[2020] JMCA Civ 56

JAMAICA

IN THE COURT OF APPEAL

SUPREME COURT CIVIL APPEAL NO 105/2015

BEFORE: THE HON MR JUSTICE MORRISON P
THE HON MISS JUSTICE STRAW JA
THE HON MISS JUSTICE EDWARDS JA

BETWEEN	**THE ATTORNEY GENERAL FOR JAMAICA**	**1st APPELLANT**
AND	**THE SOUTH EAST REGIONAL HEALTH AUTHORITY**	**2nd APPELLANT**
AND	**TAHJAY ROWE (A Minor, suing by Tasha Howell His Mother and Next Friend)**	**RESPONDENT**

Ms Christine McNeil instructed by the Director of State Proceedings for the appellants

Alexander Williams and Ms Topazia Brown instructed by Alexander Williams & Company for the respondent

18 June 2019 and 13 November 2020

MORRISON P

[1] I have read in draft the judgment of Edwards JA, I agree with her reasoning and conclusion and have nothing further to add.

STRAW JA

[2] I too have read in draft, the judgment of Edwards JA and I am in agreement with her reasoning and conclusion. I have nothing useful to add.

EDWARDS JA

Introduction

[3] This is an appeal against the decision of Lindo J (Ag) (as she then was) ("the judge"), made on 10 September 2015, giving judgment in favour of Tahjay Rowe (a minor suing by his mother and next friend, Tasha Howell) ("the respondent"), against the appellants, the Attorney General for Jamaica ("the 1st appellant") and the South-East Regional Health Authority ("the 2nd appellant") in a case of medical negligence. The judge, in her written decision cited at [2015] JMSC Civ 177, found that the medical staff at the Victoria Jubilee Hospital ("the hospital") were negligent in respect of the management and treatment of the respondent and his mother whilst they were patients at the hospital, resulting in severe injury and damage to the respondent. The hospital falls under the auspices of the 2nd appellant pursuant to the National Health Services (South-East Regional Health Authority) Management Scheme 1997 and the National Health Services Act of 1997. The Attorney General of Jamaica was sued by virtue of the Crown Proceedings Act.

[4] I find it prudent to indicate from the outset what my decision is in this matter, as, based on the medical evidence and the applicable law, my reasons for coming to this decision will, regretfully, be quite lengthy. Therefore, for the reasons set out below, I

agree with the appellants that the judge was wrong to have concluded that the appellants were liable in negligence for the injuries suffered by the respondent.

Background

[5] The following is a brief synopsis of what occurred whilst the respondent and his mother were in the hospital. The respondent was born at the hospital on 27 April 2004. He appeared, at least in the first 18 to 23 hours of life, to be a healthy baby boy. However, by his 18th hour of life his mother reported that he was not feeding, that he cried incessantly and that his breathing was rapid. He was checked by the nurse mid-wife and subsequently taken to the hospital's nursery where he was examined by a doctor. The results of that examination caused the doctors to be concerned enough to run several diagnostic tests on the respondent to see what could possibly be causing his symptoms. His symptoms included pallor of the skin, bulging fontanelle, lethargy and possibly seizures. The initial test results showed that he was anaemic, his platelets were persistently low, and his body sodium was also low. Several other diagnostic tests were conducted, which ruled out several possible causes of these symptoms, including meningitis, sepsis and other infections. His treatment included whole-body blood transfusions and antibiotics.

[6] The treatment given to the respondent apparently appeared to his doctors to have worked, as he appeared to be more active, and the repeated blood works showed improvements, although he still had a low blood count. He was declared to be well and was discharged from hospital after two weeks, with a date to return for outpatient assessment and with a requisition for a cranial ultrasound. No abnormality had been

detected when the infant was seen at the outpatient clinic on 19 May 2004, no seizures had been noted by his mother, and she reported that he had been breastfeeding well. He was discharged from his outpatient visit as being a normal healthy baby. Unfortunately, his condition deteriorated soon thereafter, and he was taken by his mother to the Bustamante Hospital for Children ("the BHC") where, after an ultrasound and CT scan were done, he was found to be severely brain damaged with signs of cerebral palsy and epilepsy.

[7] The claim against the appellants was filed by the respondent on 3 June 2009.The particulars of negligence alleged in the claim were as follows:

> "1) Failure to deliver the [respondent] in an expeditious and timely manner;
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> 2) Inexcusable delay in delivering a post-term baby;
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> 3) Failure to properly monitor the [respondent's] mother during labour in view of the [respondent] being a post-term infant;
>
> 4) Failure to carry out proper management of the [respondent] after his birth and prior to his transfer to the Bustamante Hospital for Children;
>
> 5) Inexcusable delay in transferring the [respondent] to the Bustamante Hospital for Children;
>
> 6) Failure to properly care for the [respondent] after birth."

[8] The respondent further relied on the doctrine of *res ipsa loquitur*, claiming that, at the time of his birth, the respondent was "apparently a normal healthy baby but was found to be brain damaged, while under the management and control of the 2nd [appellant], its servants and/or agents". The respondent alleged that he suffered injury,

loss and damage as a result of the negligent care given to him by doctors at the hospital prior to, during, and after his birth on 27 April 2004 by the servants and/or agents of the 2nd respondent at the hospital.

[9] The injuries alleged to have been suffered by the respondent were set out in his particulars of claim as follows:

> "1) Jerking of limbs and neo-natal seizures
>
> 2) Difficulty breathing and feeding
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> 3) Hydranencephaly
>
> 4) Hypertonic in upper limbs with macrocephaly
>
> 5) Grade 4 Hypoxic Ischaemic Encephalopathy
>
> 6) Symmetrical Advanced Cystic Leukomalacia
>
> 7) Central visual deficit
>
> 8) Hypotonic in lower limbs
>
> 9) Global Development Delay secondary to Hypoxic Ischaemic Encephalopathy, with visual and social inattention
>
> 10) Psychomotor developmental delay
>
> 11) 30° head lag and prone
>
> 12) Truncal hypotonia
>
> 13) Generalized hyper-reflexia with bilateral knee and ankle clonus and bilateral extensor plantar responses. [sic]
>
> 14) Epilepsy
>
> 15) Hyper explexia
>
> 16) Generalized spasticity, being early signs of spastic quadriparetic cerebral palsy."

[10] In a joint defence filed 22 October 2009, the appellants admitted that the 2nd appellant owed a duty of care to the respondent, but disputed the claim on the basis that the medical and nursing staff of the hospital at all times exercised reasonable care in the treatment, examination and care of the respondent and his mother. The appellants admitted that after birth the respondent fed poorly, became lethargic and developed seizures, but averred that he had been admitted to the hospital's nursery and a series of tests had been conducted, including blood investigations, which showed that his platelets were persistently low. It was also averred that no abnormality had been detected when the infant was seen at the outpatient clinic on 19 May 2004, no seizures had been noted by his mother, and he had been breastfeeding well. At the time of his discharge, he had been scheduled for a cranial ultrasound. Ultimately, the appellants contended that the unfavourable outcome suffered by the respondent was most likely as a result of "an intracranial bleed as a consequence of hereditary alloimmune thrombocytopenia which is unpredictable and untreatable in the index pregnancy".

The proceedings in the court below

[11] At the trial, held on 18 June 2015, the judge heard oral evidence from three witnesses. Tasha Howell, mother of the respondent, and Yvonne Beckford, mother of Tasha Howell, gave evidence on behalf of the respondent. Natanee Dalhouse, the mid-wife assigned to the delivery ward at the material time, gave evidence on behalf of the appellants.

[12] Four medical reports were in evidence. The reports from Dr Michelle-Ann Richards-Dawson and Dr Judy Tapper were attached to the particulars of claim and admitted in

evidence on behalf of the respondent. Two expert reports were in evidence, one provided by the respondent and the other by the appellants. These were from Dr Leslie Gabay and Dr Roxanne Melbourne-Chambers. The medical records of the respondent's treatment and that of his mother at the hospital were not tendered into evidence, but it is clear that these records were accessible and were utilized by the aforementioned doctors in the preparation of their reports.

[13] The only other evidence before the court was a letter tendered on behalf of the respondent, dated 1 June 2002, from Yvonne Beckford to the personnel officer at the hospital. The judge did no assessment of this letter in her judgment.

The respondent's case in the court below

(1) <u>The evidence of Tasha Howell</u>

[14] Tasha Howell's evidence was that she became pregnant in 2003 and attended the Sunshine Clinic on several occasions as the pregnancy progressed. Tests done during that period revealed no complications. In early 2004, in the first week of her ninth month, she began visiting the clinic at the hospital. The baby, she said, was due on 15 April 2004 and she mentioned to hospital staff that the baby was overdue. However, she was only admitted to ward 4 of the hospital on 25 April 2004. She was seen by a doctor in the early morning of 26 April 2004, and was given an injection, but according to her, she was not examined by the doctor. She was then moved to ward 2 on the instructions of the doctor and put on a drip. She was in no pain and had no contractions.

[15] On the morning of 27 April 2004 she was given a pill to induce labour. She received an injection in the drip bag and started to feel contractions. She was examined by a female doctor who stayed with her and monitored her contractions. She subsequently had a baby boy at 11:38 am that day. The baby was taken to the nursery and brought back 15 minutes later. She noticed that the baby was not eating and was crying a lot. She told this to the nurses. She was given a feeding bottle but the baby still would not feed. The baby cried throughout the night, and at about 4:00 or 5:00 am she told the nurse the baby had not eaten since birth. The baby was taken to the nursery, and the following day she was informed by the nurse that tests had been done on the baby and the results were not yet back. Thereafter, she was told the blood test result came back, the baby was okay, and she was not to worry. She was discharged on 29 April 2004. The baby remained in hospital. However, during her visits to see the baby that week she noticed that he was still getting blood in his head through the drip. She was also told the baby would soon be released but they were watching to see how the medication worked.

[16] The baby was eventually discharged two weeks after his birth. She returned a week later with him as she was told, and the baby was examined by a doctor. The doctor enquired if the baby was shaking, to which she responded that she had not noticed anything. She was told the baby was okay. However, two days later, she noticed that the baby would shake when she bathed him. She took him to the BHC, and was sent to have the cranial ultra sound done on the baby, which she did at the Oxford Medical Centre. Upon returning to the BHC with the ultra sound results, she was told by Dr Richards-Dawson that "it wasn't showing much in the brain". The baby was admitted, and two

days later a CT scan was done on him. She was told that the respondent had brain damage and cysts on the brain due to lack of oxygen and blood to the brain.

[17] Ms Howell stated she visited the BHC for about five to six years, thereafter, and then started visiting a clinic and a private doctor in Spanish Town. Her baby (the respondent), she said, could not move or talk, and was in a vegetative state. She has had to spend money weekly and bi-weekly on special food and syrup for his epilepsy.

[18] On cross-examination, Ms Howell admitted that when she went to the hospital she was uncertain of her last period and an ultra sound had to be done to determine a due date. She also admitted to being informed that it could have been two weeks before or two weeks after.

(2) The evidence of Yvonne Beckford

[19] Ms Howell's mother, Yvonne Beckford, gave evidence that three weeks after the birth of the respondent, she accompanied her daughter to the BHC. At the time, the baby was crying constantly and was having twitches. She spoke with Dr Richards-Dawson in respect of the respondent's condition following the ultra sound which was done on his brain, and was informed that due to the lack of oxygen to the brain, he would be like a 'vegetable' and would not be able to do anything. She gave evidence that she lived with her daughter and the respondent, which was hard because at nine years old, he could not eat any solids and was on Ventolin to help him breathe, due to asthma. Under cross-examination, Ms Beckford admitted that she was not present for the delivery of the respondent.

(3) The medical reports

[20] The report of Dr Michelle-Ann Richards-Dawson, consultant paediatrician and neonatologist at the BHC, dated 23 October 2008, rehearsed the respondent's medical history and treatment following his birth at the hospital and his presentation at and admission to the special care nursery at the BHC. In summary, she reported that the respondent presented to the casualty department of the BHC with a history of jerking of the limbs for two days and with the results of a cranial ultra sound. She noted that the cranial ultrasound done on 20 May 2004 reported findings of hydranencephaly. Upon admission and further investigation at the nursery at the BHC, the significant findings were confined to the central nervous system. The respondent was noted to be hypertonic in the upper limbs with macrocephaly. His anterior fontanelle was wide and full. His pupils were normal size but did not react to light well. Blood and urine cultures were drawn and he was treated with intravenous antibiotics.

[21] Dr Richards-Dawson indicated that the results of a CT scan performed on 22 May 2004 revealed cystic replacement of both cerebral hemispheres sparing the deep gray matter. These were features, she said, which were consistent with hypoxic ischaemic encephalopathy (HIE). The matter was referred to Dr Tapper, and the scans were reviewed by a Dr Bullock, a consultant radiologist at the University Hospital, who made findings of symmetrical advanced cystic leukomalaci, consistent with grade four HIE, which is associated with a poor prognosis. The respondent was subsequently discharged on 28 May 2008 on the medicines phenytoin and clonazepam. When he returned for review on 31 May 2008, no further seizures were reported. Visual assessment done on 1

June 2004 by a consultant ophthalmologist was reported as abnormal, and he was subsequently evaluated as having central visual deficit. On the respondent's last visit to the clinic at the BHC in November 2004, he was noted to be hypertonic in the upper limbs, hypotonic in the lower limbs, with brisk reflexes and both feet everted. He was reviewed in the paediatric neurology clinic on August 5, 2004 where he was evaluated as having global development delay secondary to HIE. Dr Richards-Dawson also described the respondent's resultant treatments and referrals until his default from all clinics at the BHC.

[22] The report of Dr Judy Tapper, consultant paediatric neurologist at the BHC, dated 20 August 2008, in summary, indicated that the respondent was first seen in paediatric neurology consultation on 25 May 2008 (which it appears should have read 25 May 2004), presenting with neonatal seizures starting at 48 hours of age. She noted that a CT scan dated 22 May 2004 showed symmetric advanced cystic leukomalacia in keeping with grade IV HIE. She also noted that clinical and radiological features were consistent with grade IV HIE. She further reported that the respondent was reviewed at the paediatric neurology clinic on 5 August 2004 at three months of age. At that time, his mother reported that he had no further seizures, that she thought he was hearing and seeing normally, that he cooed, developed a social smile, was not irritable and knew family members. She reported no feeding difficulties or history of a squint. However, he showed psychomotor developmental delay functioning at a level of 0-6 weeks, had not achieved head control, and did not roll. He was fisted bilaterally, intermittently and did not grasp or mouth his hands.

[23] Upon examination, the respondent's weight was 9.45 kg, height 63.5 cm and head circumference 46 cm (a >95th percentile). The doctor found the respondent to be obese, visually and socially inattentive, and mildly irritable. She observed no cooing. There was no evidence of strabismus and pupils were equal and reactive to light. Fundi were not well visualized and extra-ocular movements were full. The rest of the cranial nerve examination was unremarkable. There was evidence of truncal hypotonia, and moro response was present symmetrically and he was jittery. There was a paucity of movement in the extremities and generalized hyper-reflexia with bilateral knee and ankle clonus, and bilateral extensor plantar responses. The ophthalmology consultation was normal.

[24] Dr Tapper assessed the respondent as having HIE with neurological sequelae which included:

> "(1) Epilepsy
>
> (2) Hyperexplexia, being jittery with excessive startle response and irritability
>
> (3) Global developmental delay, functioning at 0-6-week level, with visual and social inattention and
>
> (4) Generalised spasticity, [sic] early signs of spastic quadriparetic cerebral palsy."

She reported that follow-up treatment was recommended along with a referral to physiotherapy at the BHC. Several other tests were recommended and a referral made for early infant stimulation, however, the respondent defaulted from the neurology paediatric clinic.

