[2018] JMSC Civ.170

IN THE SUPREME COURT OF JUDICATURE OF JAMAICA

IN THE CIVIL DIVISION

CLAIM NO. 2001 CLJ 00104

BETWEEN	**ENID JOHNSON (Administratrix in the Estate of Yorksladda Johnson, Deceased)**	**CLAIMANT**
AND	**SOUTH EAST REGIONAL HEALTH AUTHORITY**	**1ST DEFENDANT**
AND	**THE ATTORNEY GENERAL OF JAMAICA**	**2ND DEFENDANT**

IN OPEN COURT

Mr. Norman Hill QC and Mr. Raymond Samuels instructed by Samuels Samuels Attorneys-at-Law for the Claimant

Ms. Donia J. Fuller- Barrett instructed by the Director of State Proceedings for the Defendants

Heard: December 13, & 14, 2017 & July 27, 2018

PALMER HAMILTON, J. (AG.)

Negligence– Medical negligence– Contributory negligence– Application of the test in Bolam v Friern Hospital Management

BACKGROUND

[1] This Claim arose out of the alleged negligence of the health care staff at the Kingston Public Hospital (hereinafter referred to as "the Hospital") in the parish of Kingston. This Hospital falls under the management of the statutory body South

East Regional Health Authority (SERHA), the 1st Defendant herein. The 2nd Defendant is being sued by virtue of the Crown Proceedings Act.

[2] Mr. Yorksladda Johnson (hereinafter referred to as "the deceased") brought a Claim against the Defendants for medical negligence in respect of treatment administered to him between the period of the 31st day of July 1996 to the 7th day of January 1997. He died on the 24th day of April 2002 and Ms. Enid Johnson, the widow of the deceased, was substituted as the Claimant in her capacity as personal representative of his estate.

[3] The deceased was injured in a motor vehicle accident on the 31st day of July 1996. He was admitted to the Hospital on the same date and remained in their care for approximately twenty-six (26) weeks. He was discharged on the 7th day of January 1997. Upon admission to the Hospital, the deceased was suffering from a fractured distal left femur, fracture to the mid-shaft of the left tibia, swollen and deformed distal third of the left thigh, a laceration over the left leg exposing the left tibia and the distal part of the left leg was externally rotated.

[4] The Amended Statement of Claim revealed that the agents of the 1st Defendant treated these injuries, inter alia as follows: -

a) Skeletal traction with calcaneal pin and proximal tibia pin;

b) External fixator put in left femur.

[5] This treatment resulted in the following: -

a) Pus being discharged from the wound over tibia;

b) Infection at pin sites mentioned above;

c) Callous formation at injury sites;

d) Development of osteomyelitis;

e) Inability to arrest discharge of pus;

f) Gentamicin beads inserted in affected sites.

[6] The Amended Statement of Claim also disclosed that the deceased, after being discharged became an outpatient of the Hospital and attended the fracture clinic to receive further treatment on the following dates: -

"May 22, 1998	*June 19,1998*	*July 10, 1998*
July 31, 1998	*September 11, 1998*	*November 6, 1998*
December 4, 1998	*January 15, 1999*	*August 13, 1999*
August 27, 1999	*September 24, 1999*	*October 22, 1999*
November 19, 1999	*January 7, 2000."*	

[7] The right leg of the deceased was not injured in the accident, however, it was subsequently amputated as of result of the negligence of the agents of the Defendants.

THE CLAIMANT'S CASE

[8] By way of a Writ of Summons and Endorsement, the Claimant sought to recover damages for negligence, consequential loss and damage due to acts of commission and omission in the medical care of the deceased while he was both an inpatient and outpatient of the Hospital.

[9] The Claimant's case is that the negligent acts of commission and omission in the period when the deceased was committed to the professional care of the agents and/or servants of the 1st Defendant, resulted in the deceased having to have the right lower limb amputated and surgery done to his left lower limb as well. Further, that these negligent acts and acts of commission and omission in the course of his medical treatment were done and left undone during the period of July 1996 to January 2000.

[10] The Claimant averred that on each visit in the year 1999, the deceased was not able to get any form of treatment whatsoever at the outpatient fracture clinic at the Hospital and that the condition at the fracture site deteriorated to the extent that the gentamicin beads became dislodged. This was as a result of repeated cancelled appointments by the Hospital without administering any treatments to the deceased.

[11] The Claimant also asserted that during his period of hospitalization and continuous visits to the outpatient fracture clinic, the deceased complained to the Hospital staff, nurses and doctors attending to him that he was experiencing severe pains in the right leg, (the uninjured leg) but they all ignored his complaints. She further declared that on a visit to the orthopaedic clinic at the Hospital on or around the 11th day of September 1999, she engaged a doctor's attention to the dark condition of the deceased's toes as well as his constant complaints of severe pains in the right leg but the same doctor remarked "*he will have to live with it*".

[12] The deceased, finding that the pains to the right leg became more severe and blackened consulted Dr. Excel in Linstead who referred him to see Dr. G.G. Dundas.

[13] The Claimant claimed that at the point of consulting with Dr. Dundas, the left leg had become incapable of healing, with the gentamicin beads which were inserted in the injury site becoming dislodged and with pus still oozing from the fracture site. Upon seeing the deceased's right leg and the blackened toes with the crust-like formations, Dr. Dundas immediately ordered x-rays to be done. The x-rays results disclosed that the blood was not circulating properly in the right leg and the supply of blood was altogether cut off from the entire foot. A diagnosis of Peripheral Circulatory Disorder was made.

[14] Further tests on the deceased revealed that he was suffering from Diabetes Mellitus. Dr. Dundas advised radical surgery to remove the great toe and the little toe of the right leg and this was performed under general anesthesia.

Notwithstanding this surgery, Dr. Dundas after consulting with Dr. Granville Smith, advised more radical surgery to remove the portion of the deceased's right leg below the knee.

[15] The Claimant stated that the deceased also had surgery to the left limb to remove the gentamicin beads and states that this operation was long delayed and stymied by repeated cancellation of appointments at the Hospital.

[16] The Claimant further contended that the deceased's admission and continuous stay at the Hospital for a period of approximately twenty-six (26) weeks afforded the entire medical staff the opportunity to observe the general physical condition of the deceased and to take all necessary steps to prevent and provide care for all or any evidence of decline or deterioration in his general health.

[17] According to the allegations of the Claimant, the amputation of the right leg and surgery to the left leg were due to the negligence of the 1st Defendant, its servants and/or agents. Alternatively, it was due to breaches of the National Health Services Act and Regulations made hereunder.

