

EASTERN CARIBBEAN SUPREME COURT

COMMONWEALTH OF DOMINICA

IN THE HIGH COURT OF JUSTICE

CLAIM NO. DOMHCV2012/0329

BETWEEN:

**[1] ENIS ST.ROSE JOHNSON as Personal Representative
of Cassandra Muriel St. Rose**

Claimant

And

**[1] DR. ROBERTSON THOMAS
[2] THE ATTORNEY GENERAL OF THE COMMONWEALTH
OF DOMINICA**

Defendants

Appearances:

Mrs. Kathy Buffong Royer and Mrs. Wynante Adrien-Roberts for the Claimant

Ms. Tameka Hyacinth and Mrs. Jo-Ann Xavier Cuffy for the Defendants

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2014: May 21st, 22nd

October 3rd
.....

JUDGMENT

- [1] **THOMAS, J: [AG]** Before the court is a claim in negligence against the 1st defendant and the contention is that the 2nd defendant is joined by virtue of the **State Proceedings Act**¹ as he is vicariously liable for the acts of the 1st defendant.
- [2] The claimant's case is that on April 10th, 2012 Cassandra Muriel St. Rose, the deceased, attended the hospital complaining of pain in her left ankle at which time the 1st defendant was on duty at the Accident and Emergency Department, and in this connection the following are pleaded: the 1st defendant examined the deceased's ankle and diagnosed the deceased as having a fractured ankle; the 1st defendant fitted the deceased's ankle with a cast and authorized the deceased medical leave from work; on April 16th 2012, at approximately 2:00 pm the deceased attended the Accident and Emergency Department at the hospital with a complaint of feeling extremely weak and of having severe difficulty breathing, shortness of breath and chest pain; the deceased was fitted with an oxygen mask and told to await the 1st defendant who was on duty at the Accident and Emergency Department; throughout the entire afternoon the deceased's breathing became progressively worse and the deceased's blood sugar became elevated; the 1st defendant did not examine the deceased on the afternoon of April 16th 2012; approximately 5 hours after lying in the Accident and Emergency of the hospital, the 1st defendant came into the room where the deceased was and informed the claimant that her daughter would not be going home that night and the deceased was admitted to Glover Ward at the hospital and died within one hour after being so admitted.
- [3] In the premises, it is the claimant's contention that the defendants owed a duty of care to the deceased to act with reasonable skill and care when treating her. It is the claimant's further contention that the death of the deceased was caused by the negligence of the 1st defendant and liability for which resides in the 2nd defendant as the 1st defendant was acting in the execution of his duties as an employee of the State. In this connection certain particulars of negligence are pleaded.

¹ Chap.7.80 Revised Laws of Dominica

- [4] In the premises the claimant claims: special damages in the sum of EC\$7,753.25; general damages, interest at the rate of 5% from the date of judgment; further or other relief and costs.

Defence

- [5] In the defence it is admitted that the 1st defendant owed a duty of care to the deceased in respect of the treatment he provided to the deceased.
- [6] At paragraph 7 of the defence the attendance at the hospital is admitted an given treatment and told to “stay off the foot” and given an instructional leaflet and its contents explained. And contrary to what is pleaded at paragraph 7 of the statement of claim, the defendants aver that the deceased attended the Accident and Emergency Department and complained of having visited once, having palpitations, being weak from the morning and feeling like she was blacking out when she stands, but it is denied that the deceased complained of chest pain.
- [7] In terms of the events regarding the deceased on the afternoon of April 16th, 2012 the following averments are advanced: the 1st defendant physically examined the deceased in the Accident and Emergency Department the waiting time in this case is not unacceptable for an Accident and Emergency Department of similar characteristics as that of the Accident and Emergency Department of the Princess Margaret Hospital; the physical examination of the deceased included an interview as well as a check of the deceased; the deceased did not appear to have shortness of breath; she did not indicate chest pain, but the deceased's blood sugar was also still elevated; the 1st defendant being unable to ascertain the cause of the high blood sugar admitted the deceased, and instructed that certain tests be conducted and certain medicines be given to the deceased; the deceased died as a result of pulmonary embolism shortly after she was admitted to Glover Ward.

- [8] In so far as the death of the deceased is concerned, the defendants accept that they owed a duty of care to the deceased and that it was appropriately discharged; and as such the 1st defendant was not negligent and as such the vicarious liability of the 2nd defendant is denied.
- [9] The particulars of negligence as pleaded are denied and it is further contended that the 1st defendant was unable to accurately diagnose the deceased due to the nature of the symptoms presented by the deceased when he examined her and instructed that she be admitted to the ward where further diagnostic test and care could be given.
- [10] In further averments on the matter of diagnosis the contentions are that: the 1st defendant was negligent in not to have considered a pulmonary embolism in light of the examination of the deceased; the deceased did not complain of any calf pain so as to give rise to a consideration of the risk factors demonstrated for deep vein thrombosis.
- [11] At paragraph 24, the negligence as alleged by the claimant is further denied by contending that the 1st defendant was not negligent in failing to order tests alleged or undertake the course of action pleaded as they are of limited, if any, diagnostic value in the case of pulmonary embolism. They continue thus: it is averred that the treatment of the deceased by the 1st defendant was in accordance with the standard practice of an ordinary prudent medical practitioner. Further, as it related to causation, the defendants aver that the development of pulmonary embolism was in no way caused by any act or omission of the 1st defendant. Yet further, the defendants aver that on a balance of probabilities there is no evidence that the deceased would not have still succumbed to death even had she undergone the treatment suggested at paragraph 16.
- [12] Finally, the defendants deny that the claimant is entitled to the relief or interest claimed as alleged or at all.

Evidence

Enis St. Rose Johnson

- [13] Enis St. Rose Johnson in her witness statement says that the deceased, Cassandra Muriel St. Rose, is her daughter and that her daughter attended the Princess Margaret Hospital on 10th and 16th April 2012. With respect to these two days the witness gave details of her interaction with Nurse John and Dr. Thomas, the 1st defendant.
- [14] Included in the details of the events witnessed by her in relation to her daughter are the following:
- (a) on 10th April 2012 the fitting of the plaster of paris cast by Dr. Thomas as a result of a fractured left ankle; and authorized sick leave;
 - (b) a conversation with her daughter on 16th April 2012 in which her daughter indicated that she was not well;
 - (c) the deceased visited the hospital on the said 16th April 2012 at about 3:00 pm;
 - (d) her conversation with Nurse John; concerning the deceased;
 - (e) at the hospital the deceased was wearing an oxygen mask and I V in her hand, but despite the oxygen mask the deceased's chest was still heaving;
 - (f) saw Dr. Thomas at about 7:00 pm on 16th April 2013 at which time Dr. Thomas did not go to her daughter but told her (the witness) that her daughter would not be going home tonight;
 - (g) Dr. Thomas did not try to help the deceased or give her any reassuring words, his only role was to say she was going on the ward;
 - (h) informed that the doctor who could permit the deceased to eat was Dr. Issa who had not examine the deceased;
 - (i) said goodbye to the deceased and went home and shortly after arriving home a man who identified himself as Dr. Issa told her that her daughter had taken a turn for the worse; and that she should come to look at her;
 - (j) on arrival at the hospital she saw Dr. Thomas and Pastor Rodney and was informed that her daughter had died;

- (k) Dr. Thomas with a clenched fist to his chest said “ I think it was a clot, but the autopsy will show”;
- (l) the autopsy performed on 27th April 2012 revealed that death was caused by pulmonary embolism;
- (m) request, through her attorney for the deceased’s medical records while at the hospital were ignored.

[15] On commenting on paragraph 5 of the 1st defendant’s witness statement, Enis St. Rose Johnson said that from the first time she went to the hospital her daughter was lying in the Accident and Emergency Department and she stayed there all the time. She went on to say that she went there at 3:58 pm and never saw Dr. Thomas, as he did not come.

[16] Further in commenting on paragraph 7 of the 1st defendant’s witness statement, the witness denied that this ever happened. She added that Dr. Thomas spoke to her before 7:00 pm and he was not coming from the patient. According to her, Dr. Thomas entered from a door on the opposite side and walked over and spoke to me.

[17] Under cross-examination Enis St. Rose Johnson testified that she was scared because she did not know what was going on and nobody was helping her daughter.

[18] Under further cross-examination as to the time when Dr. Thomas spoke to her, the witness maintained that it was minutes to seven and not 3:58pm as she knows the difference between the two times.

[19] As to whether Dr. Thomas saw her daughter, the witness also maintained that this event did not occur.

Malcolm St. Rose

- [20] Malcolm St. Rose's evidence is that he is the brother of the deceased. In giving evidence of events of the date when his sister died, St. Rose said he spoke to his mother at about 4:50 pm and arrived at the hospital just before 5:00 pm and went to the Accident and Emergency Department where he met his mother sitting on a chair next to the bed on which his sister was lying. According to the witness: "Cassandra looked pale and sick, and I could see and hear that she had difficulty breathing."
- [21] In further evidence, Malcolm St. Rose said that his mother left the room and when she returned, he left the hospital with his family at about 6:10 pm. He added that: "the doctor did not come to Sandy while I waited with her."
- [22] Still further, Malcolm St. Rose says that while at home he received a call from his mother and as a result he went to his mother's home to collect her and "rushed to the PMH", where a nurse told them that Sandy had died.
- [23] Malcolm St. Rose also gave evidence of seeing Dr. Thomas on Glover Ward at that time and stood up near to him and said that: "Cassandra had died at about 8:30 pm". Further that he put a clenched fist to his chest and said 'I think it was a clot but the autopsy will show.'
- [24] Under cross-examination Malcolm testified that he was at the hospital before 5:00 pm and he left when he got a call at ten to five. The witness went on to say that when he went to the hospital he was at his sister's bed and that when he saw Dr. Thomas, he was still standing next to his sister.

