REPUBLIC OF TRINIDAD AND TOBAGO

IN THE HIGH COURT OF JUSTICE

CLAIM NO. CV2015-02479

BETWEEN

BHAGWANTEE SINGH-WEEKES

AND

BHAGWANTEE SINGH-WEEKES

(As Legal Representative of the Estate of Navin Singh)

Claimant

AND

SOUTH-WEST REGIONAL HEALTH AUTHORITY

Defendant

Before the Honourable Madame Justice Quinlan-Williams

Appearances: Mr. Anand Ramlogan SC leads Mr. Jared Jagroo instructed by Dr. Che Nevin Dindial for the Claimant

Mr. Vijai Deonarine instructed by Ms. Krystal Kawal for the Defendant.

Date of Delivery: 14th February 2020

JUDGMENT

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1. The undisputed facts, among other things provides a window into normative family life in Trinidad and Tobago, where it is common for adult tricenarian children to live at home with their parents.

2. In October 2014, Navin Singh was the 30 year old adult son of the claimant (Bhagwantee Singh-Weekes); he lived at home with his parents. Navin worked as a welder. He had neither been married nor fathered any children.

3. Prior to October 2014, Navin was diagnosed with haemorrhoids and polonidal abscess. On the 14th October 2014, Navin visited the Princes Town District Health Facility (PTDHF) complaining about pain to this heel. He was referred to the San Fernando General Hospital (SFGH) for X-Rays, thereafter the diagnosis of heel spurs was confirmed and he was treated accordingly.

4. Otherwise, according to Navin's mother, he was a healthy adult.

5. On the 25th October 2014, Navin complained about pain to his leg. His mother believed that he had fever and he vomited once at home. A decision was made and Navin attended the PTDHF with his medical complaint. Navin walked into the PTDHF to seek medical assistance. He was treated by Dr Shane Karim and was diagnosed with sciatica to his right side.

6. On the 27th October 2014, Navin was not better. He was taken back to the PTDHF by his family. Apart from the use of a wheelchair on the 27th October 2014, Navin's condition and presentation were in not dispute between the parties. Dr Stephen Mc Benedict treated Navin and diagnosed him with Sciatica right side. He was treated and discharged.

7. There is no dispute as to what followed. The claimant avers that by Wednesday 29th October 2014 her son's condition had deteriorated to

the point where his eyes became yellow and glossed over as if he was in a daze. He had a roasting fever, was vomiting continuously and was in extreme pain as he could not move. His right knee was even more swollen and darkened with three black spots. During the move of the claimant's son to the hospital, the said three dark spots burst, excreting a dark, foul smelling gooey fluid.

8. At the hospital, the claimant and her husband begged for immediate attention but was told that they had to wait to see a doctor. Whilst waiting the claimant saw an orderly whom she recognised as a family friend and begged for his assistance. The orderly immediately rushed the deceased in to see the doctor on duty, Dr. Sunil Roopnarine. The medical orderly Mr. Renaldo Marcano on duty that day gave evidence for the defendant. Mr. Marcano's evidence was that he knew Mr. Navin Singh through his aunt. On the 29th October 2014 he received a phone call from his aunt informing him that Mr. Singh was visiting the hospital and to look out for him. He stated that he saw Mr. Singh in a wheelchair who was looking very pale and weak with his head hung back.

9. The claimant averred that Dr. Roopnarine conducted blood work and laboratory tests which according to him, a simple CBC test should have been done which would have red flagged an infection at that point. The tests conducted revealed an elevated white blood cell count indicative of infection. The medical reports for that day recorded that the deceased had an infected, oozing wound to his right leg with pain radiating down the said leg which was swollen and painful and that he was cold sweating, very ill looking and was constantly vomiting. The claimant was then informed that her son was dying, his organs were failing, and he had a serious infection and was going into septic shock. The deceased was then rushed to the SFGH where a team of doctors examined and diagnosed him with Subcutaneous Gangrene with Necrotising Fasciitis.

10. At or about 6:55pm that day the claimant's son was taken into the operating theatre at the SFGH where a fasciotomy was performed, excising the whole skin from the mid-right thigh to the ankle, irrigating the exposed flesh. In spite of the intensive critical care being administered to her son, his blood pressure began dropping and around 6:15am on the 30th October 2014 Navin Singh was pronounced dead.

11. On the 1st November 2014 a Post Mortem Examination was conducted at the Mortuary of the SFGH by Professor Hurbert Daisley which concluded that Navin Singh died from septic shock and that he had necrotising fasciitis of his right lower extremity.

12. The claimant, the deceased's mother and Legal Personal Representative of his estate by this action, claims that the defendant failed to perform appropriate medical diagnostics which may have saved his life.

13. There is no dispute that the defendant was at all times the Regional Health Authority responsible for the administration, control and management of the PTDHF.

14. Accordingly, the claimant claimed that the defendant through its servants and/or agents was negligent as they:
    a. Failed to take any or sufficient measures to safeguard the life, interest and welfare of the deceased to ensure that he did not contract Necrotising Fasciitis at the defendant's facilities;
    b. Failed to heed and/or give any proper consideration to the deceased's medical condition and the severity of the symptoms shown by the deceased during presentation, triage and examination during the period 25th October, 2014 to 27th October 2014;

c. Failed to conduct a proper examination of the deceased and to observe and/or analyse the signs and symptoms of the deceased's condition, resulting in a missed diagnosis;
d. Failed to observe and properly assess and analyse the indicators and to conduct proper and adequate and relevant tests on the deceased in order to make any or any sufficient inquiries about the symptoms shown by the deceased during the examination period 25th October to the 27th October 2014 resulting in a fatal missed diagnosis;
e. Failed to consider or to make the correct diagnosis and wrongly concluding that the deceased was not suffering from any serious condition during the period 25th October 2014 to the 27th October 2014, resulting in a severe and fatal misdiagnosis;
f. Failed to diagnose Necrotising Fasciitis or any infection at all during the period 25th October 2014 to the 27th October 2014;
g. Failed to effect a prompt and appropriate treatment for the symptoms shown by the deceased during the period 25th October 2014 to the 27th October 2014;
h. Wrongly advising the deceased, on the 27th October 2014, to continue with the prescribed medication;
i. Failed to treat, deal with, manage or otherwise properly provide care for the deceased;
j. Failed to provide competent and/or sufficiently experience staff on duty capable of managing, and/or controlling the deceased's condition appropriately or properly;
k. Failed to provide competent and/or sufficiently experienced staff on duty capable of managing, and/or controlling the deceased's condition appropriately or properly;
l. Failed to used reasonable care, and/or diligence in the treatment of and/or attendance given to the deceased;

m. Allowed five (5) days to elapse between the initial examination and diagnosis on the 25th October 2014 and the curative procedure being undertaken on the 29th October 2014.

15. The defendant accepts that it is true that Navin was diagnosed with sciatica and not with NF on the 25th October 2014 and 27th October 2014. However this diagnosis was made as a consequence of the pathophysiology of NF itself, being a rapid, progressive, occult and fatal disease and not because of the negligence of any of the defendant's servants or agents.

The Issues

16. The main issues for the court's determination are threefold, whether:
    I. based on Navin's presentation, among other factors, on the 25th October 2014 the misdiagnosis of sciatica was negligent;
    II. based on Navin's presentation, among other factors, on the 27th October 2014 the misdiagnosis of sciatica was negligent; and
    III. the misdiagnosis of sciatica, on the 25th October 2014 and/or the 27th October 2014 and the late diagnosis of NF on the 29th October 2014 caused Navin's pain and suffering and his death.

Law

17. The law around medical negligence and misdiagnosis is settled and does not require a syntopical analysis. The court is of the view that the parties do not disagree about the relevant and applicable legal principles that bind this court. The court will now outline the law and the relevant cases that it will apply to the facts, as the court finds them.

18. The principles most often quoted in the determination of whether a medical practitioner was negligent has been formulated by Mc Nair J in the case of *Bolam -v- Friern Hopsital Management Committee* [1957] 2 All ER 118 at 121-122. Now commonly referred to as the Bolam test, Mc Nair J stated:

> "… where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art … 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 … Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view."

19. Therefore, in proving negligence the claimant must show that the medical practitioner failed to exercise a reasonable degree of skill and care, in that he failed to act in accordance with the practice accepted as proper by a reasonable body of medical men skilled in that particular art.

20. In proving that a doctor deviated from the normal practice, Lord President Clyde in *Hunter -v- Hanley* [1955] SC 200 at 206 stated that firstly it must be proved that there is a usual and normal practice. Secondly, that the defender has not adopted that practice and thirdly, of crucial importance, that the course adopted by the doctor is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care. The onus on the claimant is heavy, they must establish all three facts as without all three, his case will fail.

21. The defendant does not escape liability because it leads evidence from a number of medical experts who support the course adopted in the circumstance. Neither, is negligence in the realm of diagnosis and treatment established by a judge's preference for one respectable

body of professional opinion to another[1]. In the case of *Bolitho -v- City and Hackney Health Authority* [1997] 4 All ER 771 at 778 Lord Browne-Wilkinson stated the approach:

> "… the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In Bolam's case … McNair J stated that the defendant had to have acted in accordance with the practice accepted as proper by a "responsible body of medical men" … Later he referred to "a standard of practice recognised as proper by a competent reasonable body of opinion" … Again, in the passage which I have cited from Maynard's case, 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."

