IN THE HIGH COURT OF JUSTICE **CLAIM NO: G52YJ691**
KING'S BENCH DIVISION
LIVERPOOL DISTRICT REGISTRY

NEUTRAL CITATION NUMBER: [2023] EWHC 1911 (KB)

B E T W E E N:-

MISS. KIRSTY CANAVAN

Claimant

-v-

DR. EDWARD GAYNOR

Defendant

APPROVED JUDGMENT

1. This is the judgment on the issue of breach of duty in the claim between Kirsty Cameron and Dr Edward Gaynor. This is a tragic case where the Clamant suffered life changing injuries, including the total loss of a lower limb.

The background

2. The defendant, Dr Gaynor, is a general practitioner at the Brownlow General Practice in Liverpool where, at the relevant time, he ran a drop-in clinic for the homeless, a service which he had set up a number of years previously. On 29 December 2016 the claimant, who at the time was homeless and an intravenous drug user, attended the defendant's clinic. A history was given of her having made an intravenous injection some days earlier, missing the right side and being in agony since. She had pain in her leg and was struggling to walk. It is her case that the defendant failed to make a diagnosis of an abscess or infection in her right groin and refer her to hospital. Instead, the defendant diagnosed a haematoma and sent the claimant away with painkilling medication and some safety netting advice (the details of which are in

dispute). Over the next few days, the claimant became increasingly unwell, and, on 4 January 2017, she was admitted to hospital. It was identified at that stage that the condition had developed into necrotising fasciitis which was extending to the right ankle. Ultimately the claimant's right leg had to be amputated at the hip joint in order to save her life.

3. The issues for me to determine are relatively narrow. Neither factual nor medical causation is in dispute. It is accepted by the defendant that if a diagnosis of an abscess (or infection) had been made on 29th December 2016 the claimant should have been referred to hospital. In the defence the defendant conceded that, had the claimant been admitted to hospital on or about 29 December 2016, she would have received treatment which would have avoided the need for her lower limb to be amputated at the hip and avoided the other serious injuries suffered by the claimant. However, the defendant denies that there has been any breach of duty and denies that any failure to diagnose an abscess amounted to negligence. The matter therefore proceeded to trial on the issue of breach of duty. It is the defendant's case that when the claimant presented he took a careful history, performed a proper examination and made an appropriate clinical note and concluded that the claimant had a large tender haematoma in her right upper thigh the size of a fist. It was said to be not hot, and no other abnormality was detected. Having taken a normal temperature and noted that there was no tachycardia (although there was an elevated pulse) the defendant's diagnosis was that the claimant had a haematoma. The defendant gave the claimant painkilling medication and, on his case, provided safety netting in terms of telling her to come back if there was a deterioration. It is the defendant's case that his management was appropriate, and it was reasonable for him to consider the claimant did not have an abscess/infection on the basis of his assessment, examination and the lack of clinical signs in support.

4. There are some factual disputes between the parties as to the presentation of the claimant at the clinic on the day in question and some of the history that was recorded. There is also a factual dispute as to what was the nature and extent of the safety netting advice given by Dr Gaynor. There is a clear dispute between the parties

on the expert evidence. Each side relies upon an expert witness in the field of general practice who hold differing opinions as to whether the defendant was in breach of duty. In short Dr Kearsley on behalf of the claimant concludes that the defendant ought to have maintained the differential diagnosis of an abscess/infection and referred the claimant to hospital. The diagnosis could not be reasonably excluded he says, the claimant should have been managed accordingly. Dr Cameron on behalf of the defendant concludes that the diagnosis that the defendant made of haematoma was reasonable given that, apart from a slightly raised pulse rate there were no recorded signs of infection, and the history and presence of the hard lump was consistent with a haematoma rather than an abscess.

5. I have had the opportunity to consider not only all written statements and medical reports but also the oral evidence of the claimant, the practice nurse Ms Bower on behalf of the defendant, and the defendant Dr Gaynor himself. I had an opportunity of carefully considering the oral expert evidence of both Dr Kearsley and Dr Cameron.

6. In the course of this judgment whilst I refer to specific parts of the evidence, I confirm that I have considered the evidence in its entirety.

The law

7. There is no dispute between the parties as to the legal principles which govern my judgment. I will therefore set out the position in relatively brief form.

8. The legal burden of proof in all clinical negligence cases lies on the claimant. The standard of proof required to discharge that burden is the balance of probabilities.

9. Where the claim involves an allegation of clinical negligence and an attack on the competence of a professional, the standard of proof required to discharge the legal burden of establishing negligence on the balance of probabilities is commensurate with the perceived gravity of the allegation. The principle applies that: "*In proportion*

as the charge is grave, so ought the proof to be clear": see **Hornal v Neuberger Products Ltd [1957] 1 QB 247.**

10. The standard of care expected of the Defendant is that defined by McNair J in the well-established test in **Bolam v Friern Hospital Management Committee (1957) 1 WLR582**

    "the real question you have to make up your minds about … is whether the defendants, in acting in the way they did, were acting in accordance with a practice of competent respected professional opinion"

    "he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art."

11. The House of Lords in **Bolitho v. City and Hackney Health Authority [1997] UKHL 46;** Lord Browne-Wilkinson (with whom the other Law Lords agreed), whilst confirming the authority of *Bolam*, and its applicability to the issue of causation as well as liability, approved an important development of it. This results from the emphasis he gave to the original words of McNair J in *Bolam* as follows:
    'McNair J stated that the defendant had to have acted in accordance with a practice accepted as proper by a "responsible body of medical men". Later he referred to "a standard of practice recognised as proper by a competent reasonable body of opinion". Again, [in Maynard] Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives—responsible, reasonable and respectable—all show that the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter'

12. It was, the House held, to be expected that in most cases, in the light of the evidence of a professional body of opinion in support of the defendant's conduct, such conduct would be demonstrably reasonable. If, however, the professional opinion called in support of the defence case was not capable of withstanding logical analysis, then the court would be entitled to hold that the body of opinion was not reasonable or responsible.

13. Further, applying Hucks v Cole, the House of Lords accepted that where there is a lacuna in a professional practice by which the risks of grave danger are knowingly taken, the court must anxiously examine the lacuna, particularly if the risk can be easily and inexpensively avoided. "*If the court finds, on an analysis of the reasons given for not taking those precautions that, in the light of current professional knowledge, there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact and where necessary to state that it constitutes negligence*" Sachs LJ at 397.

14. Lord Brown-Wilkinson concluded: "*These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible*"

"It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed"

15. I remind myself of Lord Scarman's judgment in **Maynard v. West Midlands Regional Health Authority** [1984] 1 W.L.R. 634, 639:
"... I have to say that a judge's 'preference' for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his judgment he stated the law correctly. For in the realm of diagnosis and treatment negligence is not established by C preferring one respectable body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate speciality, if he be a specialist) is necessary."

<u>The lay witness evidence</u>

16. In assessing the evidence in respect of events which occurred during a relatively brief medical examination over six years ago it is important to exercise a degree of care. I recognise that for the defendant and his witness Ms Bower, this was a standard clinical examination in respect of which it would be difficult to recall precise details. In fact, Ms Bower honestly says she has no independent recall of the appointment she had with the claimant but relies wholly on the records and her usual practice. The defendant, however, whilst accepting that memory can be tricky and that he does not recall every detail, indicated that in the month after his appointment on 29 December 2016 he reviewed the claimant's clinical records because he had been informed of the serious deterioration in the claimant's condition. His evidence is that he reviewed the notes but would not have amended or annotated them (as such would, in his view, have been improper). However, this review relatively shortly after the examination, reinforced his recollection. As against that, the claimant presents with having a vivid recollection of events but has provided some accounts which are not consistent either with the contemporaneous medical records nor are they always

internally consistent. I look at all of this evidence in the round. I remind myself that memories may be fallible.

