

**EASTERN CARIBBEAN SUPREME COURT
TERRITORY OF THE VIRGIN ISLANDS**

**IN THE HIGH COURT OF JUSTICE
(CIVIL)**

**Claim No. BVIHCV 2019/0201
BETWEEN:**

BOYCIE FAHIE

Claimant

And

THE BVI HEALTH SERVICES AUTHORITY

Defendant

Appearances: Mr. Paul Edwards of Hunte & Co., for the Claimant
Mr. Terrence Neale and Ms. Elizabeth Ryan of Mc W. Todman & Co., for the Defendant

2021: December 6th, 7th
2022: July 29th

JUDGMENT

[1] **Ellis J.:** Before the Court is a medical negligence claim brought by the Claimant, on behalf of the Estate of Judith Fahie, (the “Deceased”). The Claim is brought against the BVI Health Services Authority, a statutory authority entrusted with the responsibility for the provision of public healthcare in the British Virgin Islands (the “Defendant”). The Claimant alleges that the Defendant and its servants or agents were negligent in their treatment of the Deceased during the period 13th October, 2018 and 7th December, 2018 when she was a patient at the Defendant’s hospital.

[2] The Claimant seeks the following relief from the Court:

- i. Damages for negligence resulting from the death of Judith Fahie, deceased
- ii. Damages under the Fatal Accidents Act, Cap. 26 Revised Laws of the Virgin Islands.

- iii. Damages under the Cause of Action (Survival) Act Cap. 10 Revised Laws of the Virgin Islands.
- iv. Special damages in the sum of \$22,990.83.
- v. Interest.
- vi. Costs.

[3] At the trial, the Claimant, who was the Deceased's husband, gave evidence on his own behalf but he also relied on the evidence of several witnesses including Jasin Fahie and Curlyn Fahie-Hodge the son and daughter of the Deceased. The Claimant also relied on the expert testimony of Dr. Mitchell Penn. The Defendant on the other hand relied on the evidence of the medical staff who treated the Deceased including Dr. Panchan Bhattacharya and Dr. Marjorie Yee-Sing. The Defendant also relied on the expert testimony of Professor Ashraf Rasheed.

The Claimant's Case

[4] The Claimant contends that on or about 9th October 2018, the Deceased began to complain of abdominal pain. She was admitted to the Defendant's hospital where a series of tests were conducted. At the time, the Deceased was a 70 year old woman with a medical history of general poor health, diabetic, hypertensive with rheumatoid arthritis.

[5] Following the results of those tests, a decision was taken to perform an appendectomy. On 13th October 2018, the Deceased was prepped for surgery. Interoperation revealed that she had gastric perforations (stomach ulcers). The treating doctors continued with the appendectomy as well as closure of the gastric perforations.

[6] The Claimant asserts that post operation, the doctors employed by the Defendant advised the Claimant and the Deceased's family that the Deceased was doing well. Sometime later, Dr. Bhattacharya suggested to the Deceased's family that a tube be inserted through the deceased nose into her stomach, so that she could be fed to speed up the healing process. The Defendant did not have the size tube needed to insert into the Deceased's nose and as such the family would have had to source the said tube. However, following advice of another doctor, the Claimant made the

decision to hold off on having the tube inserted into the Deceased, as it was suggested that the tube may have caused ruptures in the stomach.

[7] The Deceased continued to deteriorate and arrangements were made on 5th December 2018 to transfer the Deceased from the care of the Defendant's Hospital to Holy Cross Hospital in Fort Lauderdale, Florida on 7th December 2018. The Deceased eventually passed away on 9th December 2018 at the Holy Cross Hospital.

[8] The Claimant contends that the Defendant employee's care of the Deceased was negligent and they alleged the following particulars of negligence:

- i. Failing to properly diagnose the Deceased.
- ii. Failing to properly care for the Deceased causing her to develop sepsis.
- iii. Failing to inform the Claimant and/or any of the deceased immediate family of the true nature of the Deceased's condition.
- iv. Failing to or properly administer the appropriate medical care required of the Deceased.
- v. Negligently misrepresenting the true state of health of the Deceased.

[9] The Claimant contends that neither he nor any other member of the Deceased's family was ever truthfully advised about the Deceased's condition or of the fact that she had developed sepsis. He contends that they learned of this diagnosis when Jasin Fahie, the Deceased's son overheard the doctor's discussions during the air bus trip to Fort Lauderdale. The Claimant further contends that the family attempted to transfer the Deceased from the Defendant's Hospital on multiple occasions but they were invariably advised by the Defendant that was not possible or practical.

[10] In addition to the particulars of negligence pleaded in the claim, the Claimant also allege that the failure to have proper hand over arrangements between treating doctors and the delay in seeking advance supportive care, fell well below the standard of care expected for medical professionals as outlined in the expert report of Dr. Mitchell Penn dated 7th May 2020. According to the Claimant, the Deceased's death was caused by cardiopulmonary arrest, septic shock, bilateral hospital acquired pneumonia and hypercapnic respiratory failure. Additional factors which lead to the Deceased's death are perforated gastric ulcer, post exploratory laparotomy and sever metabolic acidosis. On the basis of the expert report of Dr. Penn, the Claimant asserts that the failure to treat and operate within a reasonable time and refer the Deceased to more advanced supportive care

facility caused a delay which significantly; increased the mortality rate of the Deceased's postoperative leaks which eventually led to sepsis. The Claimant contends that the Defendant's delays materially contributed to the Deceased's death.

