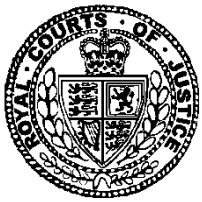

Neutral Citation Number: [2020] EWHC 3453 (QB)

Case No: HQ16C01791

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16 December 2020

Before:

HIS HONOUR JUDGE FREEDMAN
(sitting as a Judge of the High Court)

- -

Between:

Naziyah ISMAIL	**Claimant**
- and -	
Ciaran JOYCE	**Defendant**

- -
- -

Gerwyn Samuel (instructed by **Powell & Co LLP**) for the **Claimant**
John de Bono QC (instructed by **MDU Services Ltd**) for the **Defendant**

Hearing dates: 2-5 November 2020

- -

Approved Judgment

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

HIS HONOUR JUDGE FREEDMAN

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email, release to BAILII and publication on the Court and Tribunals Judiciary website. The date for hand-down is deemed to be on 16th December 2020.

HHJ Freedman:

Introduction

1. Ms Naziyah Ismail ('the Claimant') has brought a claim in clinical negligence against a general practitioner ('GP'), Dr Ciaran Joyce. In short, it is alleged that when Dr Joyce saw the Claimant at his surgery on 10 August 2011, he should have referred her for a chest x-ray because there were signs that she might be suffering from tuberculosis ('TB'). In the event, the correct diagnosis was indeed TB infecting her lung and then spreading to other organs including the brain and the spinal cord. It is the Claimant's case that if Dr Joyce had referred her for a chest x-ray at the time of, or shortly after the consultation on 10 August 2011, the TB would have been diagnosed much earlier, with a better outcome.

2. Unhappily, the Claimant (who was born on 29 May 1995 and is therefore now aged 25 years) has made an incomplete recovery from the TB. She has some residual brain damage, albeit mild, coupled with more marked spinal cord damage. The latter has caused significant back pain and mobility problems, such that she is currently reliant upon a wheelchair. She also suffers from fatigue and headaches, as well as bladder and bowel problems. She did manage a year at university between 2015 and 2016 but there was a marked deterioration in her health and she had a number of inpatient hospital admissions. Currently, she is taking a break but it is her desire to return to university in the future.

3. The scope of the hearing before me was confined to the issue of breach of duty. At a hearing before Master Yoxall on 16 January 2020, it was directed as follows:

> "*A preliminary issue should be tried between the Claimant and the Defendant as to whether or not the Defendant was in breach of duty owed to the Claimant by reason of the matters alleged in the Particulars of Claim. Any further directions as to the issues of causation and quantum are to be given, if required, at the conclusion of the trial.*"

4. Determination of that preliminary issue requires the Court to undertake a fact-finding inquiry as to what symptoms the Claimant was suffering from at, and in the days preceding, the consultation with Dr Joyce and what information was communicated to Dr Joyce, or would have been given to him if appropriate questions had been asked.

5. For the purposes of the fact-finding inquiry, I received evidence from the Claimant herself and her sister, Ms Aasiya Ismail, who lived in the family home with the Claimant and accompanied her to the consultation with Dr Joyce and to other medical consultations. I also received evidence from Dr Joyce but, as it emerged in the course of his oral evidence, he had (understandably) no recollection whatsoever of the consultation. He was, therefore, entirely reliant upon the notes which he made at the time of the consultation. I also heard evidence from Dr Sarah Wood, who saw the Claimant at the surgery on 20 July 2011.

6. In determining the nature, extent and duration of symptoms from which the Claimant was suffering at the time of the examination by Dr Joyce, and in deciding what might or might not have been said to Dr Joyce, I have been assisted by looking at records of medical consultations, both before, and after the consultation with Dr Joyce.

7. Once I have formed a view, on the balance of probabilities, as to what information was given to Dr Joyce and what, if any, further information should have been elicited by him, the next stage is to determine how a reasonably competent GP (applying the *Bolam* test) should have managed the Claimant. Specifically, whether it is established that no reasonably competent GP would have failed to ensure that the Claimant was referred for an x-ray immediately after the consultation on 10 August 2011, or within a relatively short time thereafter.

8. In making this determination, I have been assisted by expert evidence from Dr Lieberman called on behalf of the Claimant, and Dr Smith called on behalf of Dr Joyce. On the face of their written evidence and answers to questions in the joint statement, there appeared to be a wide divergence of opinion between the two medical experts. Indeed, to some extent, that remained the case during the course of the hearing but, in one key area, there was a broad measure of agreement. The consequence of the latter is that it is not necessary, in this judgment, to explore and analyse the medical literature referred to by the respective experts.

9. The final matter to mention, at this stage, is that this trial proceeded as a 'hybrid' hearing. The Claimant, her sister and Dr Joyce all attended in person. Dr Wood attended by video link, as did Dr Lieberman and Dr Smith. The need for some evidence to be given remotely was due to the current Covid-19 pandemic. Obviously, ideally, all oral evidence in a trial of this type should be given directly from the witness box. That said, however, I am quite satisfied that a fair trial took place and neither party was disadvantaged by the fact that some evidence was given remotely.

