Neutral Citation Number: [2017] EWHC 1894 (QB)

Case No: HQ14CO3775

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 24/07/2017

Before :

MR JUSTICE NICOL

- -

Between :

Pa Abubacarr Jabang	**Claimant**
- and -	
(2) Dr Simon Wadman	**Defendants**
(3) Dr Andrew Pool	
(4) East Sussex NHS Trust	
(5) Dr Yvonne Underhill	

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Mr D. Westcott QC and Mr R. Cartwright (instructed by **Irwin Mitchell**) for the **Claimant**
Mr S. Readhead QC (instructed by **Brachers**) for the **2nd and 5th Defendants**
Ms C. Toogood (instructed by **Clyde**) for the **3rd Defendant**
Mr M. de Navarro QC (instructed by **Capsticks**) for the **4th Defendant**

Hearing dates: 7th - 8th June, 12th - 20th June and 22nd - 23rd June 2017

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Judgment Approved

Mr Justice Nicol :

1. In early September 2011 Pa Jabang, the Claimant, was 35. He came from the Gambia but had lived in England for some years. He had married Nina in 2007. He appeared to be fit and well. He enjoyed sports and he used to go running each day with his dog. He worked for Nina's brother installing air conditioning units into vehicles.

2. One day in early September 2011 he woke with severe pain across his upper back. It is now known that in fact the Claimant was infected with spinal tuberculosis ('spinal TB'). Over the next four months or so, the Claimant consulted a great many doctors. None of them identified spinal TB as the cause of his pain. On 9th January 2012 the Claimant returned to the Gambia. He came back to the UK in May 2012. On that occasion he had to be taken immediately to the hospital. By then the disease had progressed to a point where it could not be effectively treated. The Claimant is now paraplegic and unable to walk or to work.

3. In these proceedings the Claimant alleges that some of the doctors he consulted were negligent because of their failure to take sufficient care to investigate or to identify the cause of his pain. Had they not been negligent, he argues, prompt and appropriate further investigation would have been conducted which, in turn, would have led to the

true diagnosis of the cause of his pain and its timely treatment. He would not in those circumstances, he says, have suffered paraplegia or had to endure the operations which he underwent following his return to England in May 2012.

4. Dr Simon Wadman, the 2nd Defendant, is a general practitioner ('GP') at the Heathfield Practice. The Claimant saw Dr Wadman on 21st September 2011 (no complaint is made about that consultation) and again on 5th October 2011. In due course it will be necessary for me to describe in more detail what occurred. Presently, I am just identifying the parties. The Claimant saw Dr Yvonne Underhill, the 5th Defendant, who is another GP at the Heathfield Practice, on 18th October 2011 and 14th November 2011. At the end of her second consultation with the Claimant, Dr Underhill remained uncertain as to the cause of the Claimant's pain. The Claimant had private health insurance (for a limited amount per diagnosis) and she referred the Claimant to a consultant rheumatologist, Dr Simon Pool, the 3rd Defendant. The Claimant saw Dr Pool on 1st December 2011.

5. As a result of his consultation, Dr Pool ordered some blood tests (additional to ones which had already been arranged by the GPs) and other tests. He arranged a follow up appointment with the Claimant.

6. The Claimant still has family in the Gambia. He visited them between 13th and 27th December 2011.

7. On 5th January 2012 the Claimant's pain was particularly bad. His legs were also very stiff. That evening he and Mrs Jabang went to the Accident and Emergency Department of the Eastbourne Hospital which is run by the 4th Defendant. They saw Dr Nkrumah (for whom the 4th Defendant is vicariously responsible). By this time the follow up appointment with Dr Pool had been fixed for either 10th or 12th January 2012.

8. The Claimant was concerned that his pain appeared to be getting worse yet none of the doctors whom he had seen appeared to be able to identify its cause or propose effective treatment. He says that his family in Gambia had suggested that he may have been placed under a curse by someone who was jealous of the lifestyle they imagined he enjoyed in England and that his family told him this should be addressed by a course of spiritual healing. The Claimant says he began to think that his family might be right. Mrs Jabang respected his wish to go back to Gambia for this purpose. Because the Claimant believed that the longer he postponed the spiritual healing the worse the curse would become, he wanted to return as soon as possible. On 7th January 2012 Mrs Jabang booked a flight for Mr Jabang to go back to the Gambia on 9th January. As a result, the Claimant did not attend the follow-up appointment with Dr Pool on the following day.

9. On 29th December 2015 Master Roberts directed a split trial. Consequently, my task has been to decide whether the Claimant has established negligence in respect of each of the Defendants and, if so, what injury (in physical terms) that caused him. The Defendants each deny that they were negligent and dispute causation. The 2nd and 5th Defendants originally pleaded contributory negligence on the Claimant's part by not going to the second appointment with Dr Pool. However, in his closing submissions Mr Readhead QC on behalf of the 2nd and 5th Defendants, withdrew that plea. However, the 3rd and 4th Defendants argue that, if the Claimant had attended the follow-up appointment a different chain of events would have ensued.

10. When the Claim Form was issued, the 1st Defendant was the NHS Commissioning Board. However, on 26th May 2017 the Claimant gave notice of discontinuance against the 1st Defendant. In those circumstances, it is unnecessary for me to say any more about that claim.

Terminology

11. Some elementary anatomy may be helpful. The meanings I give are not intended to be as precise as doctors might use but, I hope they are sufficient to understand important distinctions made in the course of the evidence. The *spine* is conventionally divided into four parts: *cervical* (not relevant to this case); *thoracic* and *lumbar*. The vertebrae in each part are numbered, starting at the top. The thoracic spine has 12 vertebrae - T1 (nearest the neck) to T12. The lumbar spine has 5 vertebrae (L1 – L5). The point at which the thoracic and lumbar spines meet is called the *thoracolumbar joint.* Below L5 are the coccyx and the sacrum (again not relevant to this case). The thorax or chest has pairs of ribs. One pair of ribs comes from each of the thoracic vertebrae. The *abdomen* is the part of the trunk below the diaphragm.

12. The term *back* is rather more elastic. In the widest sense it may be used to mean the posterior or dorsal aspect of the trunk. In the narrowest sense it refers only to the spinal column. An intermediate meaning seemed to be favoured by most of the witnesses in the case – namely the spine plus a few centimetres either side. That would embrace the series of muscles (*paravertebral muscles*) in that vicinity of the spine and which are closely associated with it. When I use the term 'back' I shall use it in this intermediate sense unless I indicate otherwise. However, I recognise that I must be alert to whether it is used in the same sense by all the witnesses and in all of the contemporary records.

13. When a patient consults a doctor, he or she will complain of particular *symptoms*. The doctor will take a *history* which will be a description of the patient's presenting symptoms and so much of their personal history as is considered relevant. As part of the doctor's *examination* measurements may be taken or further tests commissioned. These observations or *signs* will be considered together with the patient's history and the examination in considering the appropriate *diagnosis.* Sometimes, it is not possible to make a precise diagnosis. In those circumstances various possibilities may be included in a *differential diagnosis.*

14. Pain which is experienced in one part of the body may originate from another part. Such pain is then said to have been *referred.* One means by which pain can be referred is if it is transmitted along nerves or *dermatomes*. Where pain has its origin in the root of a spinal nerve it may be referred to as *radicular pain*.

15. One possible cause of pain is *trauma* when the body is subject to a force such as a fall or a blow. *Mechanical back pain* is pain which is triggered by the movements of the spine (including movements of the ligaments, tendons, muscles, intervertebral bodies and facet joints). *Musculoskeletal pain* is sometimes used as a synonym for mechanical back pain. Mechanical pain usually includes the absence of serious *pathology* (i.e. any deviation from a healthy normal or efficient condition which is attributable to an underlying disease process). Pain may also be due to *inflammation*, the presence of which may be shown by *inflammatory markers* (blood tests for inflammation which include Erythrolyte Sedimentation Rate – 'ESR' and C-reactive protein - 'CRP'). One possible cause of inflammation is infection. Spinal TB is an example of an infection.

Disease is a wider term than infection. Cancer, for instance, is regarded as a disease but is not an infection. Rheumatoid Arthritis is another example of a disease (and a possible source of inflammation) but which is not an infection. *Sarcoid* or *sarcoidosis* is another form of inflammatory condition which is not caused by infection.

16. One of the investigative tools available to doctors is *imaging*. One of the alternative forms of imaging discussed in this case were *x-rays*. Some x-rays involve the use of chemicals injected or ingested which allow for a clearer contrast. X-rays which do not involve that additional technique are referred to as *plain x-rays.* A second form of imaging is a *CT scan.* Both X rays and CT scans involve exposing the patient's body to radiation. The third form of imaging, an *MRI scan,* does not involve such exposure. An MRI is, however, quite expensive. The exact cost depends on the size of the area to be scanned, but the cost of an MRI of the whole spine was in the order of £1,000. There has also been a reference to *ultrasound* which may be regarded as another form of imaging.

17. The term *red flag* did not have a precise definition. It may be described as a symptom which (at least in combination with other symptoms) would prompt a GP to refer a patient to a specialist. In the joint meeting of the respiratory physicians and spinal surgeon, Professor Davies and Professor Barnes thought that the concept of red flags was 'poorly evidenced based' and the spinal surgeon, Mr Sell, said 'red flags need to be multiple, they are not well validated for spinal disorders except for cancer and vertebral fractures in the elderly.' The GP experts, Dr Boyd and Dr Hicks, agreed that red flags are potential pointers to serious pathology. However, it is both the number and the nature of the red flags that will influence the potential diagnoses that should be considered and red flags must always be interpreted in the context of the overall presentation when considering a differential diagnosis and the need for, and nature of, any investigation. There was disagreement as to whether the term had any value for the specialists. Dr Struthers (the rheumatologist called by the Claimant) thought that it did. Dr Rees (the rheumatologist called by the 3rd Defendant) thought that it did not since most of the patients who were referred to him had at least one red flag symptom.

18. It is now necessary for me to revisit the chronology in greater detail. At this stage I shall do so primarily by reference to the notes which were made by the doctors or other medical staff. Of course those notes are not infallible and I shall need to return later to consider where they are disputed. However, the notes do have two advantages. First, they were made either contemporaneously with the events and conditions referred to, or very shortly afterwards. Secondly, they were written before any dispute had arisen. In order for this account to be more coherent, I have expanded the shorthand which was used where that is uncontroversial.

The GPs

The Claimant's first consultation with Dr Wadman: 21st September 2011

19. The Claimant had registered with the Heathfield Practice in 2007. He had seen doctors that year and there was a record of him having visited the Accident and Emergency Department of the Eastbourne General Hospital in 2009 (for a matter which had nothing to do with the present disputes). His visit to the Practice on 21st September 2011 was the first time since 2007. Dr Wadman had not seen him before. In his witness statement

Dr Wadman said that he remembered Mr Jabang fairly well because Mrs Jabang had been his patient for many years.

20. Dr Wadman's notes of this meeting recorded as follows: Mr Jabang was complaining of right sided back/chest pain which had continued for 2 weeks. There had been no trauma. It was worse on bending and breathing. There was no shortness of breath. His temperature and oxygen saturation level were unremarkable. His chest was clear and the right rib cage was tender. Dr Wadman prescribed a pain killer, Co-codamol, and noted that his impression of the problem was that this was musculoskeletal pain.

21. In his witness statement dated 7th November 2013 Dr Wadman says that his usual practice would have been to *palpate* the spine i.e. to press gently but firmly on each of the vertebrae to see if there was any tenderness. He says that if he had found any such tenderness he would have been concerned because this would have been a sign of a spinal lesion and he would have made a note in his records. He invites me to infer from the absence of a note that he did follow his usual practice and found nothing untoward. Mr Westcott QC, on behalf of the Claimant, invites me to infer from the fact that Dr Wadman carried out this procedure that he was investigating a 'back' pain in the intermediate sense which I have previously described.

22. Dr Wadman and Dr Underhill say that the usual time they spend with a patient at a consultation is about 10 minutes and that is the approximate time that each of their consultations with Mr Jabang took.

The Claimant's second consultation with Dr Wadman: 5th October 2011

23. The Claimant found that Co-codamol did not relieve his pain. It also made him feel sick. He went back to see Dr Wadman.

24. Dr Wadman's notes (again with abbreviations expanded) said:

> 'Subjective report: Ongoing right chest / back pain. Worse on movement and inspiration (i.e. breathing in). No cough. No significant shortness of breath. No haemoptysis (i.e. coughing up blood).
>
> Objective report: Afebrile (i.e. normal temperature). Pulse 70 (which was normal). Sr chest clear. Chest wall pain on rib springing (a technique for pressing the front and back of the chest).
>
> Plan: Physiotherapy and Chest X ray.
>
> Blood Pressure recorded as 133/67 mm Hg (which was normal).'

The notes also recorded that Dr Wadman had completed the referral forms for physiotherapy and for an X ray.

25. The physiotherapy referral form described the reason for referral as

> 'Thoracic back pain radiating around chest.'

The form had a tick box questionnaire which asked the referring clinician to say whether the patient had previously had physiotherapy, to give the time for which the patient had

experienced the problem (within particular bands), to state whether the symptoms had kept the patient off work and whether it had kept him awake at night. Dr Wadman left all of these blank.

26. The radiology request form said that the reason for the request and clinical history was,

> 'right sided chest pain – clinically musculoskeletal but persistent.'

