[2018] JMSC Civ 108

IN THE SUPREME COURT OF JUDICATURE OF JAMAICA

CIVIL DIVISION

CLAIM NO. 2011 HCV 07605

BETWEEN **CHEAVELA SMITH** **CLAIMANT**

(By Her Mother & Next Friend Sharon Martin)

AND **THE UNIVERSITY HOSPITAL BOARD OF MANAGEMENT** **DEFENDANT**

Mr. Kevin Page instructed by Page & Haisley for the claimant

Mr. Christopher Kelman and Miss Stephanie Ewbank instructed by Myers, Fletcher & Gordon for the defendant

September 19, 20 and 21 2016, November 14, 2016 and February 9, 2018

Medical Negligence- Obstetrics- Whether decision to deliver baby by Caesarean section made too late – whether delivery by Caesarean section caused injury to the claimant

SIMMONS J

[1] The University Hospital of the West Indies (UHWI) was established by an Act of Parliament with a board of management which is responsible for managing, controlling and operating the hospital and making all such appointments as may be necessary to ensure that its duties under the Act are properly performed.

[2] The claimant's mother, Miss Sharon Martin registered for antenatal care at the hospital on March 31, 2006. At that time, she gave a history of being a known

hypertensive patient for seven (7) years and of having had type II diabetes for one (1) year.

[3] On October 19, 2006 she was admitted to the hospital because she was noted to be having increased blood pressure. At that time, her pregnancy was thirty six (36) weeks and six (6) days.

[4] On October 25, 2006 at 12:45 pm when Miss Martin's pregnancy was thirty seven (37) weeks and five (5) days the decision was made to induce labour. She was transferred to the Labour Ward at the UHWI at 7:00pm that evening.

[5] At 8:00 pm she was examined by Dr. Leslie Samuels. He again examined her at 11:35 pm at which point her cervix was only 5 cm dilated. At 1:03 am on October 26, 2006, Miss Martin was fully dilated. She started to experience strong contractions. The foetal heart rate dropped at 1:08 am but returned to normal levels at 1:11am. At 1:40 am there was however, no descent of the foetal head. As a result, Miss Martin was prepared for a Caesarean section.

[6] At 1:51 am Miss Martin was transferred to the operating theatre and the first incision was made at 2:13 am. At 2:16 am the claimant was extracted. After her birth, the claimant experienced numerous seizures. The claimant was subsequently diagnosed with cerebral palsy.

The Claim

[7] By way of an amended claim form and particulars of claim both dated and filed on January 6, 2015, a medical negligence claim was brought by the claimant by her mother and next friend Miss Sharon Martin against the University Hospital Board of Management. The claimant claims that on or about the 26th day of October 2006, the servants and/or agents of the defendant failed to perform a Caesarean section delivery in a timely manner. She has asserted that the procedure was necessary because she suffered from diabetes, hypertension and her pelvis was assessed to be too small.

[8] The claimant claims that as a result of the said negligence she has sustained serious personal injury in the form of brain damage and has suffered loss and damage.

[9] The particulars of negligence were outlined as follows:-

i. In all the circumstances failing to provide a safe system for the provision of health care;

ii. In all the circumstances failing to provide a safe place for the provision of health care;

iii. Failing to ensure that the claimant (sic) was properly prepared for the procedure;

iv. Failing to ensure that no instrument or equipment was used in such a way to cause injury to the claimant;

v. Failing to perform the Caesarean delivery in a timely and safe manner

[10] In refuting the claimant's case, the defendant filed an amended defence on October 8, 2015. It is dated October 5, 2015. In essence, the defendant stated that:-

i. An ultrasound was done to assess the foetal weight and well being and that test disclosed that the foetal weight was 2.74 kg which was well within the normal range and known, and approved obstetric management does not indicate that a Caesarean section is necessary in cases where the foetal weight is 2.74kg.

ii. The medical condition of the claimant's mother did not require that a Caesarean section be conducted upon her admittance to the defendant's medical facilities.

iii. Miss Martin was treated between March and October 2006 by a strict dietary programme as a result of which her blood sugar remained within normal range for the rest of her pregnancy and her blood pressure remained within normal range until her final antenatal visit when it was elevated.

iv. Upon Miss Martin's admittance to the hospital on October 19, 2006 she was started on Aldomet 500 mg (an anti-hypertensive drug) for blood pressure control and as a result of its use, her blood pressure was stabilized.

v. On October 26, 2006 at 1:40 am significant caput and moulding were identified on examination and this constituted the first objective data that vaginal delivery could not be safely accomplished. Cephalopelvic disproportion was diagnosed and the decision was made to proceed by way of Caesarean section. The operation was performed within thirty (30) minutes without incident.

vi. At all material times it fully discharged its duty to the claimant. At all material times it provided a safe system and safe place for the provision of healthcare in relation to the claimant's antenatal and delivery care.

vii. At no time during the management of Miss Martin in the labour ward was any instrument used or administered in a way to cause her injury.

viii. At all material times, the management and treatment of the claimant at the defendant's hospital accorded with good, approved and accepted medical and obstetric and surgical practice in Jamaica in 2006.

The Claimant's Case

[11] The claimant, in seeking to establish her claim, relied on two witnesses: Miss Sharon Martin and Dr. Eve Palomino Lue.

[12] On September 19, 2016, Miss Martin's witness statement, dated and filed April 8, 2015, was permitted to stand as her examination-in-chief save for paragraph eleven (11) which was struck out as a result of it being an expression of opinion which Miss Martin was not suitably qualified to make.

[13] Miss Martin's evidence is to the effect that on October 25, 2006 she was pregnant and lawfully a patient at the UHWI. She had been admitted one week before due elevated blood pressure and the servants and/or agents of the defendant informed her that she should do a Caesarean section. She also stated that on October 25, 2006 she started having contractions as a result of labour induction. She began feeling pain around 4:00pm that same day and was taken to the Labour Ward for further management and delivery.

[14] At 8:00 pm the servants and/or agents of the defendant burst her membrane to help the baby to come down and she immediately started to feel much more pain and was then instructed to push. She informed the doctor that she was not supposed to push as she was supposed to get a Caesarean section. She said that she was in tremendous pain and was instructed to push. She was told by the servants/agents of the defendant that "we do not cut like that."

[15] In the wee hours of the morning she was then told to sit up and sign a paper to do the Caesarean section. At that time, she had been in labour for several hours. She signed the documents and then the doctor was called to do a Caesarean section upon the realization that the heartbeat of her child was dropping and her labour efforts were futile.

[16] The baby was delivered on October 26, 2006 in the early hours of the morning. The baby was blue and not making any sound. Her daughter was then rushed to the nursery and Miss Martin was transferred to the ward for recovery. When she was able to walk around she visited her daughter and was informed that her daughter had been having seizures. Her daughter was kept on the ward for two (2) weeks.

[17] As a consequence of the defendant's negligence, she suffered personal injuries and incurred medical and transportation expenses in excess of ten thousand ($10,000) dollars. She also stated that her personal functions and professional functions were affected as she is traumatized. She has also been unable to work as she has to be with her daughter around the clock as her daughter is brain damaged and she is unable to afford further medical care.

[18] During her brief cross-examination, Mr. Kelman suggested to Miss Martin that it is not true that she was told by any staff of the hospital that a Caesarean section would have to be done. Miss Martin's response was that she was told that a Caesarean section was required and it was written down in her docket. After the doctor had completed his examination she was told that her pelvis was not opening wide enough so she would have to do a Caesarean section.

[19] When she was asked if she recalled the month that she was told of this requirement, she informed the Court that it was in March during her first visit. Mr. Kelman then asked if that was the only time that was said to her. She testified that, although she could not remember the date, she was told that the baby was in a breech position and if she did not turn she would have to be delivered by way of a Caesarean section.

Dr. Eve Palomino-Lue

[20] Dr. Palomino Lue's expert report dated April 7, 2016 was admitted into evidence.

[21] Dr. Palomino-Lue is a Consultant Paediatrician who has been a registered Medical Practitioner with the Medical Council of Jamaica for the last forty one (41) years. She is a graduate of the University of the West Indies where she obtained the Bachelor of Medicine and Surgery Degree (MBBS) in 1967 and Doctor of Medicine in Paediatrics in 1973.

[22] Her evidence indicates that she did not see the claimant when she initially came to the office on January 15, 2007. She was seen by a colleague who made a

diagnosis of Hypoxic Ischaemic Encephalopathy (HIE), a condition which is caused when the oxygen supply to the brain is compromised during the perinatal period. She informed the Court that the severe HIE which the claimant suffers is a severe disabling condition with a poor prognosis.

[23] Dr. Palomino-Lue also stated that it became evident that the claimant had severe cerebral palsy and significant developmental delays. On October 30, 2015 she took a detailed history from the claimant's mother who told her that she attended the antenatal clinic at the UHWI when she was seven (7) weeks and five (5) days pregnant and she was told then by the attending doctor that she had a small pelvis and would need to deliver by Caesarean section. Miss Martin also informed her that she had attended the high risk antenatal clinic as she was diabetic and hypertensive and she was admitted to the hospital late in the pregnancy for one (1) week as her blood pressure was elevated. The following week she was informed that the doctor wanted to deliver the baby as her blood pressure was unstable. Labour was induced and she went into labour and had the urge to push at approximately 9:00pm on October 25, 2006.

[24] Dr. Palomino-Lue indicated that Miss Martin also informed her that she told the attending doctor that it was written in her notes that the claimant should be delivered by Caesarean section because of a small pelvis and the doctor told her that "they do not just do a Caesarean section just like that." Miss Martin also told her that sometime during the night, the decision was made to deliver the claimant by Caesarean section but there was some delay and the baby was delivered on October 26, 2006 at about 3:45am. The baby did not cry and was "blue" and was subsequently transferred to the special care newborn nursery. Miss Martin was then told that the infant was having seizures and was being treated as a result.

[25] Dr. Palomino-Lue stated that Miss Martin told her that she (Miss Martin) was subsequently told that the prolonged period that the baby was in the birth canal caused a lack of oxygen to the baby's brain resulting in the seizures.

[26] Dr. Palomino-Lue indicated that on October 30, 2015, she plotted the claimant's head measurement on a chart intended for babies up to age twenty four (24) months and the measurement fell below the normal measurement for an eighteen (18) month old child. At that time, the claimant's weight was that of an average two (2) year old or a small three (3) year old.

[27] She informed the Court that the claimant also has a squint and wears glasses. Additionally, she has severe spasticity and flexion deformities of all limbs, severe muscular atrophy and severe scoliosis. The claimant is unable to sit, stand or walk, is non-verbal and unable to communicate. She makes spontaneous sounds and smiles but not in response to a stimulus. If touched, the claimant cries out or groans and stiffens her body.

[28] It was her evidence that Miss Martin told her that the child's condition makes it very difficult to cope as the child is very difficult to feed as she has difficulty swallowing and chokes often, the child has to be lifted because of her deformities. Miss Martin is unable to work as it is difficult to find a caregiver as no-one will take the job. She was also informed by Miss Martin that she is unable to adequately provide the nourishment as prescribed by the Nutrition Clinic and her child's condition causes her much distress as the normal expectations of a parent for their child's growth and education cannot be achieved by the claimant because of the severity of her condition.

[29] Dr. Palomino-Lue indicated that at the time of preparing the report she did not have the hospital records of the mother or the baby and she would have liked to examine the records so as to have a more comprehensive picture of events surrounding the claimant's birth. She simply relied on the history given to her by the claimant's mother.

[30] The evidence of Dr. Palomino-Lue that was elicited upon cross-examination is as follows: She has never qualified as an obstetrician and she has never practiced as one. In simplistic layman terms obstetrics can be described as the treatment

of a pregnant woman for the period of her pregnancy up to the time she delivers her child. A paediatrician, however, manages the infant from the time of delivery or childbirth up to eighteen (18) years.

[31] Issues relating to the management of pregnant women fall squarely within the province of the obstetrician and not the paediatrician but paediatricians are consulted whenever the woman had a difficult delivery. Where some problem is anticipated, the paediatrician will also be in the delivery room.

