sample of his cerebrospinal fluid was taken.

Expert evidence

30. I heard from experts in general practice, Dr Boyd (instructed by the claimant) and Dr Shutkever (instructed by the defendant). They both prepared reports dated July 2020 and they prepared a joint statement dated March 2021 following a discussion.

31. Dr Boyd was critical of Dr Altaf's note of the consultation on 14th June. At paragraph 5.4 of his report, he said "Rather curiously," the record of the history started with "Tonsillitis (Xa710)" "when that is a diagnosis and not a symptom". He was critical of the fact that Dr Altaf did not record how alert Edward was during the consultation. He criticised the fact that Dr Altaf had not recorded Edward's heart rate or respiration rate or noted whether his neck could be flexed.

32. In my judgment, paragraph 5.5 of Dr Boyd's report is significant. The relevant parts of this paragraph state:

> “Dr Altaf made a diagnosis of tonsillitis on the basis of finding an inflamed throat "with pus". In her later letter of referral (paragraph 4.14) she expanded on this examination finding by stating that there were a "few pustules on his right tonsil". Although there is a great deal of subjectivity about the judgement concerning whether or not throat is inflamed, the finding of pustules is quite objective and I would expect there to be little or no disagreement between competent general practitioners about this. I note that no signs of tonsillitis were found two days later (paragraph 4.10). I think it is improbable that Edward had tonsillitis on 14 June when he had meningococcal meningitis two days later and his throat was thought to be essentially normal and there was no cervical lymphadenopathy. If no competent diagnosis of tonsillitis could have been made on this occasion then there should have been no prescription of antibiotics… Dr Altaf recorded that Edward's capillary refill time was ">3", which is an amber feature in the NICE guidelines, requiring 'safety-netting' or referral to specialist paediatric care because an increased capillary refill time is an indicator of dehydration or sepsis. I note that Dr Altaf states (paragraph 4.5) that she recorded it wrongly but correctly the CRT documented it in her learning log, but does not say when the log was completed. It is for the Court to determine whether Dr Altaf's account is credible.”

Dr Boyd told me that he felt competent to make the assertion that Edward did not have tonsillitis based on his wide experience of dealing with cases of tonsilitis. He agreed that a finding of pustules on the tonsils is an objective indication of tonsilitis. Dr Boyd maintained the approach that Edward could not have had tonsillitis in the joint statement, though in cross-examination, he conceded that Dr Altaf was not mistaken in her diagnosis of tonsilitis.

33. Dr Boyd is critical of the fact that Dr Altaf did not identify any follow up plan or safety netting. At paragraph 5.8 of his report, he says:

> “Dr Altaf did not note any plans for follow-up on 14 June 2010 (paragraph 4.4). If a plan was made then it should have been noted. I note that Dr Altaf says (paragraph 4.15) that it was "quite normal practice" for her to call patients in the morning for follow-up. In my experience as a GP educator the practice of following up patients with apparently straightforward conditions such as tonsillitis represents an unusually conscientious approach. The fact that the 15 June telephone call was made in the afternoon might suggest that it was more likely to have been initiated by Rebecca Graham: that is a matter for the Court.”

34. In relation to the call on 15th June, Dr Boyd states that if Mrs Graham’s account is accepted, then it was mandatory for Edward to be seen that afternoon. Dr Boyd thought that if the account set out in Dr Altaf’s note was preferred, he was nevertheless critical because the account there recorded indicated that Edward’s antibiotic therapy was likely to be ineffective, he was able to drink only sips and Dr Altaf had recorded that his CRT was >3 seconds the day before. He thought that Dr Altaf ought to have called Edward into the clinic for examination.