17. Useful guidance for assessing witness evidence was provided in Gestmin SGPS SA v Credit Suisse (UK) Ltd & Anor [2013] EWHC 3560 (Comm) and has been followed in a number of cases. In summary the following points are relevant:
    - We believe memories to be more faithful than they are. Two common errors are to suppose (1) that the stronger and more vivid the recollection, the more likely it is to be accurate; (2) the more confident another person is in their recollection, the more likely it is to be accurate.
    - Memories are fluid and malleable, being constantly rewritten whenever they are retrieved. This is even true of "flash bulb" memories (a misleading term), i.e., memories of experiencing or learning of a particularly shocking or traumatic event.
    - Events can come to be recalled as memories which did not happen at all, or which happened to somebody else.
    - The process of civil litigation itself subjects the memories of witnesses to powerful biases.
    - Considerable interference with memory is introduced in civil litigation by the procedure of preparing for trial. Statements are often taken a long time after relevant events and drafted by a lawyer who is conscious of the significance for the issues in the case of what the witness does or does not say.
    - The best approach from a judge is to base factual findings on inferences drawn from documentary evidence and known or probable facts. "This does not mean that oral testimony serves no useful purpose… But its value lies largely… in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of supposing that, because a witness has

confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth".

18. Of course, each case must depend on its facts. The present case is not a commercial case. It may be said that the Claimant attending a GP appointment is likely to have a good recollection as to why she attended. Nevertheless, the above factors are a helpful general guide to evaluating oral evidence and the accuracy or reliability of memory.

19. In closing submissions, defendant's counsel urged caution in terms of the reliability of the claimant's evidence. It was said that there were clear inconsistencies between the claimant's account and the contemporaneous medical records. For example, whether the claimant's leg was red and "hot as a kettle" when she was examined. The claimant gave a vivid description as to this in her evidence, but such details are not documented in either Nurse Bower' or Dr Gaynor's evidence: their recollection relying in part on the records was that this was not the position. It is said that the court is entitled to look at the claimant's presentation and history in assessing her reliability. I accept that the claimant has had a difficult history due to her homelessness and intravenous drug use. That in itself does not mean she is not a reliable and credible witness. Further it was stated that inconsistencies in the claimant's account affect her reliability as a witness overall. To a degree, again, that is a fair point, but I look at the claimant's evidence as a whole rather than piecemeal. The fact that there may be some inconsistencies as to some issues does not mean that other parts of her evidence were not convincing and reliable. I therefore exercise great care in analysing and evaluating the evidence of not only the claimant but of all witnesses before this court, doing their best to recall the events of over six years previously.

20. The claimant's evidence: the claimant made two relatively brief witness statements which she confirmed on oath. She confirmed that she had been an intravenous drug user for a number of years. She has struggled with that addiction, attending organisations such as Addaction and receiving a prescription for methadone.

Traumatic situations in her life had led to her relapsing into drug use. It is clear that some stage after these events in question, she was clean of drugs particularly when she was fighting for custody of her daughter. Unfortunately, that struggle has not always been successful.

21. In December 2016 the claimant was not registered at a GP practice but attended the defendant's walk-in clinic at Brownlow practice. Her witness statement confirms she went to the doctors "because my right leg, mainly the upper part of my leg was painful, swollen and red and had been like this for the past 4 days. I had been feeling dizzy and nauseous and had coughed up green sputum so I thought it was an infection… I had struggled to walk with the pain and was going in between feeling hot and shivery. Dr Gaynor examined me and said it wasn't hot, but it was bright red and as hot as a kettle. I was given tramadol and paracetamol and was told to rest and if it worsened to come back." Her statement, which as I said was very brief, makes no mention of having seen the nurse. At paragraph 29 she states, "I really felt that I should have been given antibiotics that day and I begged him and told him that I was in a bad way, my leg was clearly hot to touch, and something was not right with my leg". The balance of her statements deal with the aftermath of the examination and the effect of her lower limb amputation of her life.

22. The claimant was cross examined as to the inconsistency between her recollection of her leg being red hot and what is contained in the medical records. She described there being an examination by the doctor but not by the practice nurse. She accepted that she saw the practice nurse, who took her temperature but who said she would leave examination for the doctor. She describes examination by Dr Gaynor and that at that time her leg was red and red hot. She said it should have been apparent to anyone who looked at it, touched or examined it. She described the examination as being brief, "he put no time into it.. he just didn't want to know… he wanted the next patient" (I note, these details are not in her witness evidence). The claimant was cross-examined as to the history and why she came to the clinic that day. There is reference in Nurse Bower's notes to the claimant having previously had

a chest infection and having lost her antibiotics. She accepted she had lost her antibiotics, but her concern was to get antibiotics for her new symptoms because of the injection into her groin area. The conversation about a chest infection, she said, was a different conversation. She remembers asking Dr Gaynor for antibiotics because she knew she had an infection because of how she felt, she was hot and shivering and her leg was bright red. She was not asking for antibiotics for her chest, she was "on about her leg". Her evidence was that the reason she attended the clinic was "about my leg". She was limping. She remembered thinking she needed antibiotics "because I knew I had an infection"; she did not recall a conversation with Dr Gaynor about her chest and the appointment was, as far as the claimant was concerned, nothing to do with the chest. She said she was told by the doctor that she did not have an infection, to go home and rest her leg, and she took his advice. She thought she needed antibiotics, but he said that he was not giving her any as there was no infection. She provided a vivid description that her leg was bright red and hot as a kettle and therefore she thought it was infected. The claimant was asked why, if she was unhappy with the advice she had been given, she did not go to A&E in the nearby hospital: she responded, "he (the defendant) is a professional and made me doubt what I believed about an infection". In re-examination she described that she knew what infection was like because she felt it. She had suffered infections a lot in the past including ones related to her chest and asthma and she had been hot and cold and shivery. She describes the symptoms of withdrawing from drugs as being very different from that. In terms of safety netting advice provided by Dr Gaynor, the claimant accepted that there had been some conversation (despite the fact that none is noted by Dr Gaynor's medical records). Her recollection was that she had been told to rest her legs for two weeks and if it got worse to come back. She had not been told to go to A&E; she had been told by Dr Gaynor that there was a haematoma the size of his fist. He did not give a time span as to how long it would take to get better, but she was told "come back if it gets worse after two weeks" (this additional element of a two-week time frame only arose in cross examination and was not I note in her witness statement). She did not recall being advised to get an ambulance or to go to the GP or Accident and Emergency if things got worse.

23. The claimant described the condition deteriorating over the next few days. Her partner continued to inject her in the arm with street drugs to stop having symptoms of withdrawal. In this period, she could not stand up and remained on the settee. She was asked about needles that she used to inject herself and described that they could be all different sizes in different parts of her body. She accepted that a needle that went into the groin would be between an inch to 1 1/2 inches.

24. It is right to say that the medical records prepared by Ms Bower and Dr Gaynor on the day support, in part, the claimant's account. However, there are some aspects which considerably differ from the Claimant's recall. It is helpful at this stage therefore to refer to what is actually recorded in the medical records.