[18] The Particulars of Negligence of the 1st Defendant pleaded are as follows: -

> *"The Medical staff and Nursing Staff being the servants or agents of the first Defendant failed in their duty of care to the Plaintiff in that they:*
>
> 1. *Failed to determine generally the state of the Plaintiff's health at the time of admission in the Kingston Public Hospital.*
>
> 2. *They failed to determine generally or on a day-to-day basis the general state of the Plaintiff's health in that:*
>
>   i. *They failed to carry out or ignored the results of any test that would indicate the Plaintiff was suffering from Diabetes Miletus.*
>
>   ii. *They failed to carry out or ignored the results of any test that would indicate the Plaintiff was suffering from Peripheral Circulatory Disorder.*
>
>   iii. *They failed to observe that a gangrenous condition was developing in the Plaintiff's right leg and foot during the*

period July 1996 to January 1997 when the plaintiff was a patient in the said Hospital and during the period January 1997 to January 2000 when the Plaintiff visited the Orthopaedic Clinic as an outpatient regularly.

iv. *They callously ignored the Plaintiff when he called their attention to the blue/black condition of his great toe as also the increasing crust formation of the right great and small toe and foot conditions which the plaintiff reported to them was accompanied by severe pains.*

v. *They failed to pay any or any sufficient attention to the gentamicin beads which were inserted at the fracture site to the Plaintiff's left leg and which were now falling apart and unnecessarily delaying the healing of the said left leg and by repeated cancellation of the Plaintiff's visits to the Orthopaedic Clinic for treatment which forced the Plaintiff to incur expenses in obtaining that treatment elsewhere.*

vi. *The Plaintiff while he was a patient in the said Hospital from the 31st day of July 1996 being the date of his admission down to the date of his discharge on the 7th day of January 1997 was led by the First Defendant to believe and did believe that the First Defendant would supply all the necessary medical care to (a) ascertain the general state of health of the Plaintiff and (b) to ensure that any condition resulting in the decline of the Plaintiff's general health would be diagnosed and adequately treated.*

vii. *That the First Defendant while the Plaintiff was a patient in the said Hospital for a period of 94 weeks i.e. from the 31st day of July 1996 to the 7th day of January 2000 failed in its duty of care to the Plaintiff in the areas mentioned at (a) and (b) above. Further the Plaintiff was led to believe by the 1st Defendant and did believe that all findings relative to the general state of health of the Plaintiff and not relating to the affected limb only but to the general state of health of the Plaintiff's whole body would be revealed to him and if necessary treated by the First Defendant.*

viii. *The Plaintiff further will rely on the Res Ipsa Loquitor Doctrine.*

ix. *They failed to prevent the said gangrenous condition from developing on the area of the Plaintiff's right foot as aforesaid and subsequently failed to treat the said gangrenous condition.*

> x. *They failed to diagnose that the Plaintiff had developed Diabetes miletus and Peripheral circulatory Disorder which conditions if treated early would not have resulted in the Plaintiff's right leg becoming gangrenous and thereby resulting in amputation.*
>
> xi. *They failed properly to listen to and investigate the Plaintiff's numerous complaints of the blue/black condition of his right foot and pain in that foot and right leg generally.*
>
> xii. *The Defendants their servants or agents failed to appreciate or be alerted by the condition of the Plaintiff's right leg and foot and the complaints of pains in the right leg at the risk of something serious happening to the said right leg and foot.*
>
> xiii. *They failed to answer or ignored the Plaintiff's enquires as to the cause of pains in the Plaintiff's right leg as well as to the reason for the blue/black condition of his great and small toes and also the reason for the crust-like formation of the said great and small toes."*

[19] The Particulars of Breaches of the National Health Services Act and Regulations pleaded are as follows: -

> *"viii. The Plaintiff will subject to the regulations made under the Act, from time to time rely on Sec 2 (a) of section 13 as to the admission into, the treatment at and the discharge from the said Hospital and will rely on the particulars of negligence as they relate to treatment at the said Hospital.*
>
> xiv. *The Plaintiff will also rely on the Bill submitted to him for settlement of all Hospital charges while he was a patient in the said Hospital as evidence of the Defendants involvement and obligations to him as regards his general health.*
>
> xv. *The Plaintiff will also rely on sec 2 (e) of section 13 of the said Act and in particular "any other matter that is relevant to the delivery of public services" and will rely on the particulars of Negligence as evidence that the Defendants failed in their duty to deliver good medical care to the Plaintiff."*

[20] The Claimant and Dr. Denton Barnes MB.BS, MRCS(Ed), LLM gave oral evidence on behalf of the Claimant and their witness statements were allowed to stand as their evidence in chief.

[21] The medical evidence consisted of the medical reports of Dr. G.G. Dundas, F.R.C.S. dated the 17th day of March 2000, Dr. Granville Smith, M.B., B.S., F.R.C.S. (EDIN) dated the 26th day of June, 2000, Dr. E.W. Lowe BSc., M.B.B.S dated the 5th day of October 2005 and Dr. Derrick McDowell, BSc., MBBS, DM (Ortho), Pg Dip SEM dated the 10th day of November 2017.

THE DEFENDANTS' CASE

[22] The Defendants contended that the deceased presented at the Hospital on the 31st day of July 1996 after he was reportedly hit by a motor vehicle. Initially, he was taken to the Linstead Hospital, however that Hospital was not equipped to handle his injuries, therefore he was transferred to the Kingston Public Hospital. There, the following diagnosis was made:

> *"(i) Severely comminuted, open (Type IIIB) fracture of the left tibia and fibula;*
>
> *(ii) Closed fracture of the distal left femoral shaft."*

[23] It is further alleged that the initial treatment was undertaken whilst doctors awaited the earliest opportunity for the deceased to be taken to the operating theatre for surgical treatment. The delay in so doing was on account of shortages of operating time, gross shortage of equipment to do the required surgery and excessive amounts of emergency cases which were of higher priority. The earliest opportunity to do the surgery arose two weeks after his admission. During this time, the reason for the delay was explained to the deceased.

[24] Initial blood investigations were requested on the day of admission and again on August 11, 1996 and were made available August 13, 1996. His initial results were aberrant and incompatible with the deceased's clinical state and grossly out of sync with the history he gave the casualty officer when he was first examined. The

second results returned normal results and confirmed that he was, among other things, not diabetic.

[25] The Defendants further alleged that the deceased made an uneventful recovery in respect of the initial surgery and was discharged on January 9, 1997. He was requested to make visits as an outpatient one week later and thereafter on several occasions throughout 1997 to 1999, his last documented visit being November 11, 1999. During this time, he was readmitted to the ward for further surgical procedures and on some of these occasions, delay was experienced due to challenges with sufficiency of surgical equipment, operating theatre availability and excessive numbers of emergency cases. This difficulty was explained to the deceased.

[26] As a complication of the initial injury, the deceased developed a chronic infection in the left tibia. This was treated with antibiotics, both systematically and as a high dose depot preparation via gentamicin beads. Unavoidable delays were experienced in getting the deceased to the operating theatre for the introduction of the beads and to remove them. The reasons for the delays were discussed with the deceased on various occasions prior to his discharge from the ward.

[27] The Defendants in their Amended Defence denied that the deceased complained of severe pains in his right leg to the Hospital staff, nurses and doctors during his Hospitalization and that the said complaints were ignored as alleged by the Claimant.

