EASTERN CARIBBEAN SUPREME COURT
TERRITORY OF THE VIRGIN ISLANDS

IN THE HIGH COURT OF JUSTICE
(CIVIL)

Claim No. BVIHCV 2013/0163
BETWEEN:

RAWLE HANNIBAL

Claimant

And

THE BVI HEALTH SERVICES AUTHORITY

Defendant

Appearances: Mr. Sydney Bennett QC with him Ms. Anthea Smith for the Claimant
Mr. Terrence Neale of Mc W. Todman Chambers for the Defendant

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2017: February

JUDGMENT

[1] Ellis J.: Before this Court is a medical negligence claim brought by the Claimant, Rawle Hannibal, against the Defendant, The BVI Health Services Authority, a statutory authority responsible for the administration of public health in the British Virgin Islands ("the Authority"). The Claimant alleges that the employees of the Authority were negligent in their treatment during his stay at the Peebles Hospital. The particulars of negligence alleged by the Claimant include the following:

i. Failure to provide competent and sufficiently experienced staff on duty capable of managing and controlling the Claimant's condition appropriately or properly.
ii. Failure to observe the minimum protocol for initial treatment of patients presenting symptoms of emergent transient ischemic attack (TIA)
iii. Failure to afford the Claimant's immediate access to neurological expertise.
iv. Waiting until 7:00 p.m. on December 17, 2012 some 19 hours after diagnoses to admit the Claimant to the Intensive Care Unit of the hospital.

v. Failure to control the Claimant's hypertension so as to decrease the risk of recurrence of a T.I.A. or the occurrence of a stroke.

vi. After ascertaining from the computed tomography (CT) scan that there was no hemorrhage or space occupying lesion within his brain.

i. Failing to undertake immediate treatment with anti-platelet drugs such as low dose aspirin, Plavix, or Dipyrimadole (Persantin)

ii. Failing to immediately commence thrombolytic therapy on the Claimant

iii. Failing to administer tissue plasminogen activator (TPA) to the Claimant as quickly as possible in the circumstances or at all.

vii. Failure to treat the Claimant's condition in a timely and appropriate manner or at all.

[2] At the trial, the Claimant gave evidence on his own behalf. He also relied on the expert testimony of Dr. Marjorie Yee-Sing. The Defendant relied on the evidence of Dr. June Samuel given in her capacity as the Chief of Medical Staff and the Defendant's hospital. She indicated that she reviewed the medical records and files pertaining to the Deceased. The Defendant also relied on the expert testimony of Dr. Richard Hardie.

The Claimant's Case

[3] The Claimant contends that had the Defendant's employees taken reasonable care in administering urgent and active treatment with respect of the TIA, his condition would probably not have deteriorated to the extent that he suffered a right cerebral vascular accident within 24 hours of his admission to the hospital. Indeed, he states that even if such an event had occurred, he would probably have recovered from that event with little to no disability within 3 months of the occurrence of the same.

[4] The Claimant further contends that as a result of the Authority's negligence he has suffered loss and damage. He seeks unspecified general damages for pain and suffering and loss or amenities as well as special damages in the sum of $70,635.

[5] The Claimant's factual recount commences at about 3:00 a.m. on 17 December 2012, when he attempted to rise from his bed at his home at Fort Hill, Tortola but instead fell to the floor. Although he made several attempts to stand up he was initially unable to do so. He experienced a

pronounced weakness on the left side of his body and an unusual sensation in his head. After an interval some feeling and strength returned to his left side and he was able to dress and drive to the Defendant's hospital.

[6] He arrived at the Hospital at 3:30 a.m. but it was only at 4:00 a.m. that he was seen in the emergency room by Dr. Ojobor a physician who after administering a number of tests, made a provisional diagnosis of TIA – mild cerebra vascular accident (CVA) with (L) hemiparesis.

[7] The Claimant contends that he should have been closely monitored, but instead he was placed on trolley in a passage of the Emergency Room, out of sight of nursing staff. At 4:50 a.m. the Claimant underwent a brain scan which showed no hemorrhage. At 5:33 a.m. Labetalol, a drug used to control hypertension (i.e. high blood pressure) was given intravenously. At 6:24 a.m. Tramadol and Gravol were also administered. The Claimant contends that these are narcotic drugs which should not be administered to a person showing signs of TIA as they could mask the symptoms of a subsequent TIA or CVA.

[8] At 7:00 a.m. a blood glucose test was administered. At 7:18 a.m. the medical notes reflect that the Claimant's speech was slurred and that he appeared drowsy. At 7:39 a.m. the Claimant was given Metoprolol 50 mg and Nifedipine 10 mg to control hypertension and Daimicon and Metformin, to control blood sugar.

[9] At 8:00 a.m. the Claimant was found on floor, having fallen off the trolley. He contends that the fact that no one observed this incident demonstrates that he was not being closely monitored as he should have been. The nursing notes states:

> *"Client fell down at bedside (heard thud) Patient found on floor. Body partly on floor, buttock and legs on the floor, then the waist up was elevated in sitting position. Left injured arm is on the bottom of trolley…client stated he was attempting to hold onto bed rail when he missed and fell down…no external injury noted. Hoisted back to bed and was advised not to come out of bed without assistance."*

[10] At 8:15 a.m. the Claimant was seen by Dr. Roberts, who replaced Dr. Ojobor as emergency room doctor on duty. Dr. Roberts observed the following: an olecranon fracture ("olecranon"); query abscess left elbow and TIA. Dr. Roberts consulted medical internist Dr. Onuwaegubu (also known as Dr. Kelechi) who was in the emergency room at the time. At 8:55 a.m. Dr. Roberts consulted with Dr. Oyetunji who concluded; inter alia "possible resolved TIA". Dr. Oyetunji ordered that the

Claimant be admitted to the surgical ward for care of his elbow but according to the medical notes this was delayed because "awaiting internist physician to review for TIA and poor blood pressure control."

[11] At 9:50 a.m. Voltaren was administered to the Claimant and at 10:40 a.m. he was transferred to radiology department for a CT scan. By this time Dr. Onuwaegabu ("Kelechi") still had not arrived to attend to the Claimant despite having promised to do so. As a result, Dr. Roberts contacted Dr. Onuwaegabu at 11:05 a.m. who again promised that "he will come to see the patient….."

[12] At 13:15 p.m. the Claimant was visited by relatives. There is an indication that the Claimant's condition was improving. He was examined and there is a plan to admit him. At 13:30 His blood pressure continued to be elevated, showing a reading of 160/122 and so further review by the medical team was requested and an antibiotic was prescribed for his infected elbow. His visitors were asked to leave. At 13:35 Dr. Oyetunji of the surgical team was informed of Dr. Hannibal's condition. The record reflects that his reaction "will ask Dr. Roberts to call the medical doctor".

[13] At 13:40 p.m. Dr. Hannibal was given antibiotics but no treatment for blood pressure that was so high that visitors had to be restrained.

[14] At 2:00 p.m. Dr. Kelechi, Medical Registrar and a member of the medical team finally arrived. The Claimants case is that it is this medical team which takes the lead in controlling high blood pressure and dealing with the TIA. Dr. Kelechi observed ("IMP TIA") impression TIA: "slight mouth deviation to the right" and "left knee reflex very brisk". These are classic signs of impending stroke. The Claimant submitted that since the medical notes on admission reflect that his reflexes were normal this development demonstrated that his neurological condition was showing signs of deterioration. Dr. Kelechi's treatment plan included:

(i) Clexane, an anticoagulant which was to be given at 6:00 a.m. the next day; (pg 80 of record);

(ii) Enteric coated aspirin which was to be given at 8:00 a.m. the next day (pg 80 of record);

(iii) Metoprolol – to control high blood pressure 50 mg twice daily to be given at 5:00 a.m. next day (pg 87 of record) [in fact 100 mg was given at 8:00 p.m. that night];

(iv) Amlodipine which was given at 4:10 p.m. (pg 87 of record);

(v) Metformin for blood sugar control, administered at 8:00 p.m.

[15] The plan also called for a CT scan of Dr. Hannibal's brain *in contrast*. This was not done. None of the prescribed drugs was administered within a reasonable time given Dr. Hannibal's condition, and, despite the doctor having confirmed his impression that Dr. Hannibal had suffered a TIA; no antithrombotic treatment was given for TIA, immediately as required, or at all.

[16] At 3:30 p.m. Dr. Hannibal received antibiotic intravenously. At 3:55 p.m. it was noted that "patient appears drowsy". At 4:25 p.m. the nurse's note recorded that "patient speech appears slurred – his eyes look puffy. From the medical notes it is clear that Dr. Kelechukwu ("Dr. Kelechi") and the medical team are aware of the patient's condition' but were doing nothing about it.

[17] At 5:30 p.m. Dr. Hannibal was admitted to the Surgical Ward presumably for treatment of his elbow. Although he clearly required treatment for a TIA, this fact appeared to have been ignored by the hospital. Critically the notes reflect that there was a "slight drooping to left side of face and mouth" which the Claimant's submits is a classic sign of impending CVA (stroke).