[25] Dr Leslie Gabay, who is a consultant paediatrician and paediatric endocrinologist, provided an expert report at the respondent's request. His assessment and opinion, which I will shortly summarise, was based solely on the particulars in the antenatal record of the respondent's mother and the medical record of the respondent from the hospital. In his report dated 5 July 2010, he noted that the respondent was born 21 days 'postdates', with Apgar scores at 8 and then 9, out of a possible 10. He saw no documentation that the mandatory vitamin K was given. Lack of vitamin K, he reported, could lead to haemorrhagic disease of the new-born. He noted the symptoms of the infant which were documented in the "progress notes" on 28 April 2004 at 10:55 am which were that the infant had not been sucking, and that upon examination by a physician, he was lethargic, tachpnoeic (respiratory rate increased) and he had a full anterior fontanelle. A full anterior fontanelle (the soft spot on the top of the infant's skull), Dr Gabay reported, suggested an increase in intracranial pressure. He noted that the initial appropriate measures were undertaken (oxygen therapy, IV fluids, and antibiotic therapy), along with initial appropriate investigations.

[26] He further noted that there was no physician documentation of the infant's condition or response to therapy, after the initial measures were taken, until 29 April at 8:00 am, 21 hours later. By that time, the infant was having a tense anterior fontanelle associated with seizures, and abnormal posturing of the body, which, he said, indicated worsening intracranial pathology. This was so, despite "nursing notes" indicating that at 5:40 am the infant was demonstrating seizure activity (fisting, he opined, suggested seizure activity) and the doctor was informed. He stated that investigations documented

on 29 April 2004 at 8:00 am revealed that the respondent was anaemic (low blood count which could suggest blood loss or blood destruction), thrombocytopenic (low platelets) and had hyponatremia (low body sodium). A cerebrospinal tap was done on 28 April, the results of which, according to Dr Gabay, revealed findings which were not in keeping with a diagnosis of meningitis (an infection of the lining of the brain), but was more in keeping with a diagnosis of intracranial bleed.

[27] Dr Gabay gave the description of neonatal thrombocytopenia taken from Hoffman: Haematology: Basic Principles and Practice, 5th Edition, 2008, where it stated as follows:

> '"**The majority of causes involve increased platelet destruction. In well-appearing newborns, thrombocytopenia is usually an immune-mediated phenomenon related to maternal transplacental IgG antibodies.'**
>
> **'Treatment with platelet infusion is standard if bleeding is present."'** (Emphasis added)

[28] He also gave a description of hyponatremia, taken from Fraser CL, Arieff AI: Epidemiology, Pathophysiology, and Management of Hyponatremic Encephalopathy, American Journal of Medicine 1997; 102:67. The parts quoted in his report state that:

> '"**clinical manifestations of hyponatremia usually occur only at a serum Na concentration below 125 mmol/L**. Although gastrointestinal complaints occur early, the majority of the manifestations are neuropsychiatric, including lethargy, psychosis, and seizures, designated as hyponatremic encephalopathy."
>
> "In its severe form, hyponatremic encephalopathy can cause brainstem compression leading to pulmonary edema and hypoxemia.'"

[29] Dr Gabay then noted that the infant respondent was given a whole blood transfusion on 1 May 2004, which would have corrected his anaemia and thrombocytopenia, with normal values shown on his lab report on 3 May 2004. Although Dr Gabay had, earlier in his report, indicated that the initial appropriate measures and investigations had been taken, he, nevertheless, opined that the respondent should have had intracranial imaging done, as an early investigation, once meningitis was less likely, and intracranial haemorrhage became the likely diagnosis. The cranial imaging, he opined, should have been done in order to confirm the diagnosis and extent of the bleeding. He also noted that correction of thrombocytopenia and hyponatremia should have been done urgently in an infant with a suspected intracranial bleed, of which the latter can cause or worsen brain damage.

[30] Dr Gabay opined that the respondent had had a number of events most likely initiated by an intracranial haemorrhage, resulting in significant brain injury and disability. He also ruled out the diagnosis of HIE. This is how he put it;

> "The infant...had a number of events most likely initiated by an intra cranial haemorrhage, which included hyponatremia, acidosis, and possible hypoxia which resulted in significant brain injury and disability, not hypoxic ischaemic encephalopathy which would suggest intrauterine or birth asphyxia."

[31] Dr Gabay specifically listed inadequacies in the respondent's care to include:

> "a. No documentation of vitamin K administration.

b. Inadequate documentation in first twenty-three hours of life as to infant's medical condition, so as to adequately recognise and respond in a timely manner to infant's deterioration.

c. Inadequate documentation, and follow up of infants [sic] progress in subsequent twenty-four (24) hours from initial assessment, eg. Clinical examination of fontanel [sic], head circumference and pending laboratory values, as well repeating of abnormal values.

d. Inadequate response to seizures, documented by nurses in relation to time to [sic] treatment.

e. Inadequate assessment of causes of hyponatremia, and thrombocytopenia (including appropriate referrals) resulting in delayed treatment. No documentation in physician notes as to probable diagnoses of intracranial haemorrhage, thrombocytopenia or hyponatremia eg. SIADH (Syndrome of Inappropriate ADH secretion), alloimmune thrombocytopenia.

f. Delayed transfusion of whole blood or platelets, which may have resulted in extension of any intracranial haemorrhage.

g. Delayed neuro-imaging to assess intra cranial compartment, confirm diagnosis and extent of lesion."

[32] He thus concluded his opinion with the statement that the respondent:

> "...had an intracranial event resulting from a significant thrombocytopenia, however the documentation of his care and management indicate inadequacies in both areas, which if they had not occurred may or may not have resulted in lesser disabilities for this child."

The appellant's case in the court below

(i) <u>The evidence of Natanee Dalhouse</u>

[33] Natanee Dalhouse was the registered midwife employed to the hospital who had conduct of the delivery of the respondent at the material time. Her duties included ante-natal, intra-natal and post-natal care of patients, as well as the care of neonates (new born babies). She deponed that she did not recall the actual delivery of the respondent, but her knowledge of the relevant events was taken from the hospital's records. Based on the obstetric record summary that was completed by her immediately after delivery, she was the midwife who had conducted the respondent's delivery. She stated that 18-year-old Ms Howell first presented at the antenatal clinic of the hospital on 26 February 2004 expecting her first child and unsure of the date of her last menstrual period. Ms Howell had given a history of being asthmatic, her last attack having been three weeks prior. She was seen by a doctor and an ultrasound was ordered. She returned on 11 March 2004 and was again seen by a doctor. Her ultrasound indicated a gestational age of 35 weeks and a possible due date of 15 April 2004.

[34] Ms Howell next visited the hospital on 19 April 2004 as instructed, and was examined. Her gestational age was put at 40 weeks and four days and her fundal height was 40 cm. She was instructed to return for admission on 25 April 2004. On her return to the hospital, she was admitted to the antenatal ward for induction of labour. Her vital signs were normal. The following morning, Ms Howell was transferred to the labour ward and was examined by a doctor. At about 11:10 am, Cytotec/Misoprotol 50 mcg was inserted vaginally by the doctor. Ms Howell was cared for in the induction room and monitored throughout the day and into the next by a registered nurse/midwife, and her vital signs were recorded as normal. There were no uterine contractions and she was

hydrated by intravenous fluids. The baby's heart rate was also monitored. When her cervix was fully effaced and dilated she was transferred to the delivery room.

[35] Ms Dalhouse commenced duties on 27 April 2004 on the 7:00 am to 3:00 pm shift, and was assigned to the delivery room. She said that based on the obstetric record summary, Ms Howell delivered "a live male infant at 11:38 am with a birth weight of 3.71 Kg, and an APGAR score of 8 at one minute and 9 at five minutes". The Apgar scores are arrived at from the total sum of scores from several categories. For the Apgar score of 8, the heart rate, respiratory effort and muscle tone each scored at 2 and reflex irritability and colour each scored at 1. For the Apgar score of 9, the heart rate, respiratory effort, muscle tone and reflex irritability each scored at 2 and colour scored at 1. The baby was suctioned, given oxygen, eye prophylaxis and vitamin K, and he passed meconium at birth. He was transferred to the post natal ward with his mother.

[36] Under cross-examination, Ms Dalhouse admitted that everyone who cared for the baby would have had the responsibility to make entries on the record, including herself, but denied that she was responsible to record any investigation of clotting mechanism or the number of platelet counts. Whilst she admitted that she would have been responsible to measure the circumference of the baby's head at the time of birth, and that she could not recall if she had done so, she stated that prior to 2009 such measurement was not routine protocol at the hospital. Further, she could not recall if any investigation was done in relation to anaemia in the baby, nor could she recall any complaints by Ms Howell

that the baby was not feeding or that he had had any seizures. She admitted she could not say much in respect of the delivery and immediate care given to him.

(ii) The medical report

[37] Dr Roxanne Melbourne-Chambers, a paediatrician and paediatric neurologist employed to the University of Hospital the West Indies and the University of the West Indies as a consultant and lecturer, respectively, submitted an expert report to the court at the behest of the appellants. In her report dated 13 December 2013, Dr Melbourne-Chambers summarized what she called the 'clinical details' of the infant respondent from the relevant medical records from both the hospital and the BHC. She noted that the respondent was born to an 18-year-old 'primagravid' female at the hospital after induction of labour, postdates. Apart from asthma, no maternal illnesses were recorded, and post induction and throughout labour maternal vital signs and foetal heart rates were normal. There was a normal vaginal delivery and the respondent was assigned APGAR scores of 8 at 1 minute and 9 at 5 minutes, out of a maximum of 10. Vitamin K 1 mg. i.m. was administered, cord blood was taken, and the placenta membranes were recorded to be complete.

[38] It might be useful to set out a detailed summary of Dr Melbourne-Chambers' report on the respondent's symptoms and the investigations/responses of the hospital staff, that were recorded in the relevant medical records from the hospital, when they were first noted. They are as follows:

'It was documented that on 28 April 2004 at 5:41 a.m., 18 hours after delivery, Ms Howell reported to a nurse that her baby's heart rate was rapid. The nurse confirmed a heart rate of 160 bpm and recorded that she would inform the doctor. At 11 am the same day, 23 hours after delivery, Ms Howell reported concerns that the baby was not sucking. Examination by the nurse revealed lethargy, pallor of the skin, normal fontanelles and mild tachypnea (rapid breathing) with a slightly high respiratory rate. The baby was transferred to the nursery at the hospital, and the first entry in his record there is that he had a history of not sucking the breast and had an episode of cyanosis (blue discolouration of the mucous membranes) during a cup feed. Examination revealed mild lethargy, responsiveness to stimuli, fullness of the anterior fontanelle, tone and "ok" reflexes, mild abdominal distension and normal bowel sounds. An episode of cyanosis and increased tone of limbs occurred during the setting up of an intravenous access. Glucose was recorded as normal and meningitis and sepsis were ruled out. Orders were written for NPO (nil by mouth), nasogastric tube, complete blood count, blood culture, random glucose, urea, creatinine and electrolytes, lumbar puncture and treatment of Amoxil 125 mg 3 times daily and Genta 9 mg twice daily. The results of the lumbar puncture was recorded as revealing clear cerebral spinal fluid at high pressure. This was sent for cells, culture, glucose and protein.

The results of the other tests recorded on 29 April 2004, day 2 of the infant's life, revealed low haemoglobin (Hb), low platelets, low sodium, low bicarbonate, but normal white blood cells, potassium, chloride, random blood glucose and cerebrospinal fluid glucose.

Examination on day 2 revealed pallor of the infant, grunting respirations (marked increased respiratory effort), tense anterior fontanelle, opisthotonus (abnormal posture of stiffening of the trunk and extremities with retraction of the neck and hyperextension of the spine), fisting both hands, RR 62 (elevated), and mild subcostal recessions (SCR) (a sign of increased respiratory effort). The antibiotic doses were ordered to be increased, potassium and calcium was added to intravenous fluids, and phenobarb (an anticonvulsant drug) was ordered. It was on this day that a whole blood transfusion was ordered.

On 30 April 2004, day 3, the blood and CSF cultures were recorded as no growth after 24 hours (sterile), and the other laboratory tests done were noted as a complete blood count and urea, creatinine and electrolytes tests. A review of the lab tests the following day, 1 May 2004, showed low Hb, PCV 0.27 (correlated with Hb), low sodium,

> low bicarbonate, normal white blood cell count, normal platelets, normal potassium, normal chloride, normal creatinine and normal Urea (BUN). Orders were written for feeds via the nasogastric tube, once again for a blood transfusion, and for tests for various infections. The baby was transfused on day 4 of life, 1 May 2004.
>
> On day 6, 3 May 2004, mild jaundice and a full anterior fontanelle were noted and tests for a complete blood count, urea, creatinine and electrolytes were repeated. Results showed mildly decreased potassium and sodium. On day 9 of life, the baby's head circumference was recorded for the first time and was noted to be large for his age. The lumbar puncture was repeated. On day 10 of the infant's life, 7 May 2004, he was noted to be sleepy and fontanelle was not bulging. The anticonvulsant was discontinued. The following day, 8 May 2004, the infant was described to be more active, but a repeat of complete blood count test revealed low Hb and platelets. His progress, nonetheless, was recorded as normal. On 9 May 2004, day 13 of life, he was given a transfusion of packed red blood cells, and on 10 May 2004 a complete blood count showed an improved though still low Hb, PCV, white blood cells and platelets. The infant was discharged the following day, 11 May 2004, on his 14th day of life with an iron supplement and for out-patient review and a cranial ultra sound. He was reviewed on 19 May 2004, day 22, the results of which were recorded as normal.'

[39] Dr Melbourne-Chambers pointed out that the respondent had become symptomatic at age 23 hours with poor feeding and a cyanotic episode (blue discolouration of the mucous membranes) which may have been due to a seizure. Clinical and laboratory findings, she opined, indicated raised intracranial pressure (bulging anterior fontanelle), abnormal tone (suggesting cerebral dysfunction/injury), seizures (suggesting cerebral dysfunction/injury) and pallor with anaemia and thrombocytopenia (low platelet count), as well as hyponatremia (low serum sodium) and acidosis (low bicarbonate). She noted that the cause of the thrombocytopenia and anaemia was not ascertained, although intrauterine infection with toxoplasma, rubella, herpes and syphilis, meningitis and bacterial sepsis were excluded. She also concluded that it would be

impossible to determine the cause due to the absence of other investigations of the infant's clotting mechanisms.

[40] Dr Melbourne-Chambers also examined the results of the ultrasound scan done on the respondent on 20 May 2004, day 23 of the respondent's life. The ultrasound report read:

> "The cerebral hemispheres have been largely replaced by multiple thin walled cysts creating a honeycomb appearance. The falx is intact and the lateral ventricles are not dilated. Normal thalamus. Posterior fossa was difficult to visualize. Impression: Probable a form of hydranencephaly."

[41] She also examined the report of the CT scan of the brain done on the respondent on 22 May 2004 at day 25 of his life. She noted that it revealed the following:

> "Both cerebral hemispheres are almost completely replaced by cystic masses. There is sparing of the deep gray matter, i.e. the head of the caudate nucleus, basal ganglia and thalami. The cerebellum is spared. No evidence of any enhancement occurred post IV contrast administration. The ventricular system is normal in appearance with no evidence of any dilatation or midline shift. No extra-axial lesion is identified. Impression: Cystic replacement of both hemispheres, sparing the deep gray matter. Features consistent with HIE."

[42] Having examined the records and the results of the investigations, Dr Melbourne-Chambers gave her own professional opinion. She opined that the respondent's injuries could not be attributed to HIE, as had been diagnosed by Dr Tapper and Dr Richards-Dawson. She noted that maternal vital signs and foetal heart rates were normal post induction and throughout labour, and that there was a normal delivery. It was her opinion that "the normal foetal heart rates during the labour period, the clear appearance of the amniotic fluid at artificial rupture of membranes during labour, and the infant's APGAR

scores at birth [were] not supportive of hypoxia/ischemia during the delivery process". She stated that there were four essential criteria to define an "acute intrapartum event of HIE severe enough to cause cerebral palsy", all four of which must be met. She noted that only two of the criteria were established in this case. Five other criteria were required to suggest an intrapartum timing and she indicated that none of them had been established. She also opined that the fact that the respondent's head circumference remained large for his age was also a significant factor in ruling out HIE, as with diffused cerebral injury there is usually a shrinkage or failure of growth of the head, resulting in microcephaly (small head).

