THE EASTERN CARIBBEAN SUPREME COURT

IN THE HIGH COURT OF JUSTICE

SAINT LUCIA

Claim No SLUHCV 2004/0362

BETWEEN:

GEMYMA SHAUNERVA NORVILLE

Claimant

AND

ATTORNEY GENERAL OF SAINT LUCIA

Defendant

Appearances:

Mr. Mark Maragh for the Claimant
Mrs. Brenda Portland – Reynolds and
Mr. Dwight Lay for the Defendant

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2005: November 21, 22
December 15, 19
2005: March 16
September 11
2007: September 28
2008: June 5

……..

JUDGMENT

Mason J

[1] This action is brought by the administratrix of the estate of a twenty four (24) year old man (hereinafter referred to as "the deceased") who arrived at the Victoria Hospital in the early hours of 9th November, 2003 after having sustained stab wounds – one to the abdomen and one to the shoulder. The deceased presented in obvious distress, was cold and clammy with signs of hypovolemic shock.

[2] On admission, the medical officers on duty at the Accident and Emergency Department classified the deceased's condition as urgent, needing immediate surgical intervention and thereupon initiated emergency care in preparation for such surgery. His wounds were bandaged, his feet elevated, he was given crystalloid fluids, oxygen was administered, a catheter was inserted to drain blood stained urine, blood was collected for purposes of cross matching and instructions were given for the on call surgeons to be summoned.

[3] Telephone calls were repeatedly made to the on call consultant surgeon and the registrar but all efforts to reach them proved futile. Some time later at the request of his family, the deceased was transferred to the Tapion Hospital where he underwent emergency surgery but he succumbed to his injuries and died.

[4] The Claimant bases her claim for damages for negligence by the Defendant on the grounds that by virtue of admittance of the deceased to the Victoria Hospital, that the hospital undertook to provide for the deceased's general medical care, treatment,

attendance and advice for and in respect to his injuries and as such owed a duty of care to the deceased to use reasonable care, skill and diligence in observing, attending, treating and/or advising the deceased with respect to his injuries.

[5] The Claimant relies in the alternative on the principle of res ipsa locquitur in proof of negligence against the Defendant, its servants or agents.

[6] The particulars of negligence as alleged by the Claimant are that the Defendant, its servants or agents:

- *Failed to exercise the necessary skill, care and precaution in treatment of the Deceased while in their care and custody;*
- *Failed to provide at all and/or in a timely manner circulatory support including correcting hypovolemic shock with fluids and blood within a reasonable time of the Deceased's admission at the said Hospital.*
- *Failed to perform surgical intervention to arrest the bleeding, promptly or within a reasonable time;*
- *Failed to observe or to act upon or to investigate properly or at all the steady and serious and obvious deterioration in the condition of the Deceased while under their care;*
- *Failed to diagnose or suspect that the Deceased had suffered any internal injuries, and failed to give or procure any treatment for the same or perform any investigation which would have discovered same*

- *Failed to act in a timely or urgent manner in treating the Deceased for his injuries as the circumstances ought to have revealed.*
- *Failed to take any or any proper or effective measures whether by way of examination, test or otherwise to properly diagnose the nature, extent and/or gravity of the Deceased's injuries;*
- *Failed to have a physician on call qualified to deal with accident and emergency situations.*

[7] The Defendant while admitting that it owed a duty of care to the deceased makes no distinction between "observing and advising" and "attending and treating" and contends that at all material times, this duty of care was satisfied. The Defendant also denies the allegations of negligence (enumerated above at paragraph 6) and asserts that the deceased's injuries were properly diagnosed and that the treatment provided was in accordance with accepted medical standards. The Defendant refutes application of the principle of "res ipsa locquitur".

Issues

[8] The court is being asked to determine :

- *whether there was a breach of duty on the part of the Defendant in failing/omitting to perform surgery on the deceased as a consequence of which the Defendant can be viewed to have been negligent ; and*
- *whether there is a causal link between the Defendant's failing/omitting to*

treat the deceased and the deceased's subsequent death.

It was decided at trial that if the Claimant succeeded on the question of liability that the issue of quantum would be subsequently considered.

Evidence

[9] Thirteen (13) witnesses gave evidence - inclusive of one (1) medical expert for each party, one of the on call surgeons and the pathologist.

[10] The sum of the evidence of the lay witnesses for the Claimant – the mother of the deceased, the deceased's girlfriend and her mother and the Claimant herself – indicates that the deceased was taken to the Accident and Emergency Department of the Victoria Hospital at around 1:00 a.m. on the morning in question, that on admittance his wounds were bandaged and an oxygen mask placed on his face, that although he continued to communicate with them he was in obvious pain and was bleeding profusely, that as early as 2:00 a.m. they requested a transfer of the deceased to the Tapion Hospital when it appeared to them that nothing was being done for the deceased and that the agreement to transfer the deceased was made at about 2:45 a.m. It was the deceased's girlfriend who eventually arranged for the ambulance to transfer the deceased and it was the deceased's mother who at about 2:45 a.m. went personally to Tapion to have the transfer effected. The deceased was transferred at around 3:30 a.m.

[11] Dr. Christie Daniel the medical expert for the Claimant attended to and operated on the deceased at the Tapion Hospital.

[12] It is his evidence that when he first saw the deceased at Tapion Hospital sometime after 3:30 a.m. that day he was very ill and was in full blown shock with blood pressure readings of 70/30. a pulse rate of 124 and two (2) intravenous lines in progress with crystalised solutions being administered. He stated that he was aware that if the deceased were to have a chance of survival that he needed lots of blood immediately. On his request for blood, he was advised that the laboratory at the Victoria Hospital had indicated that it would be another twenty (20) minutes before blood would be available. He then issued instructions for the technician at the Victoria Hospital to send whatever blood was available. He was informed that there had been a problem with the cross match of the blood. This would necessitate a further ten (10) minute wait to complete the cross match. He was also informed that no O negative blood was available. He stated that by the time the blood arrived from the Victoria Hospital and the transfusion commenced, the patient's condition had begun to rapidly deteriorate and all efforts failed to save him.

[13] Dr. Daniel is of the view that had the deceased received immediate blood .transfusion and surgical intervention he would have had "a fairly good chance of survival".

[14] Dr. Daniel also provided an expert report, prepared after reference to a number of documents:

- *The post mortem report*
- *The medical report of Dr. Newton Jerome*
- *The medical report of Dr. Marcia Gossai*
- *The report of Professor Walrond*
- *The patient's chart notes – Victoria Hospital*
- *Referral letter from Victoria Hospital undated by Senior House Officer, general surgery*
- *Tapion Hospital admission/discharge record, nurses' notes, doctors' notes, pre and post operative vital signs form and surgeon's record of operations*

[15] He concluded his report by stating:

> *"It is my opinion that the patient's chances of survival were significantly compromised due to the delay in receiving definitive surgery to stem his hemorrhage. Had he received competent surgical and resuscitative treatment at Victoria, he should have survived. The fact that he arrived in shock and remained in shock throughout his stay in the emergency room at Victoria Hospital except for one vital sign reading before his transfer which in fact was not normal. Given his respiratory rate of 38 per minute, hardly describes a stabilized individual. The patient was passing blood per rectum on arrival at Tapion emergency room which implied he was having massive ongoing bleeding into his gastro-intestinal (GI) tract. The patient's condition*

was critical and deteriorating rapidly when I saw him sometime after 3:30 a.m. He was, in my opinion in Stage 4 shock at the time. Even with the best of facilities at the time I saw him, his chance of survival was less than one percent. With no blood to replace his ongoing hemorrhage his chances of survival were almost non-existent, but nevertheless attempts were still made to save his life".

[16] Under cross examination Dr. Daniel emphasised the necessity for surgical intervention stating that a blood transfusion would not stop the bleeding and that was why surgery would have to be performed. He stated that when the deceased arrived at Tapion he was in profound shock and that the fact that a pulse beat could not be taken was indicative of profound shock. Dr. Daniel then went on to list the degrees of shock from compensated through mild, moderate to irreversible. This last he stated is caused when a person remains in shock for so long a period resulting in damage which it becomes difficult to reverse.

[17] Dr. Daniel stated that when the deceased arrived at Tapion the blood did not arrive in a timely manner and that the operation was performed when the deceased was already dying. He denied that when the deceased arrived that the opportunity for a successful surgical intervention was present. He stated that if a blood transfusion had been administered while at Victoria, it would have prolonged the deceased's life although it was to be admitted that a transfusion on rare occasions can be dangerous. He reiterated that when the deceased arrived at Tapion he was in profound shock. He stated that the blood

bank at Victoria Hospital is the national blood bank, it serves the entire island and that a request for blood by the Tapion Hospital has nothing to do with a request by the Victoria Hospital.

[18] Under reexamination Dr. Daniel concluded that the fatal consequences were a lack of timely transfusion which should have started within the first hours of the deceased arriving at the medical facility.

