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Judgment: approved by the Court for handing down | *Delivered:* **18/3/10**
(subject to editorial corrections)

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

Between:

CM

Plaintiff;

-and-

UNITED HOSPITALS TRUST

Defendant.

HIGGINS LJ

[1] The plaintiff was born in 1987 and is now 22 years of age. He works as an automotive engineer. In September 2000 he was thirteen years of age and attended High School. Around 0400 on Monday 4 September 2000 his mother was alerted that the plaintiff was unwell. He had been well the previous evening. On going to his bedroom she found him rolling on the floor and starting to vomit. His mother thought the symptoms indicative of appendicitis and took him to Antrim Area Hospital where he was seen almost immediately and admitted. His mother said that a female doctor told her that he was "presenting with appendicitis and that he should be in theatre within the hour". About an hour later the doctor told her that his blood tests had become available and that his condition was not due to appendicitis. He was admitted to Ward II where he remained until the following day 5 September when he was discharged shortly after 1.30pm with a letter for his General Practitioner. Later on that day he complained of severe pain in the genitalia and it was noted that his scrotum was swollen.

[2] The following morning 6 September he was taken to see his GP who, having read the hospital letter and examined him, prescribed an antibiotic. He returned home to bed where he remained until late on the evening of Thursday 7 September when he came down to the living room and collapsed

onto the floor. An ambulance was summoned and he was taken to Antrim Area Hospital where he was admitted at 0001 on 8 September. Following examination and initial diagnosis he was transferred to the Royal Victoria Hospital. Later he was transferred to Belfast City Hospital where his right scrotum was noted to be tender, red and swollen and he was diagnosed as suffering from severe right-sided epididymo-orchitis. An exploratory operation on 9 September confirmed this diagnosis it being noted that the right testis was swollen and oedematous, but viable and the epididymis was grossly swollen. He was continued on antibiotics and discharged home on 11 September. He was reviewed in May 2001 when it was found that the right testis had atrophied, though the left testis was normal. Later the atrophied testis was removed and a prosthetic implanted.

[3] The plaintiff gave evidence about the pain and discomfort suffered during this period and the embarrassment that he now feels and a more general feeling of 'not being normal'. Tests suggest that his ability to reproduce has not been affected.

[4] Paragraph 4 of the Statement of Claim alleges –

> "The Defendant's servants and agents failed to examine the Plaintiff properly when he first attended on 4 September 2000. If proper examination had been carried out the defendants would have noted a problem with the testicle, treated the Plaintiff with antibiotics and he would have made a full recovery. By reason of the foregoing the Plaintiff has suffered severe personal injuries, loss and damage as hereinafter appears."

Paragraph 5 set out the Particulars of Negligence alleged whilst the Plaintiff was in the care of the Antrim Area Hospital on 4 and 5 September 2000.

The Defence served on behalf of the defendant on 3 May 2005 denies each and every allegation by the plaintiff including that he was admitted to the Antrim Area Hospital with a short history of lower abdominal pain, nausea and vomiting and the entire subsequent history there and elsewhere.

[5] The Plaintiff and his mother gave evidence. The plaintiff has a limited memory of the period due to his age and the principal source of information was his mother. The only other witnesses called were Mr John H Scurr, FRCS, on behalf of the plaintiff and Mr J Moorhead , FRCS, on behalf of the defendant. There was a significant disagreement between the medical witnesses about the examination and treatment of the plaintiff at Antrim Area Hospital and about the signs and development of epididymo-orchitis. Each of

the medical witnesses was challenged as to his expertise in this medical condition.