Background

10. At the time of these events, the Claimant was living with her mother, father, her older brother Hussain, and her older sister Aasiya in the family home in Newham, east London. Her father originates from India whilst her mother was born in Uganda but grew up in the United Kingdom.

11. The Claimant's medical history, before she contracted TB, was unexceptional. During the latter part of 2010 she felt somewhat 'run down' and developed 'flu-like symptoms. Blood tests were carried out and were normal.

12. In early 2011, the Claimant complained of frequent colds with a runny nose, sore throat and feeling heavy headed. On 9 May 2011, she saw Dr Manam at the GP surgery. Her throat was said to be slightly inflamed but it was not thought necessary to prescribe any medication. At this time, the Claimant was taking her GCSEs, and she was finding it difficult to concentrate because of her 'flu-like' symptoms.

13. Sometime after this consultation, the Claimant developed an intermittent dry cough. If her recollection is correct (and, indeed, that of her sister) this was about the time of her brother's wedding which took place over three days, on 1, 2 and 3 July 2011. At this time the Claimant was also taking her Islamic exams. She described the cough as

coming in "*waves"*: coughing for long bouts of time, before settling down and then recurring. The cough aggravated her sore throat.

14. According to the Claimant, there were two separate incidents when she saw specks of blood in her saliva. The first occasion occurred while she was coughing into the basin in the bathroom. It cannot be dated precisely but it may have happened some time during the week of her brother's wedding. She mentioned the specks of blood to her mother, who apparently said that the probable cause was straining her throat whilst coughing. The second occasion is said to have happened the week after her brother's wedding. The Claimant described being in the kitchen at home when she started to cough up saliva into the kitchen sink. She called her sister over to have a look; and she confirmed that there were some specks of blood. This second incident apparently prompted the family to make an appointment for the Claimant at the surgery.

15. The appointment was arranged for 20 July 2011 when the Claimant saw Dr Wood. She was accompanied by her sister. By this time, the Claimant had developed pain in her left elbow. Indeed, it is clear from Dr Wood's note of the consultation that the main presenting complaint was "*painful elbow"*. It seems that the Claimant told Dr Wood that she thought she may have injured her elbow when moving furniture around in preparation for her brother's wedding. Dr Wood examined the elbow and noted that there was a lack of extension. She prescribed ibuprofen and gave the Claimant an x-ray request form. The Claimant duly went to the Shrewsbury Road Clinic on the same day so that her elbow could be x-rayed.

16. It is apparent that the Claimant also mentioned that she had a cough. The duration was noted to be one week. The Claimant recalls Dr Wood examining her chest with a stethoscope. Her chest was noted to be "*clear*". Dr Wood did not record any further symptoms associated with the cough. In particular, there is no mention of any blood in the sputum or saliva. No medication was prescribed. Dr Wood recorded that the Claimant was "*well hydrated*".

17. Following the appointment with Dr Wood, according to the Claimant's witness statement, for approximately a week the cough stopped. (In her oral evidence, she said the cough did not disappear altogether, but rather it settled somewhat.) She said, however, that her general health deteriorated with loss of appetite, nausea, a headache, and fatigue. She complained of bright lights hurting her eyes. Within a week of the appointment with Dr Wood, her cough had returned and she was coughing on and off during the day.

18. Significantly, for the purposes of attempting to date the onset of certain symptoms, she places weight on the fact that Ramadan started on 1 August 2011. The Claimant describes that, even though she was fasting during the day, when attempting to break her fast she had no appetite and was not able to eat very much. She also complained of night sweats. The nature and extent of the night sweats, when they occurred, and over what period of time requires further close analysis because they form a central plank of the Claimant's claim.

19. In terms of the chronology, this brings me to the focal point of the claim, namely the consultation with Dr Joyce on 10 August 2011. As I have already observed, it would be surprising if Dr Joyce has any independent recollection of the consultation. He is entirely reliant upon his note in the GP records. There is, inevitably, a dispute as

between what he says would have happened and what the Claimant and her sister say actually occurred, and, indeed, what was said. For the present, I merely record that Dr Joyce noted that the Claimant had had a cough for the last three weeks and that she was *sweaty at night.* He noted that she was fasting. He prescribed an antibiotic, Clarithromycin (250mg). It emerged during the trial that the prescription period was five days. In relation to the elbow, it was noted that there was still some tenderness but that the x-ray had been normal. Dr Joyce gave the Claimant some Ibuprofen gel.

20. Following this appointment, and although the Claimant had taken the antibiotics, there was no improvement in her symptoms, and, indeed, her condition continued to deteriorate. At some stage, there must have been an acute deterioration because at about 11:30pm on 23 August 2011, the Claimant attended at the walk-in centre at Whipps Cross Hospital in the company of her mother and sister. Her presentation was noted to be a severe headache and high temperature for the past three weeks. She was seen by a female doctor, Dr George, who recorded a history of headaches and sore throat. It was stated that there was no fever, rash, nausea or photophobia.

