

EASTERN CARIBBEAN SUPREME COURT
TERRITORY OF THE VIRGIN ISLANDS

IN THE HIGH COURT OF JUSTICE
(CIVIL)

Claim No. BVIHCV 2012/104

BETWEEN:

JASON JAMES
(Widower and Intended Personal Representative of the Estate of Chivarane James, Deceased)
Claimant

And

THE BVI HEALTH SERVICES AUTHORITY
Defendant

Appearances: Mrs. Patricia Archibald - Bowers for the Claimant
Mr. Terrence Neale and Ms. Elizabeth Ryan of Mc W. Todman Chambers for the Defendant

2016: April 15

JUDGMENT

- [1] **Ellis J.:** On 16th April 2012, the Claimant commenced a claim in negligence against the Defendant in which he seeks general and special damages for loss allegedly suffered as a result of the death of his wife Chivarane James, a patient at the Defendant's hospital.
- [2] The Claimant is the widower and Administrator of the Estate of Chivarane James ("**the Deceased**") and brings this claim on behalf of himself as well as the mother and father of the Deceased pursuant to the Fatal Accidents Act Cap 26 Revised Laws of the Virgin Islands.

- [3] The Claim alleges that on 30th September 2011, the Deceased was admitted to the emergency department of Peebles Hospital complaining of a nose bleed and a saturation level which had dropped below 80. The Deceased was eventually admitted to the surgical ward where she was tested for tuberculosis (TB), pneumonia and asthma. An x-ray was taken which showed that the Deceased had a chest infection. No electrocardiogram (**EKG** or **ECG**) test¹ was carried out on the Deceased on that date because the doctors were of the view that the medical symptoms exhibited by the Deceased did not warrant such a test. However, the Claimant contends that on 1st October 2011, an EKG test was carried out, although neither the Deceased nor the Claimant ever saw or was told about the results until after the Deceased's death.
- [4] The diagnosis of the Deceased's medical condition was a lower respiratory tract infection. The Deceased was discharged from the hospital on 4th October 2011 with instructions to complete a course of antibiotics and to follow up in the medical outpatient clinic in a month's time.
- [5] On 8th October 2011, the Deceased again began to bleed through her nose; she was taken to the hospital and treated for sinus discharge. She was also asked to do an x-ray and a computed tomography (CT) scan. She later returned home. She returned to the Hospital on 10th October 2011 and completed the test but again the Claimant contends that they were not advised as to the results.
- [6] On 14th October 2011, the Deceased went to shower and complained that she could not breathe. After the Claimant lifted her out of the shower, he performed CPR until she regained consciousness within 45 seconds. The Deceased was then driven to the emergency room of the Defendant's Hospital where she saw a doctor at 6:40 p.m. The Claimant contends that she was referred to a medical team who advised that she had a possible seizure disorder.

¹ ECG and EKG both stand as abbreviations for electrocardiogram and are used interchangeably in this judgment.

- [7] On 15th October 2011, the Deceased was admitted and seen by Dr. Krow who carried out an EKG. This was later followed by a further EKG. An initial assessment was made of a possible epileptic seizure. However an EKG, D-dimer=300ng/ml and a chest x-ray carried out on 16th October indicated a right ventricular hypertrophy with pruning of the pulmonary vessels and a dilated pulmonary artery. As these findings were suggestive of pulmonary hypertension, arrangements were made to carry out other tests to rule out pulmonary embolism. The Claimant and the Deceased were informed that an abnormality was found in the Deceased's heart and discussions were held with the Claimant to fly her out to Puerto Rico and to have the echocardiogram done on 17th October 2012.
- [8] On 16th October 2011, Dr. Suresh noted that the Deceased had clinical signs of heart strain and pulmonary hypertension. The Deceased remained on the surgical ward. At 10:00 p.m. a nurse's note indicates that the Deceased was resting comfortably with no signs of distress. At 2:00 a.m. on the following day, when her vitals were taken the Deceased's pulse rate was recorded as 102. Sometime between that time and 2:15, the Deceased went into respiratory distress. The Deceased lapsed into a state of consciousness from which she did not recover. She was pronounced dead at 4:11 a.m. on 17th October 2011.
- [9] A post mortem analysis was performed on October 22, 2011 by an Barbados based pathologist, Dr. David Gaskin, who concluded that:
- "The clinical suspicion of pulmonary hypertension/right ventricular hypertrophy was confirmed at autopsy. The etiology of pulmonary hypertension needs to be elucidated."*
- The cause of death indicated on the death certificate was cardiopulmonary failure and chronic primary pulmonary hypertension.
- [10] The Claimant contends that his wife's death was due to the negligence of the Defendant, its servants and/or agents in that they:

- (i) Failed to adequately assess, evaluate, diagnose, and/or properly diagnose and treat the Deceased during her admissions to the hospital on 30 September 2011 to 4 October 2011, 8 October 2011, 10 October 2011 and 14-17 October 2011.
- (ii) Failed to perform an echocardiogram during the first admission of the deceased or at all to evaluate her abnormal EKG, SOB and CXR.
- (iii) Failed overall to properly care and treat the Deceased during her period of stay at the Peebles Hospital from September 30 – October 4, 2011, October 8, 2011, October 10, 2011 and October 14 – 17, 2011.

[11] The Claimant contends that the Deceased suffered much pain and suffering prior to her eventual death. He also claims that the Deceased and her dependents (Padmoutie Sookdeo and Basil Ramkisson, the mother and father of the Deceased) and the estate have suffered loss and damage. He claims that Deceased's estate incurred medical and funeral expenses in the amount of \$29,900.00.

[12] The Claimant initially relied in support of his claim on the undated medical report of Dr. Michael Boriss, a medical practitioner based in the New Jersey, United States, however the Claimant applied for and was granted leave on April 8, 2014 to call Dr. Charles H. Gaymes, MBBS, DCH, MD, FAAP, FACC professor of Pediatrics/Pediatric Cardiology at the University of Mississippi Medical Centre.

[13] The Defendant has denied that its servants and/or agents were negligent in their treatment of the Deceased. The Defendant contends that all reasonable steps were taken by the Hospital to save the Deceased's life, however despite their best efforts the Deceased passed away.

[14] The Defendant further contends that because the Deceased suffered from primary pulmonary hypertension, the prognosis for an extended life was poor as so it is unlikely that the Deceased

would have lived to the age of 77. The Authority relied on the expert evidence of Dr. Stephen Brecker, a consultant cardiologist.

[15] At the trial, the Claimant gave evidence on his own behalf. He also relied on the expert testimony of Dr. Charles H. Gaymes. The Defendants relied on the evidence of Dr. June Samuel and the expert testimony of Dr. Stephen Brecker.

[16] The Court also considered the legal submissions advanced by Counsel for the Claimant. Counsel for the Claimant failed to advance any pretrial submissions and perhaps more indictably, she failed to provide any written closing submissions in the matter notwithstanding the order of the Court. This contumelious breach meant that this Court was unassisted by Claimant on the critical legal issues which were to be determined. This was particularly inexcusable given the glaring evidential lacunas which arose in the Claim.