[32] She stated that the question of whether, in a particular pregnancy, childbirth is to be by way of vaginal delivery or Caesarean section falls squarely within the province of the obstetrician and not the paediatrician. She also gave evidence that whether the mother, by allegedly having a small pelvis, should have been booked for a Caesarean section from inception rather than allowed to proceed by way of vaginal delivery is one for an obstetrician rather than a Consultant Paediatrician.

[33] Counsel referred to page three (3) of Dr. Palomino-Lue's report where she made three (3) findings. He asked whether these findings are findings more for her colleague obstetrician rather than a Consultant Paediatrician and Dr. Palomino-Lue answered affirmatively.

[34] According to Dr. Palomino Lue the incident happened ten (10) years ago and she was just looking at the notes and the history and drawing a conclusion which she thought she could do on the basis of what all paediatricians and obstetricians will know about pregnancy and the problems with delivery.

[35] She gave further evidence that her report is her opinion and when she made her findings she did not have the notes. It was written in her report that she had not seen the hospital records and that she was making her conclusion solely on the history given by the mother and the examination of the child. She indicated that

she would have liked to examine the records so as to have a more comprehensive picture of the events surrounding the child's birth.

[36] Dr. Palomino-Lue stated that she was merely expressing a qualified view based on the accuracy of the mother's statement that there was some form of notation in the docket that she had a small pelvis and was told to do a Caesarean section. She said that one has to believe the patient.

[37] She also indicated that she has not seen any notation in the docket that at the time of her first visit Miss Martin was diagnosed with a small pelvis and was required to have a Caesarean section.

[38] She also stated that looking at the notes of Miss Martin's pregnancy and delivery she was satisfied that Miss Martin's blood sugar and hypertension were adequately managed by the University Hospital.

[39] Dr. Palomino-Lue opined that it is possible that a mother's hypertensive and diabetic conditions could expose her child to insults which could cause brain damage. One such insult could be placental insufficiency. There is also a possibility of diabetic mothers having children born with microcephaly as any other mother who does not have diabetes. The claimant was not microcephalic when she was born.

[40] The episode of foetal bradycardia at 1:08 am where the foetal heart rate fell to 90 and 110 beats per minute (bpm) was quite brief in that the foetal heart rate returned to the normal range for a foetal heart (155 to 152) within three minutes and thereafter all the subsequent readings were normal. Before 1:08 am all other entries in the records for foetal heart rate were within normal range.

[41] Though there was just a single brief episode of bradycardia that was quickly resolved she cannot agree that nothing happened because it was a brief episode. The doctors took that episode quite seriously because if a baby has bradycardia it means that the baby is in trouble and about seventeen (17)

minutes later the paediatricians were informed of the bradycardia and Miss Martin was immediately transferred to the delivery room.

[42] Ninety (90) bpm is not borderline. She agreed with Counsel that episodes of bradycardia are not unusual because increased contractions can cause such episodes. She however, did not agree with Counsel that the fact that it was brief and went back within normal range and remained within normal range lessens the likelihood of any long term damage or insult. She wondered why the doctors called the paediatrician at that time.

[43] She however, agreed that because there was an episode, no matter how brief, it would not have been unusual, in keeping with good management and continuity of management, to inform the paediatrician.

[44] Dr. Palomino-Lue was then referred to her report where she stated 'If the baby was delivered by elective section, the child could probably have been normal at birth and would not have suffered brain damage with the resulting seizures and profound mental and physical disability.' She was then asked whether in preparing her report, she at any time considered the mother's hypertensive and diabetic condition as causative of any of the conditions which the claimant suffers from. She reiterated that her report was based on the mother's history only and that she did not have the dockets but she still believes that if the baby was delivered by Caesarean section the baby would probably be normal because the child suffers from profound brain syndrome, she seized for at least four days. At one point it was said that the seizure was intractable and she really does not think that the child would have had this problem had she been delivered early before she got any damage. By early delivery she was referring to the note which says 'indication: prolonged second stage with foetal bradycardia.'

[45] Dr. Palomino-Lue also stated that no one can be absolutely certain that the fact that Miss Martin's hypertension and diabetes were well controlled means that

there was absolutely no way that there could be placental insufficiency and other complications as a result of those medical conditions.

The Defendant's Case

[46] The defendant relied on two witnesses: Dr. Leslie Samuels and Dr. Milton Hardie.

[47] In his witness statement Dr. Samuels outlined his credentials and stated that he was personally involved in the claimant's birth. He indicated that, in preparing his statement, he did a full review of the dockets maintained by the UHWI in respect of both Miss Martin and the claimant. In addition to what the docket disclosed, Dr. Samuels stated that in diabetic patients the international standard of care is to deliver between thirty eight (38) and thirty nine (39) weeks gestation because that is the time when foetal maturity is most assured. Miss Martin was induced slightly earlier because of the co-existence of hypertension which increased the risk to her and the foetus if the pregnancy was prolonged further.

[48] He stated that mothers who have delivery by Caesarean section have an increased risk of heavy bleeding, abnormal clot formation, post-operative infection, and post-partum depression. They also require a longer recovery time than those who have a vaginal delivery. Infants born by Caesarean section also tend to have a greater likelihood of initial breathing difficulties than infants born by vaginal delivery. Consequently, in his opinion a Caesarean section would have constituted a higher risk for both Miss Martin and the claimant.

[49] He further stated that before delivery the claimant was 2.84 kgs and with no documented abnormalities in presentation or position. Therefore, delivery by way of a Caesarean section would not have been in keeping with international standards.

[50] It was his evidence that hypertension and diabetes are known to be potential causes of placental problems which could lead to foetal hypoxia (low oxygen to

baby) however neither the ultrasound nor the monitoring of Miss Martin during labour showed any evidence of this.

[51] Dr. Samuels stated that no instrument or equipment was used during the initial attempt at vaginal delivery. His written evidence indicated that the claimant had APGAR scores recorded in the operative notes as 3, 4 and 7 at 1, 5 and 10 minute (s), respectively, (scores of 3, 4 and 6 recorded in nurses notes) and she was admitted to the special care nursery for further observation and management.

[52] Dr. Samuels' evidence during cross-examination was as follows: On October 25, 2006, Miss Martin's labour was induced with misoprostol at 12:45 pm. Misoprostol is a hormone that runs the labour process by priming the uterus and the cervix. When Miss Martin was admitted her cervix was 3cm long and the 'os' (which means hole in Latin) was closed; misoprostol would have been the agent that was responsible for converting the cervix to 0.5 cm long and converting a closed channel 'os' to one that was 3-4 cm dilated. Therefore, the misoprostol would have been responsible for that change in the cervix making it favourable to the delivery process.

[53] Regular contractions of the uterus will cause cervical change and will ripen the cervix but that takes a very long time. When misoprostol is used, a step is skipped which is the regular contractions of the uterus. This "traumatizes the cervix" and creates prostaglandins which will eventually ripen the cervix. Prostaglandins are the agents that promote inflammation and in the context of labour it is that inflammatory process that drives the labour. Oxytocin can also be used to induce labour and ripen a cervix but it takes a very long time. For first time mothers the current practice is to use misoprostol first and then oxytocin.

[54] He said that one of the reasons why Miss Martin was induced at thirty seven (37) weeks and five (5) days was due to her pre-existing illnesses.

[55] His evidence is that the time lapse from the induction of labour to Miss Martin's transfer to the Labour Ward at 7:00pm was approximately six (6) hours and fifteen (15) minutes. That period of time is well within normal for a first time mother. He also indicated that the fact that Miss Martin had hypertension and diabetes would have required that the period be shorter if she had not been controlled. If her hypertension had been severe and was not responding to the initial medication that would have been a reason to send Miss Martin straight to the Labour Ward but since the pressures were well controlled sending her to the Induction Ward was the protocol.

[56] After Miss Martin's transfer from the Antenatal Ward to the Labour Ward, her initial check was done by a midwife. The protocol is that if a patient is induced she is checked by a midwife every hour while on the Maternity Ward until the patient is transferred. In Miss Martin's case, she was checked at 1:35 pm, 3:30 pm, 5:30 pm, 5:45 pm, 6:00 pm, 6:35 pm and 6:45 pm. Therefore, she had regular checks while she was on the Antenatal ward.

[57] When Miss Martin was checked by the midwife at 7:25 pm she was having irregular contractions and the first time he saw Miss Martin was at 8:00 pm when an artificial rupture of membranes was done which revealed normal looking liquor.

[58] He gave further evidence that the membranes that hold the fluid and the baby could be compared to a water balloon and when the membrane is ruptured it is like bursting the balloon and allowing the fluid to pass out.

[59] He stated that if the membranes are very turgid the finger cannot be used to rupture the membranes and where that is the case, there are two instruments which are often used. One is called an amnihook. It is a plastic device and the end of it is hooked. It is used to hook the membranes and then one pulls to tear it. The other instrument is called a Kocher's and a hook at the end of its jaws which is used in a similar fashion to the amnihook. Dr. Samuels was unable to

say with absolute certainty which method he used to rupture the membrane. However, it is his practice, more often than not, to use his fingers whenever possible as it is less traumatic to the patient. That was however, not recorded in the docket. He indicated that when the membranes are ruptured it causes tissue damage which promotes the production of prostaglandins which enhances the labour process.

[60] Dr. Samuels said that there are three stages of labour: Stage one is from the beginning of the labour process and consists of uterine activities and cervical change until the cervix becomes ten (10) cm dilated. Stage two starts at ten (10) cm full dilation and it ends when the baby is expelled naturally. Stage three begins when the baby is delivered and ends when the placenta is delivered.

[61] At 11:35 pm Miss Martin was only five (5) cm dilated and at that time the foetal head was at station 0, that is, at the level of the ischial spines. This simply means that the baby's head came down into the middle of the pelvis. That is also the narrowest part of the pelvis and presents the greatest challenge in terms of traversing.

[62] The fact that the mother has both hypertension and diabetes does not affect how fast dilation takes place. However, it might affect how long a doctor will give himself/herself to accomplish a delivery but not the actual labour process. If labour is induced at 12:45 pm it is difficult to give a timeframe from induction to full dilation. He stated that the literature does not speak to a timeframe. Once a doctor is delivering a stable patient he or she is looking to achieve the outcome of cervical ripening and the time varies.

[63] His evidence is that the decision to augment Miss Martin's labour with oxytocin was not made until 11:35 pm which was almost eleven (11) hours after induction. However, the oxytocin was not administered because other deliveries were taking place and there was not enough staff to monitor her progress. He explained that when oxytocin is administered a midwife or doctor has to sit down

beside the patient one-on-one. There are two (2) doctors who are physically present on the ward and an intern is on call. That intern may not have been physically present at the time. There is also, a consultant on call. He could not speak to the number of midwives that were on duty at the time but stated that the defendant did not have enough staff to allow one person to be exclusive to Miss Martin and therefore the medication was not started.

[64] In Miss Martin's case, the second stage of labour did not begin until 1:03 am on October 26, 2006 when her cervix was fully dilated and even though she was fully dilated the foetal head had not passed station 0. Dr. Samuels stated that there is no simple answer as to what stage in a normal delivery the foetal head passes station 0. It depends on a lot of factors. Generally, once a woman is fully dilated the baby's head is usually pass station 0. He explained that first time mothers tend to do things in stages. She will efface first, which is a shortening of the cervix, then she will dilate and the baby will descend. He indicated that although the baby's head was still at station 0, at that point Miss Martin was still regarded as being in normal labour process. A first time mother has up to two (2) hours to push out the baby after full dilation.

[65] He explained cephalopelvic disproportion as follows: '*cephalo*' refers to the head of the foetus and '*pelvic*' refers to the bone. Disproportion is simply saying that, the head, in that context, is not going through that pelvis. It is also the orientation of the baby in the maternal pelvis. The baby enters the pelvis in a certain position. Around the time when it actually gets down to the end of the ischial spine, that is when rotation should occur so the back of the baby's head should be in front of the mother's pelvis. If rotation fails to occur then the head can no longer get through the pelvis. If a baby's head is too big that is one reason why it might not be able to get through the pelvis but even where the baby has a normal size head and the mother a normal size pelvis, it can sometimes fail to negotiate the birth canal because of latitude. Asynclitism is another way that a normal size baby can fail to negotiate a normal size pelvis. That means that the axis of the

baby's head is different from the axis of the baby's body. The head and the body should be coming down on the same axis under normal circumstances.