[6] On 2 November 2009, a short time before this case came on for trial, the defendant's solicitors wrote to the plaintiff's solicitor in the following terms –

> "For the avoidance of doubt, the Defendant's independent experts will deny that the Plaintiff did have epididymo orchitis on either 4th or 5th September 2000. It will be contended that the Plaintiff probably had mesenteric adenitis, which is viral in origin. This same virus then most probably led to the subsequent development of the epididymo orchitis.
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> The notes show a differential diagnosis of appendicitis. It is accepted as possible that the Plaintiff had a patent processus vaginalis and the epididymo orchitis could have been caused by direct communication from the appendix to the epididymo orchitis. However, it is felt that this is less likely than the viral theory and in any event, the appropriate treatment for the appendicitis would not have prevented this development of epididymo orchitis."

Thus the defendant's defence was that the plaintiff was suffering from another condition, more probably mesenteric adenitis, which developed into epididymo orchitis. While the possibility of a processus vaginalis was referred to, the defence concentrated on the probability of a mesenteric adenitis.

[7] On 4 September the plaintiff awoke with abdominal pain around 0400. He was seen at Antrim Area Hospital, Accident and Emergency at 0606. A history of lower abdominal pain, some nausea and vomiting was recorded. On examination he was tender in the right iliac fossa with guarding and rebound tenderness. An initial diagnosis of appendicitis was made and he was admitted and referred for surgery. He was given Cyclimorph, a strong painkiller. When he was examined at 0730 he was pale and looked unwell though he was apyrexial (without temperature). Examination revealed tenderness in the right iliac fosa with some guarding but no rebound tenderness. Later on review by the Registrar he was still complaining of lower central abdominal pain. On examination his abdomen was soft and he was tender in the suprapubic region and in the right iliac fossa. There was mild rebound tenderness with no guarding. A differential diagnosis of appendicitis, Merckel's diverticulitis and non-specific abdominal pain was made and the plan was to observe him. The nursing records show that he was much brighter that evening. He was allowed to go to the playroom but there he developed acute abdominal pain in the right iliac fossa. He was given

Voltarol orally for the pain and he then slept all night. The following day 5th September he had improved and it was decided that he could return home. At 1310 is mother was informed by a doctor that he could be allowed home and the nursing notes record that "Mum was happy with same". At 1330 he was discharged with his mother in attendance. On returning home he slept for an hour and woke with pain in his right testis. It began to swell and became inflamed and the pain increased. On the morning of 6 September he was taken to see his General Practitioner who noted the above history, prescribed antibiotics and advised him to return to hospital if the pain did not settle. After he collapsed on the living room floor an ambulance was summoned and he was readmitted to Antrim Area Hospital at 0001 on 8 September. At casualty a swollen right testis was observed and the casualty officer noted "painful swollen right testis for two days". On examination he was pyrexial, the abdomen was soft, his right testis was swollen and tender with red scrotum. The plan was for review by surgeons. He was then examined by another doctor who noted, inter alia, "impression orchitis". He was to continue on antibiotics in the meantime and then discharged home.

[8] In the course of her evidence the plaintiff's mother referred to an occasion at Antrim Area Hospital when the plaintiff was walking in a strange manner, which she described as a "John Wayne walk", which was understood to mean bow-legged. It is clear the plaintiff was seeking to avoid contact between his inner thighs and his scrotum. His mother attributed this occasion to his first discharge from Antrim Area Hospital at 1.30pm on 5 September. She said she pointed this out to the nurse and said she was not happy, but the nurse said that the doctor had said that it was alright for the plaintiff to leave.

[9] Mr Scurr qualified as a doctor in 1972 and is a Consultant Vascular and General Surgeon who, inter alia, previously held consultant and honorary consultant appointments at various hospitals in England and was a Senior Lecturer in Surgery at the University of London as well as an Examiner. Early in his medical career he spent two years as a paediatric urologist. He has now a particular interest in vascular and venous disorders. During his hospital consultancies he was mostly engaged in general surgery, but during this period gained considerable experience of orchitis, but has not encountered this condition recently. Having reviewed the medical notes and records his opinion in his report was -

> "[The plaintiff] was seen in the accident and emergency department of Antrim Area Hospital on 4th September with a one and a half hour history of lower abdominal pain associated with nausea and vomiting. On examination he was noted to be tender in the right iliac fossa with guarding. There is no mention of any examination of the scrotum. A provisional diagnosis of acute appendicitis was made