The Defendant's Case

- [11] The Parties in this claim essentially agree on the factual chronology. However, the Defendant relies on the fact that at time of the admission, the Deceased was 70 years old with a medical history of general poor health, diabetic, hypertensive with rheumatoid arthritis. The Defendant further states that on admission, the Deceased main complaint was abdominal pain. After conducting various tests, a decision was taken after obtaining the consent of the Deceased to carry out an appendectomy. The surgery was carried out on 13th October, 2018 by Dr. Majorie Yee-Singh, a consultant general surgeon. Intraoperatively it was revealed that the Deceased had gastric perforation (stomach ulcers). The Deceased later developed a surgical wound infection which was actively treated and managed by the Hospital's staff and appeared to be healing although slowly. In or around 1st December 2018, the Deceased began displaying signs of disorientation.
- [12] A decision was taken by the Deceased's family on 7th December, 2018 to transfer her to the Holy Cross Hospital in Fort Lauderdale, Florida, United States of America having obtained approval for the medical expenses from the National Health Insurance Scheme ("NHI"). However, the Defendant states that prior to the transfer, the Deceased's medical records reflected that she had continued to improve, albeit slowly, with her vital signs being recorded as normal and her wound infection continuing to heal.
- [13] The Defendant denied that its employees were negligent in their treatment of Claimant. The Defendant contends that at all times, its employees provided an acceptable standard of medical care and discharged their duties to the Deceased in an acceptable manner consistent with the ordinary skill and care of a medical practitioner or nurse in their profession.

THE ISSUES

[14] The issues which this Court are required to consider are typical of all medical negligence claims and include the following:

- i. Did the Defendant breach its duty of care to the Deceased, specifically did the Defendant's employees failed to correctly diagnose and treat the Deceased during the period that she was a patient at the Defendant's Hospital?
- ii. Assuming the Defendant breached its duty of care to the Deceased was such breach of duty the cause of the Deceased's injuries?
- iii. What would be the appropriate measure of damages should the Claimant be successful in establishing negligence on the part of the Defendant?
- iv. The costs to be awarded to the successful party.

[15] In considering these legal issues, the Claimant submitted that the Court is also called upon to resolve the following disputes as to fact:

- i. Whether the Defendant 'kept informing' the Claimant that the Deceased was doing well and recovering without making full disclosure of the true state of the Deceased's general medical condition?
- ii. Whether the Defendant informed the Claimant that the Deceased developed a wound infection prior to 1st December 2018?
- iii. Whether the Claimant was provided with the correct size of the NJT tube?
- iv. Whether the Deceased was transferred to Holy Cross Hospital due to her poor healing process and failing health?

COURT'S ANALYSIS AND CONCLUSIONS

[16] It is now well established that the main principles which determine medical negligence are in essence the same general principles which operate under the English tort of negligence. In order to establish negligence, a claimant must therefore prove: (1) that the defendant owed the claimant a duty of care in the circumstances of the case; (2) that the defendant breached this duty in the sense that he failed to conform to the standard of care required; (3) that the claimant suffered injury or loss or damage as a result of the defendant's actions. (4) that this breach of duty caused the injury or damage which is the subject of this claim. It is also now settled that a claimant is obliged to prove each of the

elements identified on a balance of probabilities, and that throughout the litigation, this onus remains on the claimant.

- [17] Typically, the last element is often determinative because courts have now accepted that simply because the patient had a complication or did not recover from the underlying injury or illness as well as he or she had hoped does not mean that the health care provider was negligent or that the provider's negligence caused the patient's injuries. Similarly, just showing that other doctors would have treated the plaintiff differently from the defendant would not be sufficient evidence of negligence or causation. The claimant's medical expert must identify precisely what the defendant did wrong and show exactly how the defendant's error caused the patient injury or death.

Is there a duty of care owed to the Claimant?

- [18] Turning to the first element, it is not disputed that the Defendant through its employees, servants or agents owed a duty of care to the Deceased at all material times. This position concurs with the generally accepted view that a duty of care exists between healthcare professionals and their patients.¹ Lord Phillips MR in **Watson v British Boxing Board of Control Ltd (2005) 2 WLR 1256** put it in the following way:

“the duty to take reasonable care to prevent further harm and to effect a cure is founded on the acceptance of the patient as a patient, which carries with it an implicit undertaking to care for the patient's needs”.

- [19] It is common ground between the Parties that the Deceased was a patient of the Defendant who runs a hospital. The judgment in **Cassidy v Minister of Health**² also brought into focus the liability of health care authorities for the negligence of medical practitioners employed by them. Lord Denning opined:

“In my opinion, authorities who run a hospital, be they local authorities, government boards, or any other corporation, are in law under the self-same duty as the humblest doctor. Whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves: they have no ears to listen through the stethoscope, and no hands to hold the surgeon's knife.

¹ *Cephas Marshall v F.H.H. Emergency Medical Associates et al*, Suit No. 1023/2002. Although it is not made clear on the Claimant's pleadings, it appears that this action in negligence is brought against the Defendant as being vicariously liable for the negligence of the doctors and other health professionals which attended to the Deceased.

² [1951] 2 KB 343

They must do it by the staff which they employ; and if their staff are negligent in giving the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him' and 'where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for services."

[20] It follows that critical question for the Court to determine is: whether the conduct of the Defendant's employees, servants or agents amounted to a breach of the duty of care which was clearly owed to the Deceased and assuming that the Defendant breached its duty of care to the Deceased, was such breach of duty the cause of the Deceased's injury and death?

i. **Was the duty of care breached?**

ii. **Causation – Did the Authority's breach of duty cause the injury or damage which is the subject of this Claim?**

[21] The standard by which medical professionals are judged with respect to negligence is well established. In seminal case of **Bolam v Friern Hospital Management Committee**³ Mc Nair J described it in the following terms:

"...the test for negligence is not the test of the man on the Clapham omnibus, because he has not got this special skill. **The test is the standard of the ordinary skilled man exercising or professing to have that special skill. It is the duty of a professional man to exercise reasonable skill and care in the light of his actual knowledge and whether he exercised reasonable care cannot be answered by reference to a lesser degree of knowledge than he had, on the grounds that the ordinary competent practitioner would only have had that lesser degree of knowledge.** This is not a gloss upon the test of negligence as applied to a professional man. That test is only to be applied where the professional man causes damage because he lacks some knowledge or awareness. The test establishes the degree of knowledge or awareness which he ought to have in that context. Where, however, a professional man has knowledge, and acts or fails to act in way which, having that knowledge he ought reasonably to foresee would cause damage, then, if the other aspects of duty are present, he would be liable in negligence by virtue of the direct application of Lord Atkins' original test in *Donoghue v Stevenson*. **'it is not enough to show that another expert would have given a different answer... the issue is... whether [the defendant] has acted in accordance with practices which are regarded as acceptable by a respectable body of opinion in his profession'** and **'How do you test whether this act or failure is negligent? In an ordinary case it is generally said you judge it by the action of the man in the street. He is the ordinary man. But where you get a situation which involves some special skill or competence, then the test of whether there has been negligence or not is not the test of the man on the top of the Clapham omnibus,**

³ [1957] 1 WLR 582; approved in *Maynard v West Midlands Regional Health Authority* [1985] 1 ALL ER 635

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.” Emphasis mine”

[22] It follows that the Claimant must demonstrate on a balance of probabilities that the medical practitioners treating the Claimant did not act as reasonable and competent medical practitioners would have acted in the circumstances. As a general rule, a medical practitioner would generally not be regarded as negligent in his treatment of a patient if he has acted in accordance with the standard as of reasonably competent medical men at the time, even though it is possible that other medical doctors would adopt a different course.

[23] As is the norm, both Parties in this action each chose to advance expert testimony in support of their case. The Claimant relied on Dr. Mitchell Penn, a specialist in internal medicine while the Defendant relied on Professor Ashraf Rasheed, a professor and consultant in general and gastrointestinal surgery. The Parties also relied on several witnesses of fact. The Court will first consider the Parties factual witnesses and then turn to the opinion evidence advanced by the respective experts.

The Parties’ Evidence

[24] It is not surprising that the evidence of the Claimant’s two witnesses of evidence tended to focus on the interactions with the medical practitioners treating the Deceased. The Claimant alleged that he was informed that the Deceased needed surgery to remove her appendix. When he enquired of Dr. Yee-Sing, he was told that the surgery would take 1 hour to 1 ½ hours to complete and would commence sometime after 10.00 a.m. However, he stated that Dr. Yee-Sing came out of surgery after 4.00 p.m. at which point she informed him that *“it was not the appendix but she took it out anyway”*.

[25] According to the Claimant, Dr. Yee-Sing indicated that she found food particles when she made the incision to remove the appendix, so she knew it was something else. As such she cut the stomach to see what the problem was and that is when she learned that it was a perforated ulcer. The Claimant was further informed that Dr. Yee-Sing had drained the Deceased and washed her up and put seven stiches in the cut and some tape around it and that he was informed that the Deceased would be alright.

- [26] This evidence was largely corroborated by Jasin Fahie and Curlyn Fahie-Hodge. There was also substantial corroboration on the events which followed. From all accounts, the Deceased had to undergo a follow up surgical procedure on 16th October 2018 to repair leakage in the wound. There was significant concern about the risk associated with this further procedure because of the Deceased's age and medical condition. However, the Deceased's family consented to the further surgery. After this procedure, Dr. Bhattacharya took over the Deceased's care from Dr. Yee-Sing. He suggested the use of a feeding tube to be inserted through the Deceased's stomach but the Deceased's family rejected this advice after they were advised to hold off on the tube in order to give the wound time to heal.
- [27] Sometime later in November 2018, after giving the Deceased some ribena juice to drink, they discovered that the wound was still leaking. The Deceased's condition began to deteriorate. The family began to discuss transferring the Deceased to another facility but they were informed that as she was very sick no other hospital would take her.
- [28] According to the Claimant, after an unsuccessful request to the Puerto Rico facilities, the facility in Fort Lauderdale, Florida, USA agreed to accept the case. Thereafter, arrangements had to be made with NHI to fund the transfer. The arrangements were protracted but eventually the Deceased travelled to Florida on 7th December 2018. While at the hospital on Florida the family members were informed that the Deceased had sepsis and she later passed away on 9th December 2018.
- [29] The Claimant and his witnesses complain that the Defendant, its servants or agents withheld critical information from the Deceased's family as it pertains to her health and masked the seriousness of her condition by reassuring them that the Deceased's condition was improving. As a result, they say that they could not make properly informed decisions regarding her treatment.
- [30] The Claimant was not cross-examined under oath. However, when cross-examined, it became clear that Jasin Fahie was unaware of the Deceased's complete medical history. He made clear that the decision to transfer the Deceased to the overseas facility was not based on the medical advice of her treating doctors but on the advice of an external medical practitioner. According to him the decision to solicit a second opinion was based on the length of the Deceased's hospital stay.

- [31] When he was asked about whether the family had the requisite financial resources to fund the transfer to and care of the Deceased at the overseas medical facility, Mr. Fahie stated that they [the Deceased's family] had the resources but that they needed to secure the approval of the NHI which would recommend an acceptable facility. He further stated that they consulted with the NHI because they needed an air ambulance to transport the Deceased. However, it was clear from his evidence that the cost of the Deceased's medical care (which he admitted was very high) would have been largely paid through the aegis of the NHI. Certainly, the Claimant has advanced no claim in respect of the medical expenses associated with the transfer to the overseas medical facility or the care administered there.
- [32] When he was asked to explain the delay in effecting the Deceased's transfer to the overseas medical facility, (given that the family was financially able to fund the same) he indicated that they had to find a facility that was prepared to accept her. In re-examination, he confirmed that the decision to transfer the Deceased was taken on 23rd November 2018 and that arrangements were settled for the actual transfer on 5th December 2018.
- [33] Curlyn Fahie-Hodge was also cross examined. When she was asked to provide a basis for her assertion that the Defendant's care fell short of the standard of care expected, she responded that "they just did not do a good job of taking care of my mother". She concurred that the decision to transfer the Deceased was not based on the medical advice of the treating medical practitioners, who clearly did not support the medical transfer. Although she also testified that the family had the financial resources to fund the costs of the transfer to the overseas medical facility, she conceded that they sought the assistance of the NHI which paid a percentage of these costs. When she was asked who had paid the costs incurred at the overseas medical facility, she responded that the Deceased's family did but she was unable to explain why these expenses would not have formed part of the Claim.
- [34] The Defendant's witness as to fact included the relevant medical practitioners who managed the Deceased's care and administered her medical treatment. Dr. Yee-Sing who was at the time a consultant Locum surgeon employed by the Defendant, stated that following the Deceased's admission, diagnostic tests including an abdominal ultrasound and blood tests were carried out. The