[66] At 1:26 am the decision was taken to move Miss Martin to the delivery room. After she was moved to the delivery room oxytocin was then administered. At that time a midwife was available to monitor the augmentation process. He continued his efforts to achieve a vaginal delivery.

[67] At 1:40 am the foetal head had still not passed station 0 but there was significant caput and moulding. Therefore plan B, the Caesarean section, was resorted to. As part of the preparation for a Caesarean section the mother's consent is needed so it was obtained and thereafter Miss Martin was transferred to the Operating Theatre at 1:51am and spinal anaesthesia was administered at 2:08 am. The claimant was not delivered until 2:16 am.

[68] There was some difficulty in extracting the baby's head and during the Caesarean section he required the aid of an assistant to push the baby up from beneath. The assistant would have been a midwife.

[69] He also testified that when the patient is lying on the operating table after entry into the abdomen, under normal circumstances, doctors can go down in the uterus to the cervix, get their hand below the baby's head and ease it up so that the doctor can deliver the baby through the abdomen. However, when the baby is well and truly impacted a doctor may require someone's help from underneath. So a hand is passed into the vagina until one feel's the baby's head, the fingers are then spread and that action of spreading helps to separate the tissue from around the baby's head and then the flat of the palm is used to gently exert steady pressure up at the same time that the doctor is in the abdomen holding the baby's shoulders and also exerting a gently steady pressure up to dislodge the baby from the pelvis.

[70] Dr. Samuels said that labour is described as one of the top five (5) most painful experiences a human being can endure and ninety-nine (99%) of patients who are in labour beg for a Caesarean section at some point. Some patients will have perceived the need for a Caesarean section even before they actually go into labour and therefore it is not uncommon for a patient to say they need a section.

[71] He stated that the UHWI has a system in place requires that priority be given to high-risk pregnancy. A high risk pregnancy would either be because of a maternal factor, foetal factor or both. A charge system is utilized which essentially has regard for who is most sick and requires the most medical attention. Someone with diabetes and hypertension in the 21st century is high risk because she has additional morbidity and requires a little care than that which the typical pregnant woman would require.

[72] He did not remember if Miss Martin informed him that it had been written in her docket that her pelvis was too small for her baby to be delivered vaginally and that the baby should be delivered by Caesarean section. As a specialist in his field his decisions are usually made on the basis of objective documentable repeatable evidence. There was no evidence to push towards doing an elective Caesarean section.

[73] Sometime after the claimant's birth she was diagnosed as suffering from cerebral palsy. A normal child will sit up somewhere between six (6) and eight (8) months, hold on and stand at about nine (9) or ten (10) months, walk at age one (1) and talk at age (2). Cerebral palsy is diagnosed when a doctor has reason to think that the child has been deprived of oxygen at some point before or during birth and the child is failing to achieve the normal milestones, therefore the diagnosis is made months, or sometimes years after delivery.

[74] When a baby is delivered, particularly a baby that a doctor has any reason to believe is in distress; the baby is immediately handed over to the paediatric doctor in attendance. It is not the obstetrician's job to stop to examine the child.

[75] He did not notice that the claimant had a blue appearance. He stated that based on the paediatrician's notes, the baby would have been cyanotic and that is kind of blue in appearance. He indicated that there are five (5) parameters that are assessed at birth, one of which is colour. A normal appearance is pink and doctors look at pinkness in two areas: centrally, like the tongue and peripherally, like in the hands and the nails, if a baby is blue both centrally and peripherally then that would be cyanosis. That score would be 0. A number of babies are born with a score of 0 for appearance making them blue at birth and they are perfectly fine.

[76] He explained that we breathe oxygen from the air and that process is rather efficient. A baby gets oxygen from the placenta which in turn gets oxygen from the mother's circulation and the mother's circulation gets oxygen from the air. In effect, a baby's environment by adult standards is always hypoxic. In other words, the normal oxygen patterns in a baby will always be lower than the normal oxygen patterns in an adult. Therefore, seeing cyanosis in a newborn initially, when you take out the baby, does not mean very much, seeing it one minute after, does not mean very much, seeing it at five (5) minutes makes you pay attention and seeing it at ten (10) minutes can be a cause of concern.

[77] He stated that foetal hypoxia is a low oxygen baby. It is possible for a baby to be deprived of oxygen if the labour process is too long.

[78] The initial score of 0 validated the decision for the intervention but in and of itself does not mean too much. The claimant received a score of 1 which speaks to being pink centrally. The major artery in the neck is called the carotid artery and there are internal and external carotid arteries. The external carotid supplies the face and tongue. If one sees a pink tongue the oxygen supply to the tongue is normal and that can be used to say that the brain is actually normal. So within five (5) minutes of birth the central oxygen delivery of the claimant was normal.

[79] He also gave evidence that if the placenta was bad and a woman had a vaginal delivery, whether a doctor would see signs immediately after birth would depend on the severity and the duration of low oxygen to the baby. He stated that even when a baby is cyanotic usually there is still enough oxygen in the blood to support the normal basic cellular function.

[80] Dr. Samuels said that it is possible that between the time of induction to delivery the claimant could have been deprived of oxygen but it was not likely. There was never any time of persistent high heart rates or persistent low heart rates or abnormal heart ratings and those are the signs that doctors look for that are indicative of low oxygen to babies which cause harm.

[81] Counsel suggested to Dr. Samuels that there was a long delay in proceeding or performing the Caesarean section. Dr. Samuels stated that the international standard for what is called the “the decision to incision time”, that is, between the time one decides that a Caesarean section is necessary and when one actually makes the first incision, after surgery, is thirty (30) minutes. In Miss Martin’s case, the time was thirty three (33) minutes. The time was off by three (3) minutes. He said that although that is out of the range it needs to be understood that Americans, Europeans, Australians and Canadians and a lot of first world countries have tried to hold themselves to the standard of thirty (30) minutes and have failed to do so.

[82] Even though the standard of thirty (30) minutes is held (and to which doctors aim) by the American College of Obstetricians and Gynaecologists and the Royal College of Obstetricians and Gynaecologists, it is recognised that more often than seventy five (75%) of the times doctors are going to be off.

[83] Counsel suggested that since Miss Martin had both hypertension and diabetes a Caesarean section should have been performed immediately. Dr. Samuels disagreed. He stated that ten percent (10%) of the Jamaican population is hypertensive which means that doctors would be sectioning a minimum of ten

percent (10%) of our population as a base line. Three (3) to five percent (5%) of the Jamaican population in pregnancy is diabetic which now raises the base line to fifteen percent (15%) just because of morbidity that would not be in the best interest of patients.

[84] The corollary is looking at the side effects of having a Caesarean section. The woman will lose more blood than she would with a vaginal delivery, all other things being equal; the woman is getting a cut on the belly which the ladies do not like if it is not necessary; the woman requires a longer delivery time in the hospital, three (3) to four (4) days versus one day for vaginal delivery; the woman requires a longer recovery time overall, four (4) to six (6) weeks as opposed to almost immediately, certainly within twenty four (24) hours for vaginal delivery; there is a greater chance of infection; there is a greater chance of damaging the bladder or the bowel, or the baby which is inside the uterus because the knife may cut the baby by accident especially if the woman has been in labour already; there is a greater chance of abnormal blood clots, which usually forms in the pelvis and the legs and can then break off and lodge in the lungs, that is called a "pulmonary embolism" and that is one of the top three causes of maternal morbidity, the others being hypertension and haemorrhaging.

[85] He opined that if the doctors had immediately done a Caesarean section they would have independently increased Miss Martin's risk of haemorrhaging and independently and ironically, increased her risk of blood clot, both of which would have increased her risk of mortality. So at the end of the day when one looks at the benefits versus the risk, there was no reason to offer a Caesarean section until the labour process went awry.

[86] Counsel suggested that the system of health care that existed at the UHWI on October 25 and 26, 2006 fell below the required standard of care that was expected in 2006 in Jamaica. Dr. Samuels disagreed. He stated that the defendant has documentation to prove that it met the international standards of care at every stage, on all practical terms.

[87] Counsel then suggested to Dr. Samuels that because of the negligence of the hospital the claimant now suffers from a lifelong injury. Dr. Samuels stated that he disagrees that the diagnosis was made as a consequence of the defendant's lack of care. He said that the defendant did the best it could and maintained the local standard of care and it also complied with the international standard of care and unfortunately in medicine and obstetric in particular despite a doctor's best efforts he or she can never give a one hundred percent (100%) guarantee that the results would be favourable.

Dr. Milton Hardie

[88] Dr. Hardie is a Consultant Obstetrician and Gynaecologist. He has been a registered Medical Practitioner for thirty six (36) years and has been a Consultant Obstetrician and Gynaecologist for twenty nine (29) years. He holds a degree of Bachelor of Medicine, Bachelor of Surgery (MBBS) and Doctor of Medicine (DM) (O & G) from the University of the West Indies. He is a fellow of the American College of Obstetrics and Gynaecologists and President of the Jamaica Association of Obstetricians and Gynaecologists. He has published several articles and has co-authored the Obstetric Emergency Guidelines for hospitals in Jamaica. He has also been bestowed with the Order of Distinction.

[89] Dr. Hardie's written evidence is as follows: He is in private practice with admitting privileges at the Andrew's Memorial, Nuttall and St. Joseph's Hospital.

[90] He has undertaken a comprehensive review of the UHWI's medical docket (ante-natal notes, labour and delivery records and post-natal notes) in respect of Miss Martin. In his opinion, having done this review the UHWI's treatment of Miss Martin conformed to good, standard and approved obstetric practice in Jamaica in 2006.

[91] He stated that in order to assess whether there is merit in the case for an elective Caesarean section the antenatal notes need to be assessed. At booking, Miss

Martin was noted to be a diabetic who was on treatment. Her diabetic control was good for the entire pregnancy.

[92] Miss Martin's blood pressure was noted to be elevated at her antenatal clinic visit on October 19, 2006. She was admitted to the hospital and her blood pressure was stabilized and she was sent to the Labour Ward for induction of labour six (6) days later.

[93] He indicated that diabetes in pregnancy or pregnancy induced hypertension are not indicators for an elective Caesarean section and it would be less likely in a patient whose medical conditions were so well controlled and responsive to the prescribed treatments. He stated that in spite of the need for Caesarean section to ultimately conclude Miss Martin's delivery there was no reason to pursue that course up to the point when her labour was induced. Her labour progressed satisfactorily up to full dilation with contractions that were recorded as moderate, every two (2) to three (3) minutes of duration of forty five (45) seconds. It was at that stage that labour did not progress as was expected and this is not unusual. Twenty five (25%) of first time mothers will deliver with the aid of a Caesarean section after labour has commenced for various reasons. In this case, the decision for Caesarean section was taken quickly and performed in an acceptable time with the appropriate attendants in place at the delivery.

[94] The birth weight of the baby was 3.3 kg therefore the baby's size was average. In fact, her weight was 1.2 kg less than a baby who would be deemed to be macrosomic or large. A diagnosis of cephalopelvic disproportion was never made and would not have been made prior to the delivery and the baby's birth weight bears this out.

[95] Cerebral palsy is an unfortunate diagnosis but a bad pregnancy outcome does not prove negligence. One of the problems that has been listed in the paediatric notes is that the claimant suffers from microcephaly which is a congenital

condition associated with her neurological condition and not associated with her delivery events.

[96] When cross examined Dr. Hardie stated that in his report he stated that a diagnosis of cephalopelvic disproportion was never made. He indicated that on review of Miss Martin's docket, he noted that there is no mention of her having an inadequate pelvis. In fact, all the entries spoke to the adequacy of the pelvis.

[97] Dr. Hardie was asked to comment on Miss Martin's evidence that on her first antenatal visit on the 23rd March 2006, she was assessed as having a small pelvis and told that this would require her to undergo a Caesarean section rather than a normal vaginal delivery. Dr. Hardie stated that there is no entry in the docket to that effect.