> and he was admitted to hospital, again there are no notes to indicate that the scrotum was examined. When reviewed later by the registrar he was still complaining of lower central abdominal pain, he had a normal white cell count and remained apyrexial. There was no guarding and he had mild rebound tenderness. He was further assessed and I note discharged from hospital the following day.
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> On 6th September, the day after discharge, he was seen by his general practitioner. On this occasion he complained of pain in his right testicle, which had increased in size and become more painful. The general practitioner's examination of the testicle revealed the testicle to be swollen.
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> It is more likely that [the plaintiff's] symptoms when he presented with the suspicion of acute appendicitis, were in fact related to his testicles. Testicular pain is often referred to the midline and below the umbilicus. An examination of his scrotum on 4th September would have revealed epididymitis. Antibiotics at this stage would probably have prevented a severe epididymitis giving rise to an epididymal orchitis and subsequent los of the testicle. Exploration of the scrotum was appropriate, the testicle was not twisted, the epididymis was noted to be grossly swollen. [The plaintiff] was treated with antibiotics, which was entirely appropriate. The error was failing to examine the scrotum. A provisional diagnosis of acute appendicitis was made but this condition appears to have resolved spontaneously. It is likely that when [the Plaintiff] presented, he had inflammation of the testicle giving rise to abdominal symptoms. Appropriate treatment at this stage would probably have presented a severe infection giving rise to loss of the testicle. Antibiotics prescribed on 4th would have avoided a surgical procedure on 9th September and would have avoided loss of the testicle. In summary, [the Plaintiff's] treatment falls below an acceptable standard of care."

[10] In his evidence Mr Scurr expanded on the contents of his report. He was firmly of the opinion that the circumstances in which the plaintiff presented at Antrim Area Hospital warranted an examination of the scrotum and the rectum. In addition to the examination of the plaintiff's abdomen at

Antrim Area Hospital, the rectum was also examined, but not the scrotum. Mr Scurr said that male teenagers up to the age of sixteen years commonly presented with torsion of the testes or various infections, all asymptomatic. The first sign of torsion is abdominal pain, not pain in the scrotum. This only occurs when the testis becomes inflamed by which time it may be too late to save it. He was of the opinion that an examination of the plaintiff's scrotum would have revealed an early testis condition developing over 4 and 5 September, as on evening of 5 September the testis was swollen and tender. If examined it would have been found to be tender with swelling of the epididymous which would have been infected at this stage. It would more likely have been bacterial as viral epididymo orchitis is unusual in pre-pubertal children. The fact he improved after being given antibiotics tended to confirm that it was bacterial. Such a condition could arise from a urinary tract infection, from the gut, via the abdominal cavity or occasionally it could be blood-borne. An intravenous treatment of antibiotics, which is quicker and more effective, would have prevented his testis becoming atrophied. He explained that mesenteric adenitis is a specific abdominal complaint in which the glands in the mesentery in the bowel become inflamed. It is normally associated with an infection like a sore throat and it affects the neck and abdominal glands.