25. The Claimant was seen initially by Ms Bower and her notes read:
"GP Surgery (BROWNLOW GROUP PRACTICE) BOWER, Janet (Ms)
Problem: Sore right leg - pt has old, quite deep healed over wound site in groin which has
been painful for last 4 days - o/e doesn't look infected - patient limping along.
Examination: O/E tympanic temperature 36.0 degrees C • O/E blood pressure reading 118172mmHg • O/E pulse rate 97 beats/min • 0/E - pulse rhythm regular • Body mass
index 24.1 kg/m2
Patient says she has been feeling dizzy and nauseous over last 4 days - says coughing up green sputum. Says had pleurisy 3/12 ago and was told she had a "hole in the heart"·, feels run down and having pains across her chest
Patient says she has lost her antibiotics which were px recently - also has lost her inhalers so hasn't had either.
Follow up: [Inactive] Diary Entry Asthma follow-up (28-Jun-2017)
Comment: Flu vaccination offered but pt will think about having it another time.
Cervical smear refused today - but says will have it done when she feels better"
There are other entries in respect of general health and asthma reviews which I do not consider relevant.

26. The Claimant was then seen by Dr Gaynor whose notes read as follows:

"GP Surgery (BROWNLOW GROUP PRACTICE) C3AYNOR, Edward Sebastian (Dr)

Problem: Pain in leg

History: IV inj. Missed R side. In agony since

Feels hot and shivery

Struggling to walk

Examination: RSNAD

RR 16/ min

No temp

0/E - pulse rate 96 beats/min • Blood oxygen saturation 99 %

Large tender haematoma R upper thigh - size of fist. Not hot

Rest of leg NAD

Medication: Paracetamol 500mg tablets 1 OR 2 FOUR TIMES A DAY FOR PAIN 32 tablet

Tramadol 200mg modified-release tablets Twice A Day 14 tablet

Comment: Chest is clear

Large R haematoma

analgesia

attends addaction

Talking about stopping inj and getting back onto subutex"

27. It therefore follows that the medical records confirm that the claimant was presenting feeling dizzy and nauseous over four days, coughing up green sputum. She had a history of pleurisy three months ago. She was feeling rundown having pains across her chest. She had lost her antibiotics. She had a sore right leg which was quite deep healed-over wound in the right groin which had been painful she was limping. When Dr Gaynor examined this it was not hot. The rest of her leg had no abnormality. There is no record of it being red or hot around the area but it was described as a large tender haematoma in the right upper thigh. When her temperature was taken both by Nurse Bower and Dr Gaynor it was normal. This is despite the fact that the claimant had told Dr Gaynor (although apparently not Nurse Bower) that she felt hot and shivery. Her pulse rate was 97 beats a minute (which

was at the upper end of normal range) when seen by Nurse Bower and 96 beats a minute when seen by Dr Gaynor. Those vital tests were therefore carried out twice and on both occasions, in terms of pulse and temperature, were normal.

28. As such the claimant's recollection that her leg and her groin was red and "hot like a kettle" is not supported by the contemporaneous documentation. It is nevertheless recorded that she had her chest examined and it was clear. She mentioned that she lost her antibiotics. There is no specific record she was requesting further antibiotics (albeit Dr Gaynor in his evidence accepted that she was). Her complaint of being hot and shivery was recorded by Dr Gaynor and her complaint of feeling dizzy and nauseous over the past four days was recorded by Nurse Bower. There is no record of what, if anything was said as to safety netting.

29. Overall, I accept that the claimant was doing her utmost to recall a brief examination and appointment some six years before. However, I conclude that her recollection is imperfect. I accept that the events that followed this examination would have been incredibly traumatic; at some stage the claimant's leg would have become red and probably "hot like a kettle". However, the contemporaneous medical records from two medical professionals do not support her recollection as to the lump in her groin area being red and hot as of 29 December. Nor did she have a raised temperature or tachycardia at that time. Further, her evidence that the appointment was rushed does not fit in with the contemporaneous records and was not raised in her witness evidence. It is difficult to reconcile the claimant's overall recollection with what was contained in the medical records.

30. The evidence of Nurse Bower: Ms Janet Bower provided a witness statement in which she explained the background of the homeless clinic and the role of the practice nurse, which was to try and get routine tasks undertaken and to ensure that the homeless population did not miss routine health tests due to the nature of their lifestyle. In terms of the consultation with the claimant, Ms Bower properly conceded that she was relying solely on the GP electronic records (which I have fully set out

above). In oral evidence Ms Bower confirmed that these records were made immediately after seeing the claimant and they would then have been available for the doctor who was to examine her. She accepted that she did not carry out a physical examination by touching the claimant's wound area but, when she recorded "doesn't look infected," it meant that she had looked at that area. She stated that the area did not look red, or she would have recorded that. She was just looking for an obvious infection. She had recorded reference to dizziness and nausea because that is what the claimant told her; she recorded that the claimant felt rundown because it was important to record everything.

31. Ms Bower was a straightforward, careful witness who gave evidence relying on the records made at the time. The notes she prepared appear to be detailed. I have no reason to doubt her recall and her evidence. There was no significant challenge to what she said in cross-examination; when she says that the wound was not red or hot or she would have recorded that fact, I accept that evidence.

32. The evidence of Dr Gaynor: Dr Edward Gaynor is an experienced general practitioner. He has been qualified since 1986 and underwent vocational training to become a GP in 1991. In 1995 he set up the Brownlow group practice whose primary purpose was to provide care for university students and the local population with particular focus on the homeless and drug dependent population. He has significant experience of managing the homeless population for over 20 years. The clinic which the claimant attended was a weekly homeless drop-in service which provided multidisciplinary support to specifically address the health needs of the homeless. There was no requirement to be registered and the claimant attended and reregistered on the day of her examination. In his witness statement Dr Gaynor describes the challenges faced by that clinic; often there are a large number of clients in the waiting area and outside surgery whose behaviour might be unpredictable, and they may be intoxicated. It was not, he states, normal general practice. He confirmed that the claimant was seen by practice nurse Janet Bower. The notes that Ms Bower made would generally be looked at by him before the appointment. He would look at

previous health entries too. He had never met the claimant before this consultation but had access to her medical records on the computer. He noted, as set out in the medical records, that the claimant had a recent attempt (4 days previously) to inject street drugs which had gone wrong and had missed the right femoral vein. She been in agony since. He noted that the claimant gave the history of feeling hot and shivery and was struggling to walk. In his statement he says that he examined the claimant, which included listening to her chest with a stethoscope which might indicate the presence of infection. This was required because the nurse had recorded that the claimant was concerned she had lost her prescribed antibiotics and inhalers for a chest infection. He took the claimant's temperature and pulse and noted that there were no abnormalities. She did not present with rigors. He noted a large haematoma, which he describes as being the size of a fist, on the claimant's right upper thigh. It was not hot. Examination of the leg was normal and there was no evidence of trauma, poor blood supply or blood clots. In his witness statement he says that he recalled considering the level of pain the claimant appeared to be in; there was little evidence of any infection. There was, however, good evidence of a large haematoma which he would have expected to have been painful. In support of this hypothesis he noted the onset of pain immediately after attempting to inject four days earlier. His view was that the claimant had punctured either the femoral vein or artery, she may have impaired clotting from liver damage owing to her alcohol problems which resulted in such a haematoma (pausing there I note that there is no reference in the clinical notes to clotting impairment or liver damage). The haematoma was not on the right thigh but in the deep tissue beneath the skin and did not deform the skin. He "would expect an acute abscess of this size to have been inflamed, red and warm to the touch. I have specifically noted '*not hot*'. I infer from this that I did not think this was an abscess. Although Ms Canavan did describe feeling hot and shivery, she did not have a temperature or a significant tachycardia (rise in heart rate) which would be expected with an infection. The absence of these physical signs made this vague symptom of feeling shivery less concerning. I would not have expected further bleeding from the trauma 4 days earlier and would have anticipated gradual resolution of the haematoma over the next few weeks".