[18] On admission to the surgical ward the nurse noted: "slight drooping to left side of face"; grip strength "slight weakness left side"; foot strength "slightly weak on left side".

[19] At 6:00 p.m. Dr. Hannibal was finally seen by medical internist Dr. Ibrahim. Dr. Ibrahim noted "probable TIA secondary to uncontrolled hypertension…" His reaction to the situation was to quadruple the dosage of Metformin from 50 mg daily to 100 mg twice daily and prescribe Linosopril 40 mg – very high dose; a diuretic Hctz and Clonidine 3 times per day. These are dramatic increases in medication to control hypertension indicating that he felt that the Claimant's hypertension needed to be brought under control and that active measures were required.

[20] Dr. Ibrahim also ordered that the Claimant to be transferred to the intensive care unit. The record shows that for the next 2 hours 55 minutes, the Claimant was left unmonitored in the surgical ward, and no vital signs were recorded. While in that ward he was given, at 8:00 p.m. Metoprolol 100 mg for high blood pressure control; and Metformin for blood sugar control.

[21] At 8:55 p.m. the Claimant was admitted to the intensive care unit. At 9:40 p.m. it was noted that "weakness of left hand present, mild weakness of left leg. Good power in right limb. Speech

slightly slurred…." And yet, the Claimant did not receive any medication in the intensive care unit until 18th December 2012, at 4:00 a.m. when he was given Voltaren 75 mg for pain in his elbow. At 6:00 a.m. his blood pressure was recorded at 202/111. It was also recorded that "patient unable to grip in left hand".

[22] On 18th December 2012, it was determined that the Claimant had suffered a right cerebral vascular accident (stroke). There are both MRI and CT scans which show an acute infarct in the right basal ganglia and corona radiate without evidence of hemorrhagic transformation.

[23] In summarizing the Claimant's case, his Counsel submitted to the Court that his client went to the Defendant's hospital at 3:00 a.m. on the 17th December 2012, because of a TIA. Every single one of the five doctors who saw him in the emergency room on that day was of the opinion that he had experienced a TIA. Not one of those doctors treated that diagnosis as requiring urgent action. Not one of those doctors gave him any specific treatment for TIA. He was admitted to the Intensive Care Unit at 8:55 p.m. on the night of the 17th December 2012, but was not attended to by any doctor in the Intensive Care Unit whether in connection with TIA or any other condition. Counsel submitted that it is difficult to see how this could qualify as "intensive care". By the time the Claimant had sustained the stroke probably before 6:00 a.m. on the 18th December 2012, he had not received any medication other than for pain nor had he been given any treatment for TIA or mild CVD, in the emergency room, surgical ward or Intensive Care Unit. This, despite the fact that a provisional diagnosis of TIA had been made since 4:45 a.m. the previous day.

The Defendant's Case

[24] The Authority launched a robust defence to the Claim in which it denied that its employees were negligent in their treatment of Claimant. The Authority contends that at all times its employees provided an acceptable standard of medical care. Moreover, the Authority contends that even if there had been a breach of duty, the medical history of the Claimant was such that this breach of duty would not have made any difference to his condition and that he would still have suffered the stroke.

[25] The Parties in this claim essentially agree on the factual chronology. However, the Authority relies on the fact that at time of the admission, the Claimant had a history of diabetes and hypertension.

They further rely on the fact that the Claimant's admission chart indicated that he had actually taken an 80 mg aspirin prior to coming to the hospital and had in fact been taking the same daily as a means of controlling his hypertension. However, the Claimant denied this when he was cross examined.

[26] The Authority asserts that the Claimant was seen by the hospital's emergency physician at approximately 4:15 a.m. who, (after carrying out certain tests) made a provisional diagnosis that he had suffered a transient ischemic attack. Having noted the Claimant's history of diabetes and hypertension, he was prescribed Metroprolol, Nifedipine and Labetalol IVPRN to reduce his blood pressure which at the time was found to be above normal. At the same time, the Claimant's diabetes was treated with Diamicron and Metaformin.

[27] The Claimant was also treated for a fractured left olecranon with Cefuroxime IV, Voltaren IM Tramadol and Gravol IM and placed on a trolley in the emergency room for further processing. At approximately 7:18 a.m. December 17, 2012, the Claimant was found on the floor of the emergency room having apparently fallen off the bed while attempting to go to the bathroom.

[28] The Claimant was examined by the hospital's Internist Specialist at 5:30 p.m. at which time the following observations were made: no cranial nerve palsy; normal tone and reflexes through-out; power on right side grade 5 and on left lower limb 4+/5 and upper left limb difficult to assess due to elbow injury. The Claimant was diagnosed as probable TIA, secondary to uncontrolled hypertension. He was thereafter immediately transferred to the Intensive Care Unit of Peebles Hospital where mediation was administered to treat his condition.

[29] On December 18, 2012, it was determined that the Claimant had suffered a right cerebral vascular stroke. He was immediately transported by air ambulance to the Jackson Memorial Hospital in Miami, Florida, United States where he was admitted to the Neurology Unit.

THE ISSUES

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

i. Whether the Authority breached its duty of care to the Claimant while a patient at the Peebles Hospital - in particular, were the Authority's servants and/or agents negligent in their treatment of the Claimant?

ii. Assuming that the Authority's servants and/or agents were negligent in their treatment of the Claimant, whether such negligence caused or contributed to the Claimant's injuries?

iii. Assuming that the Authority employees' negligence caused the Claimant's injuries, the appropriate measure of damages?

[31] The Parties in this action each chose to advance expert testimony in support of their case. The Claimant relied on Dr. Marjorie Yee –Sing MBBS, FRCS, FCCS, FACS a general surgeon and private practitioner while the Defendant relied on Dr. Robert Hardie TD MD MA FRCP, a consultant neurologist. Both experts filed comprehensive expert reports in the matter which radically disagree on crucial matters and they were each rigorously cross examined by opposing counsel.

[32] In conducting his cross examination of Dr. Yee-Sing, Counsel for the Authority sought to attack the expertise, impartiality and credibility of Dr. Yee-Sing. First he queried her level of specific experience in treating stroke patients. Dr. Yee-Sing responded that she had previously managed patients with TIA or stroke. After managing and stabilizing them, she would then refer them to an internist. She further stated that her experience would have included the management of the risk factors associated with a TIA and which would have caused a patient to later suffer a stroke. She trenchantly asserted that she is qualified to manage stroke patients and relied on her experience as the sole specialist at the Port Antonio Hospital in Jamaica where she had to see every patient and where she was trained to manage all cases.

[33] When Counsel questioned whether the best expert to opine on these matters would be a neurologist, Dr. Yee-Sing disagreed indicating that it would be unnecessary because all that is required is a review of the medical notes and documents by an individual who is trained to manage patients who have suffered TIA's and strokes. She further stated that as a general practitioner she has expertise in not only stabilizing stroke patients but also managing the risk factors that would cause a patient to become worse.

[34] When Counsel alleged that she had personal friendship with the Claimant, Dr. Yee-Sing stated that her expert report disclosed no possible conflict of interest.[1] She asserted that there is no conflict of interest because she knows the Claimant only his capacity as a senior administrator of the Hospital and in a professional capacity.

[35] Counsel then questioned her basis of remuneration. He referred to the Claimant's oral evidence that his expert (Dr. Yee-Sing) had been retained on a contingency basis. Dr. Yee-Sing testified that at the time when she was consulted by the Claimant, he had no money and so she was happy to do it. She asserted that this did not and has never affected her judgment because in her words "the truth is the truth".

[36] In continuing his challenge to Dr. Yee-Sing's impartiality, Counsel for the Defendant questioned her employment history with the Defendant Authority. She testified that she left her employment on good terms and was not at all dismayed. For that reason she did not believe that this was a relevant matter to disclose to the Court.

[37] Finally, Dr. Yee-Sing disputed that the language of the report was unduly emotional and atypical of a person with no personal interest in the matter. She indicated that her report reflected her genuine opinion as to the quality of care administered to the Claimant. She disagreed that there was anything inappropriate about her statements.

[38] In closing submissions, Counsel for the Authority commended to the Court the qualifications and experience of Dr. Hardie and the independent and balanced analysis which informed his Report. Counsel submitted that Dr. Yee-Sing is qualified to practice as a general surgeon and not a neurologist. He therefore questioned whether she is actually qualified to act as an expert witness in a medical negligence claim which requires specialist knowledge of neurology. Counsel submitted that this would account for her apparent failure to recognize the import of the Claimant's past medical history; her assertion that the chances of avoiding a stroke would have been 80% had a single dose of aspirin been administered and finally her failure to appreciate that it is a high and not a low dose of aspirin which had to be administered.