27. Dr Wadman again says that he would have followed his usual practice and palpated the spine. Again, he invites me to infer from the absence of any note that he did do this and found no tenderness and nothing remarkable.

The Chest x-ray: 17th October 2011

28. The Claimant visited the Uckfield Hospital on 17th October 2011 where his chest was (plain) x-rayed in accordance with Dr Wadman's request. The result was viewed by a consultant radiologist, Dr Anderson, whose report, was written on 18th October, but not typed until 19th October. The report said,

> 'The heart is normal. The lungs are clear.'

29. The x-ray itself was not sent to the GP surgery, but the report was. The practice's computer record says that the document was scanned on 17th October 2011. However, it seems likely that this was intended as the date on which the x-ray was conducted. It could not have been the date the report was scanned, since the report had not been written by Dr Anderson on 17th October.

Dr Underhill's first consultation: 18th October 2011

30. The Claimant returned to the surgery on 18th October 2011. On this occasion he saw Dr Underhill. It was the first time she had seen the Claimant. Her notes recorded his subjectively reported symptoms as follows:

> 'Still has problems with pain lower ribs front and back, had chest x ray yesterday (i.e. 17th October) no result. No cough. Bowels and urine appear to be OK. No relieving features. Worse at night. Worse bending forward. No alcohol since last year. Smokes tobacco and cannabis sometimes. No other drugs. Last foreign travel Gambia 6 months ago.'

31. On examination Dr Underhill's note recorded that there was:

> 'some discomfort in spine on bending forward, no renal angle tenderness, abdomen ? slight liver tenderness.'

32. Dr Underhill recorded that she prescribed Omeprazole capsules and requested various blood tests.

33. Under the heading 'Plan', she noted that it was difficult to assess. She wanted an ultrasound scan, blood and urine tests and that she would try Omeprazole. There is also a note that she completed a radiology request form. This was a reference to the ultrasound request. She also asked for blood tests including CRP and ESR. She asked for a full blood count, bone profile, liver function test and thyroid function test.

34. A blood sample was taken on 19th October 2011 and the blood tests results were obtained very quickly. The ESR was recorded as 11 mm/h and the laboratory added an exclamation mark. This is standard practice when the result falls outside what would be expected. However, the expert evidence was agreed that while very slightly raised, it was not at a level which should have caused alarm. None of the other blood test results were notable.

The appointment with the physiotherapist, Lynn Thompson: 28th October 2011

35. At some stage in advance of this appointment, a questionnaire was completed. Mr Jabang can neither read nor write. It was not completed by him. Ms Thompson has initialled and dated the form 28th October 2011, but that was when she saw Mr Jabang. It does not help to decide when the questionnaire was completed, except that it must have been some time between 5th October 2011 (when Dr Wadman made the referral) and 28th October 2011 (when the first appointment took place).

36. The questionnaire says that the main problem was 'back pain'. It says the pain had continued for 2 weeks This suggest that the form was completed soon after 5th October, but, even then, there is an inconsistency with the information which Mr Jabang gave to Dr Wadman on 21st September, that the pain had then been ongoing for 2 weeks.

37. The questionnaire said that the pain started when he woke up, the pain was worse, it woke him at night and it did not ease when he altered his position at night. He said he could not get back to sleep.

38. The questionnaire said Mr Jabang had been signed off work for a week.

39. I have been shown a document from Mr Jabang's employer which showed that he had had unpaid leave on 5th, 6th, 7th and 18th October. In his evidence, Mr Jabang said that there were other days which he took as time off in lieu of overtime.

40. The questionnaire continued that there was no movement or position that made the symptoms better; turning made them worse. He had not had any similar problem in the past and he had not had any previous treatment for the problem.

41. The form said that he had not had any x-rays, scans, blood tests or other investigations. Since Mr Jabang did have an X ray on 17th October and did have blood tests on 19th October, it suggests that this part of the form, at least, was completed before 17th October. Of the other questions, the only one that needs to be noted is that Mr Jabang said that there had been no unexplained weight loss.

42. Ms Thompson's consultation with Mr Jabang on 28th October 2011 lasted for about 45 minutes. She completed a further form. This had pre-printed body back and front body plans on which the physiotherapist was expected to mark the sites of reported pain. On the back view, Ms Thompson put a hatched band just above a very small pre-printed 'x' on the plan. Ms Thompson explained that 'x' marked the junction between the lumbar and thoracic spines. Since her shading is all above the 'x' she agreed that it was intended to convey that the pain reported by Mr Jabang was across his posterior or dorsal aspect and in a band across the back of the thorax. Ms Thompson also wrote 'dull pain, intermittent, no pins and needles.

43. On the front facing diagram she has marked two further sites of reported pain. Both are the lowest parts of the thorax or rib cage. The right side is shaded more heavily than the left. Although Ms Thompson has written 'R<L', she confirmed in evidence that she had this the wrong way around and, consistently with the heavier shading, she meant to record that Mr Jabang had said that the pain on the right front of his chest was greater than the pain on the left front of the chest.

44. Under the pre-printed heading 'Aggravates' Ms Thompson wrote 'Cough slight, worse at night'. She also noted that he said he was always stiff and painful waking – '2 -3 hours to settle then OK' and that he told her he woke several times a night. Asked to rate his pain on a scale of 0 – 10 he said it was 6.

45. Ms Thompson also noted that his condition had been present for 4 – 5 weeks. There had been pain on waking. That had continued. He did feel weak. He had not had night sweats. His gait was normal. At this stage he was awaiting the results of blood tests. An ultrasound scan had been done two weeks previously, but there were not, as then, any results (I return below to the timing of the ultrasound).

46. Ms Thompson has noted that the Claimant's occupation was an air conditioning installer and he was at work. His hobbies were running.

47. A further check list marked Mr Jabang as suffering from thoracic pain. At night (which was when Mr Jabang was most concerned about his pain) he scored the pain as 5.

48. In her notes of this consultation with Mr Jabang, Ms Thompson recorded that Mr Jabang was slouched when sitting. He had a good range of movement with the exception of flexion (bending forwards) which was painful and rotation to the right which was painful and restricted. He had a chest expansion of 3 cms (normal, she said, would be about 7 cm). The muscles on the right side of the spine were in spasm. Accessory movements of the facet joint underlying the painful area did not reproduce his pain, nor did natural apophyseal glides of the same area performed lying on his side, but they did slightly increase his movement. This examination was performed on her couch. Mr Jabang was able to get up on to the couch.

49. At the end of this physio session, Ms Thompson gave Mr Jabang a chart showing various exercises. She demonstrated them and he did each of them in front of her. She encouraged him to try to do each of them twice a day.

50. Mr Thompson's diagnosis was '? Ankylosing Spondylitis' and '? non-mechanical'. Her plan was to check the results of the x-ray and blood test results. This was followed by a note that the x-ray had been of the chest only and the ESR was 11 mm. This note is not specifically dated but it would seem that this was also on 28th October 2011. I draw that conclusion because of the note in the physiotherapy progress notes which immediately follows and which records that Ms Thompson spoke to the surgery and left a message for the GP to request a HLAB27 blood test and a 'T/L X ray'. There is also a record by the Heathfield Practice of this call being received from Ms Thompson on 28th October 2011 at 10.18. This said, 'Lynn Thompson phoned from Uckfield Hospital to ask if the patient could be tested for Ankylosing Spondylitis as he has pain at night and he is stiff for 3 hours from waking in the morning. Also can he have a HLA27 check and be referred for a x-ray of the T/L junction.'

51. I should emphasise that the notes and diagrams which Ms Thompson made were not passed to the surgery. Her only communication with the GPs at this time was the message which she left with the receptionist.

52. The message was passed to Dr Wadman the same day. He noted that Mr Jabang had already had blood tests but he arranged an x-ray. He did not speak to Ms Thompson because he did not think her requests required any clarification. The practice's computer system noted those requests by Ms Thompson had been completed at 13.44 on 28th October 2011.

53. In order to commission this X ray, Dr Wadman completed another radiology request form. He specified the request as 'x-ray sacroiliac joints and thoracolumbar junction'. The reason for the request was given as 'Back/lower chest pain morning stiffness ?ankylosing spondylitis.'

54. This x-ray was carried out on 9th November 2011 and the report of the consultant radiologist (again Dr Anderson) was written on 11th November 2011. He reported that the image had been of the lumbar spine and the SI joints. He said, 'There is mild scoliosis concave to the left. The intervertebral disc spaces are preserved, there is no Anterior/Posterior malalignment or evidence of vertebral collapse.'

Dr Underhill's 2nd consultation: 14th November 2011

55. On 14th November 2011 Mr Jabang again saw Dr Underhill. She said that, in advance of the consultation, she would have re-read the medical notes in the GP computer system. On this occasion she has noted his subjective complaint as 'ongoing pain across upper lumbar area and around chest worse at night and morning gets better in day.' Dr Underhill noted that all the blood tests were OK and the chest x-ray was OK. The scan was still awaited. Objectively, she noted that Mr Jabang had stiff flexion but good lateral movement. She prescribed Ibuprofen tablets.

56. Under 'Plan' she wrote, odd… am I missing something? Ask for second opinion from Rheumatology at Eastbourne District General Hospital.'

57. On the same day (14th November 2011) there were two other communications from the Jabangs. At 15.22 Mrs Jabang rang and asked for a sick certificate for her husband. This was requested 'as patient goes to work for a day then has to have four days off as in too much pain. Please can he have a sick certificate for 10 days or two weeks. Patient is a refridgeration [sic] engineer and has trouble lifting these.'

58. The second message was specifically for Dr Underhill and said that Mr Jabang had private medical insurance with Benenden. The insurer had agreed for him to be referred anywhere and the request was to know where and to whom he would be referred.

59. Dr Underhill marked on the 16th November 2011 that the sick certificate had been done and that he was to be referred to Dr Pool at Eastbourne Hospital. There must have been a short delay for the letter to be typed because the letter to Benenden is dated 17th November 2011.

60. Benenden must have given its approval shortly after that since the letter of referral to Dr Pool was dated 24th November 2011. It was in exactly the same terms as the earlier letter to the insurer. It said,

> 'Reason for referral: upper lumbar spine and chest pain
>
> I would be most grateful for your help with this 36 year old gentleman of Afro-Caribbean abstraction who is causing me somewhat of a diagnostic puzzle. He presents with a medium length history of pain across his upper lumbar area and around the chest which is worse at night in bed and in the morning but gets better during the day. On examination his lumbar spine is fairly stiff but there is good lateral movement. He denies any abdominal symptoms although the pain can be relieved by bending forwards at times.
>
> I have done loads of blood tests and a chest x ray and I enclose copies of these. I am at a slight loss to explain his symptoms but they do seem to be musculoskeletal and positional and I would be most grateful for your second opinion on whether something odd is going on with this gentleman and how we could treat him.'

Claimant's contacts with the Out of Hours Service: 24th November 2011

61. The Heathfield Practice had an arrangement for patients who needed help out of hours to call a dedicated service. At 20.22 on 24th November 2011 Mrs Jabang called and, according to the note made at the time, described Mr Jabang's problem as 'back pain goes to his abdomen – undergoing tests and awaiting scan results – in more pain tonight – taken medication given by GP'.

62. That initial call was followed by a telephone triage with James Thallman at 20.54 with Mrs Jabang who said (again according to the note made at the time) that Mr Jabang,

> 'had steadily increasing pain in abdomen for about 6 weeks, says it began in back and radiates to ribs. Is constant. Worse in mornings, appears to come from back. Had scan Tuesday at Uckfield [Hospital]. Was an ultrasound scan of the upper abdomen. Has had 2 x-rays both OK. Worse when lying down. Rheumatology reference done 1 week ago. Was tried on omeprazole with no effect. Is from Gambia last time visited in February. Given Ibuprofen 400 tds and cocadamol (codeine makes him feel awful). Allergies none. Appetite OK no nausea or vomiting, bowels OK, no change, no dydspepsia. Poor pain control, wife concerned, would like to be seen for advice.'

63. Mrs Jabang was asked to take her husband to the Out of Hours service at Uckfield Hospital which she did.

64. At 22.13 Mr Jabang was seen by Dr Livia Morvay who recorded,

> 'Fit looking normal-weight young African man with slightly distended looking abdomen, complained of being too tired to exercise which he would normally love doing. Pain is not too severe at the moment (has taken ibuprofen) gets worse overnight and can barely move in the mornings.'

65. Dr Morvay recorded normal temperature, oxygen saturation level, heart rate and blood pressure. He had scans, blood tests and urine culture, chest clear Heart sounds, nothing abnormal detected.

> 'Pain in upper abdomen and around back but not localised. Spine non-tender, no localised tenderness or guarding anywhere in abdomen but bowel sounds exaggerated even though no flatulence or diarrhoea.'

66. Under diagnosis Dr Morvay wrote '?? Hookworm'. She prescribed Mebendazole 100 mg twice daily for 3 days and suggested that he see his GP for follow up.

67. The report from the Out of Hours service was received by the Heathfield Practice and scanned into its computer system.

Consultation with Dr Donnelly: 29th November 2011

68. Mr Jabang did go back to the Heathfield Practice on 29th November 2011. On this occasion he saw Dr Elaine Donnelly. She identified his problem as 'thoracic back pain'. She recorded,

> 'ongoing past 3 months had one session of physio- and exercise program felt no benefit taking Ibuprofen - no significant cough'.