Dr. Cooles

- [25] Phillip Edward Cooles is a medical doctor with a practice in Roseau Dominica. He is also employed at Ross University School of Medicine and as a consultant physician at the Princess Margaret Hospital.

- [26] The witness holds qualifications from Kings College, University of London, BSC. 1st Class Honors, St. George's Hospital Medical School, University of London, MB, BS; Liverpool School of Hygiene and Tropical Medicine, University of Liverpool, DTMH, and ESME Certificate in Medical Education.
- [27] Dr. Cooles is a member of the British Medical Association, the Dominica Medical Society, the Royal Society of Tropical Medicine, the Caribbean Diabetes Association and the American Society of Echocardiography. Dr. Cooles is an expert witness in these proceedings and prepared and filed a report on the death of Cassandra Muriel St. Rose
- [28] It is common ground that Cassandra St. Rose died of pulmonary embolism. On this account the expert begins his report in part as follows:
- “At 6:55-an order was given to admit the patient to Glover Ward. The patient died within an hour after admission to Glover Ward. The autopsy report disclosed that Ms. Cassandra died of pulmonary embolism in both pulmonary arteries.”²
- [29] The matter of the court giving a summary of an expert's medical report does not arise. Therefore, the court has extracted the following parts of the said report.
- [30] At the start of his comments the expert explains deep vein thrombosis (DVT) in this way:
- “Deep vein thrombosis (DVT) and its life-threatening complication pulmonary embolism (PE) are common causes of morbidity and mortality, affecting up to 1 person per thousand of the general population every year. The incidence is said to be higher in people of African descent. It is the commonest cause of death in hospital. It is particularly associated with trauma and immobilization such as may happen with a broken leg. (Ref 1)”
- [31] After references to various studies in relation to DVT in patients, the expert concludes that: “The most likely period for developing a DVT or PE after immobilization is 5-7 days as in this case (Ref 6.)”³.

² Trial Bundle Part II, at page 151

³ Trial Bundle Part II, at page 151

[32] In so far as what Ms. St. Rose presented and the indications of PE, Dr. Cooles gave elaborate comments and findings. These comments will feature at a later stage.

[33] The expert next goes on to make certain observations and findings:

“An electrocardiogram (ECG, EKG) and pulse oximetry test which is a simple test- all immediately available in the Accident and Emergency Department- should have been done- and would have certainly shown changes suggestive of PE.

While the ECG findings in PE are admittedly non-specific the performance of an ECG would have in over 90% of the time alerted the physician to the fact that there was a cardiopulmonary problem such as PE. The failure to perform an ECG is a serious error. Similarly while chest x-ray (CXR) findings may also be non-specific, in the PIOPED study (Ref. 8) over 88% of patients with confirmed pulmonary embolism had an abnormal CXR. Again the failure to perform a CXR in a patient with shock and breathlessness is a serious error.”

[34] Concerning diagnosis of the patient, the expert says :

“If diagnosis had been made promptly – Ms. St. Rose should have been admitted to the intensive care ward and begun on intravenous anticoagulation therapy with heparin.

Given the fact that Ms. St. Rose was in the Accident and Emergency Department for over 4 hours, it is unreasonable to assume that prompt parenteral anti-coagulation would not have been effective in this case. The absence of any record of medical examination by the physician is also inexcusable. An authoritative website for physicians states: Diabetic Ketoacidosis (DKA) is a medical emergency with a significant morbidity and mortality. It should be diagnosed promptly and managed intensively. DKA is characterized by hyperglycemia, acidosis and retonaemia. Further PE can itself be an underlying cause of DKA ref. 10”

[35] The expert, Dr. Cooles ends his report with comments on the post mortem findings and the implications of the record after admission to the Accident and Emergency Department.

[36] Under cross-examination, Dr. Cooles, in response to a question concerning the absence of chest pain in relation to PE, said that the origin of chest pain in pulmonary embolism can come from several sources, and in some circumstances where the pain is pleuritic it might mean that the infarct was quite peripheral in the lungs. So if the clot wasn't that big, it got through most of the circulation and lodged quite peripherally in the lung. And in those cases the patient may

experience pleuritic chest pain because the clot or the area of the lung affected is involving the pleura. In those circumstances, pleuritic type of chest pain may actually warn you that that particular event was actually quite small. In other circumstances, where you have a very large embolism it might produce a total lack of blood flow through the lungs and blood supplied to the heart, for example, which would become compromised and the patient would experience pain from the heart as a result of not getting the blood because the circulation is blocked.

[37] Regarding the deceased presenting with certain risk factor, Dr. Cooles testified that the pulmonary emboli had started on the morning when she first reported sick to her mother. There are probably what you might think of as showers of emboli in the lung coming through in between and at times she might feel a bit better and then another embolism reaches the lung causing blockage and she becomes very distressed and when the blockage is broken down by the body's further factors, then she seems to be better again.

[38] In further evidence regarding emboli, the witness explained that it is not a single event but a whole series of embolic events which are blood clots- some small and some bigger would go up into the lungs over a period of hours or even possibly a day.

[39] When questioned on the possibility of the deceased already having significant clots in her lung, Dr. Cooles said that definitely when she went in the hospital at two o'clock and on the basis of observations, one would have to say yes and that she was suffering cardiovascular distress.

[40] Learned counsel for the defendants sought to get evidence on whether apart from preventing the formation of clots whether heparin also dissolves existing clots. In this connection Dr. Cooles said heparin does not dissolve clots and it is left to the body itself in the process of dissolving and breaking down clots as they form. The witness went on to say that once heparin is started and the clotting is function is reduced the risk of further embolization is reduced.

- [41] Even further, learned counsel sought to find out whether there was any guarantee that after IV heparin is administered it would prevent further breakage of the embolization of clots. The witness' response was that there is no guarantee but on the balance of probability would be that the risk to the patient of further massive embolization would go down dramatically, even where there was significant embolization.
- [42] There was no re-examination of the expert.

Clement Letang

- [43] Clement Letang in his witness statement says he is the proprietor of Brighter Days Ltd where the deceased was employed. It is also his evidence that he recalled receiving a medical certificate on behalf of the deceased, on or about 10th April, 2012, indicating her inability to work. The witness also recalls receiving information about her death on 17th April 2012 at the Princess Margaret Hospital as a result of an ankle injury.
- [44] There was no cross examination

Dr. Robertson Thomas

- [45] In his witness statement –says he is a medical doctor holding a Bachelor of Science from the University of the West Indies and a medical degree from the University of Havana. The witness also details the certificates that he holds in Advanced Cardiac Life Support (ACLS), Advanced Medical Life Support (AMLS), Advanced Trauma Life Support (ATLS), Pediatric Advance Life Support (PALS), Emergency and Disaster Medicine. In addition a Master of Science (MSc.) in Disaster Medicine.

- [46] In terms of employment, the witness says that he is one of the doctors attached to the Accident and Emergency (A&E) Department at the Princess Margaret Hospital
- [47] At paragraph 3 to 5 of his witness statement, Dr. Thomas outlines the events concerning Cassandra St. Rose as follows: the patient came to the A&E Department on April 10th 2012 with a complaint about her left ankle; the injury was examined and a Plaster of Paris (POP) cast was fitted and instructions given, the instructions included what should be done in the event of swelling or change in color of the area and not to walk on the cast; on April 16th 2012 "In the early afternoon" a nurse came to him and reported about a patient in the department with high sugar; instructions were given to the nurse to administer 18 units of soluble insulin via intravenous drip and a request for a report in half an hour and one hour; he saw the patient at 3:58 pm and examined her and asked her questions about leg pain or chest pain, pregnancy and medication being taken; all answers were in the negative; from his observations the patient was not breathless or gasping, she spoke normally, was not pale, heart rhythms were normal.
- [48] Under cross-examination, Dr. Thomas testified that he was a doctor from 2001 and is familiar with PE, has seen them but keeps no record. However, he added that he could not say how many he saw in one month. The witness also described PE as a medical emergency which if not dealt with can result in death. Mention was also made of some of the medical conditions that can give rise to PE as being: obstetric issues, trauma concerns and many others.
- [49] With respect to the cast fitted on the deceased, he said that much can arise in that area. He added that lack of circulation can give rise to pain, color changes and clot formation.
- [50] When cross-examined about April 16th 2012, the witness said that he worked 2:00 pm to 9:00 pm and can recall some aspects of the day. He also described the day as being busy in terms of patients and the type of cases, except PE.

- [51] In relation to paragraph 4 of his witness statement, Dr. Thomas said that he did not know who it was and did not recall Nurse John saying anything about a particular patient. He went on to say he did recall Nurse John speaking of high insulin but she did not read out the chart notes to me.
- [52] In further evidence concerning the deceased patient, Dr. Thomas testified that when he examined the patient he was alone with her and it was between 3:50- 3:55 pm and the examination lasted 5 to 7 minutes but he did not have the benefit of the chart notes, and did not recall if he saw them before he examined the patient. The witness then went on to give further evidence of his examination and what he recalled about the patient.
- [53] On the matter of his diagnosis, Dr. Thomas said it was based on the conversation when the patient denied high sugar and the DKA was the diagnosis based on high sugar. He added that he did not do a certain test because it was not available at the time. He gave further evidence that he gave an order for blood to be taken which is always done in an emergency. Dr. Thomas went on to say that the result of the blood test was not obtained as the blood stayed in the Department for four hours. Still further, the witness said that he did not factor in oxygen in the blood as he did not consider it.