[1] Expert Declaration page 278 of Trial Bundle 2 – paragraph 5:11

[39] He further submitted that Dr. Yee-Sing's testimony is tainted with possible bias. He submitted that she failed to disclose that she is personal friends or (if one accepts her evidence in cross examination) former colleagues of the Claimant and that she was a former employee of the Defendant Authority which declined to renew her contract of employment. Counsel relied on the case of Liverpool Roman Catholic Archdiocesan Trust v Goldberg,[2] which held that where it was demonstrated that there existed a relationship between the proposed expert and the party calling him, which a reasonable observer might think was capable of affecting the views of the expert so as to make them unduly favourable to that party, his evidence should not be admitted however unbiased the conclusions of the expert might be.

[40] Counsel submitted that this case is on all fours with the case of SPE International Ltd. v John Glew[3] where the court rejected an expert report on the ground that he opined on matters which were outside his expertise and on the ground that he had also been previously employed by the instructing party.

[41] Counsel also submitted that Dr. Yee-Sing's report failed to acknowledge any positive aspects of the Defendant's treatment of the Claimant's diabetes and fractured arm, the quick processing of his admission and consultation with an on duty medical practitioner. Instead, she resorted to emotive language[4] which conveyed the impression that that no proper medical treatment was administered. Counsel referred the Court to the case of Oldham MBC v GW and Others.[5]

> "Once instructed, experts in their advice to the court should conform to the best practice of their clinical training and, in particular, should describe their own professional risk assessment process and/or the process of differential diagnosis that has been undertaken, highlighting factual assumptions, deductions there from and unusual features of the case. They should set out contradictory or inconsistent features. They should identify the range of opinion on the question to be answered, giving reasons for the opinion they hold. They should highlight whether a proposition is an hypothesis (in particular a controversial hypothesis) or an opinion deduced in accordance with peer reviewed and tested

[2] [2001] 1 WLR 2337 at page xxx
[3] [2002] EWHC 881
[4] Page 267 and 269 of Tab 7 of Trial Bindle 2
[5] [2007] EWHC 136 (Fam) at paragraph 90

technique, research and experience accepted as a consensus in the scientific community. They should highlight and analyse within the range of opinion an 'unknown cause', whether that be on the facts of the case (e.g. there is too little information to form a scientific opinion) or whether by reason of limited experience, lack of research, peer review or support in the field of skill and expertise that they profess. The use of a balance sheet approach to the factors that support or undermine an opinion can be of great assistance;"

[42] Finally, Counsel argued that accepting a retainer on a contingency basis seriously undermined Dr. Yee-Sing's objectivity and professionalism. He concluded that it is quite clear that Dr. Yee-Sing executed the expert's declaration without appreciating its full import. He submitted that to the Court that her report is sufficiently in question such that the Court should accord little weight to her opinion.

[43] Having considered the Dr. Yee-Sing's report and her viva voce evidence as well as the submission of Counsel, the Court does not accept that her opinion should be wholly rejected as inadmissible. Part 32.6 of the Civil Procedure Rules requires an intended instructing party to seek the permission of the Court before calling an expert witness or putting in the report of an expert witness. That rule also prescribes that the court's permission is to be given at a case management conference.

[44] In advancing such an application the proponent of expert testimony must prove that the testimony is reliable and so he must name the expert witness and identify the nature of his or her expertise. The Rules also obliges parties to serve the report of the evidence which the expert witness intends to give by a date prescribed by the Court (CPR Part 32.6(4)). It follows that the opposing side would have early notice of the qualifications and experience of the proposed expert and the substance of their evidence. It is apparent during case management that this course was adopted without any objection being raised by the Defendant. Likewise, there was also no objection advanced during the course of the trial when Counsel for the Claimant sought to have Dr. Yee-Sing deemed to be an expert.

[45] Modern civil and procedure practice demands that any objections as to the suitability of an expert and the admissibility of their report should properly be made and pursued in a timely fashion during case management or at pretrial review proceedings and at any event prior to the actual date of trial. In the case at bar, no explanation has been advanced which would justify the Authority's

apparent acceptance of Dr. Yee-Sing qualifications and experience in the matters which would concern this Court and the eleventh hour objections taken. Further, having failed to pursue any objection prior to the date of trial, the Defendant has not explained why its concerns were not pursued as an *in limine* objection at the first opportunity in the trial. In the Court's view the "*ambush approach*" adopted is inconsistent with the overriding objective. In any event, the Authority has failed to convince this Court that medical expertise short of neurological qualification and specialization could not assist the Court in the issues which arise in these proceedings.

[46] However, the Court agrees that an expert witness should provide independent assistance to the Court by way of objective unbiased opinion in relation to matters within his expertise. See: Polivitte Ltd v. Commercial Union Assurance Co. Plc. [1987] 1 Lloyd's Rep. 379 at p.386 per Mr. Justice Garland and Re J [1990] F.C.R. 193 per Mr. Justice Cazalet. In particular, an expert witness must not be biased towards the party responsible for paying his or her fee. The evidence should be consistent regardless of who is paying for it. In the event of any connection with any party to a claim or case that might to any degree be considered to be prejudicial to impartiality, this must be disclosed.

[47] And in that regard, the Court notes that the relevant test is an objective and not a subjective one. Particularly instructive is the dicta of Evans-Lombe J in Liverpool Roman Catholic Archdiocesan Trust v Goldberg that "*where it is demonstrated that there exists a relationship between the proposed expert and the party calling him which a reasonable observer might think was capable of affecting the views of the expert so as to make them unduly favourable to that party, his evidence should not be admitted however unbiased the conclusions of the expert might probably be*".

[48] Ultimately however, the question is one of fact, namely, the extent and nature of the relationship between the proposed witness and the party. Having had an opportunity to observe Dr. Yee-Sing under oath, the Court is satisfied that the relationship which between herself and the Claimant is professional; fostered when the Claimant was the senior administrator at the Peebles Hospital. Having considered all the evidence presented and having applied the objective test and being cognizant of the relatively small population in the BVI and the correspondingly small medical profession, the Court has some difficulty in concluding that this former professional relationship

would *without more* lead a *reasonable* observer to conclude that the views of this expert would be biased.

[49] However, prudence dictated that this former professional relationship, however inconsequential, be fully disclosed in her expert's declaration. In the same way, the Court is satisfied that on an objective view, *a reasonable observer might think* her previous employment history with the Defendant and form of remuneration may be *capable of affecting her views as an expert* and so this also ought to have been disclosed. The combination of such disclosures should certainly have been a matter of concern for the instructing Claimant given the inevitable objections which would have been raised and given that the outcome of a medical negligence claim is largely dependent on the expert opinion advanced in support. Having reviewed the Parties' evidence and their largely identical chronological summary, it is clear to this Court that a pivotal tipping point in the case at bar is the expert testimony. The Court has therefore carefully considered all of their opinions and conclusions.

[50] This Court has however considered the submissions made by Counsel for the Authority and accepts that caution must be exercised before accepting the opinions articulated by Dr. Yee-Sing. Rather than dismiss her Report as inadmissible, the Court has elected at this time to anxiously scrutinize the contents of her Report in deciding what if any weight ought to be attached to its conclusions.

EXPERT EVIDENCE

[51] Dr. Yee-Sing's report does not indicate that she had any prior history of treating the Claimant. Rather she states that her report is based on her assessment and summary of the accident and emergency and hospital/medical notes relative to the Claimant during the material period. According to her, the notes reveal that the Claimant was suffering from a TIA which evolved into an acute CVA/stroke. She concluded that this was due to a lack of urgency and delayed treatment offered to him by the doctors attending to him, initially at the Accident and Emergency Department of Peebles Hospital. At paragraph 4.01(ii) of her report she notes the following:

> *"Dr. Ojobor, Dr. Roberts, Dr. Onumaegbu including surgical doctors – Dr. Oyetungi and Gopala documented and acknowledge that Dr. Hannibal was suffering from a TIA. None of them treated him or confirmed that he was being treated for this condition. Patient was not*

physically examined by Dr. Roberts. In fact he did not see him until after he fell off the trolley. I saw no incident report about the fall in Dr. Hannibal's medical report. This is a far departure from the hospital policy on incident reporting. The diagnosis of TIA went from number 1 to number 4. Initially, he remained in the accident and emergency room for 10 hours without being treated for TIA/stroke, then to surgical ward for a few more hours before being moved to intensive care unit – still no treatment."

[52] Dr. Yee-Sing reported that treatment of TIA should be aimed at preventing a future stroke. She pointed out that the medical profession has developed simple scoring systems to estimate and help decide whether a patient should be admitted to the hospital for observation. She opined that based on the clinical signs of the Claimant on admission, he was a high risk TIA using the National Stroke Association - ABCD2 scoring system. His score is 4/7. It goes without saying that patients who have suffered a TIA require urgent evaluation and risk stratification. They should be promptly treated – not 10 or 14 hours after diagnosis. Quoting from an internet article[6], Dr. Yee-Sing observed that "initiation of stroke prevention therapy must be provided urgently. Medical management is aimed at reducing both short term and long term risk of stroke and varies according to the underlying cause of the episode.