The objective signs were decreased flexion and lateral flexion and spasm paravertebral region T8-T12. The plan was for a further physio and seeing Dr Pool that Thursday. A certificate for one month would be given referring to his pain.

69. On 29th November 2011 Dr Donnelly completed another physiotherapy referral form. This gave the reason for referral as 'thoracic back pain for 3 months Decreased flexion of the spine and lateral flexion referred to rheumatology'. This also recorded that these symptoms kept the patient off work and kept him awake at night.

Consultation with Dr Pool: 1st December 2011

70. Dr Pool saw Mr Jabang in his private clinic at the Esperance Hospital, Eastbourne on 1st December 2011. He made handwritten notes during the consultation. He dated these '1/12/13' but in his evidence he accepted that this was an error since the consultation had been in 2011 not 2013. His notes said,

> 'upper back and rib
>
> 6 weeks
>
> Not sleeping because of it
>
> Worse morning
>
> Feels well generally
>
> Weight stable
>
> Skin Ra

> Shortness of breath on exertion
>
> Painful to breathe in/out
>
> Eye no [dry eye condition]
>
> Early morning stiffness for 2 hours
>
> Waking from sleep
>
> Previous medical history: shingles
>
> Drugs: nil
>
> Family History/Social history: air condition, smoke 2/daily, Gambia, February, no alcohol, no children'

71. On examination, Dr Pool's notes say that Mr Jabang was fit and well. He had pain on minimal movement and he referred to his letter to Dr Underhill (see below).

72. Dr Pool did not have the x-rays themselves but he did have the two radiology reports by Dr Anderson. He noted that these were reported as normal.

73. Dr Pool had the results of the blood tests which Dr Underhill had ordered. He noted that the CRP was 3 and the ESR was 11 and he observed in his notes that these were both normal.

74. Under the heading Impression, Dr Pool noted,

> 'Inflammatory cause?
>
> Night pain
>
> Progressive in nature
>
> Repeat bloods include ACE, B27
>
> MRI/CT next
>
> Lung function test (Shortness of breath on exertion).'

75. In his letter of the same date to Dr Underhill, Dr Pool wrote as follows:

> 'Thank you for referring this 36 year old gentleman with a 6 week history of musculoskeletal pain primarily affecting his upper lumbar region, ribs and thoracic spine. He is not sleeping because of pain. It is much worse first thing in the morning. He feels generally well but increasingly tired. He has lost his appetite. He has not been able to work for the past month. The early morning stiffness lasts at least 2 hours. On exertion he feels mildly short of breath which would be unusual as he was extremely fit before. He reports no significant skin rash. There is no history of ocular problems. He may have lost some weight.

> His past history is completely free except for an episode of shingles. He originates from the Gambia but the last time he visited was in February. He smokes 1 – 2 cigarettes per day. He works supplying air conditioners to vehicles.
>
> There is no definite family history of rheumatic conditions, but his sister suffered from something similar. Because she lives in the Gambia no formal diagnosis was offered; he will do his best to find out what it was.
>
> On examination he looked fit and well but in obvious pain on minimal movement. His posture was very stiff, particularly in his upper torso and lumbar spine. Chest expansion was limited to 3 – 4 cm. Lumbar flexion was limited with a Schrober's distraction of 5 cm. Lateral flexion and extension of the lumbar spine were both significantly impaired. Chest exam was clear.
>
> I note all the investigations including abdominal ultrasound and chest x-ray, lumbar spine and sacroiliac joints were unremarkable. The ESR was 11. The CRP was 3. The only low finding was a low neutrophil count which is not uncommon in Afro-Caribbeans.
>
> In my opinion he has a good history for inflammatory back/chest wall pain. I have arranged for a B27. I have also repeated the inflammatory markers as the first were taken just after the onset of his condition. Sarcoid is much more common in Africans and can indeed present with this type of musculoskeletal chest pain. I have therefore requested a serum ACE level. Lung function tests will also be arranged, given his recent breathlessness on exertion.
>
> I will see him again in due course with the results. For the time being, I have prescribed a regular anti-inflammatory in the form of Naproxen 500mg twice a day.'

76. Mrs Jabang says that some blood was taken from her husband for testing immediately after the appointment with Dr Pool.

77. Mr Jabang went back to the Esperance Hospital to provide a further sample of blood for the further blood tests which Dr Pool had requested. Mrs Jabang says that this happened on 12th December 2011. As I have said, Mr Jabang left to spend Christmas with his family in the Gambia on 13th December 2011.

78. Dr Pool said that he would have received the first batch of blood test results before Christmas. They showed an ESR of 37 and a CRP of 13. Dr Pool says that these were mildly increased from normal levels. However, the tests were non-specific and only confirmed what he had previously suspected that there was some inflammation present. And that was to be expected in view of Mr Jabang's musculoskeletal pain. The ESR was higher than it had been in November and the CRP was only minimally elevated. Dr Pool did not consider these results to be alarming, particularly in the context of the normal scans and x-rays which had previously been performed by the GP and, for that reason, he did not write again to Dr Underhill.

79. The follow up appointment to which Dr Pool's letter referred was also arranged. Originally this was to be on 12th January 2012, but this was later changed to 10th January

2012. It is not entirely clear when the change was made. The letter confirming the new date was sent on 7th January 2012 but there may have been an earlier conversation.

The second physio session: 9th December 2011

80. As a result of Dr Donnelly's referral Mr Jabang went back to see Lynn Thompson on 9th December 2011.

81. Another questionnaire was completed in advance of, this visit. This has a date stamp from the physiotherapy department of 5th or 6th December 2011. This questionnaire described his problem as back/rib pain (chronic) and which had lasted for 2 months. It said he had suddenly woken one morning with severe back / rib pain. The pain was worse, it woke him at night, it did not ease when he changed position, he could not get back to sleep and he had been signed off work for 6 weeks. He was in constant pain which was worse in bed and when he got up in the morning. He had not had a similar problem in the past. He had had a previous physio referral and a referral to Uckfield Hospital. This had not helped. His aim was for the pain to go and for him to return to work and his normal active life.

82. In her notes of the session Ms Thompson recorded that Mr Jabang's rotation was 30 degrees both to the right and to the left. She noted that Mr Jabang was doing the exercises which she had set him on the first visit. He was doing them once a day. In evidence she said that he had been able to do all of them. She recorded that Mr Jabang was due to see the consultant again for further tests. When the results were obtained he would phone and fix a further physio appointment if appropriate.

83. This was the last occasion that Mr Jabang saw Ms Thompson. She discharged him and wrote a report on 30th January 2012. She noted that he had been seen for 'thoracic/lumbar spine'. He had not contacted her since the visit on 9th December 2011 and hence he was being discharged.

Travel Insurance

84. On 23rd November 2011 Mrs Jabang updated the travel insurance for herself and her husband. She reported that he was awaiting treatment for his back pain. She said that he could sit comfortably for the duration of his journey without requiring strong pain killers or special seating. In evidence she said that the travel time to the Gambia was about 6 hours. She said that he did not regularly take a morphine based or other strong pain relief and he was undergoing medical review for his condition. On 24th November 2011 the insurer confirmed that his travel insurance would include cover for his back pain.

Mr Jabang's visit to the Accident and Emergency Department of Eastbourne Hospital: 5th January 2012

85. It was 19.34 when Mr Jabang with his wife visited the A and E Department of Eastbourne Hospital on 5th January 2012. The receptionist began to complete a form which said that his complaint was

> 'Problems with walking (ongoing). Problem with back'.

86. The triage nurse described his presenting history as

> 'ongoing lower back pain and stiffness in legs. Spontaneous onset, no history of injury. Complains of increased pain. No incontinence.'

It was noted that he was taking 500 mg of Naproxen twice a day. His pain score was 8 out of 10.

87. He was offered codeine (in the form of Cocodamol) for his pain, but he declined to take it. It will be recalled that Mr Jabang had previously been given this drug but it had made him sick. At 20.41 he did, however, take paracetamol.

88. Mr Jabang saw Dr Nkrumah at 22.03.

89. Dr Nkrumah says that since October 2010 he had been a specialty doctor in Accident and Emergency Medicine at Eastbourne Hospital. Dr Cambell-Hewson described him as a middle grade doctor, 3 months short of being the equivalent of a Specialist Registrar.

90. There is a dispute between Dr Nkrumah and the Jabangs as to how Mr Jabang got from the waiting room to the cubicle where Dr Nkrumah examined him. Both agree that he walked (as opposed to being carried on a stretcher or wheeled in a wheelchair). However, Mr Jabang says that his legs were weak. For this reason and because of the pain they say he had borrowed a walking stick from his father-in-law and was reliant on that and on Mrs Jabang's assistance. I will return to this issue when I consider the claim against Dr Nkrumah.

91. Dr Nkrumah's note of his meeting with Mr Jabang reads as follows,

> 'Presenting complaint: 36 year old male with back pains and aches in the lower legs.
>
> History of Presenting Complaint: Patient is undergoing investigations for back pains, now having increased pains in the upper back and the legs. Pains worse today. Moving bowels normally. Feels legs are weak.
>
> PMH see notes. Medicine: Naproxen.
>
> On examination: walked into the cubicle. Pains settled at the moment with Co-codamol. No bone tenderness on palpating the thoracic and lumbar spine. Paravertebral pains in the muscles. Full power in the legs. No paraesthesia in the legs.
>
> Diagnosis: musculoskeletal pains. Reviewed X rays done previously. No compression fractures. Left scoliosis in the thoracic vertebrae. Ultrasound also previously showed no internal organ pathology.
>
> Plan: prescribed diazepam 2 mgs for 5 days. GP review.'

92. Dr Nkrumah says that, during his examination of Mr Jabang, he learned that some x-rays had been previously done. As can be seen, there were in fact two sets of previous x-rays. It is apparent that Dr Nkrumah is referring to the second set, i.e. those taken in

November 2011. He says that he invited both Mr and Mrs Jabang to look at the x-ray with him. Mr and Mrs Jabang say that Mr Jabang did not move but Mrs Jabang did go over to see the x-ray. She says that Dr Nkrumah pointed to an area at the top of the x-ray and asked whether Mr Jabang had ever sustained an injury to T9. 'T9' is a reference to the 9th thoracic vertebrae. Dr Nkrumah says he would never have used an expression like that to a patient to whom it would have meant nothing. Mrs Jabang was firm in her recollection that it had been used. It did indeed mean nothing to her at the time, but on her return she googled the expression and she saw that it did refer to the area where Mr Jabang was experiencing pain.

93. A letter was then signed by Dr Nkrumah to the Heathfield Practice which noted that Mr Jabang had been seen. The diagnosis was 'Muscle/tendon injury back/buttocks not applicable'. There was no investigation required. He was treated with analgesia / anti-inflammatory. The outcome was that he was discharged with no review.

94. While I will discuss the parties' submissions about these notes in due course, some immediate comments can be made:

    i) The reference to 'see notes' seems to be to the presenting history recorded by the triage nurse.

    ii) Dr Nkrumah accepted that he had made a mistake in saying that Mr Jabang's pain had settled with co-codamol. It is apparent from the other notes that Mr Jabang had declined this drug. Dr Nkrumah said he should have written 'with paracetamol'.

    iii) Dr Nkrumah said that he prescribed Diazepam for only 5 days because he was aware that Mr Jabang had an appointment to see the rheumatologist again after that period. Mrs Jabang agrees that she told Dr Nkrumah that Mr Jabang had an appointment on 10th January.

    iv) The diazepam was in fact dispensed at 23.05.

    v) It would appear therefore that Mr Jabang saw Dr Nkrumah over a period of about an hour, although they may not have been together throughout that time.

Cancellation of follow-up appointment with Dr Pool

95. As I have mentioned, on 7th January 2012 Mrs Jabang booked a flight for Mr Jabang to go to the Gambia on 9th January. She gave evidence that, at that time of year there were many flights between the UK and the Gambia. Mr Jabang left the UK on 9th January 2012.. The same day, Mrs Jabang rang the Esperance Hospital to cancel Mr Jabang's appointment with Dr Pool on 10th January.

96. On 25th January 2012 an appointment was made for Mr Jabang to attend the Respiratory Function Department at Eastbourne Hospital on 6th February 2012. I assume that this was intended to be for the lung function test which Dr Pool had proposed at the consultation on 1st December 2011. However, by 25th January 2012 Mr Jabang had already left the UK for Gambia.

On return from Gambia in May 2012

97. Mrs Jabang came back to England with her husband on 30th May 2012. She said in her witness statement that he had to be carried off the plane in a wheelchair. He was taken straight from the airport to hospital. The clinical notes from the emergency department record the arrival time as 04.57 and that Mr Jabang had gone to the Gambia in January 2012 'due to brother's illness'.

98. In his evidence, Mr Jabang said that it was correct that his brother had been ill, with malaria. He had found out about his brother's illness shortly after his own return to the UK in late December 2011. The brother's illness, though had not been why he had gone to the Gambia in January 2012. Mrs Jabang said it was she who gave this information to the hospital in May 2012. She agreed that the real reason Mr Jabang had gone to the Gambia in January was for spiritual healing. Mrs Jabang said that she did not give this as the reason for his journey 'because the doctor would have thought me completely nuts.'

The witnesses

99. I heard oral evidence from Mr and Mrs Jabang on the Claimant's behalf. Dr Wadman and Dr Underhill were called on their own behalf as was Ms Thompson. Dr Pool was called on his own behalf. Dr Nkrumah was called on behalf of the 4th Defendant.