21. It is clear that the family was very dissatisfied with the examination conducted by Dr George. There appears to have been an argument between the Claimant's mother and Dr George on the basis that the doctor was not accepting that the Claimant was very unwell. The dissatisfaction was communicated to Dr Wood on the telephone the next day by the Claimant's mother. There is a note of this telephone call in the GP records to the effect that the Claimant was eating less with slight vomiting, but she did not have a temperature. It appears that the advice was for the claimant to take the Amoxcycillin which had been prescribed by Dr George.

22. According to the Claimant, her symptoms persisted, comprising headache, dizziness, fever/shivering, persistent cough, lack of energy and night sweats. A week later on 30 August 2011, again at some time after 11:00pm, the Claimant was taken to the Whipps Cross Hospital where she was seen initially by Dr Younas. It was noted that she had been unwell for a month, the main complaint being headaches but also shivering in the morning and evening. She was admitted to hospital and on the following two days, 31 August and 1 September, she was seen by a number of doctors. By 1 September, the provisional diagnosis was TB but it was decided that the Claimant was well enough to be discharged from hospital on the basis that she should return on the following Monday, 5 September for a bronchoscopy.

23. She duly returned to hospital on 5 September, but by this time, her condition had deteriorated and she was unable to pass urine and was only able to mobilise in a wheelchair. In the event, she did not have a bronchoscopy. Instead she had an MRI scan which confirmed the diagnosis of TB. She was then transferred to Queen Square Hospital where she remained as an inpatient until February 2012.

Approach to the Assessment of the Evidence

24. Before undertaking an analysis of the salient parts of the evidence which are in dispute, it is instructive to look at one or two cases where courts have had to consider the unreliability of human memory. I turn first to what is now regarded as the 'Locus Classicus' namely, *Gestmin SGPS SA v Credit Suisse (UK) Ltd & anr* [2013] EWHC 3560 (Comm) where Leggatt J (as he then was) made these observations:

> "16. While everybody knows that memory is fallible, I do not believe that the legal system sufficiently absorbs the lessons of a century of psychological research into the nature of memory and the unreliability of eye witness testimony. One of the most important lessons of such research is that in everyday life we are not aware of the extent to which our own and other peoples' memories are unreliable and believe our memories to be more faithful then they are. Two common (and related) errors are supposed: (1) that the stronger and more vivid is our feeling or experience of recollection, the more likely the recollection is to be accurate; and (2) that the more confident another person is in their recollection, the more likely their recollection is to be accurate.
>
> 17. Underlying both these errors is a faulty model of memory as a mental record which is fixed at the time of experience of an event and then fades over (more or less slowly) over time. In fact, psychological research has demonstrated that memories are fluid and malleable, being constantly rewritten whenever they are retrieved. This is true even of so-called 'flash bulb' memories, that is memories of experiencing or learning of a particularly shocking or traumatic event. (The very description 'flash bulb' memory is in fact misleading, reflecting as it does the misconception that memory operates like a camera or other device that makes a fixed record of an experience). External information can intrude into a witness's memory, as can his or her own thoughts and beliefs, and both can cause dramatic changes in recollection. Events can come to be recalled as memories which have not happened, which did not happen at all or which happened to someone else (referred to in the literature as a failure of source memory).
>
> 18. Memory is especially unreliable when it comes to recalling past beliefs. Our memories of past beliefs are revised to make them more consistent with our present beliefs. Studies have also shown that memory is particularly vulnerable to interference and alteration when a person is presented with new information or suggestion about an event in circumstances where his or her memory of it is already weak due to the passage of time".

25. At [19]- [20] Leggatt J also drew attention to the "considerable interference with memory" introduced in civil litigation by the procedure preparing for trial. At [21], he stressed that "all remembering of distant events involves reconstructive processes".

26. In *Kimathi & ors v Foreign and Commonwealth Office* [2018] EWHC 2066 (QB) at [96], Stewart J distilled some of the key aspects of this learning, as summarised by Warby J in *R (Dutta) v General Medical Council* [2020] EWHC 1974 (Admin). At [39] Warby J, citing *Kimathi*, said:

> "The best approach from a judge is to base factual findings on inferences drawn from documentary evidence and known or probable facts. "This does not mean that all testimony serves no useful purpose…. But its value lies largely… in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of supposing that, because a witness has a confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth."

27. In *Dutta*, Warby J also cited a judgement from Mostyn J in a family case, *Lachaux v Lachaux* [2017] EWHC 385 (Fam), [2017] 4 WLR 57 to this effect:

> "Witnesses, especially those who are emotional, who think they are morally in the right, tend very easily and unconsciously to conjure up a legal right that did not exist. It is a truism, often used in accident cases, that *with every day that passes the memory becomes fainter, the imagination becomes more active.* For that reason, a witness, however honest, rarely persuades a judge that his personal recollection is preferable to that which was taken down in writing immediately after the incident occurred. Therefore, *contemporary documents are always of the upmost importance*."