[43] It was also her opinion that the reports of the CT scan and the ultra sound suggested "multifocal cerebral infarction in a vascular distribution with evolution to multiple porencephalic cysts". This imaging feature, she noted, had multiple 'etiologies' (which she listed). She further opined that whilst the clinical and laboratory findings could be explained by an intracranial bleed, there was no definitive evidence of same. She further concluded that the clinical course was "not typical of hereditary alloimmune thrombocytopenia (now called neonatal alloimmune thrombocytopenia (NAIT))". In her opinion, whilst that diagnosis was possible, it was extremely unusual for it to have produced significant complications in the absence of any signs of bruising, bleeding in the layer of the skin and mucous membranes, and any overt evidence of bleeding. She quoted a recent review article by DC Risson et al in Paediatric Child Health 2012, September issue 816-22, as follows:

> "'In a retrospective series of 88 thrombocytopenic newborns born to alloimmunised HPA-1a negative mothers, bleeding signs included the following: no bleeding (incidentally detected) (10%), petechiae (90%), haematomas (66%), gastrointestinal bleeding (30%), haemoptysis (8%), haematuria (3%), retinal haemorrhage (7%), and ICH (14%). Platelet counts continued to decrease with a nadir within the first 48 h. Without treatment, platelet counts increased to normal up to 3 weeks postpartum. In prospective studies, a greater proportion of asymptomatic cases of NAIT are seen. For example, in a prospective blood sampling study of 48 of 5632 newborns (0.9%) with immune cases of thrombocytopenia (platelets<150x109)/L), 18/48(38%) had platelets < 50 x 109 / L, with 15/48 (- 31%) being asymptomatic without any bleeding signs…'"

[44] She provided further information on the etiologies, and in respect of neonatal alloimmune thrombocytopenic purpura, she quoted from AJ Barkovich: Brain and Spine Injuries in Infancy and Childhood: Pediatric Neuroimaging 4th edition, 2005 page 234, as follows:

> "'In neonatal alloimmune thrombocytopenia, "Affected infants typically present with widespread petechiae or purpura that develop within a few hours of birth. Intracranial haemorrhage is seen in up to 30% of cases: as many as half of these occur before birth" [sic] "Imaging acutely shows large parenchymal haemorrhages or choroid plexus haemorrhages. Subdural blood may be present, as well. The regions of haemorrhage subsequently undergo liquefaction and, if imaged in the late subacute or chronic phase, large cyst-like regions of porencephaly or macrocystic encephalomalacia are present, usually with ex vacuo enlargement of the adjacent ventricle.'"

[45] Like Dr Gabay, it was her opinion that there were deficiencies in the management of the respondent by medical staff at the hospital, which she listed as follows:

> "a. Failure to document the infant's head circumference at birth and on admission to the VJHPN which limited the later assessment of the significance and timing of the onset of the infant's macrocephaly.

b. Failure to fully investigate the cause of the anaemia, thrombocytopenia and hyponatremia, to investigate for other coagulopathies (clotting abnormalities) and failure to document a plan to obtain imaging of the neonate's brain, urgently, at the time of his initial presentation with seizures, bulging anterior fontanelle, anaemia and thrombocytopenia. Results of the brain imaging may have provided a diagnosis and informed appropriate therapy.

c. There was also no documentation within the infant's medical record of sufficiently close monitoring by the medical staff, particularly with regard to ongoing seizure activity, the neonate's neurological status and the assessment of laboratory results within the period of critical illness, the first few days of his admission to the VJHPN."

[46] Dr Melbourne-Chambers, however, was unable to say whether earlier transfer or referral to the BHC would have produced a better outcome, as "the timing of the insult to the neonate's brain was not established" and could have been intrauterine, that is, "prior to labour and delivery". It was her opinion that, if the 'insult' had occurred during the intrauterine period, it would have been unlikely that the outcome could have been improved by treatment of the respondent at the BHC.

[47] I wish to note at this stage that, although Dr Gabay claimed not to have seen any documentation indicating that vitamin K was administered, Ms Dalhouse, who gave evidence from the hospital records, testified that the respondent was given vitamin K. Dr Melbourne-Chambers, who also examined the same records, saw and recorded the documentation of the administration of vitamin K and the dosage. Dr Gabay also reported that there was no repeat of abnormal laboratory values. However, Dr Melbourne-Chambers' review of the records showed that laboratory tests were repeated several times. Additionally, although Dr Gabay opined that the infant ought to have had early

cranial imaging done, the ones which were later done and presented at the BHC were not reviewed by him. He did not refer, in his report, to any examination done by him of the results of the cranial imaging done, neither did he make any reference to the medical records for the respondent from the BHC.

The decision of the judge

[48] Having heard the evidence, the judge found that the medical staff at the hospital had been negligent in their management of the respondent's mother as a patient at the hospital, as well as of the respondent during and immediately after his birth, and ordered as follows:

> "1) Judgement [sic] for the Claimant against the Defendants with damages assessed as follows:-
>
> (a) General Damages: [sic] awarded the sum of ten Million Dollars ($10,000,000.00) with interest at 3% per annum from the date of service of the claim form (5/6/09) to today's date (10/9/2015) [sic]
>
> (b) Cost of future care in the sum of Ten Million Two Hundred and Twenty Thousand ($10,220,000.00) plus One Million Five Hundred and Twenty Eight [sic] Thousand Eight Hundred Dollars ($1,528,800.00) for special syrup and One Million Four Hundred and Fifty Six Thousand ($1,456,000.00) for special food.
>
> (c) Loss of Future earnings awarded in the sum of Three Million and Eighty Seven [sic] Thousand Six Hundred ($3,067,600.00).
>
> (d) Special damages awarded in the agreed sum of $21,000.00 with interest at 6% per annum from 24/7/2004 to 21/6/2006 and 3% thereon from 22/6/2006 to today's date (10/9/2015).
>
> 2) Costs to the Claimant to be taxed, if not agreed."

The appeal

[49] On 26 October 2015 the appellants filed notice and grounds of appeal challenging the judge's decision and orders that she made in the respondent's favour. The grounds of appeal filed by the appellants are, as follows:

> 1. "The Judge erred in fact and law in finding negligence in the management of Ms. Howell when she became a patient at VJH [Victoria Jubilee Hospital] as well as the [respondent] during and immediately after his birth when there is no evidence to support these findings.
>
> 2. The Learned Judge erred in fact and in law in finding that the APGAR scores [should have] prompted the midwife or doctor on duty to take immediate action in carrying out investigations of the [respondent] when there is no medical evidence to support this finding.
>
> 3. The Learned Judge erred in fact in finding that the experts are agreed that the management of the [respondent] during delivery and immediately after birth was lacking when there is no evidence to support that finding.
>
> 4. The Learned Judge erred in fact and in law in finding that the claimant had been found to have suffered brain damage which occurred while under the management and control of the 2nd [appellant] when there is no evidence to support that finding.
>
> 5. The Learned Trial Judge failed to consider whether the failure to carry out specific investigation [sic] causative of the [respondent's] brain injury. There is no evidence to support that the omissions caused the brain damage. Alternatively, the Learned Trial Judge failed to make definitive finding on causation.
>
> 6. The Learned Judge fell in error and misdirected herself in law in the application of the doctrine of *res ipsa loquitur* which is unsupported by the evidence."

[50] The appellants sought the following orders:

"That the appeal be allowed and:

i. The judgment of the honourable Mrs. Justice Lindo (Ag) on September 10, 2015 be set aside;

ii. Costs of the Appeal to the Appellants to be agreed or taxed."

Preliminary issue

[51] In their submissions to this court, the appellants raised for the first time, the fact that the reports of Dr Tapper and Dr Richards-Dawson, which were attached to the respondent's particulars of claim, and which formed part of the record, were not in the format required by rule 32.13 of the Civil Procedure Rules (CPR). That rule sets out several requirements as to the format an expert report should take, including the fact that all the details of the expert witness's qualifications are to be given, as well as a statement that the expert witness understands his or her duty to the court and has complied with that duty. The appellant complained that these things were not done in respect of the two reports.

[52] The appellants have not included this complaint as a ground of appeal, nor does it appear that it was raised as an issue in the court below. The appellants dealt with it in this court in the most cursory way in their submissions. I also note that the appellants' own expert, Dr Melbourne-Chambers, in her report, outlined and assessed matters contained in the record of the respondent's treatment at the BHC which are contained in the said reports.

[53] It is open to any party to seek to tender evidence contained in a document, without the need to call the maker, under and by virtue of the Evidence (Amendment) Act and

pursuant to the Civil Procedure Rules 2002 (CPR), by giving the required notice. It is equally open to the other side to object, within the time prescribed by the CPR, in order to require the makers of the documents to give oral evidence. There is no evidence that the appellants objected to the documents in the court below, formally or at all. Rule 10.6 of the CPR provides special requirements for defendants in personal injury cases to dispute medical reports attached to a claim or particulars of claim. These particular reports were attached to the respondent's claim and particulars of claim but no mention was made of them in the defence filed by the appellants. A notice of intention to tender documents which listed the two medical reports was also served on the appellants by the respondent on 21 August 2013 and no objection was taken by the appellants. The reports were clearly, therefore, properly admitted into evidence in the usual manner, without objection or dispute.

[54] Even though, it would appear, no application was made to have these reports treated as expert reports under rule 32 of the CPR, the documents having been agreed and admitted into evidence, the judge was obliged to consider and assess them as evidence of the respondent's symptoms and condition at the time he was treated by these doctors and accord to them whatever weight she considered they were due, in light of the appointed expert reports that were before her.

[55] The issue of whether Dr Judy Tapper and Dr Michelle Ann Richards-Dawson were experts in their own fields and whether their reports contained opinion evidence from "experts" involves different principles, the consideration of which it is not necessary to

embark on in this case. It is enough to say that their competence in their respective fields was never challenged. Suffice it to say, also, that there is no rule or principle of law which prevented the respondent, once he had complied with the rules as to notice to tender hearsay evidence contained in a document, from relying on those reports in proof of his claim, in their original format, in the absence of any objection to same or any adverse judicial ruling. The fact that they were agreed and admitted into evidence without objection would not have meant that their contents would not be subject to scrutiny and interrogation.

[56] Only two experts were appointed by the court below, Dr Gabay and Dr Melbourne-Chambers, each of whom had a duty to the court. These two reports were extensively considered by the judge and relied upon by her. In all the circumstances, therefore, I am of the view that the belated complaint of the appellants, by way of submissions, is unmeritorious, especially since it does not form a ground of appeal.

The issues

[57] This case raises several issues including those relating to proof of causation where the negligent act is one of omission. The trial judge was required to find not only whether the respondent had established negligence on the part of the appellants but also whether that negligence was the cause of the respondent's injuries. This court, based on the grounds of appeal filed, had to determine the following:

1. Whether there was evidence to support the judge's finding that the hospital was negligent in the management of (i) the

respondent's mother as a patient; (ii) the respondent during birth and that the experts were agreed that the management of the respondent during delivery was lacking; and (iii) the respondent immediately after birth and that the experts were agreed that the management of the respondent immediately after his birth was lacking (grounds 1 and 3).

2. Whether there was medical evidence to support the judge's findings that the APGAR scores should have prompted the midwife or doctor on duty to take immediate action in carrying out investigations of the respondent (ground 2).

3. Whether the judge erred in finding that the respondent had been found to have suffered brain damage which occurred whilst under the management and control of the 2nd appellant when there was no evidence to support that finding (ground 4).

4. Did the judge fail (a) to consider whether there was evidence to support a finding that the failure to carry out specific investigations was the cause of the respondent's brain injury and whether there was evidence to support a finding that the omissions caused the brain injury; or (b) to make any definitive finding on causation (ground 5)?

5. Whether the judge erred and misdirected herself in law in finding that the doctrine of *res ipsa loquitur* was applicable to the circumstances of this case (ground 6).

The role of this court

[58] In assessing this appeal, I have borne fully in mind, the limitations on the power of this court to reverse the decision of the judge. I am mindful that this court may only disturb the judge's findings of fact if it is satisfied that the judge was plainly wrong because (a) she applied a wrong principle of law or misapplied the law to the facts, or (b) her conclusions could not be justified by any advantage of having seen and heard the witnesses. The matter will then become at large for this court, if it unmistakeably appears from the evidence or if the reasons given by the trial judge are unsatisfactory, so that it is plain that she failed to make use of the advantage of seeing and hearing the witnesses.

[59] Where inferences are to be drawn from primary facts, this court, if it becomes necessary to determine what the proper inferences to be drawn are, is in the same position as the trial judge. In determining this appeal therefore, this court is not entitled to retry the case but is entitled to examine the judge's findings and reach a conclusion whether they can be supported by the evidence, in the light of the advantages she enjoyed. These principles have been well and clearly stated before in several cases (see for example **Watt (or Thomas) v Thomas** [1947] 1 All ER 582 at 587 and **Industrial Chemical Co (Jamaica) Ltd v Ellis** [1986] 35 WIR 303).

Discussion

[60] It will now be necessary to consider the appellant's challenge to the decision of the judge in light of established principles. There is some overlapping between grounds 1 and 3 and, therefore, purely for the sake of convenience, I will discuss and determine the issues raised by those grounds together. However, because very early in the case the judge found that *res ipsa loquitur* was applicable and much of her findings seemed to have been coloured by that view, I intend to deal with the issue raised by that ground of appeal first.

Whether the learned judge erred and misdirected herself in law in finding that the doctrine of *res ipsa loquitur* applied to the circumstances of this case (ground 6)

A. Explanation of the maxim res ipsa loquitur

[61] *Res ipsa loquitur* is a Latin maxim which first appeared in reported cases as far back as in 1863 in **Byrne v Boadle** (1863) 2 H & C 722. The locus classicus on the subject is considered to be the case of **Scott v London and St Katherine Docks Co** [1861-73] All ER Rep 246. The maxim is usually invoked where the claimant has no reasonable explanation as to how and why the accident which resulted in the injury was caused, but, based on the circumstances, the fact of the accident itself gives rise to an inference, which may be rebutted, that it was caused from the defendant's want of care. In such a case, it is said that the '*res* (thing) speaks for itself' and raises a prima facie case of negligence, which requires an explanation from the defendant as to how such an accident could occur even if all due care had been taken. Where the maxim *res ipsa loquitur* applies, therefore, a prima facie case of negligence against a defendant may be inferred, and, in such a case, the defendant would be required to show that there was

some other probable explanation for the accident that is not related to any negligence on his part.

[62] It has sometimes been incorrectly described as a shift in the burden of proof onto the defendant, but it is more accurate to state that the claimant having raised a prima facie case of negligence, it falls to the defendant to provide evidence to rebut that prima facie case. The defendant, would, therefore, bear an evidential burden, so to speak.

[63] In **Scott v London and St Katherine Docks Co**, Erle CJ summed up the principle at page 248 as follows:

> "There must be reasonable evidence of negligence, but, where the thing is shown to be under the management of the defendant, or his servants, and **the accident is such as**, **in the ordinary course of things**, **does not happen if those who have the management of the machinery use proper care**, **it affords reasonable evidence, in the absence of explanation by the defendant, that the accident arose from want of care."** (Emphasis added)

[64] In **Clifford Baker v The Attorney General & Detective Corporal Lewis**, (unreported), Supreme Court, Jamaica, Suit No CL B 274 of 1983, judgment delivered 8 October 1986, Smith J (Ag) (as he then was), in considering the applicability of the maxim said, at page 4, that:

> "Certainly the plaintiff had every right to believe that at one foot from the sidewalk he would be safe. This in my view provides a classic illustration of the doctrine of res ipsa loquitur. By this doctrine where an accident happens which by its nature is more consistent with its being caused by negligence for which the defendant is responsible than by other causes, the burden of proof shifts to the defendant to explain and to show that the accident occurred without fault on his part. The defendant need not prove how and why the accident

happened. It is sufficient if he satisfies the Court that he personally was not negligent or at fault."