He stated in that he would have considered infection including abscess as a possible diagnosis but felt that this was unlikely because: "she did not have a temperature, she was not generally unwell and the collection was not warm to the touch nor red and inflamed. I recall it was also hard and firm to palpation rather than soft or fluctuant, which I also felt made the diagnosis of an abscess less likely. The claimant did not have a temperature she was not generally unwell and collection was not warm to the touch nor red and inflamed".

33. As such, Dr Gaynor explained he considered the claimant had a haematoma which was the cause of her significant pain. He noted other issues relating to her addiction, the claimant was attending Addaction (a specialist drug dependency service). The defendant accepts that in his record he has not documented any verbal safety net advice; however, he says that it is usual practice to give a verbal safety net i.e., to encourage a patient to return to the practice or seek further medical help if the problem is not improving or deteriorating: "I would have given a likely diagnosis, in this case a haematoma, and my expectation as to when it may resolve, namely within a couple of weeks but that it should settle and not get worse. I would have also specified anything to be particularly aware of – in this case the pain worsening or the swelling enlarging or developing redness, or a temperature. I would have advised that if the pain worsened or the analgesia did not provide adequate relief, then she should return to the Surgery or go to Accident & Emergency. I clearly recall being concerned about the level of pain Miss Canavan was experiencing and am confident that I would have given this advice." Whilst accepting antibiotics and A&E referral were "clearly options" he did not consider them to be appropriate as his overall assessment was that the haematoma was not infected.

34. Having analysed the computer system he concluded that the claimant would have been called into the appointment at 1511, having arrived at the practice at 1435. The next patient was called in at 1533. As such it is likely that the consultation lasted approximately 20 minutes which would in his have included time for him to consider her previous records, carry out the examination and then type (what he describes as

slow two finger typing) his record of the consultation. He considers that to be a generous time given that the usual GP consultation time would be 10 minutes.

35. Dr Gaynor was understandably cross-examined at some length. Before that however he confirmed that he was absolutely certain having reviewed his statement and the claimant's evidence that her leg was not bright red or hot as a kettle. Further she did not "beg for" antibiotics; his recollection was that the claimant was much more concerned about her chest than leg and it was for her chest that she wanted antibiotics. He accepted that this point (the focus of the attendance being the chest not the leg) was not dealt with in his witness statement and said this was because he focused in his statement on the allegations in the claim i.e., swelling in his leg. I find that to be a little surprising. He accepted it would have been helpful if he had put this point in his statement. He accepted that a GP's record includes the claimant's complaint and what he recorded in this case in relation to the claimant's complaint was a problem with pain in the leg. However, Dr Gaynor's recollection and evidence was that the claimant's concern was much more in relation to her chest. That is not what is in the records that he recorded nor is it in his witness statement. Dr Gaynor said that he had been relying on Ms Bower's notes and her history from the claimant of chest problems. He, however, was more interested in her leg. He considered that to be the most important part of the consultation. In this case he did not record any complaints of chest problems because he had seen Nurse Bower's record. There is clearly an absence in the record of a presenting complaint of chest problems which is, I find it a little surprising, if that was as Dr Gaynor recalls as the claimant's main concern. The defendant accepted that the claimant presented as being in agony and said that she was hot and shivery. He therefore examined her which included listening to her chest with a stethoscope for signs which might indicate the presence of infection (because she had complained of chest infection and lost her antibiotics). I note that, if in fact he was relying on Nurse Bower's notes, they do not say that the claimant was complaining of a chest infection. Nurse Bower had recorded that the claimant had pleurisy three months previously and was presenting with green sputum along with a history of feeling unwell. She had lost her antibiotics and

inhalers. In effect Dr Gaynor explained that he examined the claimant chest to eliminate the question of a chest infection because, when a patient complains of being a hot and shivery, it can be an indication of infection. Having examined the chest there was no crackling. He accepted that the descriptor "hot and shivery" was again a potential indication of infection, but he would want to find further evidence in support of the site of any infection so would look with care at an area where they could be an infection. In this case it could be the chest or the thigh/groin. He would have had differential diagnoses and would try to narrow them down to a working diagnosis. Being hot and shivery was, he said a non-specific symptom; one can feel shivery when cold, or when withdrawing from drugs, or as a side-effect of medication. He could not recall the order in which he examined the claimant, whether it was her leg or chest first but was reasonably confident that as she was limping he would have focused on her leg. His recall (doing the best he could) was that the claimant's request for antibiotics was actually to do with her chest. However, he stated that this consultation was a little more memorable than others because he found out about the claimant's admission to hospital and her amputation within days following an informal conversation with a colleague; that caused him to revisit his notes in relation to his consultation.

36. Dr Gaynor explained how he reached his diagnosis on the day. In terms of the swelling, he recalls that it was the size of a fist. At that point he had not made a diagnosis because he was also aware of the previous pleurisy and lost antibiotics, so he checked the claimant's chest to exclude a chest infection. When he examined the claimant's lump he did so with the possibility of it being an abscess at the front of his mind. He wanted to either rule it in or rule it out as a differential diagnosis. He explained that he had to piece together all the bits of information to come to a conclusion. Whilst he couldn't entirely exclude the possibility that it was an abscess, he stated that if you were to refer every slight suspicion of a condition for further investigation, you would end up referring a huge number of patients; you have to be guided by what you find on the day. He said you could not exclude every diagnosis. He thought an abscess was extremely unlikely because they were no local or systemic evidence of this. He accepted that the consequences of an abscess were potentially

very serious and that the threshold for referrals reflected that; there were different thresholds for a different condition depending on the seriousness of the consequences. He accepted that the history from the claimant as being hot and shivery could be very relevant, but he would want other symptoms alongside it before diagnosing an abscess or making a referral. Here there was no temperature, no tachycardia and the claimant did not give him the impression of being generally unwell (albeit I note that she had given such a description to the nurse shortly before).

37. Dr Gaynor was asked to consider the expert evidence in this case and said that he agreed with some parts of the joint statement of Drs Kearsley and Cameron, but not all. He accepted that haematoma could become infected and become an abscess. Being hot and shivery may be consistent with an abscess but he said this history from a patient could be caused by lots of factors (but not because of a haematoma). The size of the lump was consistent with it being an abscess or a haematoma. Dr Gaynor accepted that a haematoma would appear immediately upon a misplaced injection (which corresponded with the history provided by the claimant); whilst that history might suggest a diagnosis of haematoma being likely, one could not exclude the possibility of an abscess on that history. However, there was no supporting evidence of the symptom of being hot and shivery. It was a non-specific complaint and again he said it may be caused by other things for example drug withdrawal. His evidence was that he did consider a possible infection, he look for evidence and found no evidence. He positively excluded it to the level he could in primary care.

38. Dr Gaynor accepted that the claimant was homeless and had injected heroin into her groin. He accepted that there was a likelihood of dirty needles being used and that she was very much at risk of infection. Whilst the symptom described by the claimant of being hot and shivery was therefore reported, there were no signs on examination which would support this.