ultra sound revealed gallstones in the neck of the Deceased's bladder, a bulky pancreas with a small amount of fluid in the right iliac fossa of the pelvis ("RIF") with a non – compressible loop of the bowel in the RIF. The lab results revealed anaemia, leukocytes with a neutrophilia, elevated BUN levels as well as elevated levels of creatinine and pancreatic enzymes. A provisional diagnosis of cholelithiasis and pancreatitis was made.

- [35] Thereafter, in her witness statement, Dr. Yee-Sing provided a detailed account of the care and treatment administered to the Deceased up until 1st November 2020 when she handed over care to Dr. Bhattacharya. When she was examined under oath, Dr. Yee-Sing made clear that when the Deceased was admitted Dr. Bhattacharya was on vacation. However, she testified that there was a consultant surgeon Dr. Zarboski who was available along with other junior doctors. Between 10th October and 5th November 2018, she says that they all worked as a team to come for the Deceased together with other doctors including an internist and an anesthetist. She stated that when she left, Dr. Bhattacharya was not present but she handed over to Dr. Zarboski who was well aware of the case. When she cross-examined about the protocols for handing over a patient, Dr. Yee-Sing reiterated that although she did not hand over to Dr. Bhattacharya, she Dr. Zarboski who is a consultant surgeon was present during the morning rounds and was not a new attending physician.
- [36] Dr. Yee-Sing was vigorously cross-examined by Counsel for the Claimant who focused on the accuracy of the original diagnosis, the delay in administering treatment, the failure to consider alternative steps to secure better care, the observations contained in Dr. Penn's expert report and finally whether she followed the proper protocols for handing over care to Dr. Bhattacharya. The Court generally found Dr. Yee-Sing's responses to be clear and plausible. She testified that as a result of the tests which were conducted; she did consider gastric perforation as part of her provisional diagnosis. She testified that this was one of the reasons why they decided to act quickly. She stated that this was discussed with the sonographer based on the results of the chest x-ray which was done and she pointed to paragraph 7 of her witness statement which detailed the results of the Deceased's chest x-ray. Dr. Yee-Sing clarified that the presence of free air was indicative of a perforation somewhere in the body but they were unclear as to the exact source. She disagreed that her provisional diagnosis was incorrect she denied that there was any delay in the management

of the patient. She attributed any delay in treatment they need to first stabilize the Deceased who was dehydrated, vomiting and had an elevated white cell count.

- [37] Critically, Dr. Yee-Sing testified that if the attending doctors are following a line of management and a patient appears to be improving then there is no need to seek alternative health care elsewhere. She observed that in the case of the Deceased, prior to her transfer to the overseas hospital, the drainage was getting less, the wound was healing and she was tolerating fluids, had regular bowel functions and her urine output was normal. On that basis, Dr. Yee-sing concluded that the Deceased was improving and that there was no need to transfer her during the time when she was under her care.
- [38] She further disagreed with Dr. Penn's opinion that conventional surgical therapy was not appropriate in this case. According to her Dr. Penn was comparing "*apples and pears*". She stated categorically that the perforation in the Deceased's case could not have been repaired laparoscopically because of the size of the perforation and the delay in getting to the operating room. There was also gross contamination and gross soiling of the cavity which militated against laparoscopic surgery.
- [39] Dr. Bhattacharya, the head of surgery at the Defendant's hospital, gave a witness statement in which he denied the Claimant's allegations of negligence. He stated that he first examined the Deceased on 5th November 2018. He noted that she was bedridden with a dehised upper abdominal infected wound which was leaking gastric content. He also noted that although the Deceased's was diabetic and hypertensive, her temperature and pulse rate and respiration was well within normal limits. Dr. Bhattacharya then also provided a detailed recount of the treatment administered to the Deceased prior to her transfer to Florida, USA.
- [40] Importantly, he stated that on 13th November 2018 he arranged a family meeting to discuss the patient's condition and further management in detail with her husband and two daughters and son. He recommended that the Deceased be fed via a naso-jejunal tube instead of the TPN so that she would get better nutrition to heal the wound. However, the Hospital did not have one and so he issued a prescription for the Deceased's family to purchase the same. He was later advised that the family had elected to ignore this advice.

- [41] He further stated that they had several meetings with the family to keep them informed of the progress of the Deceased. Almost at every meeting, the family requested that the Hospital provide then with a recommendation to take to NHI so that they could request a transfer of the Deceased to an overseas medical facility.
- [42] During cross-examination, Dr. Bhattacharya stated that in the normal course, a transfer to alternative medical facility would be contemplated where the relevant treatment is not available in the local hospital. The relevant question for NHI would be whether the treatment would be available in the local hospital or not. If it is, then NHI would generally not accept the transfer. However, in this case the Deceased's family requested a transfer to which he agreed although it was difficult to justify on the basis of the NHI requirements.
- [43] Dr. Bhattacharya made clear that he signed off on the transfer despite his view that they had applied the only course of treatment which would have benefited the Deceased, and despite the fact that the management was correct and the Deceased was improving, albeit slowly. Critically, he testified that it is possible that the Deceased would have developed sepsis after she left the Defendant's hospital given the fact that she was transferred on an air ambulance when her immunity was quite low and there was possibility of infection in transit or in the new hospital. He also testified that it was possible that the Deceased could have developed pneumonia over the course of 1 to 1/2 days.