[98] He also stated that there is nothing in the notes of her vaginal examination which suggests that any problems with her pelvis were anticipated. In addition, professionally and globally doctors no longer do the pelvimetric assessments at booking as the best pelvimeter is the foetal head that is in the pelvis. That assessment cannot be made at booking as there is no head that the doctor can identify at that stage. He indicated that in the absence of some congenital issue with the mother's pelvis or if she had a pelvic fracture one could not make that statement with any degree of certainty or accuracy. He stated that even if the statement was made to Miss Martin it would not be of any validity. In Miss Martin's case there is no history of trauma or anything like that.

[99] The entry which relates to Miss Martin's first antenatal visit on March 23, 2006 which speaks to a vaginal examination and the cervix being three (3) cm long would be a pelvic assessment, though not mentioned, and in assessing the pelvis one would be considering its adequacy.

[100] Dr. Hardie was referred to Dr. Palomino-Lue's statement in her medical report which is as follows:

> *"if this is correct (meaning if Ms. Martin had a small pelvis) she should have been booked for an elective Caesarean Section and not to have a vaginal delivery"*

[101] When asked whether he agreed with Dr. Palomino-Lue's statement, Dr. Hardie stated that there is no indication in the statement that this was a fact known to the doctor and there is no indication in the docket which pointed in this direction at all. Even if there was such a notation of small pelvis as a practitioner he would not just act on a notation but he would make his own assessment. He would have to be satisfied in his mind that such was the case especially considering that disproportion is relative in nature. Very unlikely in a case where the baby's birth weight was 3.3 kilograms which is a very normal size baby, in fact, that is about 2/3 of the weight of what would have been considered a large baby.

[102] Dr. Hardie was also asked to comment on Miss Martin's evidence that on September 7 and 21, 2006 she was informed by medical staff that should the breech continue into labour she would require a Caesarean section rather than a normal vaginal delivery.

[103] Dr. Hardie indicated that the question marks in the docket convey that the examiner was not sure whether or not the claimant was in a breech presentation at that time. That he said, is not unusual. He stated that if Miss Martin had gone full term and the baby was still in breech, the management would be an elective Caesarean section. However, the claimant was not in the breech position when labour was induced as she was stated to be cephalic in presentation which means head coming down first.

[104] He stated that the suggestion that having regard to the mother's hypertensive and diabetic conditions the Caesarean section should have been done immediately does not conform to the standard guidelines both internationally and locally. His evidence is that a doctor embarks on an operative delivery contingent on the patient's condition and Miss Martin's condition was of such that it did not warrant that sort of intervention at that time or the decision to make that

intervention. Dr. Hardie stated that where a patient is well controlled for their medical shortcomings, vaginal delivery is still the preferred route. Sometimes a doctor may have to change during the course of a ten (10) minute vaginal delivery but vaginal delivery is the preferred route.

[105] On October 25, 2006 Miss Martin's records indicate that at 8:00 pm the vulva and vagina were assessed to be normal and the cervix was assessed to be central and soft which would make it favourable for vaginal delivery. He indicated that a cervical length of 0.5 cm suggests that the cervix was shortening because the cervix is longer than 0.5 cm if the patient is not in labour or is about to go into labour. Softening or shortening of the cervix (otherwise called effacement) occurs as the woman progresses in labour. The 'os' speaks to the area of dilation of the cervix and it was stated to be between three (3) to four (4) cm. Her membranes were intact and an ARM was done, that is, the membranes were ruptured which is standard in the initiation process of any induction procedure. The position of the head was stated to be at station -2/-1, which is a normal location for the head to be in a patient who is suitable for the induction of labour, and on assessing the pelvic capacity it was not assessed that the delivery could not occur vaginally.

[106] At 11:35 pm, there had been no change in the vulva or vagina and the cervix was now fully effaced, that is to say, that the 0.5 cm was now gone or taken up, which suggested that progress was occurring. Miss Martin was now five (5) cm dilated and the foetal head came down to station 0. Another assessment of an adequate pelvis was made; this has to be taken in the context with the fact that the contractions were still mild coming one (1) in five (5) minutes lasting forty (40) seconds, which is a little bit shorter than one would expect for maximum strength contractions (that is before a doctor begins to be concerned about them, which would be sixty (60) seconds). So from all intents, there was adequate progress between 8:00 pm and 11:35 pm.

[107] Dr. Hardie said that the assessment of slow progress at 11:35 pm has to be taken in its full context. The dilation from three (3) cm (being the normal length of

a cervix that is not in labour) to five (5) cm might not seem to have been great but there are other factors that one has to take into consideration because during that time Miss Martin became fully effaced and the foetal head had come down. In his opinion, that was reasonable progress. He also said that the fact that Miss Martin's contractions were not all that frequent has to be borne in mind. If Miss Martin was having contractions every two minutes lasting sixty (60) seconds then it would be reasonable to say that the progress was slow but not for contractions coming every five (5) minutes lasting forty (40) seconds.

[108] Dr. Hardie was referred to the following entry in the docket:-

> *"Infant noted to be firmly wedged in pelvis disengagement requires assistance of someone pushing up the head from below. Infant delivered, cord clamped and cut and infant handed to paediatrician."*

[109] He was then asked to explain his evidence that a diagnosis of cephalopelvic disproportion was never made and would not have been made prior to delivery and the claimant's birth weight actually bears this out in light of the above entry.

[110] He stated that there was no prior assessment which would have indicated any suspicion that there might be any disproportion or inadequacy in the pelvis up to the point of the decision being made for a Caesarean section.

[111] His evidence is that the foetal head being wedged in the pelvis is not indicative of inadequacy of the pelvis. The wedging is not as frightening as it might sound. It is not uncommon in cases where there is a failure to progress the labour for the foetal head to be wedged and some effort is required to disengage the head. Most of the times a doctor can actually do it without any additional assistance but it seems to be a practice at the hospital to shorten the delivery time which indeed was quite short, from beginning to delivery of the baby was over three (3) minutes by the notes and that is as fast as one could ask for anywhere else.

[112] Cephalopelvic disproportion alludes to when the capacity of the pelvis is inadequate to allow the baby to negotiate the birth canal. Failure to progress is failure to deliver in the face of strong contractions. This may not necessarily be due to disproportion. It could also be due to problems with the passages or problems with the passenger. Contractions, although strong, may also be ineffectual and this can also affect the progress of labour. Once there is a failure to progress it tends to be blanketly labelled as cephalopelvic disproportion but they all are not.

[113] Disproportion he said, is dependent on a lot of factors. For example, a patient could deliver an eight (8) pound baby in one pregnancy and fail to progress trying to deliver a six (6) pound baby in another pregnancy. There are multiple reasons why this may occur. For example, there might be faults with the baby (the passenger), there might be faults in the passage, that is, the woman's pelvis and birth canal and there might be problems with the powers, which is the uterus and its effectiveness in how it contracts. The whole question of disproportion is more about the angle of the presenting part; in this case, it would be the baby's head rather than the size of the head itself. It depends on how the baby is flexed in the whole delivery process. When the baby becomes deflected the diameter that is placed in the pelvis gets longer and it gets harder to hold or will not hold. This explains why the same mother who pushed out an eight (8) pound baby cannot push out a six (6) pound baby because in the pregnancy with the eight (8) pound baby the degree of flexion was better, so there would be a smaller diameter coming into the pelvic canal.

[114] Dr. Hardie was asked to give an obstetric view of Miss Martin's evidence that given what she was told about the necessity of a Caesarean section as early as her first antenatal visit.

[115] He stated that there was no indication from Miss Martin's medical condition at the time of the induction of labour that she required an elective Caesarean section. Her medical conditions were well-controlled, her diabetes remained normal for

the entire pregnancy. She was admitted on the 19th October 2006 because of an elevation in her blood pressure. She was stabilized and sent for induction. In situations like these where the patient's condition is stable and controlled, vaginal delivery is the desirable method of delivery. This is in accordance with the Royal College Guidelines, with the American College guidelines and with the Obstetric Emergency Guidelines for the Ministry of Health, Government of Jamaica commissioned by the Pan American Health Organisation (PAHO). He stated that those guidelines were followed in this case.

[116] Dr. Hardie was then asked to give an opinion on the effect of Miss Martin's pregestational diabetes and hypertension on her pregnancy bearing in mind Dr. Samuels' evidence that the placenta is the connection between the mother and the baby for delivering food and oxygen and both diabetes and hypertension in pregnancy can lead to oxygen compromise and result in placental insufficiency.

[117] Dr. Hardie agreed with the evidence adduced by Dr. Samuels. He stated that the degree to which either or both conditions would impact on a particular pregnancy will vary from patient to patient. With diabetes and hypertension one has to think vascularly, about blood vessels and it is all about the inadequate supply of oxygen. It could have been happening for a sustained period during the pregnancy undetected because there may not be changes that would be obvious from the usual parameters that one uses to monitor the pregnancy.

[118] In the delivery notes there is a notation about fatty deposits on the placenta, both on the maternal and foetal surface of the placenta and this may allude to some degree of placental insufficiency, but it might not. However, if the whole argument of placental insufficiency comes about then it certainly cannot be ignored.

[119] He said that Miss Martin's diabetes would increase the risk of her having a big baby, miscarrying or *having an abnormal baby*. The condition that the claimant suffers from: seizures, mental developmental delays, neurological deficits are consistent with microcephaly. The notation of microcephaly in the paediatric

notes is something one cannot ignore in a patient who has diabetes. There is a connection between microcephaly and diabetes as a diabetic mother will be more prone to having a microcephalic baby.

[120] He also indicated that any neurological deficit can present with the continuation of symptoms that the claimant has. For instance, there may be developmental delays, seizures, problems with the toes, the limbs, the movement might not be appropriate and mental retardation.

[121] Dr. Hardie stated that Hypoxia Ischemia Encephalopathy is a condition that may be caused by birth trauma. There is nothing in the docket that is indicative of any hypoxia trauma in the delivery of the claimant. There was one episode where there was a slowing of the foetal heart rate and that was the cue which triggered the Caesarean section but there was no other occurrence. The foetal heart recovered almost immediately to normal levels and that is reflected in the Labour records.

[122] At 1:08 am on October 26, 2006 there is an indication of the foetal heart rate being between 90 to 110 beats per minutes, the lower level of normal being 120, so it was not a significant thing. The heart rates following that from 1:11 am onwards were normal. So that was the only episode where the foetal heart rate went below normal based on the recordings that were made. That could actually have been caused because of a contraction. So one cannot be sure as to whether or not this was pathological because there can be a dipping in the heart rate at the height of a contraction and the speed with which it recovers is an indicator of the non-pathological nature of the fall. In the rest of the notes one can see that it became normal after that so there was no reason to get perturbed about that episode.

[123] The Caesarean section took a period of thirty (30) minutes. That is standard and normal and pretty quick and there was no indication for the Caesarean section to be performed at any time sooner than when the decision to perform it was made.

Up to the point of the decision to do the Caesarean section Miss Martin's labour and delivery were in his view progressing normally.

[124] In his opinion, the doctors were quite judicious in their decision to proceed to the Caesarean section and the decision was timely. That decision he said was well within the time that one would allow for a second stage. So there was no delay at all about the decision.

[125] During cross-examination the evidence elicited from Dr. Hardie was as follows:- At the time of the delivery of the claimant he did not work at the defendant hospital.

[126] Once a pregnant woman has hypertension and diabetes the pregnancy would be deemed a high risk pregnancy.

[127] There are various conditions that a Caesarean section is absolutely indicated. If the woman has placenta praevia (placenta coming in front of the baby), if the foetus had a breech presentation, if there are deformities of the pelvis, previous pelvic fracture, any gynaecological malignancy, baby in the transverse position (lying crossways), if the baby is assessed to be large (in an uncontrolled diabetic, a baby that is larger than 4.5 kilograms in size is a macrosomic baby), if the woman had previous uterine surgery for example removing fibroids.