[19] Professor Walrond was called by the Defendant as the medical expert. He listed the documents with which he had been provided and which included:

- *Post – Mortem examination report by Dr. Stephen King*
- *Medical report by Dr. Newton Jerome, House Officer, Department of Surgery*
- *Medical report by Dr. Marcia Gossai, Senior House Officer, Accident and Emergency Department*
- *Medical report by Dr. Sharon Smith, Senior House Officer, Accident and Emergency Department*
- *Report on doctors and technicians on call November 9th 11 p.m. to 7 a.m. by Andre Constable, Telephone Operator*
- *Report "Issuance of Blood", Ms. Ann Grose, Medical Technologist III*

[20] He noted that from the documents he considered there were several inconsistencies particularly in relation to timelines. He accepted the conclusion in the post mortem report that the cause of death was hemorrhage from the injuries received. He further concluded the deceased's life may been saved depending on the skill of the care received at both the Victoria and Tapion Hospitals. In his estimation using the Trauma Scoring System of Champion et al if there was no injury to the lung or the inferior vena cava, and the liver injury was "shallow" then given optimal facilities and skills of the surgical team, the deceased's chances of survival would be 95%. According to him, using the same scoring system the deceased's chances of survival would have improved by about 2 percentage points when he left Victoria Hospital for Tapion Hospital. He however noted that the scoring system does not take into account the delay of about an hour in operating to arrest the haemorrhage. He was of the view that the facilities and skills were not optimum at the Victoria Hospital.

[21] Professor Walrond was satisfied that the staff at the emergency department exercised the necessary skill and care within the limits of the facilities available and in keeping with the level of their training and experience. He admitted that there was a failure to perform surgery to promptly arrest the bleeding but considered that it was out of the control of the hospital, that the junior staff did not have the necessary skill to undertake the operation and made every effort to find the doctors who could. He stated that there was no failure to observe or act upon any steady and serious deterioration in the deceased's condition because the deceased's vital signs were improved at the point of his leaving the Victoria Hospital. Professor Walrond stated that the nature of the injury could not have been

diagnosed except at operation or by the use of a CT Scan and this latter was not warranted given the condition of the patient.

[22] Under cross examination and referring to the admission notes of the nurse at Victoria Hospital, Professor Walrond stated that a pulse rate of nil and a respiratory rate of 36 indicate that the deceased was in shock and gasping in a rapid shallow pattern – normal respiratory rate is 14. He noted that the significance of the increased blood pressure when the deceased left the Victoria Hospital was that what was done at Victoria had managed to improve his blood pressure. Although he was still in shock there was no significant deterioration in his condition. He was of the view that given the urine output, there was satisfactory profusion of the kidney, that the deceased's blood loss was not massive, it was contained because if it had been massive, his physiological parameters would have deteriorated and he would not have lasted as long as he had. He suggested that the deceased lost perhaps up to two (2) litres of blood, about half of his blood volume. Having regard to that fact and without any surgical intervention or transfusion, his chance of survival would diminish. He continued that if the patient is not bleeding profusely use of saline could keep the blood volume up and that it has been known that people have been resuscitated over three (3) hours from the start of the saline. The longer you go the less chance there is of surviving. The time of the injury according to him is not necessarily relevant.

[23] Professor Walrond stated that the issuance of blood was important surrounding the death of the deceased. He agreed that when a patient arrived at the emergency department

needing urgent surgery it is necessary to send off a request for blood as soon as you begin to arrange the case and that a delay of one hour is not good enough.

[24] He stated that it is the duty of doctors on call to be available when they are called but it is not the usual practice for doctors on call to call in to the hospital.

[25] On reexamination Professor Walrond stated that when the deceased arrived at Tapion Hospital, blood pressure over 90, pulse rate 125, whilst he was in shock, those parameters did not indicate irreversible shock. He considered however that the trauma scores did not take into account the time lines or what else was happening to the patient, what trauma could have befallen him in a rough transfer. He rated the deceased's chances at that time at 50%. He stated that from the report from Tapion Hospital, two (2) things suggested deterioration – the distended state of the abdomen and the board like stiffness of the abdomen. When asked whether he thought that the lack of blood or non transfusion of blood on its own could have resulted in the death of the patient, Professor Walrond responded. "It is difficult to isolate one factor if no surgery was done, the transfusion without surgery would not have made a great deal of difference. What this patient needed was surgery and this would have been better at transfusion at the time of surgery".

[26] Also giving evidence for the Defence was Mr. Andre Constable, the telephone operator at the Victoria Hospital. He indicated that while on duty, during the period that the deceased was treated, he made telephone calls to the technicians and doctors on call. He received no responses from the doctors.

[27] Under cross examination he stated that he made a record of the calls which he made that day, that he had been instructed to make those calls by a female casualty officer. He admitted that his record shows the calls to the Lab Technicians and the X ray Technicians both being at 12:30 a.m. and stated that the practice is that these two (2) are called together. He admitted that the hospital has a vehicle which is used to go to get the doctor when he cannot be reached by phone, that someone had asked him to get the bus driver to do this but he hadn't. He said the nurse did so. On re examination he indicated that he had prepared his records from memory.

[28] Dr. Marcia Gossai was one of the doctors on duty who attended to the deceased on arrival at the hospital. According to her this was at approximately 1:30 a.m. and emergency care was immediately initiated to stabilize him and to prepare him for emergency surgery which in her judgment was warranted. She accordingly paged the Department of Surgery.

[29] Under cross examination she stated that she gave the order for blood and signed the request form. She was unable to say how much blood the deceased had lost but based on his physical state and vital signs, she was able to determine that he was in hypovolemic shock. She was unable to classify the stage of shock but she knew it was significant and therefore classified the request for blood as "desperate". She was of the view that while the deceased was in her charge, that he was improving and there was no indication of internal bleeding. She said that the deceased came to the hospital with a distended

abdomen. According to her physical examination, she ruled out injury to the lung because he had air entry on both sides and no palpitations or signs of anything wrong.

[30] Dr. Newton Jerome was the other doctor in the Accident and Emergency Department that day.

[31] Under cross examination he stated that when he first saw the deceased he was being attended by two (2) doctors, one of whom was Dr. Gossai. He did not check to see the amount of blood loss nor whether the deceased was bleeding internally but was of the view that blood loss was significant because he was in shock. He agreed that in the treatment of a patient like the deceased, early surgical intervention is most important and that in order to treat the hypovolemic shock, a transfusion is needed. He admitted that neither the surgery nor the transfusion was provided by the Victoria Hospital.

[32] He stated that it did occur to him that a transfer to another facility would be needed but when the initial request was made, it could not be done because the blood pressure was low and he could not get a pulse rate but this improved. He said there was never a time that he could say that there was a significant improvement in the deceased's condition at a point in time when his pulse rate was normalised. When at 3:00 a.m. he looked at the pulse rate recording of 75, he considered it a "bit low" for the deceased's condition and suggested that it should have been higher. The respiratory rate was low. He stated that when the deceased was leaving the Victoria Hospital his blood pressure was higher than

when he had earlier checked it. He stated that the blood pressure could have improved because of the elevation of the bed and the IV fluids he was being given.

[33] One of the on call surgeons Dr. Richardson St. Rose said in his witness statement that he was awake at approximately 3:00 a.m. at his home on the day in question, that it had rained heavily with accompanying thunder and lightning. He stayed awake until 5:00 a.m. His telephone rang for the first time at 5:45 a.m. when he learnt of the deceased's death and of the frantic efforts made to reach him by telephone. He believes that the atmospheric conditions were the reason why his telephone never rang during the relevant period.

[34] In his written report for the Defence regarding the circumstances surrounding the deceased's death, he mentioned that he would still have been of help at 5:45 a.m. if :

- *the deceased had been adequately transfused on arrival at the Accident and Emergency Department, or*
- *if some effort had been made to contact the Gros Islet Police Station to get him or to get Dr. Marius who was on gynecology duty and whom he felt was capable of dealing with the problem*

[35] Under cross examination Dr. St. Rose stated that he had informed the Surgical Department that he would be at home and he was satisfied that the Victoria Hospital had all of his

contact information. He related that it is the practice of the hospital to send its transport bus to the doctor's residence or to contact the police station in the district and have them contact the doctor. He stated that it has been known for the ambulance to be dispatched to collect a doctor. As far as he was aware, neither the ambulance' nor the police nor the Victoria Hospital transport came to his house that night.

[36] He stated that he had personal knowledge of Dr. Marius' competence in performing surgical procedure if it were confined to the abdomen because Dr. Marius is always performing hysterectomies, going into the belly and if there were wounds in the belly, he would be able to stop the bleeding. With blood transfusion life can be prolonged but surgery needed to be performed as early as possible. He agreed that the most effective way of correcting hypovolemic shock would be by transfusion and surgery.

[37] When re-examined about his opinion that Dr. Marius could have performed the surgery, he admitted that he had given that opinion because he had thought that the wound was confined to the abdomen, he did not realize that it had entered the chest. On reflection he did not believe that Dr. Marius would have been able to deal with it since it had entered the chest.

[38] The medical technologist at the Victoria Hospital, Ms. Ann Grose, recalled receiving a request for blood for two (2) patients – one of whom was the deceased and immediately commencing processing the blood samples. She found the cross match for the deceased to be incompatible and so had to recrossmatch, a process which she says takes about one

hour. She recalled receiving two (2) calls from Tapion Hospital about the availability of blood for the deceased who was being transferred from the Victoria Hospital to the Tapion Hospital. She later transported that blood at 3:35 a.m.