CLAIMANT'S CASE

[17] In a brief witness statement filed on 21st May 2013, the Claimant stated that until she fell ill and consulted the doctors at the Defendant's hospital his wife was fit and healthy, enjoyed her job (working 5 days a week sometimes shifts on weekends) and jogged twice per week in the evenings. He further stated that prior to her migrating to Tortola in 2006, the Deceased was medically examined and the report which was submitted to BVI immigration authorities indicated that she had a clean bill of health. He stated that until 30th September 2011, the Deceased had no need to consult a doctor.

[18] He stated that on 30th September 2011, while his wife was at work, she called him after 5:00 p.m. to say that she was unwell and had coughed up blood. He immediately made arrangements for her

to be taken to Eureka Medical Clinic. She was treated there but she was eventually transported from there to Defendant's Hospital by ambulance. She was admitted on 30th September 2011.

[19] At paragraph 13 of his witness statement, the Claimant sought to correct his statement of claim. He stated that paragraph 13 of the Claim should state instead: *"On 4th October 2011, the bleeding from her nose has stopped and the diagnosis of severe pneumonia had also stopped and she was later discharged that day."*

[20] After her discharge on 4th October 2011, the Deceased remained at home for a few days resting. After that date, the Claimant did all the household chores. According to the Claimant at the time of her discharge the Deceased was experiencing some chest pains and in the ensuing days she did not walk with the same briskness as she normally did. She also complained of physical discomfort in not being able to breathe properly. She complained that she felt like her chest was "locking off". This continued during each day until her death. He stated that it did not appear that she had heavy pain but there was some measure of pain on and off in her chest area.

[21] When he was examined by his Counsel, the Claimant sought to first amplify paragraphs 13 and 14 of his witness statement. He testified that he found out about the Deceased's diagnosis only when she was being discharged and he was only given instructions on the medications. The Claimant told the Court that he last saw his wife alive on 16th October 2011 around 8:00 p.m. At that time, she was awake and spoke to him.

[22] When the Claimant was cross examined, he testified that when his wife travelled to the BVI in 2006 it would have been with the intention of making BVI her home. However, he conceded that the medical exam which his wife would have completed prior to coming to the BVI would have been limited because it dealt with specific matters.

[23] Counsel for the Defendant then referred the Claimant to paragraph 14 of his evidence in which he states that when his wife was discharged from the Hospital on 4th October 2011 she was experiencing some chest pains. Counsel referred the Claimant to the Hospital's Physician's Progress Notes² of Dr. Suresh dated 14th October 2011, in which the following statement is recorded:

"She however denied any chest pain, wheezing, fever ...or headache."

"However pt. noted to be comfortable at rest and continuing to deny any chest pain. She notes however that she experiences SOB on exertion but no chest pain."

Despite the obviously divergent evidence, the Claimant maintained that the Deceased continued to experience chest pain and he was unable to account for the note made in her medical records.

[24] Counsel for the Claimant then turned to the evidence filed in support of the Claim. Noting that a claim was made in respect of the Deceased's parents at paragraph 24 of the Statement of Claim, Counsel noted that there was no witness statement from either parent attesting to the contribution which the Deceased is alleged to have made, neither was there any documentary proof of the repatriated funds. The Claimant indicated that he had given receipts to his attorneys and could not account for their failure to disclose or tender the same into evidence.

[25] Counsel then asked the Claimant to provide a breakdown of the special damages claimed distinguishing funeral expenses from the medical expenses. The Claimant's response was telling. He was unable to respond with any accuracy because he did not have the relevant receipts. However, he testified that roughly \$20,000 represented the funeral expenses. Counsel then referred the Claimant to the evidence provided in support of these expenses. He noted that the total amount paid was \$4920 made up in the following way:

² Page 316 and page 319 of Trial Bundle 2

- i. The Davis Funeral Home Invoice was US\$6120. However, \$3000 of that was paid by the Social Security so that the actual claim made is **US \$3120.00**.
- ii. The Luken Newburg Funeral Home in Guyana receipt shows that GUY\$90,000.00 was paid which is equivalent to **US \$1800.00**.

Counsel then cross examined the Claimant as to what would make up the balance claimed. The Claimant testified that that balance of \$16,000 included his airfare to Guyana - \$4,920.00, clothing for the Deceased's parents and her two brothers and building a tomb. The Claimant conceded that however that there was no documentary evidence supporting these expenses.

[26] Assuming that the balance of the expenses (\$9,900.00) was medical expenses, the Claimant again conceded that there were no receipts before the Court to support those expenses. He then testified that his wife was covered by health insurance and that most of the medical expenses would have been covered by her insurance.

[27] When the Claimant was reexamined by his attorney, he was unable to address the deficiencies highlighted by Counsel for the Defendant. He simply averred that his funeral expenses included the cost of his travel to Guyana. He restated that the Claimant contributed \$214.00 to her parents who are still living on a monthly basis. He also testified that his wife had two brothers who were both younger than her.

DEFENDANT'S CASE

[28] Dr. June Samuel's evidence was given in her capacity as the Chief of Medical Staff and the Peebles Hospital. She indicated that she reviewed the medical records and files pertaining to the Deceased. They reveal that on 30th September 2011, the Deceased was admitted to the

emergency department of Peebles Hospital complaining of a nose bleed and a saturation level which had dropped below 80.

- [29] The Deceased was subsequently treated for pneumonia and asthma. An X-ray was also carried out which confirmed that she had a chest infection. Dr. Samuel stated that the medical records indicate that no test for TB was carried out at the time of admission although it was contemplated by the medical officer who admitted her. The consultant physician who eventually treated the Deceased was of the view that it was unnecessary in light of the fact that that her symptoms were more consistent with a respiratory tract infection than a condition associated with her heart. This was also based on the fact that the tests showed that all of her vital signs appeared to be within normal acceptable range except for a WBC=12, Urea=24 U/L and AST = UL.
- [30] The final diagnosis was that the Deceased had a lower respiratory tract infection. The hospital notes indicated that the deceased responded well to treatment and that there was nothing at the relevant time to suggest that there were any further medical complications. Dr. Ibrahim advised that the Deceased had informed him that she was feeling much better; that she wanted to be discharged from the Hospital and that she was not interested in performing any further tests. She was later discharged with instructions for her to complete her full course of antibiotics and to follow up in the medical outpatient clinic within a month of discharge.
- [31] Contrary to what is alleged by the Claimant, Dr. Samuel stated that the records do not indicate that a CT scan was carried out at the time of her admission or that she was instructed to have a CT scan done before being discharged from the hospital.
- [32] The Deceased was again admitted on 10th October 2011 complaining of bleeding from the nose and shortness of breath. She was treated from sinusitis and advised to undergo certain tests on an outpatient basis. Dr. Samuel states that the medical records do not show that there were any

medical symptoms exhibited which could give rise to suspicion that the Deceased had problems with her heart.

- [33] The Deceased was again admitted on 15th October 2011, complaining of difficulty breathing and loss of consciousness. The notes indicate that she denied having any chest pain, wheezing, fever, headache, nausea or vomiting but she did indicate a family history of seizures. She was seen by Dr. Krow. An initial assessment was made of a possible likely epileptic seizure however an EKG, D-dimer=300ng/ml and a chest X-ray carried out on 16th October which indicated a right ventricular hypertrophy with pruning of pulmonary vessels and a dilated pulmonary artery.