[128] He stated that a woman who had both hypertension and diabetes is not necessarily a prime candidate for a Caesarean section. It has to do with the severity of her condition because an operative delivery even if it is safe by our standards is safe, still carries some risk and his maxim is that even with a small risk it should not be taken unless necessary.

[129] When asked "are you able to say what is the standard time or average time period between trying to induce labour the natural way and then to conclude that a Caesarean section is necessary?". Dr. Hardie informed the Court that there is no specific way that such a question can be answered. However, as a rule of

thumb, twenty (20) hours after contractions have begun in a regular fashion and not for one that has abdominal tightening.

[130] Dr. Hardie said that even though Miss Martin had abdominal tightening before she did not really start having contractions until around 8:00 pm on October 25, 2006. So her labour lasted six (6) hours which is well within the standard time even for a primigravid (pregnant for the first time) patient. A primigravid patient would be expected to deliver in twenty (20) hours.

[131] Diabetes in a mother can cause or lead to cephalopelvic disproportion because one of the problems in a diabetic patient is a big baby. The UHWI he said did an excellent job at controlling Miss Martin's diabetes. There is no entry in her docket of an abnormal blood sugar reading for the entire pregnancy. However, that does not change what might have happened during the pregnancy because Miss Martin's diabetes predated the pregnancy.

[132] A diagnosis of cephalopelvic disproportion is possible in circumstances where a baby is not considered to be large. It depends on how the baby's head is flexed coming through the pelvis, the problem there is that one can only make that assessment after the fact not prior to the fact.

[133] Any hypoxic injury can lead to cerebral palsy: placental insufficiency, hypoxic episodes during the pregnancy or labour. Microcephaly can present with symptoms identical to cerebral palsy. All neurological conditions can present with the same symptoms: seizures, plasticity, developmental delays.

[134] In situations where delivery takes too long the possible effects include: cerebral effects, birth trauma if the delivery is traumatic, fracturing of the clavicles, problems with the arms, death or other problems.

[135] It is possible for the baby to suffer from cerebral palsy if the delivery process is prolonged. However, there is no evidence in the docket that this happened. The delivery time was short, not shorter than usual but the standard.

[136] Dr. Hardie did not agree with the suggestion that because the doctors or doctor took a long time to come to the decision to proceed with a Caesarean section the claimant suffered injury.

[137] In terms of assessing prolonged and normal, some people refer to a second stage lasting two (2) hours as a prolonged second stage of labour. Professionally an hour is used for primigravid patients. Miss Martin did not even go an hour, she did not even go half an hour in her second stage before the *decision* to perform a Caesarean section was made and it was made because the baby's head was not coming down. He said that no one waited to flag the baby through the pelvis so time is not an issue in this case.

[138] Miss Martin's second stage went for three minutes past an hour. He indicated that it takes an hour before one says that the second stage is prolonged and that it may be necessary to proceed to a Caesarean section. However, twenty (20) to thirty (30) minutes could be safely added to that. Depending on whose books you are reading the second stage could be anywhere up to two hours for a first baby but locally it is kept to one (1) hour. The normal time from decision to incision is thirty (30) minutes. In Miss Martin's case it took thirty three (33) minutes. He will not hold three (3) minutes against the defendant.

[139] He stated that the records indicate that the Caesarean section was started at 2:13 am and the baby was delivered at 2:16 am that does not indicate any delay or difficulty which could have caused any delay. Dr. Hardie said that sometimes when a Caesarean section is done a doctor has to *"get up there and dig out that baby's head"*. It is not an uncommon occurrence and those babies are not born with abnormalities.

[140] When asked: *"in performing this action, the pushing of the baby, would you agree that-that sometimes can cause injury to the baby?"* Dr. Hardie's response was *"not really, you know"*. He said that it is possible but not likely. If you turn up at the hospital with a baby with a broken bone they call the police, because they

don't break easily at all. It is difficult to damage the baby during the course of delivery. There are certain things that can affect the baby by doing a delivery but certainly not that action.

[141] He stated that it is possible to diagnose microcephaly in a foetus before it is born. An ultrasound test done on the foetus prior to delivery could reveal microcephaly because the head will be smaller but microcephaly can also occur after birth. Up to birth and certainly based on the head measurements at birth this was not the case with the claimant. The ultrasounds all came back normal. This leads one into the whole realm of the acquired manifestation of microcephaly and diabetes is one of the causes of microcephaly manifesting itself after delivery. For some babies with microcephaly they are actually born with normal size heads and the claimant had a normal size head at birth. The normal head circumference at birth is thirty five (35) cm; the claimant's measurements were thirty four and two tenths (34.2) which is acceptable.

[142] He said that a baby will appear blue if the baby is not breathing at the time and to say the baby is blue does not really say anything until after the baby starts breathing. The claimant's respiratory actions were pretty well scored after ten (10) minutes.

[143] If appearance is zero (0) and respiration is one (1) both scores cannot be correct. Respiration is actually something you can measure, appearance is still an opinion and for the professionals to score any score for respiration, breathing actions have to be happening. To say appearance is zero (0) and the baby is breathing is not consistent in the APGAR five (5) minutes.

[144] Dr. Hardie stated that he could not agree with the suggestion that the defendant hospital was negligent in attempting to induce labour the natural way, Royal College Guidelines were met, the American College Guidelines were met and guidelines in the Obstetric Emergency Manual were met. Even though a Caesarean section had to be resorted to, the argument for an elective Caesarean

section does not stand. In fact, most Caesarean sections in patients in their first pregnancy the decision is made well into labour.

The Claimant's Submissions

[145] Mr. Page submitted that the doctors at the UHWI fell below the required standard of care established in the House of Lords decision of ***Bolitho v City and Hackney HA*** [1977] 4 All ER 771. In this case Lord Brown-Wilkinson stated that the test for the standard of care required of a doctor is that 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 man 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".*

[146] It was Counsel's contention that the doctors fell below the required standard of care because a Caesarean section was not performed in a timely manner despite Miss Martin, informing them that her pelvis was too small for her to deliver the baby vaginally.

[147] It was submitted that the defendant breached its non-delegable duty of care in its deficiencies in the treatment and management of the claimant's mother. In support of this submission Counsel relied on the medical report of Dr. Eve Palomino- Lue which states on page three (3) that:-

> *"if the baby was delivered by elective caesarean section, the child could probably be normal at birth and would not have suffered brain damage with the resulting seizures and profound mental and physical disabilities"*

[148] Counsel then referred to paragraph fifteen (15) of the witness statement of Dr. Leslie Samuels where the doctor stated that:-

> *"An assessment of slow progress was made, and the decision was made to augment her labour with 5 units of oxytocin in 500 mls normal saline, according to usual protocol. This was not instituted, due to other deliveries in progress and a consequential lack of staff to monitor the augmentation process"*

[149] It was argued that the statement is indicative of the poor management of the claimant's mother.

[150] Mr. Page also drew the Court's attention to paragraph six (6) of the Defence which states that:

> *"At 1:40 a.m. on examination significant caput and moulding were identified and constituted the first objective data that safe vaginal delivery could not be safely accomplished, Cephalo-pelvic disproportion was diagnosed"*

[151] Counsel submitted that the delay in coming to this assessment having regard to:-

i. the length of time it took for the cervix of the claimant's mother to become fully dilated;

ii. the fact that the claimant's mother had hypertension and diabetes and was therefore acknowledged as high risk; and

iii. the fact that the claimant's mother had informed the doctor that her pelvis was too small and she had been informed that she was to get a Caesarean section

demonstrate that the defendant fell below the standard of care.

[152] It was his argument that the fact that the claimant's mother had cephalopelvic disproportion confirms the averment by the claimant's mother in her witness statement and throughout the trial that she was informed that given the nature of her pelvis she would have to undergo a Caesarean section. Therefore, a vaginal delivery should not have been initially induced.

[153] Counsel drew the Court's attention to Dr. Eve Palomino-Lue's statement in her report at page seventy one (71) to the effect that if the claimant's mother had in fact been informed that she had a small pelvis she should have been booked for an elective Caesarean section.

[154] He pointed out that the defendant had filed a Supplemental List of Documents which included the antenatal notes and it revealed that on September 21, 2006 the claimant was in breech position. Counsel then reminded the Court that the claimant's mother stated under cross-examination that at this time she was told that based on the position of the baby, the baby would have to be delivered by Caesarean section.

[155] Mr. Page submitted that the defendant breached its duty of care in omitting to sufficiently review the medical notes of the claimant's mother and/or taking a detailed assessment, in a timely manner, to determine whether her pelvis was small and in failing to do so the defendant failed to prevent the injuries sustained by the claimant.

[156] Counsel cited the case of ***Howard Genas v The Attorney General of Jamaica & Others*** (unreported), Supreme Court, Jamaica, Suit No CL 1996 G-105, judgment delivered 6 October 2006 and pointed out that the case is authority for the position that in appropriate cases the failure or omission to act may amount to medical negligence.

[157] He also cited that case of ***Tahjay Rowe, a minor, (suing by Tasha Howell, His mother and next friend) v the Attorney General for Jamaica and South Eastern Regional Health Authority*** (unreported), Supreme Court, Jamaica, Claim No. 2009 HCV 02850, judgment delivered 10 September 2015, which he submitted supports his position that it would have been reasonable to expect the defendant to carry out certain investigations which would determine the care and steps to be taken in the management of the claimant's mother.

[158] Counsel contended that the omissions by the servants and/or agents of the defendant are sufficient to ground the claim in medical negligence.

[159] Counsel also referred to the evidence of Dr. Leslie Samuels with respect to the medical condition of the claimant's mother prior to the birth of the claimant and argued that although Dr. Samuels admitted that hypertension will kill a mother faster than anything else he nevertheless attempted to deliver the baby naturally.

[160] He also drew the Court's attention to Dr. Samuels' evidence that foetal testing was conducted. Mr. Page argued that it was evident during the trial that the test can identify any gross abnormality in the brain. It was his contention that the claimant's injury was such that the ultrasound should have discovered it and what is clear is that before the claimant was delivered the ultrasound did not reveal any gross abnormality yet the claimant was born with severe brain injury.

[161] Mr. Page referred to the evidence given by Dr. Milton Hardie and pointed out that Dr. Hardie conceded that cephalopelvic disproportion could be caused by diabetes.

[162] Counsel also referred to Dr. Hardie's evidence that cerebral palsy can develop in a baby as a result of hypoxia injury and placental insufficiency which is a complication of pregnancy when the placenta is unable to deliver an adequate supply of nutrients and oxygen to the foetus. He pointed out that Dr. Hardie stated that the defendant hospital controlled the mother's diabetes and hypertension during pregnancy; it was his argument that this therefore begs the question as to how placental insufficiency could have occurred in the instant case.

[163] Mr. Page argued that the evidence reveals that both doctors acknowledged that when cephalopelvic disproportion has been diagnosed the safest type of delivery for mother and baby is a Caesarean section.

[164] Counsel pointed out that during her examination in chief Dr. Palomino-Lue stated that she had seen all the medical notes and records submitted by the defendant and her position as articulated in her report has not changed since seeing all the records.

[165] In light of all that has been stated above Mr. Page submitted that the injuries sustained by the claimant are a direct result of the actions of the servants and/or agents of the defendant and the injuries are a directly foreseeable result. Therefore, the defendant should be held liable.

[166] Mr. Page relied on three (3) cases to support the claimant's claim for damages. They are: ***Neville Hamilton v Caleb Walford*** (unreported), Supreme Court, Jamaica, Suit No. C.L 1989 H-003, damages assessed 31 January 1991, ***Karen Brown (bnf Cynthia McLaughlin) and Cynthia McLaughlin v Richard English and Alfred Jones*** (unreported), Supreme Court, Jamaica, Suit No. CL 1988 B-102, damages assessed 1 February 1991 and ***Ramon Burton (bnf Wilburn Barton) and Wilburn Barton v John McAdama, Wesley McAdama, Lawrence Dennis and Wright's Motor Service Limited*** (unreported), Supreme Court, Jamaica, Claim No. C.L 1996 B 110, judgment delivered 13 March 2008. Based on the authorities it was submitted that the claimant is entitled to a sum in excess of twenty five million dollars ($25,000,000.00) for general damages. In respect of special damages, Mr. Page submitted that the claimant should be awarded the sum of twenty thousand dollars ($20,000.00) and in respect of future medical care, it was submitted that the claimant should be awarded the sum of five million dollars ($5,000,000.00).