[65] In the Privy Council case of **Ng Chun Pui and Others v Lee Chuen Tat** Privy Council Appeal No 1 of 1988, judgment delivered 24 May 1988, the Board, in considering the trial judge's treatment of the defendant's explanation of how a motor vehicle accident occurred, described the maxim at page 3 of the judgment as follows:

> "The judge however was of the view that, despite those findings of fact, because the plaintiffs had originally relied upon the doctrine of *res ipsa loquitur*, the burden of disproving negligence remained upon the defendants and they failed to discharge it. In their Lordships' opinion this shows a misunderstanding of the so-called doctrine of *res ipsa loquitur,* which is no more than the use of a latin maxim to describe a state of the evidence from which it is proper to draw an inference of negligence. Although it has been said in a number of cases, it is misleading to talk of the burden of proof shifting to the defendant in a *res ipsa loquitur* situation. The burden of proving negligence rests throughout the case on the plaintiff. Where the plaintiff has suffered injuries as a result of an accident which ought not to have happened if the defendant had taken due care, it will often be possible for the plaintiff to discharge the burden of proof by inviting the court to draw the inference that on the balance of probabilities the defendant must have failed to exercise due care, even though the plaintiff does not know in what particular respects the failure occurred…
>
> …
>
> **So in an appropriate case the plaintiff establishes a *prima facie* case by relying upon the fact of the accident. If the defendant adduces no evidence there is nothing to rebut the inference of negligence and the plaintiff will have proved his case. But if the defendant does adduce evidence that evidence must be evaluated to see if it is still reasonable to draw the inference of negligence from the mere fact of the accident. Loosely speaking this may be referred to as a burden on the defendant to show he was not negligent, but that only means that faced with a *prima facie* case of negligence the defendant will be found negligent unless he produces evidence that is capable of rebutting the prima**

> **facie case. Resort to the burden of proof is a poor way to decide a case; it is the duty of the judge to examine all the evidence at the end of the case and decide whether on the facts he finds to have been proved and on the inferences he is prepared to draw he is satisfied that negligence has been established. In so far as resort is had to the burden of proof the burden remains at the end of the case as it was at the beginning upon the plaintiff to prove that his injury was caused by the negligence of the defendants**." (Emphasis added)

[66] Adopting the passages from the decisions in **Henderson v Henry E Jenkins & Sons and Evans** [1970] AC 282 and **Lloyde v West Midlands Gas Board** [1971] 1 WLR 749, the Board held that the burden of proof in an action for negligence never shifts. Accordingly, to the extent that it was held in **Clifford Baker v The Attorney General & Detective Corporal Lewis** that the burden of proof shifts to the defendant in a case where *res ipsa loquitur* is applicable, I would respectfully suggest that it was in error.

[67] The maxim is usually more familiarly applied in road traffic and personal injury cases. The applicability of the doctrine in medical negligence cases appears in the reported case of **Mahon v Osborne** [1939] 1 All ER 553, later in **Cassidy v Ministry of Health** [1951] 2 KB 343 and in **Roe v Ministry of Health** [1954] 2 All ER 131, which considered **Mahon v Osborne**. In **Cassidy v Ministry of Health**, the patient went into the hospital for surgery to two fingers of his left hand. After surgery and at the end of treatment he entirely lost the use of his left hand. No one knew why the hand became useless. The defendants called no evidence to explain why it could have happened without negligence on their part. The judge at first instant found for the defendant on the basis that the claimant had failed to prove negligence on the part of the hospital staff.

On the plaintiff's appeal, the Court of Appeal, applying **Scott v London and St Katherine Docks Co**, found that the resulting injury was prima facie evidence that there was negligence at some stage, which was not answered by the defendant. The court found that on those facts, in the absence of any explanation from the defendant, a jury was entitled to find that the accident arose from want of care. In **Roe v Ministry of Health**, although *res ipsa loquitur* was found to be applicable, the inference of negligence was successfully rebutted by the defendant.

[68] In **Delaney v Southmead Authority** (1992) 26 BMLR 111, the plaintiff had successful surgery to remove her gall bladder, however, she suffered injury to her brachial plexus, which caused pain and clawing of the fingers on her left hand. She blamed the anaesthesiologist for positioning her hand during surgery in such a way that it caused excessive strain on the nerve. Her claim was dismissed by the judge at first instance on the basis that the anaesthesiologist did nothing which could be said to have amounted to a departure from the degree of care and skill to be expected of a reasonably competent consultant anaesthetist. On appeal, it was contended amongst other things, that the maxim *res ipsa loquitur* should apply.

[69] The Court of Appeal, in that case, expressed doubt as to the general applicability of the maxim to cases of medical negligence, especially where all the evidence in the case has been adduced. It, nevertheless, found that the maxim did not apply in the circumstances of that case. The court also stated that even if it could have been said that the maxim applied, the prima facie case raised was rebutted by evidence that the practice

adopted by the anaesthesiologists was universally acceptable. In doing so, the court made it clear that even where the maxim was applicable, it was open to the defendant to rebut a case of *res ipsa loquitur*, by giving an explanation which was inconsistent with negligence or by showing that they had exercised all reasonable care.

[70] The court also accepted that the damage suffered by the plaintiff could be attributed to some wholly unanticipated result not inconsistent with due care, and concluded that the trial judge had been entitled, on the evidence, to come to the conclusion he arrived at.

[71] In **Ratcliffe v Plymouth and Torbay Health Authority and another** (1998) 42 BLMR 64, the English Court of Appeal, having been invited by counsel for the appellant to give guidance on the applicability of the maxim in medical negligence cases, concluded (per Brooke LJ, with whom the other judges agreed) that the maxim, in its simplest and purest form, could indeed be applied to medical cases. The court undertook a thorough assessment of several authorities in which the maxim was raised, including **Ng Chun Pui**, and four cases of medical negligence since **Cassidy v Ministry of Health** was decided. Those were: **Bull v Devon Area Health Authority** (1989) 22 BMLR 79 (maxim successfully applied where defendant failed to provide a proper explanation for the delay in the delivery of the second child of a set of twins, leading to asphyxia and severe brain damage); **Jacobs v Great Yarmouth and Waveney Health Authority** (CA 29 March 1984) [1995] 6 Med LR 192 (maxim unsuccessfully raised where the plaintiff claimed she was conscious during her operation); **Delaney v Southmead Health Authority**, and

Fallows v Randle [1997] 8 Med LR 160 (where the maxim was found to be unhelpful in a case where the judge heard two competing theories as to why the plaintiff's sterilization procedure failed and had to be repeated, and accepted the plaintiff's expert's theory over that of the defendant's).

[72] Brooke LJ also considered cases involving anaesthesia and the untoward consequences of anaesthesia and surgery and, at page 80 of the judgment, came to this conclusion:

> "It is now possible to draw some threads out of all this material, by way of explanation of the relevance of the maxim res ipsa loquitur to medical negligence cases: **(1) In its purest form, the maxim applies where the plaintiff relies on the 'res' (the thing itself) to raise the inference of negligence, which is supported by ordinary human experience, with no need for expert evidence. (2) In principle, the maxim can be applied in that form in simple situations in the medical negligence field (surgeon cuts off right foot instead of left; swab left in operation site; patient wakes up in the course of surgical operation despite general anaesthetic). (3) In practice, in contested medical negligence cases the evidence of the plaintiff, which establishes the 'res', is likely to be buttressed by expert evidence to the effect that the matter complained does not ordinarily occur in the absence of negligence. (4) The position may then be reached at the close of the plaintiff's case that the judge would be entitled to infer negligence on the defendant's part unless the defendant adduces evidence which discharges this inference. (5) This evidence may be to the effect that there is a plausible explanation of what may have happened which does not connote any negligence on the defendant's part.** The explanation must be a plausible one and not a theoretically or remotely possible one, but the defendant certainly does not have to prove that his explanation is more likely to be correct than any other. If the plaintiff has no other evidence of negligence to rely on, his claim will then fail. (6) Alternatively, the defendant's evidence may satisfy the judge on the balance of probabilities that he did exercise

> proper care. If the untoward outcome is extremely rare, or is impossible to explain in the light of the current state of medical knowledge, the judge will be bound to exercise great care in evaluating the evidence before making such a finding, but if he does so, the prima facie inference of negligence is rebutted and the plaintiff's claim will fail. The reason why the courts are willing to adopt this approach, particularly in very complex cases, is to be found in the judgments of Stuart-Smith and Dillon LJJ in *Delaney v Southmead Health Authority* [1995] 6 Med LR 355. (7) **It follows from all this that, although in very simple situations the 'res' may speak for itself at the end of the lay evidence adduced on behalf of the plaintiff, in practice the inference is then buttressed by expert evidence adduced on his behalf, and if the defendant were to call no evidence, the judge would be deciding the case on inferences he was entitled to draw from the whole of the evidence (including the expert evidence), and not on the application of the maxim in its purest form.**" (Emphasis added)

[73] In looking at the circumstances in which the maxim was applicable, Hobhouse LJ held that the appropriateness of the application of the maxim depended on the facts of the particular case and gave the following example at page 84:

> "It was suggested on behalf of the appellants that there is difficulty in deciding in medical negligence cases when an inference of negligence would be justified and whether expert evidence would be necessary. The answer is that it depends upon the facts of the particular case. If the facts of the present case had been that the plaintiff had gone into the operating theatre to have an arthrodesis to his right ankle and had come out of the theatre with his right ankle untouched and an arthrodesis to his left ankle, clearly no expert evidence would be required to support an inference of negligence on the part of the defendants. 'In the ordinary course of things', that does not happen if those conducting the operation have used proper care. But if, on the other hand, all that one knows is that a baby has been born with some brain defect, more needs to be proved and expert evidence is required to raise an inference of negligence on the part of those in charge of the management of the birth. The cases of *Cassidy v Ministry of Health* [1951] 1 All ER 574, [1951] 2 KB 343 (plaintiff went into hospital to be cured of two stiff fingers and came out with four stiff fingers) and Roe v Minister of Health

> [1954] 2 All ER 131, [1954] 2 QB 66 (routine operations followed by complete paralysis from the waist down) were apparently treated by at least some members of the Court of Appeal as coming into the first category. The vast majority of medical negligence cases will come into the second category and require the plaintiff to adduce some expert evidence before an inference of negligence can be raised."

Hobhouse LJ concluded that what amounted to an acceptable pleaded prima facie case of negligence would depend on the nature of the injuries complained of and the procedure from which it was said to have arisen.

[74] The Court of Appeal concluded that *res ipsa loquitur* was no more than a convenient Latin maxim used to describe the proof of facts which were sufficient to support an inference that a defendant was guilty of negligence and therefore to establish a prima facie case against him (page 82). It also held that the maxim was not a principle of law raising any rebuttable presumption but was merely a guide to help in identifying whether a prima facie case was made out. In a case where factual and expert evidence had been called at trial by both sides, the maxim would serve no useful purpose. In the end, the Court of Appeal upheld the finding of the first instance judge that the plaintiff had failed to prove that his injury was caused by the negligence of the defendant and that there was no inference of negligence to be drawn from the evidence.

[75] It may be seen, therefore, that the question whether the maxim is applicable depends on the facts of the particular case. As shown by the English Court of Appeal in **Ratcliffe v Plymouth and Torbay Health Authority**, with which reasoning and conclusion I entirely concur, the maxim is certainly not appropriate to all medical negligence cases. In my view, it is more appropriate to medical cases in its purest and

simplest form. In most medical cases the fact that something has gone terribly wrong is very often, not in and of itself, evidence of negligence and the *res* will not speak for itself. Very often there are injuries which occur for no ascertainable reason even where great care is taken. Even where the point at which the damage occurred is identified proof that it was caused by a lack of skill must be given. That finding on causation must be separately made.

[76] In cases where the maxim is expected to be successfully relied on, the claimant will not only have to establish the *res*, but may have to call evidence, expert or otherwise, that the injury is not one that would normally occur in the absence of negligence. It will be prima facie proof of negligence and unless the defendant calls evidence to show otherwise the trial judge would be entitled to infer that there was negligence on the part of the defendant in causing the injury.

[77] In all cases where evidence is given by the claimant and by the defendant at the trial, the court must be satisfied, either inferentially or from direct evidence, that the defendant was negligent and that his negligence caused the claimant's injury. The burden of proof rests on the claimant and never shifts. In cases where the maxim is applicable and a prima facie case is made out, the defendant has the evidential burden to show that the injury could have occurred without negligence and that there was no lack of due care on his part.

[78] It is now necessary to determine whether the judge was correct to find that the maxim was applicable in the instant case.

B. *Was the maxim applicable to this case?*

[79] In the instant case, the judge, relying on the authority of **Scott v London and St Katherine Docks Co**, more specifically paragraph 667 of that judgment, and **Clifford Baker v The Attorney General & Detective Corporal Lewis**, found that, in the circumstances, the doctrine of *res ipsa loquitur* was applicable. She found that the respondent had suffered irreparable brain damage, that the hospital staff had failed to carry out the critical tests that would put them in a position to explain how the respondent had suffered brain damage when his delivery was apparently normal, and that, the management of the respondent was sadly lacking. The judge also found that the midwife was unable to provide evidence as to the immediate care and treatment of the respondent. She went on to find, at paragraph [46], that it was within the 'realm of hypothesis' to say that if the investigations had been done early, as outlined by Dr Gabay, the respondent would not have been brain damaged.

[80] The appellant submitted that the judge was in error, as the maxim of *res ipsa loquitur* was not applicable to the facts of this case, since:

> "i. The injury was not found to have occurred while the Respondent was under the management of the 2nd [appellant], and
>
> i. It was not proven or even alleged by any of the witnesses that the injury is such as would not normally occur if there had been proper care."

[81] Counsel for the respondent maintained that *res ipsa loquitur* was applicable to this case, and argued that this court should not allow the appellants to rely on their own

wrong to escape liability. In that regard, the respondent submitted that, where the doctrine applies, a defendant is not entitled to rely on his own negligence to avoid liability where he is called upon to give an explanation consistent with no negligence. The respondent also relied on the authority of **Millen v University Hospital of the West Indies** (1986) 44 WIR 274, whereby the hospital was found liable for negligence, even though the Court of Appeal had accepted that the hospital's failure was not the initial cause of the injury but had only aggravated it.

[82] The respondent further contended, on the basis of **Cassidy v Ministry of Health** at 349, that the experts having ruled out the hereditary condition, the respondent's outcome was *prima facie* evidence of negligence. Thus, it was submitted, the judge was correct to have focused on the fact that the appellants could not explain the brain damage due to their own failure to do certain initial tests, and "it would make a mockery of the maxim res ipsa loquitur" if the appellants were allowed to rely on their own failures to assert that there was no causation. The respondent, therefore, submitted that it cannot be said that the judge was palpably wrong in arriving at her decision.

[83] I agree with the appellants that there is no evidence that the injuries to the respondent were such that, in the ordinary course of things, they could not have happened unless the staff at the hospital were negligent. Neither were the injuries, by their very nature, more consistent with being caused by negligence on the part of the appellants than with any other cause.

[84] It is clear to me, that the judge erred in finding that *res ipsa loquitur* applied to the instant case. The *res*, in this case, the respondent's brain injuries, did not speak for themselves and are not such that are "supported by ordinary human experience, with no need for expert evidence" (see **Ratcliffe v Plymouth and Torbay Health Authority and another**). Nor was it established by *prima facie* evidence, that the respondent's brain damage was such as would not normally occur had there been proper care. For *res ipsa loquitur* to be even considered, the evidence would have to show that the injury occurred at or after birth. There was no definitive proof of that. The expert evidence called by the respondent did not support such a case. In any event, the appellant did bring expert evidence to cast doubt on the claims made by the appellant. It was the duty of the learned judge to consider all the evidence in the case and determine on a balance of probabilities whether the claimant had successfully shown that the appellants were negligent and that their negligence caused his injuries.

[85] Even if this case could be considered one in which the maxim *res ipsa loquitur* was applicable, the respondent could only succeed on that basis if the appellant had failed to call evidence, either that the injury which occurred was not caused by the medical staff at the hospital, but could possibly have occurred for other plausible reasons that have nothing to do with any act or omission by the medical staff, or, that it was an injury that could have occurred without negligence on their part. In this case both sides called expert evidence. The report from Dr Melbourne-Chambers that the 'insult' could have occurred prior to delivery and birth, as well as that from Dr Gabay which indicated that the respondent's injuries may have been as a result of a condition not related to the actions

or omissions of the appellants, clearly show that the doctrine is not applicable to this case. Not only did the experts not say the injury was likely caused by the acts or omissions of the hospital staff, they were unable to say that the failures they identified contributed to or in any way aggravated the respondent's injuries. None of the experts could pinpoint when exactly the injuries occurred, and they were certainly not agreed on a diagnosis.