- [34] Dr. Samuel stated that the hospital notes do not reflect any discussions with the Deceased about arrangements to travel to Puerto Rico to do an Echocardiogram test. According to Dr. Samuel, it is possible to carry out such a test at Peebles Hospital.

- [35] She further stated that the Deceased remained at the surgical ward and further reviews were conducted by the Hospital's medical staff. She stated that findings of the initial assessment were suggestive of pulmonary hypertension and as a result arrangements were made to carry out an Echocardiogram as well as other tests (CT and venous Doppler) to rule out pulmonary embolism. However, before those tests could be carried out, the Deceased lapsed into a state of unconsciousness from which she never recovered. The Deceased when into respiratory distress at approximately 2:15 a.m. and although a concerted effort was made by the staff to save her life, she passed away at 4:11 a.m. on 17th October 2011.

- [36] A clinical summary for post mortem examination was prepared by Dr. Krow and forwarded to the Barbados based, pathologist, Dr. Gaskin. The post mortem report was eventually forwarded to the hospital on 22nd October 2011 and it indicated the cause of death was pulmonary hypertension /right ventricular hypertrophy.

[37] Dr. Samuel's substantive evidence was not challenged on cross examination. Instead, Counsel for the Claimant largely confined her cross examination of Dr. Samuel to the employment history of the persons who attended to the Deceased prior to her death. She testified that Dr. Krow, Dr. Ibrahim and Dr. Suresh are all no longer employed by the Defendant. Dr. Samuel was not able to recall the exact date when they left the Defendant's employ. However, she testified that Dr. Suresh was employed for a period of just short of 2 years; Dr. Krow would have been employed for about the same time and Dr. Ibrahim would have served just short of 4 years. Dr. Samuel was also able to say that Dr. Krow left to pursue further studies, while Dr. Suresh left to take up another assignment. She was unable to say why Dr. Ibrahim terminated his employment.

EXPERT EVIDENCE

[38] The Parties in this action each chose to advance expert testimony in support of their case. The Claimant relied on Dr. Charles Gaymes MBBS, DCH, MD, FAAP, FACC, professor of pediatrics/pediatric cardiology at the University of Mississippi Medical Centre while the Defendant relied on Dr. Stephen Brecker MS, BS, MD, FRCP, FESC, FACC, a consultant cardiologist at St. George's Hospital in London and senior lecturer at the University of London Medical School. Both experts filed expert reports in the matter which radically disagree on crucial matters.

[39] Dr. Brecker's report makes it clear that he had no prior history of the Deceased. However, he reviewed the relevant hospital notes commencing from 30th September 2011 when the Deceased was first admitted. He also reviewed the relevant post mortem report. His opinion in that regard is significant. He noted as follows:

"The post mortem is very unsatisfactory because we are simply given a very brief summary with no description of the findings in the heart and lungs. The only findings were of pulmonary hypertension with right ventricular hypertrophy, finger clubbing and some

hemorrhagic gastritis. There was no comment on whether any pulmonary thromboembolic disease was present or whether there was any congenital heart disease present.”

And later;

“One would have hoped for absolute clarification of the aetiology of the pulmonary hypertension from the postmortem but none was available. I am uncertain as to whether this is because the post mortem was inadequate or the post mortem was thorough and failed to identify the cause”

[40] When he was examined under oath, Dr. Brecker was particularly critical of the pathologist's report. According to Dr. Brecker, this was a 25 year old woman whose sudden death was unexplained and it was the job of the pathologist to definitively determine her cause of death. He noted that he is used to seeing reports of a more significant length and which were much more detailed. These observations are critical because of the substantial burden and standard of proof which rests on the Claimant.

[41] Dr. Brecker describes this case as a highly complex case, with a very unusual presentation of pulmonary hypertension. He began his analysis by describing the three most common causes of pulmonary hypertension sufficient to cause the ECG changes which presented in the Deceased.

- a. Chronic pulmonary thromboembolic disease
- b. Congenital heart disease and
- c. Primary pulmonary hypertension

[42] As there is no clear indication that the post mortem excluded the first two possibilities, he suggested that any of the three diagnoses are possible and each must be considered and analyzed. In doing so he was careful to point out that there is no one diagnosis which fits all of the data squarely and classically. Nevertheless, having considered the possibilities Dr. Brecker opined that **primary pulmonary hypertension** was the most distinct possibility. He noted that the results of the ECG, the enlarged proximal pulmonary arteries and the reported peripheral pruning on the

chest X-ray were all consistent with this diagnosis. It is also consistent with the saturation data recorded. However Dr. Brecker noted that it was inconsistent with finger clubbing because it was unusual for this to present acutely with little in the way of prior symptoms.

[43] While it is possible that the Deceased had **congenital heart disease**, Dr. Brecker noted that it would be unusual for a patient with congenital heart disease to have escaped diagnosis throughout their childhood and early adult life. He went on to point out that the cyanosis (which one would expect to be present) was not identified in the Deceased. Nevertheless he could not rule out congenital heart disease as a possibility noting that finger clubbing was consistent with that diagnosis.

[44] He described the first possibility, **chronic pulmonary thromboembolic disease** as the statistically most likely diagnosis but he noted that this typically presents with sudden onset of chest pain and breathlessness. He further noted that this does not appear to be present in this case as the Deceased initially presented with epistaxis. He suggested that a new pulmonary embolus could have been responsible for the symptoms shortly before death but according to him it is inconceivable that a pathologist would have failed to identify occlusive pulmonary embolus and chronic pulmonary thromboembolic disease given that this is the most common cause of pulmonary hypertension and a post mortem would ordinarily have examined for it to try to assess its cause. He opined that the fact that the pathologist has not identified the cause and has indicated that the cause of it needs to be elucidated is strong circumstantial evidence that pulmonary emboli were not present. Instead, the following features are noted in the pathologist's report: 1. Right ventricle thickening of the right ventricle; 2. Finger clubbing. He noted that this was indicative of pulmonary hypertension. Also noted were 3. hemorrhagic gastritis with 50 ml of blood in the stomach and 4. polycystic ovaries.

[45] He noted that there are some findings recorded (measurements of the ventricles of the heart) which indicate that there was more than a cursory examination carried out. According to Dr. Brecker this would require the pathologist to open and dissect the heart. He surmised that if there

was any congenital abnormality, the pathologist would have commented on it. Dr. Brecker also noted that there was no indication that pulmonary emboli (blood clot) were found. Given that he examined the heart, the only conclusion is that the pathologist did not find it.

[46] Moreover, Dr. Brecker opined that if the Deceased had primary pulmonary hypertension or congenital heart disease then her death would not have been preventable because it is unlikely given the timescale involved that any treatment could have been offered for either primary pulmonary hypertension or congenital heart disease which could have altered the outcome. He concluded that on the evidence which had been provided he could not agree that survival was likely on a balance of probabilities.