100. I heard expert evidence as follows;

i) On General Practice from Dr Thomas Boyd called on behalf of the Claimant and from Dr Steve Hicks called on behalf of the 2nd and 5th Defendants.

ii) On rheumatology from Dr George Struthers called on behalf of the Claimant and Dr Richard Rees called on behalf of the 3rd Defendant.

iii) On Accident and Emergency medicine from Ms Peta Longstaff called on behalf of the Claimant and from Dr Campbell-Hewson called on behalf of the 4th Defendant.

101. Reports from a number of other experts had been obtained and put before the Court. However, because a substantial area of agreement relating to causation was reached between the parties, it was not necessary for them to be called and I have set aside those reports. One qualification to that last comment is that, by agreement, the answers given at a joint meeting of the respiratory pysicians, spinal surgeon and microbiologists to questions 1 -11 and certain passages of the report of Dr Andrew Molyneux, consultant neuroradiologist, dated August 2016 were admitted in evidence.

The law

102. At the start of the trial, the parties accurately predicted that the law was not going to be controversial.

103. There is no dispute that each of Dr Wadman, Dr Underhill, Dr Pool and Dr Nkrumah owed Mr Jabang a duty of care.

104. The duty was to apply the skill and care of a reasonably competent doctor of the nature and level of the doctor in question. Thus, in the case of Dr Wadman and Dr Underhill, that was of a reasonably competent GP, in the case of Dr Pool, that of a reasonably

competent consultant rheumatologist and, in the case of Dr Nkrumah, that of a reasonably competent middle grade Accident and Emergency doctor.

105. Furthermore, it will not be enough for the Claimant to show that there was a body of professional opinion which would have considered the defendant's conduct to be unreasonable, if there was another body of opinion which would have supported his or her conduct as reasonable. The body of professional opinion supportive of the doctor's behaviour as reasonable must be capable of withstanding logical analysis, but it will be a rare case where that is not so.

106. These well known principles derive from *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 and *Bolitho v City and Hackney Health Authority* [1998] AC 232.

107. The present case concerns omissions by each Defendant which are said to have been negligent. As Mr Westcott QC put it in his closing submissions on behalf of the Claimant, the Claimant's case is not that inappropriate things were done, but that additional things should also have been done. However, the same principles apply. In effect, what I have to consider, therefore, is whether a reasonably competent doctor of the type that I am considering *had to* take the omitted step.

108. The events with which I am concerned occurred in late 2011 and early 2012. It is, of course, the standards which could have been expected then which I must apply. With that in mind, the textbooks and literature to which I have been referred date from that period and not later.

109. Spinal TB is not a common condition. The 2013 report by Public Health England gives the incidence of all TB (and so not just spinal TB) as 13.9 per 100,000 for the general population. There is a considerable discrepancy between its incidence in the UK-born population (i.e. 4.1 per 100,000) and the black-African population (i.e. 178 per 100,000). Of these cases, the numbers which involve *spinal TB* are smaller still. It is estimated that, of all cases of TB, about 4.5% are spinal TB. A study in Bradford over 6 years found that, of a total of 729 cases of TB only 12 (or 1.6%) were thoracic or thoracic/lumbar – see Talbot and others *Musculoskeletal TB in Bradford: a 6 Year Review* (2007) 89 Annals of Royal College of Surgeons England 405, 406. Dr Struthers, the Claimant's rheumatology expert had seen only 2 cases of spinal TB in the course of his whole career.

110. It may well be that, because of the rarity of spinal TB, many GPs will never come across an example of it. In the memorandum of the meeting between Dr Boyd and Dr Hicks, this is included,

> 'Dr Hicks says that in considering a differential diagnosis a practitioner will be dependent on their own knowledge and experience of clinical conditions and the incidence of those conditions.'

111. I am not dealing with a situation where a doctor *did* have personal experience of unusual conditions and I do not therefore have to consider whether, in such situations, a doctor may be required to bring to bear the experience he or she has actually acquired (and where there may be a difference between the duties owed in contract and tort – see *FB v Princess Alexandra Hospital NHS Trust* [2017] EWCA Civ 334 at [62] and [63]).

Setting that type of situation aside, though, the test which the law applies is an objective one and the objective standard is not dependent on the knowledge and experience which the particular defendant has actually acquired.

The claim against Dr Wadman: 5th October 2011

112. As I have explained above, 5th October 2011 was the second occasion when Dr Wadman saw Mr Jabang. There is no complaint about the first consultation on 21st September 2011. There is a second part to the complaint against Dr Wadman which relates to the manner in which he responded to Ms Thompson's request for an x-ray on 28th October 2011. It is convenient to postpone consideration of this second part.

113. As to 5th October, the Claimant has emphasised that it is not his case that Dr Wadman should have diagnosed that he had spinal TB. It is his case that Dr Wadman should have referred him for an x-ray or MRI of his thoracic spine following that consultation. Had that occurred, then the parties are agreed that the x-ray or MRI would have shown sufficient evidence of abnormality to warrant further investigation and the diagnosis of spinal TB would have been made promptly.

114. Central to the claim is what a reasonably competent GP in Dr Wadman's position should have understood Mr Jabang's complaint to have been.

115. In his notes Dr Wadman wrote that the pain of which Mr Jabang complained was 'ongoing' which means that, although no complaint is made about the first consultation with Dr Wadman, it is necessary to go back to consider what was said by Mr Jabang on that occasion as well.

116. In his oral evidence, Mr Jabang demonstrated where he had said his pain was. He put his hand behind his back and reached as far up his back as he could. He then drew his hand round to the front of the right side of his chest. In effect, he said that the pain had always been there and that was how he had demonstrated its location whenever he was asked.

117. By the time of the trial, the events being described were over 5 ½ years previously. It is inevitable that recollections over that distance in time will not always be accurate. In addition, Mr Jabang saw many doctors and other health professionals and it will not always have been easy to separate out what was said on any particular occasion. Mr Readhead QC for the 2nd and 5th Defendants (Dr Wadman and Dr Underhill) said that Mr Jabang's honesty and sincerity were not in issue, but it was not accepted that his recollections were reliable. In his written closing submissions, Mr Westcott said that it was inevitable that the Court would exercise some caution in assessing the evidence provided by Pa and Nina Jabang and he accepted that there were indications that they did not have a completely reliable recollection of events. That was a realistic view. There were numerous occasions when Mr and/or Mrs Jabang denied providing certain information that had been recorded in the notes and which could only have come from either or both of them. The following are only examples:

    i) Mr Jabang denied that Dr Wadman on 5th October 2011 had put his hands on Mr Jabang's ribs and pushed them. Yet the medical notes of that date said there was pain on rib springing. Mr Jabang denied that Dr Wadman had taken his pulse, yet the records include a reading for the pulse. He denied that Dr

Underhill had collected him from the Practice's waiting room when he saw her, yet her evidence (which I accept) is that she did not know how to use the electronic system for automatically summoning patients to their consultation. He denied that there had been any conversation with Dr Pool about his sister suffering something similar, yet the reference in Dr Pool's letter to Mr Jabang's sister having had a similar complaint could only have come from the Jabangs. He denied that he told Ms Thompson when he saw her for the second time on 9th December 2011 that he had been able to do the exercises which she had set once a day. Yet her notes record that that is what he said to her and I accept that this must have been because that is what he did say. He denied that Dr Nkrumah had examined him on a couch or trolley. Yet, Dr Nkrumah has recorded that he palpated Mr Jabang's spine and, while it would not be impossible to do that while the patient was sitting in a chair, it would be highly unusual and I accept Dr Nkrumah's evidence that this unusual method of examination was not used on 5th January 2012.

ii) Mrs Jabang did not attend all the meetings with doctors, but she did contact the Out of Hours Service on 24th November 2011 and she did go with Mr Jabang when he saw Dr Morvay that day. In her evidence she at first denied that she had said that her husband's pain was in the abdomen, but she then accepted that this information in Mr Thallon's note must have come from her. She also said at first that she had said the pain had been going on for 3 months, but when confronted with Mr Thallon's note she accepted that the information that it had continued for 6 weeks must also have come from her. She went with Mr Jabang to see Dr Pool. In her witness statement she said that Dr Pool had been told that the pain had begun in September 2011, but in her oral evidence she agreed that he may have been told that it had been ongoing for 6 weeks (as his handwritten notes record).

118. Accordingly, I will treat the evidence of Mr and Mrs Jabang with caution where it conflicts with the accounts noted in the contemporary records.

119. Dr. Wadman said he had a clear recollection of how Mr Jabang demonstrated the location of his pain. Mr Jabang had placed his left hand on the right front of his chest over the lower ribs and had drawn that hand to the right half of his back. Dr Wadman said that Mr Jabang had not demonstrated the pain to be in or near his spine. The first difficulty with that evidence is that it does not accord with what Dr Wadman wrote in his medical notes on 21st September 2011, namely 'right-sided *back* / chest pain'. Nor did it accord with what Dr Wadman had written in his notes for the 5th October consultation, namely, 'ongoing chest / *back* pain…' [my emphasis].

120. More critically, and of particular importance, Dr Wadman's evidence did not accord with what he wrote on 5th October 2011 on the physiotherapy referral form as the reason for referral, namely, 'thoracic back pain radiating around chest'. I agree with Mr Westcott that Dr Wadman can only have written those words because they properly reflected his findings as a result of the 5th October consultation.

121. I recognise that Dr Wadman gave a different reason for requesting a chest x-ray, namely 'right-sided chest pain – clinically musculoskeletal'. He said that his reason for using different wording in the two referral forms was that he tailored the request to the needs of the professional concerned and, if he used to the physiotherapist the wording he had

given the radiologist, she might have thought that he had not excluded other pathology in the right side of the chest. This explanation is puzzling: Dr Hicks did not think there would have been any difficulty for a physiotherapist understanding the wording which Dr Wadman used on the radiology request form. However, that does not really meet the point which is being made. The significance of the physiotherapy referral form is that it showed Dr Wadman had identified that Mr Jabang was suffering from thoracic back pain radiating around his chest.

122. Mr Readhead's primary submission on behalf of Dr Wadman was that the doctor did not believe had had found any thoracic spinal pathology. He argued that anything indicative of a potential spinal pathology would have been an important finding which Dr Wadman was likely to have included in his notes. There was no reason not to do so. It would also have been a simple matter to ask for an x-ray of Mr Jabang's thoracic spine as well as of his chest.

123. I agree that the omission of Dr Wadman to include in his medical notes the finding that is reflected in the physiotherapy referral form is also puzzling. I agree as well that an additional x-ray could have easily been requested. However, neither of Mr Readhead's points can overcome the fundamental argument in the Claimant's favour: Dr Wadman can only have written what he did on the physiotherapy referral form because he had decided that Mr Jabang did have thoracic pain radiating around his chest. I find that was indeed the case.

124. No doubt that finding was relevant to the physiotherapist. The Claimant's point is that the same finding should have prompted Dr Wadman to commission an x-ray of Mr Jabang's thoracic spine.

125. I have reached my conclusion as to the nature of Dr Wadman's findings on 5th October 2011 without reference to Ms Thompson's diagram. It is clear that the dorsal diagram marked a band of pain above the thoracolumbar joint. It was, in other words, marking thoracic rather than lumbar pain. She marked as well that Mr Jabang was suffering pain in his front chest. That was partially consistent with the term which Dr Wadman had used of 'radiating pain', although that expression is sometimes confined to pain which forms a complete band, and, in Ms Thompson's diagram, there was a gap in the front. Broadly, then Ms Thompson's diagram supports Dr Wadman's description in the physiotherapy referral form. I have, though, reached my view independently of her evidence. She saw Mr Jabang on 28th October and so more than 3 weeks after Dr Wadman's second consultation. There was evidence that symptoms of spinal TB develop over time. I heard no evidence as to whether they could change over a period of 3 weeks, but, out of an abundance of caution, I have thought it safer not to rely on Ms Thompson's records in the present context.

126. Mr Westcott submitted that when Dr Wadman found that Mr Jabang had thoracic back pain radiating around his chest, whatever else he did, he should have asked for an x-ray of Mr Jabang's thoracic spine. That was because pain in the thoracic back was itself a red flag for GPs and the fact that the pain was radiating around the chest was also significant since this suggested that the pain was travelling alone nerves which originated in the spine.

127. In his evidence, Dr Wadman accepted that if Mr Jabang had complained of central spinal pain radiating around his chest he would have referred him for investigation of the spine and that was because he might have a serious pathology there.

128. Mr Readhead's secondary submission is that, even if Dr Wadman had found thoracic back pain radiating around Mr Jabang's chest, that did not mandate the commissioning of an x-ray of his thoracic spine. Mr Readhead argues that there were other, positive, features of the case which meant that this course was not necessarily required. He referred to the following:

    i) Dr Wadman said that he had palpated Mr Jabang's spine and found no tenderness. That was not mentioned in his medical notes, but it is his usual practice when examining the back. Mr Westcott does not dispute that palpation took place. On the contrary, he relies on Dr Wadman adopting this course in support of his case that Dr Wadman was investigating thoracic back pain and he was looking to see if there was localised spinal tenderness because, when Dr Wadman used the term 'back pain' in his medical notes, he was using the expression in the intermediate sense which I have described above. I agree that Dr Wadman probably did palpate Mr Jabang's spine. I agree that, if he did find tenderness he would have recorded that and, accordingly, I should infer from the absence of the note that he found none. In Dr Hicks' view that downgraded the level of suspicion.

    ii) Mr Jabang's temperature and pulse were normal. He did not report any night sweats or unexplained weight loss.

    iii) Mr Readhead submitted that it was also reassuring that Mr Jabang remained at work. While it is right that records show that the first day of sick leave taken by Mr Jabang was 5th October itself, it is also notable that Dr Wadman had left blank the question on the physiotherapy referral form which asked whether the symptoms kept the patient off work. In his oral evidence, Dr Wadman said that he could not be sure whether he asked Mr Jabang if the pain had kept him off work. If Dr Wadman did not elicit this information, it would not be a factor to take into account in deciding whether a thoracic spine x-ray was a mandatory investigation.