[28] The Defendants further claimed that when the deceased was last seen in the outpatient department, the first record of a complaint concerning his right/uninjured leg was registered in the docket. At this time, it was also noted that peripheral vascular disease was possibly present and this was likely due to chronic smoking. He was appropriately advised to stop smoking immediately and appropriate investigations were ordered. He was also referred to the General Surgical Team for full evaluation of his vascular system. However, he did not return.

[29] The pleadings of the Defendants deny that the amputation of the deceased's right leg and surgery to the left leg were due to the negligence on their part and they denied the Particulars of Negligence as pleaded by the Claimant.

[30] The Defendants contend in the alternative, should the 1st Defendant, its servants and/or agents be found negligent, the deceased was contributory negligent in the circumstances.

[31] Dr. Konrad Lawson was the sole witness for the Defendants and his witness statement was allowed to stand as his evidence in chief. The medical docket was also tendered into evidence and relied on by the Defendants.

ISSUES

[32] There is no issue that the Defendants owed the deceased a duty of care as the parties are on accord with this issue. The Honourable Mr. Justice Roy Anderson in explaining the duty of care owed at page 11 of the case of **Howard Genas v The Attorney General of Jamaica, The Black River Hospital Board of Management and Dr. K.D. Mshana** (unreported), Supreme Court Jamaica, Suit No. C.L. 1996 G-105, judgment delivered the 6th day of October 2006, quoted Lord Diplock's dicta at page 893 in the English case of **Sidaway v Governors of Bethlem Royal Hospital and others** (1985) 1 AC 871 and I am guided by this principle. Lord Diplock stated as follows: -

> *"… the doctor's relationship with his patient which gives rise to the normal duty of care to exercise his skill and judgment to improve the patient's health in any particular respect in which the patient has sought his aid has hitherto been treated as a single comprehensive duty covering all the ways in which a doctor is called on to exercise his skill and judgment in the improvement of the physical or mental condition of the patient for which his services either as a general practitioner or as a specialist have been engaged."*

[33] Further, the authors of **Charlesworth & Percy on Negligence**, 6th Edition [1977] at page 965-966 quoted the dicta of Lord Hewitt CJ in the case of **R v Bateman** (1925) 94 L.J.K.B. 791 as follows: -

> *"If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge and he is consulted, he owes a duty to the patient to use caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering treatment."*

[34] Based on these principles, the deceased was owed a duty of care by the Defendants by virtue of his admission to the Hospital on the 31st day of July 1996.

[35] Therefore, the issues to be resolved by the Court are as follows: -

1. Were the Defendants negligent in their treatment of the deceased and by doing so, breached the duty of care owed?

2. Was the amputation of the right uninjured leg and the delay in the healing of the left leg caused by the Defendants' breach of the duty of care?

3. Whether the deceased contributed to his injuries, loss and damage suffered?

4. What quantum of damages if any, is the deceased entitled to?

[36] At this juncture it is worthy to note that the burden of proof is on the Claimant to prove her case on a balance of probabilities as he who alleges must prove. The Defendants have alleged contributory negligence on the part of the deceased. Contributory negligence, would, if proven by the Defendants on a balance of probabilities, contribute a partial defence to the Claimant's case.

[37] I am grateful for the detailed and competent submissions from both Learned Counsel in the matter.

LAW & ANALYSIS

Were the Defendants negligent in their treatment of the deceased and by doing so, breached the duty of care owed?

[38] In examining this issue, having determined that the Defendants owed a duty of care to the deceased, I must address my mind to the standard of care owed by the Defendants to the deceased. Therefore, the question to be considered in determining this issue, is what level of care does a doctor owe his patient?

[39] The locus classicus case on the standard of care test required of a medical professional is **Bolam v Friern Hospital Management Committee** [1957] 2 All ER 118, 587. McNair J gave the following influential direction to the jury at page 121 of the judgment: -

> *"Before I turn to that, I must explain what in law we mean by "negligence." In the ordinary case which does not involve any special skill, negligence in law means this: Some failure to do some act which a reasonable man in the circumstances would do, or the doing some act which a reasonable man in the circumstances would not do; and if that failure or doing of that act results in injury, then there is a cause of action. How do you test whether this act or failure is negligent? In an ordinary case it is generally said, that you judge that by the action of the man in the street. He is the ordinary man. In one case it has been said that you judge it by the conduct of the man on the top of a Clapham omnibus. He is the ordinary man. But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. 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."*

At page 122 his lordship continued: -

> *"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. I do not think there is much difference in sense. It is just a different way of expressing the same thought. 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 who would take a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion."*

[40] I am also guided by another leading authority on this principle, that of the case of **Bolitho v City & Hackney Health Authority** [1997] 4 All ER 771. Lord Browne-

Wilkinson who delivered the judgment of the court at page 778 to 779 of the judgment stated: -

> *"...in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In Bolam's case [1957] 1 WLR 583 at 587 McNair J stated that the defendant had to have acted in accordance with the practice accepted as proper by a `responsible body of medical men' (my emphasis). Later he referred to a standard of practice recognised as proper by a competent reasonable body of opinion' (see [1957] 2 All ER 118 at 122, [1957] I WLR 583 at 588; my emphasis) … Again, in the passage which I cited from Maynard's case, Lord Scarman refers to a 'respectable' body of professional opinion. The use of these adjectives - responsible, reasonable and respectable- all show that the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.*
>
> *In the vast majority of cases the facts that distinguished experts' in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.*
>
> *I emphasise that, in my view, it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgement which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which defendant's conduct falls to be assessed."*

[41] In **Bolitho v City & Hackney Health Authority** (supra), a two-year old boy had severe brain damage after admission into Hospital for respiratory problems. He

subsequently died. The paediatrician had failed to incubate him. Incubation was the only procedure that would have prevented respiratory failure but was not without risk. Lord Browne-Wilkinson pointed to the circumstances in which a court would decide that there was negligence in spite of expert evidence agreeing with the defendant's course of action.

[42] The **Bolitho v City & Hackney Health Authority** (supra) case reformed the standard of care test required by doctors when treating their patients and places an added burden on the medical doctor or professional to show that the body of opinion he or she relies on is logical. It is a higher test for the standard of care of a doctor. The court is required to analyse the scientific principle upon which the medical technique or medical procedure rests to determine if the body of medical opinion is logical.

[43] Using the guidance offered in these leading authorities, the Claimant would therefore have to prove that the Defendants did not act in accordance with ordinary competent medical practitioners. The **Bolam** and **Bolitho** Tests have been applied in the Commonwealth Caribbean and in particular, the Jamaican case of **Hinds v Craig** (1982) 19 JLR 81. At page 87 of the judgment the Honourable Mr. Justice Lensley Wolfe (as he then was) stated: -

> *"A medical man '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 ... merely because there was a body of opinion who would take a contrary view'."*

[44] I will now consider the evidence as it relates to the treatment of the deceased while he was in the care of the Hospital.

Delay in initial surgical intervention

[45] Dr. Denton Barnes is a registered practitioner with the Medical Council of Jamaica and is a practising orthopaedic surgeon. He specializes in Medical Reporting and Medico Legal Consultations and he acted as one of the expert witnesses in this matter.