The Defendant's Submissions

[167] Mr. Kelman, Counsel for the defendant, submitted that the undisputed facts are as follows:-

i. At the time of Miss Martin's pregnancy, she was a primigravida ("pregnant for the first time").

ii. Entries in Miss Martin's medical docket indicate that her pelvis was adequate.

iii. Miss Martin did not have a history of fractured pelvis, or any medical or surgical condition which would prevent her from abducting her legs, and her maternal height was 164cm. These factors are ones which from an obstetric perspective would have indicated that she should have delivered by Caesarean section.

iv. There is no entry in Miss Martin's docket indicating that she was advised to have a Caesarean section at any point prior to delivery.

v. Miss Martin suffered from pregestational diabetes and hypertension, both conditions preceded her pregnancy.

vi. Miss Martin's blood pressure and blood sugar levels were well controlled throughout her pregnancy.

vii. On September 7 and 21, 2006, Miss Martin's medical docket indicates two entries viz. "breech?" regarding the position of the foetus at those dates.

viii. If the foetus had continued in breech position at the time of labour then a Caesarean section would have been medically required.

ix. On October 19, 2006, Miss Martin's medical docket indicates that the foetus was no longer in a breech position, but rather was in a cephalic presentation, which means that the foetal head was down that is to say, in a normal position for delivery.

x. The weight of the foetus was assessed via ultrasound on October 23, 2006 and was 2.84 kilograms, which is within the normal birth range of 2.5 to 4.0 kilograms.

xi. Miss Martin's labour was induced on October 25, 2006 at 37 weeks and 5 days gestation.

xii. Miss Martin started having regular contractions at about 8:00pm on October 25, 2006, and was in labour for approximately 6 hours thereafter which is within the normal time range.

xiii. The time period between full dilation of Miss Martin's cervix to 10 cm and the decision to perform a Caesarean section was approximately 20 minutes.

xiv. Miss Martin's docket, exhibit 3, discloses that the defendant maintained documentation of foetal heart rate (FHR) during the entire labour process.

xv. During Miss Martin's labour, the FHR was normal and stable, except for a single episode of foetal bradycardia at 1:08 am which lasted less than 3 minutes.

xvi. Caput and Moulding were reasons the Caesarean section was done.

xvii. The time period between the decision to perform a Caesarean section and the first incision was 33 minutes, which is 3 minutes more than the ideal international standard of 30 minutes.

xviii. Brief episodes of foetal bradycardia in labour are not unusual because increased maternal contractions can cause them.

xix. The defendant's expert witness, Dr. Eve Palomino-Lue did not review the medical docket for either Miss Martin or Cheavela Smith in

preparation of her expert report/evidence in chief. Her report was based entirely on details conveyed to her by Miss Martin.

xx. The decision whether a patient should undergo vaginal delivery or a Caesarean section is a decision for an obstetrician, not a paediatrician.

xxi. Dr. Palomino Lue is a paediatrician and has never qualified for, or practiced in the field of obstetrics.

xxii. Miss Martin's diabetes and hypertension exposed the claimant to insults which could have caused the brain damage. Placental insufficiency also may be caused by maternal diabetes and hypertension, and is a possible cause of Hypoxic Ischaemic Encephalopathy. Maternal Diabetes can cause microcephaly.

xxiii. The claimant was assessed as being microcephalic after birth and was diagnosed with Hypoxic Ischaemic Encephalopathy.

[168] Counsel referred to the written and oral evidence adduced by Miss Martin and asserted that her reliability ought to be assessed in light of the records which have been admitted into evidence which are not in accordance with her account of events. It was submitted that Miss Martin is not a reliable witness.

[169] Mr. Kelman submitted that Miss Martin's evidence that upon examination at her first antenatal visit she was informed that her pelvis was small and she required a Caesarean section, is not credible in light of the cogent obstetric evidence that in her case, an assessment at booking of "small pelvis" was highly unlikely. Counsel also submitted that the medical evidence is far more credible than hers and any discrepancies in evidence should be resolved in the defendant's favour.

[170] He argued that Dr. Leslie Samuels, Consultant Obstetrician and Gynaecologist, although not appointed as an expert in this case, is nonetheless credible and reliable in Obstetrics. It was Mr. Kelman's contention that Dr. Samuels' evidence

was corroborated in several material respects by an independent obstetrician who was appointed as an expert by this Court.

[171] Counsel highlighted Dr. Samuels' evidence that there were very few situations where the need for a section could be predicted at booking and since Miss Martin was 164 cm tall, had no history of a fractured pelvis and was a primigravida, she did not fall into any of those situations. It was also noted that Dr. Samuels gave evidence that at the defendant hospital Caesarean sections are done only for clinical reasons and there were no clinical reasons until 1:40 am.

[172] Mr. Kelman then referred to the evidence given by Dr. Milton Hardie, that the best test for pelvic adequacy was the foetal head but as there is no foetal head to identify at a stage as early as booking, this assessment has to await onset labour. It was Counsel's submission that this opinion is easily understood for its logical basis, especially when juxtaposed with the evidence of the claimant's mother, coupled with the absence of any substantiating notation in the docket of the alleged advice. It was submitted that Dr. Hardie's evidence was reasonable, responsible and logical.

[173] It was further contended that none of this obstetric evidence was seriously challenged on the claimant's case as no obstetrician was called to give evidence. There is therefore no evidence that the defendant failed to follow the approved obstetric practice in Jamaica in 2006 and by virtue of that breach the claimant was injured. It was argued that this ipso facto is fatal to the claim.

[174] Counsel referred to Dr. Eve Palomino-Lue's evidence that the opinions in her expert report were formed just from looking at the notes and the history relayed by the claimant's mother. He submitted that another manifest shortcoming of the evidence contained in her report is her express acknowledgment of not having examined the hospital records of mother and baby as she would have liked. She did however testify that this shortcoming was cured in the interim of attending Court. Counsel submitted that an expert's opinion must be responsible and the

evidence of Dr. Palomino-Lue was not clothed with the required quality of responsibility.

[175] Reference was also made to Dr. Palomino-Lue's evidence that if Miss Martin had had an elective Caesarean section the claimant would not have had current problems which she said was linked to a prolonged second stage of labour and the episode of foetal bradycardia. Dr. Palomino-Lue did not agree that, in that brief episode, nothing happened. It was Counsel's contention that Dr. Palomino-Lue did not however relate her answer to any physiological or pathological matter regarding the foetus but simply indicated that the episode of bradycardia was significant enough for the Paediatricians to be informed. It was Counsel's submission that Dr. Palomino-Lue did not demonstrate at all how a single, brief fluctuation was detrimental to the foetus and in fact agreed that it is not unusual in labour and can arise from maternal contractions.

[176] He submitted that Dr. Palomino-Lue's paediatric opinion was unsupported by further evidence specifying what the acceptable obstetric standard of care was in 2006 and how the defendant's management of the claimant's care breached that standard.

[177] It was therefore submitted that the Court should make the following findings of facts:-

i. Miss Martin had an adequate pelvis.

ii. Miss Martin was never advised antenatally that she had a small pelvis and required Caesarean section.

iii. The brief and single episode of bradycardia at 1:08 am was not unusual and did not, without more, indicate necessity for immediate Caesarean section.

iv. There was no indication for a section, at anytime throughout the defendant's management of Miss Martin's pregnancy, until the decision taken at 1:40 am.

v. The timeframe for the second stage of labour and section was within normal limits.

vi. The claimant's brain damage could have resulted from a number of factors.

vii. The defendant's management of Miss Martin conformed to good and approved Obstetric Practice in Jamaica in 2006.

[178] It was further submitted that the burden of proof lies squarely on the claimant and that the standard of proof is on a balance of probabilities. It was contended that the Jamaican case of ***Kimola Meritt v Dr. Ian Rodriquez & Anor*** (unreported), Supreme Court, Jamaica, Suit No. C.L.M.-036 of 1991, judgment delivered 21 July 2005 shows that doctors owe a duty of care to persons they accept as patients and in order to prove that a doctor was negligent claimants must show that the doctor's acts in question fell below the required standard of care applicable to the medical profession as expressed in the English case of ***Bolam v Friern Hospital Management Committee*** [1957] 2 All ER 118.

[179] Mr. Kelman referred to the ***Bolam*** test which was expressed by McNair J as follows:-

> *"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 man is not negligent, if he is acting in accordance with such practice, merely because there is a body opinion who would take a contrary view"*

[180] According to Counsel, the test was subsequently modified by the House of Lords in ***Bolitho v City & Hackney HA*** (supra) as follows:-

> *"in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence…(because)…it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible…But if, in a rare case, it can be demonstrated that the professional opinion was not capable of withstanding logical analysis, the judge was entitled to hold that the body of opinion was not reasonable or responsible."*

[181] Counsel argued that the effect of ***Bolitho*** is that a Court can still find a defendant hospital negligent even where the hospital provides expert evidence on its behalf; however, it is a power which should be used sparingly and should not be used simply because the Court prefers the claimant's experts. Its only proper application is where a Court is satisfied that the expert evidence presented on behalf of the defendant is so flawed that even though a body of medical opinion supports it, that body is neither logical, reasonable or responsible in its support.

[182] Mr. Kelman then drew the Court's attention to Jamaican cases which have applied the ***Bolam*** and ***Bolitho*** cases, which include, among others, ***Millen v University Hospital of the West Indies*** (1986) 44 WIR 274 and ***Paula Whyte v The Attorney General & Anor*** (unreported), Supreme Court, Jamaica, Claim No. 2007 HCV 05051, judgment delivered 6 July 2012.

[183] In applying the law distilled from the cases, it was submitted by Mr. Kelman that the claim should fail as the totality of the evidence establishes that the defendant was not negligent as the standard of care was met. Counsel submitted that the obstetric evidence adduced by the defendant is overwhelmingly more logical, reasonable and responsible than that led by the claimant. It was argued that the claimant has failed to establish on a balance of probabilities that any alleged breach of duty was the proximate cause of the brain damage sustained since it is undisputed that Miss Martin's medical conditions before and during her pregnancy could have caused the claimant's injury.

The Issues

[184] The issues that arise for the Court's determination are as follows:-

i. Whether the claimant's mother should have been booked for a Caesarean section from inception rather than allowed to proceed by way of vaginal delivery?

ii. Whether the doctors at the UHWI took too long to come to the decision to proceed with the Caesarean section with the result that the claimant suffered injury?

iii. Whether the doctors at the UHWI failed to perform the Caesarean delivery in a timely and safe manner?

iv. Whether the defendant failed to provide a safe place and a safe system for the provision of health care for the claimant and her mother?

v. Whether any instrument or equipment was used in any way during the labour process so as to cause injury to the claimant?

vi. Whether the defendant is liable to the claimant in negligence?

The Law

[185] The burden of proof, on the balance of probabilities, that the defendant has been negligent falls upon the claimant.

[186] The tort of negligence consists of three essential components, each of which must arise: They are, respectively, "duty"; "breach"; and "resulting damage", that is:-

1. The existence of a duty to take care, which is owed by the defendant to the claimant;

2. The failure to attain that standard of care, prescribed by the law, thereby committing a breach of such duty; and

3. Damage, which is both causally connected with such breach and recognised by the law, has been suffered by the claimant.

(See His Honour Judge Walton, Roger Cooper and Simon. E Wood, *Charlesworth & Percy on Negligence* (10th edn, Sweet and Maxwell, London 2001) 13

Duty of care

[187] In the case of ***Caparo Industries plc v Dickman*** [1990] 2 A.C. 605[1] Lord Bridge of Harwich asseverated the following:-

> *"What emerges is that, in addition to the foreseeability of damage, necessary ingredients in any situation giving rise to a duty of care are that there should exist between the party owing the duty and the party to whom it is owed a relationship characterised by the law as one of 'proximity' or 'neighbourhood' and that the situation should be one in which the court considers it fair, just and reasonable that the law should impose a duty of a given scope upon the one party for the benefit of the other."*

[188] Therefore, the basic approach in the law of torts is that a duty of care is owed to anyone you may reasonably foreseeably injure. There is therefore little difficulty in finding that both the University Hospital of the West Indies and its medical staff owed a duty of care to the claimant.