[53] Looking at the clinical assessment and management of the Claimant, Dr. Yee-Sing noted the following failures:

i. General lack of urgency on the part of the medical staff.

ii. Inappropriate placement of the Claimant in the accident and emergency department. She noted that even after he was diagnosed he still remained in the far corner bay where continuous monitoring was difficult if not possible.

iii. Failure to be treated by Dr. Ojobor (or follow up by Dr. Roberts) after receiving the negative CT results for intracranial haemorrhage or cerebralinfarction with antiplatelet therapy. Dr. Yee-Sing noted that the current guidelines from the Royal College of Physicians, American Heart Association/American Stroke Association and the American College of Chest Physicians recommend that most patients with a TIA and no contraindication receive an anti-platelet agent to reduce the risk of subsequent

[6] Transient Ischaemic Attack treatment & Management http://emedicine.medscape.com/article.1910519-treatment

stroke. These guidelines note that aspirin, clopidogrel and the combination of aspirin plus extended release dipyridamole are all acceptable options for treatment. Dr. Yee-Sing noted that aspirin was ordered by Dr. Onumaegbu on 17th December 2012 to be administered at 8:00 a.m. on 18th December 2012, more than 24 hours later, by which time the Claimant has suffered a full blown stroke.

iv. The fact that an internist was not informed until 13 – 14 hours after the Claimant was triaged is an accident and emergency failure. By this time, the Claimant was already in evolution which means a preliminary, unstable stage in stroke syndrome in which the blockage is present but the syndrome has not progressed to the stage of a complete stroke. Again Dr. Yee-Sing referred the Court to the Recommended Stroke Evaluation Time Benchmarks for Potential Thormbolysis Candidate which prescribes that the time target for access to neurological expertise is 15 minutes; from door to treatment 60 minutes and that admission to stroke unit or ICU should be in 3 hours. Instead, the Claimant was transferred to a surgical ward to a semi private room where there was no one monitoring him for several hours.

v. Dr. Yee-Sing also observed that stroke is the second cause of death in the Virgin Islands and so the unavailability of TPA for thrombolytic intervention at the Authority's hospital was pitiful.

vi. Even with the clear diagnosis of TIA there were several missed opportunities.

[54] Dr. Yee-Sing attached to her report a copy of the text of the Royal College of Physicians, April 2010 edition of the Diagnosis and Initial Management of Transient Ischaemic Attack which prescribes the updated guidance for medical professionals on the recognition and management of TIA. She opined that the medical care afforded to the Claimant in the Accident and Emergency Department on 17th December 2012 fell below the acceptable standard of care. She concluded that there was inadequate management by the examining doctors in not treating the Claimant for his TIA by failing to administer antiplatelet therapy in a standard clinical and timely manner. According to Dr. Yee-Sing, the Claimant should have been immediately treated after a negative CT scan. Early assessment by an internist would have led to an earlier formulation of a how best the Claimant should have been managed. She felt that there was sufficient time for this to have been

done but there appears to have been no urgency reflected in the doctors notes. The result is that the Claimant suffered a massive CVA while under the care of the Authority. Dr. Yee-sing stated that if aggressive anti platelet therapy had been administered within the 1 – 3 hours window, it would have given the Claimant more than an 80 percent chance of avoiding the stroke.

[55] When she was examined under oath, Dr. Yee-Sing disagreed with Dr. Hardie's opinion that the Claimant's severe hypertension had been correctly managed by the Defendant's employees. Dr. Yee-Sing reviewed the Claimant's blood pressure charts and the readings recorded at several intervals over the course of the Claimant's stay at the Hospital. She noted that at the Claimant was triaged at 4:00 a.m. and a reading of 193/199. At 5:05 a.m. the reading was 194/120. Both readings reflected an exceedingly high blood pressure. At 5:32 a.m. having noted these readings, the doctor administered labetalol intravenously and titrated and thereafter regular monitoring reflected that by 6:00 a.m. the Claimant's blood pressure had fallen to 111/117 and 183/111 at 7:00 a.m. At 7:39 a.m. other blood pressure medication was administered as maintenance. The result is that the blood pressure came down to 140/93 at 7:55 a.m. According to Dr. Yee-Sing this would have been an acceptable result because the aim is to decrease the blood pressure gradually. However, at 8:30 a.m. the Claimant's dystolic pressure was increasing and systolic pressure had decrease to 131/109. By 9:10 a.m. the reading was 167/102 showing that the blood pressure had started to rise again. At 9:40 a.m. the reading was 171/106 and at 10:30 a.m. it had moved to 161/98.

[56] Dr. Yee-Sing also observed that between 10:30 a.m. and 13:30 p.m. there was no reading recorded one the worse of 3 hours which implies that there was no readings taken. She noted that in circumstances where, despite the initial treatment administered, the Claimant's blood pressure continued to rise, the Claimant should have been consciously monitored during this period.

[57] Dr. Yee-Sing testified that after 13:32, the recorded readings indicate that the Claimant's blood pressure was continuing to rise at a level which was high enough to cause a stroke and yet during this time there was no further medication administered. She concluded that Given the Claimant's risk factors, having hypertension which was not closely and diligently monitored and poorly controlled would contribute to a stroke.

[58] When she was further cross-examined by the Counsel for the Defendant, Dr. Yee-Sing testified in the BVI does not have resident neurologlogist but there is an Internist who would be able to treat patients with strokes. Dr. Yee-Sing also testified that there is no indication that the Claimant would have been seen by an Internist at the earliest opportunity. She noted that the records reflected that there were attempts made by the ER doctor to summon the internist but the internist failed to respond until 6:00 p.m. At that time the internist ordered 10 mg of amlodipine and also metoprolol but the amlodipine was only administered after significant delay. Dr. Yee-Sing testified that the Claimant's blood pressure ought to have been constantly monitored by an Internist and he should have received more definite treatment because of the obvious risk factors which operated. She opined that the time lapse was too long.

[59] Dr. Yee-Sing also testified that the Defendant's failure to administer anti-platelet treatment is also negligent. According to her, with the diagnosis of TIA being made at 5:33 a.m. the treatment of choice should have been an anti-platelet such an aspirin, plavix or dipyridamole. When she was cross examined by Counsel for the Defendant, Dr. Yee-Sing conceded that in her Report of 31st May 2013, she incorrectly asserted that the low dose aspirin should have been administered. She asserted that there was a typographical error and that the appropriate dose would have been a high dose of 325 mg. She denied that this error was due to her lack of knowledge and experience in the area.

[60] Counsel then confronted Dr. Yee-Sing's use and application of the Rothwell Study and her consequent conclusion at paragraph 4:03 (iii) of her Report that:

> *"If anti-platelet therapy was administered within 1 – 3 hours window, it would have given Dr. Hannibal more than an 80% chance of avoiding the stroke which he subsequently sustained."*

When Counsel put to her that she may have misinterpreted the study in the Report, Dr. Yee-Sing told the Court that she did not conduct the study herself but obtained the Report from the internet and merely quoted therefrom. She declined to make any comment about the observation made by Dr. Hardie in respect of this study which indicates that the conclusions drawn were in respect of a long term study and not a short term episode. Dr. Yee-Sing simply reiterated that the study was done and the conclusion was used to explain why early intervention was necessary. She opined that the risk factor in the Claimant's case was hypertension which should have been controlled and

properly monitored if the Defendant was to reduce the risk of stroke and she reiterated her position that the Claimant would have benefitted from the administration of anti-platelet therapy.

[61] Counsel then questioned her failure to refer to the fact that the Claimant had indicated that 'he had taken an 81 mg aspirin prior to coming to the Hospital'. She conceded that this would have been overlooked. However, she testified that while this may have made a difference, it was not evident in this case.

[62] When Counsel pointed out to Dr. Yee-Sing that her reliance on the NINDS and ACLS Recommended Stroke Evaluation Time Benchmarks for Potential Thrombolysis Candidate was irrelevant because it applies where a patient has already suffered a stroke and not a TIA, Dr. Yee-Sing maintained her position that the failure to administer anti-platelet therapy and to properly control the Claimant's blood pressure and the delay before he is assessed by an Internist (6:00 p.m.) meant that the standard of care fell below acceptable standards.

[63] Turning now to the Dr. Hardie's report, he also makes it clear that he had no prior history with the Claimant. Instead, he states that he reviewed the relevant hospital inpatient and outpatient records as well as the CT brain scans dated 17th and 18th December 2012. He commenced his analysis with a review of the Claimant's past medical history. He noted that in 1999 there was a reference in the Claimant's records to palpitations; that in 2006, the Claimant developed diabetes when an ECG confirmed that he was in sinus rhythm. He also noted that the Claimant had been hypertensive for over 20 years and had suffered a combination of obstructive sleep apnoea, dyslipidaemia and Type 2 diabetes for about 10 years. Moreover, his assessment of the Claimant's records revealed that the Claimant's blood pressure control had not been optimal for the previous two years while on a combination of a beta blocker and calcium channel antagonist. Finally, Dr. Hardie noted that that one week prior to admission, the Claimant had suffered a fracture of the olecranon bone in his left elbow which was complicated by cellulitis.