129. Not only did Dr Wadman not elicit the information about Mr Jabang's work, he failed to discover other information which would have added to his concern. The physiotherapy referral form prompted the doctor to find out if the pain kept the patient awake at night. He did not do so. The first questionnaire which Mr Jabang completed for the physiotherapists said that the pain did keep him awake at night and, although the date or dates when the questionnaire is not quite clear, Mrs Jabang said that it had been a feature of Mr Jabang's pain that it did keep him awake at nights. Dr Wadman agreed that if he had obtained this information it would have been another concerning feature.

130. I have received the reports of Dr Boyd, Dr Hicks and the report of their joint meeting. The two doctors also both gave oral evidence. The difficulty for them, as they acknowledged, was that the nature of what was reported to and observed by Dr Wadman on 5th October was disputed. They could therefore only offer contingent opinions dependent on the findings of fact which I would have to make. In Dr Hicks' view it was

reasonable for Dr Wadman to request a chest x-ray since some at least of Mr Jabang's symptoms suggested a problem in his chest. However, the issue for me, as I have already said, is not whether what Dr Wadman did was appropriate but whether a responsible body of professional opinion would support him not doing what he did not do. I understood Dr Hicks to agree that, if Mr Jabang had complained of thoracic back pain radiating around his chest then any reasonable GP would refer for an x-ray of the thoracic spine. That would also fit with Dr Wadman's own view.

131. I recognise that the absence of local tenderness of the spine on palpation was of some comfort (as were the matters in paragraph 128(ii) above). It downgraded the level of suspicion in Dr Hicks' words, but, as he also said, it did not eliminate the concern. The literature to which Ms Toogood, who appeared for the 3rd Defendant, took me emphasised that the pain caused by spinal TB can be vague at first and then later become more localised. As Dr Wadman said, the reason for considering an x-ray of the thoracic spine was because thoracic back pain radiating around the chest could be a sign of serious pathology, whose elimination ought not to be delayed.

132. Accordingly, I find that there was a breach of duty by Dr Wadman on 5th October 2011 since, having identified thoracic back pain radiating around Mr Jabang's chest, he did not refer Mr Jabang for an x-ray of his thoracic spine.

133. The chest x-ray which Dr Wadman did request on 5th October was carried out on 17th October and reported on by Dr Anderson on 19th October 2011. No one has suggested that an x-ray of Mr Jabang's spine would have taken any longer.

134. The causation agreement records that if I find that on 5th October 2011 Dr Wadman was in breach of duty and that with appropriate care by Dr Wadman an x-ray of the thoracic spine would have been achieved within around 14 days, then it is agreed that anti-tubercular treatment would have been commenced well before the end of November 2011 and the Claimant would have avoided paraplegia and instead would have made a full recovery to the state of health he was in prior to the emergence of symptoms related to his spinal TB save perhaps for minor residual back pain and damages should be assessed on that basis.

The Claim against Dr Wadman: 28th October 2011

135. Having reached the conclusion which I have done regarding 5th October, it is not strictly necessary for me to address the further complaint against Dr Wadman concerning 28th October, but the matter was fully argued and I will give my views.

136. Dr Wadman did not see Mr Jabang on 28th October. What he did do on that date was to receive Ms Thompson's telephone message and to refer Mr Jabang for a second x-ray.

137. The pleaded allegation against him is, in substance in two parts: (a) that he misunderstood Ms Thompson's request; and (b) in view of his own findings and those of Dr Underhill, as recorded in the medical notes, he should have spoken with Ms Thompson, exercised his own judgment as to what further imaging was required and requested an x-ray of Mr Jabang's thoracic spine in place of, or in addition to, an x-ray of the area in which Ms Thompson was interested.

138. There was no misunderstanding of Ms Thompson's request. Her clinical note refers to a 'T/L xray'. As I have said above, this request was recorded by the receptionist of the Heathfield Practice as a request for 'Xray of the T/L junction'. The Claimant's solicitors asked Ms Thompson whether this was a correct interpretation of her request. In her answers of 19th May 2016, Ms Thompson said that it was. She had wanted an x-ray of the thoracolumbar junction. As I have already noted, on 28th October 2011 Dr Wadman completed a radiology request form which said that the examination requested was 'x-ray of sacroiliac joints and the thoracolumbar junction'.

139. As for the second argument, it becomes difficult for me to factor out my conclusion that, as of 5th October, Dr Wadman should have commissioned an x-ray of Mr Jabang's thoracic spine. I do not, however, accept that this view is reinforced by what had happened subsequently, or that the intervening events of which Dr Wadman was, or should have been aware, added to the reasons why it was mandatory for him on 28th October to ask for an x-ray of Mr Jabang's thoracic spine;

    i) Dr Wadman did not simply acquiesce in Ms Thompson's request. By asking for the x-ray to cover Mr Jabang's sacroiliac joints, he added to it. As Mr Westcott acknowledged, that showed he had brought his own judgment to bear.

    ii) In deciding how to respond to Ms Thompson's request, Dr Wadman was entitled to take into account that she would have seen Mr Jabang more recently and for some considerable time (She said in evidence that the consultation would have lasted about 45 minutes) and that she was an experienced professional. Ms Thompson had a potential diagnosis of Ankylosing Spondylitis in mind and Dr Hicks observed that a physiotherapist was likely to have seen many more such cases than Dr Wadman. Dr Hicks also said that the thoracolumbar junction was often involved in Ankylosing Spondylitis. The area which Ms Thompson had asked to be x-rayed was not so far out of what Dr Wadman had observed as to arouse his suspicions.

140. I conclude that there was no separate breach of duty by Dr Wadman on 28th October 2011.

Dr Underhill: 18th October 2011

141. The essential complaint against Dr Underhill on this occasion is that she failed to elicit a proper history and/or evaluate the information which she did obtain, and, as a result, wrongly failed to request an x-ray of the thoracic spine which was mandated.

142. Mr Jabang gave evidence about what he told Dr Underhill. However, for the reasons which I have already given, I approach his evidence with caution so far as it contradicts or goes beyond the contemporaneous notes. Dr Underhill gave evidence of Mr Jabang describing a band of pain from his upper abdomen to his lower ribs. So far as that goes beyond the notes which she made at the time, I cannot conclude that it is more likely to be correct than not. She commented in her evidence that, in the course of this litigation, she has dissected and discussed the evidence a great deal. That is not surprising, but it does not make my task any easier.

143. I do accept that Dr Underhill (like Dr Wadman) palpated Mr Jabang's spine and found no local tenderness. I say that because she noted that Mr Jabang reported that the pain

was worse bending forwards and she recorded as well that, on examination, he had some discomfort in bending forwards. In those circumstances, her usual practice would have been to palpate his spine and I accept she did that on this occasion. I also accept that if there had been any local tenderness, she would have noted it and so I can infer, from the absence of any such note, that there was none.

144. Dr Underhill said that she primed herself for the consultation by reading Dr Wadman's note of his two consultations. On a close reading of those notes she would have seen that he had reported back pain as well as chest pain, but Dr Underhill said she was reading the notes only to get their overall flavour and from such a reading she understood the problem to have been predominantly in Mr Jabang's chest. A closer reading may have been desirable, but I accept that at that stage (i.e. prior to meeting with Mr Jabang), the purpose of consulting the notes was limited to getting a quick understanding of Mr Jabang's history. As will have been clear, Dr Wadman had not included the critical phrase 'thoracic back pain radiating around his chest' in his medical notes (I add in parenthesis that there is no separate allegation of negligence against him in that regard). The physiotherapy referral form was stored on the Practice's computer system, but in a separate section from the medical notes. It is not alleged that Dr Underhill was obliged to consult that part prior to her meeting with Mr Jabang.

145. Dr Boyd considered that, even on the evidence available to her, Dr Underhill should have concluded that Mr Jabang's problems originated in his thoracic spine and commissioned either an x-ray of that area or an MRI scan. Dr Hicks, on the other hand, considered that the Claimant had demonstrated no physical evidence of being in significant pain or discomfort in the thoracic spine and the clinical examination had revealed no tenderness. Dr Hicks' conclusion was not substantially shaken in cross examination and, in those circumstances, I do not find a breach of duty on her part on this occasion.

Dr Underhill: 14th November 2011

146. It is not entirely clear what the Claimant's criticisms are of Dr Underhill on this occasion.

147. In his written closing submissions, Mr Westcott said that the Claimant did not criticise Dr Underhill for failing to organise an x-ray on that day. That is understandable. She had decided that the diagnosis of Mr Jabang's condition was a puzzle and had, appropriately, decided to refer him to a specialist rheumatologist. It would then be for him to decide what, if any, further investigations were required.

148. There were two errors in her letter of referral to Dr Pool. First, she described Mr Jabang as being of Afro-Caribbean extraction. He is not. He is from the Gambia. Second, she said that Mr Jabang's pain could be relieved by bending forwards, when the reverse was the case: his pain was worse on bending forwards.

149. In his written closing submissions, Mr Westcott did not rely on either of these matters. Instead he argued that, had Dr Underhill taken a proper history from Mr Jabang, she would have learned that he was complaining of thoracic back pain radiating around his chest and she would have put this in her letter to Dr Pool.

150. There are two fundamental problems with this argument. The first is that I am not persuaded that it is more likely than not that Mr Jabang did frame his complaint to Dr Underhill in this way (unlike Dr Wadman who, as I have found, did identify this to be, at least, part of Mr Jabang's problem). The second difficulty is, as Mr Readhead rightly observed, there is no pleading of negligence in the letter of referral to Dr Pool.

151. Overall, I find there was no breach of duty by Dr Underhill on 14th November 2011.

Dr Pool

152. By the time closing submissions were made, the issues surrounding the claim against Dr Pool could be narrowed to three:

i) Did Dr Pool elicit symptoms or signs of pain in Mr Jabang's lumbar region as well as his thoracic spine?

ii) If he did, was he obliged to recommend an MRI scan to Mr Jabang at the consultation on 1st December 2011?

iii) If at the consultation on 1st December 2011 Dr Pool had recommended an MRI scan be carried out, would Mr Jabang have acted on that recommendation?

153. The reason for the first question is that there was agreement that, if Dr Pool had found pain in Mr Jabang's thoracic spine *alone* at the consultation on 1st December, he ought to have arranged an MRI scan then and not waited until the follow up appointment. That was the position of Dr Rees in cross examination and it matched the views expressed in *The Essential Pocket Guide to Rheumatology* (2nd ed Hakim, Clunie and Haq) p.69 which says,

> 'If there is thoracic back pain alone and it is acute and/or severe consider osteoporosis, tumours and infection.'

154. Although the Re-Amended Particulars of Claim had argued that an x-ray might have been an alternative means of carrying out that investigation, by the time of trial, the Claimant accepted that Dr Pool's recourse would then have been to an MRI.

155. I will consider these three questions in turn.

Did Dr Pool elicit symptoms or signs of pain in Mr Jabang's lumbar region as well as his thoracic spine?

156. I have quoted above Dr Pool's handwritten notes and the letter which he wrote the same day to Dr Underhill. If those, taken together, accurately recorded what Dr Pool elicited then they did include symptoms in Mr Jabang's lumbar spine as well as his thoracic spine.

157. In his first witness statement (dated 26th April 2016) Mr Jabang quoted from that part of Dr Pool's letter which set out the history of the complaint that he had received and which included the sentence

> 'Thank you for referring this 36 year old gentleman with a 6 week history of musculoskeletal pain primarily affecting his upper lumbar region, ribs and thoracic spine.'

Mr Jabang then commented,

> 'This is an accurate description of my pain at the time. However, Dr Pool comments that pain had been ongoing for 6 weeks which isn't right. The pain started in early September 2011 so it had been ongoing for 3 months by the time I saw Dr Pool and we would have explained this to Dr Pool.'.

I will return to the issue of what information Dr Pool was given as to the length of time that the pain had continued. For present purposes, though, it is notable that Mr Jabang did not in this witness statement challenge the description of his pain as including the upper lumbar region.

158. Mr Jabang did do so in his supplementary witness statement made on 17th May 2017. He then said,

> 'the description is not accurate where it refers to the pain being in the lumbar region. The pain was not in my lumbar region and I have never described my pain as being in that region. Rather, the pain up to and including that point was as per the description given in the preceding paragraph of my first statement. Namely, it was in my upper back. At paragraph 21 for example, I outlined that it wouldn't be right to describe my pain as 'lumbar' and that it was in my upper back. It was always clear to me that the pain was in that area.'

Paragraph 21 of his first witness statement, to which Mr Jabang there referred, was commenting on the note made by Dr Underhill in her medical notes for the consultation on 14th November 2011 in which she had written that he was suffering from 'ongoing pain across upper lumbar area and round chest'.