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[1] At pages 617 and 618

The breach of the duty

[189] In ***Bolam v Friern Hospital Management Committee*** (supra), McNair J stated as follows:-

> *"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[2]."*

[190] On the guidance provided by McNair J, the claimant cannot simply introduce evidence from an expert witness that he or she (the witness) would not have acted in the way the defendant did. If the defendant calls an expert who adduces evidence that the way the defendant dealt with the claimant was in accordance with acceptable practice and the Court is satisfied that such an opinion is responsible then the claimant cannot succeed.

[191] McNair J also provided the following guidance:-

> *"...where you get a situation that involves the use of some special skill or competence...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[3]."*

[192] Whether the doctor at the UHWI was negligent must be based on what is acceptable by the standard of an ordinary skilled medical man exercising and professing to have an obstetrician's skill, in the view of responsible doctors skilled in that particular art.

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[2] At page 122

[3] At page 121

[193] Similarly, whether a midwife/nurse at the UWHI was negligent must be based on the test as espoused in ***Bolam***[4].

Damage

[194] Even when a breach of a duty of care is proved or admitted, the burden still lies on the claimant to prove that such breach caused the injury suffered.

[195] In ***Howard Genas v The Attorney General and ors*** (supra) Anderson J stated the following:-

> *"Notwithstanding the existence of a duty of care, a breach of that duty and damages (sic), it is clear that unless there is a causal link between the breach and the damages (sic), judgment must be given for the defendants.*[5]*"*

Discussion

Whether the claimant's mother should have been booked for a Caesarean section from inception rather than allowed to proceed by way of vaginal delivery?

[196] The claimant's case rested on the position that her mother should have been booked for an elective Caesarean section because of the following reasons:-

i. She was assessed as having a small pelvis on her first antenatal visit and on another occasion.

ii. She was told that the claimant was in breech position and this necessitated a Caesarean section.

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[4] See also ***Bolitho v City and Hackney Health Authority*** [1998] A.C. 232

[5] See page 20

iii. She suffered from two medical conditions, pregestational diabetes and hypertension, which made her an ideal candidate for an elective Caesarean section.

Assessment of small pelvis

[197] Miss Martin gave evidence that on her first antenatal visit she was told that she would have to deliver the claimant via Caesarean section as a result of her small pelvis. She stated that it was noted in her docket. Therefore, the doctors were negligent in not carrying out a Caesarean section from the inception of labour.

[198] Dr. Palomino Lue informed the Court that if Miss Martin was assessed as having a small pelvis then the doctor should have performed an elective Caesarean section instead of allowing her to proceed to vaginal delivery.

[199] Dr. Hardie, in reference to Dr. Palomino- Lue's statement, said that that there is no indication that this was a fact known to Dr. Palomino-Lue and there is no indication in the docket which pointed in this direction at all. I cannot help but agree. The documentary proof presented to this Court does not support Miss Martin's claim. There is no entry of a small or inadequate pelvis in the docket. In fact, entries were made in Miss Martin's medical docket which indicate an assessment of adequate pelvis on a number of occasions.

[200] I am also mindful of Dr. Hardie's evidence that there was nothing in the vaginal examination suggestive of any anticipating problems with the pelvis and professionally and globally doctors no longer do the pelvimetric assessments at booking as the best pelvimeter is the foetal head that is in the pelvis and a doctor cannot make that assessment at booking. He said at that time that there is no head that the doctor can identify. Evidence was adduced that in Miss Martin's case, there was no history of trauma such as, a pelvic fracture. Therefore, in the absence of some congenital issue with her pelvis one could not make that statement with any degree of certainty or accuracy. So even if the statement was made to Miss Martin it is of little or no value.

[201] Seemingly contradictory, Dr. Hardie also stated that:-

> *"The entry which relates to Miss Martin's first antenatal visit on March 23, 2006 which speaks to a vaginal examination and the cervix being three (3) cm long would be a pelvic assessment, though not mentioned, and in assessing the pelvis one would be considering its adequacy".*

[202] The question which arises, on Dr. Hardie's evidence, is whether or not a pelvimetric assessment is done at booking. My understanding of Dr. Hardie's evidence is that when a vaginal examination is performed an assessment of the mother's pelvis and its adequacy is usually done. However, at booking, the assessment cannot be done with a great deal of accuracy as modern pelvimetric examinations assess adequacy in the context of the foetal head and this is done later in a woman's pregnancy when the foetus is more developed. This would result in a more accurate assessment as the woman is at that time closer to giving birth.

[203] Miss Martin testified that after the doctor had completed his examination she was told that her pelvis was not opening wide enough so she would have to do a Caesarean section. The question which this evidence invited was, 'opening wide enough for what?' In my mind, at a woman's first antenatal visit, barring some unique issue, it is curious that such an assessment would have been made.

[204] The evidence presented that at booking an assessment of small pelvis could not be made with any degree of certainty or accuracy was not challenged.

[205] The importance accorded to a notation was also called into question when Dr. Hardie, quite judiciously, informed the Court that even if he saw a notation of small pelvis, as a practitioner, he would not just act on it he would do his own assessment to satisfy himself that-that was in fact the case. Therefore, even if the statement was made to Miss Martin it has not been established that her obstetrician would have been required to rely heavily on it.

[206] Dr. Samuels gave evidence that a diagnosis of cephalopelvic disproportion was eventually made during the labour process. Mr. Page submitted that the fact that Miss Martin had cephalopelvic disproportion confirms her averment that she was informed by a doctor of the defendant hospital that given the nature of her pelvis she would have to undergo a Caesarean section when it was time for her to deliver her baby. The question as to whether this is indicative of a small pelvis must therefore be addressed.

[207] During the course of the trial, Dr. Hardie stated that cephalopelvic disproportion alludes to when the capacity of the pelvis is inadequate to allow the foetus to negotiate the birth canal. He said that failure to progress is failure to deliver in the face of strong contractions. Failure to progress may be as a result of: cephalopelvic disproportion, problems with the passages (birth canal and pelvis), problems with the passenger (foetus) or ineffectual contractions. Dr. Hardie stated that oftentimes occurrences of failures to progress are blanketly labelled as cephalopelvic disproportion.

[208] Dr. Hardie gave evidence that the birth weight of the claimant was 3.3 kg therefore her size was average. In fact, her weight was 1.2 kg less than a baby who would be deemed to be large. He averred that a diagnosis of cephalopelvic disproportion was never made and would not have been made prior to the delivery and the claimant's birth weight bears this out. His opinion seems to have been based on the size of the claimant. However, in the course of his evidence, Dr. Hardie also stated that a diagnosis of cephalopelvic disproportion is possible in circumstances where a baby is not considered to be large as it depends on how the baby's head is flexed coming through the pelvis, however, one can only make that assessment after the fact not prior to the fact.

[209] During the trial the following passage was also brought to Dr. Hardie's attention:-

> *"Infant noted to be firmly wedged in pelvis disengagement requires assistance of someone pushing up the head from below. Infant*

delivered, cord clamped and cut and infant handed to paediatrician."

[210] Dr. Hardie stated that the foetal head being wedged in the pelvis is not indicative of inadequacy of the pelvis. He said that it is not uncommon in cases where there is a failure to progress in labour for the foetal head to become wedged with the result that assistance is needed to disengage the head. I accept Dr. Hardie's evidence.

[211] Having regard to the foregoing, I am driven to the conclusion that I cannot be satisfied as to the reliability of Miss Martin's account. During the trial Dr. Palomino-Lue maintained that she could only believe the accuracy of what Miss Martin told her and it is undeniable that she was significantly handicapped or limited in the evidence that she could present as she did not assess the claimant herself. She also admitted to Mr. Kelman that she was not an obstetrician and such matters fell within the field of obstetrics and that she reviewed the notes at a very late stage.

[212] I must also point out that on the evidence, I cannot accept Mr. Page's submission that the medical staff of the defendant failed to sufficiently review the medical notes of the claimant's mother and carry out the necessary investigations which would determine the care and steps to be taken in her management.

[213] The case of ***Tahjay Rowe*** (supra) which was cited in this regard can be distinguished from the instant case. In ***Tahjay Rowe*** Lindo J found that the hospital staff was negligent in the post-natal care of the infant claimant. On the evidence, the delivery itself was normal yet the defendant was unable to explain how the claimant suffered brain damage. Consequently, it was the management of the claimant that was under scrutiny. Expert evidence was presented that the documentation of the claimant's care and management was inadequate and no investigations were carried out to determine the reasons behind his continuous crying and lack of feeding after birth. In the instant case, I am of the view there is

adequate documentation which challenges the allegations made by the claimant's mother.

Breech presentation

[214] Miss Martin testified that she visited the hospital and was told that the claimant was in breech position and she would have to undergo a Caesarean section.

[215] Dr. Palomino Lue gave no evidence in this regard. Dr. Hardie testified that a baby in breech presentation is one circumstance that necessitates a Caesarean Section. Miss Martin's medical records indicate that on September 7, 2006 and September 21, 2006 the claimant could have been in breech presentation. Dr. Hardie gave evidence to the effect that the question marks visible in the notes beside the word breech are an indication that the examining medical professional was not certain if the claimant was in fact in breech position. He stated that this is not unusual.

[216] Dr. Samuels indicated that as the baby was in the breech presentation Miss Martin was counselled about the possibility of a Caesarean section on the condition that the baby remained breeched. He said that due to the findings at that time, it was appropriate to counsel the expectant mother about the options of delivery. Whether this counselling was misinterpreted, I cannot say.

[217] This all becomes moot when one considers that the entries in the medical docket indicate that before birth the claimant was in a cephalic presentation (head-first presentation). On October 19, 2006 the claimant was not in breech presentation and on October 25, 2006 at 6:00 pm the claimant was noted to be cephalic in presentation. The evidence, on this particular point, does not convey that it was necessary to perform a Caesarean section.

Medical condition

[218] Dr. Palomino-Lue gave evidence that looking at the notes of Miss Martin's pregnancy and delivery she was satisfied that Miss Martin's diabetes and hypertension were adequately managed by the UHWI.

[219] All doctors, two of whom were appointed as court experts, were of the view that though Miss Martin's conditions placed her in the high risk pregnancy category, her conditions were well controlled before she gave birth to the claimant.

[220] Dr. Hardie did not agree with Mr. Page that a woman who has both hypertension and diabetes is a prime candidate for a Caesarean section. Dr. Hardie stated that it has to do with the severity of the condition because an operative delivery even though by professional standards is safe has some risk and his maxim is that even with a small risk it should not be taken unless necessary. It was his evidence that a doctor embarks on an operative delivery contingent on the patient's condition and Miss Martin's condition was such that it did not warrant that sort of intervention at the beginning of labour.

[221] Dr. Hardie gave evidence that as long as her conditions were well controlled then vaginal delivery is still the preferred route. Quite relevantly, Dr. Samuels informed the Court that mothers who have delivery by Caesarean section have an increased risk of heavy bleeding, abnormal clot formation, post-operative infection, and post-partum depression; they also require a longer recovery time than those who have a vaginal delivery. Additionally, infants born by Caesarean section also tend to have a greater likelihood of initial breathing difficulties than infants born by vaginal delivery.

[222] Dr. Hardie told the Court that he could not agree with the suggestion that the defendant hospital was negligent in attempting to induce labour the natural way. According to him, the suggestion that having regard to the mother's hypertensive and diabetic conditions, a Caesarean section should have been done

immediately does not conform to the standard guidelines both internationally and locally. Dr. Hardie averred that Royal College Guidelines were met, the American College Guidelines were met and guidelines in the Obstetric Emergency Manual were met. It was his evidence that even though a Caesarean section had to be resorted to, the argument for an elective Caesarean section does not stand.