[47] When he was further cross examined, Dr. Brecker made an important statement which was germane to the Claimant's case. Counsel for the Claimant reiterated that the Deceased was a 25 year old female whose 3 ECG tests³ were markedly abnormal. He observed that there were no substantial changes noted in the 3 tests. Dr. Brecker agreed that this should have raised a flag. In his words "*whatever else was going on the EKG defined heart disease as being present.*" He further testified that based on the fact that the Deceased was 25 years old, it would have been prudent (given these results) to do an ECHO cardiogram test. He testified that where a patient is 25 years old, with abnormal ECG, her cardiologist would normally request an Echocardiogram.

[48] He agreed that the Echocardiogram should have been done after the first EKG. He further agreed that had an Echocardiogram test been done, it may have shown right ventricular hypertrophy and pulmonary hypertension. However when Counsel for the Claimant asked whether the resultant early intervention could have assisted in saving her life, Dr. Brecker indicated that while this was possible it was also speculative. According to him he would then want to see a CT cardiogram to show whether there was a pulmonary emboli or congenital heart disease. If the diagnosis was

³ Page 208, 209 and 210 of Trial Bundle

pulmonary emboli then the appropriate course would have been anticoagulation treatment to thin the blood and then start medication.

- [49] Unfortunately we do not know what would have happened because although there is evidence that an ECHO cardiogram was requested⁴, it was never carried out.
- [50] The Court notes that the report of the Claimant's expert Mr. Gaymes was filed outside the time prescribed in the case management order and after that of Dr. Brecker. Given that it is the Claimant who bears the burden of proof; this is highly irregular. The irregularity was further exacerbated when it became clear that the Dr. Gaymes Report was essentially a critical commentary of the Dr. Brecker's report rather than original opinion evidence on the matters which concern this Court.
- [51] Ultimately, Dr. Gaymes concluded that Dr. Brecker *"makes a compelling case to substantiate the Claimant's case that Peebles Hospital failed to provide the standard of care necessary to evaluate and treat Mrs. Chivarane James."* Dr. Gaymes bases this opinion on a number of factors. First, he submitted that a having observed a pulse rate of 110 to 115, this would indicate an acute disease process requiring further valuation. He noted that this was not done. He also observed that medical service noted a history of hemoptysis, shortness of breath, dizziness and weakness. He submitted that these were serious symptoms that warranted further evaluation with blood work D-Dimer, PT, PTT and INR. A CT scan of the chest Echocardiogram and Doppler of the lower extremity veins for pulmonary embolus. This was also not done.
- [52] Dr. Gaymes' report also notes that despite the fact that a lower respiratory tract infection was the initial diagnosis, it was felt that that she should have a CT scan of chest. However, this was also not done. On 2nd October 2011, he noted that the Deceased was discharged with a prescription for

⁴ Page 186-187 of the Trial Bundle

Augmentin when it was clear that she was still tachycardic indicating an active disease process at the point of discharge.

- [53] Contrary to what is indicated by Dr. Brecker, it is Dr. Gaymes' definitive and expert opinion that the medical notes disclosed acute pulmonary hypertension with elevated D-Dimer most likely pulmonary embolus. He referred to paragraph 4.2 of Dr. Brecker's report in which he notes the Deceased's symptoms of dyspnea, epistaxis and haemoptysis, classic symptoms of pulmonary embolism. According to Dr. Gaymes the next step should have been immediate anticoagulation and urgent evaluation for pulmonary embolus. He further notes that her spitting up blood is a serious symptom which would require immediate evaluation for pulmonary embolism. Instead, the Deceased was booked for a CT scan but later discharged.
- [54] Dr. Gaymes trenchantly asserted that none of the tests or findings are consistent with a diagnosis of pulmonary hypertension. In support of this conclusion he noted that (1) the X-ray report showed that the cardiac shadow was normal; (2) the oxygen saturation of 94% – 95% because "no adult patient with primary pulmonary hypertension has oxygen saturation of 95% - 100% at room air"; (3) there was no digital clubbing recorded at 1:50 p.m. on 1st October 2011; (4) the Deceased did not have polycythemia; (5) the EKG results and (6) the enlarged pulmonary arteries.
- [55] Dr. Gaymes noted that Dr. Brecker's own expert opinion rules out any real probability of a diagnosis of primary pulmonary hypertension or congenital heart disease. He submitted that it is impossible for these diagnoses to exist given the physical and laboratory evidence. He submitted that the primary diagnoses should have been pulmonary thromboembolic disease and everything should have been done to evaluate and treat for it. He strongly disputes that anticoagulation would have been problematic as a treatment.

- [56] Dr. Gaymes concludes his critique by stating that Dr. Brecker was wrong to speculate on the intention of the pathologist beyond what is indicated in the limited report.
- [57] When he was cross examined however, Dr. Gaymes' evidence increasingly shifted from trenchant to equivocal. First, he conceded that that conclusion drawn by Dr. Brecker in paragraph 4.2 of his report was in fact accurate. So that he now concluded that symptoms of dyspnea (discomfort in breathing), haemoptysis are not necessarily specific to pulmonary embolism but can also result from asthma, pneumonia, primary pulmonary hypertension and chest infections. He further conceded that while they may be a rare symptom in pulmonary hypertension fairness demanded that this fact be pointed out in his report.
- [58] Dr. Gaymes conceded that the Deceased was initially treated for pneumonia but he opined that the X-ray report was not consistent with the severity of the symptoms to produce coughing up blood. When it was pointed out to him that the Hospital progress notes make no mention that the Deceased was coughing up blood, rather she was spitting up blood which she had swallowed from the nose bleed.⁵ Dr. Gaymes simply concluded that this was not true case of haemoptysis.
- [59] Counsel for the Defendant then suggested to Dr. Gaymes that a normal cardiac shadow was noted in her chest x-ray would not be present where there is a chronic case of thromboembolic disease.
- [60] Dr. Gaymes equivocation continued when counsel put to him that the oxygen saturation levels recorded (94% - 95%) was not consistent with his diagnoses that the Deceased had chronic thromboembolic disease. Dr. Gaymes denied that this was his diagnosis and instead stated that he had diagnosed pulmonary embolism. Counsel then referred him to paragraph 6.4 of his report and asked him to explain the inconsistency. This paragraph stated as follows:

"Death was potentially preventable if the diagnosis had been chronic pulmonary thromboembolic disease." This should have been the primary diagnosis and everything should have been done to evaluate and threat for it."

⁵ Hospital Progress Notes 1/10/2011 at page 359 of the Trial Bundle and see paragraph 9 of the witness statement of Dr. June Samuel

Dr. Gaymes indicated that there was no inconsistency in his evidence. Instead he contended that his diagnosis was that of *acute* pulmonary thromboembolic disease. This diagnosis could be justified even if Deceased had a chronic disorder or clotting problem. He testified further that while small clots may be discharged in the lungs, a big clot would be consistent with the symptoms which she exhibited i.e. the waxing and waning saturation levels.

[61] Dr. Gaymes then went on to challenge the accuracy of the radiologist report which indicated right ventricular hypertrophy with main pulmonary artery dilations and peripheral pruning of the vessels. He disputed the accuracy of those results and told the Court that the report does not make sense. When Counsel for the Defendant suggested that his contention was simply based on the fact that the report was inconsistent with the conclusions, Dr. Gaymes inexplicably testified that in fact the radiologist report which he previously challenged, was consistent with his conclusions.