35. Dr Boyd characterises Dr Altaf’s conduct on 16th June as “highly unusual”. In his report, he maintained that Dr Altaf ought to have advised Mrs Graham to call 999 and have Edward taken to hospital by ambulance; he said that Dr Altaf’s “unusual management” delayed

Edward's assessment and treatment by an hour or two. In cross-examination, Dr Boyd accepted that Dr Altaf had not unreasonably concluded that Edward's case was not an emergency, so that it was not mandatory to "blue light" him to hospital. He said that Dr Altaf ought to have seen Edward before sending him to hospital because Edward might not have been as ill as his parents made out in the phone call. He said that GPs rarely send patients to hospital without assessing them first, unless it is an emergency. I took him to be persisting in the view that Dr Altaf's conduct was not merely unusual; it was negligent.

36. Dr Shutkever's initial view was that, if Dr Altaf's recorded account of the telephone call of 15th June was correct, there was little to criticise. He would not fault the diagnosis of tonsillitis or the penicillin that was prescribed to treat it on 14th June. His initial view was that it was not mandatory to record her impression of Edward's alertness. It was reasonable for Dr Altaf, having auscultated the patient, not to record negative findings from general observation (rather than measurement) for respiration rate and heart rate. He believed that it was appropriate to diagnose tonsilitis. He accepted that if Mrs Graham's account of the conversation on 15th June were accepted, Dr Altaf ought to have asked to see Edward urgently. Otherwise, Dr Shutkever was not critical of Dr Altaf's management. He stated,

> "Although antibiotics are commonly prescribed to patients with tonsillitis, it is generally recognised that such cases usually resolve even if antibiotics are not prescribed or taken. If a child with suspected tonsillitis was reported to be improving, a GP would not be particularly concerned if the full dose of antibiotics was not being successfully administered."

He expressed a similar view in relation to the administration of anti-pyretic drugs. In relation to events on 16th June, he concluded that unless Dr Altaf had reason to think that her arrangements would lead to a significant delay in admission for Edward, they were reasonable. He considered that Dr Altaf's decision to arrange direct hospital admission was one of a range of reasonable responses. He would not criticise her for not arranging a face-to-face appointment with a GP first.

37. Dr Shutkever modified his views in the Joint Statement. He accepted that Dr Altaf ought to have recorded Edward's level of alertness on 14th June. He maintained his view that, provided Edward did not appear significantly unwell, it was not necessary to record his heart rate or respiration rate. He agreed that there was no reasonable basis to conclude that Edward was retaining some but not all of the penicillin he had been prescribed. However, he reiterated the point that a GP who is told that a child with tonsillitis is improving despite not taking some or all of any prescribed antibiotics would not be concerned.

38. I was referred to the evidence of Dr Rothburn and Professor Shaunak, who are microbiologists. They agreed that a PCR test detected meningococcal serotype B DNA in Edward's blood. The definitive test for meningococcal meningitis is from analysis of cerebrospinal fluid, and since Edward could not tolerate a lumbar puncture, this test was not undertaken. The microbiologists cannot establish the time at which the meninges were invaded from the blood stream.

39. I heard from paediatricians: Dr Conway instructed by the claimant and Dr Thomson instructed by the defendant. They agreed that the natural history of a meningococcal infection such as this is as follows: The bacteria colonise a location in the body. Bacteria then penetrate the bloodstream. They multiply exponentially. The bacteraemia is initially asymptomatic, but becomes symptomatic after a period of about 12 hours. The symptoms are non-specific. The bacteria then penetrate the blood-brain barrier and colonise the meninges. The infection develops into clinically-observable meningitis about 12 hours after penetration of the blood-brain barrier. The clinical signs include increased drowsiness, complaints of severe headache, fitting and neck stiffness. The paediatricians agreed that, since Edward's CRP was 225 on admission, it would have been roughly 60 the evening before. The CRP is an index of inflammatory response; it is elevated in both viral and bacterial illnesses, though it tends to rise more in case of a bacterial infection.

40. The principal difference between the paediatricians lay in when they considered that Edward developed bacteraemia and meningitis. Both accepted that the timings they proposed were not exact.