39. Dr Gaynor confirmed what this consultation was on Thursday, 29 December. The surgery would have been open the following day but then would have been closed due to the New Year's break from the Saturday through to the Monday inclusive. He would not have told claimant to come back the following day. He said if there were any suspicion of infection or an abscess it would require draining at hospital (he then corrected this to any reasonable suspicion). If he had such a reasonable suspicion he would have given the claimant antibiotics and referred her to hospital. He stated: "you cannot exclude differential diagnosis completely but can exclude it to a level so you can put it to one side".

40. In terms of safety netting the defendant has no recollection of what he actually said (as opposed to what was his usual practise) but said he disagreed with the claimant's assertion that he said come back after resting the leg for two weeks if it gets worse. In describing what he would have said, he stated he believed the claimant had a haematoma which would take some time to improve. He would have said it would not get worse. He normally gave a picture of normal progression and would highlight things that would be alarming for example redness and discharge. He stated he was not good at recording his safety netting advice for all patients due to the speed of his typing. It was put to him that this does not cover what he had put in his statement as to his safety netting i.e., warning the claimant that if the swelling enlarged or she got a temperature she should go to hospital, and he said he would have given such a warning. He stated that patients are not good at retaining information from safety netting in any event and remember about 1/3 of what you say. He therefore accepted the safety netting needed to be clear and straight forward.

41. In re-examination the defendant was asked when he found out about the claimant's amputation. He confirmed this was shortly afterwards (in early January) and went back to his notes to review them. He felt "very shocked and horrified, guilty lots of emotions". I accept that this was an entirely genuine description.

42. In assessing the evidence of Dr Gaynor, I accept that he is a witness who is doing his best to assist the court. It is clear that he is relying on what is written in records number of years ago. Further than that however, he had cause, shortly after the events in question, to review his notes. As such this examination is one in respect of which his memory was reinforced by recent review. There are certain inconsistencies between those records and what he recalls now. His explanation is that records are written in brief form, and he is a slow typist. I note that the records do not support Dr Gaynor's assertion that the claimant presented with a main complaint of a chest infection. In fact, there is no reference in his history of a chest infection albeit he did examine the claimant's chest. There is no record in his notes of the safety netting advice provided. It is accepted by the claimant that the defendant provided some safety netting advice but the precise details of what was said is not recorded. I note that in his oral evidence the description of the safety netting advice given differed from his statement leaving out some important factors as set out above. Of course, oral evidence is not a test of memory, but this is my judgement indicates the difficulty with a witness stating what they usually say to a patient as opposed to recalling what they actually said to this patient. However, I see no reason why the defendant would have departed from his usual practise.

43. I accept that Dr Gaynor is doing his absolute best to recall what did or did not occur in that relatively brief consultation. However, it is right to note that the recollection now given that the claimant's main concern on the day being her chest is not borne out by the records. Further that assertion is not mentioned in his witness statement nor his defence. I accept that those documents understandably focus on the allegations made against him; however, the impression gained is that Dr Gaynor is now refocusing attention on the potential chest infection being of greatest concern to the claimant because that provides a measure of explanation for the claimant's account of being hot and shivery.

44. Taking an overall view however, Dr Gaynor's evidence is that although the symptoms of "hot and shivery" were provided, he carried out a full and thorough examination and relied on the signs present i.e., no increased temperature, no tachycardia, no

redness or heat from the lump. He therefore felt, from the differential diagnoses of haematoma and abscess/infection, he could reasonably exclude the latter. He explained that the symptoms of hot/shivery might be due to other factors. I note that there is no suggestion that the examination itself was in any way inadequate or inaccurately recorded.

45. My assessment of lay evidence overall: I accept that all witnesses are doing their best to recall events. I am sure that the claimant genuinely believes now that her leg was hot and red when she saw the doctor. However, I find she is mistaken as to that, and may have confused herself with the presentation a number of days later. I say that not because of her unfortunately history, but because her account is simply not supported by the clinical contemporaneous notes nor the recollection of either Nurse Bower or Dr Gaynor. It is clear on the records that she attended the GP on that day because of her leg, as she stated. It is also clear that she had other concerns as to her chest (reference to green sputum, pleurisy, pains across her chest must have, come from the claimant herself). Her recall that she was "begging for antibiotics may be her genuine perception now, but the reason that she was requesting them is less clear. I exercise a considerable degree of caution in assessing the claimant's evidence, not because I do not think she is trying to tell the truth, but because I find her recollection is at times confused and inconsistent with contemporaneous documents. I find that the claimant's evidence has probably been affected by the passage of time and has been reinforced by her retelling of her account for the purpose of this litigation.

46. I found that both Nurse Bower and in particular Dr Gaynor were measured, calm and reliable witnesses. Nurse Bower fairly comments that her recollection is limited, and she is relying on records. Her records were full and careful. I accept her evidence.

47. Dr Gaynor impressed me as a careful, caring and professional witness. His evidence remained largely consistent. I accept some shortcomings as set out above (such as what was the point of the attendance). I have weighed those matters up. On the

whole though I accept that he was a reliable witness with a good recollection of events: that recollection was strengthened by the fact that he reviewed the case only a week or so after the consultation. He was not unnecessarily defensive in his evidence. He made appropriate concessions (whilst maintaining that he did not agree with every aspect of the expert evidence). I found him to be a reliable witness upon whose evidence I can place reliance.

48. Specifically, in relation to safety netting and what advice was given, Dr Gaynor accepted a shortfall in his system in that he made no note at all as to what advice was given. The claimant accepts that she was told something (although, I have to say that her recollection as to this point was poor). Dr Gaynor can only say what he would normally say. When he repeated it in the witness box it was less expansive than in his witness statement: nevertheless, it contained significantly more detail than the claimant provided. In so far as to whether I prefer the claimant or the defendant's evidence on this point, I accept that of Dr Gaynor, with the slight reservation that the claimant for whatever reason, clearly did not fully understand it.

The expert evidence

49. There is a significant area of agreement between the expert witnesses in this case. However there remains a fundamental disagreement as to the key issue namely whether there were reasonable grounds to suspect abscess or infection so that the diagnosis could not be excluded and ought to have been managed by transfer to hospital.

50. Both Dr Kearsley and Dr Cameron are experienced GP experts. Each have considerable experience in their fields. Each have experience, albeit slightly different experience, of working with drug users who may be going through withdrawal. Dr Kearsley explained that he had worked in a rehabilitation unit and therefore had significant experience of patients with drug addiction undergoing withdrawal and knew what the presentation was. Dr Cameron stated that in his years of general practice in Glasgow he had knowledge and experience of the same patient cohort as

the claimant i.e., homeless and drug users who presented at a GP clinic with symptoms.

51. The experts each produced their own expert report and in February of this year (only a matter of weeks before trial) they produced a single joint statement in which the areas of agreement and disagreement were set out. It is useful as a starting point to look at that single joint statement, but I confirm that I have considered with care each of their reports in full.

52. In brief there is agreement to the following:
    - The history of a missed intravenous injection could cause a haematoma or an abscess. A haematoma could become infected and become an abscess.
    - The complaint of "hot and shivery" is consistent with an infection such as an abscess. The experts would not expect such a complaint to be a clinical feature of haematoma.
    - The complaint of struggling to walk could be due to haematoma or abscess.
    - In terms of the claimant's vital signs an elevated pulse could be consistent with an abscess or pain and distress from a large haematoma.
    - The absence of a raised temperature makes an infection less likely but does not exclude it.
    - The location of the lesion as described by Dr Gaynor as within the muscle below the subcutaneous level and not deforming the skin could be consistent with an abscess or haematoma, but Dr Cameron opines that an abscess would have presented as a swollen lump with surrounding redness.
    - The size of the lesion being the size of a fist could be consistent with either an abscess or haematoma.
    - The description of the lesion as "large tender haematoma right upper thigh and not hot, rest of leg NAD" could be consistent with the haematoma. Dr Kearsley considers this is consistent with a deep abscess. Dr Cameron says in his opinion if an abscess were present it would be a visible red swelling with surrounding redness that was warm and tender to touch.