[64] Dr. Hardie submitted that a thorough appreciation of the Claimant's past medical history is critical because at the material times the Defendant's employees were faced with a patient who had significant risk factors. He submitted that a practitioner could not just treat a patient's blood pressure as its presents on a particular day. Rather he must treat the patient in the context of his past medical history.

[65] He suggested that although Dr. Yee-Sing 's examination of the Claimant's blood pressure recordings fails to appreciate that where a patient presents in the ER with a 20 year history of hypertension with poorly controlled blood pressure in the past 2 years, a reasonable medical practitioner would first need to know the patient's normal blood pressure. He explained that in a patient whose brain is used to sustained high blood pressure, the blood vessels in the brain would make certain adjustments. If well-meaning attempts were made to normalize it in a chronic hypertensive patient, one could actually cause an ischemic stroke because of the sudden reduction in blood follow to the brain.

[66] He disputed Dr. Yee-Sing's suggestion that the ideal blood pressure in a hypersensitive patient is 140/90 which sought to leave the impression that this was what the Claimant's blood pressure should have been within hours of admission. Instead, he said that the approach noted in Dr. Ibrahim's careful assessment plan[7] (BP control – not to aggressive) was the correct approach. According to Dr. Hardie, this was precisely the management which the Claimant needed when he arrived in the ER because the appropriate course was to lower the blood pressure slowly over the next couple of days or weeks and not in a matter of hours. All the actions taken were designed to control the hypertension in a non-aggressive way because the Claimant's condition had existed for many years.

[67] When he was taxed on cross examination, Dr. Hardie confirmed that the treatment administered to the Claimant was consistent with standard practice because a reading of 170/100 was probably normal for the Claimant.

[68] Dr. Hardie then noted that the nursing assessment completed upon the Claimant's admission on 17th December 2012 indicated that his regular daily medication normally comprised 5 mg bisoprolol, 50 mg metoprolol (both anti-hypertensive); 60 mg glicalazide and 1500mg metformin (both oral hypoglycaemic agents) and 80 mg aspirin, an anti-platelet agent. Under the heading Health Perception is the following manuscript note:

> *"What do you do to treat your illness (folk medicine, home remedies etc)? Please explain: Took an aspirin*.

[7] Page 130 – 133

[69] From this, Dr. Hardie concluded that the Claimant was already taking low dose aspirin and may have already taken a dose that morning. He therefore opined that Dr. Yee-Sing's conclusion that the Claimant's "*blood pressure remained uncontrolled as was documented in the ER during the course of the say of admission*" which was "*certainly in defiance of the established protocols of the management of TIA which should include the immediate treatment with anti-platelet drugs*…" failed to appreciate that the Claimant did in fact have a low dose aspirin that morning. He suggested that Dr. Yee-Sing should have indicated what treatment should have been administered in light of that fact. If the Claimant was already taking a low dose aspirin, presumably on a prophylactic basis, Dr. Hardie indicated that either a larger dose of aspirin e.g. 300mg or a loading dose of clopidogrel or both would have been reasonable.

[70] However, during cross-examination, Dr. Hardie was confronted with the Claimant's categorical evidence that he in fact took no aspirin on the morning before he went to the hospital because the pharmacy ran out of the coated aspirin. While he initially expressed some reservations about this evidence, Dr. Hardie later indicated that he was content to accept the Claimant's contention. However, notwithstanding this revised premise, he insisted that the treatment administered to the Claimant was consistent with a reasonable standard of care. In fact, when he was examined under oath, Dr. Hardie told the Court that in his own hospital, the Claimant would have been discharged with appropriate anti-thrombolic treatment but for his high temperature and injured elbow.

[71] With regard to the minimum protocol for initial treatment of person presenting with symptoms of a TIA, and the contention that there was a failure to control the Claimant's hypertension, Dr. Hardie stated that the appropriate management would depend on the degree of suspicion of TIA or stroke by the first doctor who assessed the Claimant, and the standard protocol for acute stroke management. Although he was unable to point to or identify any protocols established at the Defendant's Hospital he nevertheless, opined that appropriate steps were taken to lower high blood pressure after the initial diagnosis of TIA with both labetalol and nifedipine to good effect and he concluded that the initial management of the Claimant in the accident and emergency department was of a reasonable standard.

[72] Notwithstanding that Dr. Hardie's expert opinion endorses the treatment administered to the Claimant; he does however offer two possible areas of criticism. First, he asserted that there was

a failure to administer some specific antithrombotic treatment on the morning in question, either a large dose of aspirin or a loading does of clopidogrel or both. He also stated that there may have been a failure to consider thrombolytic therapy after it became clear that the Claimant has deteriorated neurologically on the night of the 17th December 2012. He concluded that based on his inspection of the drug charts, that the Claimant did not receive any aspirin until the next day. It is therefore not surprising that Dr. Hardie then concluded that "…*this represents a failure to provide a reasonable standard of care*."

[73] This conclusion was clearly detrimental to the Defendant's case and this was not much assisted by the equivocal notation which followed: "*However I note that a prophylactic dose of heparin was administered at 15:30 which arguably had some anti-thrombotic effect*."

[74] Dr. Hardie's also considered the allegation that there was a failure to commence anti-thrombolytic therapy or tissue plasminogen activator to the Claimant immediately or as quickly as possible in the circumstances or at all. He first explained that thrombolic therapy is a clot busting treatment which is administered intravenously as soon as possible after a TIA. He distinguished such therapy from anti-thrombolic treatment (usually aspirin) which is administered orally in order to try to prevent strokes. He maintains his criticism about the failure to administer the latter. However, with respect to the former, his opinion was premised on instructions which he appeared to have received that thrombolytic therapy was available in December 2012, in limited cases for the treatment of acute ischaemic stroke patients at Peebles Hospital. He stated that the standard protocol had been followed in the past when such treatment was administered, by specialists who would have had the experience in carrying out the protocols.

[75] Unfortunately, this equivocation could not have assisted the Court, because there is no clear indication that this was even considered, much less carried out in the Claimant's case. Dr. Hardie however, went on to state that the Claimant's blood pressure on admission was an absolute contraindication to tPA on arrival at the Hospital. In his view, the Claimant was not sufficiently bad neurologically [between 4:00 and 18:00] to justify exposing him to the risk associated with such treatment. When he taxed under oath, Dr. Hardie indicated that he was not aware whether this therapy was available of whether there were operators who were professionally trained to administer this therapy. Assuming that it was available however, he hypothesized that thrombolytic

therapy may have been rejected by doctors in the ICU because the Claimant had an abscess around a fractured spur. He confirmed that the Claimant's recent fracture would have constituted at least a relative contraindication to thrombolysis.

[76] However, Dr. Hardie reiterated that apart from managing severe hypertension, most stroke specialists would probably have recommended administering some specific antithrombotic treatment on the morning in question. Nevertheless, there are qualifiers. First, he noted that there was still no clear consensus about the best antithrombotic treatment for TIA patients in the acute phase. For example, a trial of aspirin plus clopidogrel vs aspirin alone tended to reduce the risk of recurrent stroke in patients who have had a TIA or minor ischaemic stroke within the previous 24 hours, but there was a clinically significant risk of major bleeding with the former.

[77] Turning now to the allegation that there was a failure to treat the Claimant's condition in a timely manner. According to the Claimant, this lack of urgency was manifested in the fact that the Authority failed to afford the Claimant immediate access to neurological expertise. In his Report, Dr. Hardie indicated his instructions that there is no emergency neurological service available in the BVI. His response under oath however, indicated that there was nothing untoward about this purported failure to provide specialist medical expertise. He indicated that his review of the records indicates that the Claimant's blood pressure was being supervised by an ER doctor and that he was later seen by an internist.

[78] With regard to the 19 hour delay in admission to the intensive care unit, Dr. Hardie posited that the Claimant did not require admission to the ICU that morning. According to him, the Claimant was transferred to the ICU after the diagnosis of acute stroke became apparent and within 2 hours which was reasonable. This contention was vigorously challenged by Counsel for the Claimant on cross-examination. He contended that the Claimant was not admitted to the ICU until 8:55 when Dr. Ibrahim had requested that he be admitted there at 6:00. Counsel also noted that in the interim there was no monitoring of the Claimant's vital signs recorded.

[79] Dr. Hardie's response is remarkable. First, he indicated that he could not comment if in fact the Claimant had spent 3 hours unmonitored. However, reiterated his honest belief that the Claimant's blood pressure readings were not dangerously high. When Counsel continued to tax him on the fact that it does not appear that the Claimant was seen by a doctor in the ICU after it became clear

that he was unable to grip his left hand, Dr. Hardie could only reply that he is not an ICU doctor and is therefore unable to comment on an ICU which he has not seen nor visited.