[62] Counsel then pointed out that the Deceased made no complaints about chest pains. He suggested to Dr. Gaymes that since chest pains are a classic symptom of pulmonary embolism, the fact that the Deceased did not experience this was wholly inconsistent with his diagnosis. Dr. Gaymes responded that while chest pains are one of the symptoms that may be present, it is possible for a patient to have pulmonary emboli without experiencing chest pains.

[63] Dr. Gaymes criticized the approach taken by Dr. Brecker in advancing three possible scenarios. He concluded that this was a simple, uncomplicated and straightforward case of thrombo pulmonary embolic disease. He suggested that it would be an acute process. He stated that it was possibly a small blood clot since a big blood clot would present immediate problems. He reiterated that this diagnosis would have been consistent with all the other symptoms and that chest pains would not necessarily be shown.

[64] The one point of agreement between the two experts is that the post mortem report was and is inadequate. Dr. Gaymes agreed that the conclusion of primary pulmonary hypertension warranted

further investigation in order to determine the cause. Such investigation would involve the examination of the Deceased's arteries and Dr. Gaymes agrees that there is no evidence that this was done. However, in the face of this, Dr. Gaymes observed that one of the causes of primary pulmonary hypertension is pulmonary embolism and so he concluded definitively that it is the most straightforward diagnosis in the circumstances, notwithstanding that the pathologist could not come to a similar conclusion.

[65] Finally, Dr. Gaymes testified that the appropriate treatment would have been anticoagulation. He did not accept that the same result would have obtained in any event. According to Dr. Gaymes, the Deceased's survival would have been precluded only by what happened in her terminal event. He told the Court that administering the treatment would have yielded an immediate result. He further told the Court that there would have been no complications presented by the nose bleed because it appeared to be a transient event. Further, there is no evidence that her clotting factors were abnormal.

[66] Because of the timeline in which the expert evidence was lodged and exchanged, Dr. Brecker was only able to address Dr. Gaymes evidence on the day of trial. Not surprisingly, he maintained his conclusions and was eager to clarify his report. He told the Court that throughout his report he tried to make it clear that this is a difficult to analyze this case because no one diagnosis accounts for all the data. Critically however, he testified that the EKG recordings and the post mortem finding that the right ventricle of the heart was enlarged demonstrated that there must have been a chronic process over a period of time (months or years).

[67] He further told the Court that he put forward a number of possibilities and arguments could be made in support of any one of these. He noted that Dr. Gaymes chose to focus on only one of possibility that of pulmonary embolism. Although Dr. Gaymes advanced reasons why certain factors do not support the other diagnoses, Dr. Brecker submitted that he can equally make point to other factors which do not support the diagnosis of pulmonary embolism. For example, he

pointed out that the pulmonary embolism is not characterized by the high oxygen saturation observed in the Deceased. He completely disagreed with Dr. Gaymes suggestion that the high oxygen saturation levels are inconsistent to primary pulmonary hypertension, and he pointed out that there are many publications which show otherwise.

[68] He reiterated that it is possible that the Deceased had congenital heart disease but he is hampered by the lack of a thorough autopsy and ECHO cardiogram. With regard to the other possibility of chronic thrombo embolic disease, he noted that it is unusual for there to be no history of chest pain of breathlessness prior to 2011 and so he was unable to fit this with chronic thrombo pulmonary emboli.

[69] It is therefore patently clear that the experts in this case radically differ on crucial points which have a significant bearing on the issues which concern this Court. Where such conflicting expert testimony arises a Court is required to resolve it. The Court accepts that the correct approach was prescribed by Bingham LJ in **Eckersley v Binnie**⁶:

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

[70] The Court therefore accepts that there is a duty to ‘to address and resolve the central issue and such of the subsidiary issues as it was necessary to resolve to decide that central issue.’⁷ A trial judge must therefore make a finding on conflicting medical evidence and cannot purport to rely on burden of proof alone.

⁶ [1988] 18 Con LR 1

⁷ [Sewell v Electrolux Limited](#) [1997] EWCA Civ. 2443

[71] And in seeking to resolve the conflict the Court is also mindful of the caution cited by Lord Bridge in **Wilsher v Essex Area Health Authority**⁸

“Where expert witnesses are radically at issue about complex technical questions within their own field and are examined and cross examined at length about their conflicting theories, I believe that the judge’s advantage in seeing them and hearing them is scarcely less important than when he has to resolve some conflict of primary fact between lay witnesses in purely mundane matters”.

[72] In that regard Counsel for the Defendant submitted to the Court that the impartiality and credibility of Dr. Gaymes is sufficiently in question so that the Court should accord little weight to his evidence. First, he submitted that Dr. Gaymes’ report is not a medical report on the issues in dispute but rather a critical commentary on the expert report of Dr. Brecker⁹. Counsel submitted that this is inconsistent with what is contemplated by CPR Part 32. Secondly, Counsel pointed out that Dr. Gaymes’ report was prepared on 24th March 2014 but his declaration was issued on 9th April 2014. He submitted that when the Report was prepared, Dr. Gaymes had no comprehension of his duties to the Court as an expert witness. Counsel submitted that Dr. Gaymes appeared to be only concerned with ensuring that he presented the most favorable position to assist the Claimant.

[73] Having made the declaration under Part 32 certifying that he understood his overriding duty to the Court it became clear during cross examination that Dr. Gaymes had never seen or read CPR Part 32 and had no clear idea as to its requirements. Counsel submitted that this raises serious issues as to the credibility of Dr. Gaymes because the Court must consider whether any proper reliance can be placed on the evidence of such an expert. He submitted that a prudent expert would have refused to execute the declaration unless he was provided with the relevant court rules.

[74] Counsel then turned to a critique of the substantive content of the report. He submitted that it was not objective because unlike Dr. Brecker, Dr. Gaymes failed to point out that certain conditions were not conducive to his diagnosis of chronic pulmonary embolism. Counsel further submitted that

⁸ [1988] 1 AC 1074

⁹ Dr. Gaymes report is entitled “**An analysis and Commentary on the medial report of Dr. S. J. D. Brecker on Chivarane James**”

whenever certain findings were not consistent with the doctor's diagnoses he overcame this difficulty by suggesting that there was some cause for suspicion. To illustrate the point Counsel pointed out the paragraph 4.23 where Dr. Gaymes contends that the radiology reports "must be suspicious for accuracy" and paragraph 5.5. (3) where he states "*This note may well have been a late entry after the cardiac arrest and the examination of clubbing and pruning on chest x-ray made to support chronic pulmonary hypertension.*"

- [75] Counsel further submitted that although Dr. Gaymes contended that the alternative diagnoses of primary pulmonary hypertension and congenital heart disease are unlikely, he was unable to explain why the pathologist (who had clearly examined the Deceased's heart) was nevertheless of the view that further investigation was necessary to determine the exact cause of the pulmonary hypertension. Counsel submitted that given the eminence of Dr. Breckers qualifications, Dr. Gaymes should also have been able to explain why Dr. Brecker (as well as the attending physician, Dr. Suresh) would have concluded that primary pulmonary hypertension was a distinct possibility as a diagnosis and should first be ruled out. Further, Counsel submitted that the Dr. Gaymes does not address how the pathologist failed to detect what is statistically the most common cause of pulmonary hypertension.