[11] It was put to Mr Scurr that a diagnosis of mesenteric adenitis of viral origin was a more likely diagnosis of the plaintiff's symptoms. He did not accept that and commented that it would be unusual for a patient to have a viral mesenteric adenitis without signs in the throat and lymph glands. He thought it would be unusual for such an infection to affect the abdomen and one testicle and that he had never encountered such before. While it is a common differential diagnosis to appendicitis it was not mentioned in the notes and more significantly the notes record that no abnormality was noted in the lymph glands. In cross-examination it was put to him that where there are clear signs of peritonitis (the triad of abdominal pain, guarding and rebound) it was not necessary to examine the scrotum. He disagreed with this and stated that a student who failed to examine the scrotum would not pass his medical examinations. The mere diagnosis of non-specific abdominal pain was sufficient to warrant an examination of the scrotum. He did not agree that the scale of the triad of signs exhibited by the plaintiff was sufficient to make a clinical diagnosis of appendicitis or peritionitis. In isolation these three signs were suggestive of appendicitis but they were minimal and ignored the history of severe pain, nausea and vomiting. Severe pain is unusual for appendicitis and it is not associated with vomiting. The severe pain would have prompted him to think of torsion as the explanation. He was concerned at the failure to look for an explanation for the non-specific abdominal pain, particularly as the signs of appendicitis had abated. He felt there was sufficient doubt about the diagnosis to make it essential that the scrotum be examined. The problem from the outset was epididymo orchitis and not appendicitis. He thought it very unlikely that the plaintiff had

mesenteric adenitis and did not accept that he had. It would be unusual for mesenteric adenitis to affect the testes. He did not accept the theory that the plaintiff suffered two successive ailments. It was put to him that no epididymitis or orchitis was present on either 4 or 5 September and that it was unreasonable to expect any doctor to suspect acute epididymitis. He disagreed saying that if the plaintiff had been examined properly it would have been found. It was evident that it got worse after he was sent home. He accepted that with a bacterial orchitis of sufficient severity the white cell count goes up, but commented that sometimes this takes time. In the early stages it would not be unusual for the patient to have a low white cell count. In addition the patient's temperature sometimes rises quite high. It was put to him that the specimen taken at Belfast City Hospital on 9 September indicated the absence of bacteria. He commented that the specimen would have been affected by the taking of antibiotics which suppressed any bacteria and that there would not necessarily have been any signs, for example dead cells or detritus left behind for the micro-biologist to observe. He accepted that a virus can attack any part of the body without signs in the glands and nodes, but found it surprising that such would disappear and then return. This would not be normal. The body's immune system eventually destroys the virus and commented that it would be like developing flu twice in the one week – "a virus does not come back 24 hours later in a different part of the body". It was improbable that a virus would affect one part of the body and later another. Towards the end of his cross-examination the defendant's case was put to him in this way –

> "that the plaintiff had a mesenteric adenitis, not appendicitis, that the overwhelming probability was that this infection in his abdomen was viral in origin and not bacterial, that it resolved without intervention of antibiotics and he recovered, but the virus then went on to affect the epididymous and brought about a viral epididymo orchitis and that even if he was examined nothing would have been found and that as it was viral antibiotics would have made no difference."

Mr Scurr did not accept that the plaintiff had mesenteric adenitis as he did not have the usual accompanying signs of a sore throat and problems with the lymph nodes. He could not exclude mesenteric adenitis but thought it very unlikely. If he did have mesenteric adenitis it was unknown or unusual for such to affect a testicle in a pre-pubertal child. He disagreed that it was viral as antibiotics led to his recovery.

[12] Mr Moorhead qualified as a doctor in 1978 and is presently a Consultant Surgeon at the Ulster Hospital specialising in gastro intestinal

conditions. His experience includes lecturing and examining at different levels. In his report dated March 2009 he stated his opinion –