[86] Dr Gabay opined that the appellant suffered brain damage as a result of an intracranial bleed, but nowhere did he even hint at the possibility that it was caused by or could have been caused by the hospital staff, or that this was an injury that could not occur unless there had been human error. Dr Melbourne–Chambers indicated that there could have been other causes of the injury and that the 'insult' could have occurred prior to delivery, that is, intrauterine. Whilst, the judge stated that she relied on the evidence of Dr Gabay, he, like Dr Melbourne–Chambers, could not and did not say or imply that the injury suffered by the infant respondent was one that does not normally occur if proper care is exercised. Nor could he say that had the deficiencies in documentation and investigations he listed, not occurred, the infant respondent would not have suffered the injuries that he did, or even that the injuries would not have been so severe.

[87] It is my view that the respondent's reliance on **Cassidy v Ministry of Health** and **Millen v University Hospital of the West Indies** to say that *res ipsa loquitur* applied is misplaced. There was expert evidence in this case pointing to possible causes of the respondent's condition, none of which pointed to negligence on the part of the appellants. That was not so in the case of **Cassidy v Ministry of Health**. In **Millen v**

University Hospital of the West Indies, there was evidence from which the court could have drawn the inference that the defendant's failures had aggravated the claimant's injuries. That is not the position in this case. There was no such evidence. No presumption of negligence can arise where there are a number of possible causes for a claimant's injuries (see **Wilsher v Essex Area Health Authority** [1988] 3 BMLR 37). In such a case a claimant still has the burden of proving that the cause or a substantial cause of the injury was a negligent act or omission by the defendant.

[88] The instant case does not lend itself to the application of the maxim and the burden of proof remained on the respondent throughout, and that did not shift. It is also not a correct statement of principle that because the appellants were unable to state the cause of the damage or when and how it occurred, they must necessarily be responsible for it, or, that the maxim applies simply because the possible cause of the injuries put forward by the appellant was disproved by the experts. The maxim was not applicable and the respondent would still have been required to prove his assertions that the hospital breached its duty of care and that that breach caused or was one of the causes of his injuries.

[89] I agree with the submission of counsel for the appellants that the judge had no basis to find that the maxim was applicable and, in my view, erred. This ground of appeal would, therefore, succeed.

Whether there was evidence to support the judge's finding that the hospital was negligent in the management of (i) the respondent's mother as a patient; (ii) the respondent during birth and that the experts were agreed that the management of the respondent during delivery was lacking; and (iii) the

respondent immediately after birth and that the experts were agreed that the management of the respondent immediately after his birth was lacking (grounds 1 and 3)

[90] It is convenient to summarise here, the law relating to negligence which is applicable to the present case.

The law

[91] To succeed in any case of negligence, there must not only be proof of the existence of a duty of care and a breach of that duty, but the respondent must prove that there was damage caused by that breach, which is not too remote. If a person who owes a duty of care to another fails to do an act which a reasonable man in the same or similar position would do or does some act which a reasonable man in the same or similar circumstances would not have done, and as a result injury is caused to that person to whom the duty is owed, then the one who owes the duty of care will be held liable in negligence.

[92] It is undisputed that a doctor has a duty of care to his or her patients to treat them with reasonable care (see **Bolam v Friern Hospital Management Committee** [1957] 2 All ER 118, which was considered and applied by the House of Lords in **Sidaway v Bethlem Royal Hospital Governors and others** [1985] 1 All ER 643 and the Privy Council in **Chin Keow v Government of Malaysia** (1967) 1 WLR 813). So too does a hospital and all the medical staff under whose care a patient is admitted (see also **Cassidy v Ministry of Health** and **Annissia Marshall v North East Regional Health Authority Saint Ann's Bay Hospital and the Attorney General** [2015] JMCA Civ

56]). In this regard, in **Cassidy v Ministry of Health**, Lord Denning gave the following opinion, at page 360:

> "In my opinion authorities who run a hospital, be they local authorities, government boards, or any other corporation, are in law under the selfsame [sic] duty as the humblest doctor; whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment...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."

[93] It has also long been accepted that the test of the standard of care required, where the duty of care resides in skilled professionals such as medical personnel, is not that of the reasonable man on the 'Clapham bus', as in other cases of negligence, but is that set out in the authority of **Bolam v Friern Hospital Management Committee**, where McNair J stated at page 121 as follows:

> "The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises **the ordinary skill of an ordinary competent man exercising that particular art**...Counsel for the plaintiff put it in this way, that in the case of a medical man negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if a medical man conforms with one of those proper standards then he is not negligent." (Emphasis added)

[94] At page 121 to 122, McNair J, in explaining the application of the test to the jury in that case, went on to state that:

> "I referred, before I started these observations, to a statement which is contained in a recent Scottish case, Hunter v Hanley ([1955] SLT

213 at p 217), which dealt with medical matters, where the Lord President (Lord Clyde) said this:

> 'In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. **The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.'**

> If that statement of the true test is qualified by the words "in all the circumstances", counsel for the plaintiff would not seek to say that that expression of opinion does not accord with English law. It is just a question of expression. I myself would prefer to put it this way**: A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art…Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.**" (Emphasis added)

[95] A doctor, therefore, is not negligent if in diagnosing and treating, he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that art. He also will not be negligent merely because there exists a body of opinion to the contrary, once there is evidence that there is an accepted practice by competent men. If there is an allegation of deviation from an accepted practice, there must be evidence of what that normal or usual practice is and that the practice adopted by the doctor was one which no professional man of ordinary skill and competence would have taken, if he was exercising ordinary care. A doctor who professes to exercise a special skill or competence must exercise the ordinary skill required of his speciality.

[96] It is also important to note that, where negligence is alleged, even if a breach of duty has been admitted or proved, a claimant still has to go on to prove that such breach caused the injury (see **Bolitho (administratrix of the estate of Bolitho (deceased) v City and Hackney Health Authority** [1997] 4 All ER 771). Therefore, even in a case where medical negligence has been established, the question of causation still has to be determined. In **Bolitho**, at page 776, Lord Browne-Wilkinson in delivering the judgment of the House of Lords, stated thus:

> "**Where, as in the present case, a breach of a duty of care is proved or admitted, the burden still lies on the plaintiff to prove that such breach caused the injury suffered**… In all cases, the primary question is one of fact: did the wrongful act cause the injury? But in cases where the breach of duty consists of an omission to do an act which ought to be done (eg the failure by a doctor to attend) that factual inquiry is, by definition, in the realms of hypothesis. **The question is what would have happened if an event which by definition did not occur, had occurred**." (Emphasis added)

[97] Further, in **Mike Williams v Atanascio Cob, Universal Health Services Co Ltd** and **Universal Specialist Hospital Co Ltd (doing business as Universal Health Services Medical Arts & Surgicentre)**, (unreported), Court of Appeal, Belize, Civil Appeal No 9 of 2004, judgment delivered 9 March 2005, (which is not a case cited by either side in this court) that court, relying on **Whitehouse v Jordan and another** [1981] 1 All ER 267, and disregarding any notion that the case was one in which *res ipsa loquitur* was applicable, noted that even if a plaintiff had suffered an injury as a result of an error made by a doctor, he will not be liable for negligence if that error was an error that a doctor acting with ordinary care might have made (see paragraph 18 of Morrison

JA's judgment). In **Mike Williams**, the defendant doctor admitted that he had likely caused a perforation in the plaintiff's oesophagus during a procedure he had performed given the fact that, prior to the procedure, there was no leak of barium swallow, but after the procedure there was. The court rejected the plaintiff's assertion on appeal that this admission of error was an admission of negligence, finding that the trial judge had been correct to find that the appellant had not put forward any evidence beyond the fact of the perforation. The court highlighted the 'critical need' for expert evidence to ground a finding of negligence in such cases, and distinguished the Canadian case of **Gonda v Kerbel** (1982) 24 CCLT 222 on the basis that, in that case, expert evidence had been specifically adduced that perforations of the bowel in the relevant procedure were unlikely, if due care was used. In **Mike Williams**, no such evidence had been adduced.

[98] Further that court, per Carey JA, at paragraph 13 of his judgment, stated this:

> "...[N]egligence is not proved simply because something happens to go wrong. See Denning LJ in his direction to the jury in *Hatcher v. Black* [sic] The Times 2 July 1954. The cases accept that mistakes will be made in providing medical treatment, even when administered with due skill because risk is inherent in the treatment. The duty of the medical practitioner is to exercise reasonable skill and care or as it is said, he is not obliged to achieve success in every case that he treats."

[99] **Whitehouse v Jordan** was a case which involved an infant who was alleged to have suffered brain damage leading to cerebral palsy due to asphyxia at birth. Lord Edmund-Davies, giving judgment in the House of Lords, adopted the standard of the ordinary skilled man exercising and professing to have that special skill envisaged in the **Bolam** test. He said that if a surgeon failed to measure up to that standard in any respect

(clinical judgment or otherwise) he has been negligent. At page 276, he opined that "[t]o say that a surgeon committed an error of clinical judgment is wholly ambiguous, for, while some such errors may be completely consistent with the due exercise of professional skill, other acts or omissions in the course of exercising 'clinical judgment' may be so glaringly below proper standards as to make a finding of negligence inevitable". In that case, the House of Lords, in answering the question whether the doctor had passed the limits of professional competence ultimately found that there was no evidence that the doctor, in attempting to deliver the infant plaintiff using "trial of forceps", had done so in a manner which fell below the acceptable standard.

Discussion

[100] The question that arises from these grounds, and the issues as framed, is whether the hospital staff, in their management of the respondent's mother, and their management of the respondent, which includes his treatment and care during and after his birth, were guilty of acting below the acceptable standard of reasonably competent medical personnel exercising ordinary skill and care in the practice of midwifery, general medicine, obstetrics and gynaecology, and the care of a new born baby exhibiting symptoms similar to those of the respondent. In this case there is no evidence regarding the status of the medical staff who treated the respondent, with the exception of the midwife Ms Dalhouse.

[101] The appellants submitted that the judge erred when she made several findings of fact that were not supported by the medical evidence, but which she used to come to the erroneous conclusion that the appellants were liable for negligence. It was submitted

that, notwithstanding that the judge used the correct test as set out in **Bolam v Friern Hospital Management Committee** to make her decision, in applying that test she erred in finding that the procedure adopted in treating the respondent and his mother had fallen short of the recognized and accepted procedure for treating a post term neonate, since there was no evidence from the expert witnesses specifically addressing what that accepted procedure was.

[102] It was further submitted that the respondent not having called any expert to evaluate the standard of the hospital's management of labour and delivery, there was no evidence before the court by which it could determine whether the treatment had fallen below the required or acceptable standard.

[103] The respondent submitted that the hospital staff were negligent in the care of his mother prior to his birth, and in his care from the time of his birth to his discharge, and that this resulted in him suffering injury, loss and damage. He has characterised this negligence as a failure by the hospital staff to act promptly to investigate, diagnose and treat his symptoms, as well as an inexcusable delay to refer him for further treatment. This deficiency in his management and care, it is alleged, was negligent and resulted in his injury, loss and damage.

[104] I will, therefore, consider whether the judge was correct to find that there was negligence by the hospital staff at the various stages of their management of the respondent and his mother. The particulars of negligence, as identified by the judge at paragraph [32] of her judgment, "were mainly confined to the alleged lack of care in the

treatment of the [respondent] and for failing to properly monitor his mother during labour".

(i) Whether there was evidence that the hospital was negligent in the management and treatment of the respondent's mother whilst she was a patient

[105] It was claimed that there was a failure by the medical staff at the hospital to properly monitor the respondent's mother prior to and during labour in the light of the fact that the respondent was a post-term baby. In finding that the hospital had breached its duty of care, the judge took the view that the evidence showed a lack of proper monitoring of the respondent's mother during labour. At paragraph [41] of her judgment, the judge said this:

> "[41] It is admitted that the 2nd defendant through the VJH and staff which includes Registered midwife Natanee Dalhouse, owed a duty of care to the public including the claimant. This duty of care in my view included a duty to deliver the claimant in an expeditious and timely manner, he being a post-term baby, and to properly monitor Ms. Howell during labour and properly care for the claimant after his birth. In assessing the evidence, I find that Ms. Howell's version of the events which took place during the period from when she was admitted to the VJH to the birth of the claimant, his subsequent placement in the nursery and his later discharge, shows the failure to properly monitor both mother and baby."

[106] There is, however, no evidence to support a finding that there was a breach of duty of care in the monitoring of the respondent's mother prior to or during delivery. Neither was there any evidence from which the judge could have properly concluded that there was a failure to deliver the respondent in a timely or expeditious manner.

[107] The evidence of the midwife, Ms Dalhouse, taken from the medical records, is that the respondent's mother was unable to provide information to determine her due date. An ultra sound examination was done which indicated a possible due date of 15 April and she was also determined to be 35 weeks pregnant (this was not inconsistent with Ms Howell's evidence noted at paragraph 18). She was given the date 19 April to return. At that time, her gestational age was determined to be 40 weeks and 4 days, and she was told to return to the hospital on the 25 April. On that date, she was admitted to the hospital for induction of labour the following day. Her vital signs were normal and there was foetal heartbeat at a rate of 140 beats per minute. She was transferred to the labour ward the next day, 26 April. She was seen by a doctor and nurses that day, who took her vital signs, measured the baby's heart rate, checked her cervix and hydrated her with intravenous fluids. She was induced at 11:10 am by the doctor and her vital signs were checked at 11.35 am. She reported having cramps between, 12:00 pm and 4:50 pm but on examination there were no uterine contractions. The foetal heartbeat was measured, as well as, her vital signs. A doctor attended her at 5:20 pm and she was slated for review in three to four hours. At 5:50 pm, the mother reported that she was having cramps and was assessed by the midwife for foetal heart rate and her vital signs were taken. They were normal. Between 6:50 pm and 9:05 pm, the mother was assessed by the midwife as having one in ten minutes' contractions, with foetal heart rate at 138-144 bpm (beats per minute), the same as before. At 11:25 pm, her contractions were fifteen minutes apart. Her vital signs remained normal, as did the foetal heart rate.

[108] On April 27 at 1:00 am, Ms Howell was seen by a doctor and a plan was prepared for artificial rupture of the membrane which remained intact, as well as the administration of Oxytocin. At 4:30 am, her contractions were 15 minutes apart, and at 6:00 am they were between 15 and 30 minutes apart. At 7:55 am, she was seen by a doctor who did a vaginal examination and her membrane was artificially ruptured. At 9:15 am, the midwife recorded her contractions to be 10 minutes apart. Foetal heart rate and vital signs remained normal. At 9:50 am, contractions were five minutes apart and foetal heart rates and vital signs were within the normal range. At 10:40 am, the midwife performed a vaginal examination which revealed that her cervix was fully dilated. The respondent was delivered at 11:38 am, weighing 3.71 kg. He was suctioned, given oxygen, eye prophylaxis and vitamin K, and passed meconium at birth. The mother sustained a laceration which was sutured by a doctor 13 minutes after delivery. The evidence of Ms Dalhouse, given on cross-examination, and which was not challenged, is that there was nothing unusual or untoward about that.

[109] Based on this summary, which at the end of the case remained factually unchallenged, there did not appear to be anything unusual, untoward or deficient in the care of the respondent's mother after admission to the hospital and during delivery. The evidence of the respondent's mother is that at the time of her admission to the hospital, she was not in labour. Labour was induced and she gave no evidence to suggest that her delivery was anything other than uneventful.

[110] What did the experts who examined the hospital records have to say about the respondent's mother's management and care which caused the judge to arrive at the conclusion she did? Dr Gabay made no reference to the medical record prior to delivery. His report begins with the infant's birth on the 27 April at 11:38 am. Dr Melbourne-Chambers gave a summary of the clinical details recorded in the hospital medical records for the respondent and his mother, as I have previously noted, and it was her professional opinion that the respondent was delivered post-dates after an apparently uncomplicated labour and delivery period, post induction of labour. She made no adverse professional findings regarding the monitoring, care or treatment of the respondent's mother prior to and during delivery.