Dr. Brian Charles

- [54] Dr. Brian Charles filed an expert report on behalf of the defendants. Dr. Brian Charles gave his qualification as being: MB,BS UWI 1989, MSc (Emergency Medicine) UWI 1994, D.M (Emergency Medicine) UWI 1995, Consultant Emergency Physician 1997 to present, Managing Director Sandy Crest. Medical Centre and Coventy Medical Centre, Barbados, and consultant for the Medical Protection Society, London.
- [55] In the report, Dr. Charles gives a case summary concerning the deceased and then gives some details of the Nursing Intervention Notes and then gives an analysis of the facts.

- [56]** In the latter regard, the expert records that the formation of the clots in the venous system of the body is prompted by a triad of: trauma, immobilization (stasis) and tendency to clot (hypercoagulability). He adds that a fracture, followed by immobilization in a cast with rest would provide increased risk for clot formation (thromboembolic disease). He continues: "The formation and detection of clots (thrombus) in the deep venous system is notoriously difficult and a high index of suspicion must be maintained. Clots on the deep venous system can break, move and lodge in various vital organs (embolism) causing serious pathology. Vitals of pulse 126 beats/minute indicates a tachycardia, respiratory rate 26/minutes would suggest some degree of respiratory compromise, blood pressure 97/68 mmHg (Hypotension) is low, indicating cardiovascular compromise. In a 33 year old, this would indicate severe illness as at that age, physiologic systems compensate favorably until pre-termed stages."
- [57]** The expert next deals with "Glucometer reading of "Hi" blacking out and severe metabolic derangements and then medical implications. His evaluations will be dealt with at a later stage.
- [58]** In terms of negligence, the expert says that it is satisfied by showing a breach of duty of care, a standard of care beneath that is expected of a similarly trained practitioner. As far as the breach of duty of care, the expert concludes, that from a "medical standpoint," there was no breach of duty. In relation to the standard of care, this was beneath that expected. And in respect of causation the expert concludes that it was beneath that expected and reasons given.
- [59]** With respect to causation the expert concludes that "the doctor's action did not result in this patient's death. More aggressive resuscitation may have addressed the diabetic ketoacidosis more comprehensively but the cause of death (post mortem report) was pulmonary embolism in both pulmonary arteries and right ventricle. This is almost 100% fatal unless an embolectomy and anticoagulation is immediately performed".

[60] Under cross-examination Dr. Charles informed the court that he is familiar with the case and he explained further that if the patient has high blood sugar you would read the history, for example, diabetes or if the patient had any other symptoms of diabetes that was not diagnosed before.

[61] In further testimony, Dr. Charles testified that usually chart notes are looked at especially if a nurse saw the patient. Dr. Charles further explained that if there is a case where a patient needed to be seen very quickly, I would restrict the main areas to be done as being multiple IV lines, oxygen and appropriate investigation to rule out why the patient was in this state. His evidence in this regard continues thus:

“the patient needed to be seen very quickly; immediate resuscitative measures needed to have been done; these being multiple IV lines, oxygen and appropriate investigations to rule out why she was in this shocked state.”

[62] The witness went to add that he used the word “shocked” to indicate severe cardio vascular compromise. In further evidence on his approach to the situation the witness testified that PE would be very high on the list but added that there would be other diagnosis like cardiac insufficiency and severe metabolic derangements.

[63] In speaking to the autopsy conclusions, Dr. Charles said that he noted that the cause of death given was pulmonary ventricles. In this connection the expert expressed the opinion that Dr. Thomas, did not cause the PE and he went on to explain that PE is caused by the factors being: trauma, prolonged immobilization and hyper-coagulation. He explained that in the present case the patient had two causes namely trauma and immobilization. In further evidence in this connection the expert explained that the body is always in the process of dissolving clots which are always in the body and which are called micro emboli.

[64] There was no re-examination

Yahmega John

- [65] Yahmega John in her witness statement says that she is a registered nurse at the Princess Margaret Hospital with an Associate Degree obtained in 2010 from the Dominica State College.
- [66] The witness said that at the material time she was on duty at the Accident and Emergency Department and that on 16th April 2012 she worked the 1:00 pm to 8:00 shift at the hospital with Nurse Greenaway and Nurse Laudat. She says further that it was a busy shift.
- [67] At paragraphs 4 to 7 the witness detailed her professional dealings with Cassandra Muriel St. Rose on the said 16th April 2012 from about 2:40 pm. Also detailed is what she told Dr. Thomas concerning the patient, including what she heard Dr. Thomas saying to the mother of the deceased while they were all in the same room.
- [68] Under cross-examination Yahmega John said that paragraph 5 of her witness statement is true and she did read out the notes to Dr. Thomas. The witness went on to add that she was aware that Nurse Greenaway spoke to Dr. Thomas and he gave her verbal instructions.
- [69] With respect to the clothes the deceased wore when she came into the Department, the witness said the patient had on a long dress. And she said further that she only saw the POP when the deceased was leaving the Department to go to the ward.

Issues

The following issues fall for determination:

- 1. Whether the defendants are liable in negligence with respect to the death of Cassandra Muriel St. Rose at the Princess Margaret Hospital on April 16th, 2012?**
- 2. If the defendants are liable, in negligence, whether the claimant is entitled to damages, including special damages?**

3. Who is liable to pay costs?

Issue No 1

Whether the defendants are liable in negligence with respect to the death of Cassandra Muriel St. Rose at the Princess Margaret Hospital on April 16th, 2012?

- [70] More than eighty years ago, Lord Mcmillan in **Donoghue v Stevenson**⁴ in dealing with an action against a manufacturer of drinks had the vision to say that “the categories of negligence are never closed”. So that today it is said⁵ that: the tort of negligence protects interest in physical and mental health, reputation, property interest, economic relationship and public rights.
- [71] It is said that in tort of negligence liability is based on the conduct of the defendant and has 3 elements or requirements:
1. The existence of a duty of care situation (i.e. one in which the law attaches liability to carelessness). There has to be a recognition by law that the careless infliction of the kind of damage complained of on the class of person to which the claimant belongs by the class of person to which the defendant belongs is actionable;
 2. Breach of the duty of care by the defendant (i.e) he failed to measure up to the standard set by law.
 3. A causal connection between the defendant’s careless conduct and the damage.

Existence of a duty of care

⁴ [1932] AC 562, 619

⁵ Clerk & Lindsell on Torts (19th ed) para 8.01 et seq.

- [72] In general, a duty of care will be owed wherever in the circumstances it is foreseeable that if the defendant does not exercise due care the claimant will be harmed⁶.
- [73] In this case it is a matter of the treatment of an individual at a hospital, by a medical doctor and this is one of the circumstances in which it has been held that a duty of care exists as it is foreseeable that harm can result from careless conduct on the part of the doctor. In this regard it says that a physician "... owes a duty to the patient to use diligence, care, knowledge and skill in administering the treatment. No contractual relationship is necessary, nor is it necessary that the service be rendered for reward. The law requires a fair and reasonable standard of care and competence." The legal position is stated by Justice Jacqueline Cornelius in these terms: "By the very existence of doctor and patient relationship, a medical doctor has a duty to use reasonable care and skill in examination, diagnosis and treatment of his patient."⁷ The learned judge relied on the authorities of **Gladwell v Steggall**,⁸ and **Sidaway v Board of Governors of the Bethel Royal Hospital**⁹
- [74] In the final analysis the defendants have conceded that the first defendant owed a duty of care to his patient, Cassandra Muriel St. Rose.

Breach of the duty of care

- [75] The learning is that a defendant will be regarded as in breach of duty of care if his conduct falls below the standard required by law. The standard normally set is that of a reasonable and prudent man. In this regard an early statement of the requisite test is the reasoning of Baron Alderson in **Blyth v Birmingham Water Works**¹⁰ where he said that:

⁶ See: Clerk & Lindsell on Torts, (19th ed) at paras 8-05 et seq

⁷ Cephas Marshall v F.H.H Emergency Medical Associates et al, Suit No. 1023/2002

⁸ [1839] 5 Bing 12 ER 1283 and Sidaway v Board of Governors of the Bethel Royal Hospital and others [1895] AC 871, 892 per Lord Diplock

⁹ [1985] AC 871, 892 per Lord Diplock

¹⁰ [1856] 11 Exch 781

“Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do”¹¹

- [76] The foregoing is in ordinary or general terms, but in the case of medical doctors the standard was developed in a number of cases¹². And in **Bolam v Friern Hospital Management Committee**¹³, Mr. Justice McNair laid down the following test:

“The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established that it is sufficient if he exercises the ordinary skill of an ordinary skilled man exercising that particular art. A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.”

- [77] The **Bolam** test has become the operative test over time, but in **Bolitho (deceased) v City and Hackney Health Authority**, Lord Brown- Wilkenson in his judgment in the **House of Lords** added the following to the to the **Bolam** test. He said that a doctor did not escape negligence simply because a body of medical experts was of the opinion that his treatment on diagnoses accorded with sound medical practice; the court had to satisfy itself that the body of medical opinion had a logical basis.