[46] In his evidence, Dr. Barnes indicated that the deceased's fracture was most likely Grade 3A in an initial stage and this was confirmed by the documentation of the Operating Surgeon at the Hospital. He stated that open fractures are surgical emergencies that perhaps should be thought of as incomplete amputations. He further expressed that in the case of the deceased, he sustained an Open Fracture on the 31st day of July 1996 when the Admitting Officer noted that his presented complaint was pain and swelling of the left thigh and left leg for four (4) hours. The deceased was taken to the operating theatre on the 13th day of August 1996, which was fourteen (14) days later, to have Wound Debridement and Application of an External Fixator.

[47] Dr. Barnes indicated that this was not in keeping with established protocol and as far back as 1984, early debridement and irrigation of wound along with external fixation is the gold standard. He further stated that after the first debridement is done, the patient should be taken back to the operating theatre within twenty-four (24) to forty-eight (48) hours to have further wound inspection under anesthesia and further irrigation and debridement to remove all dead and devitalized tissue so that there is no presence of infection in long term disease. The deceased was not taken back to the operating theatre until he went back for insertion of gentamicin beads. The insertion of the gentamicin beads was done on the 11th day of May 1998. This is a twenty-one (21) month period from the date of the first surgery to the date he was presented back at the operating theatre.

[48] Dr. Konrad Lawson acted as the other expert witness in this matter. He is a medical doctor specializing in orthopaedic surgery and is currently an Orthopaedic Surgeon at the Hospital. He was also a member of the orthopaedic team that administered treatment to the deceased during his admission at the Hospital.

[49] Dr. Lawson in his witness statement indicated that when a patient is admitted with injuries of the type of that of the deceased, it is the usual practice to assess the patient for emergency surgery and at the earliest opportunity, the patient would be taken to surgery for fixation. A time period of six (6) to eight (8) hours is the standard

accepted internationally within which to take a patient with injuries of the nature suffered by the deceased into surgery. He further stated that surgical intervention in the deceased's case was deemed necessary to prevent complications.

[50] Dr. Lawson also admitted that this time period was not adhered to and this was because of the Hospital's limitations, such as, limited resources and excessive amount of prioritized cases. He indicated that the deceased was advised of these limitations and was told that he would be taken into surgery at the earliest opportunity.

[51] Further, during cross examination, I enquired from Dr. Lawson as to what obtains when there is a delay due to resource constraints at the Hospital. He explained that it is conveyed to the patient that there may be a delay and he or she is informed that he can exercise the option to seek that care privately, if he or she opts to do so. He further stated that in his experience, many do not and cannot afford to do so.

[52] Dr. Lawson under cross examination, indicated that there was no consideration given by the Defendants to send the deceased to another Hospital in order to adhere to the standard protocol for treating the injuries of the deceased.

[53] Learned Counsel for the Defendant submitted that it was not the Claimant's case that there was not a failing to inform the deceased of this option, nor was any evidence of whether this option was put to him before the Court. I find this submission very convenient as failure on the part of the Defendant to advise the deceased of his options would suggest that the Defendants breached their own protocol in dealing with delays.

[54] One must further ask if the deceased was given the option to seek this care privately, would he have selected this option. I believe so, as the evidence reveals that he ultimately sought treatment from private medical practitioners after several cancelled appointments by the Hospital. This question raises the issue of a doctor's duty of disclosure and the principle of informed consent. The Honourable Mr. Roy

Anderson in the case of **Howard Genas v The Attorney General of Jamaica, The Black River Hospital Board of Management and Dr. K.D. Mshana** (supra) considered the duty of disclosure. He stated at page 16 of the judgment: -

> *"In the United States, several of the state courts have developed the doctrine of informed consent which seeks to ensure that a patient gives consent to the medical treatment proposed by a medical practitioner. Usually, this is in relation to surgical procedures where it has been held that the risk associated with the particular procedure must be disclosed to the patient.*

[55] His Lordship after examining cases that disposed of the doctrine of informed consent continued on page 20: -

> *"Although most of these cases concern situations where there was the option of some surgical procedure, I am of the view that the principles articulated apply whenever a doctor directs his mind to the type of treatment which is to be given in any particular case. If some risk in a procedure or course of treatment, however small, it would seem that it is the responsibility of the doctor to bring it to the attention of the patient. In the instant case, the risk of waiting and watching should have been explained to the to the Claimant and also the risk of moving him to the Kingston Public Hospital. It seems clear from the evidence before that the Claimant would have taken the risk of being transported rather than the risk of remaining in the Black River Hospital. (Emphasis applied)*

[56] I adopt this assessment and find that the 1st Defendant in the case at bar breached their duty of disclosure by failing to inform the patient of his option to seek care privately.

[57] In my view, the responsibility of informing patients of the delay and advising them of their option to seek care privately, would alleviate the shortages of resources that the Hospital is plagued with. It would therefore stand to reason that in the event patients are presented with this option and they decline to exercise same, they would be accepting whatever risk may flow from the Hospital's lack of resources. Consequently, I find that failure on the part of the Hospital to advise the deceased of this option added to the issues which arose from any lack of resources and limitations it was facing by increasing their burden of treating him expeditiously and conforming to the approved standard.

[58] The Defendants notably submitted that whilst there might be a delay in performing the initial surgery, the Court has to look at the issue of limits of duties owed to patients in situations where the demand for medical services outstrips a public Hospital's capacity to provide the said services. Learned Counsel for the Defendants relied on the following cases to support this submission: -

1. **R v Secretary of State for Social Services and Others ex parte Hicks** [1980] 1 BMLR 93;

2. **R v Central Birmingham Health Authority ex p Collier** Court of Appeal, United Kingdom, delivered on the 6th day of January, 1988 (unreported);

3. **Ball v Wirral Health Authority and another** 73 BMLR 31.

[59] In **R v Secretary of State for Social Services and Others ex parte Hicks** (supra), orthopaedic patients sought a declaration against the Secretary of State and the Hospital authorities, that they were in breach of their duties under section 1 of the National Health Services Act. The duty under the Act was to promote a comprehensive health service designed to secure improvement in health and to prevent illness. The orthopaedic patients had been obliged to wait for periods longer than was medically advisable for operations. The court held that it would not interfere with the Secretary of State's duty under the National Health Act unless he acted in a manner that was unreasonable.

[60] In **R v Central Birmingham Health Authority ex p Collier** (supra), the father of a child sought leave to review judicially the health authority's failure to operate on his son who was desperately ill and needed surgery. The child was in fact at the top of the waiting list, but due to a shortage of intensive care beds and nurses, he was left for months without an operation. The court highlighted the fact that it had no power to allocate financial resources and there was no breach of public duty on the part of the health authority.