[39] Under cross examination she recalled receiving the request for blood from Dr. Smith about 2:15 a.m.' that the time recorded on the form was 2:00 a.m. She stated that when she received the request for blood for the two (2) patients, she started to process both at the same time. She admitted that the request regarding the deceased was listed as "desperate". She stated that the hospital's policy was that all blood had to be crossmatched even if the doctor had requested uncrossmatched blood. She did not at any time contact the Accident and Emergency Department to inform them of the trouble she was having with the cross-matching but according to her in any event by this time, Tapion had called her to inform her that the deceased was being transferred.

[40] The pathologist Dr. Stephen King, after recording his observations during his post mortem examination concluded his report thus:

> *"In summary, the cause of death was hemorrhagic shock secondary to a stab wound to the right lumbar area. There was evidence of surgical intervention and resuscitation attempts. Mr. Norville had a fair chance of survival if early intervention to correct shock and arrest the bleeding had been performed. The major source of bleeding was from the severed renal artery. The bleeding was slowed because of the tissue pressure in the etroperitoneum*

which created the window of opportunity for surgical intervention. The other major source of bleeding was the liver which was bleeding freely into the abdominal cavity and the right chest cavity through the wound in the right hemidiaphragm. The two main principles of treating a patient in this condition are:

- *To provide circulatory support including hypovolemic (low volume) shock with fluids and blood*
- *Early surgical intervention to arrest the bleeding*

[41] In response to questions from Counsel for the Claimant Dr. King was of the opinion that the deceased on arrival at the Victoria Hospital was in stage 3 shock. According to him there are four (4) stages of shock, stage 4 being profound shock which includes irreversible shock at the end stage i.e. when the patient cannot be resuscitated.

[42] He stated that he examined the deceased's right lung but did not see evidence of a puncture and that if there had been a puncture, he would have expected to see haemorrhaging. He did not see any evidence of a tension in the pneumothorax. Upon examination of the chest wound, the injury did not pierce the chest cavity so there was no danger of injury to the lung.

[43] He was of the opinion that it is possible to be in stage 3 shock and still be able to communicate. He was also of the view that the last reading of the patient's vital signs is out of context and not much weight ought to be put on it in terms of interpretation.

[44] Dr. King said that he found 2.2 litres of blood in the chest cavity, this means that on arrival at Tapion, he would have lost about 4.2 litres and that a man has about 5 litres of blood in his body. He said that there was also blood in the back of the abdomen in the tissue. He stated that it would be difficult to assess the whole volume lost because the volumes referred to do not include loss before arrival at the Victoria Hospital, in the bedsheets or in the urine.

[45] Dr. King posited that provision of fluids alone would only prevent hypovolemic shock in the early stage up to stage 2 of shock and at stage 3 the fluids would only correct for a short period of time.

[46] On being questioned by Counsel for the Defendant, Dr. King reiterated that when the deceased arrived at the Victoria Hospital he was in stage 3 shock and that when he left for Tapion Hospital he was also in stage 3 shock. He stated that the treatment for haemorragic shock was immediate crystalloid fluids, blood transfusion and surgery to arrest the bleeding. He agreed that the administering of crystalloid fluids would help a patient to improve, that it was the correct medical procedure, that the doctors did what they needed to do until they could get blood and do surgery. He said that the gasping which Dr. Daniel spoke about is terminal breathing relating to a brain that was dying. He was not of the view that the transportation to Tapion would have affected the deceased's vital signs because the journey was a short one over reasonable roads.

[47] When questioned again by Counsel for the Claimant, Dr. King stated that at the Victoria Hospital the deceased's status was never reversed to normality, it was maintained at level 3 shock. It would not be correct to say that he arrived at the Tapion Hospital in the same way he left Victoria Hospital because when a body remains in shock over a period of time, the metabolic derangements get worse because of the poor tissue profusion so that the body is now progressing towards that stage of irreversible shock when the cells die.

Breach of Duty

[48] Counsel for the Claimant asserts that the Defendant owed a duty of care to the Claimant. In defining that duty Counsel made reference to paragraph 205 of Halsbury's Laws which states in part:

> *"A Hospital Authority is in principle liable for its failure to provide sufficient and properly qualified and competent medical staff for a specialist unit in a Hospital. In addition it seems that in principle a Hospital Authority is liable for the acts or omissions of any part-time or visiting consultants and specialists if they are employed as part of its organization for providing treatment, whether they are in law the employees of the Hospital Authority or not; for in such circumstances the Hospital Authority undertakes the obligation of giving to any patients who require treatment of the kind which the consultants and specialists are employed to provide……"*

[49] Counsel cited the case of Wilsher v Essex Area Health Authority (1986) 3 AER 801 as authority for the proposition that an authority can be held directly liable to a Claimant for failure to provide sufficient or properly qualified and competent medical staff for a specialist unit, as in the present case, an Accident and Emergency Unit. Counsel is of the view that the Victoria Hospital owed a direct duty to the Claimant, inter alia, to ensure that there was available at the Accident and Emergency Unit, a doctor/surgeon whether on call or in house, capable of diagnosing and adequately treating his injuries. It was the duty of the Victoria Hospital to ensure that doctors on "call duty" were readily available, and to put in place procedures to ensure their availability. Counsel considers that an Accident and Emergency Department is effective and useless unless it is properly staffed.

[50] Counsel for the Claimant submits therefore that the evidence has established a breach of the duty of care by the Victoria Hospital both vicariously in the failure to advise and treat the deceased and directly in failing to provide sufficient or qualified and/or competent staff.

[51] The Defendant in its pleadings admitted to owing the Claimant a duty of care but now contends that no common law duty of care arose on the part of the Victoria Hospital in respect of its omission to perform surgery on the patient. This, according to Counsel is because although the Hospital at the time it treated and cared for the patient was vested with both the statutory power and the statutory duty to perform the surgery that was required, such power and duty did not give rise to any common law duty of care to perform such surgery. For this proposition Counsel referred to a number of decided cases and

more particularly to the House of Lords decision in Gorringe v Calderdale Metropolitan Borough Council (2004) 2 AER 326 and Stovin v Wise (1996) 3AER 827.

[52] Counsel asserts that the facts show that the Hospital had not undertaken any responsibilities to perform surgery on the patient but rather only undertook to treat and care for the patient in the Accident and Emergency Department. Counsel argues that it cannot be said that by accepting the patient at the Accident and Emergency Department or by taking steps to contact the stand-by doctors that the hospital assumed a duty to perform emergency surgery on the patient, that in addition, there was no common law duty of care on the stand-by doctors to respond to the calls for them to report for duty.

[53] It is the view of Counsel for the Defendant that a review of the legislation under which the Hospital operates shows clearly that there is nothing either expressly or impliedly stated that the statutory duty of the hospital gives rise to a private cause of action and/or that the language of the legislation indicates an intention that such liability be imposed on the hospital.

[54] According to Counsel the Hospital's duty was limited to providing reasonable treatment at the Accident and Emergency Department, such treatment as was in the best interests of the patient. To support this contention Counsel referred to a statement by Lord Phillips of Worth Matravers MR in Watson v British Boxing Board of Control Ltd (2005) 2 WLR 1256 that:

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

[55] By virtue of such duty Counsel argues, the doctors and the hospital were under a continuing obligation that lasted only up to the time the patient was handed over to Tapion.

Findings

[56] The Defendant has admitted in its defence owing a duty of care to the Claimant. However the onus of proving breach of that duty is on the Claimant i.e to prove that it was the Defendant who caused or materially caused the death of the deceased and that it was foreseeable as a result of the breach.

[57] The standard by which medical professionals are judged with respect to negligence was enunciated by Mc Nair J in Bolam v Friern Hospital Management Committee (1957) 1WLR 582:

"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 law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.....A doctor is not guilty of negligence if he has acted in accordance

with a practice accepted as proper by a responsible body of medical men skilled in that particular art".

the eponymous "Bolam Test".

[58] It is not in dispute in this case that the Accident and Emergency doctors in initiating the necessary emergency procedures acted appropriately and by doing so did all they could within the limits of their skill and training, that they recognized these limits and did the correct thing by having the surgeons summoned.

[59] The medical experts were united in the view that the deceased from inception i.e. from his arrival at the Victoria Hospital in a state of hypovolemic shock, was in dire need of a blood transfusion and more particularly urgent surgery . The experts were also of one accord that the medical staff at the Accident and Emergency did not have the necessary skills to undertake these tasks.

[60] I therefore accept the consensus that the Accident and Emergency doctors having generally "acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion" cannot prima facie be regarded as having been negligent. However it will be seen later that their delay of one (1) hour in requesting blood for transfusion and surgery for a patient who presents at the Accident and Emergency Department in hypovolemic shock is regarded as negligence as was their delay in acceding to the family's request for a transfer to an alternate medical facility.