> "When [the plaintiff] presented in September 200 he gave a short history of lower abdominal pain and some nausea and vomiting and when initially seen in Casualty, had quite definite abdominal signs. He was reported as having tenderness ++ in the right iliac fossa along with rebound tenderness and guarding. The history and these abdominal signs were very suggestive of a diagnosis of acute appendicitis. However, when he was seen on the ward a little later, the abdominal signs were less marked and it was decided to observe him. When he was seen on the morning ward-round he was still complaining of some lower abdominal pain and nausea although he apyrexic and his white cell count was not elevated. Abdominal examination revealed his abdomen to be soft on this occasion although he still had some tenderness in the suprapublic region and right iliac fossa. A differential diagnosis of appendicitis, Meckel's diverticulitis and non-specific abdominal pain was made and the management plan was to continue to observe him. His symptoms improved with conservative measures and he was fit for discharge home at lunch time on 5 September 2000. Mr Humphries' discharge letter suggests a diagnosis of non-specific abdominal pain. Overall, I can find no fault in [the Plaintiff's] management during this short period of hospitalization.
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> The clinical presentation was a very common one and the ultimate diagnosis of non-specific abdominal pain was equally common. In the presence of significant abdominal signs such as those elicited in Casualty, i.e. tenderness, rebound and guarding, and in the absence of scrotal pain, it would not be normal clinical practice to examine the external genitalia of a boy of this age. From the Particulars of Negligence, it appears to be suggested that every 13 year old boy such as [the Plaintiff] should have his external genitalia examined, irrespective of the mode of presentation. However, I would suggest that in the hands of a responsible body of surgical opinion, this would not be common practice. The reason for this is very simple. Acute epididymitis is almost never seen

> in pre-pubertal males and is rare even in late adolescence (ref Paediatric Surgery 4th edition vol.2.page 1331) Torsion of the testis however does occur in boys of this age group and when this arises it presents with acute scrotal pain and swelling, a very different clinical presentation. In the absence of scrotal pain, a diagnosis of epididymitis in a boy of this age would be extremely rare and as a result of this, routine scrotal examination would not be normally carried out, particularly when abdominal signs were present. I therefore think that the treatment during this initial presentation at Antrim Hospital was reasonable and there was no indication to commence antibiotics at that time."

He considered the treatment the plaintiff received at Antrim Area Hospital on 4th and 5th September and concluded –

> "In summary I feel that the initial treatment given to [the Plaintiff] when he presented to Antrim Hospital on 4th September was entirely appropriate. From the information in the hospital records there was no indication to consider any other diagnosis apart from non-specific abdominal pain and there was certainly no indication to commence antibiotics at that time. With the benefit of hindsight [the Plaintiff] may well have been developing epididymo-orchitis when he presented but there was certainly nothing in the history to point towards this diagnosis and under these circumstances I do no think that a failure it examine the scrotum was wrong."

[13] Mr Moorhead in his evidence expanded on this report. He said that the plaintiff had the classical triad of signs of peritonism. These signs only occur in the abdomen and are not associated with epididymo orchitis. The casualty officer was correct in the provisional diagnosis of appendicitis. As signs of peritonism were elicited, and nothing else, it was not necessary to examine the scrotum. In any event examination of the scrotum in the absence of scrotum pain would not have revealed anything. He also said that the examination of the rectum was unnecessary. While medical students are told to examine everything doctors learn to discriminate. He agreed with Mr Scurr that in most settings a doctor would examine the genitalia, but there were exceptions, for example, presentation with a hand injury. Classical appendicitis is accompanied by a low grade temperature and a raised blood count. Because the cell count was normal and as he had no temperature the Registrar was confused and not certain as to the diagnosis, but appendicitis

was the most credible diagnosis at that point. With hindsight he did not have appendicitis or diverticulitis and therefore he probably had non-specific abdominal pain probably caused by mesenteric adenitis. The triad of signs were not explainable by epididymo orchitis. This condition is rapidly progressive and if he had it at 0400 on 4 September it would have progressed rapidly and he would have been in agony. Epididymo orchitis is common but exceptionally rare in a 13 year old boy and is usually associated with pain in the scrotum as well as the abdomen, pyrexia and a raised white cell count. Sleeping all night after being given Voltarol (a mild painkiller) was not consistent with epididymo orchitis. He had woken the previous night. Whatever caused that was no longer persisting. If he was suffering from epididymo orchitis on the morning of 5 September one would expect he would be complaining of severe pain. His interpretation of the notes and records was that the plaintiff was admitted with an acute abdominal mischief which resolved quickly. The fact it resolved ruled out appendicitis. He thought it was likely the plaintiff had mesenteric adenitis which was viral in origin. Then the situation changed and he developed epididymo orchitis. Mesenteric adenitis could not cause epididymo orchitis which is a rare condition for a boy of this age and one could only speculate as to its origins. Spontaneous epididymo orchitis is extremely rare. The urinary test was negative. The absence of a urinary tract infection suggested it was likely to be viral. Nothing can be done for a patient with a viral epididymo orchitis, but rather than do nothing, antibiotics will often be prescribed. The plaintiff presented with abdominal pains at 0600 on 4 September. If epididymo orchitis was present he would have expected a rapidly developing situation with a painful red scrotum. By midday he would have expected the epididymo orchitis to be crystal clear. The patient would not be well and symptom free.