159. Ms Toogood, for Dr Pool, is entitled to comment that the supplementary statement was made some 5 ½ years after the consultation with Dr Pool and three weeks before the trial. Nonetheless, I will examine the evidence for and against the proposition that Dr Pool did *not* elicit from Mr Jabang that he had symptoms of pain in his upper lumbar region.

160. It is certainly the case that Dr Pool made other errors.

i) His handwritten notes record the date of the consultation as '1/12/13'.

ii) In his letter to Dr Underhill, he referred to Mr Jabang as 'Afro-Caribbean'. He knew that was not the case because his handwritten notes as well as his letter include the information that Mr Jabang came from the Gambia.

iii) In his witness statement (dated 6th May 2016) he wrote 'When I examined him [i.e. Mr Jabang] he did not appear, on minimal movement, to be in any obvious pain'. In his examination in chief and before adopting his witness statement as the truth, he agreed that this was wrong. The sentence should have expressed

the exact opposite. It should have said, 'When I examined him, he did appear, on minimal movement to be in obvious pain.'

iv) In the last sentence of the same paragraph of his witness statement he had written, 'These findings suggested that there had been loss of movement in the spine and costochrondral joints.' In the course of cross examination by Mr Westcott, he corrected this: he should have said the *costovertebral* joints, that is the joints between the ribs and the vertebrae, not the *costochrondral joints* (the joints between the ribs and the sternum).

161. When, in cross examination by Mr Westcott, Dr Pool was asked how he came to make the error in the date of the consultation, he replied, 'I get dates wrong all the time'. When he was asked about the third example which I have given above, he agreed that this was not a simple typographical error. He said he had been careless in re-reading the statement before he signed it. The same may be said of the second and fourth examples which I have given above. I am afraid to say that the accumulation of these errors did show a tendency to sloppiness on Dr Pool's part.

162. However, that does not mean that all factual disputes are to be resolved in favour of Mr Jabang's account. I said that I would revert to the information given to Dr Pool about the length of time that the pain had persisted. We can see from Dr Wadman's note of his first consultation with Mr Jabang that he was told on 21st September that the pain had then continued for 2 weeks. On that basis, it began in the beginning of September and had indeed continued for 3 months when the Jabangs saw Dr Pool. But it does not necessarily follow that this was the information which they gave to Dr Pool. About a week previously (on 24th November 2011) Mrs Jabang had told James Thallman, the out of hours' triage nurse that Mr Jabang's pain had persisted for 6 weeks. In cross-examination she agreed that she may have made this mistake. She also agreed that she may have said to Dr Pool that Mr Jabang's pain had continued for 6 weeks. She could not remember. It would also seem that the wrong period for which the pain had lasted had also been given on the first physiotherapy questionnaire. That said the pain had been experienced for 2 weeks, but the earliest which the form could have been completed was 5th October, yet Mr Jabang said to Dr Wadman on the first consultation on 21st September that the pain at that stage had lasted 2 weeks. On this matter, I conclude that Dr Pool's handwritten note ('6/52') and his letter to Dr Underhill ('a 6 week history of musculoskeletal pain') accurately reflects what he was told by Mr and Mrs Jabang.

163. I have not overlooked Mr Jabang's evidence that he demonstrated to Dr Pool the location of his pain in the same way as he said he did to all the doctors. Dr Pool did not agree that this is what Mr Jabang had done. For the reasons which I have already given, I cannot conclude that Mr Jabang's recollection is accurate.

164. In his closing submissions, Mr Westcott submitted that the demonstration or history given by Mr Jabang 'was the same as that given to all the other clinicians'. So far as this submission rests on the proposition that Mr Jabang was consistent in his description of his pain, I am afraid that I do not accept it.

i) I have found that Dr Wadman identified Mr Jabang's pain as being (or including) thoracic back pain radiating around his chest.

ii) Dr Underhill on 18th October 2011 was told that there was still pain in the lower ribs front and back. On 14th November she received a report from him of ongoing pain across the upper lumbar area and round the chest.

iii) Ms Thompson's diagram shows a band of pain across the thoracic back. It may be rather lower on the thorax than Mr Jabang demonstrated in court, but I do not place significance on that relatively minor difference. She did tick the box on the form for 'thoracic pain.'

iv) Dr Morvay received a report that Mr Jabang had pain in his upper abdomen (and around his back). It was suggested to Mrs Jabang in re-examination that she had been prompted to say this by Dr Underhill ordering an ultrasound scan and she agreed. Mr Readhead argued that this was unlikely to be the explanation since Dr Underhill had requested the scan some 5 weeks earlier on 18th October 2011. I do not think that this is a good point. The Practice records show that, on 22nd November 2011 an entry was made for a scanned letter from the Radiologist at the Uckfield Hospital. Dr Underhill said in her witness statement that this was the date that the ultrasound report was received. However, I can see from other entries that the Practice's computer system entered the date when the investigation in question was undertaken (rather than when the report was subsequently received). I, therefore, think it more likely that the ultrasound was undertaken on 22nd November, two days before the meeting with Dr Morvay. That would also fit with the telephone triage note by James Thallman which said that Mr Jabang had had a scan 'on Tuesday'. 22nd November was the Tuesday before the day that Mr Thallman spoke to Mrs Jabang. While, therefore, I do not think that the dates support Mr Readhead's submission, a more fundamental point does. On 24th November, Mrs Jabang took the trouble to call the out of hours service. The reason for taking that step must have been uppermost in her mind. She told Mr Thallman that her husband had had pain *in his abdomen* for the previous 6 weeks. Furthermore, when Dr Morvay examined Mr Jabang, she found he had a slightly distended abdomen and pain in his upper abdomen (as well as around his back). Mrs Jabang's and his complaints must at least have included pain in Mr Jabang's abdomen.

v) When Mr Jabang saw Dr Donnelly he did report thoracic back pain.

Of course, the explanation for the differences may be that the pain was experienced in different places on different occasions, but it does mean that there was not the consistency of reporting from which Mr Westcott was seeking to extrapolate.

165. Mr Westcott argues that Dr Pool had accurately recorded the site of Mr Jabang's report of his pain in the handwritten notes which said 'upper back and ribs'. Dr Pool's letter to Dr Underhill had been wrong to add that Mr Jabang had also reported pain in his upper lumbar back. Mr Westcott observes that the error regarding Mr Jabang's ethnicity must have come from Dr Underhill's letter of referral which, as I have already said, also wrongly described him as 'Afro-Caribbean'. Mr Westcott argues that, in the same way, Dr Pool erroneously took from Dr Underhill's letter that Mr Jabang was complaining of pain in his upper lumbar region.

166. Dr Pool knew that a lumbar x-ray had been requested. He did not have the x-ray itself, but he did have the radiologist's report. Mr Westcott submits that Dr Pool may have

assumed that such an investigation had only been requested because Mr Jabang had complained of pain in that area. Had he done so, then, as Dr Rees said in his evidence, such an assumption would be erroneous. It may be reasonable to infer that a clinician would not have needlessly commissioned an x-ray (or other investigation) but another doctor, seeing a patient for the first time, should take his or her own history from the patient.

167. Dr Pool said candidly that he had little recollection of the consultation with Mr and Mrs Jabang aside from what was in his notes and his letter to Dr Underhill. He said that his practice would be to dictate the first part of such a letter (setting out the history provided by the patient) while the patient was getting undressed, then continue with next part of such a letter (describing what was found on examination) while the patient was getting dressed. The last part, with his own conclusions, would be completed after the patient had left the room. I accept that this would have been an efficient use of time. The handwritten notes, under 'on examination' say 'see type letter' which is strong evidence that Dr Pool adopted this usual practice when he saw the Jabangs. Mrs Jabang did not think that Dr Pool had used a dictating machine while they were in the room, but I accept his evidence that he spoke softly and, for this reason, she may not have noticed.

168. Mr Westcott commented that the reference to the letter in the handwritten notes was under 'on examination' and there was no comparable cross reference in the part of the notes recording Mr Jabang's history. In my view this is an over-literalistic approach to the relationship between the letter and the notes. I accept Dr Pool's evidence that he used the notes as shorthand from which the letter was dictated within a matter of minutes and that, if he needed to refer back to his record of the consultation, it would be to his letter to the referring clinician to which he would look, rather than the handwritten notes. While it is true that the notes do not include the phrase 'upper lumbar', it is not likely that Dr Pool erred in recalling that this had been part of the history which the Jabangs had provided such a short time before the letter was composed.

169. I conclude that Dr Pool did obtain a history which included pain in the lumbar spine.

170. In any case, it does not seem to be disputed that Dr Pool examined Mr Jabang's lumbar spine. He noted that it (like the upper torso) was very stiff. Lumbar flexion was limited. He noted that lateral flexion and extension of the lumbar spine were both significantly impaired. Thus, quite apart from the history which Dr Pool obtained, he found signs or symptoms in the lumbar spine region.

171. My conclusion to this first question, therefore, is that Dr Pool did elicit signs or symptoms of pain in Mr Jabang's lumbar region.

172. In these circumstances, it is not necessary for me to reach a final view on a further argument advanced by Ms Toogood, namely that the Re-Amended Particulars of Claim did not plead negligence by Dr Pool in wrongly recording a history of lumbar pain. It is sufficient for me to say that there seemed to be considerable force in her point. I found unconvincing Mr Westcott's reply that it was unnecessary to plead this since the handwritten notes *did* accurately record Mr Jabang's reported symptoms. That was unpersuasive since it was clear that the letter to Dr Underhill was treated, at the very least, as part of his record of the consultation.

If Dr Pool did elicit symptoms of pain in Mr Jabang's lumbar region was he obliged to recommend an MRI scan to Mr Jabang at the consultation on 1st December 2011?

173. In his witness statement Dr Pool says that he would have had in mind a number of differential diagnoses

> 'including inflammatory disorders such as spondyloarthropathies and sarcoidosis, malignancy (i.e. metastatic cancer, primary spinal tumour and lymphomas) and infections including TB.'

He explains that he did not list all of these in his letter to Dr Underhill

> 'where it is my standard practice to copy patients in to such correspondence and where mentioning things like 'malignancy' can cause distress to patients. That would have been unnecessary here where, in this case, the diagnosis was completely unknown and *any* suggested diagnoses were speculative rather than confirmed or even likely.' [emphasis in the original]

174. Dr Pool did have the possibility of an MRI scan in mind in the future. His note of the consultation says 'MRI/CT next'. Furthermore, Mrs Jabang recalled a conversation at this consultation when Dr Pool discussed the possibility of an MRI and saying that, if necessary, it could be arranged on the NHS. Ms Toogood is right, therefore, to say that the issue I have to decide is not whether an MRI scan would have been a reasonable investigation tool, but whether Dr Pool should have recommended it at this consultation rather than at the follow-up meeting which was also arranged on 1st December 2011. The *Bolam / Bolitho* test requires me to consider whether it was mandatory for a reasonable rheumatologist consultant to recommend an MRI scan at that stage.

175. Ms Toogood points to the following features of Mr Jabang's case which were reassuring:

i) Infection (as opposed to pure inflammatory cause) of back pain is very rare. Dr Struthers when cross examined did not have the figures to hand but thought that approximately only 2 – 5% of patients had infection.

ii) The blood tests which had been arranged by Dr Underhill showed normal ESR (11) and CRP (3). Dr Struthers noted that these were taken on samples obtained 6 weeks previously, but, Ms Toogood argued, that fact supported Dr Pool's decision to request fresh blood tests. When the results from these samples were obtained, they showed slightly raised ESR (37) and CRP (13), but not alarmingly so. Dr Pool said that if they had shown a marked elevation (as they had, for instance, when Mr Jabang returned to the UK in May 2012 – his ESR was then 84 and his CRP was then 322) he would have called Mr Jabang in as a matter of urgency.

iii) Mr Jabang was generally fit and well.

iv) He did not have night sweats (This was not specifically elicited by Dr Pool, save so far as it was embraced by generally fit and well).

v) Dr Pool's letter said that Mr Jabang 'may have lost some weight'. This was not further specified, but Ms Toogood is entitled to note that, in advance of his second physiotherapy session with Ms Thompson on 9th December 2011 another questionnaire was completed. This said that Mr Jabang had had no unexplained weight loss. In cross examination Mrs Jabang said that she had completed this questionnaire on 29th November and thus two days before the appointment with Dr Pool. Mr Jabang's condition had not changed in that interval. In his handwritten notes, Dr Pool noted that Mr Jabang's weight was stable. It seems unlikely that any loss of weight was significant.

vi) Had there been signs of malignancy this would have been relevant, because it would have been another reason to consider an MRI scan. However, Mr Jabang's age made cancer unlikely.

vii) Dr Pool said that his usual practice would have been to palpate a patient's spine. However, he had made no note of doing so in this case (and it was not mentioned in the letter to Dr Underhill) and so he could not be sure that he had done so in this case. Dr Pool was not therefore entitled to rely on the absence of local tenderness as another reassuring feature. On the finding which I have made, Mr Jabang reported pain in his lumbar as well as his thoracic spine. On his examination, Dr Pool found significant stiffness in the lumbar spine. Thus, in this sense, the symptoms were not localised. Furthermore, Dr Morvay had palpated Mr Jabang's spine on 24th November 2011 and found that it was non-tender. Looking forwards, on 5th January 2012, Dr Nkrumah palpated the spine and found no bone tenderness. Although I must be cautious about assuming Mr Jabang's symptoms remained the same, it would seem unlikely that his spine would have been tender if Dr Pool had palpated it. On this basis, it can, at least, be said that Dr Pool did not miss a sign which would have been alarming.