[61] Was appropriate care at the Accident and Emergency Department the extent of the Defendant's responsibility as was argued by Counsel for the Defendant? That there was no duty to ensure the attendance of the call doctors to perform surgery? I am not so persuaded.

[62] It has been established that a hospital has a primary non-delegable duty of care - which can be both vicarious and direct – to provide proper treatment. Such was the view of Denning LJ in Cassidy v Ministry of Health (1951) 2KB 343:

> *"I take it to be clear law as well as good sense that where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of services or to an independent contractor under a contract for services".*

and again in Roe v Minister of Health (1954) 2QB 66.

[63] With respect to the direct liability of hospitals, Lord Mustill in Wilsher v Essex Area Health Authority (supra) was of the view that the Defendants owed a duty of care to ensure that the specialist unit functioned according to the standard reasonably expected of such a unit. This approach he continued, would not require any consideration of the extent to which the individual doctors measured up to the standard demanded of them as individuals, but would focus attention on the performance of the unit as a whole.

[64] See also the comment by Sir Browne-Wilkinson VC in that case:

> *"...a health authority which so conducts its hospital that it fails to provide doctors of sufficient skill and experience to give the treatment offered at the hospital may be directly liable in negligence to the patient"*

[65] And again later in X (Minors) v Bedfordshire County Council (1995) 2 AC 633, Lord Browne- Wilkinson said:

> *"This allegation of a direct duty of care owed by the authority to the plaintiff is to be contrasted with those claims which are based on the vicarious liability of the local authority for the negligence of its servants, i.e. for the breach of a duty of care owned by the servant to the plaintiff, the authority itself not being under any relevant duty of care to the plaintiff..."*
>
> *"This distinction between direct and vicarious liability can be important since the authority may not be under a direct duty of care at all or the extent of the duty of care directly by the authority to the Plaintiff may well differ from that owed by a professional to the patient. However, it is important not to lose sight of the fact that, even in the absence of a claim based on vicarious liability, an authority under a direct duty of care to the Plaintiff will be liable for the negligent acts or omissions of its servant which constitute a breach*

of the direct duty. The authority can only act through its servants". (my emphasis)

"The position can be illustrated by reference to the hospital cases. It is established that those conducting a hospital are under a direct duty of care to those admitted as patients to the hospital (I express no view as to the extent of that duty). They are liable for the negligent acts of a member of the hospital staff which constitute a breach of that duty, whether or not the member of the staff is himself in breach of a separate duty of care owed by him to the plaintiff".

[66] Counsel for the Defendant argued that although the hospital was vested with both the statutory power and the statutory duty to perform the surgery, this did not give rise to any common law duty to perform that surgery.

[67] Lord Hoffman however in the case of Gorringe (supra) was of the view that the fact that the public authority acted pursuant to a statutory power or public duty does not necessarily negative the existence of a duty. The acceptance of such common law duty owed by a hospital trust based upon the acceptance of a professional relationship with the patient was cited by Lord Hoffmann in Phelps v Hillingdon LBC (2001) AC 619 as an example of a negligence duty where the service was provided pursuant to a public law duty.

[68] I am satisfied that just as the existence of a statutory power or duty does not generate a common law duty neither does it preclude such a duty.

[69] It is my view that the Defendant in accepting the deceased as a patient – after he presented himself to the Accident and Emergency Department, and was not turned away but emergency care instituted – assumed responsibility for the deceased who relied on the Defendant to ensure that his needs would be taken care of. The statement by Lord Phillips of Worth Matravers MR in Watson v British Boxing Board of Control (supra) quoted by Counsel for the Defendant is most apt:

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

[70] In the case of Sandhar v Department of Transport May LJ rejected the claim because there was no evidence that the deceased had relied on the salt gritting process for the road or that the Defendant had assumed a general responsibility to all road users to ensure that all roads be salted in freezing conditions. May LJ was of the view that:

> *"An assumption of responsibility sufficient to create a duty of care normally requires a particular relationship with an individual or individuals ...a general expectation cannot alone support an assumption of responsibility.*

I am however inclined to the view of Lord Browne – Wilkinson in White v Jones (1995) 2 AC 207:

> *"If the responsibility for the task is assumed by the defendant he thereby creates a special relationship between himself and the (Claimant) in relation to which the law (not the Defendant) attaches a duty to carry out carefully the task so assumed".*

[71] Lord Devlin in Hedley Byrne & Co., Ltd v Heller & Partners Ltd 1964 AC 465 commented that the categories of special relationships which may give rise to a duty to take care are not limited to contractual relationships or to relationships of fiduciary duty but also include relationships which are equivalent to contract, that is, where there is an assumption of responsibility in circumstances in which but for the absence of consideration, there would be a contract.

[72] Lord Goff in Henderson v Merrett Syndicates Ltd (1995) 2 AC 145 in reference to the concept of assumption of responsibility noted:

> *...if a person assumes responsibility to another in respect of certain services, there is no reason why he should not be liable in damages in respect of ... loss which flows from the negligent performance of those services.*

[73] In emphasizing that the test of assumption of responsibility was an objective one, Lord Steyne in Williams v Natural Life Health Foods Ltd (1998) 1 WLR 830 had this to say:

> *"The touchstone of liability is not the state of mind of the Defendant. An objective test means that the primary focus must be on things said or done by the Defendant or on his behalf in his dealings with the Claimant. Obviously the impact of what the Defendant says or does must be judged in the light of the relevant contextual scene .... The test is not simply reliance on fact. The test is whether the plaintiff could reasonably rely on an assumption of ...responsibility by the individual on behalf of the (company)".*

[74] To say therefore that the Defendant is not under a duty to ensure that the on call doctors report for duty and to perform the surgery is tantamount to issuing of a disclaimer after having accepted and assumed the responsibility implicit or otherwise of undertaking to care for the deceased's needs. The uncontroverted evidence is that the Accident and Emergency doctors recognizing that immediate surgery was necessary put in place all requirements for such surgery to be performed thereby evidencing their continued commitment and duty to care for the deceased. They made the requisite call for the blood which would be needed for the surgery and put in calls to the on call duty surgeons. They at no time during the deceased's stay at the Victoria Hospital indicated that they were unwilling to perform the surgery. They kept the deceased in their care ministering to his needs to the extent of their ability while waiting for the surgeons to arrive. They made no move to transfer him out of their hospital even when the initial request was made by the

deceased's family. They continued their ministrations until in their estimation they could no longer await the surgeons' arrival by which time the deceased's chances of survival were significantly reduced. I am not persuaded that the Defendant can be allowed to deny any duty or responsibility at this stage nor can I accept the Defendant's contention that the Hospital's duty was limited to the provision of treatment at the Accident and Emergency Department. The Defendant must be answerable for the omission to perform the surgery which it intended and then neglected to carry out, for in the words of Denning LJ in Cassidy v Minister of Health: (supra)

> *"...when hospital authorities undertake to treat a patient and themselves select and appoint and employ the professional men and women who are to give the treatment, then they are responsible for the negligence of the persons in failing to give proper treatment, no matter whether they are doctors, surgeons, nurses or anyone else.*

[75] Similarly as in the case of Barnett v Chelsea and Kensington Hospital Management Committee (1969) 1 QB428 Nield J held that a hospital owed a duty to act vis-à-vis a person who presented himself at the Casualty Department, for once the activity of treatment and care by examination in the first instance has started, there is a duty to take all reasonable steps which in the case at bar it has been determined to be blood transfusion and surgery.

[76] It is the testimony of the telephone operator that while unaware of any practice on the part of the Victoria Hospital to enlist the help .of the police station nearest to the residence of the on call doctor if that doctor cannot be reached by telephone, he knew that the hospital kept a vehicle which is used for that purpose. He knew that the driver of the bus was on the compound and although someone asked him to get the bus driver to go out and collect the doctor, he did not do so. He stated that it was a nurse who got in touch with the bus driver. There was no indication of the bus driver's response to the request. Professor Walrond in his cross examination stated that while it is the duty of doctors on call to be available when they are called, it is not the usual practice for doctors on call to call in to the hospital. He noted in his expert report for the court "according to the telephone operator's log, efforts to locate the surgical team ceased before the decision was taken to take the patient to Tapion Hospital. In addition, there appeared to be no system in place to reach staff if telephone contact cannot be made".

[77] On the other hand it was the testimony of Dr. Richardson St. Rose, one of the on call surgeons, that it is the practice of the hospital to send its transport bus to the residence of the doctors and also contact the police station in the district and have them contact the doctor. He is even aware that on occasion, the Hospital has sent out the ambulance to fetch the doctor. He stated that in spite of being at home for all of the time, nothing or no one came at his home that night.

[78] In my opinion by failing to ensure by whatever means that the on call doctors were readily available to attend to the needs of the deceased i.e. to perform surgery, and by failing to

ensure that there were proper systems in place for communicating with and summoning the doctors, the Defendant is found to be neglectful of its duty to the deceased and can be held directly liable and in breach of its duty to the Claimant. The Defendant by merely disclaiming any duty or responsibility to the deceased has failed to discharge the burden of disproving negligence.