COURT'S ANALYSIS AND CONCLUSIONS

- [76] 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 and (3) that the claimant suffered injury or loss as a result of the defendant's actions.

- [77] In the Court's judgment therefore the following issues arise for determination:

- a. Whether the Defendant's servants or agents breached its duty to care to the Deceased during the period that she was a patient at Hospital?
- b. Assuming that the Defendant's servants or agents breached its duty of care to the Deceased whether such breach of duty resulted in the death of the Deceased.
- c. Assuming that the breach of duty resulted in the death of the Deceased the appropriate measure of damages to be awarded to the Claimant as compensation for the loss.

[78] It is also the generally accepted view and certainly one which is not disputed by the Parties, that a duty of care exists between healthcare professionals and their patients.¹⁰ 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”.

[79] **Cassidy v Minister of Health [1951] 2 KB 343** brought into focus the liability of respondents for the negligence of medical practitioners employed by them. Lord Denning put the position this way:

‘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. 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

¹⁰ **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.

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.'

[80] It was never in dispute that Defendant through its employees, servants or agents owed a duty to the Deceased at all material times. It follows that the 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 owed to the deceased? The standard by which medical professionals are judged with respect to negligence was prescribed by Mc Nair J in seminal case of **Bolam v Friern Hospital Management Committee**¹¹:

"...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, 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"

¹¹ [1957] 1 WLR 582; approved in *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635

[81] The onus of proving a breach of that duty remains throughout on the Claimant. In order to succeed in his claim, the Claimant must therefore satisfy the Court on a balance of probabilities of the merits of his case. In applying the standard of balance of probabilities the Court is guided by the dicta of Baroness Hale in the House of Lords decision **Re B (Minors) 2008 EWCA Civ.282** and by Lord Nicholls in **Re H (Minors) (Sexual Abuse: standard of proof) 1996 AC 563 at 586 D-H**.

“The balance of probability standard means that a court is satisfied an event occurred if the court considers that, on the evidence, the occurrence of the event was more likely than not. When assessing the probabilities the court will have in mind as a factor, to whatever extent is appropriate in the particular case, that the more serious the allegation the less likely it is that the event occurred and, hence, the stronger should be the evidence before the court concludes that the allegation is established on the balance of probability. ...

Although the result is much the same, this does not mean that where a serious allegation is in issue the standard of proof required is higher. It means only that the inherent probability or improbability of an event is itself a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred. The more improbable the event, the stronger must be the evidence that it did occur before, on the balance of probability, its occurrence will be established.”

[82] It follows that the Claimant must demonstrate on a balance of probabilities that the medical practitioners treating the Deceased did not act as reasonable and competent medical practitioners would have acted in the circumstances.

[83] In the case at bar, the Claimant contends that the Defendant, its servants or agents failed to perform an echocardiogram during the first admission of the Deceased or at all in order to evaluate her abnormal EKG, SOB and CXR results. The Claimant’s contends that this resulted in a failure to adequately assess, evaluate, diagnose and treat the Deceased while she was in their care. It became very clear to the Court during the oral testimony of the Defendant’s expert that he was of the view that an echocardiogram should in fact have been carried out. In his words, “*An echocardiogram should have been done after the first ECG. It would have assisted with the next course to be done.*” He went on to conclude that if a patient is 25 years old , has no chest pain , has an abnormal ECG, her cardiologist will request an ECHO cardiogram.

[84] It is readily apparent from the evidence before the Court, that although it may have been contemplated, none of the medical staff who attended to the Deceased over the course of 30th September 2011 to 17th October 2011 ensured that the appropriate diagnostic test (an echocardiogram) was administered, notwithstanding that she had all of three abnormal ECGs. Given the evidence advanced by the Defence's expert that independently supported the Claimant's case. The Court finds that this conduct fell below the required standard of care. It was clear to the Court that both experts would have acted differently and in light of this the Court is satisfied that there is evidence on a balance of probabilities that the Defendant's servants or agents breach of their duty of care to the Deceased in that they failed to perform the appropriate diagnostic testing following the irregular ECGs and as a result they failed to adequately assess, evaluate and diagnose the Deceased.

CAUSATION

[85] Although the Claimant has 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 the death of the Deceased and that it was foreseeable as a result of the breach. **Bonnington Castings Ltd. v. Wardlaw [1956] A.C. 613; Wilsher v. Essex Area Health Authority [1988] A.C. 1074.** The claim will fail unless this can be proven.

[86] Again, causation must be proved on a balance of probabilities; which means that it has to be shown that it is more probable than not that the negligence caused the injury or damage which is the subject of this claim.

[87] The Claimant has to prove that the Defendant caused the injury in fact and in law and the injury must not be too remote. In most cases where a claimant is attempting to prove as a "matter of fact" that a defendant caused the loss or injury, 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.

- [88] There are a plethora of English cases which apply these legal principles. In **Hotson v East Berkshire Area Health Authority**¹³, the claimant sustained a fall and was taken to hospital. Five days passed before his injury was correctly diagnosed and treated; he subsequently developed necrosis. Negligence had been admitted but causation remained an issue at trial. There was a conflict of expert evidence. The Law Lords held that the weight of the evidence indicated that the injury was the primary cause of the necrosis. This was a '*but for*' case and the evidence had not established that the delay was a causative factor.
- [89] Likewise, in **Wilsher v Essex Area Health Authority**¹⁴ a premature baby required additional oxygen administered through a catheter. Unfortunately, the catheter was inserted in the wrong place but this was not noticed by the medical staff. The meters showed abnormal readings over a period of weeks and the baby developed fibroplasia which eventually resulted in blindness. The medical evidence was that there were four other possible causes of the fibroplasia apart from the excess oxygen administered. It was held that this was a '*but for*' case and that no presumption could be made that the negligent insertion of the catheter made a material contribution to the injury.
- [90] In **Gregg v Scott**,¹⁵ a lump under the claimant's arm was diagnosed as benign, but it was a non-hodgkin's lymphoma. By the time of the correct diagnosis some nine weeks later, the tumour had spread into the claimant's chest. Treatment was only of limited success and the prospect of the claimant surviving for 10 years was assessed at only 25%. A majority of the lords held that the '*but for*' test could not be satisfied because the claimant could not prove that the delay in diagnosis was the cause of his likely premature death.

¹² Barnett v Chelsea [1969] 1 QB 428

¹³ [1987] 1 AC 750

¹⁴ [1988] 1 AC 1074

¹⁵ [2005] 2 AC 176

- [91] 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 maybe 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**¹⁶ 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.
- [92] The issue was revisited by the Court of Appeal in **Bailey v Ministry of Defence & Anor**¹⁷. In that case, the claimant had suffered brain damage following cardiac arrest after inhaling vomit. She had inhaled her vomit because she was in a very weakened state. Two causes had contributed to her weakness, one tortious, the other not. The judge below held that the tortious cause had made a material contribution to the weakness and the claimant succeeded in full. The employer appealed.
- [93] The English Court of Appeal dismissed the appeal, holding that it was not possible to say with any confidence whether, without the tortious contribution, the claimant would have been so weak as to inhale her vomit. It was not suggested either in this court or below that the damages should be apportioned. Waller LJ summarized the position in the following way:

‘I would summarise the position in relation to cumulative cause cases as follows. If the evidence demonstrates on a balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the claimant will have failed to establish that the tortious cause contributed. Hotson exemplifies such a situation. If the evidence demonstrates that ‘but for’ the contribution of the tortious cause the injury would probably not have occurred, the claimant will (obviously) have discharged the burden. In a

¹⁶ [1956] AC 613

¹⁷ [2008] EWCA Civ 883; subsequently been followed in *Dickins v O2 Plc* [2008] EWCA Civ 1144

case where medical science cannot establish the probability that 'but for' an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the 'but for' test is modified, and the claimant will succeed.'