[14] In cross-examination Mr Scurr said there was no note of the plaintiff having been examined by the consultant under whose care he was admitted. He said this was not good practice, though it can happen in exceptional circumstances. He accepted that it was well recognised that scrotum pain can be referred elsewhere. He maintained that if a doctor examined the abdomen and found signs of peritonism it was unnecessary to examine the scrotum. When the triad of signs are elicited then the only explanation was that the condition was intra-abdomen. He agreed that the presenting signs changed but they did not disappear. There remained two signs, tenderness and some guarding. The initial plan was to take the plaintiff to theatre but this became unnecessary as he was apyrexic (without temperature) and his white cell count was normal. By 5 September he considered the plaintiff was well and symptom-free and that it would not be normal practice to examine him again at that stage nor immediately prior to discharge. He considered the plaintiff had made an excellent recovery at discharge on 5 September. He also considered that the plaintiff was well for a number of hours on the afternoon of 4 September until he again suffered acute pain while in the playroom. Overall the picture was one of the condition resolving and the plaintiff getting

better. He stated that the cause of the pain on admission and later was unknown. But it was typical of a viral mesenteric adenitis infection which occurs in young boy and girls, but he could not be sure of this explanation. However it was the likely explanation. Mesenteric adenitis is associated with enlarged glands which are inflamed and this causes the pain. If such a viral infection was severe the patient would have a raised temperature and a high white cell count. In the absence of these he concluded that the viral attack was mild. There was improvement in the abdomen and then the virus moved to the testicle. He said it was well recognised that a virus could resolve in one place and then develop in another. But he acknowledged that this was rare. Equally it was exceptionally rare for mesenteric adenitis to cause an infection in the epididymous and lead to epididymo orchitis, but it was recognised. He was asked why his viral infection theory did not feature in his first report and replied that this theory was self-evident in his first report because the infection could not have been bacterial as the evidence for a bacterial infection was not present. Later he was informed that this was not obvious from his first report and he was asked to explain this in detail. This he did in his second report which he maintained was supplementary to his first report and not intended to replace it. He stated - "I tried to put forward a theory which offers a plausible explanation in very unusual circumstances". For a bacterial infection one would be looking for a history of recurrent urinary tract infection or sexual activity. In the absence of these the infection was not bacterial and must therefore have been viral. When his urine was examined at Belfast City Hospital there was no 'debris' which suggested that it was viral. Whether bacterial or viral a doctor will err on the side of caution and treat the patient as if bacterial. He accepted that it was possible the plaintiff had some infection in the epididymous while in Antrim Area Hospital on 4 and 5 September, but if so it was not clinically obvious. It was possible for the two conditions to co-exist but the scant nature of the evidence suggested he had one condition followed by the other. He agreed that if the infection was bacterial, antibiotics administered intravenously might have led to a different outcome for the plaintiff.