22. It was pointed out in *Mahon -v- Osborne* [1939] 2 KB 14 at 31 that it is not every slip or mistake which imports negligence, as an error in diagnosis may have been reached upon information which might have well misled the ordinary competent doctor into the mistaken diagnosis[2]. Denning MR in *Whitehouse -v- Jordan* [1980] 1 All ER 650[3] at 658 stated:

> "In the second sentence the judge required Mr Jordan to come up to 'the very high standard of professional competence that the law requires'. That suggests that the law makes no allowance for errors of judgment. This would be a mistake. Else there would be a danger, in all cases of professional men, of their being made liable whenever something happens to go

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[1] *Maynard -v- West Midlands RHA* [1985] 1 All ER 635 per Lord Scarman

[2] CA Russel LJ in *Walker -v- Semple* (Unrep.) 30 March 1993

[3] The decision was upheld on appeal by the House of Lords in *Whitehouse -v- Jordan* [1981] 1 All ER 267 at 276

wrong. Whenever I give a judgment, and it is afterwards reversed by the House of Lords, is it to be said that I was negligent? That I did not pay enough attention to a previous binding authority or the like? Every one of us every day gives a judgment which is afterwards found to be wrong. It may be an error of judgment but it is not negligent. So also with a barrister who advises that there is a good cause of action and it afterwards fails. Is it to be said on that account that he was negligent? Likewise with medical men. If they are to be found liable whenever they do not effect a cure, or whenever anything untoward happens, it would do a great disservice to the profession itself. Not only to the profession but to society at large. Take heed of what has happened in the United States. 'Medical malpractice' cases there are very worrying, especially as they are tried by juries who have sympathy for the patient and none for the doctor, who is insured. The damages are colossal. The doctors insure but the premiums become very high: and these have to be passed on in fees to the patients. Experienced practitioners are known to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved. In the interests of all, we must avoid such consequences in England. Not only must we avoid excessive damages. We must say, and say firmly, that, in a professional man, an error of judgment is not negligent. To test it, I would suggest that you ask the average competent and careful practitioner: 'Is this the sort of mistake that you yourself might have made?' If he says: 'Yes, even doing the best I could, it might have happened to me', then it is not negligent. In saying this, I am only reaffirming what I said in Hatcher v Black (a case I tried myself), Roe v Ministry of Health and Hucks v Cole. Perhaps I may remind you of the saying of John Bradford over 450 years ago. On seeing some criminal taken to execution he exclaimed: 'But for the Grace of God, there goes John Bradford.' So now if this judgment against Mr Jordan stands, all the doctors in England will say: 'But for the Grace of God, there go I.'

23. Jones, Medical Negligence[4] stated that it was not negligent if the triage nurse failed to take a detailed history or perform an extensive diagnosis of the patient as any assessment of the conduct of a triage nurse has to take into account the context of a busy A&E department which requires a quick judgment call as to where next to send the patient. The

[4] 5th Edition (Dec 2017) at 310 citing inter alia *Mullholand -v- Medway NHS Foundation Trust* [2015] EWHC 268

reasonable nurse is one who operated in a busy A&E and had a procedure to follow for streaming which does not contemplate an exhaustive diagnosis being formed. There is even less scope for a minute and detailed analysis of a triage nurse's brief notes than there is in relation to an A&E doctor's notes[5].

24. By the same token what can reasonably be expected of a doctor in an A&E department must also take into account the context in which they function, i.e. generally a pressurised environment, where decisions have to be taken at short notice. The standard of care must be calibrated in a manner reflecting reality[6]. Therefore, in *Hall -v- Thomas* [2014] EWHC 1625 at paragraph 106 the court declined to hold that the lack of record keeping gave rise to an inference that the claimant's version was correct as there was other evidence available which addressed that issue.

25. The defendant submitted that the point was also made in *Nathanson -v- Barnet & Chase Farm Hospitals NHS Trust* [2008] EWHC 460 at paragraph 52:

> "If doctors are to be required to take detailed medical and psychiatric histories whenever anyone presents with as simple injury or condition, casualty departments would grind to a halt and everyone would have to wait for hours before they were treated, whilst doctors took down details of medical and psychiatric history which in the vast majority of cases would have no bearing at all on the condition for which the patient was seeking treatment; that cannot be right."

26. In cases of misdiagnosis, in determining whether the defendant was negligent, Justice Dean Armorer in the case of No. 1291 of 1998 *Rana Ramlal -v- The South West Regional Health Authority and others* made

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[5] *Jaciubek -v- Gulati* [2016] EWHC 269 at 130
[6] Jones Medical Negligence 5th Edition (Dec 2017) at 310

reference to the text of Jackson and Powell on Professional Negligence (4th Edition), paragraph 6 -118:

> "At the date of trial there is often no dispute as to what illness or injury the plaintiff was in fact suffering from at the time when he consulted the defendant. Thus there is no dispute as to whether the diagnosis made by the defendant was correct or incorrect. If the diagnosis was incorrect, often the sole question is whether the "mistake" was negligent. This issue is seldom resolved by reference to "general and approved practice" or "schools of thought." The question simply is whether, on the symptoms and material presented or available to the defendant, a reasonably careful and skilful medical practitioner might have made the same mistakes. In determining whether an incorrect diagnosis was negligent, the court must have regard to all the circumstances at the time the diagnosis was made. These include, obviously, the symptoms exhibited by the patient, the information available to the doctor from other sources, the age of the patient and the rarity (or commonness) of the disease from which the patient was suffering. Thus in Sadler v. Henry Cassels J held that the defendant was not negligent in failing to diagnose localized meningitis, since there were no signs or symptoms which could reasonably have led him to suspect that condition. In Hulse v.Wilson it was held that the defendants were not negligent in failing to diagnose cancer of the penis earlier than they did. Owing to the rarity of such cancer in a young man, the second defendant adhered for some time to the view that the plaintiff simply to accept what is related by the patient or the person speaking for him."

27. In *Roe -v- Minister of Health* [1954] 2 QB 66 at 83 Lord Denning highlighted the fact that it is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. Lawton LJ in *Whitehouse* [supra] stated that allegations of negligence against medical practitioners ought to be considered serious as the defendant's professional reputation is under attack and a finding of negligence against him may jeopardise his career and cause him substantial financial loss over many years. The learned judge also cautioned that courts ought not to make findings of negligence based on flimsy evidence or not to regard failure to produce an expected result as strong evidence of negligence as it promotes doctors

protecting themselves through defensive medicine, that is to say, adopting procedures which are not for the benefit of the patient but safeguards against the possibility of the patient making a claim for negligence. Dunn LJ in the Court of Appeal case of *Sidaway -v- Bethlem Royal Hospital Governors and others* [1984] 1 All ER 1018 at 1031 emphasized that an increase in the claims for professional negligence would adversely affect the general standard of medical care as doctors would inevitably be concerned to safeguard themselves rather than to concentrate on their primary duty of treating their patients.

Expert Evidence

28. The claimant and the defendant were each granted permission to call an expert witness pursuant to Part 33 of the CPR. The court will now consider the evidence of the expert witness called by the claimant and the expert witness called by the defendant, in turns.

- The Claimant's Expert Evidence of Dr. David Mayer

29. Dr. Mayer is a physician licensed to practice medicine in the State of New York since 1974. He is certified by the American Board of Surgery and a Fellow and Vice-Regent of the International College of Surgeons. Dr. Mayer confined his practice of medicine to the specialities of general and vascular surgery and over the course of his career he has personally diagnosed and treated some 35 patients with necrotizing soft tissue infections, including NF arising in the lower extremities. Dr. Mayer prepared an independent report dated the 27th November 2018 wherein he provided his expert opinion based on the claimant's version of events, the medical records and the use of medical literature to form his opinion.

30. Dr. Mayer's opinion is that even on the 25th October 2014, there ought not to have been a misdiagnosis of sciatica. Navin was febrile with a

recorded temperature of 38.2 and a recorded episode of vomiting. He described these as clear signs of sepsis. Dr. Mayer noted that inconsistent with standard of care requirements, no differential diagnosis was made by the examining doctor on the 25th October 2014. He further noted that sciatica was assumed without imaging such as an X-Ray or CT/MRI to make the diagnosis of sciatica. Dr. Mayer's opinion is that basic blood work of a complete CBC (complete blood count) would have shown an elevated white cell count and prompted further investigation into the true nature of Navin's medical condition. He further noted that obtaining a CBC in a febrile patient is a basic part of emergency medicine.

31. Dr. Mayer noted that in relation to Navin's visit on the 27th October 2014, the medical notes recorded that Navin's pain in the right buttock radiating down his right leg had not subsided since his last visit. It was significant in Dr. Mayer's opinion that no temperature was taken or recorded in the medical notes. No blood work, X-Ray, CT/MRI were performed on this visit. The blood work would have shown an elevated white blood cells and the imaging would have shown gas in the soft tissues pathognomonic of NF. These test would have adverted the misdiagnosis on sciatica. According to Dr. Mayer:

> "The documentation of the October 27th patient encounter was skeletal (cursory) concluding with the misdiagnosis of "?Sciatica." The question mark is significant because it is further evidence that Mr. Singh needed a proper differential diagnosis with the more serious life-threatening diagnoses, such as NF, ruled out first before merely assuming Mr. Singh's complains were sciatic in nature"[7]

32. Dr. Mayer's opinion that it was indefensible that the PTDHF did not do a thorough physical examination of Navin, draw blood for basic bloodwork or do a simple X-Ray or CT/MRI/Ultrasound. Any of these

[7] Dr David Mayer's Expert Report. Page 284 of the Trial Bundle.

would have led to the correct diagnosis of NF and therefore averted the misdiagnosis of sciatica.

33. By the 29th October 2014, Navin was immediately diagnosed as being in septic shock and the diagnosis of NF followed.

34. Dr. Mayer emphasized that NF is not a recently-discovered disease. It is however a disease that requires early clinical suspicion to avoid the fatal error of misdiagnosis because the "classic" risk factors and findings of NF might not be present in every case. He noted that the mortality rate for NF has decreased over the last decade to 20-40% in several reported series[8] due to "the improved awareness for necrotizing fasciitis at general practitioners and ED-physicians, probably due to the attention that has been given to this disease in medical journals and general media" in accordance with Heitbrink et al (2017).