The Expert Reports

- [44] Both Parties relied on medical experts who filed comprehensive expert reports in the matter which radically disagree on crucial matters. They were also rigorously cross-examined by opposing counsel. The Claimant relied on the medical opinion of Dr. Mitchell Penn, who, in his Expert Report frankly disclosed that he has served as private doctor for the Deceased, prior to her death. It is also apparent from the evidence of the Claimant that Dr. Penn was personally involved in the decision to transfer the Deceased to the overseas facility. At paragraph 21 of his witness statement he stated that;

“That same day of the 2nd meeting Dr. Penn came along with Hon. Marlon Penn to visit her [the Deceased]. Dr. Penn was her regular physician and he was displeased with her

condition and he made some calls to get her out. He called Puerto Rico and Fort Lauderdale to see which facility would take her.”

- [45] This evidence was corroborated by that of Jasin Fahie who at paragraph 19 of his evidence stated: *“After this we contacted Dr. Penn, my mother’s longtime physician he made contact with a hospital in Puerto Rico and one in Fort Lauderdale....”* and by Curlyn Fahie-Hodge who, at paragraph 23 of her evidence, stated *“One day Dr. Penn came to visit her and he was not pleased with her current condition and right away he contacted NHI and requested that she be flown out immediately.”*
- [46] When he was examined under oath, Dr. Penn confirmed that he is familiar with the inner workings of the NHI system. He further stated that there was a dichotomy of care between the public institutions and private facilities whereby transfer to alternative medical facilities are done much more quickly in the private sector. He made clear that he personally “went to the top” and petitioned a minister of government to try to expedite the Deceased’s transfer to an overseas medical facility.
- [47] This evidence brought into sharp focus the role and function of court experts. It is clear that the duty of an expert witness is to provide independent assistance to a court by way of objective unbiased opinion in relation to matters within his expertise. See: **Polivitte Ltd v. Commercial Union Assurance Co. Plc.**⁴ and **Re J**⁵. In particular, an expert witness must not be biased towards the party responsible for paying his or her fee. Moreover, in the event of any connection with any party to a claim or case that might to any degree be considered to be prejudicial to impartiality, this must be disclosed.
- [48] In that regard, the Court notes that the relevant test is an objective and not a subjective one. Particularly instructive is the dicta of Evans-Lombe J in **Liverpool Roman Catholic Archdiocesan Trust v Goldberg**⁶ that *“where it is demonstrated that there exists a relationship between the proposed expert and the party calling him which a reasonable observer might think was capable of affecting the views of the expert so as to make them unduly favourable to that party, his evidence should not be admitted however unbiased the conclusions of the expert might probably be”*.

⁴ [1987] 1 Lloyd's Rep. 379 at p.386 per Mr. Justice Garland

⁵ [1990] F.C.R. 193 per Mr. Justice Cazalet

⁶ [2001] EW HC Ch 396

- [49] There is some concern that Dr. Penn was the Deceased's long term physician. However, of greater concern is his active involvement in the effecting the Deceased's transfer to the overseas medical facility following his visit to her in the hospital when he had clearly formed an opinion on her treatment and condition and the quality of her care. Given that the pivotal tipping point in claims of medical negligence invariably is the expert testimony, it is surprising that the Claimant would not advance a wholly independent expert to assist the Court in its findings.
- [50] Ultimately however, the question is one of fact, namely, the extent and nature of the relationship between the expert and the party. There is a substantial risk that his evidence would be coloured not only by his previous relationship with the Deceased but by his own personal actions in the matter. The Court is satisfied that on an objective view, a reasonable observer might think Dr. Penn previous history with the Deceased and his subsequent actions which, would no doubt have been informed by his views and observations, would affect his views as an expert. However, objective he might claim to be, it is clearly incompatible with the need for justice to be seem to be done.
- [51] This Court has however considered the legal submissions advanced by the Parties and has determined that caution must be exercised before accepting the opinions articulated by Dr. Penn. Rather than dismiss his Report as inadmissible, the Court will anxiously scrutinize the contents of his Report in deciding what, if any weight ought to be attached to its conclusions.
- [52] With that in mind, the Court will now consider Dr. Penn's report within the context of the particulars of negligence which are alleged. What is immediately clear is that Dr. Penn is not a gastrointestinal surgeon and instead had to rely on the relevant literature, published peer reviews, medical journals and the like in order to opine on "*what one should be doing in a particular situation.*" Unfortunately, although several excerpts were referenced, the actual extracts from these documents did not form part of his report.
- [53] When he was cross-examined, it became clear that although he had served as the Deceased's private doctor in the past, Dr. Penn was not one of the doctors charged with treating the Deceased at the material time. Despite this, he frankly admitted that he had no discussions with any of the doctors who had in fact been treating the Deceased, neither did he review her medical reports. Instead, he chose to rely on a colleague who had expressed concerns about the length of the

Deceased's stay in the ICU. Nevertheless, Dr. Penn concluded that there was a systemic failure at the Defendant's hospital and he began to actively seek the transfer to an overseas medical facility.

- [54] It is also clear is that Dr. Penn's report does not address critical aspects of the Claimant's case. Instead, he opined that the standard of care definition should be broadened to include the other levels of care that the Deceased would have received by the more advanced regional hospitals. According to Dr. Penn, given that the Deceased's condition carried a high mortality rate, the conventional post-operative management should not have continued at the Defendant's hospital. He noted that high mortality risk cases being managed in a resource limited local facility attributed to the poor outcome. Instead, he posited that the Defendant had a duty to refer this case in a timely manner and that the prolonged delay in recommending transfer for the Deceased became denial of life saving medical intervention. The gravamen of his opinion is set out in the following excerpt:

"While other regional facilities have well established multispecialty departments, this is not the case in the territory at present. The Virgin Islands healthcare system frequently uses of hospital services overseas to complement the local care provided. Hence the definition of standard care has broadened to include this new component post 2016. There are no insurmountable financial barriers for patients to access overseas cares since the National health insurance single-payer system launch in 2016.