[79] I find support for my view in the statement of Glade LJ in the case of Bull and Another v Devon Area Health Authority CA22 BMLR 99:

> *"I have no means of making a finding as to what went wrong with the system on this occasion. It is sufficient for me to find as I do, that a properly working system would not have left this Plaintiff unprotected by experienced doctors for such a long time at such an important stage. In my judgment the system was inefficient or some members of the administrative staff failed properly to carry out his or her duty in securing the registrar's attendance. The Defendants were negligent in that respect".*

- a statement which I would wish to fully adopt for our present case.

[80] In the case of Bull there was a medically unacceptable delay of one hour in securing the attendance of a suitably qualified doctor to deal with an emergency arising in the delivery of a second twin as a result of which he suffered brain damage. The judge at first instance found that the failure to have a registrar in attendance on Mrs. Bull at the critical

period was attributable to negligence. On appeal Mustill LJ found that it was not a question of an "ideal solution".

> *"This was not a question of highly specialist techniques or advanced new instrumentation which it would be unrealistic to accept in provincial hospitals. It was just a question of getting the right people together in the right place at the right time".*

[81] The health authority was thus held liable for a systems failure.

[82] In the case of Robertson v Nottingham Health Authority (1987) 8 Med LRI which followed the decision in Bull, Brooke LJ in delivering the judgment of the court was of the view that although it is customary to say that a health authority is vicariously liable for breach of duty if its responsible servants or agents fail to set up a safe system of operation in relation to what are essentially management as opposed to clinical matters, in any event it has a non-delegable duty to establish a proper system of care just as much as it has a duty to engage competent staff and a duty to provide proper and safe equipment and premises. Thus if effective systems had been in place at the hospital for ensuring that so far as reasonably practicable communications breakdown did not occur in connection with such a significant area of a patient's treatment then the health authority would be vicariously liable for any negligence of those of its servants or agents who did not take proper care to ensure as far as was reasonably practicable that the communications systems worked

efficiently. If on the other hand, no effective systems were in place at all then the authority would be directly liable in negligence for this lacuna. Brooke LJ continued:

> *"The only rule that this court has to apply in the present case is that if a patient is injured by reason of a negligent breakdown in the systems for communicating material information to their clinicians responsible for her case, she is not to be denied redress merely because no identifiable person or persons are to blame for deficiencies in setting up and monitoring the effectiveness of the relevant communications systems. She is entitled to say, like the successful Plaintiff in Bull: "You the health authority were responsible for my care: you are responsible if there is a breakdown, reasonably attributable to improper practice in the systems used at your hospital for communicating material information to the clinicians responsible for my care: and I was injured as a result of this negligence".*

[83] I would wish to apply those findings to the present case thereby determining that it is indisputable that there was a significant breach of duty on the part of the Defendant. Following Slade LJ in Bull, in my judgment the Claimant has succeeded in proving by the ordinary civil standards of proof, that the failure to provide for the deceased the prompt attendance that he needed was attributable to the negligence of the Defendant in implementing an unreliable and essentially unsatisfactory system for summoning the on call surgeons.

Causation

[84] It is the argument of Counsel for the Claimant that it must be taken to be accepted that the risk of death to the deceased if the Defendant breached the duty of care owed to the deceased was reasonably foreseeable.

[85] Counsel acknowledges that the burden of proof of causation rests with the Claimant on a balance of probabilities and that the breach caused or materially contributed to the injury.

[86] Counsel submits that the Defendant's own expert admitted that the deceased's chances of survival if proper care had been provided at the Victoria Hospital within a reasonable time would have been at least 89%. Further according to Dr. King's post mortem report the `deceased had a "fair chance" of survival if early intervention to correct shock and arrest the bleeding had been performed. Counsel states that what is clear is that by the time the deceased arrived at the Tapion Hospital he had virtually bled to death, with very little if any chance of survival. The cause of death according to Counsel is not in dispute, the Defendant having admitted same in the Defence. Accordingly not only was the Claimant absolved of proof of this issue but adequate evidence was admitted as to that issue by Dr. King whom the Defendant also used as expert as to cause of death.

[87] Counsel for the Defendant contends that the question of causation is one of fact to be considered in light of all of the circumstances and possibilities of the case. Upon consideration of all of the evidence there had been no breach of duty on the part of the

Hospital that can be linked to the death. There was no common law duty on the part of the Hospital in respect of the omission to perform surgery, nor was there any breach of duty of care in relation to the treatment and care that it provided for the deceased's injuries.

Findings

[88] As stated by Counsel for the Claimant, it is incumbent upon the Claimant to establish on a balance of probabilities that the Defendant's negligence/breach of duty caused or materially contributed to the deceased's death.

[89] The House of Lords held in Bonnington Castings Ltd v Wardlaw (1956) AC 613 that the Claimant does not have to prove that the defendant's breach of duty was the sole or even the main cause of damage, provided he can demonstrate that it made a material contribution to the damage, that anything which did not fall within the principle de minimis non curat lex contributes a material contribution.

[90] However, before a reference can be drawn that the defendant's breach of duty made a material contribution, there must be some evidence to link the defendant's breach of duty to the Claimant's harm other than the simple assertion that it increased the general risk of harm.

[91] In Tahir v Haringey Health Authority (1998) Lloyds's Rep. Med 104 the Claimant alleged that the delay in providing medical treatment rendered his condition worse than it would otherwise have been, on the basis that, in general terms, delay in operating in his type of

case increases the neurological defect and impairs the prospect of recovery. The Court of Appeal held that where there has been negligence in delayed medical treatment, it was not sufficient for the Claimant to show that there was a material increase in the risk or that delay can cause damage. He has to go further and prove that some measurable damage was actually caused by the delay.

[92] Thus it is not enough in our case to show that the Defendant's non transfusion of blood, and non performance of surgery increased the likelihood of the deceased's death and may have caused it. It must be proved on a balance of probabilities that the Defendant's inability to transfuse the blood and perform the surgery did cause the decedent's death in the sense that it would not otherwise have happened: see Lord Hoffman in Barker v Corus (UK) plc (2006) 2 WLR 1027.

[93) Dr. King in his post mortem examination report gave as the cause of death – haemorrhagic shock secondary to a stab wound in the right lumbar area. In his opinion there was a fair chance of survival if early intervention to arrest the bleeding and correct the haemorrhagic shock were taken.

[94] Professor Walrond, although he prefaced his opinion by stating that the percentage chance of survival depended on the exact nature of the injury, the skill of the surgical team and the facilities available, indicated that with injuries of this nature, the chances of survival would be 89%.

[95] Dr. Daniel estimated the chances of survival at about 95% if the deceased had received immediate surgical care.

[96] It therefore having been agreed that the deceased's chances of survival were optimal and it having been established that the Defendant was in breach of its duty to the deceased, where then is that evidence that links the Defendant's breach of duty to the Claimant's harm in order to determine that the Defendant caused the death.

[97] I am of the view that it began with the Defendant's delay in accommodating the family's request for a transfer of the deceased to an alternative facility when it registered with the family that the Victoria Hospital was unable to perform the surgery due to the unavailability of the surgeons. I accept the evidence of the Claimant and her witnesses that they made their request at around 2:00 a.m. and that they personally made the arrangements for the transfer which eventually occurred at 3:30 a.m. Dr. Newton for the Defendants, one of the Accident and Emergency doctors, stated that it did occur to him that "at some time we would need to request a transfer to another facility" but initially when the request was made by the family for the transfer, the deceased's blood pressure was too low and a pulse rate could not be obtained.

[98] It is to be noted that there were few areas of dispute between the parties. One such was the time of arrival by the deceased to the Victoria Hospital. While from the evidence it is not possible to state the precise time of arrival, I am more inclined to accept that time as

being “around 1:00a.m.” as given by the Claimant and her witnesses than to place reliance on the hospital records which put the time at 1:30p.m.

[99] It is the evidence of Dr. Gossai of the Accident and Emergency Department that the notes as recorded by the nurse at that department and produced in evidence were made after the deceased had left the Victoria Hospital. She indicated under cross examination that she was not sure if the nurse’s notes were different from hers and when one reading by the nurse of the deceased’s vital signs was pointed out to her, she was adamant that the nurse’s notes were incorrect. For her part she compiled her own records from a “group of papers” and from notes “scribbled” on a piece of paper she had in her possession. She also stated that she got the time of arrival of 1:30 a.m. from another colleague, either a nurse or doctor, she was not sure. She accepted that she was unable to dispute the telephone operator’s records but that she knew that the time of arrival was some time after 12:00.

[100] It is clear to me that the records collated on behalf of the Defendant using 1:30 a.m. as the time of arrival would have been based on a timeline which I consider unsafe to accept. I am of the view that the time of 1:30 a.m. was produced by the Defendant’s witnesses in order to represent that the deceased was in the care of the hospital for no more than two (2) hours rather than in excess of the two and a half (2 ½) as borne out by the Claimant, principally because of possible implications for the Defendant’s case.

[101] Professor Walrond, while acknowledging that there were several inconsistencies in the reports submitted to him particularly in relation to timelines, admitted that he based his expert report on those timelines, proffered by the Defendant's witnesses which in my view would in turn have implications for his observations and conclusions.