35. He stated that despite Professor Naraynsingh's opinion that NF is extremely uncommon and has a high misdiagnosis upon admission, in attempts to convince the court that it was acceptable to misdiagnose Mr. Singh on the 25th October and 27th October 2014, Dr. Mayer emphasized that standard of care is a constantly evolving construct and a doctor's errors and omission should only be judged by the prevailing standard of care at the time of the challenged conduct. Therefore, in October 2014 when Mr. Singh entrusted his medical care and life to the PTDHF, the standard of care at that time required "increased awareness" of the early manifestations of NF among the medical community of physicians.

36. Dr. Mayer highlighted that the mainstream media assisted in bringing NF front and centre before the public at large as there were various

[8] Hodgin et al (2015); Nordqvist et al (2015); Swain et al (2013; van Stigt et al (2016)

articles published about NF affecting people on forums such as CBS News, ABC News, Fox News and CNN News just in 2014 before the events surrounding Mr. Singh occurred. Therefore, the position adopted by Professor Naraynsingh is unacceptable, no longer tenable and in direct violation of the standard of care.

37. It was noted that the mortality rate for NF has been found to decrease significantly if patients are timely diagnosed and treated with early and aggressive surgical debridement and broad-spectrum antibiotics.

38. The expert avowed that on the 25th October 2014 Mr. Singh should have been diagnosed with NF because he presented with clear signs of sepsis i.e. vomiting and fever along with right leg pain. Dr. Mayer's findings were based, in part, on his belief that the nurse claimed she retook the temperature of 32.8^{o} and found it to be normal. He stated that nurse's account was not credible as she failed to record it in the contemporaneous clinic chart.

39. Dr. Mayer opined that in light of Mr. Singh's presentation, PTDHF failed to have the requisite clinical index of suspicion and failed to form a differential diagnosis. He explained that a differential diagnosis is a list of potential diagnoses for the patient's presentation, listing the more serious life-threatening diagnoses first and the least serious diagnoses last. The more serious conditions must be "ruled out" first before the doctor can assume the patient has a less serious condition.

40. Instead, they merely assumed the cause of Mr. Singh's complaints to be the least serious possibility of sciatica without ordering even the simplest bloodwork or X-Ray imaging tests. This was a gross deviation from the standard of care. He stated that on the 25th October 2014 had the PTDHF ordered a CBC an elevation in the white cells would have been identified or if an X-Ray had been performed it would have shown

gas in the soft tissues of the right leg. These tests would have alerted the clinicians to the diagnosis of infection and ultimately to the diagnosis of NF.

41. He further asserted that CT or MRI scans, also required by standard of care, would have ruled out sciatica and avoided the fatal misdiagnosis. If such was unavailable Dr. Mayer averred that a simple rapid bedside ultrasound test could have been done which would have shown subcutaneous thickening, air and fascial fluid, allowing for the diagnosis of NF.

42. Therefore, in Dr. Mayer's opinion the deceased being sent home on the 25th October 2014 with the misdiagnosis of sciatica was a gross deviation from the standard of care because his NF was survivable with prompt surgical debridement and broad spectrum antibiotics.

43. Dr. Mayer also averred that a diagnosis of NF ought to have been made on the 27th October 2014 as Mr. Singh returned to the PTDHF with worsening right leg pain. He stated that the evidence showed that Mr. Singh had worsening swelling with skin changes on that date and he was tachycardic with a heart rate of 112, consistent with infection. Therefore the examination was cursory and below the standard of care as there was no documentation that a skin evaluation was done. Additionally, although the notation after the word "swelling" on the medical records is illegible, the SFGH October 29th admission H & P stated that Mr. Singh experienced gradual right lower limb swelling, fever and decreased appetite beginning 5 days ago which could have included the 27th October visit.

44. Furthermore, Dr. Mayer highlighted that on the 27th October 2014, the PTDHF made a diagnosis of "? Sciatica" which indicated that even the examining doctor(s) were unsure that Mr. Singh had sciatica. Yet, on the day in question they failed to take Mr. Singh temperature despite

him being febrile two days earlier as no temperature was documented in the clinic chart. In addition, they failed to order a simple CBC blood test, X-Ray, CT or MRI scans or even a simple rapid bedside ultrasound test to rule out sciatica. As a result, there was a gross deviation in the standard of care provided on that day.

45. Under cross-examination Dr. Mayer's opinion was that Navin's medical records were consistent with an infection and not sciatica. Dr. Mayer insisted under cross-examination that Navin, with the elevated temperature of 38.2 on the 25th October 2014 was febrile. Dr. Mayer admitted that he was mistaken about the fact that the temperature was retaken on the 25th October 2014 and recorded at 37, he however did not change his professional opinion. The fact that the temperature when retaken, had dropped to 37 was not unusual as temperatures, even when a patient is febrile at one time, can fluctuate and fall into the normal range.

46. Under cross-examination, Dr. Mayer said that an X-Ray would not normally be used to diagnose sciatica, as it involves nerve impingement. As such a CT or an MRI imaging would be used to diagnose sciatica. He said that because Navin came in on the 25th of October 2014 with a fever of 38.8 and vomiting he had an infection which was inconsistent with sciatica.

47. Dr. Mayer insisted in cross-examination that the patient having presented with fever, vomiting, sepsis and pain out of proportion – the physical findings, suggested an infection and until it was proven otherwise the patient's presentation should have led to basic testing, referrals, surgical consult and lifesaving treatment.

48. When questioned in cross-examination Dr. Mayer stated again that a patient with vomiting, fever and pain is exhibiting an infectious process and therefore by the second visit with changes of coloration to his knee

NF must have been a differential diagnosis. He further stated that any misdiagnosis should have been of an infectious disease.

49. Dr. Mayer further stated that Dr. Benedict, on the 27th October 2014, simply parroted the diagnosis of sciatica.

50. Dr. Mayer's opinion was that from Navin's first relevant visit, the 25th October 2014, the patient's presentation should have alerted the medical practitioners to the possibility of NF. Although NF, he admitted is a rare disease that is difficult to diagnose, he asserted that it is not a new disease and should be on the radar of doctors. He further asserted that especially within recent years publications around the disease have served to heighten the awareness of this infectious disease.

51. Dr. Mayer further asserted that based on Navin's presentation on the 27th October 2014, there was no way a doctor examining Navin should not have NF within their contemplation. He concluded that the diagnosis of sciatica on the 25th October and the 27th October 2014 were negligent. If there was any misdiagnosis, based on Navin's presentation it should have been a misdiagnosis of an infectious disease.

- The Defendant's Expert Evidence of Professor Vijay Naraynsingh

52. Professor Vijay Naraynsingh is a Professor of Surgery and has obtained his MBBS from the University of the West Indies in 1974. He is a fellow of the Royal College of Surgeons of Edinburgh (1978), the International College of Angiology (1983), the International College of Surgeons (1984), the American College of Surgeons (1987), the Royal College of Surgeons England (2003) and the Caribbean College of Surgeons (2004).

53. In these proceedings he provided his expert report dated the 9th October 2015 and a supplemental report dated the 13th November 2015. In the preparation of his report, his opinion was heavily dependent on the contemporaneous notes of the doctors and nurses involved on the days in question along with medical literature on the subject of NF.

54. Professor Naraynsingh expressed the opinion that if on the 27th October 2014, Navin had "intense pain, swelling to his right knee and having three dark spots behind his knee, then the diagnosis of NF should have been considered and the patient referred for specialist care…"[9]

55. Professor Naraynsingh conceded that a correct diagnosis on the 27th October 2014 could have improved the outcomes - saving life or limb - as it is well recognised that the best results are seen with early diagnosis and aggressive medical treatment. However, he alluded that even in the best centres, NF has a high mortality rate of 25-35% and limb loss rate of about 50%.

56. Professor Naraynsingh opined that on the 25th October 2014 Mr. Singh presented with pain and stiffness of the lower back radiating down the right leg for one day. The pain was worse on movement and he had vomited once. Mr. Singh was triaged as a level 3 patient. He highlighted that it was noteworthy that the treating doctor on that day did not repeat Diclofenac which was given on the 14th October 2014, which may have caused the single episode of vomiting[10] and prescribed Zantac which was not given on the previous visit.

[9] Professor Vijay Naraynsingh Expert Report dated 9th October, 2015. Page 252 of the Trial Bundle.

[10] Under cross examination Professor Naraynsingh admitted that this was an error in his report: Transcript for Trial Day 3 dated 3rd July 2019 apt page 53 lines 3 to 5

57. He averred that pursuant to the doctor's report dated the 6th November 2014, the patient was able to ambulate into the examination room, sit on a chair and get on an examination couch. It was documented that Mr. Singh was examined and the abdominal findings and straight leg raising test were recorded. He commented that the attending staff did the correct thing in repeating the abnormal temperature of 38.2 to find that it was in fact 37°C and the abnormal pulse of 50/mm to find that it was 84/min.

58. Based on the presentation, Professor Naraynsingh was of the view that it would have been unreasonable to expect a doctor in the circumstances to make a diagnosis of septic shock and/or NF on the 25th October 2014. The medical literature of Vijayakumar et al (2014) and Mc Henry's paper (Annals Surgery, 1995) identifies numerous predisposing factors to NF such as age over 50 years, burns, cancer, alcoholism, steroid use and drug abuse, diabetes, obesity, malnutrition, peripheral vascular disease, inter alia. Patients with NF often exhibited more than one of these factors existing at the same time - comorbidities, however, Mr. Singh did not have those features.