Submissions

- [78] Against the foregoing, the submissions on both sides must be set out and examined.
- [79] Learned counsel for the claimant in her submissions first examines the evidence of the first defendant and then that of the claimant. With respect to the first defendant learned counsel points

¹¹ [1856] 11 Exch 781,784

¹² Cassidy v Ministry of Health [1951] 1 ALL ER 574, 585; Hunter v Hanley [1955] S.C 200, 204-205 per Lord Patrick

¹³ [1957] 2 ALL ER 118,121

to the following: “ the 1st defendant stated that he was informed of the presence of the deceased at the A & E Department by a nurse, who described a patient whose sugar was high, but that he was unable to attend to her immediately because he was writing out his notes. However he eventually went in to the patient about 3:50 pm, and examined her... At the time of the examination, no one was present. He did not have the deceased’s chart notes nor did he request it. His examination lasted 5-7 minutes, but this did not include a check of any of her vitals including her blood pressure, temperature, pulse on respiration. He also did not make any notes of his examination, either then or at any time subsequently.”

[80] In examining the first defendant’s evidence of his recollection of the afternoon, the following is stated: “Although he recognized the deceased as a patient whom he had seen six days earlier and fitted the cast on her left ankle, he could not recall if he saw the cast during the examination, but knows that he did not check it. He made a presumptive diagnosis of diabetic ketocaidosis on account of her high blood sugar reading (which he did not measure), and on coming from the examination; he saw the claimant and informed her that her daughter was going on the ward tonight. When he subsequently documented his diagnosis, he did not recall whether he took specific notice of the deceased’s chart notes.”

[81] As far as the claimant’s evidence is concerned the following aspects are highlighted: her daughter’s state at 1:00 pm at Salisbury as being weak, cold to touch, breathing difficulties, and complaints of chest pains and weakness. At the Accident and Emergency Department at the hospital shortly after 3:00 pm the deceased was waiting to see a doctor on a bed fitted with an oxygen mask and IV tubes. While at the hospital she was always at her daughter’s side except for 5 minutes about 5:00pm when she went to the bathroom and again between 5:00 and 6: pm when her son and family visited the claimant’s evidence that she only saw the first defendant at about 7:00 p.m. for the first time on that day, when she was informed that her daughter was going to the ward.

[82] The claimant's evidence of what she was certain is expressed thus:

"The claimant was certain that while she was at the A & E Department her daughter was only attended to by nurses. At no time while she was present did the 1st defendant attend to or even come to her daughter, and certainly, not at 3:48pm or 'fourish', since she was present with her daughter. She was certain that her brief exchange with the first defendant was at 7 pm.

Under cross-examination the claimant was unwavering that while she concerned about her daughter's ill health and the fact that nothing was being done to improve her condition, she was neither confused nor emotionally stressed. She was not confused about the time the doctor spoke with her which she gives at 7 pm and certainly not 4pm. She was very aware of the time as she had a watch on her hand and she knows very well the difference between 4pm and 7pm."

[83] In the circumstances, learned counsel for the claimant, submits that there is ample evidence to support a finding that the first defendant was negligent in that he did not attend to or examined the deceased on the afternoon of April 16th 2012. Learned counsel adds that apart from the first defendant's vague recollection there is no independent or credible evidence that he attended the deceased. These contentions are based on the following:

1. There is no absence of any documentation indicative of an examination which is also commented on by the expert witness, Dr. Charles¹⁴
2. The first defendant's explanation for his failure to take notes was lame and not to be believed. On the contrary, the need to take proper documentation should be more pertinent where there is high traffic in the Accident and Emergency Department which should be recognized by a doctor with 10 years practice.
3. The absence of documentation should be considered with the fact that that first defendant did not see the deceased's chart notes nor request them prior to his alleged examination, his admission that even after not having seen the chart notes he did not take a history or check any of the deceased's vitals, the admission that he missed the cast prominently displayed on the defendant's left ankle, his findings that she was breathing normally stands in contrast to the claimant's evidence.
4. The claimant's evidence was that of a very credible witness as opposed to the first defendant who was vague, evasive and unwilling to make concessions. The

¹⁴ In support *Rhodes v Spokes and Farbridge* [1996] 7 Med LR 135 per Smith J is cited

claimant's evidence that she was present at the deceased's bedside at the time of the alleged examination was not shaken and is to be believed.

5. Nurse Yahmega John gave evidence that she heard the first defendant speaking to the deceased but she was unaware of the time. This is to be contrasted with the evidence of the claimant that she was aware of the time and that she had her watch on her wrist.

[84] As far as the requisite standard of care is concerned, the following are highlighted: first, both experts were in agreement, that based on the noted presentation, the deceased was seriously ill at the time of the attendance at the Accident and Emergency Department and should have been treated as an emergency. Second, based on her complaints they agreed that a doctor should have immediately examined the deceased. Third, none of them would have seen the patient without the chart notes and details of the examination would have been recorded contemporaneously. Fourth, neither would have missed the POP or fail to recognize its significance. Fifth, both experts agree that PE would have been first/ high on a list of possible diagnosis and because of its potentially fatal consequences it would have been the first condition to rule out. Sixth, Dr. Cooles in commenting on the standard of care to manage such a patient which presented with those vitals, he would have expected the patient to be sent urgently to the intensive care unit, and not be allowed to remain in the Accident and Emergency Department for in the excess of 4 hours. Seventh, the first defendant did not order any tests except to test her blood gases. Eighth, the first defendant's diagnosis of DKA was unfounded and this according to Dr. Cooles could have easily been ruled out. Ninth, in the words of Dr. Cooles, his treatment of the deceased was inadequate and fell below the standard of care of an ordinary competent doctor in the Accident and Emergency Department.

Reasoning

[85] It is important at this stage to set out the particulars of negligence pleaded. They are as follows as pleaded at paragraph 15 of the statement of claim:

- (a) Failure to attend to and or examine the deceased while at the Accident and Emergency Department of the hospital;
- (b) Failure to take a history and a proper history of the deceased;
- (c) Failure to respond adequately to the deceased complaints;
- (d) Failure to properly diagnose the deceased or at all;
- (e) Failure to attend the deceased after having been made aware of her condition;
- (f) Delegating his responsibility of examining the deceased to a nurse;

- (g) Allowing the deceased to remain in the Accident and Emergency Department for over five hours in light of symptoms exhibited and complained of;
- (h) Failure to admit/refer the deceased to the ward immediately upon her arrival;
- (i) Failing to take any appropriate steps, whether by way of examination, test or otherwise to treat the deceased for her symptoms;
- (j) Failing to consider a diagnosis of pulmonary embolism in light of the deceased demonstrated symptoms of difficulty in breathing, shortness of breath, chest pain and the presence of the deceased's fracture and her immobilized state;
- (k) Failing to take heed of the risk factors demonstrated for deep vein thrombosis (DVT);
- (l) Diagnosing the deceased post humus;
- (m) In all the circumstances, failing to provide a safe system for the provision of care to the deceased.

[86] Against the backdrop of the particulars of negligence pleaded, the totality of the evidence and the submissions on the duty of care, it becomes necessary to determine whether the first defendant was in breach of his duty of care owed to the deceased.

[87] It will be recalled that the **Bolam** test embodied the standard of the ordinary skilled man exercising and professing to exercise that special skill. In this context learned counsel for the claimant has submitted that there is ample evidence to support a finding that the first defendant did not attend or examine the deceased on the afternoon of April 16th 2012. On the other hand, learned counsel for the defendants has acknowledged that both expert witnesses are in agreement that Dr. Thomas' failure to carry out certain diagnostic test and in all the circumstances, to consider the diagnosis of pulmonary embolism (PE) was below the standard of care of a reasonably skilled practitioner.

[88] Even with that acknowledgment, given the nature and complexity, the court considers it necessary to go further in terms of the evidence in order to put the case in a proper perspective, for this reason the following findings of fact are made:

1. Prior to her death Cassandra St. Rose the deceased on April 10th 2012 suffered injury to her left ankle and at the hospital she was fitted with a POP by the first defendant after a diagnosis of a fractured left ankle.
2. On April 16th, 2012 the deceased, who was on sick leave authorized by the first defendant, messaged her mother Enis St. Rose Johnson, the claimant, at approximately 11:45 am asking her to call.
3. When the contact was made between the two parties the deceased complained of not feeling well.
4. The complainant proceeded from her home in Canefield to Salisbury, where the deceased was at the time, and noticed that her daughter's eyes and hands were pale and had difficulty breathing and she felt cold. The deceased also told her mother that she had difficulty breathing and felt weak.
5. The deceased was prepared to be taken to the hospital. She was dressed in her underwear and a "blue flowered tube knee length dress" and the right side of a pink slipper.
6. The deceased had to be assisted by her mother and brother to get to and into the vehicle.
7. The deceased arrived at approximately 2:40 pm with her brother, taken to the Accident and Emergency Department and eventually taken to Room 1.
8. The claimant, who had stopped off while on the way to the hospital to collect supplies, arrived at the hospital at approximately 3:00 pm
9. Nurse John attended to the deceased in the department.
10. Nurse John was told by the young man who accompanied the deceased that the deceased was vomiting, was weak and her heart was racing. The deceased also told Nurse John that she was weak.
11. Nurse John examined the deceased's vital signs: blood pressure, respiration, pulse and temperature and also noticed her mucus membrane was pale. The deceased RBS (blood sugar) reading was "hi" on the glucometer.
12. Nurse John wrote the results of her observations and examinations on the casualty notes form
13. Nurse John informed the charge nurse of the deceased's status and Dr. Thomas was told that the deceased was in Room 1 and the deceased's vitals read out to him and her assessment.
14. Dr. Thomas, the first defendant, gave oral instructions to administer 18 units of soluble insulin and to set up the normal saline. Other instructions were that the RBS reading be reviewed every half hour to an hour.
15. Blood was taken from the deceased and the IV set up at approximately 3:15 pm.