Mostyn J also considered the learning in *Gestmin* in another family case, *Carmarthenshire Council v Y* [2017] EWHC 36 (Fam), [2017] 4 WLR 136. Warby J summarised it in this way:

> "The general rule is that oral evidence given under cross-examination is the gold standard because it reflects the long-established common law consensus that the best way of assessing the reliability of the evidence is by confronting the witness."

28. However, all evidence under cross examination is far from the be all or end all of forensic proof. Referring to paragraph 22 of *Gestmin*, Mostyn J said in *Carmarthenshire Council*:

> "… this approach applies equally to all fact-finding exercises, especially where the facts in issue are in the distant past. This approach does not dilute the importance that the law places on cross-examination as a vital component of due process, but it does place it in its correct context."

29. In evaluating the lay evidence in this case, in particular that of the Claimant and her sister, I have found all these *dicta* to be of considerable assistance. They are of particular application in circumstances where medical records do not necessarily bear out of what is recalled by the Claimant and her sister. The inherent unreliability of

memory does mean that it is fair and proper to test the accuracy of recollections of medical consultations against what is documented in the records.

30. On the other hand, it does not necessarily follow that just because the complaint of a particular symptom does not feature in the record of a consultation, it was not, in fact, mentioned by the patient. Sometimes a doctor will obtain an extensive history and make a very detailed record. Sometimes, because of pressure of work or for whatever other reason, a doctor may take a less extensive history and will make a somewhat briefer note.

31. I must also bear in mind that it is human nature for a patient not always to give precisely the same account of his or her symptoms to every doctor who examines him or her. Much may depend upon the questions which are asked by the doctor. Equally, the patient is likely to emphasise and stress the symptoms which are troubling them the most at the particular time of the examination. The medical records need to be scrutinised, with these matters in mind.

32. In the specific context of this case, I must also bear in mind that the Claimant was barely 16 years old when these events occurred, although her sister was 22 years old. It is also right that the Claimant did not approach solicitors until 2015, some four years after her TB was diagnosed. At the trial, she was giving evidence of events which had occurred more than nine years ago. Coupled with these matters, I do need to take into account the fact that the Claimant suffered a degree of brain damage. Although she was able to understand and digest questions and give lucid answers, it was clear, that, at times, she was struggling and, indeed, cross-examination on the first day had to be brought to a halt because she was fatigued. It was then recommenced the following morning. At this point, I should make it clear that Mr de Bono, although, of course, trying to pin her down, cross-examined her in a very gentle and sensitive manner.

33. The final general point to be made in relation to the assessment of the evidence given by the Claimant and her sister is this: it seems to me to be perfectly legitimate to find that, in some instances, their memories may be unreliable but, in other instances, their recollections of what was said or done can be relied upon. The latter will be particularly be the case if there is support in the medical records for what is said by them in their written and oral evidence. The central point is that just because in some instances, it is not possible to accept their evidence as to what happened or as to what was said, it does not render them unreliable witnesses, in the sense that the totality of their evidence falls to be rejected.

The witnesses

34. I formed the view that the Claimant was an utterly genuine witness who was doing her level best to remember events as they occurred. I am satisfied that, whether consciously or subconsciously, there was no attempt to mislead the Court. Her evidence was given in a measured and dignified way.

35. True it is, as Mr de Bono observes, she felt that she had been the victim of an injustice because her TB had not been diagnosed earlier. It is right to note that when she first consulted solicitors, her complaint was not levelled specifically at Dr Joyce but against the medical profession generally who had, as she saw it, failed to take

seriously her complaints of illness and failed to recognise the significance of her symptoms. It will inevitably be the case in virtually every clinical negligence claim that the claimant considers that he or she has received poor treatment from one or more doctors and, obviously, to some extent, that will inform their evidence. But that does not, of itself, render their evidence unreliable.

36. Nevertheless, I must deal with specific criticisms made by Mr de Bono of the Claimant's oral evidence (and indeed that of her sister). Mr de Bono is right to point out that when asked, for example, about the failure to mention, in her witness statement, an examination of her elbow by Dr Joyce, her response was that "I was not asked about that". (The Claimant's sister answered in similar fashion.) I am not, however, troubled by such a response. The reality is that witness statements are often prepared by a solicitor asking a series of questions. The alternative explanation is that it was simply their way of telling the Court that certain details had been forgotten but they were, sub-consciously, protecting themselves by saying that the questions had not been asked. Either way, such response does not undermine the strength of their testimony to any significant degree.

37. Mr de Bono also points out that when they were asked about the cough, both were at pains to mention the instances of coughing up of blood. All this tells me is that they both considered this to be an important part of the narrative and that although not recorded by either Dr Wood or Dr Joyce, they were keen to impress upon the Court that the coughing up of blood had occurred. Mr de Bono was also somewhat sceptical about the use of the word "sputum", given that the Claimant herself was not talking about coughing up mucus but rather saliva. The word "sputum" may well have been imported by the Claimant's sister, given her pharmacological background, and then adopted by the Claimant. Whatever be the position, I see no particular force in the criticism of the use of the word "sputum".