[102] In Rhodes v Spokes and Farbridge (1996) 7 Med LR 135 Smith J said :

> *" A doctor's contemporaneous record of a consultation should form a reliable evidential base ... The failure to take a proper note is not evidence of a doctor's negligence or of the inadequacy of treatment. But a doctor who fails to keep an adequate note of a consultation lays himself open to a finding that his recollection is faulty and someone else's is correct. After all, a patient has only to remember his or her own case, whereas the doctor has to remember one case out of hundreds which occupied his mind at the material time".*

[103] Apart from being ad idem on the need for a blood transfusion and surgery, the views and opinions of the medical experts with respect to the outcome of the case diverged somewhat. The court thus faced with these alternate views must state on the balance of probabilities which is preferable.

[104] The legal authorities indicate that the assessment of medical risks and benefits is a matter of clinical judgment which a judge would not be able to make without expert evidence

(Lord Browne – Wilkinson in Bolitho v City and Hackney Health Authority (1997) 4 AER 771) but the judge must refrain from using a preference for the practice of one body of respectable medical opinion over another as a basis for making a determination of medical negligence:

> *"It is not enough to show that there is a body of competent professional opinion which considers that there was a wrong decision if there also exists a body of professional opinion equally competent which supports the decision as reasonable in the circumstances"*

- per Lord Scarman in Maynard v West Midlands Regional Health Authority (1984) 1 WLR 634.

[105] However it is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed (Lord Browne – Wilkinson in Bolitho (supra). For as stated by Bingham LJ in Eckersley v Binnie (1988) 18 Con LRI:

> *"In resolving conflicts of expert evidence the judge remains the judge, he is not obliged to accept evidence simply because it comes from an illustrious source, he can take account of demonstrated partisanship and lack of objectivity. But save where an expert is guilty of a deliberate attempt to mislead (as happens only very rarely), a coherent reasoned opinion*

expressed by a suitably qualified expert shall be the subject of a coherent reasoned rebuttal, unless it can be discounted for other good reason".

[106] The court also has to bear in mind the warning given by Lord Bridge of Harwich in Wilsher (supra):

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

[107] There was a measure of common ground with respect to the issuance of blood - a factor which weighs quite heavily into the Claimant's case.

[108] Professor Walrond under cross examination considered that "the issuance of blood was important surrounding the death of Mr. Norville".

[109] The Doctors all agreed that a blood transfusion was useful but if blood was transfused into the deceased without surgical intervention it may have resulted in fatal consequences as surgery was necessary to stop the bleeding and because a transfusion on its own would not stop the bleeding. Professor Walrond noted that transfusion of blood without surgery

would not have made a great deal of difference. "What this patient needed was surgery and this would have been better with transfusion at time of surgery". The other doctors agreed with him that it is best to transfuse the blood immediately before and during surgery.

[110] Dr. St. Rose for the Defendant indicated in his report that he would have been "of help" at 5:45 a.m. if the deceased had been adequately transfused on arrival at the Accident and Emergency Department. Professor Walrond was however not in agreement with this view:

> *"To have transfused a patient from 1:30a.m. to 5:45 a.m. would mean a lot of blood but it would only have worked if the patient had stopped bleeding. You would have been running into massive transfusion especially if you were using stored blood and that would have its own its own complications. It would not have been prudent to transfuse a patient for that length of time. There is a great deal of difference of opinion with respect to a patient to be transfused in the absence of a surgeon. It is best to give the blood immediately before and during surgery".*

[111] From the evidence adduced and the medical opinions expressed, I am satisfied that in any event the blood transfusion even if blood were available could not take place since the Accident and Emergency medical team was neither equipped nor qualified to administer it.

[112] It was also made clear that the administration of crystalloids fluids on arrival at the Victoria Hospital albeit the correct procedure was a mere "stop gap" measure. In the words of Professor Walrond use of saline keeps the blood volume up but only in cases where the patient is not bleeding profusely. "When you bleed, you are bleeding out your red blood cells, your haemoglobin is still high but when you start putting in saline, it dilutes the concentration and although it has been known that people have been resuscitated even after three (3) hours from the start of saline, the longer you go, the less chance you have of surviving". This opinion was echoed by Dr. Daniel for the Claimant but in rather more graphic terms:

> *"If a bucket has red dye and you pour in water, then after a point, the solution which pours out is no longer red.... It would be tantamount to putting water in a bucket with a hole without blocking the hole".*

The evidence revealed that the deceased continued to bleed throughout his stay at Victoria Hospital.

[113] It is the opinion of the medical experts that immediately on arrival of the deceased at the Victoria Hospital in a state of hypovolemic shock the Accident and Emergency doctors ought to have made the request for blood. The evidence reveals that the deceased remained in the Accident and Emergency for in excess of one (1) hour before the Accident and Emergency doctors made the request. In the opinion of Professor Walrond a delay of one (1) hour between a patient arriving needing surgery and a request for blood is "not good enough".

[114] It is what transpires thereafter which also gives cause for concern.

[115] Ms. Grose, the medical technologist, stated that at 2:15 a.m. she received two (2) requests for blood. The request form lists the request as having been made at 2:00 a.m.. There was no explanation given by the Defendant for the delay of fifteen minutes before the form was handed to the medical technologist. One of the forms was labelled “desperate” and indicated it was for the deceased. Despite this label of “desperate”, according to Ms. Grose, she processed the two (2) requests together because there were no instructions given that she should process one in priority to the other and in keeping with Victoria Hospital policy that all blood has to be crossmatched whether or not the doctor had requested uncrossmatched blood. Mr. Grose admitted under cross examination that she understood the term “desperate" to mean that the blood was needed at once. She felt that if blood is needed in a hurry, it would be the person making the request to contact her. After the request for blood was made no one contacted her nor did she contact the Accident and Emergency Department at any time to inform them of the trouble she was having with the crossmatching. Under reexamination she stated that after crossmatcing the blood when she realized that the blood was incompatible, the deceased was already being transferred Tapion Hospital and she saw no need to call the Accident and Emergency to inform them that the blood was incompatible.

[116] It was made clear to me that Ms. Grose had no regard for or plainly disregarded the urgency of the situation although she acknowledged the process of crossmatching of blood

takes approximately one (1) hour. It is my view that while Ms. Grose may be competent at her job, her nonchalant reaction to the "desperate" request did not augur well for the situation. In fact it exacerbated the situation when she was unable to provide the Tapion Hospital with the much needed blood and in sufficient quantity to save the deceased's life. This nonchalance was made evident even during her testimony.

[117] The disparity in timelines referred to by Professor Walrond in his report was also clearly indicated in the circumstances surrounding the issuance of the blood.

[118] It is accepted by all that the deceased arrived at Tapion Hospital at 3:30 a.m. On his arrival there was an immediate call for blood by the Tapion Hospital personnel. From the evidence of Dr. Daniel, which I accept, he was advised that it would take another twenty minutes before blood could be available. When he asked for whatever blood was available, he was further advised that there had been a problem with the crossmatch and it would be another ten (10) minutes to complete the crossmatch.

[119] Although Dr, Daniel admits to not knowing when the blood actually arrived at Tapion Hospital, that hospital's records show it was 4:00 a.m. In my estimation the computation of time does not accord with the testimony of Ms. Grose that she took the blood to the Tapion Hospital at 3:35 a.m. if she received the request from Victoria Hospital at 2:15 a.m., and it took her about one hour to process and having encountered problems with the crossmatch having to redo the process. It would seem that having indicated to Tapion Hospital that there would be another half hour delay, the time falls closer to the 4:00 a.m.

record which Tapion Hospital indicated for the receipt of blood from Victoria Hospital and the commencement of the transfusion. Professor Walrond in cross examination suggested that:

> *"most labs take half hour to forty five (45) minutes to perform the first crossmatch and if there is incompatibility (as there was in this case) it would take about the same time since the process is the same". He continued that "in light of the request if fresh frozen plasma was available they should have sent it immediately because that would only have taken as long as looking to see whether it was there"*

[120] Using Professor Walrond's equation, it is 90 minutes to perform the crossmatch and recrossmatch. Thus, if one considers that the process began at 2:15a.m. Ms. Grose would not have been able to complete by 3:35 a.m. as she avers. The earliest time she could have completed the process would be 3:45 a.m. Similarly when one takes into account that the deceased left Victoria Hospital at 3:30 a.m. and according to the accepted evidence, an immediate request was made by Tapion Hospital to Victoria Hospital for blood and a 30 minute delay was indicated, the blood could not have reached Tapion Hospital at 3:35 a.m.

[121] It was also indicated by Dr. Daniel that only two (2) units of blood was received from Ms. Grose and this would have been inadequate to resuscitate the deceased given the amount of blood loss. Professor Walrond concurred with this view:

"It appears the blood was not enough - two (2) units were not sufficient for his injuries. Again from the report - the rapidity with which the circulation disappeared and could not be repaired - I cannot say that any more blood would have made a difference".

[122] The evidence also revealed that the blood bank at the Victoria Hospital is the national blood bank which services all requests for blood throughout the Island and so Tapion Hospital had to await production of the blood from Victoria Hospital because as stated by Dr. Daniel, a request for blood by Tapion Hospital has nothing to do with a request from Victoria Hospital.