- Dr Gaynor’s description in his statement : “not hot” (not inflamed, red or warm to the touch) and as hard and firm and not soft or fluctuant”: Dr Kearsley’s opinion is that this is consistent with a haematoma or a deep abscess. In Dr Cameron’s opinion abscesses are usually warm to touch and soft and fluctuant but whilst haematomas may initially feel rubbery, the blood clots resulting in a hard mass.
- The experts commented on what was meant by the term rigors (Dr Gaynor had said in his statement that “Miss Canavan did not present with rigors”). “We agree that rigors are typically a sudden onset of feeling cold with severe shivering/shaking, and a rise in temperature. They are usually associated with significant infection. We agree that Dr Gaynor wrote ‘Feels hot and shivery’. It is difficult for us to know from this note the severity or frequency of these symptoms. It is not possible to conclude or exclude rigors based on this note”.
- There is some agreement as to safety netting. “We agree that the Claimant says that she was advised to come back if it worsened. Dr Kearsley says that if she was not being admitted that day (which he thinks was mandatory) it was mandatory to review her the next day because she felt hot and shivery, and an abscess must have been part of the differential diagnosis. On this basis the safety netting was inadequate. Dr Cameron says that in the circumstances described by the claimant, the safety netting advice the claimant reported was given to her by Dr Gaynor was inadequate. In Dr Cameron’s opinion the safety netting advice should have included information on the expected natural history of the illness, advice on worrying symptoms to look out for, and specific information on how and when to seek help. However, if the defendant’s evidence were accepted and on the basis of Dr Gaynor’s written evidence as to safety netting, the experts agreed that “the safety netting described by Dr Gaynor would be adequate if there were no symptoms or signs of an abscess. If the claimant’s evidence is accepted that she was advised to come back if it worsened in the circumstances she described this would be inadequate. Dr Kearsley says she should have been admitted but in any event Dr Cameron’s opinion safety netting should have included information on the expected natural history of illness worrying symptoms et

cetera if the claimant recall is correct that she was told to rest for two weeks and then come back that would not be adequate".

- The experts note that Dr Gaynor did not document his verbal safety net advice but commented on his usual practice; "Whether Dr Gaynor did give such advice will be a matter for the Court. We agree that no safety netting was recorded. We agree that the safety netting described by Dr Gaynor would be adequate if there were no symptoms or signs of an abscess".

53. As stated there are areas of significant disagreement between the experts. In summary form, looking at the totality of the evidence, Dr Kearsley maintains that overall the claimant presented as hot and shivery, struggling to walk and with a slightly raised pulse rate of 96. She had a groin lump the size of the fist after a missed attempt at intravenous injection (possibly, he concludes, with a dirty needle). In his opinion a reasonably competent GP in those circumstances could not reasonably have excluded diagnosis of an abscess and therefore admission to hospital was mandatory. The competent GP would have known in failing to admit if the claimant has an abscess this would have been a life-threatening situation. Dr Kearsley noted that, in his witness statement, the defendant said that he would have considered infection including abscess as a possible diagnosis but felt that clinical features made the diagnosis less likely. However, Dr Gaynor did not exclude abscess. In concluding that the claimant was not generally unwell Dr Kearsley criticises the defendant because his conclusion did not take into consideration the symptoms from the claimant that she was hot and shivery nor Nurse Bower's comments that she was dizzy and nauseous. Feeling hot and shivery is consistent with a significant infection and was not consistent with the non-infected haematoma. Dr Kearsley's opinion is that it is not a question of which diagnosis is more likely because the consequences of missing abscess were likely to be devastating; a GP would need to be reasonably confident that it was not an abscess before dismissing such a potential diagnosis. Given the claimant's background, she was at increased risk of infection and was vulnerable because she was homeless and had a complex medical history including hepatitis C, alcohol dependence and intravenous drug use. In effect it is said that Dr

Gaynor did not look at the full picture and could not therefore have safely or reasonably excluded the possibility that this was an abscess or infection.

54. Dr Cameron's opinion differs. He confirms that Dr Gaynor ran a weekly homeless clinic and therefore had significant experience in managing patients from the same cohort as the claimant. The claimant had a normal temperature and apart from a slightly high pulse rate there were no signs of abscess or infection. Considering the claimant's constitutional history, the examination findings of Dr Gaynor were consistent with a diagnosis of haematoma. The missed injection and the presence of a hard lump (and how it felt) was consistent with a haematoma. Whilst the diagnosis of abscess should have been considered as a possible diagnosis, Dr Gaynor's examination findings were not in keeping with a diagnosis of abscess. As such, he concluded that Dr Gaynor made a reasonable diagnosis; the presentation did not mandate admission to hospital. If an abscess was suspected the patient should have been referred to hospital that day, however the presentation was typical of a haematoma and there were no signs of an abscess so review the following day was not mandated.

55. I have carefully considered the oral evidence of both medical experts. Both experts gave evidence in a measured and balanced fashion. Both are clearly experienced and respected experts in their field.

56. Dr Kearsley, on behalf of the Claimant placed considerable weight upon the Claimant's social history, the fact she was a drug user, and her description of symptoms of being "hot and shivery". It is of note that he did not appear to place any real reliance on her description of her leg as red and hot, in the absence of such being recorded in the clinical notes. He accepted that the appropriate approach was for a GP to formulate differential diagnoses, explore the history and examine the patient working towards a working diagnosis. A reasonably competent GP would explore what was said by further questions, and examinations, for example listening to the chest if a chest infection was one of the differential diagnosis. The lack of any

chest crackling might suggest the differential diagnosis would be between viral and bacterial infection. It was accepted that the skill of the GP was to home in on important symptoms or working diagnosis. Although Dr Kearsley did not criticise Dr Gaynor's record keeping per se he said that the experts agree that it would be useful to know more about the symptoms including the shivering (for example how long they had lasted). He had interpreted that description of symptoms (hot and shivery) as meaning rigors (contrary to what Dr Gaynor says in his statement that there were no rigors); this was now disputed. Dr Kealey's view was that a description from a patient of being hot and shivery would mean a febrile illness; if it had meant something more or different the GP should record something more. He stated that if Dr Gaynor had not meant that the patient was presenting with a febrile illness he should have explained that.

57. Dr Kearsley accepted that there was a distinction between symptoms and signs. Symptoms were what were described by the claimant and signs were what would be found on examination by the doctor. Being shivery was a symptom described by the claimant. Dr Kearsley's opinion stated that if there were other possible explanations save for it being that the claimant was febrile then alternative explanations would be expected to be seen in the medical records (which was not the case here). It was put to Dr Kearsley that one explanation may be that the claimant was withdrawing from drugs. Dr Kearsley did not accept that such a presentation matched his experience of patients' withdrawing (admittingly in an inpatient setting). In any event the claimant was on methadone and other drugs at that time and so there is no evidence that she was in fact withdrawing to explain such symptomatology. He accepted that the claimant's description of being dizzy and nauseous and feeling rundown (as recorded by the nurse) could be symptoms of withdrawal but looking at the whole clinical picture he did not accept that the claimant was withdrawing at that point. Dr Kearsley accepted that the examination by Dr Gaynor appeared to be acceptable. It was appropriate to examine the chest area and the groin area.