38. Of course, these observations do not mean that, in every instance, where there are factual issues, the Claimant's evidence falls to be preferred. Her evidence must be scrutinised and looked at with caution.

39. The observations which I made about the Claimant presenting as a genuine witness apply equally to her sister. But, of course, as with the Claimant, it does not follow that her recollections can be accepted in every respect.

40. Dr Wood, who has now been retired for seven years, struck me as an entirely credible and plausible witness who gave her evidence in a robust and forthright manner. I shall return to her evidence in due course, but she struck me as a convincing and compelling witness.

41. Finally, at this stage, I turn to Dr Joyce. It is worth noting that he qualified some thirty-three years ago in 1987. He has a wealth of experience and of, particular note, on qualifying as a GP, he travelled to Africa and worked in a mission hospital. That brought him in to contact with infectious diseases such as HIV and TB. He became a full-time partner at the GP surgery in 2003.

42. Not only did he have extensive experience of infectious diseases when working in Africa, but he has also seen many cases whilst working in the Newham area: as I shall explain later in this judgment, Newham has one of the highest TB rates in England.

His best estimate is that he would see one new case of TB each year, and that was very often in the younger population.

43. As to his evidence, as I have previously noted, although his witness statement may have suggested otherwise, he has no recollection of the consultation in question. Accordingly, he has had to attempt to reconstruct what occurred and what was said at the consultation based on his note and his usual practice. In order to determine whether that reconstruction can be accepted, it is necessary to form a view as to both his clinical competence and his credibility as a witness.

44. I have no doubt whatsoever that Dr Joyce is a caring, compassionate and sympathetic doctor who generally meets the highest standards of general practice. I also found him to be a credible, honest and convincing witness who was doing his very best to assist the Court.

Factual issues

45. It is convenient to divide up the factual issues in to a series of sub-headings.

Did the claimant cough up spots of blood in her saliva?

46. The Claimant has a vivid image of having coughed up specks of blood on two separate occasions, the latter occasion being witnessed by the Claimant's sister. But the fact that she has such a clear and vivid recollection is by no means conclusive: see *Gestmin*. It is necessary to see whether any confirmation is to be found in the medical records. As I have already noted, neither Dr Joyce nor Dr Wood made any reference to the coughing up of blood. But support is to be found in the notes made by Dr Donnelly on a morning ward round on 31 August 2011. He recorded, "bringing up blood-red little drops". Additionally, on the following day, the minutes of the MDT meeting contained the following entry: "initially had 1x episode of haemoptysis now not producing any sputum".

47. To find that the Claimant did not have one or more episodes of coughing up blood would lead ineluctably to the conclusion that she made up a story when she was asked for a history by Dr Donnelly. I reject out of hand such a suggestion. Moreover, I find the account given by the Claimant and her sister to be convincing and plausible, even if they were guilty of over-emphasising the fact that she had coughed up blood on two separate occasions.

48. It should be said that this was not true haemoptysis: that is, frank blood in the sputum. Rather, as I find, the evidence demonstrates that on two separate occasions, there was some small spots of blood in the Claimant's saliva. Mr de Bono points out that the records do not indicate that she had two separate episodes and that this serves to undermine her evidence on this point. It seems to me, however, that it would be inconsistent to find that the Claimant is right about one incident but not the other. This is an example of either the clinician not obtaining a full and complete history, or, alternatively, not recording all that has been said.

Did the claimant or her sister inform Dr Joyce about the blood?

49. In relation to this issue, it is convenient to look first at what Dr Wood says at paragraph 11 of her witness statement:

> "When presented with a complaint of cough it was my standard and invariable practice to ask about the nature of the cough i.e. was it dry or productive, and if productive the colour of any sputum produced. If the patient advised that it was a productive cough and that sputum was being produced, I would then enquire as to whether they had noted any signs of blood in the sputum."

And at paragraph 14:

> "I do not believe that there was any report of the cough producing sputum, as that is a symptom I would note in my records. As indicated above, with a productive cough I would make further enquiries whether blood was seen in the saliva or sputum, and if that were affirmative then I would ask further questions regarding duration and amount of blood seen. In that situation I would invariably examine the patient's throat which I have not done on this occasion and also examine the lymph glands which again I did not do. Had I received a report of blood in the saliva or the sputum then I would have taken the patient's temperature. Owing to the fact that I did not undertake any of these further examinations I am able to confirm that blood in the sputum or saliva was not reported to me at this consultation."

50. Despite what the claimant and her sister say, namely that they told Dr Wood that there had been two incidents when the Claimant had coughed up some blood, it seems to me that there is very considerable force in what Dr Wood says. As a careful and competent GP, I am persuaded that she would indeed have asked whether the cough was productive and if told that it was, she would have investigated further. I also find that it is highly probable that if the Claimant or her sister had volunteered information about blood in the saliva, this would have been recorded by Dr Wood because it is a matter of some significance. She would also have undertaken the further examinations to which she refers in paragraph 14 of her statement.