"It amounts to negligence to have delayed this patient's transfer by approximately four to five weeks despite evidence that she continued to have bile leaking from the abdomen. According to the established standard of care, Mrs. Fahie should have been referred to NHI for consideration for transfer to a hospital with an endocrinologist to manage diabetes, an infectious disease specialist to handle ongoing infections, the neurologist to manage her brain, and an endoscopic surgeon to manage the chronic peptic ulcer leak. It is my opinion that the standard of care applied to this client fell below the bar as described in medical literature."

- [55] Counsel for the Defendant has submitted that Dr. Penn's expert report does not appear to criticize the treatment provided to the Deceased by the Defendant's employees during his stay at the Defendant's hospital but appears to focus on the protocols of the Defendant for the transfer of patients to an overseas medical facility in circumstances where it does not possess the necessary equipment or specialist medical practitioners to treat the patient. Indeed, the report does little to address the actual allegations of negligent breach of duty set out in the Claimant's Statement of Claim. Rather, it addresses an allegation which was not raised by the Claimant in his Statement of Claim.

- [56] The Court finds significant force in these submissions. Having reviewed the Report it is clear that it addresses the critical issues which arise on the claim only tangentially. First, he pointed out that the average stay for a patient with perforated gastric ulcers internationally is approximately 10 days, compared with the Deceased's hospital stay which was approximately 8 weeks.
- [57] He then contended that Dr. Yee-Sing, the locum surgeon, neglected to properly hand over the care of the patient to the succeeding surgeon. In that regard he relied solely on Dr. Bhattacharya's report where he stated "*she was not handed over to me by the Locum Surgeon Dr. Yee-Sing, who operated on her for gastric perforation on October 13th 2018 and on October 16th 2018....*" According to Dr. Penn, the failure of Dr. Yee-Sing to formally brief Dr. Bhattacharya was "*unacceptable professional behaviour*" because an ICU patient being abandoned may negatively impact the care being provided.
- [58] Later, Dr. Penn also opined that the Defendant's physician's report did not show all of the laboratory tests ordered for the Deceased for the duration of her ICU admission. Without providing a basis, he opined that the care standard was inappropriately applied according to the demographic of the Deceased and that the infection complications were not recognized. As a result pneumonia and overwhelming sepsis resulted. He opined:
- "As in the case of Mrs. Fahie, the postoperative leak became the catalyst for other clinical problems. Early diagnosis and appropriate treatment are crucial to reduce this mortality. "A systemic inflammatory response syndrome, septic shock, increased levels of C-reactive protein and a raised white blood cell count. (Kumar & Thompson, 2013) are known complications."
- [59] Rather than providing an analysis of a specific area of mismanagement or breach of duty, Dr. Penn instead opined that "*The Defendant failed to properly diagnose the Deceased and the Defendant failed to properly care for the Deceased causing her to develop sepsis.*" Given the Claimant's burden of proof, the lack of depth in the analysis did not assist the Claimant's case.
- [60] When he was cross examined under oath, Dr. Penn's attention was directed to the contrasting expert report of Professor Rasheed. In particular he was asked to address Professor Rasheed's opinion that the Deceased would have suffered no harm [as a result of the failure of hand over from the operating surgeon to the substantive surgical consultant] because the Deceased continued to receive the required treatment. Dr. Penn's response was unconvincing.

- [61] Later, when questioned by the Court, he opined that what was required in the Deceased's case was a multi-disciplinary approach. According to him, because the source of the leakage could not be identified, it would have been useful to have another specialist review the matter. He surmised that those treating the Deceased may have been waiting for the leaks to spontaneously seal themselves off but he stated that given the Deceased's medical condition, it would have been better to move to plug the leaks to prevent her condition from further deteriorating. Instead, the Defendant's servants or agents adopted a "wait and see" approach when there are different advanced techniques which could have been imposed to give the Deceased a fighting chance and which would not have been available in the Territory.
- [62] Counsel for the Defendant submitted that Dr. Penn's report appears not to give any adequate consideration to the medical evidence in the matter. He submitted that the medical records of Hospital confirm that the Defendant's medical staff were fully aware that the Deceased had developed a surgical wound infection and that there was some leakage through the wound. Further that the Defendant's staff were taking the necessary steps to manage both the wound infection and leakage with antibiotics, daily wound dressing changes and total parental nutrition to provide the nutrients necessary to assist the wound healing process.
- [63] Most importantly, there is no indication from the medical records that the Deceased required specialist medical care from an overseas medical facility or that the transfer of the Deceased to an overseas facility given her weakened physical state was the best decision in the circumstances.⁷ Further, the medical records also reflect that the Deceased was generally in poor health (the Deceased was diabetic, hypertensive with rheumatoid arthritis) at the time of her admission to the hospital⁸ but was being provided with appropriate medical care to address her medical condition. At the time of the Deceased's transfer from the Defendant's hospital, the Deceased's condition was stable and that her health was gradually improving.
- [64] This submission finds support in the expert report authored by Professor Rasheed. It was clear that unlike Dr. Penn, Dr. Rasheed is an advanced gastrointestinal surgeon and an advanced therapeutic

⁷ Witness Statement of Dr. Bhattacharya

⁸ Witness Statement of Dr. Bhattacharya

upper GI endoscopist who has carried out over 300 laparoscopic biliary and oesophago-gastric procedures per year and that his opinion evidence directly addressed the matters alleged in the Claim. Having independently reviewed the Deceased's medical records, the claim herein and Dr. Penn's expert report, Professor Rasheed opined that there were no significant breaches of duty on the part of the Defendant's servants or agents. At pages 17 – 18 he noted that:

"The only substandard care I found was the failure of the consultant-to-consultant hand over of the deceased. However, I do not believe that such substandard care led "*sic*" to harm as the deceased continued to receive the appropriate care...