[61] In **Ball v Wirral Health Authority and another** (supra), the issue concerned the delay in performing a medical procedure and whether this was negligent. Simon J noted at paragraph 32 that: -

> *"In the field of medicine where resources are limited and the demands on those resources are many, it may be necessary to make difficult decisions as to how resources are to be allocated. In general, English public and private law leaves such decisions to those who have the legal responsibility for making such decisions. The fact that an area of medicine may be under-funded (for example, neonatal care in the 1970's) or that a particular hospital may not have the facilities that another hospital has, may give rise to a concern among the general public and experts in the field; but it does not necessarily provide the basis of a claim in negligence by a patient who may suffer from effects of the under-funding or the lack of facilities, see for example the discussion in Jackson & Powell Professional Negligence (5th edn) para 12-160."*

[62] I find that these authorities are distinguishable from the present case. The cases of **R v Secretary of State for Social Services and Others ex parte Hicks** (supra) and **R v Central Birmingham Health Authority ex p Collier** (supra) do not assist in the determination of the issue of medical negligence. In these cases, the issue was whether there was a breach of public duty by the public departments in failing to provide adequate resources to the Hospitals and whether their allocation of these resources were unreasonable. In the case at bar, the issue is whether the Defendants were negligent in the manner in which they carried out their public duties, in particular, the treatment of the deceased.

[63] In **Ball v Wirral Health Authority and another** (supra), the court acknowledged that resources are limited and the demands on those resources are many. However, the ultimate consideration was whether the actions of the medical practitioners were negligent in carrying out their duties against the background of the **Bolam v Friern Hospital Management Committee** (supra). The court analysed the circumstances of case and held that any breach of duty was not causative of the damage suffered by the claimant.

[64] In my judgment, the evidence supports that the Defendants, by virtue of their delay did not act in accordance with generally approved practice in performing the

surgical intervention. I also find that the reasons proffered for the delay is inadequate as the Defendants breached their duty of disclosure.

The removal of the gentamicin beads

[65] The Claimant pleaded that the Defendants failed to pay any or any sufficient attention to the gentamicin beads which were inserted at the fracture site to the deceased's left leg and which fell apart. This she claimed unnecessarily delayed the healing of the left leg.

[66] Dr. Lawson indicated that the deceased developed Osteomyelitis which is a common complication of Type IIIB fractures, the worst type of open fracture that can be sustained by a patient. The deceased suffered from this type of fracture. He stated that the deceased was treated with increased doses of antibiotics, both systemically and as a high dose depot preparation via gentamicin beads, which were placed in the area of open fracture. The beads were intended to help eradicate the infection at the open site.

[67] The beads were inserted on the 11th day of May 1998 and were still in place up to October 1999. This, he stated was not unusual, as the intention was to have these beads removed at the time of further surgical procedures. He also stated that the gentamicin beads are used to treat infections and do not themselves cause infection irrespective of the length of time they remain at the fracture site.

[68] Dr. Lawson averred that the deceased was readmitted to the ward on a number of occasions for further surgical procedures however, some of these were unable to be done for reasons previously indicated, inter alia.

[69] Dr. Barnes indicated that after the deceased had the insertion of gentamicin beads, the Culture and Sensitivity Report returned an organism which was resistant to gentamicin, however, the beads were maintained. He asserted that the deceased was not placed on an antibiotic to which the organism was sensitive at any point.

He further stated that the use of gentamicin beads is usually a temporary measure to afford some level of control of organisms present in an infective bed. However, this is usually removed relatively quickly after the procedure within six (6) to twelve (12) weeks, unlike in the case of the deceased where the beads remained for approximately seventeen (17) months.

[70] I am not convinced that the gentamicin beads do not themselves cause infection irrespective of the length of time they remain at the fracture site and I am more inclined to accept the position of Dr. Barnes on this issue. Further, the Medical Report of Dr. Derrick McDowell confirms my analysis.

[71] Dr. McDowell is a registered medical doctor with the Medical Council of Jamaica. He is currently the head of the Orthopaedic Department at the Saint Ann's Bay Hospital in the parish of Saint Ann. Dr. McDowell compiled a report based on the review of the medical docket of the deceased and this report was read by Dr. Barnes in Court.

[72] In his report, Dr. McDowell indicated that the insertion of the gentamicin beads would have been to treat the osteomyelitis. After six (6) weeks, all the antibiotics would have eluted or left the beads that were inserted into the wound site. At this point in time, the beads should have treated the infection and if not removed they can act as a cnidus or focal point for infection. The report suggested that there was persistent infection in the case of the deceased despite healing being achieved.

[73] Respectfully, I reject the submission made by the Defendants that despite there being a delay in performing the initial surgery to remove the gentamicin beads, the deceased did not suffer any damage as a result of the delay. The deceased had to seek private intervention to have these beads removed, a cost he would not have to incur otherwise had the medical staff at the Hospital acted in accordance with generally approved medical practice.

[74] I find that there was a failure on the part of the Defendants to conduct the surgery within standard accepted time to remove the gentamicin beads, which led to the delayed healing of the injury to the left leg of the deceased.

The treatment, or lack thereof of the uninjured right leg

[75] The Defendants submitted that the first complaint of the deceased as it regards to the pain in his right leg was registered in the patient docket on the 19th of November 1999 when the deceased was last seen in the outpatient department. At the time, Dr. Lawson indicated that it was suspected that the deceased may be suffering from peripheral vascular disease. Several blood investigations were ordered to confirm this and the appropriate referral was made to the General Surgical Service.

[76] Dr. Lawson however indicated that the deceased defaulted from medical care at the Hospital and as such they were unable to determine whether in fact a presumptive diagnosis of peripheral vascular disease was confirmed. He stated that if peripheral vascular disease was present, then this would likely have been the result of chronic cigarette smoking and the deceased gave a history of being a chronic smoker. Diabetes mellitus is also well known to damage the vascular system.

[77] He further indicated that neither at the time of the deceased's admission nor at any point during his treatment was he known to be a diabetic and he gave no history of diabetes. Dr. Lawson disclosed that two (2) blood investigations were ordered. The first showed blood sugar levels of one who would have been grossly diabetic. He stated that they did not initiate treatment based on the abnormal results since it was thought that it was either not the deceased's results or that the sample was contaminated or was processed too long after it was received. Dr. Lawson also stated that a second set of blood investigations were immediately requested and these results were normal and in keeping with the deceased's clinical picture.

[78] In my view, the existence of two conflicting results begs the question of whether an ordinary competent medical practitioner, exercising the ordinary degree of

professional skill would have ordered a third test to settle the inconsistency. I see no evidence that this was ordered or done by the Defendants.

[79] Dr. Barnes indicated that the complaints of severe pains in the leg of any patient are genuine complaints which ought to be investigated and treated. In the case of the deceased, a proper history of the complaint should have been taken and his leg examined. He went on to say that the deceased should have been examined and investigated prior to being referred to the General Surgical Services for definitive management.

[80] According to Dr. Barnes, the mere advice of the possibility of peripheral vascular disease by the Defendants is insufficient and I find his testimony compelling in that regard. Dr. Barnes also indicated that a more urgent approach should have been taken. The advice to stop smoking is correct however, there are other measures which should have been included in the treatment which could have stabilized the deceased's condition or improved it. He described such measures as checking the deceased's cholesterol level and then starting lipid lowering drugs which assist with decreasing arthrosclerosis.