[94] The material contribution test has also been applied within the Eastern Caribbean.¹⁸ Mason J in **Norville v Attorney General of St. Lucia** drew the following conclusion "... before a reference can be drawn that the defendant's breach of duty made a material contribution, there must be some evidence to link the defendant's breach of duty to the Claimant's harm other than the simple assertion that it increased the general risk of harm."

[95] Having considered both tests, the Court concurs that whichever test is applied, a mere assertion by the Claimant would not be sufficient to prove causation.

[96] Looking now to the evidence in the case at bar, it becomes immediately clear there is no contention that there are multiple causes contributing to the demise of the Deceased. In the Court's view the "but for" test of causation is the appropriate test to be applied. It follows that in the case at bar it would not be enough to show that the Defendant's failure to ensure the appropriate diagnostic testing was carried out increased the likelihood of the deceased's death and may have caused it. It must be proved on a balance of probabilities that it did cause the deceased's death in the sense that it would not otherwise have happened.

[97] Unfortunately, the Claimant's burden is complicated by the fact that the relevant post mortem report is obviously incomplete and therefore inadequate. The Court accepts the evidence of both experts in that regard. Although there is some evidence that the body of the Deceased was indeed examined by the Dr. Gaskin, his conclusions are equivocal at best. His provisional anatomical diagnoses indicated **Pulmonary Hypertension: Haemorrhagic Gastritis**. His findings related to the principal disease noted as follows: (1) Pulmonary hypertension with (a) right ventricular

¹⁸ Gemyma Shaunerva Norville v Attorney General Of Saint Lucia Claim No SLUHCv 2004/0362

hypertrophy, RV 8 MM, LV 10mm (b) finger clubbing and (2) Haemorrhagic gastritis with 50 ml of blood in the stomach. For completeness Dr. Gaskin's Summary is set out below:

*"This twenty five year-old (25) woman with a history of asthma died October 17th 2011 at the Peebles Hospital. Of significance was treatment for lower respiratory tract infection and haematemesis, epistaxis and SOB in the period preceding her death. She complained for chest tightening and SOB and was brought to hospital after collapsing at home. Clinical evaluation, radiological and E.C.G findings were consistent with right ventricular hypertrophy. **The clinical suspicion of pulmonary hypertension/right ventricular hypertrophy was confirmed at autopsy. The etiology of the pulmonary hypertension needs to be elucidated.**"*

[98] While it is apparent that the post mortem results disclose that the cause of death was *pulmonary hypertension/right ventricular hypertrophy*, the cause of that disease or condition is not made clear. This factor becomes important when it is accepted by both sides that *pulmonary hypertension/right ventricular hypertrophy* could generally result from a number of causes. The experts presented to this Court have each presented their opinions on the question of aetiology but at best these opinions amount to no more than intelligent guesswork on an issue which is crucial to the Court's determination and in respect of which there really should have been no cause for conjecture. The autopsy/post mortem report presented to the Court in this case should be thorough, and definitive on this point.

[99] The difficulty which this poses to the Claimant's case is clearly illustrated when the Court considers that the question of causation is directly linked to the possible causes of the Deceased's pulmonary hypertension/right ventricular hypertrophy. This is best illustrated in the following excerpt from Dr. Brecker's report:

6.3 “If the diagnosis was of **primary pulmonary hypertension** or **congenital heart disease** then I am not able to identify any mechanism by which the death was preventable on a balance of probability.

6.4 “It was potentially preventable if the diagnosis had been **chronic pulmonary thromboembolic disease** but anticoagulation would have been problematic because of the patient’s epistaxis. It is possible that an IV filter would have been placed but I am not able to state that the death would have been preventable on balance of probabilities.”

[100] The Court notes that while Dr. Gaymes does not accept that the alternatives presented at paragraph 6.3 were at all possible in this case, he does not disagree with the substantive opinion that death would have been inevitable in any event. The critical point of divergence for these two experts is Dr. Gaymes unequivocal opinion that the primary cause of the Deceased’s pulmonary hypertension/right ventricular hypertrophy was chronic pulmonary thromboembolic disease and in his words “*everything should have been done to evaluate and treat for it*”. He further dismissed any contention that anticoagulation would have been problematic.

[101] The Court has some difficulty in discerning how the Claimant’s expert could properly draw the absolute and unqualified conclusions which he did given that the post mortem report is so inconclusive and given that there were observations made in the medical notes which were inconsistent with his diagnosis and which he was unable to convincingly justify. It seems to the Court that where there were multiple aetiological possibilities, that they should have all been objectively assessed for the Court’s benefit.

[102] Moreover, while Dr. Gaymes’ report disclosed his definite opinion that something ought to have been done to assess for and treat for *chronic* pulmonary thromboembolic disease, when he was examined under oath he testified that his diagnosis was in fact *acute* pulmonary embolus. The

Court is satisfied that this distinction is critical and should have been fully explored in his Report because it was not raised by Dr. Brecker in his Report.

- [103] The clear message in Dr. Gaymes' report is that the Defendant's employees, servants or agents failed *to provide the standard of care necessary to evaluate and treat the Deceased*. At paragraph (4.20) of his Report, he trenchantly asserts that "*The next step should be immediate anticoagulation and urgent evaluation for pulmonary embolus*." However in order for the claim to succeed, the Claimant clearly needs to go further. Whether by lay or expert evidence, the Claimant is obliged to prove on a balance of probabilities that *but for* the Defendant's failure to provide the standard of care necessary to evaluate and properly treat the Deceased would not have died.
- [104] Unfortunately, this is where the Claimant's claim falters because apart from the mere assertion in the Statement of Claim, the Claimant has done little to satisfy the Court of this crucial element of the claim. The Court considered it glaring that the Claimant's expert asserted no positive opinion on the issue of causation in his Report. Instead, this critical factor was only addressed on cross examination by Counsel for the Claimant. In that exchange Counsel for the Claimant suggested to Dr. Gaymes that it would be unusual for a patient to survive an acute pulmonary embolus in such a case. Dr. Gaymes responded stating; "*Not at all. Survival would be precluded only by what happened in her terminal event*." He then suggested that it would depend on the size of the embolus.
- [105] The Court notes that the pathologist recorded no finding of an embolus in his post mortem and so the Court is left to speculate as to the size of a suppositious embolus and the likely impact which this may have had on the chance of survival. The Court was therefore not assisted by this equivocal response advanced by the Claimant's expert.
- [106] The Court is guided by the judgment in **Tahir v Haringey Health Authority**.¹⁹ That case a 15 year old boy who had a spinal abscess which resulted in some permanent paralysis alleged that the

¹⁹ (1998) Lloyds's Rep. Med 104

delay in providing medical treatment rendered his condition worse than it would otherwise have been, on the basis that, in general terms, delay in operating in his type of case increases the neurological defect and impairs the prospect of recovery. The trial judge found that there was a negligent delay of 3 hours in the treatment. However, the claimant had not adduced any evidence to demonstrate that the delay due to negligence did cause additional injury. Indeed there was no clear evidence as to what his outcome would have been in these circumstances (his case was that the period of negligent delay was 24 hours and that his injuries would have been avoided in their entirety) and so the Court of Appeal overturned the trial judge's decision that the delay had caused £4,000 worth of damage.