The only factor that would have improved her condition and chance of survival would have been the earliest detection of the perforation and the control of sepsis. Unfortunately, due to the non-specific nature of the presentation and the radiological findings suggestive of other possible pathologies, the caring team were mislead into an incorrect diagnosis and hence incorrect treatment. The actions of the caring team prior to clenching the correct diagnosis based on information available to them was appropriate and their actions following making the correct diagnosis was appropriate too.

It is my view that the combination of the deceased co-morbidities and the nature of the presentation would have threaten the deceased life even when diagnosed and treated without delay (I am however unable to provide the risk in % terms but it is not minute)."

[65] Although he clearly highlighted that the primary diagnosis and the treatment of the Deceased's pathology i.e. perforated gastric ulcer was not recognized or treated in a timely manner and that such delay increased her chances of complications and reduced her chance of survival,⁹ nevertheless, Professor Rasheed concluded that the Defendant is not liable in negligence. At paragraph 14 of his Report he explained his position in these terms:

14. Having said the above, such delay was not due to incompetence or recklessness but due to the non-specific nature of her presentation and appropriate actions were taken following the detection of any new signs/symptoms or any new findings on any of the radiological imaging."

[66] When he was examined under oath, Professor Rasheed was asked to address the contents of Dr. Penn's report. In doing so, he pointed to a number of weaknesses in Dr. Penn's report and opinion. First, he noted that the literary references in that report were irrelevant to the case because they were outdated (1994). According to Professor Rasheed, Dr. Penn failed to recognise that the case

⁹ Paragraph 13 of the Expert report of Professor Rahseed

at bar concerned a large gastric (stomach) ulcer. Professor Rasheed referenced (but did not provide) a guideline published in 2020, which made clear that in that case, the gold standard method is open surgery. He agreed that no other method is appropriate because there is usually a lot of contamination in the area. Professor Rasheed further made clear that the “clips” referred to by Dr. Penn would not work in the case of a diseased organ and cannot be used in esophageal leaks. Open surgery rather than endoscopic management was needed to close the leak and cleanse all contamination.

[67] Critically, when he was asked to address the issue of causation, Professor Rasheed noted that the Deceased was diabetic which reduced her ability to fight infection. She was also taking medication which would have impacted her white blood cells. He stated that by the time that she was admitted, the Deceased was already in a bad place. Ultimately, a late nonspecific presentation, led to late treatment and this would reduce the ability of the doctors to favourably impact the outcome. He testified that based on the non-specific presentation (abdominal pain) and the test results he stated that it was reasonable to assume that it was pancreatitis and he would have come to the same conclusion. He also testified that 6 weeks is very short in the life of the disease. According to Professor Rahseed there are patients who have stayed in the hospital for 9 – 13 months. He described the medical treatment administered to the Deceased as standard management and he concluded that he would not have treated the Deceased in any different way.

[68] Having reviewed the totality of the written evidence in this case including the conflicting expert reports and having had a chance to observe the witnesses under oath, this Court makes the following findings:

- i. That little weight should be ascribed to the Dr. Penn’s expert report as it is clear that he formed preliminary opinions on this matter which were informed by third party reports and not from the attending doctors or from the relevant medical reports and test results. He would therefore have been woefully uninformed when he formed the opinion that overseas care was more appropriate. It is also clear that he was intimately and critically involved in the decision to transfer the Deceased to the overseas medical facility and this would have coloured his views and impacted his evidence and opinions.

- ii. Moreover, although Dr. Penn provided references to resource materials or peer review reports the actual extracts were not attached. It is apparent that Dr. Penn's expert opinion was formed on the basis of dated materials which had very limited relevance to Deceased's case. His main focus appears to have been the extended period during which the Deceased was at the Hospital and the delay in transfer to a medical facility which would afford a multidisciplinary approach and which had the proper services and facilities. It provided very little assistance on the actual particulars of negligence alleged (including the failure to properly diagnose the Deceased; failure to properly care for the Deceased causing her to develop sepsis, failure to inform the Claimant and/or any of the deceased immediate family of the true nature of the Deceased's condition or negligently misrepresenting the true state of health of the Deceased and finally the failure to or properly administer the appropriate medical care required of the Deceased) and which would form a basis for liability in this claim. Dr. Penn's Report failed to establish the necessary connection between the breach of duty allegations in the statement of claim and the Defendant's responsibility for same but instead focused on whether there were suitable protocols in place for the transfer of patients to overseas medical facilities notwithstanding the fact that this was not a pleaded allegation.
- iii. Dr. Penn's Report also ignores the fact that the delay in transfer to the medical facility may have been impacted by matters which were outside of the control of the Defendants or their servants or agents. The Court finds that any delay in transferring the Deceased to the overseas medical facility would have been attributable to the fact that it was necessary to secure a suitable facility willing to accept the Deceased as a patient and to the fact that arrangements had to be made to fund transportation and the costs of the overseas medical care. The Court has no doubt that the approval of the financial assistance and support by the NHI was critical before steps could be taken to effect the transfer. Once the approval was provided by NHI, the Deceased was immediately transferred.
- iv. Although it did not specifically cite any authoritative resource materials or peer review reports, the expert evidence advanced by Professor Rasheed (a specialist practitioner with significant relevant practical and theoretical experience) convincingly addressed

the issues which arose on the claim. Professor Rasheed clearly had the particulars of negligence at the forefront of his mind and his conclusions at pages 14 – 18 of his Report were not undermined in cross-examination. The Court therefore has no reservations in accepting the opinions expressed therein both on issue of liability and causation.