[111] There were no inadequacies in the management of the respondent's mother prior to and during delivery listed amongst the list of deficiencies recorded by both experts.

[112] The judge took the view that the duty of care owed by the appellants included the duty to deliver the respondent in an expeditious and timely manner, and to properly monitor his mother during labour, and that the hospital had failed in this duty. In the absence of any evidence, medical or otherwise, that the care of the respondent's mother, as recorded in the hospital records, fell below acceptable standards for the care of pregnant mothers in similar situations, then respectfully, the judge had no basis to find that the appellants breached their duty to her during labour. Therefore her finding at paragraph [47] of her judgment that the appellants breached their duty of care which is

highlighted "by the evidence of the lack of proper management of Ms. Howell when she became a patient at VJH" cannot be allowed to stand.

[113] The judge also could not properly rely on the respondent's mother's evidence alone, as it stood, as a basis to find that that the medical staff at the hospital were negligent in the care they took of her during labour. The substance of her evidence was that she was admitted, she was attended to by nurses and a doctor, labour was induced and she had the baby. No issue of the credibility of the respondent's mother arose but there is no evidence from her of any incident from which the judge could have inferred that her care and management during labour was other than it ought to have been by recognisable standards or which would call into question that which was recorded by the hospital. In that regard, therefore, I agree with counsel for the appellant that the judge erred in finding that the respondent's mother's version of events showed a failure to properly monitor her during labour. It was clearly a finding made with no evidentiary support and it too cannot be allowed to stand.

(ii) Whether there was evidence to support the judge's finding that the hospital was negligent in the management of the respondent during his birth and that the experts were agreed that the management of the respondent during his delivery was lacking

[114] The judge found that there was a lack of proper management during the respondent's birth. She based her finding that the hospital was negligent in the treatment and management of the respondent during delivery on the respondent's mother's evidence, and what she found to be the 'consensus of the experts'. At paragraph [54] of her judgment she said this:

> "[54] I have placed reliance on the professional opinions of the two expert witnesses and in particular on the opinion of Dr Gabay. Although neither expert was able to state whether the claimant's disabilities would have been reduced if there had been proper care and documentation showing sufficiently close monitoring of the claimant, I accept the consensus of the experts who are agreed that the management of the claimant during delivery and immediately after birth was lacking."

[115] However, as submitted by the appellants, there is no evidence to support a finding that management of the respondent during his birth was deficient, inadequate or in any way lacking. With regard to the evidence given by the respondent's mother, as I said previously, there was nothing said by her which would indicate that she had experienced anything other than a normal delivery. Her mother was not present at the hospital at the time she gave birth and could give no evidence with respect to that. Ms Dalhouse, who gave evidence from the hospital records, gave no evidence of anything untoward occurring during the respondent's birth.

[116] As far as the expert reports are concerned, there was no mention in any of the reports of any mismanagement or shortcomings in the management and care of the respondent during delivery which fell below the required standards. Both Dr Melbourne-Chambers and Dr Gabay noted a normal delivery and normal Apgar scores, with the former doctor noting that maternal vital signs and foetal heart rates were normal post induction and throughout labour. Dr Gabay noted that the respondent's Apgar scores at birth, which he explained was a rating scale of a new-born's wellbeing, was 8 out of a possible maximum score of 10 at 1 minute after birth, and 9 out of 10 at 5 minutes after birth. Dr Melbourne-Chambers indicated that the respondent's symptoms began at 23

hours after birth. Like Dr Gabay, she did not agree with the diagnosis of the doctors at the BHC, as the indications of normal delivery did not support such a diagnosis.

[117] Therefore, in making the findings that the hospital was negligent in the management of the respondent during his birth and that the experts agreed that the management of the respondent during his delivery was lacking, the judge fell into error. There was no evidence to support such a finding.

(iii) Whether there was evidence to support the judge's finding that the hospital was negligent in the management of the respondent immediately after birth and that the experts were agreed that the management of the respondent immediately after his birth was lacking

[118] Counsel for the appellants argued that, whilst the appellants accepted that both Dr Gabay and Dr Melbourne-Chambers identified deficiencies in the management of the respondent immediately after birth, these were largely in respect of a failure to document. Counsel for the appellant further submitted that based on the authority of **Rhodes v Spokes and Fairbridge** [1996] 7 Med LR 135, a failure to document was not evidence of a doctor's negligence. Counsel argued further that, nonetheless, despite the noted deficiencies in documentation and investigation, Dr Gabay's report indicated that initial appropriate investigations were done, and seemed to have approved the action taken by the medical staff in giving the respondent a 'whole blood transfusion', which according to him would have corrected the respondent's thrombocytopenia.

[119] Counsel also argued that Dr Melbourne-Chambers' criticism was of the failure to 'fully investigate' which counsel said would suggest that investigations were undertaken, albeit, in her opinion, more investigations should have been done. It was submitted that,

even if this was so or there was in fact 'inadequate assessment', the respondent would have had to prove what investigations and/or assessments were required and whether, by not conducting same, the medical staff failed to act 'in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art'.

[120] Based on the evidence of the respondent's mother, the first noticeable sign that there was a problem with the respondent was immediately after birth when she realized that he was not eating. The respondent then started crying a lot. She gave no time after birth as to when this crying started, but said he cried throughout the night after his birth.

[121] According to both Dr Gabay's and Dr Melbourne-Chamber's summary of the hospital records, it was noted that at 5:41 am, on the morning of 28 April, the mother of the respondent complained of the respondent's rapid heart rate to a nurse. The nurse made a note of the baby's heart rate and said that she would inform a doctor.

[122] According to Dr Melbourne-Chambers, at about 11:00 am the same morning, the mother complained that the baby was not "sucking" and was examined by the nurse who found the baby to be lethargic, with pallor of the skin, normal fontanelles and mildly rapid breathing. The respondent was taken to the nursery. He was examined by a doctor who recorded his findings as mild lethargy, increased respiratory rate, response to stimuli and a full anterior fontanelle. Tone and reflexes were okay but the abdomen was mildly distended. The respondent's bowel sounds were normal.

[123] As I previously stated, Dr Gabay noted in his report that the initial appropriate measures were taken by the hospital staff including the administration of oxygen therapy,

IV fluids and antibiotics in association with initial appropriate investigations. Dr Melbourne-Chambers listed a number of tests which were conducted, which ruled out meningitis and sepsis, amongst other things. A complete blood work test was also ordered. Medication was prescribed and the respondent's cerebrospinal fluid was sent for further testing. By my count, according to Dr Melbourne-Chamber's recount of the records, the respondent's blood work was repeated at least four or five times before his discharge.

[124] Dr Gabay also noted what he considered to be inadequacies in the respondent's care. The first was the failure to document the administration of vitamin K, which from the evidence, is unlikely to be correct as Dr Melbourne Chambers, and Ms Dalhouse who both reviewed the same hospital records, noted that vitamin K had been administered. Dr Gabay also found that there was "inadequate documentation in the first twenty-three hours of life as to infant's medical condition, so as to adequately recognise and respond in a timely manner to any deterioration". However, the evidence from the medical records is that the respondent appeared to be healthy at birth and did not start showing obvious symptoms until after the first 23 hours of life. Dr Gabay failed to indicate what he would have expected to see documented as regards the infant's condition in the first 23 hours of life, if no symptoms were exhibited.

[125] Dr Melbourne-Chambers listed the failure to document the circumference of the respondent's head at birth and on admission to the nursery as a deficit in the management of his care immediately after birth. However, it is to be borne in mind that

Ms Dalhouse gave evidence that, although she could not recall if the head circumference was measured, it was not done as a matter of routine at the hospital at that time. Neither expert gave any evidence that the measurement of the circumference of a baby's head at birth was standard operating procedure at hospitals at the time, and that the failure to do so fell below that standard. It may very well have been, but no evidence was given on that score.

[126] Dr Gabay also noted that there was inadequate documentation and follow up of the infant's progress in the subsequent 24 hours after the initial assessment. In his report he noted that after the initial appropriate measures were taken on the 28th, there is no "physician documentation" of the respondent's condition and response to therapy until 8:00 am on 29 April, which he noted as 21 hours later. By this time, the respondent was having tense anterior fontanelle associated with seizures and abnormal posturing of the body, which he said indicated worsening intracranial pathology. In Dr Gabay's opinion the response to the seizures at 8:00 am, after it had been recorded from 5:00 am, was inadequate in relation to time.

[127] Dr Gabay noted also that there was no diagnosis by the respondent's doctors of intracranial bleed or any assessment done of the cause of all the symptoms the respondent was showing. This failure to assess the causes of these symptoms, he said led to a delay in referrals and treatment. He also opined that the delay in blood transfusion may have resulted in extension of intracranial haemorrhage. He also noted the delay in cranial imaging which could have confirmed a diagnosis.

[128] Dr Melbourne-Chambers was also of the view that there was a failure to fully investigate the cause of the symptoms being exhibited by the respondent and to document a plan to obtain imaging of the respondent's brain urgently at the time of his initial seizures and bulging anterior fontanelle. Dr Melbourne-Chambers noted that the circumference of the baby's head was measured for the first time on 3 May, day nine of his life. It was recorded as 39.5 cm, which was large for his age and gender.

[129] The lack of investigation she mentioned was the failure to test the blood clotting mechanism and to do the brain imaging, which she said may have provided a diagnosis and informed appropriate treatment. She too found that there was no documentation showing that the respondent was closely monitored and his laboratory results assessed during the first few days of his admission to the hospital nursery.

[130] It is clear, therefore, that both experts did in fact, indicate in their reports that there were inadequacies in the management and care of the respondent at the hospital after birth. Dr Gabay was of the view that "the documentation of his care and management indicate inadequacies in both areas".

[131] However, the deficiencies in the management of the respondent which were identified by both experts, were largely centred on the failure of the medical staff to adequately monitor, document and fully investigate the infant respondent's symptoms. This included the failure to fully investigate the cause of anaemia, thrombocytopenia and other clotting abnormalities and failure to investigate neonates brain urgently when seizures started and symptoms began to appear. Importantly, both doctors seemed to be

of the view that earlier brain scans may have provided a diagnosis and may have informed appropriate therapy and early referral and treatment.

[132] I am not sure that this court ought to be detained by the fact that the finding was in regard to the management of the respondent "immediately" after his birth. The evidence is that symptoms began at 23 hours. Whether this can be considered as 'immediately' after birth as described by the judge is a matter of how that word is to be defined. The Oxford online dictionary defines 'immediately' as 'at once', 'instantly', 'without any intervening space', and/or importantly 'in direct or very close relation' (Oxford University Press, 2020, lexico.com). Dr Gabay noted inadequate documentation in first 23 hours of life and inadequate documentation and follow-up in the subsequent 24 hours after the initial assessment. Dr Melbourne-Chambers spoke to the failure to document the infant's head circumference at birth and on admission to the hospital's nursery, which limited further assessments of the infant's macrocephaly and a failure to document a plan to obtain imaging of the respondent's brain. Both doctors, therefore, noted deficiencies in documentation and investigation following the presentation of symptoms in the respondent at birth and about 23 hours after birth when the first symptoms began to show, and in the subsequent 24 hours. The judge was, therefore, correct to find that there was agreement amongst the experts that the management and care of the respondent was inadequate immediately after birth.

[133] Whether the hospital was negligent, however, depends, not on whether there was mismanagement 'immediately after birth', but rather, on the question of whether in the

circumstances it has been proved that the management and care given to the respondent after his birth fell below the reasonably accepted standard of ordinarily skilled doctors and midwives in the position of the medical staff who treated the respondent, and, if so, whether if he had received proper management and care it would have prevented or alleviated his injuries.

[134] Dr Gabay opined that there was no documentation of a possible diagnosis of intra cranial bleed. Failure to document a possible diagnosis is not negligence. Both doctors decry the absence of documentation of close monitoring of the respondent after the symptoms first started, but again failure to document is not evidence that there was no monitoring of the respondent or that there was negligence. However, although I agree with counsel for the appellant that a failure to document is not evidence of negligence, I should point out that where a defendant is called upon to respond to a claim that he omitted to do what is normally expected and there is no documentation of having done it, he may find it more difficult to provide an answer to that claim. In this case, for instance, it is clear that the staff owed a duty of care to the respondent to closely monitor his condition as soon as it became clear that he was exhibiting symptoms of seizure. According to the experts there was no record, for a period of 21 hours after the respondent's symptoms became acute, that he was being closely monitored. He may have been, but the records do not reflect it. Ms Dalhouse could not assist with that from her own memory of events. Still there is no evidence apart from the lack of documentation, that the respondent was not being closely monitored in the nursery.

[135] Notwithstanding, there is evidence that a series of test was conducted during and after this period. Dr Gabay noted that there was no documentation of follow-up on the testing whilst the respondent's condition showed signs of worsening. However, the records show that a plethora of tests were done and repeated and the results recorded each time. It is, therefore, difficult to understand exactly, with any degree of certainty, what Dr Gabay's and to some extent Dr Melbourne Chambers' complaint was in this regard. It seems as if they were of the view that there should have been some documentation of the analysis or assessment of the laboratory tests that were done.

[136] Both experts were also of the opinion that the fact that no cranial imaging was done, and, in the case of Dr Melbourne-Chambers that, no additional test of the clotting mechanism was done, was a failure in the management of the respondent by the medical staff. Dr Melbourne-Chambers did not say what these other tests of the respondent's clotting mechanism were or how they would have assisted in early diagnosis and treatment. Neither expert said that in failing to do these tests, the medical staff at the hospital were acting below the standard expected of medical professionals in their position, faced with an infant exhibiting the symptoms the respondent was exhibiting. The respondent was, nonetheless, treated with anticoagulants, which were only discontinued just before his discharge when he was recorded as progressing normally. He was also given blood transfusions and whole blood platelets even though the causes of the anaemia and thrombocytopenia were never ascertained and the imaging was not yet done.

[137] At paragraph [55] of her judgment the learned judge stated that:

> "Applying the principles in **Bolam v Friern Hospital Management Committee** (supra), to the facts of this case, I am of the view that the standard of care owed to the Claimant was that prior to, and at birth he should have been properly monitored, and at birth certain investigations done. The absence of documentation to show, for example, if the measurement of his head had been done by the attending midwife and the inability of the [Appellants'] witness to recall what took place at the time of birth, speak volumes of the fact that the staff at VJH who saw Ms. Howell when she was admitted, and dealt with her up to the time of delivery of the claimant and to the time he was discharged from the hospital, were negligent in the treatment to her and to the claimant."

[138] It is clear that in making these findings the learned judge erred. As said before there was no evidence that the management and treatment of the respondent's mother fell below the expected standard. There is also no evidence that the management and care of the respondent at birth fell below the accepted standard, and in fact, the expert evidence was that delivery was normal. Neither was there any evidence of what investigations should have been done at birth, since birth appeared to have been normal. With regard to the failure to measure the respondent's head circumference, the evidence of the mid-wife was that she could not recall if the respondent's head circumference was measured at birth but that, at that time, it was not routine to do that measurement. None of the experts indicated that the heads of babies born in the hospital were to be routinely measured. Neither did they opine that the failure to measure the circumference of the respondent's head led to or aggravated his injuries, even though they did say it may have assisted in the timing of the "insult".

[139] In her finding that the absence of documentation spoke volumes as to the appellant's negligence, the judge also fell into error, as the failure to document, without more, is not evidence of negligence (see **Rhodes v Spokes and Fairbridge**).

[140] It is also not possible to determine what the judge meant when she said that the inability of the witness to recall what happened at birth "spoke volumes" that the appellants' were negligent. There was no evidence of anything happening at birth to speak volumes as to the appellant's liability in negligence. There was also no evidence that Ms Dalhouse, the appellants' witness, was herself guilty of negligence, and in so far as the judge concluded that Ms Dalhouse, as the mid-wife and the rest of the medical staff were negligent, simply from the fact that she could not give evidence of what happened at the respondent's birth from her own recollection of events, the judge was plainly wrong. Ms Dalhouse was giving evidence several years after the event. She gave evidence based on the records from the hospital. She was the midwife on duty at the birth. Nothing in the records as recounted by her or the experts, shows any act or omission on her part from which the judge could properly have concluded that she was negligent in her duty as a midwife. Neither could the judge properly have concluded that the appellants were negligent based only on Ms Dalhouse's inability to give evidence of the respondent's birth from memory.