[123] With this in mind I am therefore unable to accept the contention of Counsel for the Defendant that the obligation of the Defendant lasted only up to the time the deceased was handed over to Tapion Hospital. I am satisfied that the Defendant being the national and only supplier of blood and having undertaken to provide the much needed blood had a continuing duty and obligation to the Claimant to ensure prompt and adequate provision of blood.

[124] The deceased's blood loss was adjudged by all of the experts to be severe. Dr. King related that the average human has about five (5) litres of blood in his body. He estimated that to be in hypovolemic shock on arrival at Victoria Hospital, the deceased would have lost 1.5 to 2 litres. Taking into account that this blood loss continued throughout his two

(2) or more hours stay at Victoria Hospital without the benefit of a transfusion, by the time he arrived at Tapion Hospital he would have lost approximately 4.2 litres. Dr. King related that his examination showed that there were 2.2 litres in the chest cavity, blood in the back of the abdomen in the tissue. He said it would be difficult to assess that volume but it could be another 1.5 litres. He said that these volumes did not include blood before arrival at Victoria Hospital, in the bedsheets or in the urine. He thus gauged the deceased's chances on arrival at Tapion Hospital as negligible. Dr. Daniel stated that on arrival at Tapion Hospital the deceased was passing blood per rectum which implied that he was having massive ongoing bleeding into his gastro intestinal tract.

[125] In the premises I determine the lateness of the request for blood by the Accident and Emergency doctors compounded by consequent late processing of the blood, its late production and inadequate supply to the surgical team at Tapion Hospital to be evidence of the continuing negligence on the part of the Defendant sufficient to materially cause the death of the deceased.

[126] The medical experts were not in total agreement with respect to the significance of the last recording by Victoria Hospital of the vital signs of the deceased before his transfer to Tapion Hospital at 3:00 a.m. These readings were blood pressure: 114/72, pulse rate 75 and respiratory rate 38. It was explained that in a relatively fit male of the deceased's age normal blood pressure is 110/60, pulse rate 52 and over and a respiratory rate of 14. The nurse's notes produced in evidence gave the following readings:

TIME	BLOOD PRESSURE	PULSE RATE	RESPIRATORY RATE
1:30 a.m.	80/40	Nil	36
1:55 a.m.	80/50	117	36
2:10 a.m.	85/48	117	36
2:40 a.m.	80/52	113	32
3:00 a.m.	114/72	75	38

In his report Professor Walrond concluded:

> *"Using the (Trauma Injury Severity Scoring System of Champion et al) his chances of survival would have improved at the point when he left Victoria Hospital for the Tapion Hospital. However the scoring systems do not factor in the delay of about 3 to 4 hours between the injury and the 2 hours of documented shock before he left for the Tapion Hospital and this period of shock would have negated any temporary improvement in the blood pressure and pulse".*

He stated in his report that these last vital readings suggested a reasonable cardiovascular balance when the deceased was moved to the Tapion Hospital.

[127] Under cross examination he admitted that a single reading did not indicate a significant improvement but he did not think it was necessary that "when you are coming to an end stage that there is a paradoxical improvement". He continued:

> *"If the blood pressure reading is correct: 114/72 and the pulse rate is 75 when you get the paradoxical sympathetic response it causes the blood pressure to go up and also the pulse to speed up. Then you see that the blood pressure and the pulse slow, the patient is improving. I would therefore not consider that he was improving or that he was on end stage of shock – not on the one reading".*

[128] Dr. Daniel expressed the view that these last vital readings from Victoria Hospital involved a number of issues e.g. the deceased's legs had been elevated and if his legs were lowered his blood pressure would drop. He stated that a patient in prolonged shock as the deceased was can momentarily seem to have what is a normal pressure but this does not last and so one has to take account of the clinical signs rather than the blood pressure reading. He indicated that when the deceased arrived at Tapion Hospital his blood pressure was 70/30 and his pulse rate was 124 per minute and he was gasping.

[129] Dr. King stated that having regard to the fact that only crystalloid fluids had been administered while the deceased was at Victoria Hospital and there had been no transfusion or surgical intervention this last reading was out of context and much weight could not be put on it in terms of interpretation. The deceased arrived at Victoria Hospital

in stage 3 shock and remained in sustained shock during his stay, his status was never reverted to normality. He agreed with Professor Walrond that between the time of arrival and 2:40 a.m. the vital signs did not improve nor did they deteriorate but were maintained.

[130] Dr. Gossai of the Accident and Emergency Department sought to contend that the deceased while in her care was improving by the fact that stability was maintained and the vital signs were improving: "The mere fact that it wasn't getting any worse means that he was improving, stabilization implies improvement".

[131] Dr. Jerome also of the Accident and Emergency Department on the other hand stated that there was never a time when he could say there was a significant improvement. He could not say that there was a point in time when the pulse rate was normalized. He attributed the increase in blood pressure at 3:30 a.m. when the deceased was leaving Victoria Hospital to the elevation of the bed and the administering of IV fluids.

[132] Professor Walrond in his report while admitting that he did not know the distance or the terrain, was concerned at the rapid transfer between the two (2) hospitals – the records indicate one (1) minute - and the trauma which might have occurred in a rough transfer. Dr. King was however of the view that the short distance between the two (2) hospitals over reasonable roads could not have affected the vitals.

[133] Taking into account the court's conclusion with respect to the unreliable state of the nurse's notes and the views expressed by Drs. King and Daniel and even Professor Walrond's

initial reaction in his report, I am of the view that the recording of these vital signs must be disregarded and I hold that the deceased left the Victoria Hospital in a state of shock with below normal vital signs.

[134] Professor Walrond suggested in his report that the deceased's chances wherever he was operated on – Victoria Hospital or Tapion Hospital – would have been improved by having a chest tube placed and his blood pressure restored if possible before operation.

[135] The testimony of Dr. Daniel who had actual management of the case at Tapion Hospital was that on arrival at Tapion Hospital the deceased was in full blown shock and began having gasping aspirations, an event which is normally a pre death event for a patient in the deceased's state. He declared that the deceased was intubated only after he began gasping and he was quickly transferred to the operating room

[136] Dr. King's opinion was that failure to put in a chest tube would not at that stage – time of surgery at Tapion Hospital - have made a significant difference although it would have given a better assessment of the volume of blood lost.

[137] When cross examined about the significance of gasping Professor Walrond admitted that he did not know what may have happened e.g. the patient may have vomited or aspirated and therefore the significance of gasping could mean a number of different things but if there is any injury to the chest and there is sufficient oxygenation the person goes into irreversible shock.

[138] Professor Walrond made the following observation in his expert report:

> *"In the timeline recorded by the hospital administrator at the Tapion this patient could have died from his haemorrhage by the sudden drop in cardiac output form the combination of the anaesthetic used, a tension pneumothorax and rapid bleeding form something like the inferior vena cave when the abdomen was opened and sufficiently rapid action was not taken to tamponade the bleeding".*

[139] Both Drs. Daniel and King refuted this conclusion with respect to the tension pneumothorax. Dr. Daniel stated that the deceased having been intubated only after he began gasping it was unlikely that tension pneumothorax from ventilating him was responsible for this event. Dr. King confirmed that when he performed the autopsy he did not find any evidence of tension pneumothorax, that the injury did not pierce the chest cavity and so there was no danger of injury to the lung. It was more fully explained by Dr. Daniel in his expert report. He indicated that Professor Walrond's assertion could not be supported for the following reasons:

> *(a) the post mortem report does not record an injury to the lung parenchyma which is a prerequisite for tension pneumothorax from positive ventilation as he purports. This implies that although the knife traversed the pleural cavity there was no injury to the lung.*

(b) None of the physicians who examined the patient's chest found any evidence of a pneumothorax. The diaphragmatice wound was noted at laboratory (surgery) and a post mortem and a more likely explanation for the blood in the thorax and the collapsed lung would be that the blood flowed by gravity from the abdomen after the omentum plugging the hole in the diaphragm was removed. The lung likely collapsed after ventilation was discontinued due to its natural elasticity and air entering the chest cavity through the said hole in the diaphragm and lower chest wall.

[140] There was also discussion about the output of urine – 200 mls – recorded by Tapion Hospital.

[141] Professor Walrond in his evidence at trial stated that he believed that this was the urine output over the two (2) hours that the deceased was at Victoria Hospital, the catheter having been put in there and at 100 mls per hour, this indicated that there was satisfactory profusion of his kidney. If the profusion of the kidney was not satisfactory then the urine output would be 30 mls per hour or less. This he explained indicated that the measures that had been instituted were allowing adequate profusion of the kidneys because in a shocked state when the blood is redistributed in order to preserve vital functions, one of the first organs to be shut off is the kidneys.

[142] Dr. Daniel on the other hand reasoned that the use of saline would have affected the production of urine. He argued that blood gets thinner as saline is introduced and so the pressure from the kidneys to filter is less and so it is possible for more urine to be produced. He recalled that the deceased arrived at Tapion Hospital at 3:30 a.m. and 200 mls of urine in four or more hours would mean that the kidneys were functioning but that this record did not indicate a timed procedure and so it would have to be queried whether the output was from the time he arrived at Victoria Hospital. This in my view is the reason which this court must accept.