58. In terms of safety netting, Dr Kearsley accepted that if Dr Gaynor used the words described in his statement that would be textbook or exemplary safety netting, but it should have been recorded in the notes.

59. Dr Kearsley remained of the view that Dr Gaynor had fallen below the appropriate standard of a reasonably competent GP as he ought not to have excluded an infected abscess. Whilst there is no specific evidence that the claimant had used a dirty needle it was, he said, a reasonable inference that the claimant was injecting street drugs in non-sterile conditions. This would increase the risk of infection. Further the claimant and her cohort of patients will be likely to be immuno-compromised and more likely to get infections which would then become serious and life-threatening. Assuming the clinical notes were accurate, taking into consideration that the patient was hot and shivery (or at least had reported to be so) and she had a very large lump in the leg his conclusion was any competent GP based on that scenario would conclude that an abscess was a realistic diagnosis. Further the consequences of missing it would be devastating, there will be a loss of limb or loss of life and a GP would need a convincing reason to dismiss the possible diagnosis. The only possible diagnoses in reality were haematoma and abscess: being "hot and shivery" was significant information as, to a degree, he said was the quick pulse rate (but not tachycardia). Excluding other causes of infection, because of a clear examination there was no evidence material infection in the chest, the diagnosis remains. Dr Kearsley did not accept that the absence of redness or heat in the groin allowed one to reasonably exclude the diagnosis of an abscess. He accepted that was no noticeable bruising, no external features of either infection or bruising. If there is a deep haematoma or a deep abscess neither would show on the surface, he stated. He stated it is only if the abscess or infection was sufficiently near the surface would one expect to see redness, heat and swelling. Again, Dr Kearsley reiterated the overall picture of the history of injection four days ago, feeling hot and shivery and the large lump: it was not proper to exclude a significant infection in the groin. The absence of systemic signs and local signs did not mean, in his opinion, that there is not an abscess which should be considered.

60. I found Dr Kearsley's evidence to be largely clear and well-argued. It addressed the obligations of the general practitioner of considering the patient against the context of her presentation. It considered all factors in a balanced way. However, it focussed on the described symptoms of "hot and shivery" but did not appear to give much weight to actual examination findings of no raised temperature, no redness, no tachycardia. His conclusion is inevitably affected by the benefit of hindsight. It is now known that the consequences of the non-referral were devastating to the claimant and that the lump was not, in all probability, a haematoma. As such, I take care in assessing Dr Kearsley's evidence to ensure that it is not formulated to too great a degree on the knowledge of what happened to the Claimant. I have some concern that he is imposing too high a standard on the defendant because of the terrible consequences that are now known.

61. Further, I exercise some caution regarding Dr Kearsley's evidence because, on a number of occasions he referred to the claimant's presentation as a febrile illness or fever. He later accepted that she was afebrile; she did not have a raised temperature. Further, he appears to place some weight on the fact that the claimant presented with rigors: ("The patient reported feeling hot and shivery and this suggested significant infection. Feeling shivery is usually due to rigors, which occur in high fever"(para 15 of his report); "Symptoms of infection include feeling hot/cold and shivery. Feeling shivery suggests rigors which is due to a high fever" para 52.) However, according to Dr Gaynor, the Claimant did not present with rigors. She had merely reported that she had felt hot and shivery. Dr Kearsley appeared somewhat taken aback by this position, despite the fact that Dr Gaynor had always said in his statement, and it was pleaded in the defence, that the claimant did not have rigors. As stated, in the joint statement it is agreed that "It is not possible to conclude or exclude rigors based on this note". To therefore assume that the claimant did have rigors is, in my judgment a flaw in Dr Kearsley's reasoning, going to the heart of his analysis. Placing reliance on the presence of rigors, and concluding therefore that there was an infection which had not been excluded, is also a flawed approach.

62. The evidence of Dr Cameron (for the Defendant): Dr Cameron explained his history of working for many years with responsibility for patients in substance-abuse practice. He accepted the difference between signs and symptoms as accepted by Dr Kearsley. He accepted that the claimant presented with pain on walking and on examination there was a lump in under the muscle. He accepted that there was no sign on the surface (or at least had no reason to dispute that Dr Gaynor did not observe any discolouration). Dr Cameron accepted that a GP does not have the ability to use the visual appearance of a lump to confirm exactly what the lump in the groin was. There was an absence of signs of redness and inflammation so no signs on visual inspection. He accepted that the history was important but said that the claimant's account was incongruous. He accepted the proposition that the overall picture when the claimant attended would cause concerns (difficulty walking, was "hot and shivery", was in pain, and she had a lifestyle of a homeless drug user trying to inject heroin possibly with a dirty needle).

63. Dr Cameron was cross-examined about his evidence as to signs and symptoms and possible lack of clarity in his language. A reading of his report and joint statement might lead one to assume that there was some confusion in his language, and that he was mistakenly using the terms interchangeably. He said that this was semantics. He reiterated in strong terms that it was difficult to be 100% sure regarding any diagnosis. It was put to him that that Dr Gaynor did not in fact exclude the diagnosis of an abscess or infection (because he had provided no other explanation for the claimant's symptoms of "hot and shivery"); Dr Cameron's position was that Dr Gaynor took reasonable steps to do so and it was reasonable to conclude there were no signs of abscess. He accepted he was referring to signs rather than symptoms and the symptoms provided by the claimant of being hot and shivery remained. He said that a GP looked for signs. It was put to Dr Cameron that if a doctor could not find signs of infection, it does not mean there was no infection if there were still symptoms (i.e., infection could not be excluded). He accepted that the existing symptoms (hot and shivery) remained, but it was impossible to exclude every diagnosis on the basis of a routine GP consultation. He said that symptoms should be reasonably considered and analysed as part of the diagnostic process.

64. Dr Cameron was vigorously cross examined as to potential inconsistencies or weaknesses in his argument compared to the joint statement. Within the joint statement in reference to safety netting the experts agreed that the safety netting described by Dr Gaynor would be adequate if there were "no symptoms or signs of an abscess"; the point was therefore put that there appeared to be some concession by Dr Cameron, in respect of safety netting at least, that even with a lack of signs on examination, symptoms could not be dismissed. The agreement of the experts in the joint report that the complaint of feeling shivery was consistent with infection but not with a haematoma was accepted. It was put to Dr Cameron that therefore the diagnosis of abscess must remain at the forefront even if there were no signs found upon examination. In response Dr Cameron stated that the question posed had been a binary one and he had not been asked to consider any other causes for the patient presenting with the reported symptoms. In my judgment, the purpose of a joint statement, whilst brevity is always to be encouraged, is that experts can and should explain and justify their views. To say that a better question should have been asked is therefore not a very attractive position for Dr Cameron to take.

65. Taking his evidence as a whole, whilst I accept that there were some shortcomings to Dr Cameron's evidence (as there were with Dr Kearsley, as stated above) on the whole I considered his view to be rational and logical. He fully considered the history recorded and the examinations carried out. He was unshaken in his fundamental analysis: "Although the patient did describe feeling hot and shivery, she did not have a temperature or a significantly elevated pulse rate which would be expected with an infection. The absence of these physical signs made this vague symptom of feeling shivery less concerning. Dr Gaynor would not have expected further bleeding from the trauma 4 days earlier and would have anticipated gradual resolution of the haematoma over the next few weeks" " Dr Gaynor would have considered infection including abscess as a possible diagnosis, hence his reference to the haematoma as not being hot but felt this was unlikely because she did not have a temperature, she was not generally unwell, and the collection was not warm to the touch nor red and inflamed. Dr Gaynor recalls it was also hard and firm to palpation rather than soft or

fluctuant, which he also felt made the diagnosis of an abscess less likely" Page 10 of his report.