[107] According to Otton LJ, once a negligent delay was found it was “*understandable that she felt that the Court should make the best estimate that it could. However, I consider that in the absence of any evidence which either identifies or quantifies additional deficit, the arithmetic or apportionment method adopted by [the Judge]... is not a valid method of assessing damages. Given the appropriate evidence, such an approach, linear or otherwise, might be appropriate but that was not the situation here*”.

[108] The Learned Judges agreed that the task was to identify what additional injury resulted from the negligent delay, but “*neither [expert] identified any respect in which the Plaintiff is actually worse of on account of the delay*” The English Court of Appeal went on to hold that where there has been negligence in delayed medical treatment, it was not sufficient for the Claimant to show that there was a material increase in the risk or that delay *can* cause damage. He has to go further and prove that some measurable damage was *actually caused* by the delay.

[109] The Court's judgment the case at bar is plague with the same difficulties.

[110] The totality of Dr. Gaymes' evidence simply does not satisfy so that the Court can find on a balance of probability that the Defendant's (servants and agents) negligent conduct either increased the chances of a premature death or that death would not otherwise have happened. In

answering the question: Is there a causal connection between the Defendant's (servants or agents) breach of duty of care and the death? The Court has had to consider the contrasting expert testimony presented. Generally, the Court was more persuaded by the measured medical opinions and analysis expressed by Dr. Brecker rather than the critique of Dr. Gaymes. While a critical analysis would have been helpful to the Court it cannot replace, an original assessment of the Deceased's symptoms and the treatment and care administered. Further, it could not overlook the critical issue of causation.

[111] The result is that while this Court has no reservations in finding that the Defendant's care was negligent, the totality of the evidence makes it impossible for the Court to conclude that the Deceased's chances of survival were significantly compromised by the negligence of Defendant's servants or agents. The simple fact is that on the critical issue of causation, the expert opinion of Dr. Brecker was not effectively disgorged.

[112] In considering the issue of causation the Court had regard to the fact that the alleged breach of duty consists of an omission to do an act which the Claimant alleges ought to have been done. For that reason the Court had regard to the decision of the House of Lords in **Bolitho (deceased) v City and Hackney Health Authority**.²⁰ In that case, a 2 year old child was admitted to hospital suffering from breathing difficulties. A doctor was summoned but did not attend as her beeper was not working due to a low battery. The child died. The child's mother brought an action claiming that the doctor should have attended and intubated the child which would have saved the child's life. The defence accepted that there had been a breach of duty by the doctor in not attending the child or ensuring that a deputy attended him on her behalf. The doctor gave evidence that had she attended she would not have intubated. She stated this was not necessary as for a young patient the procedure itself carries a certain degree of mortality and morbidity. Another doctor gave evidence that they would not have intubated. The claimant's expert medical witnesses contended that she should have intubated him, as this would have protected his airway and thus saved his

²⁰ [1998] 1 Lloyd's Rep Med 26

life. so that as in the case at bar, the expert witnesses for both sides held wholly opposed views as to whether or not it would have been reasonable to fail to intubate.

- [113] The critical consideration for that court was causation. The trial judge applied the **Bolam test** and held that there was no breach of duty. The claimant appealed to the Court of Appeal who upheld the trial judge's decision. The claimant appealed to the House of Lords. The House of Lords also held that the doctor had not breached her duty of care, despite her admitted negligence in her failure to attend the patient.
- [114] The House of Lords further held that there would have to be a logical basis for the opinion not to intubate. This would involve a weighing of risks against benefit in order to achieve a defensible conclusion. On the facts, it was decided that not intubating the child in the particular circumstances at hand was not a negligent course to take, even though the expert opinion on the matter was divided.

CONCLUSION

- [115] Ultimately, the Court is called upon to consider what would have happened if an event which by definition did not occur had occurred. In the **Bolitho** case the claimant had to prove that the continuing exercise of proper care would have resulted in his being intubated. In order to prove his case, the Claimant in the case at bar, would have to prove that the Deceased's death would have been avoided if the proper diagnostic test had been done and appropriate treatment administered. This task was made significantly more complicated when the Court considered the autopsy report which provided no definitive conclusion as to the cause of death beyond the fact that finding of pulmonary hypertension. It became clear that the Deceased's condition may result from a number of possible causes, some of which would have been treatable while others would not.
- [116] The Claimant's case was not sufficiently assisted by his expert. He attributed the Deceased's death to an acute pulmonary embolus on the basis that there were symptoms which supported this

diagnosis but he was unable to convincingly explain those symptoms which were inconsistent with that conclusion. Further, the Court is not satisfied that he directed his mind to the comparative risks and benefits of the anticoagulation treatment given the Deceased's presentation.

[117] The Court noted the expert evidence of Dr. Brecker as follows:

5.10 "The next area to address is whether or not anything could have been done to prevent the death. If the patient has had the very unusual causes of a left myxoma or mitral valve disease then I believe the death would have been preventable. However, I do not believe that if this patient had had primary pulmonary hypertension or congenital heart disease that the death would have been preventable.

5.11 The reason I state this is it is unlikely given the timescale involved that treatment could have been offered or either primary pulmonary hypertension or congenital heart disease that would have altered the outcome.

5.12 If however the diagnosis of chronic pulmonary thromboembolic disease had been made then consideration would have been given to anticoagulation although this would have been problematic given the patient's recent presentation of epistaxis and haemoptysis. If the patient had had deep venous thrombosis then it is possible that an IVC filter could have been given.

5.13 On the evidence I have been provided with I did not see however that the Claimant can claim that survival was likely on a balance of probabilities."

In the Court's judgment this has some basis in logic. He clearly directed his mind to the comparative risks and benefits and he appears to have reached a defensible conclusion on the matter. Dr. Gaymes' expert evidence did not satisfy the Court that the views of the Defendant's expert could not be dismissed as unreasonable or illogical.

[118] 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 and there is evidence pointing to the fact that the Defendant breach of its duty of care in failing to undertake the appropriate diagnostic testing. However, the Court is not satisfied that Claimant has fully discharged his burden by proving on a balance of probabilities that it is more probable than not that this negligence caused the Deceased's death.

[119] For the reasons set out herein the Court order is therefore as follows:

- i. The Claim is dismissed.
- ii. As agreed by the Parties, the Claimant will pay the Defendant's costs of \$7,500.00.

Vicki Ann Ellis
High Court Judge