59. In addition, Professor Naraynsingh stated that the clinical signs of NF are well documented in the literature such as Khamnuan et al (2015) and Vijayakumar et al (2014) which include erythema, fever, patchy discoloration of the skin with pain and swelling with the development of tense edema, a grayish-brown discharge, vesicles, bullae, necrosis and crepitus. NF patients have fever with a toxic appearance, altered mental state, tachycardia, tachypnoea, dehydration, decreased urine output and possibly diabetic ketoacidosis. These features were not evident in Mr. Singh.

60. In his supplemental report, Professor Naraynsingh stated that in almost all world literature, the skin and subcutaneous tissue changes are

evident within a day or two of circulatory collapse. Therefore, it is unlikely that these changes would have been evident on the 25th October 2014, four days prior to circulatory collapse.

61. Professor Nayansingh averred that upon Mr. Singh's return on the 27th October 2014 he was triaged as a level 4 patient, had no hypotension (BP 135/96), no tachypnoea (R 20/mm) but had a tachycardia[11] of 112/mm. He admitted that it was a significant omission that the patient's temperature was not documented. There was no record in the doctor's or nurse's notes of swelling and "3 dark spots behind his knee" nor was there any records of the patient complaining of swelling or skin discoloration which in Professor Naraynsingh's experience, skin changes are more difficult to appreciate in coloured than in white people. The doctor did examine the limb and specifically documented no swelling or deformity, there was a good range of movement and the sensation was also tested (although it was not specified as a pin prick or light touch).

62. The learned doctor stated that even at this point Mr. Singh did not show either the local or systemic features of NF as described in Khamnuan et al (2015) or Vijayakumar et al (2014) and many patients do not have the typical signs and symptoms early in the disease. Accurate diagnosis at an early stage is extremely difficult in all reported series. Professor Naraynsingh made reference to the learnings in Singapore by Wong et al (2003) whereby 86% of their cases had the wrong diagnosis on admission. In another paper by Hefny et al (2007) the initial diagnosis was wrong in 64% of cases.

63. Moreover, he stated that NF is extremely uncommon. In the Canadian Family Physician Journal (2009), Puvanendran et al state "Necrotising

[11] Explained by Professor Naraynsingh to be an elevated heart rate generally above 100 beats per minute

Fasciitis is prevalent enough that most primary care physicians will be involved with managing at least 1 case during their time in practice, but infrequent enough for most to be unfamiliar with the disease.” They go on to say, “only 15-34% of patients with NF have an accurate admitting diagnosis.”

64. For these reasons and his own experience, Professor Naraynsingh concluded that in his view, the doctor did not have a duty to revise the initial diagnosis based on the findings of Nurse Ramogan-Stoute and Dr. Karim recorded on the 25th October 2014. Had their findings indicated intense pain, swelling to his right knee and having three dark spots behind the knee, then a diagnosis of NF should have been considered and the patient referred for specialist care. However, these were not noted either in the doctor’s or nurse’s findings on that day.

65. Professor Naraynsingh’s opinion was that the diagnosis of sciatica on the 25th October 2014 and the 27th October 2014 were not negligent. He opined however if Navin had presented on the 27th October 2014 in the manner described by his mother, then a more thorough review of the patient was required and that NF should have been within the contemplation of treating doctors.

66. The claimant submitted that Professor Naraynsingh failed to comply with the requirements of Part 33.9 of the CPR. The Professor received instructions from the attorneys representing the defendants in this matter along with Ms. Allyson Cudjoe, the Senior Legal Officer of the SWRHA. Despite admitting that he was aware of his Part 33 duties, the Professor addressed both his reports to Ms. Allyson Cudjoe. In a similar vein the claimants alleged that Professor Naraynsingh failed to comply with Part 33.10(2) as he failed to include a statement in his expert reports that he understood his duty to the court and further the

Professor did not attach the written instructions to the report pursuant to Part 33.10(3).

67. The court notes that a statement filed on the 27th November 2018 was addressed to the court bringing the contents of the expert report to its attention. Within the statement he disclosed all the instructions he received to compile his report, regardless of its origin in accordance with Part 33.10(3). In addition he included the statement pursuant to Part 33.10(2) that he understands his duty to the court as set out in rules 33.1 and 33.2.

68. The court is certain that the defendant's Senior Legal Officer was incorrect in providing instructions and trust that such will not occur in the future. Whether intentional or not it gives the appearance that defendant, through their Senior Legal Officer was attempting to secure a partial opinion from the expert to support the defendant's defence rather than an impartial professional opinion of what occurred.

69. In this instance having read Professor Naraynsingh's Reports and hearing his evidence the court is satisfied that Professor Naraynsingh understood his obligations pursuant to Part 33.10(2), that he understood his duty to the court and that he fulfilled his duty. In accordance with the court's overriding objective to deal with cases justly ensuring that as far as is practicable, the parties are on an equal footing, the expert report of Professor Naraynsingh shall stand.

70. Conversely, the defendant asserted that there were deficiencies and omissions in the expert report of Dr. Mayer. The defendant highlighted that despite listing the classic signs for NF under cross examination he failed to address it in his report. Dr. Mayer also failed to discuss comorbidities despite its relevance as highlighted by the literature.

71. Dr. Mayer also did not substantively comply with the expert's duty to disclose instructions and materials relied on in his report pursuant to Part 33.3. Despite listing the materials he reviewed to reach his opinions and conclusion therein, nowhere in that list or in his report did he mention that he had seen "family statements" which he believed included the "mother's statement" also described as the "mother's testimony" which was revealed for the first time in cross examination[12]. It was clear from cross examination that the "family statements"/ "mother's statement"/ "mother's testimony" was not the "brief note" attached to his report as it made no mention of "dark spots" at all which he averred came to his knowledge by way of the "family statements."[13]

72. It was also noted that Dr. Mayer's opinion as it relates to the events on the 25th October 2014 was based on incorrect information. The error of fact in his report was that the repeated temperature on the 25th was not recorded when it was indeed recorded as 37 ^{o}. He went on to say in his report that he did not believe the nurse's claim was credible that she retook the 38.2^{o} temperature and found it to be normal as it was not recorded in the contemporaneous clinic chart. Therefore, it would appear that his expert opinion for the 25th October 2014 would be skewed as it was based on errors of fact.

73. Further, in several instances Dr. Mayer failed to summarise the range of opinion in the articles he cited pursuant to Part 33.10 (1)(e). This was evident when he alluded to the decrease in mortality rates over the last decade to 20-40% in reported series which he says has been attributed to improved awareness for NF in accordance with Heitbrink (2016).

74. However, Dr. Mayer failed to mention the flip side which was presented in the literature that he used to support his opinion. Hodgins

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[12] Transcript Trial Day 2 dated 2nd July 2019 page 18 line 18 to 20; page 21 lines 5 to 6
[13] Transcript Trial Day 2 dated 2nd July 2019 page 18 line 14 to 18

(2014) stated, "Incidence of the disease in the UK is estimated at approximately 500 cases per year, with mortality reaching 20-40% in some patient series despite recognised medical interventions. Early surgical exploration and debridement, complemented by early antimicrobial therapy, remains the mainstay of treatment to improve survival, limit extensive resections, and reduce postoperative morbidity."[14]

75. Another medical journal he cited Nordqvist (2015) was also contrary to his statement, "At an early stage, the symptoms can resemble those of other soft tissue infections, mainly cellulitis, which often leads to misdiagnosis and/or delayed treatment, and consequently to an increase in morbidity and mortality. A review of studies conducted between 1924 and 1994 showed mortality rates ranging from 6% to 76%, with a cumulative mortality rate of 34% and no clear improvement over time."[15]

76. The opinions in Heitbrink (2016) is demonstrably at odds with those in Hodgins (2014) and Nordqvist (2015) which are all relatively close in time to when the studies were conducted. However, Dr. Mayer while referencing them in relation to mortality rates failed to highlight the range of opinions and give reasons for his opinion.

77. The defendant submitted that, while Dr. Mayer repeatedly recommended the use of X-Rays in his report he omitted to mention their limited diagnostic value in breach of Part 33.10 (1)(e). However, the court disagrees with this submission as Dr. Mayer opined that X-Rays should have been used to rule out sciatica and not as a mechanism to diagnose NF.

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[14] STB page 12
[15] STB page 20

78. The court also disagrees with the defendant's submissions that Dr. Mayer's experience with NF was more limited than suggested. Dr. Mayer indicated that he treated 35 cases of NF over his 40 year career. In one third of those cases he was actually in the shoes of Dr. Mc Benedict and Dr. Karim in the emergency room as the other cases came to him after a diagnosis was made. However, the defendant own expert opined that according to Puvanendran et al most primary care physicians will be involved with managing at least 1 case during their time in practice, but infrequent enough for most to be unfamiliar with the disease. Therefore, Dr. Mayer being exposed to 35 cases in his career compared to 1 does not allude to limited experience with NF as suggested.

79. Furthermore, the defendant submission as it relates to Dr. Mayer's standard of medical care deficient in the knowledge and experience of local health care is irrelevant as the Court of Appeal (panelled by Mendonca, Jones and Rajkumar JJA) in allowing Dr. Mayer's expert report opined[16]:

> "We are also of the view that some of the matter which the judge referred to were irrelevant or erroneous considerations, such as the distinction between local and international standard of care. We see no basis on things as they stand at this stage to say that there is a distinction between local and international care. That really is a matter that would be dependent on the evidence, whether there is, in fact, such a distinction to be made in our local context. We don't however think medicine is really that sort of cloistered discipline, to say that what happens outside of our geographic limits is of no real concern. To refuse the report at this stage without evidence because of such a difference in the standard of care is erroneous. What Dr. Mayer was saying is that in his opinion, based on medical studies and his experience, there is greater awareness of this condition. He also make reference to certain recent cases of the conditions being highlighted on television channels which are readily assessable here. These matters cannot be readily dismissed as of no weight, and serve to support his opinion that the medical officers should have been

[16] CA transcript lines 43 page 30 to line 17 of page 31

alive to the possibility that the deceased may have been suffering from the condition, and should have taken appropriate measure to exclude it as a possible diagnosis."