[81] Respectfully, I reject the Defendants' contention that the deceased and his wife did not complain of severe pains in his right leg to the Hospital staff, nurses and doctors during his hospitalization until November 1999. Under cross examination, it was revealed by Dr. Barnes that there is a possibility that the deceased would have complained about his right leg and no note was made of it.

[82] In regard to the issue of the failure in ascertaining the general health of the deceased, in particular, the failure to diagnose diabetes mellitus, Dr. Barnes averred that it may very well be that the deceased on his initial presentation at the Hospital, did not suffer from this disease, however, he developed the disease whilst he was in the care of the 1st Defendant and they failed to diagnose it. The report of Dr. E.W. Lowe buttressed this analysis.

[83] The report of Dr. Lowe reveals that when the deceased visited his office in January 1998, his right leg showed signs of peripheral vascular disease due to his diabetic mellitus. This resulted in pain and discolouration in the right leg.

[84] Since the deceased's last visit to the Hospital was recorded in January 2000, it would therefore mean that he was in the care of the Hospital for approximately two (2) years after Dr. Lowe made the finding of peripheral vascular disease and diabetes mellitus. This evidence is therefore telling and in my judgment, the treatment of the right leg seemed wholly inadequate and deficient. In my view Defendants breached the standard of care owed to the deceased by failing to diagnose and adequately treat the deceased for these conditions.

[85] In considering all the foregoing evidence, I find that the Defendants were negligent in their treatment of the deceased. They breached the duty of care owed to him by failing to exercise the necessary level of care. Specifically, the 1st Defendant should have conducted the initial surgical intervention more expeditiously, conducted surgery to remove the gentamicin beads and ascertained the general health of the deceased, in particular, diagnose diabetes mellitus and peripheral vascular disease. This approach is what would have been expected from someone professing to have the ordinary skill of doctors and medical staff attending to the patients.

Was the amputation of the right uninjured leg and the delay in the healing of the left leg caused by the breach of the duty of care by the Defendants?

[86] It is trite law that notwithstanding the existence of a duty of care and the breach of that duty of care that led to damages, the Defendants cannot be found negligent, unless it is shown that there is a clear causal link between the breach and the damages or that the breach materially contributed to the damages.

[87] The traditional test applied to determine causation is the 'but for' test. An instructive case on the 'but for' test is **McGhee v National Coal Board** [1972] 3 All ER 1008. In this case the claimant who was employed to clean out brick kilns developed

dermatitis from the accumulation of coal dust on his skin. There were no shower facilities at work and as such the claimant would cycle home each day covered with the dust. It was found as a fact that had the coal dust been washed off before cycling, the risk of harm would have been less. The challenge for the claimant was to show that it was the failure to provide shower facilities that led to his condition. The House of Lords held that the risk of harm had been materially increased by the prolonged exposure to the dust. Lord Reid at page 1011 stated that *"The medical evidence is to the effect that the fact that the man had to cycle home caked with grime and sweat added materially to the risk that this disease might develop."*

[88] The Honourable Mr. Justice Roy Anderson authored a chapter in the **Commonwealth Caribbean Tort Law**, Gilbert Kodiliyne, 5th edition entitled **Medical Negligence in the Commonwealth Caribbean**. In analysing the case of **McGhee v National Coal Board** (supra) he stated at page 429-430 the following: -

> *"The 'material increase risk' was treated as being equivalent to a material contribution to damage. This seems to have been a signal that a claimant could satisfy the requirement for causation short of showing that but for an act of the defendant he would not have suffered the damage. Rather, if he could show that the defendant's actions materially increased the risk of injury, and thus damage, to the claimant, this would suffice."*

[89] The case of **Bailey v Ministry of Defence and Anor** [2008] EWCA Civ 833, cited by Learned Counsel for the Claimant also buttress this principle. In this case the claimant had suffered brain damage following cardiac arrest after inhaling vomit. She had inhaled her vomit because she was in a very weakened state. Two (2) causes had contributed to her weakness, one tortious, the other not. The judge below held that the tortious cause had made a material contribution to the weakness and the claimant succeeded in full. The employer appealed. The appeal failed and it was held that it was not possible to say with any confidence whether, without the tortious contribution, the claimant would have been so weak as to inhale her vomit. At paragraph 46 Walker LJ who delivered the judgment of the court stated as follows: -

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

[90] The expert evidence of Dr. Barnes, on which I place significant reliance stated that the natural history of peripheral vascular disease, if left untreated leads to dry gangrene of the foot, which then requires amputation to a point where vascularity already exist. In relation to the non-diagnosis of the deceased's peripheral vascular disease while he was in the Hospital, Dr. Barnes stated that the suggestion that the deceased had significant pain in his right leg would have meant that he had rest pain at the time, which would have been advanced peripheral vascular disease and which ought to be investigated with some level of urgency and referred to the General Surgical Services.

[91] He further indicated that had it been diagnosed earlier, revascularization procedures may have been possible and the deceased's right leg might have been saved. Dr. Barnes also averred that the non-diagnosis and non-treatment of the peripheral vascular disease in his right leg by the medical staff is considered negligent, as the peripheral vascular disease must have existed over the years and worsened while he was in the Hospital. The addition of diabetes mellitus caused the condition to be more pronounced.

[92] I therefore find that the 1st Defendant was negligent in treating the deceased's right leg by failing to diagnose peripheral vascular disease and diabetes mellitus and as such, the negligent acts of the Defendants materially increased the risk of right leg being amputated.

[93] In relation to the admitted delay of the Defendants in removing the gentamicin beads from the left leg of the Claimant, I am satisfied that this negligent act delayed the healing of the left leg. Dr. Barnes indicated that the beads are usually removed relatively quickly after the procedure within six (6) to twelve (12) weeks. However, the beads remained for seventeen (17) weeks due to the delay of the Defendants. The Medical report of Dr. Dundas stated that: -

> *"the removal of the Gentamicin Beads has resulted in the consolidation of his right tibial fracture. The process, however, may take a year or more to complete. If it goes as planned (and indications are at present that it will) we would be able to get Mr. Johnson up and weight-bearing on the left lower extremity in about four months."*

[94] It is therefore in the realm of hypothesis that had the beads been removed by the Defendants in the standard accepted time mentioned by Dr. Barnes, the left leg would have healed earlier than forecasted by Dr. Dundas. Dr. Barnes concluded in his report dated the 19th day of September 2016 that the deceased's fracture to the left leg would have healed in approximately six (6) months had he had the proper treatment of the fracture. I therefore find that the delay in removing the gentamicin beads made a material contribution to the stymied healing of the left leg.

[95] I therefore hold that on a balance of probabilities, the Claimant has discharged the burden and has proved that the amputation of the right uninjured leg and the delay in the healing of the left leg was caused by the breach of the duty of care by the Defendants.

Res Ipsa loquitur

[96] At this juncture, I will deal with the Claimant's reliance on the doctrine of res ipsa loquitur. The Claimant's case is that the amputation of the right leg and delayed surgery to the left leg were due to the negligence of the 1st Defendant, its servants and/or agents.