176. Dr Struthers was asked what in his view mandated an early MRI. He said it was the combination of symptoms. This was a previously fit 36 year old man who presented with persistent progressive pain in his upper lumbar lower thoracic spine and ribs. The pain woke him at night. He was not able to work. He said that the only investigation which would have revealed the cause for this rapid deterioration would have been an MRI scan of the thoracolumbar spine. The nature and seriousness of the potential diagnoses (infection and malignancy can kill) meant that the scan needed to be done expeditiously.

177. Dr Struthers did agree that this was not a case which required immediate referral to a hospital for an MRI scan on an emergency basis.

178. Ms Toogood relied on the evidence of Dr Rees that, at least, a body of professional opinion supported Dr Pool's decision not to recommend an MRI scan immediately. She and Dr Rees observed:

i) The reassuring features which I have referred to above meant that this was not an obvious case of pain caused by infection or malignancy.

ii) The other tests which Dr Pool requested – the further blood tests and lung function test would help to identify the cause of Mr Jabang's pain (contrary to

the views expressed by Dr Struthers in his report). *French's Index of Differential Diagnosis* (14th edition by Kinirons and Ellis) at p. 53 says,

> 'Do not neglect simple blood investigations such as … ESR. In particular, if the ESR is normal one is unlikely to have missed either the inflammatory or infective group of disease.'

Dr Struthers relied on *The Essential Pocket Guide to Rheumatology* (2nd ed Hakim, Clunie and Haq) p.69 which says

> 'If there is thoracic back pain alone and it is acute and/or severe consider osteoporosis, tumours and infection.'

But Ms Toogood submitted that this was not the position presented to Dr Pool because (and I have found) Mr Jabang did not present with thoracic back pain *alone.*

iii) Dr Rees accepted that it was not appropriate to wait to do an MRI scan if spinal TB was a realistic possibility. But, he said, the likelihood of that being the case on the basis of what Dr Pool had seen and been told on 1st December was too small to meet that standard and it was not incumbent on a reasonable rheumatologist to recommend an MRI scan immediately.

iv) An alternative possible explanation for Mr Jabang's condition might have lain in his chest, in which case a CT scan would have been more appropriate than an MRI scan. However, a CT scan involved a significant dose of radiation and it was desirable to be reasonably sure that this investigation would be useful before exposing him to that. Dr Rees did not agree that the chest x-ray (which was reported to be clear) meant that sarcoid (one of the possible diagnoses which Dr Pool had in mind) could be ruled out.

v) As Dr Struthers agreed, the cost of an MRI scan was a relevant consideration whether the scan was to be done privately through an insurance company, or on the NHS. In the course of his cross examination, Dr Pool said that if they did an MRI of every back pain the NHS would struggle to cope.

vi) An MRI scan would not be necessary if there was a significant improvement by the time of the follow-up appointment.

vii) Dr Struthers was reasoning backwards from his knowledge that Mr Jabang in fact had spinal TB to reach his view that only an MRI scan would have helped detect that condition. But this was to make use of hindsight, which was inappropriate in judging whether Dr Pool exercised reasonable care and skill when he saw Mr Jabang on 1st December 2011.

179. In his submissions, Mr Westcott argued that it was unreasonable and illogical for Dr Pool to make the immediate use of an MRI scan dependent on identifying the precise vertebra which was the cause of the pain. However, I am not sure that Dr Pool was saying any more than it would be different if the site of the pain was localised in this sense. After all, *Spinal Tuberculosis: A Review* by Garg and Somvanshi in (2011) 34 The Journal of Spinal Medicine 440 says at p. 442

> 'The characteristic clinical features of spinal tuberculosis include local pain, local tenderness…Pain is typically localised to the site of involvement.'

Whether 'localised' means a particular vertebra or whether it means localised to the thoracic rather than the lumbar spine does not matter on my finding that in neither sense was Mr Jabang's pain localised.

180. In my view, Dr Pool's decision not to recommend an MRI scan at the consultation on 1st December, was consistent with at least one body of responsible professional opinion. Nor do I think that the supportive opinion expressed by Dr Rees is an example of one of those rare cases where that body of opinion lacks a logical basis.

181. It follows that I find that the Claimant has not proved that Dr Pool was in breach of his duty of care.

Dr Pool: would Mr Jabang have followed Dr Pool's recommendation if he had proposed an MRI scan

182. Because I have found no breach of duty, this issue does not arise. I will deal with it briefly.

183. Ms Toogood argues that it is far from clear that the Jabangs would have followed any recommendation by Dr Pool for an MRI scan, even if one had been made. She points to the following:

i) Mrs Jabang kept a careful tally of how much of the policy limit (£1,500) had been spent. She discussed with Dr Pool the possibility of the scan being done on the NHS. She was obviously concerned about money.

ii) Mr Jabang was keen (and well enough) to return to the Gambia for Christmas between 13th - 27th December 2011. This delayed the follow-up appointment with Dr Pool.

iii) Because of his view that only spiritual healing would help him, Mr Jabang abandoned the follow-up appointment and it is unclear that he would have stayed if an MRI scan had been arranged.

184. I did not find these submissions persuasive:

i) While Mrs Jabang was watchful of costs, the insurance limit had not been reached. Mr Jabang took £1,000 with him to the Gambia in January 2012 and I find, that, if necessary, he would have used this to pay for the MRI so far as the policy limit was exceeded.

ii) Mr Jabang did not leave for his Christmas trip to the Gambia until 13th December. That was after he had returned to the Esperance Hospital to provide the second blood sample following the consultation with Dr Pool. A private MRI scan could have been arranged within a few days of the consultation with Dr Pool and there would have been time enough to do that before his departure for his Christmas trip.

iii) Mr Jabang's recourse to spiritual healing was, in part, because of his belief that the doctors in the UK had not been able to help him to understand the cause of his pain. The causation agreement records that, if Dr Pool was in breach of duty and an MRI scan was achieved on a private basis within around 7 days then that would have led to a diagnosis of spinal TB and anti-tubercular treatment would have commenced by the end of December 2011. Mr Jabang would not then have had the same disenchantment with the British medical system which led him to have recourse to spiritual healing.

Dr Nkrumah

185. Dr Nkrumah was aware that Mr Jabang had seen a specialist rheumatologist and was due to see him again in a few days time for a follow-up appointment. The letter changing the date of the appointment from 12th to 10th January 2012 was written on 7th January, but I think it more likely than not that there had been some earlier conversation and Mrs Jabang knew of the new date when they went to the A and E Department. In her witness statement, Mrs Jabang said that she told Dr Nkrumah that they were due to see Dr Pool on 10th. More significantly, Dr Nkrumah prescribed Diazepam for Mr Jabang, but only for 5 days which would match the expected interval before a follow-up appointment on 10th January. But, in any case, the difference between the two dates is too small to be of importance: even if the Jabangs still believed the follow-up appointment was on 12th January, it would still have been only a few days away.

186. The experts in emergency medicine, Ms Peta Longstaff and Dr Campbell-Hewson, were agreed that, in these circumstances, Dr Nkrumah's task was to see whether there was any significant deterioration in Mr Jabang's condition or any significant new symptom which required urgent attention and which could not wait for that follow-up appointment.

Dr Nkrumah: factual disputes

187. There are a number of factual disputes concerning this occasion. It will be convenient if I now address them and make my findings in respect of them.

188. The receptionist noted that Mr Jabang's complaint was,

> 'Problems walking (ongoing). Problem with back.'

189. Mr Westcott argued that this must be wrong. It was the problems with Mr Jabang's back which were ongoing, not the problems with his walking. This may not be of major significance, since the experts agreed that Dr Nkrumah had to take his own history, but, for what it is worth, I agree with Mr de Navarro QC (for the 4th Defendant) that there is evidence that Mr Jabang had had ongoing problems with walking. He said in his witness statement that the pains had first appeared in September 2011 and they had made it difficult for him to take his dog for a walk or a run. In addition, when Mr Jabang returned to the UK in May 2012, the history which was then taken was that he had started developing back pains and 'mild difficulty walking about 1 year ago'. I find therefore, that the Claimant has not shown that there was an error in what the receptionist wrote about the complaint regarding walking being an ongoing one.

190. The triage nurse wrote that Mr Jabang's presenting history was,

> 'ongoing lower back pain and stiffness in legs. Spontaneous onset, no history of injury. Complaining of increased pain. No incontinence.'

191. Mr Westcott says that the reference to *lower* back pain was an error. Once again, this issue has limited significance since it was for Dr Nkrumah to take a history and carry out an investigation for himself. It was, however, not the case that Mr Jabang had previously complained only of thoracic back pain. As I have already noted, Dr Underhill recorded a complaint of upper lumbar back pain. I have already found that Mr Jabang gave a history to Dr Pool of pain in his upper lumbar back (among other things) and on his examination of Mr Jabang, Dr Pool found stiffness in Mr Jabang's lower back. In her evidence, Mrs Jabang said that the triage nurse wrote what she did after seeing Mr Jabang demonstrate where his pain was. In all the circumstances, I am not persuaded that the triage nurse erred in her record of the presenting history.

192. A potentially more important dispute is how Mr Jabang got into the cubicle where he was seen by Dr Nkrumah. There is no dispute that he walked in. However, he and Mrs Jabang say that he was only able to walk with the aid of a walking stick and with the assistance of Mrs Jabang. In his notes, Dr Nkrumah said simply that he 'walked into cubicle' without further qualification. In their letter before claim dated 11th June 2013 to the 4th Defendant, the Claimant's solicitors, Irwin Mitchell, wrote that,

> 'Mr Jabang needed to use a walking stick (and help from Nina) to walk into the cubicle'.

In their letter of response, dated 21st March 2014, Capsticks, on behalf of the 4th Defendant, wrote that,

> 'Dr Nkrumah observed Mr Jabang walk *unaided* into the cubicle.' [my emphasis]

In his witness statement of 13th May 2016, Dr Nkrumah wrote,

> 'I remember that I saw Mr Jabang in cubicle 11 and I watched him walk from the waiting room into the cubicle. I remember that he walked *briskly* into the cubicle. He did not present as a patient in severe pain.' [my emphasis]

I agree with Mr Westcott that the elaboration in Dr Nkrumah's account needs to be treated with considerable caution, especially as Dr Nkrumah will inevitably have seen hundreds, if not thousands, of patients since 5th January 2012 and there was nothing particularly remarkable about this one. For the Jabangs on the other hand, this was likely to have been a memorable occasion: it was the last time that Mr Jabang went to a doctor in the UK before leaving for the Gambia for spiritual healing. Mr and Mrs Jabang said also that this was the first time that Mr Jabang had needed to use a walking stick. I accept that he had needed a walking stick to get to the hospital. However, he took paracetamol at 20.41. He did not see Dr Nkrumah until 22.03. He reported that the pain had settled. I address below the dispute about that part of Dr Nkrumah's notes, but I find that was what he was told. Dr Nkrumah was a reasonably careful notetaker (there was an error over the exact analgesic which had helped Mr Jabang's pain, but I do not regard that as significant in the present context). I accept the submission of Mr de Navarro that, if Mr Jabang had still needed to use a stick when he came to the cubicle or if he had needed significant help from Mrs Jabang, those matters would have been included in Dr Nkrumah's notes. He had, after all, been alerted by the receptionist's

note to a patient with a history of a problem with walking and the triage nurse had said that Mr Jabang had stiffness in his legs. That was no doubt why the first entry in the notes under 'on examination' was 'walked into cubicle'. That Mr Jabang was walking despite such a history was reassuring. But the reassurance would have been significantly tempered if Mr Jabang could only do so with a stick or with the substantial help of his wife. Thus, while I do not find that Mr Jabang walked in 'briskly', I do find that, as he walked into the cubicle, he did not then require a walking stick or substantial help from his wife.

193. As I have said, Mr Jabang disputes that his pain had settled by the time he and his wife saw Dr Nkrumah. Mrs Jabang also disagreed, although she accepted that the pain had eased by the time they saw Dr Nkrumah. Mr Westcott asks me to note that, when Mr Jabang saw Dr Donnelly on 29th November 2011, she wrote that he had,

> 'on going [thoracic back pain] past 3 months had one session of physio – and exercise program - felt no benefit taking Ibuprofen'.

There is an ambiguity in Dr Donnelly's note: was there no benefit from the physio and exercise program, or no benefit from the Ibuprofen? However, even if that ambiguity is resolved in favour of Mr Jabang (i.e. there was no benefit from the Ibuprofen), the effect of analgesics on Mr Jabang does not seem to have been consistent. When he saw Dr Morvay on 24th November 2011 he told her that the pain

> 'is not too severe at the moment (has taken Ibuprofen).'

Furthermore, by the time that Mr Jabang saw Dr Nkrumah on 5th January 2012, for over a month he had been taking the anti-inflammatory, Naproxen, which Dr Pool had prescribed. Ms Longstaff said that this would have added to the effect of the paracetamol.

As Mr de Navarro pointed out, the term 'settle' was one which Mr Jabang used. He notes that word appears in Ms Thompson's record of her first physiotherapy session with Mr Jabang.

Finally, Dr Nkrumah is very unlikely to have included this remark in his notes unless he had been given that information by Mr or Mrs Jabang.