[141] The judge also concluded that the procedure adopted in dealing with the respondent and his mother at birth fell short of what is recognised and accepted as the procedure for treating a 'post term neonate' but it is unclear how she came to this

conclusion, as there was no evidence from any of the doctors as to any procedure regarding what was the expected treatment and management of a post term neonate. Neither did any of the experts indicate that the treatment and management of the respondent and his mother was below the standard required for a post term neonate.

[142] I do not put much store into the evidence by Dr Melbourne-Chambers that there should have been additional test of the infant's clotting mechanisms without further evidence of what these tests were and that the failure to do them is something that no reasonable competent doctor in the position of the respondent's doctors would have failed to do. A host of blood tests were done on the respondent and the fact that the doctors did not do the additional ones, cannot without more, be deemed to be negligent, in the absence of any evidence that no reasonably competent doctor would have failed to order those additional tests. With respect to Dr Gabay's observation that there was no physician note of a possible diagnosis of intracranial bleed, I do not think it correct to say that there was negligence because the doctors made no note of a possible diagnosis of intracranial bleed.

[143] I have also given consideration to the opinion of Dr Gabay that there was a failure to give the respondent the required blood transfusion as a matter of urgency. The blood transfusion was ordered in a timely manner, it would appear, but the request had to be repeated a day later and it actually took approximately two days after it was first requested for it to be done. I agree that this request was not treated with any urgency. The appellants gave no evidence as to why it took two days to transfuse the respondent

after it became clear it was necessary. However, there was no evidence given as to any adverse effect of the two day wait for the whole blood transfusion and, in any event, Dr Gabay's opinion was that the whole blood transfusion would have corrected the thrombocytopenia and the platelet values improved thereafter.

[144] I am, however, more concerned about the failure to conduct the cranial imaging earlier, as part of the investigations into the respondent's symptoms as an aid to early diagnosis. The respondent was having symptoms indicative of a seizure, bulging fontanelles, hydrocephaly and macrocephaly. I would have thought it prudent for the doctors at the hospital, who were in charge of the respondent's care and management, to conduct the cranial imaging as early as possible, once there was an indication of a seizure and possible trauma to the brain. Both experts were of the view that imaging of the respondent's brain should have been done as soon as those symptoms manifested themselves. Certainly, it should have been done as soon as it became clear that the symptoms persisted. The doctors, however, seemed content to treat the respondent without the aid of the imaging.

[145] It seems to me nonsensical, in the circumstances, to order cranial imaging at the point of discharge, for if it was necessary when the child appeared healthy when he was being discharged, it must have been even more necessary earlier when he was showing symptoms. The evidence of both Dr Gabay and Dr Melbourne-Chambers is that early cranial imaging may have provided an early diagnosis. This was not done by the doctors at the hospital. Although obvious symptoms did not appear until some 23 hours after

birth, in my view in so far as there were obvious signs that there was something which could be impacting the respondent's brain, an early path to testing his brain ought to have been mapped by the medical staff.

[146] I have considered the fact that neither expert gave any direct evidence that the failure to conduct the cranial imaging was not in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. There was also no evidence of the qualifications of the doctors who treated the respondent. However, even though the experts did not say that the failure to do early cranial imaging fell below the standard required of the doctors who looked after the respondent, the fact that it was labelled a failure, raises the question as to whether it was an inference the judge could have properly drawn from the fact of the evidence of the infant's symptoms and the fact that the imaging was not ordered at the early stage. In the absence of any evidence from the appellant as to why the medical staff failed to order that test earlier in the face of those symptoms, the judge would have been required to ask herself whether a reasonably competent doctor in the position of those who were in charge of the respondent's care would have failed to order an imaging test in the early stages of the infant's symptoms, bearing in mind the age of the new born and the fact that he was so ill in the nursery. Both experts, together forming a reasonable body of professional opinion, found the omission to be a failure. It seemed, without any evidence to the contrary from the appellants, to have been an unreasonable and illogical stance for the medical staff to take. For this reason, although there is no evidence that the experts agreed that the management and treatment of the respondent was inadequate during

birth, I am of the view that there was in fact evidence from which the judge could have concluded that there was agreement amongst the experts that the management of the respondent was lacking immediately after birth.

[147] In so far as the management and care of a patient includes treatment and care, there was no evidence that the treatment and care of the respondent was lacking, for although there were complaints that specific tests were not done, there was no complaint that the appropriate treatment was not given, or that there was a more appropriate treatment which could or ought to have been given but which was not. The consensus amongst the experts was that all the appropriate treatments were given. Even though cranial imaging was not done early, the evidence was that treatment with blood transfusions and whole blood platelets was appropriate to alleviate thrombocytopenia caused by any possible bleeding. Anticoagulants were administered to deal with any clotting abnormalities although the clotting mechanism was not tested. Treatment was also given for the low body sodium, and antibiotics were administered in case of infections. Therefore, in so far as it appears to me that the judge equated the management and care of the respondent's symptoms with his treatment, to find that the appellants were negligent, she went too far.

Whether there was medical evidence to support the judge's findings that the APGAR scores should have prompted the midwife or doctor on duty to take immediate action in carrying out investigations on the respondent (Ground 2)

[148] The medical evidence is that the well-being of a new born baby at the hospital is measured by what is known as an Apgar score (Activity, Pulse, Grimace, Appearance, Respiration). These are rated on a points scale and the maximum overall score that can

be given is 10 points. For each of the 5 categories - appearance (skin colour), pulse (heart rate), grimace (reflex irritability/response), activity (muscle tone), and respiration (breathing ability) - the baby can be scored between 0 and 2 points.

[149] In relation to the respondent, the undisputed evidence is that he was given an Apgar score of 8 at 1 minute, and 9 at 5 minutes after birth. In relation to the score of 8 at 1 minute after birth, the respondent's heart rate, respiratory effort and muscle tone were scored at 2 and reflex irritability and colour were scored at 1. Whilst, for the score of 9 at 5 minutes after birth, the respondent's heart rate, respiratory effort, muscle tone and reflex irritability were scored at 2, and his colour scored at 1.

[150] Unfortunately, because the experts did not give evidence in person and were not cross-examined, the significance or meaning of these scores were not properly explained to the judge. The judge erroneously found that the latter scores of 1 and 2 were bad and should have prompted immediate investigations by the medical staff on duty. At paragraph [44] she stated:

> "[44] Neither party placed significance on the Apgar score which is used to measure the baby's general condition at birth. The scores of 8 and 9 were found to be normal by the medical professionals. However, I find that the scores for heart rate, respiratory effort, muscle tone and colour should have prompted the midwife or doctor on duty to take immediate action in carrying out investigations."

The appellant argued that the judge erred when she made this finding as there was no medical evidence to support it.

[151] I must agree with counsel for the appellant. This finding by the judge was erroneous and not a finding she could have properly made on the evidence. It would appear from this finding that the judge misunderstood the way in which the Apgar scores were to be assessed. This is evident due to the fact that for the first score, the respondent had scored the highest amount of points for three of the categories, which was 2, and then 1 point each for the remaining categories. In respect of the second score, he scored maximum points for all but one category. There were no zeros. Thus, it could be said that the respondent had scored near perfect scores, being 8 and 9 out of 10.

[152] There was no evidence from anyone and certainly not from any of the doctors that the respondent's APGAR scores were indicative of ill-health, or that they were a cause for alarm and, therefore, should have 'prompted the midwife or doctor on duty to take immediate action,' as found by the judge.

[153] To the contrary, both Dr Gabay and Dr Melbourne-Chambers expressly indicated that the respondent's APGAR scores were normal, a fact which the judge herself acknowledged in paragraph [44] of her judgment. Despite that evidence, however, she went on to make the erroneous finding that she did.

[154] In **Bolitho v City of Hackney Health Authority**, the court dealt with the importance of expert evidence in these types of cases. Lord Browne–Wilkinson noted that "[t]he assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence". The judge was of course entitled to accept or reject part or all of the evidence. However, in doing so she

ought to have had a valid reason. There was no plausible reason proffered for her departure from the opinion of these trained professionals and actual medical science. In that regard she undoubtedly erred.

Whether the judge erred in finding that the respondent had been found to have suffered brain damage which occurred whilst under the management and control of the 2nd appellant when there was no evidence to support that finding (ground 4)

[155] The appellants take particular issue with the judge's finding that the respondent was found to have suffered brain damage which occurred whilst under the management and control of the 2nd appellant, for which, they say, there was no such evidence to support such a finding. The context within which the finding was made by the judge is bound up with her findings that, since the respondent was seemingly normal at birth, and the experts determined that there was some level of mismanagement in his care, his injuries must have occurred whilst he was under the management and care of the hospital.

[156] I must agree with the appellants that this was a finding the judge could not properly make. Whilst the evidence is that the respondent was under the management and control of the hospital immediately prior to birth up until he became symptomatic, that fact in and of itself, does not automatically lead to an inference that the brain damage occurred whilst he was under the management and control of the hospital and its medical staff. Dr Gabay gave no opinion on the timing of the injury, and the evidence of Dr Melbourne-Chambers is that "the timing of the insult to the respondent's brain was not established", but that it could have been prior to labour and delivery, that is, intrauterine.

[157] There was no evidence before the judge as to when the brain damage occurred. The judge, therefore, erred when she found that the brain damage occurred whilst the respondent was under the management and control of the medical staff of the hospital.

Did the judge fail (a) to consider whether there was evidence to support a finding that the failure to carry out specific investigations was the cause of the respondent's brain injury and whether there was evidence to support a finding that the omissions caused the brain injury; or (b) to make any definitive finding on causation (ground 5)

[158] The remaining issue is whether the judge failed to consider the question of causation and whether in fact there was evidence from which the judge could have concluded that the respondent's injuries were caused by the acts or omissions of the hospital staff.

[159] The appellants have contended that the judge erred in finding that the respondent's injuries were a direct result of inadequate management of the respondent by the hospital staff, as (1) nowhere in the judge's findings did she examine the cause of the respondent's injuries; (2) the judge accepted at paragraph [54] of her judgment that "'neither expert was able to state whether the claimant's disabilities would have been reduced if there had been proper management and documentation showing close monitoring of the Claimant"; and (3) none of the experts were able to definitively state that the respondent's injuries were caused as a result of any act or omission of the appellants.

[160] In this respect, the appellants have relied on the authority of **Bolitho (administratrix of the estate of Bolitho (deceased) v City of Hackney Health**

Authority at page 776, for the proposition that, even where a breach of duty has been proven or admitted, the claimant still has the burden to prove that the breach caused the injury suffered. The cases of **Barnett v Chelsea and Kensington Hospital Management Committee** [1969] 1 QB 428 and **Wilsher Essex Area Health Authority** were similarly relied on.

[161] The appellants submitted further, on the authority of **Joyce v Merton Sutton and Wandsworth Authority**, that the respondent had the burden of proving, on a balance of probabilities, that his brain injury would have been avoided had the investigations and documentation complained of, been done by the medical staff at the hospital, however, he failed to discharge that burden. It was submitted that, from Dr Gabay's finding that thrombocytopenia appearing in newborns is usually "an autoimmune–mediated phenomenon related to maternal transplacental IgG antibodies", it is clear that such an illness could have resulted from a cause other than the acts or omissions of the appellants. The appellants also rely on the opinion of Dr Gabay that "the documentation of the respondent's care and management indicate inadequacies that may or may not have resulted in lesser disabilities for the child had they not occurred".

[162] The appellants further relied on the authority of **Wilsher Essex Area Health Authority** where it was said that a claimant must prove, on a balance of probabilities, either that his injury was directly caused by the act of negligence or breach of duty alleged, or that the same materially contributed to the said injury. On that basis, the appellants have argued that none of the experts stated that the respondent's injuries

"occurred as a result of or was materially contributed to by any act or omission of the appellants".

[163] The respondent, however, maintained that the conclusions arrived at by the judge were reasonably justified, as the expert evidence before the judge on behalf of both parties indicated that negligence had occurred in the management and care of the respondent, and that the respondent's outcome was not caused by "hereditary alloimmune thrombocytopenia" as alleged by the appellants in their defence. The respondent also pointed to the report by Dr Melbourne-Chambers in which she stated that she could not conclude that if earlier tests, diagnosis or transfer of the respondent to the BHC had been done it would have produced a different outcome in the respondent's condition. This, the respondent has argued, is due to the appellants' own failures in the care and management of the respondent, and the appellants should not be allowed to rely on their own failures.

[164] The judge found that the injury and damage suffered by the respondent was a direct result of the omissions of the medical staff at the hospital. She based this finding on the fact that the respondent appeared to be normal at the time of delivery, but was required to spend two weeks in the hospital's nursery where he was found to be brain damaged. On this basis, she found that he was suffering from brain damage that occurred whilst he was in the management and control of the hospital and that it was caused by the acts and or omissions of the medical staff who cared for him. She seemed to have

also found that the brain damage could have been prevented if early investigations had been done. At paragraph [46], she put it this way:

> "[46] **It is therefore within the realm of hypothesis to say that if the investigations had been done early, as outlined by Dr Gabay the claimant would not have had brain damage**. However, I find that the claimant, **having been delivered as an apparently normal child** and to have had to remain in the nursery for two weeks before being discharged **and to have been found to have suffered brain damage which occurred while under the management and control of the 2nd defendant is a clear indication that the acts and or omissions of the persons under whose care he was …are the cause of the injury and damage suffered by him**." (Emphasis added)

[165] This statement by the judge is a clear misinterpretation of Dr Gabay's opinion. Dr Gabay gave no opinion on the cause of the injury or its timing, and was inconclusive as to whether earlier diagnosis or referral would have made a difference. There was nothing in the expert opinion of Dr Gabay from which the judge could find that it was within the "realm of hypothesis" that the respondent would not have suffered brain damage if the investigations highlighted by Dr Gabay had been done earlier. The only investigation referred to by Dr Gabay which was not done by the hospital staff was the cranial imaging. According to Dr Gabay this may have provided an early diagnosis of intracranial bleeding and suggested a treatment. However, it is also clear from his opinion that the main treatment for any possible cranial bleeding and resulting thrombocytopenia was blood transfusion. Even without the cranial imaging the medical staff did transfuse the respondent. The transfusions, according to Dr Gabay, corrected the low platelets, anaemia and the thrombocytopenia caused from any bleeding. So, even without the imaging, it seems to me that the respondent received the proper treatment for what the

experts said the imaging may possibly have shown. Dr Gabay was also opining in the realm of speculation rather than hypothesis when he said that earlier diagnosis and referral may or may not have given a better outcome.

[166] Dr Gabay, ruled out HIE which was the diagnosis by the specialists after the respondent did both a cranial ultrasound and a CT scan of the brain, two weeks after birth. He said HIE would have suggested intrauterine or birth asphyxia but that was not supported by the Apgar scores or the clinical indications. He too was unable to say definitively what had caused the respondent's injuries but suggested an intracranial bleed was the possible diagnosis. At no time did he state that if it had been an intracranial bleed, it would have been caused by an act or failure to act on the part of the hospital staff. Having not commented on the imaging that was in fact done, he failed to say what else other than HIE was consistent with the state of the respondent's brain, as shown in the imaging results or even how long it would have taken for the damage to have reached that stage shown on the scans between the first symptoms and when the scans were done.

[167] Dr Melbourne-Chambers opined that it was impossible to determine the cause of the respondent's injury due to the absence of other investigations of the respondent's clotting mechanisms. She also opined that because the timing of the injury to the brain was not established she was unable to say if early referral would have made a difference. She stated that injury could have been prior to labour and delivery (that is intrauterine), and if that was the case, it would have been unlikely that his condition could have been

improved by earlier treatment at the BHC. It would then follow that, if the 'insult' to the respondent's brain occurred prior to labour and delivery, it would have been intrauterine and the acts or omissions of the medical staff at the hospital would not have been the cause of the brain damage. She ruled out HIE occurring during labour and delivery as asserted by Drs Tapper and Richards–Dawson for the respondent.