51. In relation to the conversation with Dr Joyce, the Claimant and her sister say that they told him that they had told Dr Wood that the Claimant had coughed up spots of blood in her saliva. Like Dr Wood, Dr Joyce is very clear that on being told about a cough it would have been standard practice to ask whether the cough was productive. At paragraph 23 of his witness statement he says this:

> "Had any mention of blood in the sputum been reported then I am sure I would have gone on to ask additional questions regarding the amount of blood, frequency of blood being present, duration etc. I am sure that I would then have recorded any significant responses to those questions in my note. Had

> she reported that she had coughed up blood then I have no doubt that I would have recorded this because it would have been important."

52. The comments I made about Dr Wood apply equally to Dr Joyce. He is a careful and competent clinician who would have acted in accordance with standard practice. It strikes me as unlikely that if told that there was blood in her saliva on two previous occasions, he would not have questioned further and made a note about the coughing up of blood.

53. The other important point which lends support to what both Dr Wood and Dr Joyce say is that it would be a striking coincidence that whilst both were told she had coughed up blood, neither bothered to write it down. That seems to me to be inherently improbable.

54. I conclude that both the Claimant and her sister now firmly believe that they told both Dr Wood and Dr Joyce about the blood in the saliva (not least because they appreciate that it was a significant part of the Claimant's history), but that they are mistaken about this. They may have been distracted by the Claimant's problem with her elbow or quite simply, they may have forgotten to pass on the information. At a subconscious level they know they should have passed on that information and that explains why they have convinced themselves that this part of the history was given to the doctors.

Did Dr Joyce examine the claimant before reaching a diagnosis of upper respiratory tract infection?

55. Neither the Claimant nor the Claimant's sister recalled Dr Joyce examining the Claimant's chest, neck or throat. Frankly, I do not see how the Claimant or her sister can accurately recall what examinations were undertaken by the many doctors who saw the Claimant over this period of time. It is pertinent to note that the Claimant, in her witness statement, did not recall Dr Joyce examining her elbow.

56. To repeat, Dr Joyce is a careful and competent clinician who, having been given a history of a cough of three weeks would very likely carry out an appropriate examination. Unlike Dr Wood, he has not recorded that he undertook such an examination but that does not mean that it did not take place. The reality is that doctors very often do not record examinations where the outcome is negative. I think it improbable that Dr Joyce would have reached a diagnosis of Upper Respiratory Tract Infection without listening to the Claimant's chest and without carrying out an ENT examination.

57. Accordingly, I prefer Dr Joyce's evidence in relation to this matter, albeit that it has to be based upon what would have been his usual practice.

Did the Claimant suffer night sweats; and, was Dr Joyce told about them?

58. In paragraph 17 of her witness statement, the Claimant says this;

> "In 2011 Ramadan started at the beginning of August. Even though I was fasting during the day, when I broke my fast, I

> still had no appetite and could eat very little. After the appointment with Dr Wood I also began to sweat very heavily at night I was sweating so much I had to change my pyjamas and bedding. Sometimes I would wake up at 3am to do this and have a shower. On occasions I would have to do this more than once a night I was sweating so much. I shared a bedroom with my sister, Aasiya, who would help me change the bedding. I often felt shivery as if I had a fever. Sometimes I was so tired I slept on the sofa downstairs until about 1am when my family rose to eat and pray."

At paragraph 10 of her witness statement, the Claimant's sister says this;

> "Also, after the appointment with Dr Wood, Naziyah started to have very bad sweats at night. She said she had a bad headache and felt shivery and feverish. On some nights she felt too tired to go up to bed and so slept on the sofa until 1am, then getting up to have a shower. The sweats were so bad that Naziyah would get up during the night to change her pyjamas and bedding before having a shower and going back to bed. I know this as I was sharing a bedroom with Naziyah and helped to change the bedding when she got up."

The fact that the two accounts are similar is not surprising. As Mr de Bono points out, the sisters have spent much time discussing this case. On the other hand, it is not unreasonable to regard Aasiya's evidence as being, at the very least, supportive of the Claimant's account; and, of course, she was in a position to know what was happening at night because they shared a bedroom.

59. But, as with the other issues in dispute, it is necessary to look to the medical records to see whether there is any support for the contention that prior to this conversation the Claimant was suffering night sweats. The following entries are relevant:

i) 30 August 2011, at Whipps Cross Hospital: "shivering in the morning and evening";

ii) 31 August 2011, at 5:40am, the medical registrar: "shivering and night sweats";

iii) 31 August 2011, Dr Donnelly: "temperature, shivering morning/pm";

iv) 5 September 2011, at 5:10pm: "night sweats-1 month"

v) 7 September 2011, the specialist registrar: "fevers, night sweats"; and

vi) 16 September 2011, the infectious disease Dr: "last eight weeks –fever night sweats, loss of appetite, cough"

60. The evidence, therefore, seems to be to be overwhelming that during the course of her illness, the Claimant suffered night sweats. Indeed, Mr de Bono does not seek to persuade me otherwise. Nor could he, on any sensible basis: not only because of the

entries in the medical records to which I have referred but also because Dr Joyce himself recorded "sweaty at night".