16. The examination and treatment of the deceased on the first defendant's instructions was between 2:40 and 3:15pm
17. The RBS reading was reviewed at 4:00 pm and 5:30pm.
18. Based on a query from the deceased's male companion, the deceased, she (Nurse John) said she was following the doctor's instructions and that he would be with her shortly.
19. The claimant, who had stopped off to get supplies on her way to the hospital, arrived at the hospital shortly after 3:00 pm and met her daughter in the Accident and Emergency Department wearing an oxygen mask and IV in her hand.
20. The claimant was told by Nurse John that the deceased's blood sugar was high and she would receive insulin and that she had spoken to the doctor who said he would deal with it.
21. The claimant waited to see the doctor but did not see him.
22. The claimant remained with the deceased from the time of her arrival at the hospital and only left the room for 5 minutes to go to the bathroom shortly before 5:00 pm and returned.
23. The first defendant in his evidence said he examined the deceased at about 3:38 pm this is contradicted by the claimant who said that the first defendant did not come to see her daughter at that time.
24. The claimant saw the first defendant for the first time at about 7:00 pm on the day in question, being April 16, 2012
25. The first defendant told the claimant that her daughter would not be going home as she was going to be kept on the ward.
26. The claimant left for home and shortly after arriving at her home she received a message that her daughter had died.
27. The claimant returned to the hospital and the first defendant told her and her son Malcolm that Cassandra had died at about 8:30 pm
28. The first defendant also told the claimant the he believed the deceased died from a clot but the autopsy will say.
29. Nurse John could not have heard the doctor talk to the deceased as this event never took place.
30. The claimant, Mrs. Enis St. Rose Johnson is a witness of the truth

Conclusion on breach of duty of care

[89] The case of **Whitehouse v Jordon**¹⁵ establishes that a mistake or mishap in diagnosis on treatment is not necessarily negligent and whether it amounts to negligence will depend on

¹⁵ [1981]1 ALL ER 267

whether the doctor committing the error acted as a reasonable and competent medical practitioner would have acted in the circumstances. In this case both experts said that the first defendants were below the required standard for a doctor. They also said that they would have dealt with the case as an emergency. In short they would have acted differently. Further having regard to the particulars of negligence pleaded, the evidence as a whole and the findings of fact therefrom and the law the court by implication accepts the submissions on behalf of the claimant and determines that there is an abundance of evidence pointing to the first defendant's breach of his duty of care to the deceased. Is there a causal connection between the first defendant's breach of his duty of care and the death?

- [90] The rule in this regard is that the claimant has the onus to establish that the defendant's negligence caused or in the very least materially contributed¹⁶ to, in this case, death of Cassandra Muriel St. Rose.

Submissions

- [91] Learned counsel for the claimant points to the following to support her argument on causation. First, Dr. Cooles' evidence that intravenous heparin would have made a major difference to the outcome and that the deceased's chance of survival if an anticoagulant had been administered would have been at least 90%. Second, Dr. Cooles' further evidence that heparin works quickly and although it does not dissolve clots it reduces the body's clotting function. Third, reference is made to Dr. Charles' evidence that the deceased had large embolus and was at a pre-terminal stage at the time of her admission on account of her vitals and complaints and that heparin would have done little to change the effects on the embolus. And further, that the only treatment to dissolve clot or surgery would have removed the clot, would have been effective. Fourth, that since the first defendant did not attend to the deceased while she was a patient at the Accident &

¹⁶ Clerk & Lindsell on Torts, (19th ed.) at paras 10-88 to 10-94; *Bonnington Castings Ltd v Wardlan* [1956] AC 613

Emergency Department and the evidence of both experts that the deceased should have been treated as an emergency immediately upon her arrival. Fifth, the first defendant's unsupported misdiagnosis is another act of negligence which materially contributed to the death of the deceased, since if a proper diagnosis had been made the deceased would have been treated promptly and adequately. Sixth, there is no evidence that the deceased had a large clot. While she was present at the Accident & Emergency Department. Seventh, Dr. Cooles' evidence that: "[F]or some 4 hours or more there was a window from the time she reaches casualty when the formation of further clots could have been prevented by full anti-coagulation with intravenous heparin, and the subsequent death averted. Clots are continually forming and breaking down. Indeed one of the standard tests for PE and DVT (D- Dimer test) is to test the blood for such clot breakdown products". Eighth, Dr. Cooles' evidence that PE is a medical emergency by itself of common occurrence in Dominica. Ninth, Dr. Cooles' evidence that the risk of death is greatly reduced where anti-coagulation is employed, and that this has been seen with his patients. This view has not been dispelled by Dr. Charles or by the first defendant who admitted that he is familiar with PE and has managed such cases over the course of his career. Tenth, the court ought to prefer the expert evidence of Dr. Cooles on the issue of causation as it was clear and logical and supported by sound reasoning and not challenged under cross-examination. Eleventh, there is clear evidence to link the first defendant's breach of duty to the death of the deceased. Twelfth, the first defendant's failure to attend to, examine, diagnose and treat the deceased for her condition was a material contribution to the death of the deceased.

[92] In short, the claimant has cited a number of procedures which were not followed and which have yielded positive results.

[93] In case of the submissions on behalf of the defendants, these begin with the observation that the only issue on which the expert evidence is not in alignment is on the issue of causation. The submissions continue thus: First; Dr. Charles was accepted by the court as an expert witness and according to his expert report his qualifications include both an MSc in emergency medicine and

a DM in emergency medicine. The evidence of Dr. Charles should be accepted over that of Dr. Cooles. Second, Dr. Cooles' evidence is that when the deceased called her mother and complained of certain symptoms, the PE would have started hours before the deceased came to the Accident & Emergency Department. Further, the clot would have already gone to the lungs by the time she displayed the symptoms noted by the nurse. Further still, that chest pain could indicate that clots have lodged in the lungs. Third, Dr. Cooles' evidence is that heparin does not dissolve clots, and gave evidence that there is a 90% chance that if the deceased's patient had been properly managed she would not have succumb to PE several hours later. However under cross-examination Dr. Cooles did testify that there is no guarantee that on a balance of probability of risk that further PE would decrease dramatically with the administration of heparin. Therefore, the defendants submit that taken as a whole, Dr. Cooles' evidence does not support his opinion that there is a 90% chance that the deceased would have survived had she been properly managed. Fourth, according to Dr. Charles where PE is large enough to cause severe compromise of the systems, the morbidity and mortality is great if medical or surgical intervention is not done very soon afterwards. Further, the modalities to dissolve clots are surgery which is not available in Dominica. Fifth, Dr. Charles in commenting on the respiration of the deceased (2m per minute) as recorded by the nurse stated that for a young person to have a respiratory rate that high, normal being 14 to 18 per minute, 1 pulse rate that high, the normal average being 72 beats per minute and blood pressure that low, the normal being 120/80 it means that the individual must have already been suffering heurodynamic and respiratory compromise. Dr. Charles explained that he stressed on young person because the body compensates very well for any severe insult and only shows these derangements in vital signs after very severe insults or in terminal phases. Sixth, Dr. Charles in his expert report noted that the cause of death from the post mortem was pulmonary embolus in both pulmonary arteries. This is almost 100% fatal unless an embolectomy and anti-coagulation is immediately performed. Dr. Charles also gave evidence that embolectomy (surgery) is not available in Dominica. This evidence is supported by Dr. Cooles. Seventh, Dr. Charles' evidence is relation to the prospects of recovery from massive or significant PE is more cogent and persuasive than that of Dr. Cooles and therefore should be

preferred. Eighth, it is therefore likely than not the failure of Dr. Thomas to diagnose the deceased patient with PE did not cause or materially contribute to her death. Ninth, although the evidence before the court is that the standard of care given to the patient by Dr. Thomas was wanting this did not cause the deceased patient's death. It is the defendants' submission that causation, a necessary ingredient of clinical negligence, has not been proved by the claimant. Tenth, it is the defendants' case that on a balance of probabilities the death of the deceased patient was not caused or materially contributed to by Dr. Thomas, the defendants are not liable to the claimant in "clinical negligence".

- [94] In sum the submissions seek to show that the deceased was at a terminal stage from earlier in the day so that the failure of Dr. Thomas to give a proper diagnosis did not cause the death of the deceased.

Reasoning

- [95] It is acknowledged on both sides that the expert witnesses, Dr. Cooles and Dr. Charles do not come to the same conclusion on the matter of causation. This is not fatal since there is a whole body of other relevant evidence from both experts.

- [96] In this connection the dictum of Bingham LJ (as he then was) in **Eckersley v Binnie**¹⁷ provides guidance to this court. It is as follows:

"In resolving conflicts of expert evidence the judge remain the judge, he is not obligated 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 shall be the subject of a coherent reasoned rebuttal, unless it can be discounted for other good reason."