[168] Although the judge stated that she relied Dr Gabay's evidence, she did not reconcile differences in opinion between Drs Tapper and Richards-Dawson, and Dr Gabay's opinion nor between Dr Melbourne-Chambers' opinion and that of Dr Gabay. Dr Gabay did not review or comment on the imaging results. None of the doctors, all specialists in their fields, provided any evidence or any medical supposition from which the judge could have concluded as she did, that is, that the respondent's brain damage could have been prevented if early investigations had been done and the omission to do so was the cause of his injuries.

[169] Dr Melbourne-Chambers agreed that the injuries could have been explained by an intracranial bleed but declared there was no evidence of it. Dr Gabay cited medical literature suggesting that in a well appearing child thrombocytopenia is usually an immune-mediated phenomenon related to maternal transplacental IgG antibodies, which appears to support the appellant's supposition as to the cause of the respondent's brain injury, the respondent having appeared well at birth.

[170] At paragraphs [51] to [53] of her judgment, the judge accepted the reports of both Dr Gabay and Dr Melbourne-Chambers as evidence of what the hospital staff ought

to have done "according to proper medical practice and procedure". I should indicate that in none of the expert's opinion did either of them refer to what was "proper medical practice and procedure". They simply indicated what they considered failures by the medical staff of the hospital.

[171] The judge relied on Dr Gabay's opinion that "the infant should have had intracranial imaging (cranial ultra sound, CT Scan or MRI) as an early investigation", and that "correction of thrombocytopenia should have been done urgently". She also relied on Dr Melbourne-Chamber's evidence that the staff had failed to "fully investigate the cause of anaemia, thrombocytopenia and hyponatremia, to investigate for other…clotting abnormalities and failure to document a plan to obtain imaging of the neonate's brain, urgently at the time of his initial presentation with seizures, bulging anterior fontanelle, anaemia, and thrombocytopenia. Results...may have provided a diagnosis and informed appropriate therapy", as sufficient reasons to give judgment to the respondent. At paragraph [53] she found that:

> "It is my view that the inadequacies in care and deficits in management of Tahjay Rowe by the medical staff at VJH as stated in the evidence of the claimant and highlighted in the expert reports of Drs Gabay and Melbourne-Chambers, point to breach of duty by the defendants who would reasonably have been expected to carry out certain investigations which could determine steps to be taken in the proper care and management of the claimant. These omissions by the defendants' servants are in my view sufficient to ground the claim. I therefore find that the injury to the claimant is a reasonably foreseeable result of the action and omission of the defendants' servants."

[172] At the end of the case, the judge was left with evidence which showed that both experts agreed that there were inadequacies in documentation, monitoring, and

investigation, including delayed blood transfusion, no additional testing of the infant's clotting mechanism, delayed brain imaging and late referral. However, what is significant, is that they both were unable to conclude that the injuries were caused by these failures or that the injuries could or would have been prevented had these inadequacies not occurred. None of the experts could say that the respondent's injury would have been reduced if there had not been the failures in the documentation, investigation, and late referral of the respondent, highlighted by them. The highest their opinion could be taken is the speculation that it may have provided a diagnosis and informed appropriate therapy. None of the experts indicated a possible alternate and appropriate therapy that could have been administered to the respondent if his symptoms or his brain damage had been diagnosed earlier.

[173] In **Bolitho v City of Hackney Health Authority** the test for causation was identified to be two-pronged: firstly, did the doctors fail to do something that they would have ordinarily done in the circumstances that could have prevented the injury, and, secondly, if not, would that inaction have met the professional standard of care of an ordinarily skilled doctor in that field. Where the test of causation involves a breach by omission it is described as being in the realm of hypothesis. In this case where the omission was the failure to fully investigate, the question is what would have happened if there had been early investigation such as cranial imaging. In this case the experts say it would have led to a possible diagnosis and early treatment. In the case of Dr Gabay that diagnosis may have been intracranial bleeding. That diagnosis would have led to early treatment to cure the effects of that. What were the effects of intracranial bleeding,

according to Dr Gabay? The effects he identified were thrombocytopenia, anaemia, low platelets and low blood count. However, in this case, the evidence is that the respondent did receive treatment for these conditions, even though no earlier imaging had been done. Significant only in its absence, is the lack of any evidence from the doctors as to how long it would take for the injury to the brain to "evolve" to the stage where it showed almost complete "cystic replacement of both cerebral hemispheres" in order to assist in determining whether the injury could have occurred before or after birth.

[174] There was the complaint that the blood transfusion was not urgently done. It was ordered immediately after it was seen to be required, but the hospital records indicate that it was ordered a second time before it was seemingly administered. That appeared to have taken two days. There is no evidence why it took so long. But there is no evidence that the delay of two days caused the injury or contributed to any worsening of the respondent's condition.

[175] In the case of Dr Melbourne-Chambers, she identified the failure to do additional test of the respondent's clotting mechanism. However, despite this failure, the respondent was treated with anti-coagulants until his discharge. Dr Melbourne-Chambers did not indicate what other treatments could have been given if the other tests of the respondent's clotting mechanism had been tested.

[176] In **Joyce v Merton Sutton and Wandsworth Health Authority**, the requirement to prove causation was noted by Hobhouse LJ at page 155 as follows:

> "A plaintiff must prove that the defendant was at fault and that the defendant's fault was a cause of ('materially contributed' to) the plaintiff's injury or loss. Medical negligence cases are no exception to this rule. The general burden of proof remains on the plaintiff although he may be able to rely upon inferences from the evidence which, if not rebutted by the defendant, lead to the conclusion that the plaintiff has proved his case. Where the fault consists of an act which is alleged to have had physical consequences, the question to be asked is straightforward even though its answer may not be: was the act a cause of the injury? Where the fault consists of an omission, or an act which does not in itself have physical consequences, identifying the correct question to ask may be less easy."

[177] The court then went on to explain that, in the case of an omission to act, a claimant proves his case by proving that his injuries would have been avoided if proper care had been taken. The following dicta of Hobhouse LJ in **Joyce Merton** (at page 156), in which he commented on the Court of Appeal's decision in **Bolitho**, was later approved, at page 777, by the House of Lords in the appeal of **Bolitho** before it:

> "Thus, a plaintiff can discharge the burden of proof on causation by satisfying the court *either* that the relevant person would in fact have taken the requisite action (although she would not have been at fault if she had not) or that the proper discharge of the relevant person's duty towards the plaintiff required that she take that action. The former alternative calls for no explanation since it is simply the factual proof of the causative effect of the original fault. The latter is slightly more sophisticated: it involves the factual situation that the original fault did not itself cause the injury but that this was because there would have been some further fault on the part of the defendants; the plaintiff proves his case by proving that his injuries would have been avoided if proper care had continued to be taken. In *Bolitho* the plaintiff had to prove that the continuing exercise of proper care would have resulted in his being intubated."

[178] In **Wilsher v Essex Area Health Authority**, the House of Lords dealt with the issue of the proper approach to causation. The facts were that the infant plaintiff who was born almost three months prematurely could not breathe effectively and was given

extra oxygen for a period of 11 weeks by the hospital. He also suffered from several other complications that commonly afflicted premature babies which caused him to lean close to death. Following a long stint at the hospital he recovered, however, he was found to be suffering from an incurable condition of the retina which caused him to be nearly blind. It was alleged by the plaintiff that this was as a result of negligence by the hospital in the management of his oxygen supply. It was accepted as common ground that hospital staff had oversupplied oxygen to the infant, having mistakenly inserted a catheter through the umbilical artery into the infant's vein instead of the aorta, resulting in the electronic sensor on the catheter giving a false reading of a lower level of oxygen than was actually in the arterial blood. It was also accepted, in view of the expert evidence that over oxygenation was but one possible cause of the retina condition, which could have also been caused by any one of or a combination of the other conditions that the baby had been afflicted with, through no fault of the hospital staff. The trial judge held the hospital authority liable, and the Court of Appeal, though disagreeing with certain findings, affirmed that outcome.

[179] On appeal to the House of Lords, however, the House of Lords set aside the decision on the basis that causation had not been established, and ordered a retrial of the issue of causation. The House of Lords came to that view on the basis that where there are several possible causes of the injury complained of, the defendant's breach of duty being one of them, the onus of proving causation remained on the plaintiff. Although causation may be inferred from the evidence, there is no presumption that the defendant's breach caused the injury. The trial judge had, therefore, been wrong to find

that, in the circumstances, the burden had switched to the defendant to show that it had not breached its duty of care and that that breach did not cause or materially contribute to the injury, and thus, that the defendant had not discharged this burden and was therefore liable. The Court of Appeal was also wrong to find that "the authority's negligence being one of the possible causes of the infant's injury was sufficient to enable the court to conclude that this negligence was taken to have caused the injury".

[180] In the instant case, although the judge noted that the appellants were unable to explain how the respondent suffered brain damage, she accepted the submissions of counsel for the respondent that it was the hospital's own 'failure to conduct critical tests' why this was so, and that, since the delivery was normal, the management of the claimant was obviously 'sadly lacking'. She then went on to find, along with the findings earlier noted that: "...the injury to the [respondent] was a direct result of the deficient treatment received as I find that the treatment fell below the required standard of reasonably competent mid-wives and paediatricians and find on a balance of probabilities that the VJH staff were negligent in the delivery of the claimant and in his immediate post-natal care and that the injury is a reasonably foreseeable result".

[181] It is clear that the judge was not entitled to make this finding. There was no evidence on which she could properly find that the injury was a direct result of any deficiency in management and or treatment, as the respondent failed to prove causation whether to the initial insult or to its aggravation thereafter. None of the experts said the respondent's injury was caused by any act or omission of the staff at the hospital. At its

highest, the report of Dr Gabay is speculative. Even in this realm of speculation he was unable to say the omissions by the staff at the hospital to document and investigate either caused the injury or exacerbated the injury.

[182] Neither was there any evidence from which the judge could properly conclude that the treatment of the respondent fell below the required standard of reasonably competent midwives and paediatricians. There was no evidence of the required standard of reasonably competent midwives in Ms Dalhouse's position and as the evidence was that she was on duty at the birth of the infant, there was no evidence on which the judge could find she breached any duty of care to the respondent at birth or in his immediate post- natal care. Equally, there was no evidence of the qualifications or positions of the doctors who treated the respondent and the standard of care expected from doctors of their qualification, skill or competence. Nor was there any evidence that the treatment given to the respondent fell below the required standard of reasonable competent doctors in the position of the medical staff who were in charge of the respondent's care.

[183] Both the respondent and the judge sought to rely on **Millen v University of the West Indies**, to say causation was proved. However, in that case this court found the hospital to be negligent even though it considered that the breach may not have been the initial cause of the injury but had only aggravated it. That case can be distinguished from the one at bar, as in that case it was proven, from expert evidence, that the hospital's failure was a substantial cause of the appellant's suffering. The hospital had failed to remove a special suture during the appellant's post-natal care, particularly in

light of her continued complaints of pain and other symptoms, and her complicated medical history that was known to them, and it aggravated the appellant's suffering. It was accepted on both sides that although the suture would not have ordinarily caused any complications in a healthy cervix, in an unhealthy cervix it would have. On the evidence, the appellant had an unhealthy cervix and pre-existing infections, known to the hospital, that were aggravated by the failure of the hospital to remove the suture, causing the appellant much suffering.

[184] In the instant case, there is no statement from any of the experts that the failure of the hospital staff to adequately document and conduct the investigations which they specified, substantially contributed to or aggravated the condition of the infant respondent. HIE was disproved by both experts and neither of them opined that the hospital staff did anything which may have caused the respondent's injuries. Even though they both pointed to a failure to conduct early imaging, as I said previously, and is worth repeating, the respondent was given the appropriate treatment for the possible diagnosis of intra cranial bleed suggested by Dr Gabay. It was the same treatment which would have been appropriate for alloimune thrombocytopenia, which was the proposed diagnosis of the appellants. Thrombocytopenia, based on the excerpt cited by Dr Gabay, "in well appearing newborns…is usually an immune-mediated phenomenon related to maternal transplacental IgG antibodies" and is, therefore, a cause unrelated to any act or omission by the appellants. Although Dr Melbourne-Chambers was of the view that the diagnosis suggested by the appellant was possible but that the clinical manifestation in

this case was not typical, the literature cited by her indicated that it was indeed possible, even if unusual (in terms of percentages).

[185] As was said in **Whitehouse v Jordon** (at page 17) merely to describe an omission as a failure tells nothing about whether there is negligence or not. Although the judge did consider the issue of causation, she failed to properly consider that there was no evidence to support a finding that the failures by the medical staff caused the respondent's injuries. In that regard she erred.

[186] The burden to prove causation rests on the respondent to show that, on a balance of probabilities, his injuries were caused or aggravated by the actions or omissions of the medical staff, or that it could have been avoided or alleviated if proper documentation, investigation and early referral had been undertaken by them (see **Joyce v Merton Sutton and Wandsworth Authority**). That burden was not discharged. The judge, having wrongly concluded that the maxim *res ipsa loquitur* applied to this case, failed to properly consider the evidence in determining the issue of causation on the evidence, that is whether there was evidence to support a finding that the acts or omissions of the medical staff at the hospital caused or substantially contributed to the respondent's injuries. In failing to assess the evidence and properly consider this question she arrived at the wrong conclusion.

[187] I, therefore, find that there is merit in these grounds and in this appeal.

Conclusion

[188] The overarching question for this court is whether there was evidence before the judge on which she could properly find that the medical staff at the hospital did any act or failed to do any act which caused or contributed to the respondent's injuries. Whilst this case is undoubtedly a sad one, and this court is not without sympathy for the suffering of the respondent and indeed his mother, the answer to that question is no. There was simply insufficient evidence before the court that the medical staff did something they shouldn't have, or omitted to do something that they ought to have, that directly or indirectly caused the injuries suffered by the respondent. Neither was there any evidence that their failure to act aggravated the respondent's condition. For my part, I see the force of the observation made by Stuart-Smith LJ in **Delaney v Southmead Health Authority**, at page 117, where he said that "if the human body was a machine where it is possible to see the internal workings and which operates in accordance with the immutable laws of mechanics and with arithmetical precision, I think that the argument might well be unanswerable. But in spite of the wonders of modern medical science, even at post-mortem not everything is known about an individual human being."

[189] The evidence indicated that the hospital staff had failed to fully investigate, by conducting brain scans urgently and by doing additional tests of the respondent's clotting mechanisms, in order to assist with the diagnosis of his symptoms and early referral. They also failed to adequately document the close monitoring of the infant respondent's condition and to measure his head circumference at birth. However, it was not established, on the evidence, that the treatment given to the respondent, by the hospital staff, fell below the requisite standard of ordinarily skilled professionals exercising the

skills expected of the doctors and midwives who treated him. Nor was it established that these omissions caused or aggravated the respondent's injury. It could be said that the medical staff were negligent in failing to order brain imaging earlier in the face of the respondent's symptoms which suggested brain trauma, but there was no evidence that this failure led to or aggravated his brain injury. This is so especially since, despite the fact that no imaging was done, the respondent nevertheless was given the appropriate treatment and the evidence was that he appeared well at the time of his discharge from the hospital and his subsequent follow-up visits to the hospital's outpatient clinic.

[190] In the instant case, it could not be said on the evidence that the hospital staff gave treatment that was below that which was acceptable of reasonably skilled hospital staff professing to be skilled in the area of midwifery, general medicine, obstetrics and gynaecology, paediatrics and in the care of a new born baby. Nor was there evidence on which the judge could properly have found that the hospital caused or contributed to the unfortunate outcome in the respondent's condition.

[191] Finally, the judge misapplied the law and was plainly wrong when she found that *res ipsa loquitur* was applicable to the facts of this case. Since the respondent had failed to prove that the appellants' acts or omissions caused his injuries or substantially contributed to them, he is not entitled to damages.

[192] For these reasons, therefore, I would allow the appeal, set aside the decision and orders of Lindo J (Ag) made on 19 September 2015, and enter judgment for the

appellants. In light of the nature of this case, I would order that each party bear their own costs, here and in the court below.

MORRISON P

ORDER

1. The appeal is allowed.

2. The decision and orders of Lindo J (Ag) (as she then was), made on 10 September 2015, are set aside.

3. Judgment entered for the appellants.

4. Each party to bear their own costs of the appeal and in the court below.