61. Nevertheless, Mr de Bono argues that the Court cannot be satisfied that the Claimant had "drenching" night sweats as described by her and her sister. True it is that Dr Joyce recorded only "sweaty at night" but that may simply be terminology. It seems to me that there is no more than a semantic difference between "sweaty at night" and "night sweats". The other entries in the medical records referred to "night sweats".

62. At all events, on this aspect of the case, I found the description provided by the Claimant and her sister to be convincing. I do not accept that together they have manufactured an account of the Claimant getting up in the middle of the night to change her pyjamas and having a shower. On the contrary, it seems to me that their account has a distinct air of plausibility.

63. But Mr de Bono further submits that even if I am satisfied that the Claimant had drenching night sweats, I cannot be satisfied that they occurred during the period leading up to the appointment with Dr Joyce. I reject that submission: at the time of appointment with Dr Joyce, on any view, the Claimant was "sweaty at night" and I see no basis for a suggestion that somehow being "sweaty at night" then developed into drenching night sweats. What the Claimant has complained of, consistently, is drenching night sweats.

64. It cannot be established precisely for how long the Claimant had suffered such night sweats. However, on the basis of the evidence from the Claimant and her sister, I think it probable that she had suffered night sweats for a week or more prior to the consultation with Dr Joyce, given that they both recall that the sweating began at or around the beginning of Ramadan. Mr de Bono suggests that the drenching night sweats may have started at some time after the consultation with Dr Joyce but that is entirely speculative. It is to be noted that night sweats were not one of the presenting complaints when the Claimant attended at Whips Cross hospital on 23 and 30 August 2011. Further, in terms of timing, it seems to be that the note made by the infectious disease doctor on 16 September 2011 is of assistance.

65. It may be said that, on the one hand, to reject the Claimant and her sister's evidence about telling Dr Wood and Dr Joyce about the blood in the saliva and, then, to accept their evidence about the drenching night sweats is in some way inconsistent. I am satisfied that it is not. The major difference is that whereas Dr Joyce does not make any record of blood in the saliva, he has made reference in his note to the Claimant being "sweaty at night". That is a very important distinction. Moreover, as I have observed, there is a good deal of support in the medical records for the fact that, over time, the Claimant had suffered night sweats.

66. For the sake of completeness in relation to this aspect of the matter, Dr Joyce accepted, at least with the benefit of hindsight, that he should have asked the Claimant more about her sweating at night. Having found that at this point in time, the Claimant was suffering nightly drenching sweats, I have no doubt that if the question had been asked about the nature of the sweats, she would have described them as she has done in her witness statement. Had he been given such information, Dr Joyce accepted that he would have then be alerted to the possibility that the Claimant was suffering from a more sinister condition such as TB rather than a straightforward

chest infection. He says that whilst he would still have diagnosed an upper respiratory tract infection and given antibiotics, he would at the same time have given the Claimant a request form for a chest x-ray, advising her that if the antibiotics did not do the trick, she should go to the clinic to have a chest x-ray.

Were there other symptoms?

67. The Claimant says that she told Dr Joyce that she was "heavy headed" with nausea and loss of appetite. Whatever precisely she said, I think that Dr Joyce was told that she was generally feeling unwell. She recalls Dr Joyce saying something to the effect of: "We are a little run down then, are we?"

68. My view is that Dr Joyce was made aware that the Claimant was feeling poorly but he attributed this to the upper respiratory tract infection, and to the fact that she was fasting for Ramadan.

Did Dr Joyce provide safety netting advice?

69. Dr Joyce said that in accordance with his usual practice, he would have advised the Claimant that if the symptoms did not improve that she should come back to the surgery; equally, if her condition deteriorated she should make another appointment. He accepts he made no record in the notes but, at least in 2011, this was probably not uncommon. The Claimant and his sister have no recollection of Dr Joyce giving such advice.

70. In accordance with my view of Dr Joyce as a careful and competent doctor, I think that, probably, he did say something to the effect that if the Claimant's symptoms did not improve, she should return to the surgery.

Expert evidence

71. One matter, in particular, is not in dispute between the experts namely, that the rate of TB in Newham is almost ten times that of the average in the UK. In 2011, the overall rate of TB cases in the UK was around 13 cases per 100,000 of the population. In Newham, the latest figures show that the TB rate to be 180 per 100,000 people. In such circumstances, Dr Lieberman expressed the view that any GP working in the area of Newham should have a high suspicion as to the signs and symptoms of TB. Dr Smith did not disagree.

72. It is also beyond dispute that the main symptoms of TB are weight loss, lack of appetite, fever, night sweats, extreme tiredness and fatigue. It is also the case that if TB is in the lungs, then a persistent cough may be present and there may be blood in the sputum.

73. Beyond those matters, on the face of it, there was a wide gulf between the views expressed respectively by Dr Lieberman and Dr Smith. Dr Lieberman's opinion, expressed succinctly, was this:

> "She is 16 years old, with a cough for three weeks, night sweats, in an area where there is ten times the national average of TB. A chest x-ray at the very least was mandatory."