[15] Central to the issues in this case was the extent of the examination of the plaintiff during his stay at Antrim Area Hospital. Counsel on behalf of each party urged the court to accept their expert's opinion in preference to the other. No other approach was put forward nor was it suggested that one of them did not represent a responsible body of medical opinion that should be preferred. The case was put presented and defended on the basis that the court had to decide which evidence of the two medical experts it preferred. The defendant challenged the qualifications of Mr Scurr to comment on the medical condition epididymo orchitis. It was stated that he was no longer "at the coal-face ", unlike Mr Moorhead. It was submitted that the triad of signs elicited from the plaintiff when he presented at hospital were classical signs of appendicitis and that their presence excluded any necessity to examine his scrotum. If the problem was abdominal, examination of the scrotum would

have revealed nothing and his mother's recollection of the manner of his gait on leaving the hospital must be incorrect. On behalf of the plaintiff it was submitted that Mr Scurr's evidence remained intact and should be preferred. On the other hand the emergence of Mr Moorhead's second report and the omissions from his first report undermined his credibility, as did the unyielding manner in which he gave his evidence. A simple manual examination of the scrotum would have revealed the medical problem.

[16] It became evident that the defendant had in its possession since November 2005 a report from Dr Best, a Consultant Urologist at the Ulster Hospital. He was not called as a witness, though Mr Moorhead spoke to him about whether he was attending but did not see the contents of his report. It was submitted by Counsel on behalf of the plaintiff that this report must be contrary to the report provided by Mr Moorhead, which was dated March 2009, otherwise the defendant would have called him as a witness, particularly as he is a Consultant Urologist, which Mr Moorhead is not. Counsel invited the court to draw the inference that this report was favourable to the plaintiff and unfavourable to the defendant, in particular that it supported the evidence of Mr Scurr that the plaintiff's scrotum should have been examined. It was submitted that such a tactical approach by the defendant was inimical to the change in the culture of modern litigation where each side should "lay its cards on the table". In addition none of the clinicians was called when they might have resolved ambiguities in the notes and records. Reliance was placed on Wiszniewski (aka Wisniewski) v Central Manchester Health Authority 1998 PIQR P324. In that case the trial judge drew an inference from a doctor's non-attendance and the failure of the defendant to call him to give evidence by video-link (he was in Australia), in conjunction with other evidence, that had he attended a patient at 0340 he would have made the necessary investigations and subsequently performed a caesarean section, despite the evidence of two expert witnesses that they would not have done so. An appeal to the Court of Appeal was dismissed. In giving judgment the Court recognised that in certain circumstances adverse inferences may be drawn form the absence or silence of a witness who might be expected to have material evidence to give on an issue in the action. Such inferences if drawn may go to strengthen the evidence on the issue adduced by the party relying on them or weaken the case (or an issues) of the party who fails to call the witness. However some prima facie evidence of the issue must be adduced before an adverse inference can be drawn. However no inference could be drawn where the court is satisfied with the reason for the absence of the witness. Counsel on behalf of the defendant sought to distinguish Wiszniewski on the basis that it involved a blatant failure to call a witness to deal with issues of fact, the issue being what would the absent doctor have done if he had attended the patient at 0340, whereas the instant case involved not a witness as to fact but an expert witness on the negligence alleged. He also submitted that no prima facie evidence had been called by

the plaintiff on any point on which Dr Best might be expected to give evidence.

[17] No authority was produced to suggest that adverse inferences could not be drawn in relation to expert witnesses. I see no reason in principle why expert witnesses should be excluded from such a commonsense rule. Much will depend on the circumstances. Prima facie evidence was given by Mr Scurr that examination of the scrotum was warranted. However the relevant evidence of Mr Scurr was limited to the events of 4 and 5 September. Much happened to the plaintiff over the succeeding six days and subsequent years. It was of a urological nature. While there must be a strong suspicion that the submission of counsel on behalf of the plaintiff is correct, I cannot excluded the reasonable possibility that Dr Best's report relates to some other aspect of the plaintiff's treatment over the succeeding days and years. Therefore I consider it would be inappropriate to drawn any inference from the failure of the defendant to call Dr Best as a witness.