66. In his evidence he carefully analysed the diagnosis of necrotising fasciitis, upon which he was not significantly challenged. He analysed the "symptoms" or "signs" as presented and concluded that Dr Gaynor's approach was not one that could be criticised. That included taking into account the claimant's history as street homeless and an IV drug user. He did not avoid addressing any of those issues and, in fact, in the body of his main report, did so in a logical and analytical way. He remains non-critical of the approach taken by Dr Gaynor, both in not referring to hospital on that day and in not calling the claimant in for a review the next day. He weighed up the risks and benefits, recognising the pressure on A&E departments if every case were referred, balanced with the safety netting that was provided by Dr Gaynor.

67. In respect of the expert evidence as a whole, as a lay person I have some sympathy with the approach pursued on behalf of the claimant towards the evidence of Dr Cameron: if there was no explanation objectively found for a street homeless drug user presenting with a huge lump in her groin and a history of being hot and shivery, should a GP exclude the possibility of an abscess? However, the defendant's position remains resolutely that what Dr Gaynor did was enough. He carried out an examination which is not criticised (by the experts at least). He did the appropriate tests. He provided safety netting advice. The claimant is, I accept, effectively asking the court to disregard or give no weight to important clinical findings on examination, which was important and warranted. The defendant poses the question: why would the examination be needed at all if a negative examination as to every relevant clinical sign does not feed into the decision to refer or not? That is, in my judgment, a relevant question. Putting it the other way though, if the complaint of feeling hot and shivery, and generally unwell, remains (accompanied by a request for antibiotics, albeit possibly for other reasons) should a reasonably competent GP simply discharge with safety netting advice? Dr Cameron, who is an experienced GP says that what the defendant did was enough and was, in effect, what was expected of a reasonably competent GP.

68. What approach ought a court to take when there are two opposing and apparently logical views held by experts in a case such as this? I remind myself of the legal principles set out above and particularly the following

- A doctor "*is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art" Bolam*
- Is there a lacuna in medical practice in this case, such as in *Hucks v Cole*? Upon considering the case of *Edward Wong Finance Co. Ltd. v. Johnson Stokes & Master* H [1984] A.C. 296 I do not see that this is a case where there is a lacuna such that now it is clear that GPs across the land should now always refer in a case such as this. This is not a case where science has moved on. I am not assisted in this case by any "lacuna" argument.
- *"..in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter" Bolitho*
- "*In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible" Bolitho*[1]
- "*It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed"*

69. In this case, the defendant has clear expert opinion supporting his position. I have provided an analysis of Dr Cameron's evidence. I remind myself that in the context of a claim such as this, it is not simply a matter of determining which side has produced expert evidence which is the more persuasive and which I would prefer. I have to determine whether the body of opinion, as represented by Dr Cameron's position is reasonable and respectable; whether he has weighed up and balanced the relative risks and benefits, and whether his opinion withstands logical analysis. The burden remains on the Claimant to persuade me otherwise.

70. In this case, Dr Cameron has, in my judgment looked at the case in the round. Whilst it could be said that the decision to refer to hospital is an easy one to make, and in itself has little risks involved (compared to the decision not to refer) he explained in frank terms that if he or other GPs referred all cases such as the claimant to hospital, the A&E departments would be over-run, and his hospital colleagues "would not thank him for it": the clear impression was that he weighed-up all of the relevant factors. He considered logically the lack of signs, no temperature, no clamminess (according to Nurse Bower), no tachycardia, a lump that was neither hot nor red, that was solid: all of this together pointed in the direction of a diagnosis of a haematoma not an abscess or infection. The decision not to refer is therefore one logically reached. The risk of not referring is mitigated by the safety-netting. If Dr Gaynor advised the claimant to go to hospital if things got worse (which, on balance I find he did) that is a significant factor which mitigates the risk against an immediate hospital referral. Dr Cameron clearly weighed that up in reaching his opinion. That was a reasonable balance of the risks and benefits.

71. Further, despite rigorous cross examination and detailed analysis of the semantics of what he had said in his various reports, I am satisfied that Dr Cameron's evidence withstands a logical analysis. His approach, saying that all signs pointed to haematoma and that it was therefore possible to reasonably exclude an abscess/infection is, in my judgment, logically sound. The risk of infection, although tragically ultimately proven to be the case, was very small. In those circumstances, I accept that Dr Cameron's

evidence, supporting as it does the treatment provided by the defendant, represents a reasonable and responsible body of professional opinion.

Findings

72. I find that the Claimant attended the GP's surgery on 29th December 2016 presenting with a limp and pain in her hip/groin. She was also complaining of chest problems and wanted antibiotics. She said she had felt unwell and had been hot and shivery. She was seen by Nurse Bower and Dr Gaynor. Each of those appropriately carried out examinations (not a physical one of the groin area in the nurse's case). The examinations were reasonable and appropriate. The Claimant had a normal temperature, slightly elevated pulse but no tachycardia. Her chest was clear of cracking indicating no bacterial infection. She had a lump in her groin. This was quite deep seated. It was not red or hot. It felt solid. It was causing her pain. She was told that it was the size of a fist, and it was a haematoma (she had previously missed the vein/artery when injecting into that area 4 days earlier). She was not given antibiotics. She was not referred to hospital. I find that this was following what a reasonable body of GPs would have considered to be appropriate.

73. I find that the Claimant was given appropriate safety netting advice. I reject the assertion that she was told to stay at home for 2 weeks and not to go to hospital or back to her GP before then. I accept she was told to go to hospital or back to the GP if it got worse, a description of what that meant was probably given as was the standard practise of Dr Gaynor. A time span for expected recovery was probably given. I accept the written evidence of Dr Gaynor reflects, in all probability, his standard safety netting advice, which was indeed "text-book" and I find it was probably given in those or sufficiently similar terms. I can find no reason why he would have significantly amended his standard approach.

74. Tragically, when the claimant's condition worsened she did not refer herself to hospital for 4 days. At that stage she was suffering a significant infection leading to the loss of her lower limb.

75. I find that the decision by Dr Gaynor not to refer the claimant to hospital or for further investigations was one which a reasonable body of GPs would have taken and would support. Whilst, with the benefit of hindsight, everyone wishes that the claimant had received treatment which would have saved her leg, I do not find that the decision taken by Dr Gaynor was an unreasonable one. He had made a differential diagnosis of haematoma or abscess. The full examination he carried out, taken as a whole, allowed him to reasonably exclude the diagnosis of abscess. As such, it was reasonable not to refer to hospital.

76. The decision of the defendant is supported by Dr Cameron. I find that his opinion is logical and reasoned. It weighs up the risks and benefits appropriately.

77. I do not therefore find that the claimant has made out her case in negligence against the defendant. I am not satisfied on balance that the defendant was in error. In fact, to the contrary, I find that he is a caring, competent GP who took an entirely reasonable course in terms of his treatment of the claimant. He was not negligent. As such, the claimant's case fails.

78. None of that diminishes of course, the tragedy suffered by the claimant in losing her leg and suffering life-changing injuries. I have every sympathy for the situation in which she now finds herself and wish her all the very best for the future.

HHJ Howells

Sitting as a s9 judge of the High Court

20 April 2023