41. Dr Conway believes that Edward had meningococcal bacteraemia on 14th June. He relies upon the account given by Mrs Graham and upon the record of a prolonged capillary refill time above 3 seconds. In the joint statement, he repeats this view, but makes this concession:

> "If the Court rejects Mrs Graham's evidence in total and accepts Dr Altaf's evidence in total that says that the capillary refill time was less than 3 seconds, that Edward was alert, responding normally, and interacting, that he was not drowsy, and that she established that there was no neck stiffness or excessive vomiting and if the Court accepts that Edward's heart rate and breathing pattern were assessed and were normal, thus countering the deficiencies in Dr Altaf's clinical assessment as identified by Dr Boyd, it is possible that when seen by Altaf on the 14th Edward had pharyngitis/tonsillitis only and had not yet developed meningococcal bacteraemia."

Dr Conway states that it is possible that Edward had meningitis on 14th June. When it was put to Dr Conway that neck stiffness only emerged after Edward had been examined by Dr Samanta and that consequently the meningitis must have developed much later than Dr

Conway postulated, Dr Conway dismissed Dr Samanta's examination on the basis that he was a GP trainee.

42. Dr Thomson considers that Edward probably had viral tonsillitis on 14th June. He referred to Dr Altaf's finding that Edward had pus on his throat. He pointed out that there was a history, obtained by the hospital doctors, of wheeziness and a cough. He said that meningococcal infections rarely present with these signs and symptoms. He postulates that the viral infection in the throat allowed colonisation by meningococcal bacteria. His timeline was that symptomatic bacteraemia probably developed in the morning of 15th, penetration of the blood-brain barrier during the day on 15th and the development of symptomatic meningitis late on 15th or early on 16th June. He was careful to emphasise that he had considered both Mrs Graham's account and that recorded in Edward's notes in formulating his theory: see paragraph 8.6.4 of his report.

Discussion and findings

43. It is convenient to deal first with the experts' evidence.

44. I formed the impression that Dr Boyd was acting as an advocate for the party by whom he was instructed, rather than providing the court with a disinterested, objective, opinion.

45. I was surprised that Dr Boyd thought it appropriate to suggest that Dr Altaf had made a diagnosis before recording the history. As he accepted when cross-examined about this issue, "Tonsillitis (Xa710)" is a read code generated by the software used in the clinic; it plainly was not inserted by Dr Altaf as part of the history. When called upon to justify this remark and to answer the question whether he was making a cheap point, I felt that he blustered; he certainly did not convince.

46. The construction I put on paragraph 5.5 of Dr Boyd's report is that it seeks to suggest that Dr Altaf simply could not have seen pustules on Edward's throat because if pustules were present on 14th June then there would have been signs of the infection when Edward was admitted to hospital on 16th – and there was none. The corollary is that Dr Altaf is either singularly incompetent or has simply invented the findings she records. However, Dr Thomson, a consultant paediatrician with long experience, had no difficulty in accepting that Edward had suffered from tonsillitis even though there was no sign of it when Edward was admitted to hospital. Even Dr Conway gave the qualified acceptance to the concept that I have quoted in paragraph 41. above. Dr Boyd was confident in the correctness of his own opinion about the disappearance of the pustules, but I find that his confidence was misplaced. I accept the evidence of the paediatricians that Edward could have had signs of tonsillitis on 14th June but

none on 16th. I am critical of Dr Boyd for two reasons: one is that he arrogates to himself expertise about the course of a tonsillitis infection which I find to be incorrect; the second is that he discounts the observations of a colleague – Dr Altaf – in what struck me as a summary and dismissive fashion.

47. I read the passage from paragraph 5.8 of his report cited above to be a thinly-veiled suggestion that Dr Altaf invented the story that she follows up patients. I read the remark that it was more likely that Rebecca Graham made the call on the 15th June because it was made in the afternoon as a pure advocate's point. Moreover, it is a point that is misconceived. The only call that Dr Altaf says that she *might* have made was the call at 8:40 on 16th June i.e. first thing in the morning; I did not understand her to be suggesting that she called on 15th June. The fact that Dr Boyd adds to his remarks the words, "that is a matter for the Court" does not detract from the fact that, in my view, he has sought to influence the court's decision on matters of fact.