[80] Ultimately, a critical issue in the case at bar is question of causation and this where Dr. Hardie was most critical of Dr. Yee-Sings's evidence. He first deals with Dr. Yee-Sing's reliance on the unspecified study published in 2007 which concluded that "*early initiation of existing treatment after TIA or minor stroke was associated with an 80% reduction in the risk of early recurrent stroke*." In Dr. Hardie's view, Dr. Yee-Sing conclusion and her reliance on this study is misconceived. He explained that the Rothwell Study is a population based study of all incident and recurrent TIA and stroke in Oxfordshire UK. This group studied the benefits of earlier intervention with an observation study of the phased introduction of early assessment and treatment for stroke. The treatment protocol recommended in the latter phase of the EXPRESS study generally included: aspirin 300 mg daily in patients not already on antiplatelet therapy or clopidogrel, if aspirin was contraindicated; simvastatin 40 mg daily; appropriate BP lowering medication and anticoagulation as required. In patients thought to be at high risk, 300 mg clopidogrel stat then 75 mg was recommended in addition to aspirin.

[81] More importantly, Dr. Hardie noted that the conclusion that early initiation of existing treatment after TIA is associated with an 80% reduction in the risk of early recurrent stroke is based on data collected at the point of the 90 day follow up. When he was examined under oath, Dr. Hardie took pains to point out that this statistic probably referred to the results of the EXPRESS study and is based on data collected at 90 day follow up and not over the course of 24 hours. For that reason, he contends that Dr. Yee-Sing's contention is flawed.

[82] Further to Dr. Yee-Sing Report, Dr. Hardie then referred to the NATIONAL CLINICAL GUIDELINES FOR THE DIAGNOSIS AND INITIAL MANAGEMENT OF ACUTE STROKE AND TIA published by the Royal College Physicians of London. He endorsed the application of the ABCD scoring system in identifying those people at high early risk of stroke as well as the measures to be applied and his report does not appear to disagree with Dr. Yee-Sing's assessment that the Claimant scores placed him at the high early risk category. In fact, Dr. Hardie opined that the Claimant was "*clearly at high risk of going on to develop a stroke. Using the*

standard clinical ABCD risk stratification, his score was at least 5 or 6 out of the maximum of 7 and he should have been managed appropriately."

[83] What he does say is that this group published another prospective study which concluded that about half of all recurrent strokes during the 7 days after a TIA occur in the first 24 hours which highlights the need for an emergency assessment. This study had shown that the majority of patients who had a recurrent stroke within 24 hours of a TIA did seek medical attention prior to their occurrence but they were not treated as an emergency.

[84] In directly addressing the issue of causation, Dr. Hardie asserts that the severity of the Claimant's ischaemic stroke at the material time was determined by the underlying pathology which is likely to have been small vessel secondary to poorly controlled hypertension and diabetes. He went on to state that on the morning of 18th December 2012, the records reflect that the Claimant has a dense hemiplegia (by 6:00) an infarction was already visible and established on the repeat scan done at 10:47. He concluded that it is extremely unlikely that a single dose of either aspirin or clopidogrel or both given would have altered the outcome if the Claimant had been given antithrombotic treatment on admission on 17th December.

[85] Further, he goes on to state that despite the initial optimism when thrombolytic therapy was first investigated two decades ago, the benefits have proved to be disappointing. He asserted that even in the best medical centres of the world, it has been calculated that between three and eight eligible patients have to be treated with tPA to prevent one severe stroke causing death of disability at 3 months. He suggested that on a strong balance of probabilities, thrombolytic therapy would have made no material difference in the unlikely event that it had been given in the Claimant's case. Dr. Hardie therefore strongly disagreed with Dr. Yee-Sing's conclusion that the Claimant would or should have recovered with little or no disability within three months had the correct treatment been administered.

[86] It is therefore patently clear that the experts in this case radically differ on crucial points which have a significant bearing on the issues which concern this Court. Where such conflicting expert

testimony arises a Court is required to resolve it. Bingham LJ in Eckersley v Binnie prescribed the correct approach: [8]

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

[87] And in seeking to resolve the conflict the Court is also mindful of the caution cited by Lord Bridge in Wilsher v Essex Area Health Authority[9]

> "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".

[88] The Court therefore accepts that there is a duty to 'to address and resolve the central issue and such of the subsidiary issues as it was necessary to resolve to decide that central issue.'[10]

COURT'S ANALYSIS AND CONCLUSIONS

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

[8] [1988] 18 Con LR 1
[9] [1988] 1 AC 1074
[10] Sewell v Electrolux Limited [1997] EWCA Civ. 2443

to prove each of the elements identified on a balance of probabilities. Throughout the litigation this onus remains on the Claimant.

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

Is there a duty of care owed to the Claimant?

[91] Turning to the first element, it is not disputed that the Defendant through its employees, servants or agents owed a duty of care to the Claimant at all material times. This position concurs with the generally accepted view that a duty of care exists between healthcare professionals and their patients.[11] Lord Phillips MR in Watson v British Boxing Board of Control Ltd (2005) 2 WLR 1256 put it in the following way:

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

[92] The judgment in Cassidy v Minister of Health [1951] 2 KB 343 also brought into focus the liability of health care authorities for the negligence of medical practitioners employed by them. Lord Denning opined:

> "Whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves: they have no ears to listen through the stethoscope, and no hands to hold the surgeon's knife. They must do it by the staff which they employ; and if their staff are negligent in giving the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him.' and 'where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for services."

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

[93] It follows that a critical question for the Court to determine is: whether the conduct of the Defendant's employees, servants or agents amounted to a breach of the duty of care which was clearly owed to the Claimant?

Was the duty of care breached?

[94] The standard by which medical professionals are judged with respect to negligence was prescribed by Mc Nair J in seminal case of Bolam v Friern Hospital Management Committee[12]:

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

[12] [1957] 1 WLR 582; approved in Maynard v West Midlands Regional Health Authority [1985] 1 All ER 635

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

[96] In the case at bar, the Claimant contends that the Defendant, its servants or agents;

i. Failed to provide competent and sufficiently experienced staff on duty capable of managing and controlling the Claimant's condition appropriately or properly.

ii. Failed to observe the minimum protocol for initial treatment of patients presenting symptoms of emergent transient ischemic attack (TIA)

iii. Failed to afford the Claimant's immediate access to neurological expertise.

iv. Negligently waited until 7:00 p.m. on December 17, 2012 some 19 hours after diagnoses to admit the Claimant to the Intensive Care Unit of the hospital.

v. Failed to control the Claimant's hypertension so as to decrease the risk of recurrence of a TIA or the occurrence of a stroke.

vi. After ascertaining from the computed tomography (CT) scan that there was no hemorrhage or space occupying lesion within his brain.

    i. Failed to undertake immediate treatment with anti-platelet drugs such as low dose aspirin, Plavix, or Dipyrimadole (Persantin)

    ii. Failed to immediately commence thrombolytic therapy on the Claimant

    iii. Failed to administer tissue plasminogen activator (TPA) to the Claimant as quickly as possible in the circumstances or at all.

vii. Failed to treat the Claimant's condition in a timely and appropriate manner or at all.

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

i. There were periods where the Defendant's employees, servants or agents failed to adequately monitor of the Claimant. The obvious and glaring lacuna in the medical notes leads the Court to conclude that no notes were made because the Claimant was not observed or reviewed during these periods. This is particularly startling give the nature of his complaint. It begs the question how the Claimant's blood pressure could have been adequately controlled if he was not constantly being monitored. Indeed, the untraversed contention that the Defendant is unable to accurately indicate at what

point the stroke occurred is significant. In fact, the highest evidence before the Court is expert testimony of Dr. Hardie that the Claimant's blood pressure reading at 6:00 a.m. and the fact that Dr Hannibal couldn't grip with his left hand "*is probably symptomatic that the stroke had already happened….*" [13]

ii. Although there is general disagreement between the experts, their one point of concurrence leads the Court to find that there was a failure to administer some specific antithrombotic treatment on the morning in question, either a large dose of aspirin or a loading dose of clopidogrel or both. The drug charts reveal that the Claimant did not receive any aspirin until the next day. This finding is without equivocation. The suggestion that the Claimant may have taken a dose of aspirin before arriving at the Hospital should clearly have been definitively verified by those treating him and in any event would not have excused the failure to promptly administer proper treatment based on the recorded readings. In the Court's judgment this represents a failure to provide a reasonable standard of care.

iii. The Court also finds that those treating the Claimant failed to at the very least consider thrombolytic therapy after it became clear that the Claimant had deteriorated neurologically on the night of 17th December 2012. While the Court has considered Dr. Hardie's expert opinion that there may have been contraindications to such treatment, there is simply no evidence of what, if any, weight this carried because there is simply to evidence that such treatment was even considered by those treating the Claimant.

iv. The Court also finds it remarkable that the Defendant did not identify what, if any, protocols existed at its Hospital for the initial treatment of a person presenting with symptoms of a TIA or indeed for acute stroke management. This leaves the Court to draw the logical conclusion that in fact no such protocols exist.

v. The Court also finds that there was a general lack of urgency on the part of the medical staff manifested in the fact that:

[13] See page 124 of transcript 24 February 9:00 a.m. to 2:45 a.m.

i. The internist did not present himself until 6:00 p.m. several hours after the Claimant had been triaged 8:15 a.m. This is critical since it appears that there was no other specialist care (neurologist) available.

ii. The transfer to the ICU was also delayed no doubt because the Claimant was only seen by the internist several hours after a consult had been recommended at 8:15 a.m.

iii. The antithrombotic medication was not promptly administered. From all accounts it was only administered the following day despite the fact that it had been prescribed much earlier.