[18] The manner and timing of the emergence of the issue of mesenteric adenitis was certainly curious. The letter dated 2 November 2009 was explicit and unambiguous. It stated that the defendant would deny that the plaintiff had epididymo orchitis on 4 or 5 September and that the plaintiff probably had viral mesenteric adenitis which led to the development of the epididymo orchitis. The defence evidence in support of this was not so definite. The possibility that the plaintiff had epididymo orchitis on 4 or 5 September was recognised, although it was qualified as not being clinically obvious. Both experts acknowledged that mesenteric adenitis is usually accompanied by a sore throat and enlarged or inflamed glands in the neck and abdomen. Neither of these signs was present. Mr Moorhead explained their absence on the basis that the infection must have been mild, but this does not appear to reflect the distress of the plaintiff when he awoke at 0400 and was taken to hospital, and thereafter. More critically, perhaps, mesenteric adenitis was not considered a possible diagnosis by any of the doctors who dealt with the plaintiff on 4 or 5 September. Many of the opinions expressed were given with the benefit of hindsight and depended on the known development of the epididymo orchitis through to the plaintiff's final discharge from the Belfast City Hospital, as well as the tests and operation which were carried out. There was much criticism of the failure to admit the plaintiff to investigate the possibility of torsion, but no recognition of the later correct diagnosis of epididymo orchitis in a boy aged thirteen years, despite this condition being exceptionally rare in a boy of that age. Minor issues arose about the definition of guarding and the quality of the note-taking at the hospital, but neither of these assisted in the resolution of the principal issues in the case. Furthermore an issue arose about the plaintiff's gait on leaving hospital. I do not doubt that the plaintiff was walking in such a manner as described by his mother. Nor do I doubt that an incident of the nature she described took place. However I

think it more likely that this occurred on the second admission to Antrim Area Hospital and not the first.

[19] The critical periods are the presentation of the plaintiff at the Antrim Area Hospital at 0600 on 4 September and the history then given and the early dismissal of appendicitis as the diagnosis. Diverticulitis did not feature and in the absence of mesenteric adenitis that left non-specific abdominal pain for which no explanation was then sought. Within a short period of time of being discharged from hospital the plaintiff had severe scrotal pain. It is difficult to dismiss the coincidence in time of this onset of pain with his recent admission to and discharge from hospital. The evidence that he was admitted with one condition and discharged, in effect, with another is not persuasive. The opinion that he probably had epididymo orchitis during his first admission to Antrim Area Hospital seems in the circumstances quite reasonable. That progression of this condition can vary, is undoubtedly correct. The declaration that a medical student who omitted to examine the scrotum of a patient with non-specific abdominal pain would fail his examinations was delivered with firm conviction. It was not dissented from in evidence (though initially it was clearly challenged in cross-examination). Rather it was explained that once qualified and more experienced, a doctor could discriminate those circumstances in which it was necessary to examine the scrotum and those when it was not. No doubt those dealing with the plaintiff on 4 and 5 September were much closer to medical school than a consultant, but to discriminate there must be something else with which to do so. Appendicitis was ruled out early on and mesenteric adenitis was not considered. Whether his condition was bacterial or viral was not relevant at that time and should not cloud the issue which has to be considered. That is whether, in the circumstances then pertaining during his first admission to Antrim Area Hospital, the investigation of the plaintiff and his symptoms should have included an examination of the scrotum? On that question I prefer the body of medical opinion expressed by Mr Scurr that it should and that it would have revealed a problem with his scrotum despite the absence of pain in that area until a short time after his discharge. Appropriate treatment at that stage would probably have prevented the acute orchitis that led to atrophy of the testis and its subsequent removal and replacement. Therefore, I find negligence proved against the servants and agents of the defendant.

[20] The loss of a testicle is an unusual occurrence. While the reproductive organs are intact, the plaintiff is not. He suffered an adjustment reaction and a loss of confidence. I have no doubt the embarrassment early on was considerable. He was a keen sportsman who found it difficult to continue as he was embarrassed to shower afterwards with his team- mates. He was subjected to two operations and experienced a painful time in hospital as an in-patient. I assess damages in the sum of £35,000.