48. Dr Boyd appeared to accept in cross-examination that Edward's condition on 16th June was not so serious as to require him to be conveyed to hospital as an emergency. This was contrary to the arguments he advanced in his report. I was unable to understand the logic of his assertion that it was nevertheless a breach of duty to insist that Edward be seen in clinic before being referred to hospital.

49. The court would have been assisted by an analysis that fairly dealt with both of the accounts put forward by Mrs Graham and by Dr Altaf. For example, Dr Boyd knew that Dr Altaf's case was that the CRP was <3 and not >3 as she had mistakenly recorded, but he did not address the position if the court found Dr Altaf's case to be true. I felt that, although Dr Boyd finally conceded in cross-examination that Edward probably had tonsillitis when Dr Altaf saw him on 14th June, the concession was a grudging one. I am afraid that these matters call into question Dr Boyd's objectivity.

50. Dr Shutkever modified his views between the preparation of his original report and the joint statement. I regard this as an indication that Dr Shutkever was prepared to be sufficiently flexible in thought to accept the points that Dr Boyd made, for example, that a record of Edward's responsiveness might be useful for continuity of care, should a different practitioner see the notes on a different occasion. He was prepared to criticise Dr Altaf, even though he was instructed on her behalf. I found him to be altogether a more impressive witness than Dr Boyd. Where their evidence differs, I prefer that of Dr Shutkever.

51. I formed the view that Dr Conway failed to grapple with the evidence that Edward had suffered from tonsilitis, in particular, Dr Altaf's finding that he had pustules on his throat, that it was reported that he had been coughing and wheezy, all of which are consistent with a diagnosis of viral tonsillitis and none of which are common in cases of meningococcal infection. Although it was entirely proper that he should deal with the claimant's case (which was that Dr Altaf had not undertaken the assessments of alertness, respiration and pulse at all when she saw Edward on 14th June), I would have been assisted by his view on the defendant's case (which was that, although Dr Altaf had not *recorded* those things, she had *assessed* them – the defendant's case was apparent from her witness statement, of which Dr Conway had a copy). Even during cross-examination, he appeared to find it difficult to perform the intellectual exercise of assuming that the account of Dr Altaf, rather than Mrs Graham, was accurate.

52. I found Dr Thomson to be an impressive witness. I found his theory to be plausible. Importantly, and in contrast to Dr Conway, he took account of all the evidence; where there was a significant conflict of evidence (in particular, about the phone call of 15th June), he gave the court the benefit of his views in relation to each account. I prefer his evidence to that of Dr Conway.

53. I turn to consider the factual disputes at the heart of this case. I bear in mind that the events in issue occurred about 12½ years ago. I remind myself of the remarks about evidence based on recollection made by Leggatt, J. in *Gestmin SGPS S.A. v Credit Suisse (UK) Limited*, *Credit Suisse Securities (Europe) Limited* [2013] EWHC 3560 (Comm) at paragraphs [15] – [22]. Although Leggatt, J. identified his approach as being appropriate for a judge in a commercial case, I take the view that the principles he expounded are similarly applicable to a case such as this. In my view, I ought to base my factual findings on inferences drawn from the documentary evidence and known or probable facts.

54. Mr McNamara submitted that the evidence of Mrs Graham was sufficiently compelling to demonstrate the inaccuracy of the documentary evidence. I test the validity of that submission by considering what I believe is the most consequential factual dispute, namely, what was discussed in the telephone call on 15th June. The documentary evidence on this issue consists of Dr Altaf's note of 15th June, which states, "mum feels he is slightly better today. no worse." This account is supported by the note of 16th June, which states, "mum just getting worried as thought he was getting better yesterday but now thinks he is worse." It is also supported by Dr Altaf's referral letter.

55. Dr Altaf's notes are contemporaneous; there was not (and could not be) any suggestion that she tailored her notes to defeat a claim which had not yet been advanced. The two passages I have cited above tell a consistent story, namely that Mrs Graham had said that Edward was a little better on the 15th. It follows that if Dr Altaf was wrong to record what she did on the 15th she was doubly wrong to repeat the error on the 16th.