¹⁷ [1988] 18 Con LR 1. See also: *Deonarine v Ramlal* [2007] T&T:CA 4 per Mendoca JA @ paras 30-41

[97] Dr. Charles' reasoning regarding causation is premised on Dr. Thomas having seen the deceased at the time when he said he spoke to her and examined her for 5-7 minutes at about 3:58p.m on April 16th, 2012. This has been rejected by the court utterly for the reason given before and which points in the direction of no examination whatsoever. This in turn rests on Dr. Thomas' clear evidence that he did not see the POP when he examined the deceased, when he had fitted it six days earlier. More than that on her mother's un-contradicted evidence the deceased wore a knee length dress at the material time. And Nurse John's evidence that she too did not see the POP only compounds the issue as she had real and substantial interactions with the deceased in making her notes. In any event both experts testified that they would not have missed the POP.

[98] Not having seen the deceased this lets in the presumptive diagnosis of Diabetic Keto Acidosis (DKA) rather than PE. This rests on what Nurse John said she read out to Dr. Thomas following which he gave her certain instructions as to how the patient was to be treated. In any event the diagnosis was wrong or inappropriate given the symptoms of which the deceased complained and what Nurse John noted. Further, both experts said that PE should have been high on the list given the symptoms and its prevalence in Dominica plus Dr. Thomas' own evidence that he has treated persons with PE in his practice¹⁸. Dr. Cooles even goes further by saying that PE is more prevalent in persons of African descent. And in this connection the court takes judicial notice of the fact that the majority of persons in Dominica are of African descent.

[99] The fact that Dr. Cooles gave evidence that if heparin was administered to the deceased she would have had a 90% chance of survival and then under cross-examination he conceded that there was no guarantee on a balance of probability of risk that further PE would decrease dramatically with the administration of heparin is not fatal. The point is that in such a context certainty is not in the equation. What arises there is the measure taken by the doctor. This in turn

¹⁸ Dr. Cooles' first medical post was House Officer, St. Helen Hospital London. See the Trial Bundle Part II at page 184

would go towards negating causation since the link between the breach of the duty of care and causation is set is irrefutable. And the point is that with Dr. Thomas being on the wrong path because he did not examine the deceased makes the link stronger. Put otherwise, while death is inevitable with certain illnesses, this is not a reason for a doctor to cease to act as a reasonable doctor in order to try to save the person's life in accordance with a certain oath and the law. Thus, it is not uncommon to hear of doctors working for hours to save a life. Dr. Thomas had over 4 hours to do what he should do and did not even see the patient and consequently made a wrong diagnosis. And the patient having died, how did Dr. Thomas know that she died because of a clot even before the post mortem which he told the claimant would reveal the cause? The answer must be that if Dr. Thomas knew at 8:30pm that the deceased died as a result of a blood clot he would have known that she had PE based on what Nurse John read out to him from the notes taken.

- [100] The concession made by Dr. Cooles under cross-examination that there was no guarantee on a balance of probability of risk that further PE would decrease dramatically with the administration of heparin brings to the fore a dictum Madam Justice Reifer in **C. Londe and S. Londe v Boyce and Bayview Hospital Ltd**¹⁹ that in the matters of medical negligence, there was unlikely to be definitive scientific knowledge as to how various causes took effect and led to the claimant's injuries and the court was therefore "forced to speculate according to degrees of probability."
- [101] The point is that even with the concession by Dr. Cooles does not defeat the known effect of heparin in such circumstances.

¹⁹ Suits No. 262 and 2481 of 2001 (Barbados)

[102] In the case of **Deonarine v Ramlal**²⁰ Justice of Appeal Mendonca in giving his judgment in a medical negligence case commenting on the duty of a medical practitioner cited the following dictum from the case of **LanPhier v Phipos**²¹ at paragraph 17 of his judgment:

“Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill. There may be persons, who have higher education and greater advantage than he has, but he undertakes to bring a fair, reasonable and competent degree of skill and you will say whether, in this case the injury was occasioned by the want of such skill in the defendant.”

[103] The point here is that the foregoing is dated over 170 years ago and the courts even then insisted on a reasonable degree of care and skill.

[104] Both of the expert witnesses testified that they would have sent the deceased to the Intensive Care Unit (ICU). The first defendant had more than 4 clear hours to assess the patient and do what a reasonable and competent medical practitioner would do. Rather than sending her to the ICU, the first defendant sent her to Glover Ward at 7:00 pm to spend her last hour.

[105] As mentioned above, Dr. Cooles did give extensive evidence on the matter of the diagnosis of the deceased. This is part of his evidence:

“Ms. St. Rose presented with typical features of pulmonary embolism six days after immobilization of the lower limb in a plaster cast for a fractured ankle. She had not been given DVT prophylaxis. DVT and PE should have been first in a list of possible diagnosis. PE typically presents with chest pain, dizziness and fainting, palpitations and breathlessness. A patient will usually exhibit a fast heartbeat, rapid respirations and a low blood pressure (hypotension). The patient may also be pale due to a drop in blood pressure (Ref.5). According to the casualty notes, Ms. St. Rose presented with dizziness and fainting and palpitations. Her blood pressure (BP) was low -and she was breathing rapidly. All of these are features of a patient in shock due to PE. The possible absence of chest pain in this case should have not, in any way, ruled out PE in this case. Chest pain in PE usually indicates a small infarction which affects the pleura- or linings of the lungs

²⁰ [2007] T&T CA,4

²¹ [1838] 173 ER 581

and chest pain may well be absent in larger, more serious PEs. Harrison's Text Book of Internal Medicine (18th ed.) states: ...“Dyspnea, Syncope, hypotension, or cyanosis indicates a massive PE. Whereas pleuritic pain, cough or hemoptysis often suggest a small embolism situated distally near the pleura.

Thus it is not surprising that chest pain was not a prominent feature of when Ms. St. Rose presented to the A & E Department.”

[106] In the case of Dr. Charles he gives an evaluation on the first defendant as follows:

“Doctor's evaluation; there is no documentation of the doctor's history nor examination. Medical documentation and notes are constructed to provide accurate reconstruction of a medical encounter and are written contemporaneous to avoid recollection of events from memory.

Post mortem findings indicate death from pulmonary embolism. There is no documentation of the full blood electrolytes or acid base balance, but documentation of a white blood cell count of 14.3, and blood sugar 700mg/dl also supports severe metabolic derangements.”

[107] The case of **Barnett v Chelsea & Kensington Hospital Management Committee**²² being a case turning on causation has some bearing on this case as it is case of apparent arsenic poisoning of 3 men who presented to the casualty department of the defendants, but who were sent home without treatment and told to see their own doctors. One of them died 5 hours later. On this account it held that the medical casualty officer was negligent in not seeing and examining the deceased, in not admitting him to the ward and in not treating him or causing him to be treated and accordingly the defendants were in breach of their duty to the deceased. It was held further that since the deceased, would have died of the poisoning even if he had been admitted to the ward five hours before his death and treated with all care, the plaintiff had failed to establish on the balance of probabilities that the defendants' negligence had caused the death and therefore the claim failed.

[108] It is clear from the judgment that there was enormous amount of technical evidence before the court on arsenic poisoning, the diagnosis and the treatment thereof.

²² [1969] 1 QB 428

[109] Mr. Justice Neil having examined the law and the evidence came to the conclusion that there was negligence. He then went on to consider the issue of causation. And given the issue and the context, the court finds it necessary to quote the entirety of the reasoning in this regard:

"Thus it is that I find that under all four headings the defendants were negligent and in breach of their duty in that they or their servants or agents did not see and did not examine and did not admit and did not treat the deceased.

It remains to consider whether it is shown that the deceased's death was caused by that negligence or whether, as the defendants have said, the deceased must have died in any event. In his concluding submission Mr. Pain submitted that the casualty officer should have examined the deceased and had he done so he would have caused tests to be made which would have indicated the treatment required and that, since the defendants were at fault in these respects, therefore the onus of proof passed to the defendants to show that the appropriate treatment would have failed, and authorities were cited to me. I find myself unable to accept that argument, and I am of the view that the onus of proof remains upon the plaintiff, and I have in mind (without quoting it) the decision cited by Mr. Wilmer in *Bonnington Castings Ltd.v.*

Wardlaw. However, were it otherwise and the onus did pass to the defendants, then I would find that they have discharged it, as I would proceed to show.

There has been put before me a timetable which I think is of much importance. The deceased attended at the casualty department at five or 10 minutes past eight in the morning. If the casualty officer had got up and dressed and come to see the three men and examined them and decided to admit them, the deceased (and Dr. Lockett agreed with this) could not have been in bed in a ward before 11 a.m. I accept Dr. Goulding's evidence that an intravenous drip would not have been set up before 12 noon, and if potassium loss was suspected it could not have been discovered until 12.30 p.m. Dr. Lockett, dealing with this, said: "If this man had not been treated until after 12 noon the chances of survival were not good."

Without going in detail into the considerable volume of technical evidence which has been put before me, it seems to me to be the case that when death results from arsenical poisoning it is brought about by two conditions; on the one hand dehydration and on the other disturbance of the enzyme processes. If the principal condition is one of enzyme disturbance-as I am of the view it was here-then the only method of treatment which is likely to succeed is the use of the specific antidote which is commonly called B.A.L. Dr. Goulding said in the course of his evidence:

"The only way to deal with this is to use the specific B.A.L. I see no reasonable prospect of the deceased being given B.A.L. before the time at which he died "-and at a later point in his evidence- I feel that even if fluid loss had been discovered death would have been caused by the enzyme disturbance. Death might have occurred later."