Dr Lieberman also relied upon other matters as indicators for a chest x-ray, including low body weight and a visit to Saudi Arabia. However, for the reasons which will become apparent, it is not necessary to consider further those other matters.

74. Dr Smith, who practised in Liverpool and had not himself seen a patient with TB as a GP, accepted that if the Claimant had been complaining of a persistent productive cough for three weeks or more with night sweats, then a chest x-ray was mandatory. He expressed the view that if the Court accepted the Claimant's version of events, then that history would not be typical of a simple bacterial upper respiratory tract infection. Nevertheless, he considered that a responsible body of reasonably competent GPs would have acted in the same way as Dr Joyce in prescribing antibiotics for a presumptive diagnosis of upper respiratory tract infection. He considered, however, that it was mandatory to give safety netting advice to the Claimant to return within seven days, if symptoms did not improve or sooner if the symptoms should deteriorate.

75. Although, quite properly, both counsel explored the opinions of the respective experts in some detail with a view to showing that their conclusions were not tenable; in the end, and subject to my factual findings about night sweats, those differences of opinion effectively fell away. Ultimately, as it seems to me, the resolution of this case comes down to a very fine and narrow point.

76. In the course of cross-examination (including some questions posed by me), Dr Smith accepted that if the claimant reported being "sweaty at night", or indeed, having "sweats at night" then it was incumbent upon any GP to ask about the problem. He agreed that this further questioning was mandated because night sweats are one of the symptoms of TB, albeit far from being diagnostic of TB. In particular, he said it was essential to enquire as to the nature and extent of the sweatiness at night and for how long the night sweats had persisted. He said that if a history of drenching night sweats had been elicited then that information, coupled with a persistent cough over three or more weeks and the relatively high incidence of TB in Newham, would have prompted many GPs to ask for a chest x-ray because of a real concern that that the Claimant may be suffering from something more sinister than a simple chest infection, in particular, TB. On the other hand, he considered that a responsible body of competent GPs might well have still prescribed antibiotics but if there was not a positive response to the antibiotics, then there needed to be an urgent review within seven days. When asked what he thought about Dr Joyce's preferred option of giving a chest x-ray request form to be taken to the clinic if the antibiotics did not work, he said that an instruction to the patient to return the surgery would have been the better option. He said that general safety netting advice would not have been sufficient in these circumstances.

77. This, as it seemed to me, was an appropriate concession for Dr Smith to make; and it chimes with the opinion of Dr Lieberman. Of course, its significance depends crucially on my factual findings. At all events, by virtue of my findings, as appear below, it is not necessary to discuss further the merits or otherwise of the opinions expressed by the two experts.

Conclusion

78. In conclusion, I find as follows:

i) for a week or more prior to the consultation with Dr Joyce the Claimant had been experiencing drenching night sweats, as described by her and her sister in their respective witness statements;

ii) Dr Joyce was told, as recorded by him, that the Claimant was "sweaty at night" or had "sweats at night";

iii) as accepted by Dr Smith, no reasonably competent GP would have failed to ask about the sweating at night (and Dr Joyce does not suggest that he did so);

iv) if an appropriate enquiry had been made, the Claimant would have given an account similar to that which appeared in her witness statement;

v) if that history had been elicited, coupled with a three or four-week persistent cough, then, as conceded by Mr de Bono in scenario three of his written closing argument, it was mandatory either to give a request form for a chest x-ray or to instruct the Claimant to return a week later (it was *Bolam* negligent not to do so);

vi) with a history of drenching night sweats over a week or more with a persistent cough, general safety netting advice was insufficient to meet the standard of a reasonably competent GP;

vii) for what it is worth, and although I did not receive specific submissions about this, I think it probable that had the Claimant been given the specific advice about going to the clinic for a chest x-ray, she would have complied with such advice, leading to an earlier diagnosis of TB;

79. With a history of a cough of 3/4 weeks' duration and sweating at night, I am confident that it would have been Dr Joyce's usual practice to enquire further about the night sweats but, on this occasion, there was a negligent omission to do so. Had he explored further the history of night sweats, he would have ascertained the extent and duration of the sweats. Given the significance of drenching night sweats, in the context of a persistent cough, a different outcome would have eventuated in that arrangements would have been made for a chest x-ray within approximately 7 days of the consultation.

80. On that very narrow point, this claim succeeds.

81. Finally, I should like to thank both counsel for their very considerable help and assistance in the preparation and conduct of this case.

82. As a post-script, I should record that, following the circulation of the Draft Judgment, Mr Samuel raised certain matters upon which he seeks judicial determination and which, currently, do not fall within the ambit of this Judgment. I have some sympathy with his position. It was, however, agreed by both Counsel, at a Hearing on 14 December 2020, that any determination of these matters (if required) should be deferred until the defendants have had an opportunity to investigate further issues relating to causation. In the interim, it was decided that the parties would provide the Court with an agreed position statement by 5th April 2021. If necessary, there will then be a Directions Hearing before me during the week beginning 12th April 2021.