80. In assessing the credibility of a witness Kokaram J summarised the approach that the court ought to take in the case of CV2015-03194 *Jackson -v- The Attorney General:*

> "9. In Horace Reid v Dowling Charles and Percival Bain Privy Council Appeal No. 36 of 1987 at page 6 the Privy Council outlines an aspect of this forensic exercise. See also Mumtaz Properties v Ahmed [2011] EWCA 610 where the Judge agreed that the witness's credibility should be assessed not just from their "general demeanour" but the Court should also consider what other independent evidence was available. Contemporaneous written documentation is stated to be of "the greatest importance in assessing credibility". See also the assessment of credibility in AG V Anino Garcia CA Civ 86/2011 and the CCJ in Shanique Myrie v Barbados [2013] CCJ 3.
>
> 10. Demeanour of witnesses now plays a diminishing part of the Court's exercise of truth determination and fact finding. On its own it is misleading and can give rise to intuitive but analytically incorrect decisions. Truth determination must be arrived at by an overall assessment of the witness's evidence cross checking contemporaneous documents, the pleadings and witness statements, reflecting on the inherent plausibility or probabilities of the respective version of the incident, assessing the expressed or implied motives and interests of witnesses to serve and being alive to any opportunity for fabrication or allegations of manipulation of documentation."

81. The court had the opportunity of viewing both experts under cross examination. In relation to Professor Naraynsingh the court found that he was a truthful witness. He was honest and admitted to an error in his report where he said that Diclofenac may have caused vomiting some two weeks later[17]. The Professor admitted that the omission of the temperature on the 27th October 2014 was significant[18] and when posed with the claimant's version of events gave his honest opinion

[17] Transcript Trial Day 3 dated 3rd July 2019 page 53 line 3 to 5
[18] Transcript Trial Day 3 dated 3rd July 2019 page 83 lines 22 to 26

which was opposite to the opinion he provided based on the defendant's instructions and medical records[19]. His medical report was also thorough as it touched and addressed all the main factors that had to be considered in making a diagnosis of NF which was fully supported by the medical literature. Professor Naraynsingh also stood up well to cross examination as he demonstrated his honest opinion in accordance with medical literature and was even able to quote specific articles, statistics and case studies from his fingertips.

82. The court did not agree with the claimant's submission that Professor Naraynsingh came across as someone who was giving evidence to support the defendant because of his longstanding relationship with the defendant.

83. While the court acknowledges that Dr. Mayer has a wealth of experience in dealing with cases of NF, this expertise was not conveyed effectively in his expert report. Based on Dr. Mayer's own experiences the court did not view his report as one containing several omissions and deficiencies with the intent to skew the true effect and meaning that the medical literature portrayed. But rather one containing what in his opinion was relevant to the particular circumstances of this case. For instance comorbidities which were mentioned in most of medical literature was clearly not a factor here. What was relevant, was the patient's presentation with fever and pain out of proportion to his complaint. Dr. Mayer could not have been said to cherry pick bits and pieces of the medical literature when he disclosed it.

84. With regard to the errors of fact Dr. Mayer was a truthful and cooperative witness as he admitted to the errors of fact contained in his report while explaining why they would not have altered his

[19] Transcript Trial Day 3 dated 3rd July 2019 page 90 to 91

opinion. The fact that the nurse retook the temperature and it was 37° did not change what Dr. Mayer considered to relevant; that Navin presented with signs of sepsis (vomiting and fever) and pain to the right leg.

85. With respect to the changes to Navin's skin by the 27th October 2014 referenced by Dr. Mayer, the report refers to "skin changes". The court notes that the Brief Note to Dr. David Mayer dated the 21st August 2017 noted that "the skin around the knee darkened". Nowhere in Dr. Mayer's report did he specifically reference three dark spots. By the time of the trial one would imagine that the full context of the skin changes became known as all the evidence, including witness statements were filed. The court is not of the view that Dr. Mayer considered information which he did not disclose in the manner suggested by the defendant.

86. The court also was mindful of the fact that while NF, the correct diagnosis was in the forefront of the evidence, with respect to negligence the issue was whether or not the defendant, their servants and/or agents were negligent in diagnosing sciatica on the 25th October 2014 and 27th October 2014.

87. Both experts agreed on some points and disagreed on others in relation to the diagnosis of NF. On assessing expert evidence Lord Bingham in *Eckersley* [supra] guided:

> "In resolving conflicts of expert evidence, the judge remains the judge; he is not obliged to accept evidence simply because it come from an illustrious source; he can take account of demonstrated partisanship and lack of objectivity. But save where an expert is guilty of a deliberate attempt to mislead (as happens only very rarely), a coherent reason opinion expressed by a suitably qualified expert should be the subject of a coherent reasoned rebuttal, unless it can be discounted for other good reason."

88. In assessing whether the servants and/or agents of the defendant fell below the acceptable standard of care in accordance with the *Bolam* test and as later refined by the case of *Bolitho* [supra], the expert's opinions have to be considered as they relate to the evidence.

89. Based on the expert opinions proffered by Dr. Mayer and Professor Naraynsingh the issues for the court's determination can only be resolved after the court makes its findings of fact on how Navin presented on the 25th October 2014 and the 27th October 2014 as well as the veracity of what was reported by the agents and servants of the defendant. The opinions of the experts were premised on a certain set of facts. The claimant's and defendant's account of Navin's presentation as well as what occurred at the PTDHF on the 25th October 2014 and the 27th October 2014 are not ad idem, rather they are in stark conflict.

The evidence and findings of fact

25th October 2014

90. The claimant says that on 25th October 2014 Navin came to her and complained of pain and stiffness in his right knee. She said that he started to have elevated body temperature and severe vomiting. The claimant and her husband took Navin to the PTDHF where he was examined by Dr. Shane Karim who diagnosed him with sciatica. He was treated with Zantac, Tramadol and Gravol. He was told to return if the pain increased or if he felt weakness or loss of consciousness.

91. The claimant stated that she stood by her son's side together with her husband from his admission to his discharge. At no point were any auxiliary tests, blood work, X-Rays or any other routine tests performed on her son nor were there any laboratory investigations of his skin in

spite of the visible the symptoms. He was summarily discharged and sent home.

92. Dr. Karim gave evidence on behalf of the defendant. Dr. Karim stated that before he saw the deceased, he perused the nurse's notes which indicated that the deceased had an elevated temperature. As was standard practice, he began to evaluate the patient from the moment he walked into the doctor's office and noted that the deceased walked in and sat on the patient's chair without difficulty. Based on a visual assessment, the deceased did not appear to be in pain or any distress.

93. Upon Dr. Karim's enquiry as to the reason for the visit, the deceased informed that he had a pain on the right side of his back going down his leg for about a day and that the pain was worse with movement. The deceased also indicated that he had vomited once during the course of the day. With respect to his medical history Mr. Singh informed that he was previously treated by his private doctor for haemorrhoids as he was given antibiotics and sitz baths and that he was doing well. The deceased then indicated that the pain in his leg was present but not as bad as earlier on that day.

94. Dr. Karim conducted a physical examination of the deceased's chest and heart using a stethoscope which were in normal range. Dr. Karim then noticed that the deceased's body temperature was not elevated contrary to the nurse's notes. As a result, he sent the deceased to a nurse to retake his temperature which came back within the normal range of $37^{o}C$.

95. Dr. Karim explained that a complete blood count (CBC) is a test used when a patient has an infection, low blood count or viral infection. As Mr. Singh's repeat temperature was normal and there was an isolated episode of vomiting during the day, this was thought to have been

caused by the pain or discomfort. Dr. Karim asserted that he did not think a CBC was necessary in the circumstances.

96. The deceased was then asked to sit on the exam bunk which is higher than the patient's chair. This activity was also used as test to determine if the patient had difficulty getting up on the exam bunk as he would have had to rotate his body and lift his lower limbs to lie flat on the bunk. The deceased was able to sit and lie on the exam bunk without any assistance and at no point did he complain or hesitate indicating pain.

97. Dr. Karim examined the deceased's abdomen which did not reveal any abnormalities and then proceeded to examine his back in order to ascertain the location of pain and tenderness. A straight leg test was performed to detect back pain. The test involves the doctor lifting the leg between 30-70 degrees or to where the patient indicates pain. No pain was indicated when the left leg was raised but was present upon the lifting of the right leg.

98. Based on the examination and discussions with the deceased, Dr. Karim made a diagnosis of sciatica which is a pain involving the sciatic nerve running from the lower back down to the hip and buttocks and branches into other nerves down the back of the legs. It can be caused by something impinging on the sciatic nerve which is illustrated through the use of the straight leg test. Dr. Karim affirmed that the pain the deceased indicated was evidence of sciatica. The deceased was then prescribed Tramadol (injection), Gravol and Zantac and was instructed to return if his pain got worse.

99. Dr. Karim affirmed that the deceased was coherent throughout the examination and was able to explain himself without difficulty. As a result, there was no need to ask a relative to be present during the

examination neither did the deceased request that a family member be present.

Fact findings of Navin's presentation on the 25th October 2014.

100. The evidence leads the court to find that Navin did complain to his mother about pain to his knee, that he had an elevated temperature and a severe episode of vomiting. The symptoms Navin had were enough for him and his family to decide that it was important for him to visit the doctor.