- v. The nonspecific nature of the Deceased's presentation would have accounted for the delay in the primary diagnosis and the treatment for the perforated ulcer. However, ultimately, the management was reasonable, and the decision to operate and the type of surgery were appropriate. Moreover, the presence of a leak notwithstanding, there is nothing to indicate that the original surgery and the re-laparotomy was not completed to a reasonable standard. The source of the leak could not be identified but the decision not to disturb the repair was appropriate.
- vi. The handover between Dr. Yee-Sing and Dr. Bhattacharaya may have been irregular and not consistent with the standard of an ordinary skilled doctor exercising special skill but there is no evidence that this would have materially contributed to the Deceased's injury and death.
- vii. The Claimant's contention that the treating doctors were aware that the Deceased had developed sepsis and had not informed the family stems from the hearsay evidence advanced in the witness statement of Curlyn Fahie-Hodge in which she recounts a conversation with Dr. Samuel. The Court could ascribe no weight to this evidence. The Claimant also relies on Dr. Yee-Sing's evidence at paragraph 12 of her witness statement where she observed that a decision was taken to reassess the Deceased's abdomen with a CT scan "in light of the evidence of sepsis and rising pancreatic enzymes". It is however; clear that this observation would have been made in October 2018 and prior to the full battery of tests, the diagnosis and 2 surgical interventions. Moreover, Dr. Yee-Sing's goes on (at paragraph 14 of her witness statement) to state that the Deceased's son was called and informed of the medical findings and was advised that surgical intervention was necessary.

- viii. The evidence discloses that the Claimant and/or any of the Deceased immediate family had multiple meeting with the Deceased's treating doctors and were kept informed at all stages of the Deceased's treatment and care. The Defendant's servants were clearly optimistic about the Deceased's recovery prior to her discharge and transfer. It was represented that the Deceased was improving. Based on the medical evidence of the treating doctors and that of Professor Rasheed, the Court is unable to conclude that this would have been a negligent misrepresentation of the true state of health of the Deceased at the material time. Moreover, the Court is not satisfied that any connection could be drawn between this purported failure and the Deceased's passing.
- ix. Ultimately, the Court is unable to conclude that the Defendant (its servants or agents) conduct fell below the required standard of care. Having reviewed the totality of the evidence, this Court finds on a balance of probabilities that the Defendant's servants or agents did not breach their duty of care in the manner alleged by the claim or at all.

[69] Even if the Claimant had satisfactorily proved that the Defendant breached its duty of care to the Deceased, his burden is not completely discharged. The Claimant also has the onus of proving that this breach of that duty caused or materially caused Deceased's and was foreseeable as a result of the breach. **Bonnington Castings Ltd. v Wardlaw**¹⁰; **Wilsher v Essex Area Health Authority**¹¹. A claim in medical negligence will fail unless this can be proven on a balance of probabilities; which means that the Claimant must demonstrate that it is more probable than not that the negligence caused the damage which is the subject of this claim.

[70] The Claimant has to prove that the Defendant's negligence caused the damage in fact and in law. In most cases where a claimant is attempting to prove as a "matter of fact" that a defendant caused the loss or damage, a simple "*but for*" test is normally used. The question for the Court is: would the Deceased have suffered the injury *but for* the Defendant's negligence?¹² If yes, the defendant is not liable. If no, the defendant is liable.

¹⁰ [1956] A.C. 613

¹¹ [1988] A.C. 1074

¹² *Barnett v Chelsea* [1969] 1 QB 428 and see: *Hotson v East Berkshire Area Health Authority* [1987] 1 AC 750 and *Gregg v Scott* [2005] 2 AC 176

- [71] However, in proving causation, the English courts have on occasion applied a different test than the “*but for*” test. Where there exists two or more causes which operate concurrently, it may be factually impossible to determine which one was the cause. This becomes problematic because the claimant bears the burden of establishing which one was the cause on a balance of probabilities. In order to circumvent the strict approach, the courts have developed the ‘material contribution’ test. In **Bonnington Castings Ltd v Wardlaw**¹³ the House of Lords held that the claimant does not have to prove that the defendant’s breach of duty was the sole or even the main cause of damage, provided he can demonstrate that it made a material contribution to the damage.
- [72] In legal submissions filed with the Court, Counsel for the Claimant appeared to rely on the material contribution’ test¹⁴ and submitted that the Defendant’s failure to treat and operate within a reasonable time and the failure to refer the Deceased to a more advanced supportive care facility caused delays which significantly increased the mortality rate of the Deceased post-operative leaks which eventually lead to sepsis and materially contributed to her death.
- [73] First, the Court finds that the latter contention is not part of the Claimant’s pleaded case. Second, even if it were part of his case, (other than the opinions expressed by Dr. Penn) there is simply no primary evidence before the Court which could inform a conclusion that the Defendant lacked the appropriate facilities and professional expertise and competence and that such deficiency made it unreasonable or negligent to continue to administer treatment. Third, in answering the question: Is there a causal connection the Court has had to consider the contrasting expert testimony presented. The totality of Dr. Penn’s evidence simply does not satisfy so that the Court can find on a balance of probability that the Defendant’s negligent conduct caused the Deceased’s death. Consistent with the expert opinion of Professor Rasheed, the Court finds that the nonspecific nature of her presentation would have contributed to the consequential delays in diagnosis and treatment and together with the Deceased’s co–morbidities would have led to her deterioration and eventual passing.

¹³[1956] AC 613

¹⁴ Williams v Bermuda Hospital Board [2016] UKPC 4

CONCLUSION

[74] Having regard to the particulars of negligence pleaded, the evidence as a whole and the findings of fact and law, the Court accepts that there was a clear duty of care owed to the Deceased. However, the Court is not satisfied that Claimant has discharged his burden to proving that the Defendant was negligent in the manner contended in the Claim. Given the findings herein the Court does not need to go on to assess damages and will decline to do so.

[75] In accordance with the usual rule costs will follow the event and so the Defendant will have its costs to be quantified on a prescribed basis.

[76] For the reasons set out herein the Court's order is therefore as follows.

- i. The Claimant's claim is dismissed.
- ii. The Defendant will have their costs to be quantified on a prescribed basis.

**Vicki Ann Ellis
High Court Judge**

By the Court

Registrar