[98] The Court finds that this conduct fell below the required standard of care. It was clear that both experts would have acted differently from those practitioners who treated the Claimant. Having reviewed the totality of the evidence, this Court finds on a balance of probabilities that the Defendant's servants or agents breach of their duty of care to the Claimant.

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

[99] Although the Claimant has satisfactorily proved that the Defendant breached its duty of care to him, his burden is not completely discharged. The Claimant also has the onus of proving that this breach of that duty caused or materially caused his stroke and that it was foreseeable as a result of the breach. Bonnington Castings Ltd. v. Wardlaw [1956] A.C. 613; Wilsher v. Essex Area Health Authority [1988] A.C. 1074. The claim will fail unless this can be proven on a balance of probabilities; which means that the Claimant must demonstrate that it is more probable than not that the negligence caused the damage which is the subject of this claim.

[100] The Claimant has to prove that the Defendant's negligence caused the damage in fact and in law. In most cases where a claimant is attempting to prove as a "matter of fact" that a defendant caused the loss or damage, a simple "*but for*" test is normally used. The question for the Court is: would

the Deceased have suffered the injury *but for* the Defendant's negligence?[14] If yes, the defendant is not liable. If no, the defendant is liable.

[101] There are a plethora of English cases which apply these legal principles. In Hotson v East Berkshire Area Health Authority[15], the claimant sustained a fall and was taken to hospital. Five days passed before his injury was correctly diagnosed and treated; he subsequently developed necrosis. Negligence had been admitted but causation remained an issue at trial. There was a conflict of expert evidence. The Law Lords held that the weight of the evidence indicated that the injury was the primary cause of the necrosis. This was a '*but for'* case and the evidence had not established that the delay was a causative factor.

[102] In Gregg v Scott,[16] a lump under the claimant's arm was diagnosed as benign, but it was a non-Hodgkin's lymphoma. By the time of the correct diagnosis some nine weeks later, the tumour had spread into the claimant's chest. Treatment was only of limited success and the prospect of the claimant surviving for 10 years was assessed at only 25%. A majority of the lords held that the 'but for' test could not be satisfied because the claimant could not prove that the delay in diagnosis was the cause of his likely premature death.

[103] In proving causation, the English courts have on occasion applied a different test than the "*but for*" test. Where there exists two or more causes which operate concurrently, it maybe factually impossible to determine which one was the case. This becomes problematic because the claimant bears the burden of establishing which one was the cause on a balance of probabilities. In order to circumvent the strict approach, the courts have developed the 'material contribution' test. In Bonnington Castings Ltd v Wardlaw[17] the House of Lords held that the claimant does not have to prove that the defendant's breach of duty was the sole or even the main cause of damage, provided he can demonstrate that it made a material contribution to the damage.

[104] The issue was revisited by the Court of Appeal in Bailey v Ministry of Defence & Anor[18]. In that case, the claimant had suffered brain damage following cardiac arrest after inhaling vomit. She

[14] Barnett v Chelsea [1969] 1 QB 428
[15] [1987] 1 AC 750
[16] [2005] 2 AC 176
[17] [1956] AC 613
[18] [2008] EWCA CIV 883; subsequently been followed in Dickins v O2 Plc *[*2008] EWCA Civ 1144

had inhaled her vomit because she was in a very weakened state. Two causes had contributed to her weakness, one tortious, the other not. The judge below held that the tortious cause had made a material contribution to the weakness and the claimant succeeded in full. The employer appealed. The English Court of Appeal dismissed the appeal, holding that it was not possible to say with any confidence whether, without the tortious contribution, the claimant would have been so weak as to inhale her vomit. It was not suggested either in this court or below that the damages should be apportioned. Waller LJ summarized the position in the following way:

> 'I would summarise the position in relation to cumulative cause cases as follows. If the evidence demonstrates on a balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the claimant will have failed to establish that the tortious cause contributed. Hotson exemplifies such a situation. If the evidence demonstrates that 'but for' the contribution of the tortious cause the injury would probably not have occurred, the claimant will (obviously) have discharged the burden. In a case where medical science cannot establish the probability that 'but for' an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the 'but for' test is modified, and the claimant will succeed.'

[105] Looking to the evidence in the case at bar, it becomes immediately clear that there is no contention that there are multiple causes contributing to Claimant's stroke. In the Court's view the "but for" test of causation is the appropriate test to be applied.

[106] In this regard the Court is particularly guided by the judgment in Tahir v Haringey Health Authority.[19] In that case, a 15 year old boy who had a spinal abscess which resulted in some permanent paralysis 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 trial judge found that there was a negligent delay of 3 hours in the treatment. However, the claimant had not adduced any evidence to demonstrate that the delay due to negligence did cause additional injury. Indeed, there was no clear evidence as to what his outcome would have been in these circumstances (his case was that the period of negligent delay was 24 hours and that his

[19] (1998) Lloyds's Rep. Med 104

injuries would have been avoided in their entirety) and so the Court of Appeal overturned the trial judge's decision that the delay had caused £4,000 worth of damage.

[107] In the case at bar, the Claimant contends that "had the Defendant taken reasonable care in urgently administering active treatment to the Claimant with respect to a TIA which had been diagnosed; a) the Claimant's condition would probably not have deteriorated to the extent that he suffered a right cerebral vascular accident within 24 hours of his admission to the Hospital; b) even if such an event had occurred, the Claimant would have probably have recovered from that event with little to no disability within 3 months of the occurrence of the same."[20]

[108] This contention is premised solely on the expert testimony of Dr. Yee-Sing which was successfully impugned during the course of the trial. The Court is satisfied that her interpretation and application of the Rothwell Study was misguided because the conclusions were based on data collected at 90 day follow up, not overnight. Dr. Yee-Sing's unfortunate failure to grasp the true scope of the study is a shortcoming which would have obviously misrepresented the conclusions drawn and ultimately compromised the Claimant's premise that:

> *"If anti-platelet therapy was administered within 1 – 3 hours window, it would have given Dr. Hannibal more than an 80% chance of avoiding the stroke which he subsequently sustained."*

[109] When the critical issue in the Claimant's case is causation, it is simply not enough when challenged, for the Claimant's expert to suggest to the Court that she did not conduct the study herself but obtained the Report from the internet and merely quoted therefrom. The fact that this Report was not actually attached to her report is also of concern. It was also critical that she vigorously defend her analysis and conclusions rather than simply decline to make any comment about the opposition's critique on this issue. Her blithe reiteration that the study was done and the conclusions were used to explain why early intervention was necessary, did little to assist the Court.

[110] Instead, this Court is asked to rely on the analysis of the Claimant's attorneys who in written legal submissions filed after the trial attempted to interpret this medical study. Although accepting, Dr. Hardie's views as to the scope of the Study, Counsel argued that it is unclear why the fact that

[20] Paragraph 11.8 of the Statement of Claim

Rothwell's conclusion was based on data collected at 90 day follow up should make it inapplicable to persons who suffer a recurrent stroke overnight. He based this rationale on the fact that the Study concludes that "early initiation of existing treatment after TIA or minor stroke was associated with an 80% reduction in the risk of early recurrent stroke." He submitted that there is nothing in that study which excludes from the definition of "early recurrent strokes occurring within 24 hours of a TIA. He further submitted that about half of all early recurrent strokes occur within the first 24 hours (referring to paragraph 81 of Dr. Hardie's report) so there is no reason to exclude overnight recurrence of TIA or occurrence of stroke from this conclusion by Rothwell.

[111] Surprisingly, Counsel also relied extensively on Dr. Hardie's Report which explained that "….about half of all recurrent strokes during the 7 days after a TIA occur in the first 24 hours thus highlighting the need for emergency assessment…"[21] Counsel pointed out that the Rothwell report noted the 90 day risk of recurring stroke in patients with TIA or a minor stroke was 10.3 per cent in those patients who underwent assessment up to a medium of 3 days, compared to 2.1 per cent in those assessed in a medium of 1 day who then received prompt treatment – a significant difference.