101. Nowhere in Dr Karim's evidence did he say that the examined the patient's leg. Had he examined the patient's leg, he may have ascertained that the source of pain was not the back. It may have caused him to rethink his diagnosis of sciatica or develop alternatives to the diagnosis of sciatica. It may have caused him to run tests to confirm his diagnosis of sciatica or rule out other diagnoses.

102. The fact that Navin's temperature was 37° when retaken, did not change the fact that he presented with fever or that he presented with pain and vomiting. Dr. Karim's evidence is that he considered an infection was possible and he should have done more to rule out the possibility of an infection or to confirm his diagnosis of sciatica. The court notes that Dr. Karim's treatment plan for Navin did not include any steps to confirm what he thought was sciatic pain did really relate to sciatica especially as he had considered infection.

103. Based on the evidence before the court, it was possible for patients to be sent to SFGH for test to confirm diagnosis made by the doctors at PTDHF. This was done when Navin was diagnosed with heel spurs on the 14th October 2014.

104. Dr. Karim's evidence was that the episode of vomiting may have resulted from the pain associated with the patient's sciatica. Dr. Karim, however did not explain why the patient would have experienced the episode of vomiting. Further, if Dr. Karim's account is correct, that the patient did not complain about pain and was able to "pass" the test of being pain free and mobile, then what accounts for the vomiting?

105. It is clear to the court that based on how Navin presented on the 25th October 2014; with fever, pain to his right leg, a temperature that the diagnosis of sciatica was inconsistent with a diagnosis of sciatica.

106. But was the misdiagnosis of sciatica on the 25th October 2014 negligent? The court finds that it was a negligent misdiagnosis.

107. In making this finding, the court considered Dr. Mayer's evidence that he was mistaken when he reported that there was no evidence that the nurse retook Navin's temperature on the 25th October 2014, and that a later normal temperature would not have altered his professional opinion.

108. According to the medical records, Navin presented with pain to the lower back radiating to his leg on the right side. According to the triage nurse, the patient reported pain and stiffness by two days. The notes showed that the patient reported that he had one episode of vomiting and that the pain was worse with movement.

109. The notes from the triage nurse showed that the patient was admitted at 7:07am with pain and stiffness to the right leg for the past two days. She administered the intramuscular injection and the patient was later discharged.

110. Dr. Karim does not give any evidence that he examined the patient's right leg. Dr. Karim's Report on Navin Singh dated 6th October 2014, refers to examination of abdomen and lower back. Although the examination of the lower abdomen found increase pain on the right side on straight leg raise, Dr. Karim still did not examine Navin's right leg. Navin's complaint upon being triaged was pain and stiffness to this right leg for the past two days.

111. Dr Karim, according to his evidence, even asked Navin where he was having pain and he said to the right side of his leg. He said Navin did not give him a clear direction as to the cause of his pain.

112. Dr. Karim said since Navin complained about pain to his back he examined his lower back. But Navin also complained about pain to his right leg to the triage nurse and to Dr. Karim, yet Dr. Karin did not examine his leg. Dr. Karim said he lifted both legs and the patient experienced pain when his right leg was raised. Yet again he did not examine his right leg.

113. With respect to pain, Dr. Karim's evidence is curious at best. He noted that the patient complained about pain to the triage nurse. He also said that he asked Navin to sit on the examination bunk as part of his test to evaluate the patient for pain, since the height of examination bunk would present difficulty for a patient in pain. Dr. Karim noted that Navin was able to sit and lie on the bunk without any assistance and that at no time did he complain or hesitate indicating any pain when getting on the exam bunk.

114. The court does not understand this finding. The patient told Dr. Karim, according to Dr. Karim that he had pain. Dr. Karim found that the patient was in pain when he did the examination. In fact Dr. Karim ascribed the episode of vomiting to pain.

115. So the impression that Dr. Karim attempted to give that the patient was not in pain because he got up on the examination bunk is inconsistent with his own evidence of his findings, including the fact Dr. Karim prescribed Tramadol for pain.

116. Professor Naraynsingh 's opinion is that a diagnosis of NF on the 25th October 2014 was near impossible given the symptoms that would have been present, or rather that symptoms that would not have obviously manifested themselves on that date. However, whether or not a diagnosis of NF should have been made on the 25th October 2014 does not answer the question whether the misdiagnosis of sciatica on the 25th October 2014 was a negligent misdiagnosis.

117. The court agrees with Professor Naraynsingh that based on Navin's presentation on the 25th October 2014, it may have been unlikely for a medical practitioner to have diagnosed Navin with NF. The court reiterates that this is different from whether Navin should have been diagnosed, incorrectly, with sciatica.

118. The court notes, that the triaging of Navin at level 3 on the 25th October 2014, seemed to be consistent with what the triage nurse found, given the patient's history and the results of her examination. The court also notes that it seemed unlikely that both Navin's parents would have been present with him from admission to discharge. Nothing turns on this finding of fact as the medical notes and the Dr. Karim's evidence were able to speak for themselves and for Navin.

119. With respect to whether there was one episode or more than one episode of vomiting before the 25th October 2014, the court resolved this issue by recourse to the medical notes from the notes from the triage nurse. The triage nurse noted that the patient said he was also having vomiting by one episode.

120. It is clear, and the court is satisfied on a balance of probabilities, that the misdiagnosis of sciatica on the 25th October was negligent.

121. On the 25th October 2014, Navin complained to his mother that he was having pain to this right knee. He had fever and at least one episode of vomiting. The triage notes confirmed this presentation. Upon initial assessment by the triage nurse he was febrile. Upon examination by the medical doctor, he complained of pain to his leg. There is no reason to believe that Navin would not have told the doctor that he was experiencing pain to his right knee, this would be illogical. That is what took him to the doctor. The doctor never examined his leg. He did cause the nurse to retake the patient's temperature and it was within the non-febrile range.

122. The court finds that based on Navin's presentation, his history, the nature of the doctor's examination in its limited scope, the fact that there was no consideration of an alternative diagnoses, the evidence from the doctor that the patient could not identify a traumatic incursion to account for his pain, that there were no test done either to confirm sciatica or rule out other possibilities, leads the court to conclude that the misdiagnosis of sciatica on the 25th of October 2014 was a negligent misdiagnosis. The treatment of Navin was below the standard of care expected in the circumstances. The court prefers and agrees with the opinion proffered by Dr. Mayer.

27th October 2014

123. By Monday 27th October 2014, the claimant noticed that the deceased's right knee began to swell and the skin surrounding the said knee had darkened. At that point the deceased was in so much pain that he could not walk and had to be bodily lifted into the vehicle to be transported to PTDHF. When the deceased arrived at PTDHF, he was

placed in a wheelchair and was seen by Dr. Mc Benedict. The claimant avers that despite the increased symptoms of extreme fever, nausea, weakness, fatigue and now a swollen and blackened knee, Dr. Mc Benedict again diagnosed her son with sciatica and was given a Tramadol injection for the pain and a dosage of Gravol. The deceased was again sent home in his condition without any blood work, laboratory investigations, X-Rays or any other routine test being performed.

124. Ms. Allison Rambhajan was the triaging nurse on the 27th October 2014. Her evidence was that on average she triages approximately 80-100 patients a day. Triage is the first contact with the patient and allows for an overall view of the patient's status when they first arrive at a Hospital or Health Facility. It is a quick process which determines the priority to assign to patients based on the severity of their condition. Based on this first assessment, a patient is assigned a number by the triaging nurse between 1-5; 1 being the most critical such as an unconscious patient, whereas 5 is very minor as in a case where a patient has a small cut or rash. A patient with a lower score is therefore given priority to see a doctor. The triaging system at the PTDHF as at 2014 was based in the Canadian Triage and Acuity Scale.

125. On the day in question, Ms. Rambhajan avers that the deceased was alone and did not ask for a relative to be present with him. While speaking to him about the reason for his visit, she took his vitals which were all within the normal range and the patient did not require any assistance. Ms. Rambhajan stated that she took the deceased's temperature and asserts that it was in the normal range which is between 35.5^{o}C and 37°C. However, she admitted that while it is customary practice for her to write the temperature in the nurse's notes, she omitted to do so on this occasion and could not recall the reason for not doing so.

126. The deceased informed Ms. Rambhajan that he had pain from the right buttock going down to the leg which she recorded in the nurse's notes. Based on her assessment of the deceased, she triaged him as a level 4 patient as she considered him to be stable. Ms. Rambhajan asserts that at no point in time did the deceased inform her that he was experiencing fatigue, weakness, fever or vomiting, otherwise he would have been triaged as level 3.

127. Dr. Mc Benedict was the treating doctor on Monday 27th October 2014 and gave evidence on the further events that transpired on that day for the defendant. Dr. Mc Benedict stated that during his time at the Accident and Emergency Department of the PTDHF, he would sometimes walk along the corridor to speak to patients who were waiting, in efforts of assisting any patients triaged at levels 4 or 5, as those triaged at levels 1-3 would require and receive immediate attention.

128. On Monday 27th October 2014, Dr. Mc Benedict averred that around 8:00pm he was walking along the corridor and the deceased was the first patient he saw. The patient was sitting on a wheelchair and he was by himself. When asked what was wrong, the deceased indicated that he had pain in his right hip radiating down the leg. Dr. Mc Benedict then went to retrieve the deceased's file while an attendant wheeled the deceased into the doctor's office.

129. Before reading the notes pertaining to the deceased in the file retrieved, Dr. Mc Benedict stated that he preferred to listen to the patient's complaints himself so that he would be unaffected by any previous diagnosis in the notes. When the deceased indicated that he felt pain from the right hip going down to the right leg, Dr. Mc Benedict enquired whether it was due to a fall or if he 'got a lash' to cause the pain. The deceased answered in the negative.