56. Mr McNamara submitted that, when considering the accuracy of the note, I should take into account the deficiencies of Dr Altaf's notes generally, along the lines suggested in paragraph 4 of the Particulars of Claim. I reject that submission. The allegations made about Dr Altaf's conduct on 14th June relate to alleged failures to assess and record various matters. I intend to make no findings in relation to those allegations. They are not causatively relevant. I am not persuaded that, even if true, they assist me in reaching a conclusion on what was said on the 15th. A failure to assess and record is wholly different, in my judgment, from making a note that conveys the very opposite of what the doctor was told by a concerned parent. I do not believe that a failure to assess or record makes it more likely that Dr Altaf would have made a completely misleading entry in the notes on two occasions.

57. In cross-examination, Mr Graham conceded that Mrs Graham had told Dr Altaf that Edward was "slightly better". Mr McNamara made detailed submissions to the effect that I should give little weight to this piece of evidence. I formed the view that when Mr Graham gave this evidence, he thought carefully about his answer. He must have recognised the importance of his reply. In my judgment, it is an important piece of evidence and it carries substantial weight. I accept it.

58. I agree with Mr McNamara's submission that Mrs Graham was a careful and impressive witness. I entirely accept that Mrs Graham was seeking to assist the court. There is no question but that she gave me her honest recollection of events. There are some aspects of her evidence that lead me to question her reconstruction of events. I find it very difficult to accept that she called the clinic in the afternoon of 14th June. If Edward's condition has deteriorated as much as Mrs Graham told me it had, I cannot understand why she did not insist on speaking with a doctor (as Dr Altaf had told her she should if she had concerns). There is no record of this call and Mrs Graham could not recall whom she spoke to. In my view, the fact that Mrs Graham went to work on the morning of 15th June is significant. Mrs Graham stayed away from work on 14th June because she was so concerned about Edward's health. If Edward was worse on 15th June, as Mrs Graham alleges, it is unlikely that she would have chosen to go to work that morning, having stayed off work the day before. A plausible explanation for her decision to go to work on 15th is that Edward was slightly better. I was not

told precisely when Mrs Graham was away at work. I was left wondering how much she knew about Edward's condition given that she had been at work all morning. In my assessment of Mrs Graham's evidence, I must take these factors into account, as well as the warnings about recollection that Leggatt, J. provided in *Gestmin*.

59. I observe that the explanation of Edward's condition suggested by Dr Thomson is not inconsistent with either the account given by Mrs Graham or that set out in Dr Altaf's notes. I reject the suggestion made by Dr Boyd that the likely progress of Edward's illness is inconsistent with Dr Altaf's account.

60. Taking all these matters into account, I find that the overwhelming preponderance of evidence supports the defendant's submission that during the phone call of 15th June, Mrs Graham told Dr Altaf that Edward's condition was a little better, no worse than the previous day. The most probable explanation of Mrs Graham's words to Dr Altaf is that at the time the call was made, Edward's condition was a little better and no worse than the previous day. I conclude that Mrs Graham's evidence about the progress of Edward's illness is not reliable; Dr Altaf's notes are more likely to be accurate.

61. I accept that "CRP >3" is a typographical error in the notes of 14th June. I find that Edward's capillary refill time was less than three seconds when Dr Altaf assessed it on 14th June. I accept that Dr Altaf sometimes confused the 'greater than' and the 'less than' sign, which is why she mis-recorded the result. This finding is consistent with the reflective learning note Dr Altaf made on 29th June and also with the finding made when Edward was admitted to hospital (when his CRP was unremarkable). I am confident that Dr Altaf appreciated that Edward's CRT did not give grounds for concern, even though her clinical record mistakenly suggests the contrary.