I conclude that he did so because that is what he was told.

194. Dr Nkrumah's notes say 'no bone tenderness on palpating the thoracic and lumbar spine. Paravertebral pains in the muscles.' Neither the note nor Dr Nkrumah's witness statement said where Mr Jabang was when these examinations were performed. In his evidence, Dr Nkrumah said he did them while Mr Jabang was lying on a trolley in the cubicle.

195. Mr Jabang denied that he had been on a trolley or couch. He said that he remained sitting in a chair while Dr Nkrumah felt down his back and the muscles to the side of his spine. Mrs Jabang agreed with her husband's description.

196. I have already noted that, while palpation of a patient's spine would not be impossible if the patient was sitting in a chair, it would be highly unusual. Had it occurred on this

occasion, I would have expected Dr Nkrumah to note the fact. I infer from the absence of such a note to this effect that he followed the usual course and examined Mr Jabang on a couch or trolley in the cubicle. I accept, as the notes record, that Dr Nkrumah palpated Mr Jabang's lumbar as well as his thoracic spine.

197. Dr Nkrumah's notes record paravertebral pains in the muscles. In his witness statement Dr Nkrumah said only that there was 'some tenderness' in the paravertebral muscles. In cross examination Dr Nkrumah said that the pains were from the top to the bottom of Mr Jabang's back. That additional detail was not in his notes and, at this distance in time, I cannot think it more likely than not that his recollection of it is reliable.

198. Dr Nkrumah's notes say he found 'full power in legs'. In his witness statement he said that he tested for power by asking Mr Jabang to do straight leg raises against resistance. In his oral evidence he said that Mr Jabang was then still on the trolley, but he had raised the bed of the trolley so as to allow Mr Jabang to sit up. He asked Mr Jabang to raise each leg while straight. Mr Jabang was able to do this and was also able to raise each leg even when Dr Nkrumah was pressing down on the leg with his hand (this is what is meant by straight leg resistance). Dr Nkrumah's notes also say 'no paraesthesia in legs'. This meant there was no numbness in the legs. To test for this, he touched the skin of each of Mr Jabang's legs along the inside (down from the groin) and then along the outside (down from the hip). Mr Jabang reported that he could feel Dr Nkrumah's touch all the way down each leg.

199. Mr Jabang said that Dr Nkrumah did not ask him to raise his legs, nor did he press down with his hands and see if Mr Jabang could still raise his legs. He was not asked to take his trousers off, but he had been asked at one point to roll his trousers up from the bottom. Dr Nkrumah had not touched his bare legs all the up the inside or the outside. Dr Nkrumah had at one stage asked him to wiggle his toes, but this was when Mr Jabang still had his shoes on. Mrs Jabang could not recall any straight leg raise test. She did remember that Dr Nkrumah had tested Mr Jabang's legs for numbness.

200. The straight leg raise is a standard means for testing power in legs (though Ms Longstaff said that it was an incomplete method) and the method which Dr Nkrumah describes is also a standard one for seeing whether there is paraesthesia. His evidence is in accordance with his notes and I prefer his evidence on this matter to that of Mr and Mrs Jabang. Asking Mr Jabang to wiggle his toes while retaining his shoes would serve no obvious purpose. So far as the Jabangs thought this had occurred, their recollection is faulty.

201. Dr Nkrumah's notes say 'reviewed x-ray done previously. No compression fractures – left scoliosis in the thoracic vertebrae.' In her witness statement Mrs Jabang says that she told Dr Nkrumah that an x-ray had previously been taken of Mr Jabang. She says the doctor checked the system and found the x-ray. As I have said previously, this must have been the second x-ray commissioned by Dr Wadman – that of (or which included) the thoracolumbar joint.

202. Mrs Jabang says that the doctor called her over to see the x-ray on the screen and pointed to something 'up here'. She says Dr Nkrumah asked her if Mr Jabang had ever sustained an injury to T9. She says that she was sure he used the expression 'T9' which meant nothing to her at the time. However, she says that when she went home she googled T9 and understood what the doctor had been referring to. Dr Nkrumah denied saying

anything to Mrs Jabang about T9. He had not seen anything that specific on the x-ray and, if he had done so, he would have included a reference to it in his notes. All he had seen was a slight curvature of the spine (scoliosis) which takes place over several vertebrae. He did include reference to this in his notes.

203. I accept Dr Nkrumah's evidence on this issue. The causation agreement records that there was in fact a deformity at T9 in the x-ray which Dr Nkrumah examined. However, it had not been spotted by Dr Anderson the radiologist who reviewed the x-ray in his report of 11th November 2011. Dr Nkrumah did not think he had that report available to him, but it would be surprising if a busy A and E doctor had picked up a feature which a consultant radiologist had failed to spot. Had he done so, I accept Dr Nkrumah's evidence that he would have mentioned that in his notes (as he did with the scoliosis). Mr de Navarro points out that the hospital records from May 2012 (when Mr Jabang was admitted on his return to the UK) did refer to a problem at T9. Mrs Jabang says that she was not with her husband on that occasion, but I find that it is likely that by one route or another she did come across the term at about that time and she has mistaken when she looked up its meaning on Google. In any event, for all the other reasons I have given, I do not accept her evidence that the term was used by Dr Nkrumah.

204. Mrs Jabang says that, at the conclusion of the meeting with the doctor, he said there was no sinister or obvious cause for Mr Jabang's back pain and it was probably due to a muscle or tendon injury. Dr Nkrumah did send a letter to Mr Jabang's GP which recorded Mr Jabang's attendance at A and E and said 'Diagnosis: Muscle/tendon injury back/buttocks not applicable.' Dr Nkrumah denied telling Mrs Jabang that there was nothing sinister. He said he knew that there was ongoing investigation by the consultant. The letter to the GP was generated automatically by the charge nurse following a discharge. I accept Dr Nkrumah's evidence on this issue.

Dr Nkrumah: The Claimant's case for breach of duty

205. Ms Longstaff's evidence was that in this case there was both a marked deterioration and a significant new symptom. The deterioration was that Mr Jabang's pain was markedly worse. That was illustrated by the fact that, despite having a GP and despite having an imminent appointment with a consultant rheumatologist, he had chosen to come into the Accident and Emergency Department of the Hospital at night. Furthermore, although he had not previously been to an Accident and Emergency Department, he had made many visits to his GP (including one visit to the GP's out of hours service). In those circumstances he should have been regarded as a 'return attender', or alternatively, as someone who was looking for a second opinion. The new symptom was Mr Jabang's experience of weakness in his legs. That was a neurological symptom which should have led a clinician to be concerned about motor pathways. In all these circumstances, the A and E doctor should have taken a full history. This would have included a history of his previous attendances with other clinicians which Dr Nkrumah did not do. Dr Nkrumah did not find out that Mr Jabang's pain was worse at night when lying down, that it interfered with his sleep and was associated with stiffness on rising, nor that it was unrelieved by analgesics. There should have been a more thorough physical examination of Mr Jabang's legs: the straight leg raise test would not have allowed Dr Nkrumah to test the full extent of the power in Mr Jabang's legs. There should have been a full neurological examination. Had Dr Nkrumah pursued these lines of inquiry and investigation, he would have realised that Mr Jabang had not had an x-

ray or MRI scan of his thoracic spine and he would have been obliged to commission one or the other.

Dr Nkrumah's alleged breach of duty: discussion

206. The Particulars of negligence by Dr Nkrumah in the Re-Amended Particulars of Claim include the following:

> 'failed to identify thoracic back pain with the following characteristics: it was unremitting, progressive, worse at night when lying down, interfering with sleep, associated with stiffness on rising, not relieved by recent analgesics and not explained by recent trauma.'

207. However, Dr Nkrumah did note that Mr Jabang reported pain was in (or included) his 'upper back' (effectively thoracic back pain). He did record that the pains were 'worse today' (and, in that sense, at least, were progressive). The triage nurse had written that there was no history of injury and, in his notes under 'PMH', or past medical history, Dr Nkrumah wrote 'see notes' which was a cross reference to what the triage nurse had written and which he had read. Thus, the absence of trauma was elicited. It was not the case that the pain was 'unremitting' or 'unrelieved by analgesics' since, as I have found, the pain had settled following Mr Jabang taking paracetamol. Dr Campbell-Hewson commented that paracetamol was a relatively mild analgesic and, if Mr Jabang's pain had settled with that, it was even more reassuring. I do not accept that this was an additional matter relevant to my inquiry for two reasons. First, Dr Nkrumah made a mistake as to which analgesic Mr Jabang had taken. It may be that Co-codamol (the painkiller which he thought that Mr Jabang had taken) is also a relatively mild analgesic, but I had no evidence as to this. Secondly, Ms Longstaff said that the effect of paracetamol would have been enhanced by the Naproxen which Mr Jabang was also taking. Neither she nor Dr Campbell-Hewson gave evidence as to whether there would have been the same additional reassurance if the combination of paracetamol and Naproxen was taken into account.

208. It was the case, as Mr de Navarro accepted, that Dr Nkrumah did not discover that the pain was 'worse at night when lying down, interfering with sleep, associated with stiffness on rising.' I accept that there is a body of professional opinion which does consider that there is significance if thoracic back pain is worse at night and interferes with sleep. However, Dr Campbell-Hewson gave an alternative view that it is not unusual for a patient to be more acutely aware of pain at night because nothing else is then happening. There is then a body of responsible professional opinion which does not attribute significance to the matters which Dr Nkrumah did not elicit and which the Claimant has pleaded. But, even if the existence of pain in the night is troublesome (as the GP experts agreed) it was only one feature which had to be considered in weighing the fundamental issue of whether Mr Jabang presented with a condition which had to be treated or investigated there and then rather than being left for the follow-up appointment with the consultant rheumatologist.

209. In Dr Campbell-Hewson's view, an Accident and Emergency doctor would not regard Mr Jabang as a 'repeat attender': he had not previously been to the A and E department and his previous visits to his GP or the Out of Hours Service would not be regarded as equivalent. Mr Jabang was not asking for a second opinion. In his view, therefore, the guidance on how a doctor should deal with a repeat attender or a patient seeking a

second opinion was not relevant. He and Ms Longstaff held different views on this subject, but his views represent one body of professional opinion. It is not illogical.

210. Dr Campbell-Hewson accepted that Mr Jabang's perceived weakness in his legs was a new symptom and it required investigation. However, that is what Dr Nkrumah had done. He had tested the legs for power (having observed that Mr Jabang walked into the cubicle). Dr Campbell-Hewson accepted that the straight leg raise would not test all the muscle groups or the full extent of power but there had been some investigation. He had also established that there was no paraesthesia. The palpation of the spine had shown no tenderness and so no focal localised problem. He had not done a full neurological examination, but, in Dr Campbell-Hewson's view a full neurological examination would be very unusual in an A and E department.

211. Dr Campbell-Hewson came back to the function of Dr Nkrumah: to see whether there was a significant deterioration or a significant new symptom which meant that urgent treatment or investigation was required and which could not wait for the imminent appointment with the specialist.

212. In those circumstances, Dr Campbell-Hewson said, Dr Nkrumah's repeated references in his oral evidence to his concern to eliminate cord compression as a possible diagnosis was understandable. Weakness in the legs could have been a sign of cord compression. If cord compression was a possibility, it did require very urgent attention. The *Oxford Handbook of Emergency Medicine* (3rd ed 2005 by Wyatt and others) at p. 490 advises that with suspected cord compression, the doctor should treat immediate neurosurgical / orthopaedic referral as mandatory. Cauda equina would also have required speedy action. Dr Nkrumah satisfied himself that both cord compression and cauda equina could be eliminated as possible causes of Mr Jabang's pain and neither expert has suggested that he was wrong to do so. Dr Nkrumah had not spotted the flaw at T9 on the x-ray, but Ms Longstaff agreed that that omission was not negligent. He could have noted that there was no x-ray of Mr Jabang's thoracic spine, but, in the absence of other indications that urgent treatment or investigation was required, Dr Campbell-Hewson thought it was reasonable for Dr Nkrumah to leave the specialist to decide what further imaging was appropriate. If it was, it might take the form of an MRI scan which would not (unlike an x-ray) involve a dose of radiation.

213. Overall, Dr Campbell-Hewson considered that Dr Nkrumah was entitled to consider, on the basis of the information he obtained from Mr and Mrs Jabang and on the basis of his examination that Mr Jabang's condition did not require immediate treatment or investigation in advance of the expected appointment with Dr Pool. The pain had been sufficiently severe to bring Mr Jabang to the A and E Department in the evening and despite having an appointment to see the specialist in a few days time. On the other hand, the pain had settled within about an hour and 20 minutes. Although Ms Longstaff was more critical, I accept that Dr Campbell-Hewson's view represents that of a responsible body of practitioners. His position is not one of those rare cases which can be characterised as illogical.

214. It follows that I do not find that Dr Nkrumah was in breach of his duty of care towards Mr Jabang.

Overall Conclusion

215. Dr Wadman was in breach of his duty of care on 5th October 2011, but not on 28th October 2011. There will need to be an assessment of damages.

216. Dr Underhill was not in breach of her duty of care on either 18th October 2011 or 14th November 2011. The claim against her is dismissed.

217. Dr Pool was not in breach of his duty of care on 1st December 2011. The claim against him is dismissed.

218. Dr Nkrumah was not in breach of his duty of care on 5th January 2012. The claim against the 4th Defendant is dismissed.