130. In accordance with the standard of the emergency department, Dr. Mc Benedict then ask Mr. Singh whether he had any cough, vomiting or fever to which he again answered in the negative. In response to his past medical history, the deceased appraised Dr. Mc Benedict that he was given a Tramadol injection on his last visit and that he had taken two doses of Arcoxia and Mydocalm tablets for the pain.

131. Dr. Mc Benedict asserted that he examined Mr. Singh's ability to get up from the wheelchair, walk to and get onto the exam bunk which he did unassisted and without any complaints. The deceased then laid down on the exam bunk and Dr. Mc Benedict ascertained that he was stable and not febrile to touch. As the deceased's breath sounds and heartbeat was normal, Dr. Mc Benedict focused on the area of complaint i.e. the right hip/buttock radiating down to the leg.

132. In conducting an examination of the hip and entire leg, Dr. Mc Benedict asked the deceased to remove his short pants to identify whether there was any discoloration, bruises, swelling, cuts or any other deformities. However, Dr Mc Benedict asserts that there was none which could have been easily identified as Mr. Singh was light skinned.

133. The muscle compartments of the deceased's thigh and leg were palpated for tenderness and Dr. Mc Benedict affirmed that he did not feel febrile to the touch and had good sensation. The deceased was also asked to move his lower limb starting from the ankle joint to the knee joint and ending with the hip joint. He indicated tenderness (pain) at the lateral aspect of the right hip, just above the thigh.

134. Dr. Mc Benedict asserted that based on the physical examination conducted illustrating the nature and radiation of pain

complained and that Mr. Singh did not have any trauma, his diagnosis was sciatica. There was no deformity that indicated the need for an X-Ray to be performed nor did he have a high temperature which could have indicated a possible infection requiring a blood test at that time. Furthermore, Dr. Mc Benedict stated that if there was swelling or signs of infection on the limb, he would have referred Mr. Singh to the Emergency Department of SFGH.

135. Following the examination, the deceased returned to the wheelchair without complaints which required him to get down from the examination bunk and take a few steps. Dr. Mc Benedict then prescribed an intra-muscular injection of Tramadol and Gravol. The deceased was then told to continue with the medication prescribed at the last visit but if he still had pain or there were any other complications, he should return without hesitation.

136. Dr. Mc Benedict said the attendant wheeled Navin out of his office.

Findings of fact

137. The court finds that on the 27th October 2014, Navin presented with severe pain to this right leg in the area of his knee. The court finds that his knee was swollen and he had fever. He was unable to ambulate and his family lifted him into the vehicle to take him for medical attention. Because he was unable to ambulate, upon his arrival at the PTDHF he required wheelchair assistance. He was taken into the PTDHF by wheelchair. Had his temperature been taken by the triage nurse, she would have found it to be elevated. The court makes this finding based on the professional opinions expressed by Dr. Mayer and Professor Naraynsingh on the progression of NF. Further the advice given to

Navin as part of his treatment plan on his visit to PTDHF was to return ASAP if the pain increases, he had weakness or loss of consciousness.

138. Clearly Navin was worse and he returned ASAP. He could not ambulate he was lifted to the vehicle and he needed wheelchair assistance. It is difficult for the court to understand how a patient whose condition had deteriorated could have been assessed, on his second visit, as requiring less urgent care than his first visit. The fact that Navin's temperature was not taken by the triage nurse, his history not factored by the triage nurse and the assessment by the triage nurse of level 4 the court finds to be below the standard of care required by the servants and agents of the defendant. It was negligent.

139. Based on the evidence adduced by Ms. Rambhajan under cross examination, it is difficult to accept that she took the temperature on the 27th October 2014, and furthermore that it was normal. The witness herself admitted that she could not rely on her memory as she saw many patients on a daily basis, around 100. She relied on her written accounts in the records. Therefore, since the temperature was not recorded in the medical records, the court is not satisfied that the temperature was taken moreover, that it was within the normal range as Ms. Rambhajan stated in her witness statement.

140. The court also discounted Nurse Rambhajan's more contemporaneous account of having taken Navin's temperature and that it was within the normal range appearing in her Report dated the 6th November 2014. Under cross-examination Nurse Rambhajan's evidence is that the Head Nurse prepared that report, and presented it for her signature. She further stated that she was uncomfortable signing it. Nurse Rambhajan's evidence is that when the report said that the patient showed no signs of distress on the 27th October 2014,

that was not true. It was the Head Nurse who included that inaccuracy about Navin's presentation.

141. To be clear the court did not believe Nurse Rambhajan's evidence. According to Nurse Rambhajan, Navin was alone sitting in a wheelchair and did not ask for a relative to be present with him. She said that while speaking to him about the reason for his visit she took his vitals which were all within the normal range and that "He did not require any additional assistance." Clearly this is not true, Navin required additional assistance, he needed wheelchair assistance. He was taken from triage by an attendant. According to Nurse Rambhajan, based on the CTAS a level 4 patient is one who is not very serious and would be considered stable.

142. The court also found it unlikely and did not believe Nurse Rambhajan that Navin had no relative present and that he did not ask for a relative to be present. Given human nature and the deterioration in Navin's condition, the court believes that the claimant would have been present with her son.

143. The court considered the situation that would persist in an accident and emergency department; the hustle and bustle as a consequence of the number of patients passing through and the need to make as quick as possible an assessment based on the patient's presentation, history and the clinical findings.

144. In this case, Navin was told to come back if he got worse. Clearly he got worse and obviously so as he needed wheelchair assistance. Evidence of his worsening state also comes from the evidence of the claimant. In those circumstances not taking Navin's temperature was a critical oversight and below the standard of care required. It appears and the court finds that from the time Navin was wheeled in on the 27th October 2014, the defendant's servants and agents, including Nurse

Rambhajan were content to treat his visit as a continuation of his last visit.

145. The court also does not believe Dr. Mc Benedict. Had he examined the patient in the manner he testified to he would have, firstly recorded his findings. More importantly, the examination would certainly not have led to a misdiagnosis of sciatica.

146. In assessing Dr. Mc Benedict's credibility, the court considered the contemporaneous records. The court notes the vital signs and the fact that the temperature was not taken. The patient complained about pain to his buttocks radiating to his leg not subsiding since his last visit. The examining doctor diagnosed him with? Sciatica right side.

147. From all accounts the "?" represents a questioned or uncertain diagnosis. Why did Dr. Mc Benedict question this diagnosis of sciatica?

148. The medical notes recorded that Dr. Mc Benedict did not see any swelling or deformity to the leg and that there was a good range of movement. How could this be when the evidence is that he was in a wheelchair.

149. The obvious question for the court is how did Navin present on the 27th October 2014? The court has considered the claimant's evidence and found her to be a credible witness on this issue. It is clear that Navin was worse off on the 27th October 2014 than he was on the 25th October 2014. We know this because he needed wheelchair assistance. The court accepts the claimant's evidence that Navin, on that day could not walk. That they assisted him to get to the vehicle to take him to the hospital and that when he got to the hospital he needed assistance. Common sense and the expert evidence presented by both Dr. Mayer and Professor is that NF would cause pain out of proportion to the complaint.

150. As Professor Naraynsingh opined, if however, the patient had intense pain, swelling to his right knee and having three dark spots behind his knee, then the diagnosis of NF should have been considered and the patient referred for specialist care.

151. The court does not believe Dr. Mc Benedict's evidence that he asked Navin to get up from the wheelchair and was able to walk to the exam bunk unassisted and without any complaints. According to Mc Benedict, Navin told him that he had cause to return since the 25th October 2014 for tramadol because it was more effective in relieving his pain. In addition to tramadol for the pain Dr. Mc Benedict noted that the patient told him that he had also taken arcoxia and mydocalm tablets for pain. From the account provided by Dr. Mc Benedict, Navin was describing more severe pain that not only caused him to return for more pain relief medication, but also to take two additional tablets for pain; tablets that had not been prescribed by Dr. Karim on the 25th October 2014.

152. What the court finds suspicious about Dr. Mc Benedict's evidence is the details provided about the patient not being in any distress and not being febrile to the touch. The fact that there was no temperature recorded by the triage nurse leaves the court to believe that if Dr. Mc Benedict had made any observations about the patient's temperature, whether he appeared febrile or not, the findings would have been recorded by him in his contemporaneous notes. From all accounts temperature is vitally important.

153. This observation about Navin not having a temperature also did not form part of Dr. Mc Benedict's Report dated 6th November 2014; two weeks or so after the examination. It first appeared in Dr. Mc Benedict's witness statement dated the 29th October, 2018, some four years after his examination of Navin.

154. The omission of the triage nurse and Dr. Mc Benedict to take Navin's temperature on the 27th October 2014 is an important fact on its own. The omission was even more critical in light of the notes from the triage nurse which recorded that the deceased was experiencing tachycardia with a heart rate of 112. Tachycardia is consistent with infection and an elevated temperature as well as tachycardia should have alerted Dr. Mc Benedict to infectious disease. According to Professor Narayansingh in cross-examination tachycardia is a racing heart - is a non-specific finding but when you see it you have to look for possible cause, they should have taken the temperature - they should have been looking at the cause of the tachycardia.

155. Further, the details provided by Dr. Mc Benedict in his witness statement, about his examination of Navin were not recorded contemporaneously by him. Dr. Mc Benedict's evidence in the trial is that he asked Navin to removed his short pants and that he examined his hip and entire leg for discoloration, bruises, swelling, cuts or any other deformities. Dr. Mc Benedict also testified that he palpated the muscle compartments of the thigh and leg for tenderness. That he asked him to move his lower limb starting from the ankle joint, to the knee joint and ending with the hip joint.