62. I find that when Dr Altaf examined Edward's throat on 14th June, she found that it was red and inflamed with pus. Mr McNamara properly accepted that he had no basis to dispute Dr Altaf's account, which was not challenged in cross-examination. I accept the opinion of Dr Thomson that Edward probably had viral tonsillitis at that stage. I accept the evidence of Dr Shutkever that it was reasonable for Dr Altaf to conclude that Edward had tonsillitis and to prescribe antibiotics in case the infection was bacterial. Although Edward may have appeared to his parents to be less responsive than usual, I do not consider that his alertness was so obviously reduced as to warrant remark. In reaching this conclusion, I have regard to the evidence of Dr Altaf (who said that she would have made a note if Edward's responsiveness was markedly reduced) and the evidence of Mrs Graham, who stated in cross-examination that he was

awake and responding to his examination. I accept that, consistently with her usual practice, Dr Altaf told Mr and Mrs Graham that they should call the clinic if Edward was not better the following day.

63. I find that when Mrs Graham came back from work on 15th June, Edward was a little better, no worse than the previous day. However, he remained unwell, which is why, consistently with Dr Altaf's follow-up advice, Mrs Graham called the clinic. I find that Mrs Graham explained to Dr Altaf about Edward's condition and said that Edward was vomiting when he was given anything other than small sips of water. It was, or ought to have been, clear to Dr Altaf that Edward may not have been receiving all or any of the antibiotics she had prescribed. I accept the view expressed by Dr Shutkever that a responsible body of general practitioners would not have been particularly concerned about this: the diagnosis was tonsilitis; if the infection were bacterial, it might not respond to antibiotics; if the infection were viral, it would not respond to antibiotics at all. It was not inappropriate that Dr Altaf gave further safety-netting advice and did not refer him for further assessment and treatment. It seems to me that there was no obvious evidence available to Dr Altaf that some new pathology was involved. I reject the allegation that it was mandatory for Dr Altaf to advise that Edward be re-assessed on 15th either by another general practitioner or in hospital.

64. I accept Dr Thomson's view that Edward developed symptomatic bacteraemia during the day on 15th June. I find that, consequently, Edward's condition deteriorated significantly in the afternoon and evening of 15th June. It is entirely conceivable that the vivid description of Edward's decline that I refer to in paragraph 11. above applies to the afternoon of 15th June. Edward developed meningococcal meningitis during the night.

65. On the morning of 16th June, Edward was very poorly. It is more likely that Mrs Graham called the clinic as soon as it opened in order to speak to a doctor than that Dr Altaf called Mrs Graham. Dr Altaf was sufficiently concerned about Edward's condition that she referred him to hospital. Because she did not believe that Edward's condition was sufficiently serious to "blue light" him to hospital, she referred him and asked his parents to call in at the surgery to pick up her letter of referral. I reject Dr Boyd's criticism of Dr Altaf's actions on 16th June: I prefer the views of Dr Shutkever and I do not understand the rationale for the practice that Dr Boyd insisted was the only responsible course to take.

Conclusion on breach of duty

66. I refer to my analysis of the allegations of breach of duty that had a causative effect in paragraph 4. above. My conclusions in relation to the alleged breaches are as follows:

(1) On 15th June, Dr Altaf was not told that Edward's condition had significantly deteriorated; on the contrary, she was told that he was "slightly better, no worse". Having regard to her previous diagnosis of tonsillitis and the absence of any evidence that Edward was worse or had some other pathology, Dr Altaf did not refer him for further assessment or investigation. Having regard to what she was told, Dr Altaf's actions were consistent with the practice of a responsible body of general practitioners.

(2) Dr Altaf was given sufficient information to realise that Edward may not have taken all or any of the antibiotics that had been prescribed for him. Her actions following the giving of this information was consistent with the practice of a responsible body of general practitioners.

(3) On 14th June, Dr Altaf found Edward's CRT gave no grounds for concern. Despite her misleading note of her examination, Dr Altaf had no reason to suppose that Edward's capillary refill time should raise any alarm.

67. There has been no causative breach of duty. The claim must therefore be dismissed.