[97] It is trite law that although the principle of res ipsa loquitur does not generally arise in actions of medical negligence, there may be circumstances when it may arise. For it to arise in such actions, some positive evidence of neglect of duty is required.

[98] The case of **Mahon v Osbourne** [1939] 2 KB, 14 is instructive on this principle. Scott L.J. at page 21 stated as follows: -

> *"The very essence of the rule when applied to an action for negligence is that on the mere fact of the event happening, for example, an injury to the plaintiff, there arise two presumptions of fact: (I.) that the event was caused by a breach by somebody of the duty of care towards the plaintiff, and (2.) that the defendant was that somebody. The presumption of fact only arises because it is an inference which the reasonable man knowing the facts would naturally draw, and that is in most cases for two reasons: (I.) because the control over the happening of such event rested solely with the defendant, and (2.) that in the ordinary experience of mankind such an event does not happen unless the person in control has failed to exercise care."*

[99] Scott L.J. continued at page 22: -

> *"Where complete control rests with the defendant, and it is the general experience of mankind that the accident in question does not happen without negligence, the maxim may well apply."*

[100] The Honourable Mr. Justice Horace Marsh in analysing the res ipsa loquitur doctrine at page 20 of the case of **Anthony Jackson v Dr. George Donaldson and The Attorney General of Jamaica** (unreported), Supreme Court Jamaica, Suit No. C.L.J 015 of 1995, judgment delivered the 25th day of June 2008 stated the following: -

> *"This is an exception to the general rule that the claimant bears the burden of proof of the negligence alleged, arising where the facts established are such as that immediate inference arising from that is that the injury complained of was caused by the defendant's negligence; or where the event providing the basis of the negligence, tells its own story of negligence on the part of the defendant, the story so told being clear and unambiguous."*

[101] I find the Claimant's case to be clear and unambiguous as detailed evidence was provided as to the cause of the injuries. The soundness of the evidence disclosed that the injuries would not have happened without the negligence of the

Defendants. I find that each of the conditionalities for the applicability of the doctrine have been met in this case.

Whether the deceased contributed to his injuries, loss and damage suffered?

[102] The Defendants pleaded that should the 1st Defendant, its servants and/or agents be found negligent, the deceased was contributorily negligent in the circumstances.

[103] The burden of proof is on the 1st Defendant to show that the deceased was in fact contributorily negligent. Lord Wright in the case of **Caswell v Powell Duffryn Associated Collieries Ltd** [1940] AC 152 concisely stated at page 172 that: -

> *"If the defendants' negligence or breach of duty is established as causing the death, the onus is on the defendants to establish that the plaintiff's contributory negligence was a substantial or material co-operating cause."*

[104] It is trite law that a court may make a finding of contributory negligence on the claimant's part. The law in relation to contributory negligence, is well settled and captured in section 3(1) of the **Law Reform (Contributory Negligence) Act**. This section states: -

> *"Where any person suffers damage as the result partly of his own fault and partly of the fault of another person or persons, a claim in respect of that damage shall not be defeated, but the damages recoverable in respect thereof shall be reduced to the extent as the court thinks just and equitable having regard to the claimant's share in the responsibility of damage..."*

[105] In the case of **Martia King v Mathew Hilbert and Rohan Grant** [2017] JMSC Civ 122, the Honourable Mr. Justice Lennox Campbell in analysing the doctrine of contributory negligence stated at paragraph 41 of the judgment: -

> *"The essence of contributory negligence in law is not that the plaintiff's carelessness was a cause of the accident but rather that it contributed to his damage. In establishing a claim of contributory negligence, there is no requirement to demonstrate a duty owed by the injured to the party sued that has been breached, <u>what is required is proof that the injured party did not take reasonable care of himself and contributed to his own injury</u>." (emphasis applied)*

[106] His Lordship further cited the dicta of Du Parcq L.J in the case of **Lewis v Denye** [1939] 1 K.B. 540, at page 554 as follows: -

> *"Contributory negligence means there has been some act or omission on the Claimant's part which has materially contributed to the damage caused, and is of such a nature that it may properly be described as negligence; for these purposes "negligence" is to be taken in the sense of careless conduct rather than in its technical meaning involving breach of duty of care and other concomitants of the tort. According to Lord Simon in* ***Nance v British Columbia Electric Ry*** *[1951] A.C. 601 at 611:*
>
>> *"When contributory negligence is set up as a defence, its existence does not depend on any duty owed by the injured party to the party sued, and all that is necessary to establish such a defence* ***is to prove…that the injured party did not in his own interest take reasonable care of himself and contributed, by this want of care, to his own injury****. For when contributory negligence is set up as a shield against the obligation to satisfy the whole of the plaintiff's claim, the principle* ***involved is that, were a man is part author of his own injury, he cannot call on the other party to compensate him in full****."*

[107] I accept the evidence of Dr. Lawson that revealed that since the admission of the deceased and at several points during his treatment at the Hospital, the deceased gave a history of being a chronic smoker. At the time he made the complaint regarding his right leg in November 1999, he was advised to stop smoking immediately as this habit could likely have resulted in the suspected vascular complications. The evidence of Dr. McDowell also revealed that the deceased was a chronic smoker for fifty (50) years and smoked ten (10) cigarettes per day.

[108] Dr. Lawson further indicated that if peripheral vascular disease was present, then this would quite likely have been the result of chronic cigarette smoking. Cigarette smoking is well known to damage the vascular system. Diabetes mellitus is also well known to be associated with and in fact cause vascular complications.

[109] The Claimant in her evidence stated that she did not see the deceased smoke. In analysing what evidence should be considered to determine the issue of liability, the Honourable Mr. Justice Kirk Anderson in the case of **Chrismore Reid v**

Andrae Aarons, Warren Wilson and Steadman Wright [2015] JMSC Civ.15 stated at paragraph 28 that: -

> *"A witness may not be truthful, for a variety of reasons – some innocent, while others, blameworthy. Also, it is always open to this court, as the tribunal of fact, to accept part of a witness' evidence and reject another part."*

[110] In applying this dictum, and in considering the Claimant's evidence, I do not accept that part of her evidence. In the circumstances I am convinced that the chronic smoking habit of the deceased resulted in the development of his peripheral vascular disease, and as such he is partially responsible for his injuries, in particular, the amputation of his right leg.

[111] There was evidence that the deceased failed to follow up with outpatient care after January 2000, and that he deferred in seeking alternative care, when he realized that the 1st Defendant was neglectful in their treatment of his injuries. That being said, I am of the view that this amounts to some degree of careless conduct on the part of the deceased.

[112] Considering the circumstances of the case, I find that whatever damages the deceased may be entitled to by reason of the negligence of the Defendants should be reduced by 10%.

What quantum of damages if any, is the deceased entitled to?

General Damages

[113] The headings of general damages developed by Wooding CJ in the influential case of **Corniliac v St. Louis** (1965) 7 WIR will be used for assessment.