156. None of those details appear in the hospital notes, nor do they appear in Dr. Mc Benedict's Report dated 6th November 2014, which can also be said to be contemporaneous with the event. Those details appear for the first time in Dr. Mc Benedict's witness statement dated 29th October 2018, more than four years after the date of Dr. Mc Benedict's examination of Navin.

157. Interestingly, Dr. Mc Benedict's evidence is that he focused his examination to Navin's thigh and leg. He said that he asked Navin to move his lower limb starting from the ankle joint to the knee joint and

ending with the hip joint. He did say, that Navin indicated tenderness (pain) at the lateral aspect of the right hip.

158. By comparison, Dr. Mc Benedict's report on Navin Singh dated 6th November 2014 stated that Navin complained of pain for two days. Dr. Mc Benedict had access to the patient's medical records and a cursory examination would have shown that the patient's complaint about pain was for more than two days. He had pain for one or two days before his visit on the 25th October 2014. He noted that the patient had no other complaints. It is hard to believe that the patient did not complain that his pain had not subsided and in fact had gotten worse since the last visit on the 25th October 2014.

159. On examination, Dr. Mc Benedict noted that the patient was stable and was in no obvious distress. This is inconsistent with a patient having to be wheeled in to see the doctor. The court notes that Dr. Mc Benedict's Report of the 6th November 2014, makes no reference to the patient sitting in the corridor in a wheelchair nor that the patient's comfort or discomfort was tested by Dr. Mc Benedict by having the patient walk for the wheelchair to the exam bunk and lie down.

160. Dr. Mc Benedict's evidence raised in the court's mind, suspicion about the nature and manner of the examination if any, he conducted. The court is satisfied that Dr. Mc Benedict could not have and did not examine Navin in the manner he described in his evidence to the court. Had it been as described by Dr. Mc Benedict, he would have seen what the claimant described; the swelling, discolouration and black spots behind Navin's knee.

161. The court accepts the evidence of the claimant that Dr. Mc Benedict did not re-examine Navin but relied on Dr. Karim's notes.

162. Support for the court's findings come from the medical records from the San Fernando General Hospital on the 29th October 2014. The Progress Notes for Navin stated that the patient began having pain and swelling of the right leg about five to seven days before which became progressively worse. Further the Report on Navin Singh from the South-West Regional Health Authority dated the 1st December 2014 noted that Navin's mother gave the patient's history. According to the report, the mother said that Navin began experiencing pain to this right knee and thigh approximately 3-5 days earlier, with progressive leg swelling and the inability to ambulate.

163. It seems logical that the claimant would report accurate information to the health authorities in her quest to get her son the appropriate medical attention. The claimant's account on the 29th October 2014 is consistent with her evidence about Navin's presentation on the 27th October 2014 and inconsistent with Dr. Mc Benedict's account of Navin's presentation on the 27th October 2014.

164. In this regard, both experts agree, that based on Navin's presentation, as the court found it, a diagnosis of sciatica should not have been made on the 27th October 2014. At the least, in Professor Naraynsingh's opinion, NF should have been considered and the appropriate medical intervention made to treat with the suspicion of that serious disease. In cross-examination Professor Naraynsingh said that if the deceased on the 27th October 2014, could not move and his parents had to lift him and bring him down the stairs and he could not move and they put him in the vehicle and they had to lift his foot and they put him in a wheelchair because he could not bend his knee and there was severe blackening, which was all inconsistent with the medical notes, then that should have caused a siren in the mind about NF.

165. What Professor Naraynsingh hypothesised about in cross-examination were in fact not hypothetical in nature. Those were the facts as the court found them.

166. At the highest Dr. Mayer is sure that a doctor exercising due care would have diagnosed Navin with NF on the 27th October 2014 and certainly would not have diagnosed Navin with sciatica.

167. For the record, the court considered the submission made by the defendant that there was inconsistency in the claimant's evidence about when the three dark spots were observed; the 27th October 2014 or the 29th October 2014. The court could understand that based on the progressive nature of the disease of NF and Navin's worsening condition over time that the claimant's recollection of these details could be mistaken and confused.

168. In that regard, the court considered that the Pre Action Letters alleged that on the Monday 27th October 2014 three dark spots behind the deceased's knee were observed, the claimant's pleadings indicated that it was by Wednesday 29th October 2014 his right knee had "three (3) extra dark spots on it."[20] Her witness statement also indicated that it was by Wednesday 29th October 2014 "We noticed three black spots situated on the knee."[21] Under cross examination, the claimant's explanation was that the Pre Action Letter although written on her instructions was wrong for stating that the dark spots were observed on the 27th October 2014[22].

169. Based on the evidence the court is satisfied that when the deceased presented on the 27th October 2014, his right lower limb was

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[20] Statement of Case filed on the 17th July 2015 at paragraph 11

[21] Witness Statement of Bhagwantee Singh Weekes filed on the 13 November 2018 at paragraph 22

[22] Transcript for Trial Day 1 dated 1st July 2019 page 35 lines 1 to 12

swollen and skin changes. The court is also satisfied that by the 29th October 2014 the skin changes had progressively worsen and that there were three dark spots behind Navin's knee.

170. The court finds, and is satisfied that the misdiagnosis of sciatica on the 27th October 2014 was a negligent misdiagnosis.

Causation

171. The court having found that the diagnosis of sciatica on the 25th October 2014 and the 27th October 2014 were negligent misdiagnoses, the next issue was whether the ultimate result caused by NF was caused by these misdiagnoses.

Law

172. The court applied the test for causation as outlined by Lord Browne-Wilkson in *Bolitho* (supra), that whether or not negligence was admitted or proved, the burden of proof lies on the claimant to prove that the breach caused the injury suffered. This inquiry, according to Lord Browne-Wilkson in *Bolitho* (supra) is a question of fact for the court to find; whether the wrongful act caused the injury. In this case the injuries were Navin's pain and suffering and later his death.

173. In *Peter Christopher Duffy -v- Dr Adrian Phillip Mairs and others* [1997] SCLR Lord Hamilton found that the defendant was negligent in its failure to diagnose NF at the first doctor's visit with referral taking place some two days after. He found that had the patient been referred earlier than he did, the extent of damage suffered would have been less. The failure to diagnose therefore caused delay in treatment.

174. In *Barnett -v- Chelsea and Kensington Hospital Management Committee [1968] 1 All ER* it was found that the defendant's examination should have been more thorough and the severity of the symptoms demanded that the patient should have been referred to the hospital for further tests.

175. In the case of *Layden -v- Cope* (1984) CCLT 140 Alt QB it was stated that in medical negligence there are instances where treatment becomes narrow and blinded by previous treatment or diagnoses and the doctor does not keep an open mind to revise the initial diagnosis. Rowbotham J held that the general practitioners were negligent on the basis that they failed to reconsider their diagnosis or treatment, or both and had failed to consult or refer the patient to a specialist.

176. Jones on Medical Negligence[23] made reference to the case of *Gardner -v- Northampton General Hospital NHS Trust* [2014] EWHC 4217. In that case there was a catalogue of errors made by the defendant hospital but there was no admittance for failure to diagnose NF. NF was diagnosed too late and the patient died. Sir David Rady held that the failure to diagnose NF in time was negligent and this had caused the patient's death, either on the basis that the patient could probably have been successfully operated on but for the negligent treatment, or on the basis that negligence made a material contribution to the fact that it became too late to operate with any reasonable prospect of survival.

Evidence and analysis

25th October 2014

[23] 5th Edition page 398

177. Regarding the negligent misdiagnosis of the 25th October 2014, had the defendant's agents and/or servants not made the negligent misdiagnosis the court is not certain that NF should or would have been diagnosed. But the court agrees with the opinion offered by Dr. Mayer, that any misdiagnosis should have been of an infectious disease based on Navin's presentation and the history he provided.

178. In those circumstances the court is satisfied that Navin should have been treated for an infection. The negligent misdiagnosis therefore caused Navin to suffer pain and suffering.

27th October 2017

179. According to Dr. Mayer, imaging techniques could have been adopted as a screening mechanism for ailments of the leg which could have detected infection and possibly NF[24]. Counsel for the defendant in citing Goh (2013) indicated that the detection rate of gas in flesh tissue using plain X-Ray was low at around 24.8% so it was of no significant difference if diagnostic imaging was used or not. Nevertheless, while admitting that it was not the best diagnostic aid, Dr. Mayer responded that it was still useful.

180. The court agrees with Dr Mayer's expert opinion. Furthermore, while Goh (2013) describes the misdiagnosis of NF as 71.4%, the misdiagnosis made was cellulitis or abscess in their systematic review. The misdiagnosis was made with similar infections processes and there is no mention in the medical literature that misdiagnosis was ever made with sciatica or some non-infectious cause.

181. The failure to diagnose therefore caused delay in treatment. The deceased died from NF when the diseased reached a late and

[24] Transcript Trial Day 2 dated 2nd July 2019 page 28 line 13 to 18

extensive stage because the servants and/or agents of the defendant failed to diagnose and/or take the relevant steps to assist diagnosis of NF on the 27th October 2014. But for this failure to diagnose NF and the negligent misdiagnosis of sciatica, the deceased more likely than not, would have been alive today as both experts agreed. The delay in treatment caused by the negligent misdiagnosis led to Navin's death

182. The failure to consider a differential diagnosis of NF and/or some other infectious disease and the failure to diagnose NF was despite the deceased exhibiting the classical signs of NF raising "red flags". In this case, had the deceased been diagnosed with NF on the 27th October 2014, been referred to a primary care facility and started treatment is it likely that he would have been alive today.

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Justice Avason Quinlan-Williams

JRC: Romela Ramberran