I regard that evidence as very moderate, and it might be a true assessment of the situation to say that there was no chance of B.A.L. being administered before the death of the deceased.

For those reasons, I find that the plaintiff has failed to establish, on the balance of probabilities, that the defendants' negligence caused the death of the deceased."

[110] The court interprets the ruling on the issue of causation as a matter of insufficient time to deal with the case based on a timetable put before the judge to get different procedures activated. The other issue was the deceased in that case was the possibility of the deceased being given an antidote B.A.L. In this regard the learned judge accepted the evidence of Dr. Goulding, that there was no reasonable prospect of the deceased being giving the B.A.L before his death.

[111] How does the **Barnett** case impact on the St. Rose case? The court is of the view that it is distinguishable because: the poison arsenic was involved, there were issues involved in the Casualty Department in activating the necessary procedures, and given the time of the arrival of 8:05 or 8:10 am if B.A.L had been administered the chances of survival were not good. This was Dr. Lockett's opinion which the court accepted.

[112] In this case the deceased presented at the Accident and Emergency Department with these symptoms recorded by Nurse John and later read out to the first defendant. The first defendant testified that when he examined the deceased these symptoms had disappeared and he made a presumptive diagnosis. In this regard the court has already determined that the first defendant did not see the deceased at all prior to her death.

- [113] Another distinguishing feature of the case is the issue of arsenic which is not the case in this instance. And based on the evidence accepted in the **Barnett** case if the deceased had been given B.A.L five hours after being admitted his chances of survival were not good. This contrast with Dr. Cooles' evidence that had the deceased had been diagnosed promptly, admitted to the intensive care ward and begun on intravenous anti coagulation therapy with heparin she had a 90% chance of survival. This was explained under cross- examination in terms of probability but survival was not ruled out entirely as Dr. Charles did. The short point in all of this is that the court accepts the evidence of Dr. Cooles regarding the emergency attention and certain procedures being followed giving the deceased a chance of survival.
- [114] The evidence accepted in the **Barnett case**²³ established that at that time arsenic poisoning was a rare event. The figures given are these: out of 6000 deaths between 1955 and 1965 from poisoning only 5 were due to arsenic poisoning. And of the 3,000,000 or 4,000,000 people admitted to about 5000 hospitals in the course of a year, only 60 were cases of arsenical poisoning or potassium loss.
- [115] This contrasts drastically with PE in Dominica. And in this regard Dr. Cooles' evidence that 15% of deaths in hospital are due to PE.
- [116] The court readily accepts that the date in the **Barnett** case is some 50 years old, but it does give a guide in the circumstances.
- [117] The symptom in the **Barnett** case was vomiting, but in this case the nurse read out the symptoms to the first defendant which caused the two experts to say that PE should have been high on the list. Nurse John in her witness statement at paragraphs 3 and 4 says as follows:
- “3. On that day in the afternoon at about 2:40 pm Cassandra Muriel St. Rose, the deceased client came into the department...As a result of that conversation I put the deceased client in wheel chair and wheeled her to Room 1. She was

²³ Loc cit @ p. 437

accompanied by a young man. He informed me that the deceased client had vomiting, weakness and from the morning her heart was racing. I asked the deceased person questions. She told me she was feeling weak.

4. I commenced an examination of the vital signs. I took her blood pressure, respiration, pulse and temperature. I noticed her mucus membranes were pale. I also took her RBS (blood sugar) reading. It stated “hi” on the glucometer. I asked her whether she had any chronic conditions such as diabetes. She said no. I placed her on a couch and I administered O2 therapy. I then placed her in the fowler’s position (half lying, half sitting). I completed the assessment by asking her additional questions. I then wrote the results of my observations and examination on the casualty notes form.”

[118] At paragraphs 5 and 6 of her witness statement Nurse John details her contact with Dr. Thomas, including the deceased client was in Room 1, reading the notes to him a “verbal order” from him to give 18 units of soluble insulin IV and to set up a litre normal saline, blood taken and further instructions that the RBS reading be reviewed every half hour to an hour. According to Nurse John the IV was set up about 3:15 pm and the RBS reading reviewed at 4:00 and 5:30 pm. Finally, the patient was informed that the doctor will be with her shortly.

[119] The short point about Nurse John’s evidence, which the court accepted is that the first defendant had far more information than the casualty doctor in the **Barnett** case that should have led him to put PE high on the list of diagnosis. Plus, there is no evidence that the casualty doctor in **Barnett** knew the patient while the first defendant had fitted a POP on the deceased 6 days prior with all the medical implication, hence the instructions leaflet and oral instructions.

Conclusion on causation

[120] Given the law and the evidence accepted by the court, the submissions from both sides, it is the determination of the court that the first defendant contributed materially to the death of the deceased by failing to do what a reasonable doctor with his skills would have done in light of the information provided by Nurse John concerning the deceased as a basis for diagnosis and treatment rather than diagnosing diabetic ketoacidosis of which there was no evidence.

Conclusion on Issue No. 1

- [121] It is the determination of the court that the defendants are liable in negligence because:
- (a) the first defendant owed a duty of care to the deceased (conceded by the defendant);
 - (b) the defendants were in breach of the duty of care on account of *inter alia*, his failure to attend to the deceased during the entire period of her stay at the Accident and Emergency Department and rendered a diagnosis on the symptoms the deceased presented on her arrival and stay at the Accident and Emergency Department and later at the Glover Ward in accordance with the established practice in the medical profession, and
 - (c) the first defendant failed to do what a reasonable doctor with his skills would have done in light of the information provided to him by Nurse John concerning the deceased as a basis for diagnosis and treatment, instead of diagnosing diabetic ketoacidosis of which there was no evidence.

Issue No.2

If the defendants are liable in negligence, whether the claimant is entitled to damages including special damages.

- [122] Based on the determination of the court that the defendants are liable in damages, this issue of damages follows as prayed. These are special damages and general damages. These two types of damages are governed by common law but two statutes also have a bearing on the issue

under consideration. These are the **Law Reform (Miscellaneous Provisions) Act**²⁴ and the **Fatal Accident Act**²⁵.

- [123] In broad outline the **Law Reform (Miscellaneous Provisions) Act** seeks to protect the survival of causes of action in favour of and against the estate of the deceased. At the same time, the Act places restrictions on types of damages that are excluded in any award, namely exemplary and damages for loss of income and exclusion of damages for any loss or gain to the estate consequent on the death.

Special damages

- [124] The rule regarding special damages is that they must be pleaded and proven²⁶. In this instance the claim is for \$7,753.25 but the receipts in evidence only go towards the sum of \$4,853.25. The court therefore agrees with the submissions on behalf of the defendants that this is the amount that should be awarded. Accordingly the sum of \$4,853.25 is awarded as special damages.

General damages

- [125] In a claim for general damages the heads of damages available to the claimant are: loss of expectation of life, pain and suffering and loss of amenities.

Loss of expectation of life

²⁴ Chap 7:99 Revised Laws of Dominica

²⁵ Chap 7: 59 Revised Laws of Dominica

²⁶ See: *Perestrello E. Compagnia v United Paint Co. Ltd* [1969] 3 ALL ER 478

- [126] The submission on behalf of the claimant is that a review of the cases from our jurisdiction has generally been fairly consistent in the quantum of damages awarded in the category with a range of \$3,500.00 to \$7,000.00. The point is also made that in **Bertha Compton (nee) Blaize v Dr. Christiana Nathaniel, Dr. Gerard Saltibus, the Hon. Attorney General and the Hospital Administrator, Victoria Hospital**²⁷, in awarding the sum of \$3,000.00, the court recognized the need to progressively raise the standard sum to accommodate inflation.
- [127] In submitting that an award of \$6,500.00 is reasonable and just learned counsel cites and examines a number of cases²⁸.
- [128] It is submitted on behalf of the defendants that “damages may be awarded for the shortening of life but should not be calculated solely, or even mainly, on the basis of length of life that is lost; they should be fixed at a reasonable figure for the loss of a measure of prospective happiness. No regard must be had to financial loss or gains during the period of which the victim has been deprived, damages being awarded in respect of loss of life not loss of future pecuniary prospects: **Benham v Gambling**.” The submission goes on to say that on the above mentioned case The House of Lords held that only moderate award should be made²⁹.
- [129] Learned counsel cites a number of cases³⁰ showing the awards made in other jurisdictions. In these cases the awards range from \$3,500.00 to \$7,000.00. However, learned counsel has

²⁷ SLUHCv2000/0031

²⁸ Mary Augustine v Joseph Ghinawoo, SLUHCv2003/0483, Alfred Jackson v David Balcombe, SVGHCv1994/138, Yvonne Thomas v James Mitchell et al GDAHCv2005/0391, Irma Smith and Marinus Smith v Omari Phillip and Vaughn Jackson t/a Tropical Express Rentals, ANUHCv2009/0579 and George Jolly and Ann Charles v Vallen Francoise and Gabriel Francoise, GDAHCv2010/302

²⁹ See: McGregor on Damages (17th ed.) at paras 36-127 and 37-128.

³⁰ These are: Mary Augustine Jallim v Joseph Ghinawoo, SLUHCv2003/0483 (2005 judgment); Bertha Compton (nee) Blaize v Dr. Christiana Nathaniel, Dr. Gerard Saltibus, the Hon. Attorney General and the Hospital Administrator, Victoria Hospital SLUHCv2003/031; Irma Smith and Marinus Smith v Omari Phillip and Vaughn Jackson t/a Tropical Express Rentals, ANUHCv2009/0579; Yvonne Thomas v James Mitchell et al GDAHCv2005/0391

pointed out that the latter award was by consent. However the court is urged to award between \$4,000.00 and \$4,500.00.