Pain & Suffering

[114] In seeking to arrive at an award for pain and suffering, the Honourable Mrs. Justice Audre Lindo at paragraph 20 in the case of **Kamaal Pitterson v The Attorney General of Jamaica** [2016] JMSC Civ. 49 adopted the dictum of Lord Hope of Craighead in **Wells v Wells** [1998] 3 All ER 481. The dictum is as follows: -

> *"The amount of award for pain and suffering and loss of amenities cannot be precisely calculated. All that can be done is to award such sum within the board criterion of what is reasonable and in line with similar awards in comparable cases as represents the court's best estimate of the claimant's general damages."*

[115] The Consumer Price Index (C.P.I) that is applicable at this time is the July 2018 250.4. I have considered the physical injury to the deceased, his pain and suffering, as well as the procedures he had to undergo for treatment.

[116] Learned Counsel for the Claimant cited the following cases in support of his submissions for the award of general damages for the amputation of the deceased's right leg: -

1. **Howard Genas v The Attorney General of Jamaica, The Black River Hospital Board of Management and Dr. K.D. Mshana** (supra);

2. **Lealan Shaw v Coolit Limited and Glenford Coleman**, reported in Recent Personal Injury Awards Made in The Supreme Court of Judicature of Jamaica, Ursula Khan Volume 4, pages 41-42; and

3. **Trevor Clarke v National Water Commission, Kenneth Hewit and Vernon Smith**, reported in Recent Personal Injury Awards Made in The Supreme Court of Judicature of Jamaica, Ursula Khan Volume 5, pages 21-22.

[117] In relation to the delayed healing of the left leg Learned Counsel cited the following cases: -

1. **Malcom Moody (infant b.n.f Colene Moody) v Andrea Stephenson**, reported in Recent Personal Injury Awards Made in The Supreme Court of Judicature of Jamaica, Ursula Khan Volume 6, pages 74-75;

2. **Errol Turner v Cigarette Company of Jamaica Limited, Anthony Gopie, Attorney General for Jamaica and Headly Nicholas**, reported in Recent Personal Injury Awards Made in The Supreme Court of Judicature of Jamaica, Ursula Khan Volume 4, pages 73-74; and

3. **Carlton Brown v Manchester Beverage Limited & Anor**, reported in Recent Personal Injury Awards Made in The Supreme Court of Judicature of Jamaica, Ursula Khan Volume 5, pages 272-273.

[118] I will say at this juncture that the averment by Learned Counsel for the Claimant to the loss of amenity suffered was insufficient.

[119] Learned Counsel for the Defendants cited the case of **Joseph Frazier v Tyell Morgan & Trevor Corrol**, reported in Recent Personal Injury Awards Made in The Supreme Court of Judicature of Jamaica, Ursula Khan Volume 5, pages 19-20.

[120] I find the following cases to be closely aligned with the injuries suffered by the deceased. In the case of **Howard Genas v The Attorney General of Jamaica, The Black River Hospital Board of Management and Dr. K.D. Mshana** (supra), the claimant fell from his motor cycle and injured his right leg. He was taken to the Black River Hospital with a suspected fracture of the tibia and circulatory compromise. He remained there for eight (8) days before being transferred to the Orthopaedic Department of the Kingston Public Hospital. As a result of the delay in treatment given, the claimant's leg was amputated. He was awarded $4,500,000.00 (which included loss of amenities) which updates to $11,288,319.00 today.

[121] In **Joseph Frazier v Tyell Morgan & Trevor Corrol** (supra), the claimant suffered a severe crush injury resulting in a high below knee amputation of the left leg. The

stump healed without complications. He was awarded $2,000,000.00 for pain and suffering, loss of amenities and future earnings, which today updates to $9,188,990.83.

[122] In **Clifton McKenzie v South East Regional Health Authority and the Attorney General,** (unreported), Supreme Court Jamaica, Claim No. C.L. 2000 M-140, judgment delivered the 1st day of April 2011, the claimant was involved in a motor vehicle accident and suffered serious injuries. He was initially seen at the Port Antonio Hospital and later transferred to the Kingston Public Hospital where he spent three (3) months. He suffered multiple injuries including cerebral contusion, multiple fractures, laceration over the middle half of the right leg, obvious deformity to the right wrist, fractures of his right femur and right tibia as well as an unstable left knee with vascular compromise. He had an amputation of the left leg. No loss of amenities was averred. He was awarded $5,500,000.00 for pain & suffering which today updates to $8,115,498.00.

[123] In relation to the delayed healing of the left leg, I find the case of **Trevor Clarke v National Water Commission, Kenneth Hewit and Vernon Smith** (supra) is instructive. In this case the claimant underwent two amputations and suffered a 36% permanent disability of the whole person. He was sent home with an unhealed wound to the amputated leg, and would have suffered pain as a result. In the instant case the delay in removing the gentamicin beads delayed healing and convalescing of the left leg, which resulted in the deceased suffering pain as a result. The claimant in the **Trevor Clarke** case was awarded $3,000,000.00 which today updates to $12,437,086.00.

[124] Based on the foregoing I am satisfied that an award of $9,500,000.00 is adequate to compensate the deceased for his pain and suffering.

Aggravated damages

[125] I am not convinced that there is evidence that the deceased's injury was aggravated by the conduct of the 1st Defendant in this matter. Whilst I agree that the Hospital

staff was callous in treating the complaints of the deceased and his wife, I do not find that the conduct injured the deceased's feeling of dignity and pride. This type of award is made in exceptional circumstances and I do not find this case to be one such circumstance.

Special Damages

[126] There was no averment of loss of income. There were a number of items claimed in relation to medical expenses. I find that these costs flowed from the injuries suffered for which I have found the Hospital liable. Special damages are as follows: -

Surgical intervention to repair malunion of the left femur and left tibia $253,450.00	
Ultra Sound (6 at $1500 each) at Oxford X Ray Limited	$9,000.00
Caledonia Medical Lab Ltd Biomedical	$400.00
Medical Associates Ltd. for Hospital administration, fees & Initial drug	$850.00
Medical X Ray Institute Limited	$900.00
Physiotherapy treatments	$900.00
Drugs & Medication	$3,375.00
Electrocardiogram	$1,800.00
Medical Associates Hospital dressing and lab test	$570.00
Medical Associates Hospital admission and accommodation fees	$43,024.00
Cost of leg brace	$12,000.00

Surgery for amputation of right leg	$175,000.00
Transportation expenses	$156,120.00
Total	**$657,389.00**

ORDERS AND DISPOSITION

[127] For the reasons herein the Court makes the following orders: -

1. Judgment for the Claimant with liability assessed at 10% on the part of the Claimant and 90% on the part of the Defendants;

   I. Special damages are awarded at $657,389.00 but having regard to the Court's finding of contributory negligence the Defendants are to pay the sum of $591,650.01 with interest awarded at 3% per annum from 31 July 1996 to the date of this judgment;

   II. General damages are awarded at $9,500,000.00 but having regard to the Court's finding of contributory negligence the Defendants are to pay the sum of $8,550,000.00 with Interest at 3% per annum from the date of service of the Writ of Summons to the date of this judgment;

2. Costs to the Claimant to be taxed if not agreed.