[112] Counsel further submitted that as per Dr. Hardie's report, trials of aspirin plus clopidogrel versus aspirin alone tended to reduce the risk of recurrent stroke in patients who has a TIA or minor ischemic stroke within the previous 24 hours.[22] Counsel submitted that it is safe to conclude that the risk of early recurrent stroke, i.e. within the first 24 hours after a TIA can be greatly reduced by prompt and appropriate treatment. Indeed, he submitted that the majority of patients who had a recurrent stroke within 24 hours of a TIA did seek medical attention prior to recurrence but they were not treated as an emergency.[23]

[113] According to Counsel, this is precisely what occurred in the case of the Claimant. He contended that on the ABCD scale the Claimant was "at least 5 or 6 out of 7" but yet his case was not treated as an emergency. The 24 hour period within which expert assessment and treatment was necessary expired at 3:00 a.m. on the 18th December without him receiving any specific treatment for TIA. Counsel concluded that such treatment would have greatly improved his chances of avoiding a recurrent attack.

[21] Dr. Hardie's report at pg 81
[22] Dr. Hardie's at paragraph 83
[23] Dr. Hardie's report, paragraph 82

[114] The legal analysis advanced by Counsel for the Claimant is clearly premised on the proposition that "every hour counts" so that the earlier treatment is administered, the greater the chances of recovery. This general premise was also advanced by the plaintiff in Tahir v Haringey Health Authority with little success. In that case, it became clear that there was insufficient statistical evidence to enable the court to assess the effect of the additional delay and there was also no evidence to measure the extent or duration of the additional deficit resulting from the negligent delay. The Court ultimately rejected the plaintiff's contention that any culpable delay (which is more than minimal) would warrant damages even though it may not be possible to identify or quantify the additional damage of deficit resulting from it.

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

[116] In summarizing the position Otton LJ stated; "…*In my judgment, it is not sufficient to show a general increment from the delay. He must go further and prove some measureable damage*." He considered it unfortunate that the plaintiff's expert evidence was not specifically directed to that issue so that the judge at first instance could not assess the actual residual disability and the residual disability that the Plaintiff would have suffered had there been no breach of duty.

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

[118] In the case at bar, it appears to be common ground that the Rothwell study, which formed the basis of Dr. Yee-Sing's opinion, contains "much of the evidence base for current management of TIA's" and demonstrates that there was a material increase in the risk or that delay *can* cause damage.

However, the Claimant's evidence must in law go further than this. He must on a balance of probabilities prove that some measurable damage was *actually caused* by the delay in his case.

[119] Unfortunately, the Claimant's evidence fails to adequately address this. At its highest, the Claimant's evidence is that *"If anti-platelet therapy was administered within 1 – 3 hours window, it would have given Dr. Hannibal more than an 80% chance of avoiding the stroke which he subsequently sustained."*

[120] What is more, English courts have long maintained that;

> *"A plaintiff cannot recover damages for loss of a chance of a complete of better recovery: see Hotson v East Berkshire District Health Authority [1987] 1 AC 750."*[24]

[121] This was principle of law was later considered by the English House of Lords in Gregg v Scott.[25] In that case the patient saw his doctor and complained about a lump under his arm. The doctor failed to diagnose cancer. It was nine months before treatment was begun. The claimant sought damages for the reduction in his prospects of disease-free survival for ten years from 42%, when he first consulted the doctor to 25%. The House of Lords had to consider how the loss suffered by a patient in this position could be identified. Notwithstanding the powerful dissent of Lord Nicholls, the House of Lords, in a majority decision, affirmed the Hotson decision and held that the delay had not deprived the patient of the prospect of a cure because on a balance of probability he would probably not have been cured anyway, and loss of a chance was not in itself a recoverable head of damage for clinical negligence.

[122] The Law Lords rationalized that a claim for damages for clinical negligence required proof on a balance of probability that the negligence was the cause of the adverse consequences complained of. They concluded that an exception would not be made to that requirement so as to allow a percentage reduction in the prospects of a favorable outcome as a recoverable head of damage. Accordingly, the finding that the claimant could not show as a matter of probability that the delay in treatment was the cause of his likely premature death and the lack of remedy for reduction in the chance of a cure, precluded an award of damages.

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[24] Tahir v Haringey Health Authority
[25] Gregg v Scott [2005] UKHL 2

[123] Ultimately, in a majority ruling, the leaned judges took the view that the introduction of liability for loss of a chance in medical negligence cases would mean unpredictability and complexity for the law of personal injury/clinical negligence and a radical departure from established legal precedent which they were not prepared to countenance. Although these authorities are not binding, the soundness of the reasoning in both judgments is sufficient to persuade this Court that the Claimant's contention could not be maintained.

[124] The Claimant's case is further taxed by the Dr. Hardie's contention that the delay in administering the treatment was not the cause of the Claimant's stroke because on a balance of probability he would probably have suffered the stroke anyway. The Court has no doubt that the relevant risk factor in the Claimant's case was hypertension which should have been controlled and properly monitored if the Defendant was to reduce the risk of a stroke. The Court also has no doubt that proper monitoring and the earlier administration of anti-platelet therapy were obvious elements of appropriate care. But in order to succeed in this litigation, the Claimant must demonstrate that *but for* the purported failures, a stroke would have been averted.

[125] The Defendant's expert categorical assertion is that:

> "It is extremely unlikely that as single dose of either aspirin or clopidogrel or both given would have altered the outcome if the Claimant had been given anti-thrombotic treatment on admission on 17 December."

He goes on to state that:

> "Despite initial therapeutic optimism when thrombolytic therapy was first investigated two decades ago, and enormous efforts to make it available in health care systems in the developed world, the benefits have proved disappointing. Even in the best centers around the world, it has been calculated that between 3 and 8 eligible patients have to be treated with tPA to prevent one severe causing death or disability at 3 months."

[126] Dr. Hardie asserted that the severity of the Claimant's ischaemic stroke at the material time was determined by the underlying pathology which he surmised was likely small vessel disease secondary to the fact that the Claimant was a smoker and had poorly controlled hypertension and diabetes.

[127] Not surprisingly, the contention that the Claimant had small vessel disease was vigorously opposed by Counsel for the Claimant. Counsel submitted that Dr. Hardie's conclusion is not supported by any positive evidence (such as a contrast CT scan) and that the process of

elimination by which Dr. Hardie arrived at his conclusion is based on speculation and mere guess work. Counsel posited that before Dr. Hardie's hypothesis can be accepted, it is necessary to have proper radiological test carried out to confirm the accuracy of that hypothesis.

[128] In the Court's judgment there is some force to this argument. However there is equal force to the Defendant's contention that the Claimant has failed to discharge his burden to prove causation. The irony is that the Defendant's expert was forced to hypothesize because of the Claimant failed to provide his medical records from the Jackson Memorial Hospital, Miami. Cr. Hardie suggested that those records would have provided conclusive evidence as to what caused the Claimant's stroke because that hospital would not doubt have conducted the very tests/investigations which were planned by the Defendant's Hospital but which were not done before the Claimant was airlifted to Miami for emergency medical treatment.

[129] The failure to disclose these medical reports was viewed with suspicion by Counsel for the Defendant who posited that the only reason why they were not disclosed was that they would have revealed the reasons for the Claimant's stroke which were not supportive of his claim. Given the Claimant's own professional background, Counsel also submitted that he would have been well aware of the critical importance of these reports and records.

[130] While this Court is not prepared to speculate on the motive informing this deliberate non-disclosure, there is no doubt that it left a gaping evidential lacuna. It seems to the Court that any prudent claimant would seek to rely on the medical report of the medical facility which successfully treated him, as evidence that his treatment at the defendant facility fell below acceptable standards. In the absence of objective, cogent evidence as to the cause of the Claimant's stroke, this Court has no way to determining whether the treatment suggested by the Claimant's expert would have made any real difference to the outcome. And essentially, the Court has no way of determining on a balance of probabilities whether the Defendant's negligence actually caused the damage.

[131] In answering the question: Is there a causal connection the Court has had to consider the contrasting expert testimony presented. The totality of Dr. Yee-Sing's evidence simply does not satisfy so that the Court can find on a balance of probability that the Defendant's negligent conduct caused the Defendant's stroke.

CONCLUSION

[132] Having regard to the particulars of negligence pleaded, the evidence as a whole and the findings of fact and law, the Court accepts that there was a clear duty of care owed to the Claimant and there is evidence pointing to the fact that the Defendant breach of its duty of care. However, the Court is not satisfied that Claimant has fully discharged his burden.

[133] Ultimately, while this Court has no reservations in finding that the Defendant's care was negligent; the totality of the evidence makes it impossible for the Court to conclude that the Claimant's condition was significantly compromised by the negligence of Defendant's servants or agents. The simple fact is that on the critical issue of causation, the expert opinion of Dr. Hardie was not significantly undermined.

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

i. The Claimant's claim is dismissed

ii. The Defendant will have their costs assessed on a prescribed basis.

…….
Vicki Ann Ellis
High Court Judge