[130] In this connection, the court also notes that in the **Bertha Compton** case the court made mention of accommodating the inflation factor.

[131] This court agrees that this is relevant consideration and given the dates of the award, being between 2002 and 2011. Accordingly, an award of \$5,000.00 is made for loss of expectation of life.

Pain and suffering

[132] On behalf of the claimant under this head of damages a survivorship claim will be made in any case where there is evidence of actual pain and suffering experienced prior to death.³¹

[133] After examining the award in a number of cases the following is submitted

“The unchallenged evidence in the instant case is that the deceased arrived at hospital at 2:40pm and died approximately 8:30pm almost 6 hours later. The evidence of the Claimant and her witness Malcolm St. Rose reveals that the deceased was conscious from arrival at the hospital, up to the time of her death (at least up to the time the Claimant left the hospital). Their evidence is while at the hospital, they observed suffering on the part of the deceased of which she would have been conscious. She had chest pains, breathing difficulties, was weak and pale, unable to walk or stand and was extremely anxious, not wanting the Claimant to leave her side. Indeed, the deceased, may have been aware of her impending death. It should be reiterated that the 1st Defendant’s evidence that the deceased appeared seemingly ‘normal’ should not be believed as explained in the Claimant’s earlier submissions.

In the premises, bearing in mind that the deceased would have suffered at the hospital for almost 6 hours after arriving there, and taking into account the relatively high nominal awards made where death occurred almost immediately after the fatal accident, and taking into account inflation, it is submitted that an award in the region of \$8,500.00 should be granted for the deceased’s pain and suffering.”

³¹ Hicks v Chief Constable of South Yorkshire Police [1992] 1 ALL ER 660, 694

- [134] It is submitted on behalf of the defendants that under this head the award should be small since death so often follows quickly upon injury. And it is further submitted that the award for pain and suffering should be made in the absence of clear evidence of actual pain and suffering experienced prior to death.
- [135] In an elaboration, the contention is that the difficulty breathing, shortness of breath and chest pain suffered by the deceased when she presented at the Accident and Emergency Department cannot be attributed to the defendants as they were symptoms of the PE. Further, the allegation is that the first defendant failed to diagnosed and treat the PE, not that he caused it. The submission continues in this way: “what may be attributed is the prolongation of these symptoms, the deceased came into the Accident and Emergency Department at approximately 3:00 pm and died at about 8:30pm. Hence she would have experienced the symptoms for at most 5 ½ hours.” It continues even further by saying that: “If the court accepts Dr. Thomas’ evidence that he saw the patient and when he saw her she did not indicate that she had chest pain and was not suffering from shortness of breath, then it is submitted that the suffering was much less that 5 ½ hours.”
- [136] The court’s response to the submissions is that it has already found as a fact that the first defendant never saw the deceased, so that what the deceased told him cannot arise. In any event, Nurse John also gave evidence as to the manner in which the deceased presented. The court therefore accepts that the suffering was for a period of 5 ½ hours.
- [137] Learned counsel has referred the court to four cases³² in which awards of \$4,000.00, \$7,500.00, \$22,000.00 and \$100,000.00 were made for pain and suffering in three of the cases and in one case loss of expectation of life.

³² The cases are: Maria Guye as Personal Representative of Arthur L. Waldron deceased v Faustinus Toussaint DOMHCV2007/0175; Mary Augustine Jallim v Joseph Ghirawoo; George Jolly and Ann Charles v Vallen Francoise and Gabriel Francoise, GDAHCV2010/302

[138] The learning in **McGregor on Damages**³³ is that such damages are generally small and cases³⁴ are cited and discussed to illustrate the approach of the courts and that in recent times the award was £4,000.00 an amount which would now be nearer to £5,000.00.

[139] Having regard to the submissions, the law and the circumstances, the award is \$5,000.00 for pain and suffering.

Loss of amenities

[140] The following represents the submissions on behalf of the claimant under the head of loss of amenities:

“The estate is entitled to recover the deceased loss of amenities of life to the time of her death. In **Alfred Jackson v David Balcolme, SVGHCV #138 OF 1994** delivered in 2000, Mitchell J awarded the nominal amount of \$5,000.00 for loss of amenities. He explained then that this nominal amount was granted in the absence of any authority suggesting a reasonable amount in St. Vincent.

On this authority and in the absence of any cases to the contrary, it is submitted that the claimant should be awarded the sum of \$7,500.00 for the deceased's loss of amenities.”

[141] In submissions on behalf of the defendants the point is made of the entitlement of the estate to recover the deceased's loss of amenities of life up to the time of death, but as with pain and suffering, awards will be small as death so often follows quickly upon injury.

[142] In **McGregor on Damages** at para 36-127 a number of cases are cited under this head involving unconsciousness prior to death and the varying awards made. However it cannot be said that all the awards are small and they tend to increase with the gravity of the case and reaching as high as £11,000.00 “representing over £50,000.00 in today's value.”³⁵

³³ At paras 36-124 to 36-125

³⁴ Cases cited include: *Bishop v Cunard White Star* [1970] P 240; *Hicks v Chief Constable of South Yorkshire Police* [1992], 1 ALL ER 950; *Rose v Ford* [1937] AL 826; *Robertson v Lestrangle* [1985] 1 ALL ER 950; *Roughead v Rarleyway Executive* [1989] 65 T.L.R. 435 and *Watson v Willmoth* [1991] 1 QB 140

³⁵ *McGregor on Damages, loc cit*

[143] The cases³⁶ also establish that damages from loss of amenities are not based upon loss of happiness and the victim's ignorance of the loss suffered is no ground for reducing the award³⁷. In the circumstances the court accepts the reasoning tendered in this regard and an award of \$6,000.00 is made

Issue No. 3

Who is liable to pay costs?

[144] By virtue of **Rule 64.6 (1)** of CPR 2000 the claimant is entitled to prescribed costs.

Interest

[145] The court awards interest on the special damages at the rate of 3% from the date of the service of the claim form to the date of this judgment and interest of 5% on the total award from the date of this judgment until satisfaction.

ORDER

IT IS HEREBY ORDERED as follows:

1. The defendants are liable in negligence because:
 - (a) the first defendant owed a duty of care to the deceased (conceded by the defendant);

³⁶ West v Shephard [1965] AL 326; Andrews v Freeborough [1967] 1QB1; Kralj v McGrath [1986] 1 ALLER 54; and Benham v Gambling [1941] AC 157

³⁷ McGregor on Damages, *loc cit*

- (b) the defendant was in breach of the duty of care on account of *inter alia*, his failure to attend to the deceased during the entire period of her stay at the Accident and Emergency Department and rendered a diagnosis on the symptoms the deceased presented on her arrival and stay at the Accident and Emergency Department and later at the Glover Ward in accordance with the established practice in the medical profession, and
 - (c) the first defendant failed to do what a reasonable doctor with his skills would have done in light of the information provided to him by Nurse John concerning the deceased as a basis for diagnosis and treatment, instead of diagnosing diabetic ketoacidosis of which there was no evidence.
2. The claimant is entitled to damages and the following amounts are awarded: \$4,853.25 as special damages, plus general damages of \$5,000.00 for loss of expectation of life; \$5,000.00 for pain and suffering and \$6,000.00 for loss of amenities yielding a total amount of \$20,853.25
 3. The claimant is entitled to prescribed costs.
 4. The claimant is awarded interest on the special damages from the date of the service of the claim form to the date of this judgment, and interest of 5% on the total award from the date of this judgment until satisfaction.

Appreciation

At the ecumenical church service marking the start of the Law Term on September 16th, 2014 held at the Anglican Cathedral, Roseau, the homily titled "The Value of Law" was delivered by Bishop Gabriel Melzairé. It is Bishop Melzairé who reminded the judges, the attorney-at-law and

all others of the pursuit of truth in courts of law and how it translates in the wider society. The following is part of what the distinguished Bishop Malzaire had to say:

“The negative perceptions that have been formed about lawyers and the exercise of the law today, how do you personally navigate through it in such a way that each of you will be known as a true pursuer of justice?”

Jesus in today’s Gospel selection reminds us that he had not come to abolish the Law of the Prophet, but he came to complete them

It seems to me that your task as upholders of the Law has a similar role. I believe that every time human persons find true justice mitted out to them, the whole world stands to benefit. In some instances that good may not be perceived immediately, but in the wider scheme of things it will be realized. So it is not a question of someone escaping the law because of some technicality or the other, but it is a matter of being in pursuit of truth.”

Such words coming from a Bishop in the context of the start of the Law Term with numerous and critical decisions (including this case) to be given in our courts carry great weight and significance as they have an added element of reality. More than that, the truth must always be found if justice is to prevail. On this account, the court wishes to thank the distinguished Bishop Gabriel Malzaire for his contributions to truth and justice.

This case, without a doubt, is a very important case in our jurisprudence and the court is of the view that counsel on both sides treated it that way and rose to the occasion. The court wishes in particular to commend learned counsel on both sides for the skills exhibited during cross-examination as it reflected a considerable reading of relevant medical literature. This augers well for our jurisprudence. In seeking to guide the court to the truth they have both contributed considerably to this important case and the truth and honesty will reflect their contribution.

Justice Errol L. Thomas

High Court Judge (Ag)