[143] It is left to the Court to decide whose evidence to accept giving reasons for the preference. It must be stated here that it has been established that where there is an issue of causation such as whether treatment which was not given could have cured the patient or otherwise reduced or avoided injury, a dispute between the experts does not involve the Bolam test (supra). In Fallows v Randle (1987) 8 Med LR 160 Stuart – Smith said:

> *"In my judgment that principle (Bolam) has really no application where what the judge has to decide is, on balance, which of two explanations for something which undoubtedly occurred ……..is to be preferred. That is a question of fact which the judge has to determine on the ordinary basis on a balance of probability. It is not a question of saying whether there was a respectable body of medical opinion here which says that this can happen by chance without any evidence, it is a question for the judge to weigh up the*

evidence on both sides, and he is, in my judgment, entitled in a situation like this, to prefer the evidence of one witness to that of the other".

[144] Having sifted through the evidence and contemplated the observations and conclusions of the medical experts I prefer to accept the conclusions given by Drs. Daniel and King for while the esteem with which Professor Walrond is held in the medical field as a consequence of his extensive knowledge, experience and expertise has to be acknowledged, his opinions in the present case though weighty have been largely theoretical and hypothetical and based on reports and inaccurate records submitted by the Defendant. Drs. Daniel and King on the other hand, themselves experts in their own fields, have had the benefit of actual and "intimate" contact and management of the case. Dr. Daniel conducted the final surgery and Dr. King the autopsy. In my view their conclusions based on the aforesaid are more consistent, rational convincing and substantial. They have succeeded in assisting the Claimant to prove on a balance of probabilities that necessary causal link by the Defendant to the deceased's death and which the Defendant was unable to disprove.

[145] Reference is made to the dicta in the case of McGhee v National Coal Board (1973) 1 WLR that where a claimant has been injured as a result of a state of affairs and the defendant's negligence had been such as to bring about the state of affairs, then the defendant was liable unless he positively disproved any connection between his fault and the damage suffered. Thus in a case where it is clear what state of affairs caused the injury but unclear who had brought about that state of affairs, the burden of proof was on the defendant to

exculpate himself if he could. (see Fairchild v Glenhaven Funeral Services Ltd (2003) 1AC 32). Such however was not the situation in the present case. The Claimant has succeeded in proving to the satisfaction of the court that the Defendant's negligence on a balance of probability caused the death of the deceased.

[146] In the circumstances I find myself obliged to hold that the deceased's chances of survival initially regarded as optimal were significantly compromised due to the negligence of the Defendant in its delay and subsequent inability to provide definite surgery to stem his haemorrhage. Had the deceased received the needed competent resuscitative treatment and surgical intervention at the Victoria Hospital, he should have survived. Even with adequate facilities at the Tapion Hospital (the Defendant has not proved otherwise) but with no support through the provision of blood to replace his ongoing haemorrhage, the deceased lost his chance of survival.

[147] I would wish at this juncture to consider the concept of loss of a chance.

[148] It has been established by the legal authorities that in medical negligence cases, the possibility in claiming for a lost chance normally arises in the context of a failure by the defendant to treat the claimant adequately or in time as a result of which the claimant has lost a chance of recovery or other beneficial outcome.

[149] In Hotson v East Berkshire Area Health Authority (1987) 1 AER 210 the claimant fell and injured his hip. The defendants' negligence resulted in a delay in treatment as a result of

which the claimant developed a disability. The evidence established that even had he received prompt and proper treatment there was a 75% likelihood that the disability would have occurred. The House of Lords decided that the claim failed because the finding of fact that there was only a 25% chance that any treatment would have been beneficial in preventing the disability was equivalent to a finding that the claimant had not proved on the balance of probabilities that the defendants' negligence had caused the resulting disability.

[150] In the later case of Gregg v Scott (2005) WLR 268 the defendant negligently failed to refer the claimant for specialist cancer treatment with the result that his cancer was not diagnosed until about 9 months after it should have been. The trial judge found that the negligent delay reduced the claimant's chances of survival from 42% to 25% and it was therefore not possible to conclude, on the balance of probabilities, that earlier treatment would have affected his chances of survival. Both the Court of Appeal and the House of Lords agreed, with regard to the loss of a chance argument. It was pointed out (Lord Hoffman and Lady Hale) that before one gets to the stage of quantification, the causal connection between a tort and consequential loss of any kind has to be proved on a balance of probabilities. The ratio of the case was that where a claimant has suffered a loss of a chance of recovery as a result of medical negligence, but the chance is less than evens, the claimant is not entitled to compensation for that lost chance.

Lord Hoffman surmised :

> *The law regards the world as, in principle, bound by laws of causality. Everything has a determinate cause, even if we do not know what it is. The blood starved hip joint in Hotson, the blindness in Wilsher the mesothelioma in Fairchild; each had its cause and it was for the plaintiff to prove that it was an act or omission for which the defendant was responsible ….. The fact that proof is rendered difficult or impossible because no examination was made at the time, as in Hotson or because medical science cannot provide the answer, as in Wilsher, makes no difference. There is no inherent uncertainty about what caused something to happen in the past or about whether something which happened in the past will cause something to happen in the future. Everything is determined by causality. What we lack is knowledge, and the law deals with lack of knowledge by the concept of burden of proof.*

[151] The case at bar can be distinguished from the "loss of a chance" cases. The deceased suffered an injury which the evidence reveals that he had an optimal chance of overcoming. His diminution of a chance of survival was not exacerbated by any extrinsic circumstances, any debilitating disease which would ultimately result in death or disease, like the cancer in Gregg or the onset of vascular necrosis in Hotson. This case was "cut and dried", it did not involve a hypothetical question of what would have happened had the deceased been appropriately treated. There were "no inherent factors in his genetic makeup or subsequent events outside the control of the defendant". It is also quite possible to say what the outcome for the deceased would have been were it not for the

Defendant's negligence and the Claimant was able to show on a balance of probabilities that the Defendant's negligence caused the death.

Res ipsa locquitur

[152] The Claimant relied in the alternative on this principle in proof of negligence against the Defendant.

[153] Counsel for the Defendant referred to paragraph 57 of Volume 34 of Halsbury's Law of England 4th edition which explains the principle. Counsel concluded that based on that explanation because the cause of death was known and because at the time of death the Victoria Hospital was not in control of the events that caused the death and it was not responsible for the acts of all the persons who treated the deceased prior to his death, that the principle was inapplicable. Counsel noted that the evidence showed that the deceased was transferred to Tapion Hospital about 3:30 a.m., that upon arrival there, emergency room team doctors and nurses assumed responsibility for treatment and care, that soon after commencement after surgery, the deceased went into cardiac arrest and was pronounced dead at 5:00 a.m. Counsel concludes that there is no evidence to show that at any time after Tapion Hospital assumed responsibility for the deceased that Victoria Hospital was responsible for any acts of any persons who treated the deceased.

Findings

[154] I am not convinced that reliance upon the principle advances the Claimant's case although I am of the view that it could be applied.

[155] The principle is applicable where "the circumstances are more consistent, reasonably interpreted without further explanation, with ……negligence than with any other cause of the accident happening". The court is in any event entitled to make an inference as at how an accident happened upon the evidence before it and if the evidence that is given permits a reasonable inference to be drawn as to the cause, the court in drawing such an inference is not applying the principle for the principle only applies where the cause cannot be specified, whether upon direct evidence or by inference.

> *If the facts are sufficiently known the question ceases to be one where the facts speak for themselves, and the solution is to be found by determining on the facts as established, if negligence is to be inferred or not, per Lord Porter in Barkway v South Wales Transport Co., Ltd (1950) 1 AER 392.*

[156] As I have indicated earlier (see para 60) I accept that there was no prima facie negligence on the part of the emergency care doctors at the Victoria Hospital they having initially acted "in accordance with a practice accepted at the time as proper by a responsible body of medical opinion". However as I also indicated I cannot accept the suggestion that the Defendant's liability ended on transfer of the deceased to Tapion Hospital because, without recounting the events before and after 3:30 a.m. I am fully satisfied that the Claimant has proved on a balance of probabilities that the combination of events were a continuation of the negligence of the Defendant i.e. the non provision of a transfusion, an

inability to operate and the inordinate delay in the processing and provision of blood for which the Victoria Hospital as the national blood bank was solely responsible.

[157] The phrase "prior to death" as used by Counsel for the defendant cannot in the circumstances be confined to the period 3:30 a.m. to 5:00 a.m. because as it was shown the chain of events prior to the death was set in train by the negligent acts of the Defendant and continued even after the transfer to Tapion Hospital.

[158] In light of the foregoing and because I am satisfied that the Claimant has proved all of the necessary ingredients of liability and causation, judgment is entered for the Claimant.

[159] Counsel are now invited to submit by 20th June, 2008 their submissions with respect to quantification of damages

SANDRA MASON Q.C.

HIGH COURT JUDGE