[223] I am persuaded by the evidence presented by Dr. Hardie. Dr. Palomino Lue did not present evidence to the contrary. It was therefore well established on the evidence that a Caesarean section would not have been necessary for a hypertensive and diabetic patient whose conditions were well controlled, such as Miss Martin.

Whether the doctors at the UHWI took too long to come to the decision to proceed with the Caesarean section with the result that the claimant suffered injury?

[224] On October 26, 2006 at 1:03 am, Miss Martin was fully dilated. This, according to the evidence of Dr. Samuels, marks the commencement of the second stage of labour. She started to experience strong contractions and at 1:08 am the foetal heart rate was slow. The foetal heart rate returned to normal levels at 1:11am. At 1:40 am there was however, no descent of the foetal head. Dr. Samuels' written evidence is that a diagnosis of cephalopelvic disproportion was made, it was then decided that a Caesarean section should be carried out and Miss Martin was prepared for the surgery. At 1:51 am Miss Martin was transferred to the operating theatre and the first incision was made at 2:13 am. At 2:16 am the claimant was extracted.

[225] Dr. Hardie was asked the following question:-

> *"Was there any time before it was actually determined to do a section that it should have been done?"*

[226] Dr. Hardie's response was *"no, because up to the point of the decision to do the C-sec her (Miss Martin's) labour and delivery were progressing normally."*

[227] The decision to carry out the Caesarean section was made thirty seven (37) minutes after full dilation.

[228] Dr. Samuels stated that a primigravid patient has up to two (2) hours to push out the baby after full dilation. Dr. Hardie testified that depending on whose books are being read the second stage (which commences with full dilation and ends when the baby is expelled) could be anywhere up to two hours for a first baby. He however gave evidence that in accordance with obstetric practice in Jamaica, the second stage of labour is supposed to last for one (1) hour for primigravid patients. It would be remiss of me not to point out that liability must be grounded on the standard practice in 2006. Dr. Hardie's curriculum vitae (attached to his expert report) mentions the Obstetric Emergencies Management Manual for Hospitals in Jamaica; however, the year of publication seems to be 2014. The guidelines mentioned during the trial were not actually tendered in evidence but it seems to me that with the passage of time it is most likely that the medical standard would improve rather than devolve. Therefore, given the competing timeframes of two (2) hours and one (1) hour, if one hour is accepted as the standard, in my judgment, it would not be to the prejudice of the claimant.

[229] Miss Martin's medical records speak to "*prolonged second stage with foetal bradycardia"*. However, according to Dr. Hardie, it takes an hour before one says that the second stage is prolonged so it is necessary to proceed to a Caesarean section. It was his evidence that twenty (20) to thirty (30) minutes could be safely added to that time.

[230] It has been established that there was no need to perform an elective Caesarean section.

[231] On Dr. Hardie's evidence, the doctors would not have been required to conclude that Miss Martin's second stage was prolonged until 2:03 am, yet the decision to perform a Caesarean section was made at 1:40 am.

[232] Mr. Page's submission was that having regard to the length of time it took for Miss Martin's cervix to become fully dilated and the fact that Miss Martin's pregnancy was acknowledged as high risk the doctors fell below the required standard of care due to the delay in coming to the assessment of cephalopelvic disproportion and proceeding to the Caesarean section.

[233] Having regard to Dr. Hardie's evidence I am unable to conclude that the doctors took too long to come to the decision to proceed with a Caesarean section.

[234] Regarding the length of time that it took for Miss Martin to become fully dilated I must refer to Dr. Hardie's evidence that as Miss Martin's contractions were mild and infrequent there was adequate progress between 8:00 pm and 11:35 pm. He indicated that the assessment of slow progress at 11:35 pm has to be taken in its full context. He said that one has to consider the fact that during that time Miss Martin became fully effaced and the foetal head had come down. Therefore, that was reasonable progress. So the length of time it took for full dilation depends on many factors and in this case it did not give rise to undue concern.

[235] To all appearances, Miss Martin's second stage lasted past an hour (1:03 am-2:16 am). However, I have interpreted Dr. Hardie's evidence that it takes an hour before one says that the second stage is prolonged to mean that the timeframe for the second stage must be understood in its proper context and for a primigravida whose delivery plan changes during the course of labour it may exceed one hour.

[236] Dr. Hardie was asked if he could state the standard time or average time period between trying to induce labour the natural way and then concluding that a Caesarean section is necessary. He informed the Court that there is no specific

way that such a question can be answered. However, as a rule of thumb, twenty (20) hours after contractions, not abdominal tightening, have begun in a *regular* fashion. He said that even though Miss Martin had abdominal tightening before she did not really start having contractions until around 8:00 pm on October 25, 2006, so the time was well within the standard time even for a first time mother.

[237] Miss Martin's labour records indicate that she started having mild irregular contractions at 7:25 pm on October 25, 2006. At eight (8) pm Miss Martin's records indicate that she was 'now in labour'. The timeframe from 8:00 pm to 2:16 am is six (6) hours and sixteen (16) minutes. If Miss Martin was expected to deliver the claimant in twenty hours[6] after she started having regular contractions and she delivered the claimant in six (6) hours and sixteen (16) minutes, the claimant's case regarding time is unsustainable.

Whether the doctors at the UHWI failed to perform the Caesarean delivery in a timely and safe manner?

[238] The Caesarean section was performed in three minutes. According to Dr. Hardie that was as fast as one could ask for. No evidence was adduced to the contrary.

[239] During the trial, Mr. Page sought to establish that the claimant could have been injured when she was being extracted. It is worthy to note that Dr. Palomino-Lue did not present evidence to support this argument.

[240] Dr. Samuels gave evidence that during the Caesarean section there was some difficulty in extracting the claimant's head and he required the aid of a midwife to push up the head from below.

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[6] See paragraph 130

[241] During Dr. Hardie's cross-examination Mr. Page queried whether the act of pushing up the baby could cause injury. Dr. Hardie's response was *"Not really, you know."* He stated that it is possible but not likely. In this regard, the gist of his evidence was that it is difficult to damage the baby during the course of delivery. He also said that when a doctor performs a Caesarean section sometimes he or she has to *"get up there and dig out that baby's head."* According to him that is not uncommon and those babies have not suffered any adverse effects.

[242] In my judgment it has not been proven that the defendant through its servants/ agents failed to perform the Caesarean section in a safe and timely manner.

Whether the defendant failed to provide a safe place and safe system for the provision of health care for the claimant and her mother?

[243] It was pleaded that the defendant was negligent in failing to provide a safe system for the provision of health care. The claimant was therefore required to lead evidence to show that the particular system adopted was unsafe. By so doing, the claimant would be able to show, inferentially, a possible safe system for the provision of health care.

[244] The claimant presented evidence concerning the failure to administer oxytocin to Miss Martin because of the absence of staff members to monitor her. Evidence was adduced that oxytocin can be used to induce labour and ripen a cervix but it takes a very long time to achieve its effect. The Court was also informed that regular contractions of the uterus will ripen a cervix and cause cervical change but it also takes a very long time. The evidence, in my mind, conveys that whether or not oxytocin is administered to a woman ripening of the cervix will take place (all things being well). In light of this evidence, the necessity of the drug at that particular stage has not been established by the claimant. Furthermore, to succeed on a claim of negligence it would have to be proved that this failure resulted in injury to the claimant. The claimant in my view has failed to do this.

[245] There is no evidence upon which the Court can safely conclude that the defendant failed to provide a safe system and a safe place for the provision of health care.

Whether any instrument or equipment was used in any way during the labour process so as to cause injury to the claimant?

[246] No evidence was led that the doctors negligently used any instrument or equipment during the Caesarean section so it seems to me that, on the facts of this case, the success of this allegation would be dependent on actual evidence being led that an instrument was used to carry out the ARM. However, Dr. Samuels specifically indicated that he could not positively state whether he used his hands or whether an instrument was used in this particular case. He further indicated that in the majority of cases, it is his practice to use his fingers and while I will certainly not speculate, I will simply state that in light of the evidence given by Dr. Samuels the Particulars at (iv) must fail.

[247] I must also state that regarding the Particulars at (iii), that is, failing to ensure that the claimant's mother was properly prepared for the procedure, no evidence was led for the Court to conclude that the defendant was negligent in this regard.

Whether the defendant is liable to the claimant in negligence?

[248] Having found that:-

(a) there is no substance in the allegation of a small pelvis;

(b) the servants/agents of the defendant did not take too long to come to the decision to proceed with the Caesarean section; and

(c) the Caesarean section was done in a timely manner.

I will now determine if, on the evidence, there is any indication that notwithstanding my findings the servants/agents of the defendant were negligent.

[249] As early as January 2007, the claimant was diagnosed with stage two Hypoxic Ischaemic Encephalopathy. Dr. Palomino Lue stated that HIE is a condition which occurs when the oxygen supply to the brain is compromised during the perinatal period. The World Health Organization states that the perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth.

[250] The claimant was also diagnosed as suffering from microcephaly. Eventually she was diagnosed with cerebral palsy. Dr. Samuels stated that cerebral palsy is diagnosed when a doctor has reason to think that the child has been deprived of oxygen at some point before or during birth and the child is failing to achieve the normal milestones.

[251] It was noted that the claimant appeared cyanotic after birth which simply means that she was blue in appearance. Dr. Hardie informed the Court that a baby will appear blue if the baby is not breathing at the time.

[252] Dr. Samuels gave evidence that a baby gets oxygen from the placenta and the placenta gets oxygen from the mother's circulation and the mother's circulation gets oxygen from the air. Therefore, a baby's environment by adult standards is always hypoxic. In other words the normal oxygen patterns in a baby will always be lower than the normal oxygen patterns in an adult. According to him therefore seeing cyanosis in a newborn initially does not mean very much. Doctors become really concerned when the child remains blue ten (10) minutes after birth.

[253] Dr. Hardie gave similar evidence. He said that to say the baby is blue does not really say anything until after the baby starts breathing and the claimant's respiratory actions were pretty well scored after ten (10) minutes.

[254] Evidence was adduced that it is possible for a baby to be deprived of oxygen if the labour process is too long. Dr. Samuels was specifically asked if it is possible

that the claimant could have been deprived of oxygen between the time of induction to delivery. He said that it is possible but unlikely. Additionally, Dr. Hardie stated that while it is possible for a baby to suffer from cerebral palsy if the delivery process is prolonged there is no evidence in the docket that this happened.

[255] Dr. Samuels informed the Court that there were never any persistent high heart rates or persistent low heart rates or abnormal heart ratings and those are signs that doctors look for that are indicative of low oxygen to babies which cause harm.

[256] Dr. Hardie said that he read nothing in the docket that was indicative of any hypoxia trauma in the delivery of the claimant. He then referred to the foetal heart rate which, in my mind, corroborates Dr. Samuels' evidence that the heart rate is in fact what doctors look at to assess the adequacy of oxygen to the foetus.

[257] At 1:08 am the foetal heart rate fell and was recorded as 90-110 bpm. Dr Palomino-Lue gave evidence that she regarded the episode of bradycardia as quite significant and though it was brief it does not mean that it was inconsequential. Dr. Palomino-Lue went on to indicate that the doctors clearly must have thought it to be serious because the paediatrician was informed of the episode.

[258] However, Dr. Palomino-Lue did not speak to the consequences of such a drop in the foetal heart rate. She simply said that it was significant but did not elucidate. Dr. Palomino-Lue agreed with the evidence given by Dr. Hardie that the drop in the foetal heart rate could have been due to uterine contractions. Dr. Hardie also gave evidence that the time within which the heart rate returns to normal will give an indication as to the pathological or non-pathological nature of the drop in the heart rate. He said that in this case, the foetal heart rate returned to normal shortly after it dropped. This, he said, is strongly indicative that the drop was non-pathological. I accept Dr. Hardie's opinion.

[259] According to Dr. Hardie, Miss Martin's pre-existing conditions cannot be ruled out as a possible cause of the claimant's conditions. He said that with diabetes and hypertension one has to think about blood vessels and the inadequacy of the supply of oxygen.

[260] The evidence before the Court does not lead to the conclusion on a balance of probabilities that the second stage of labour was prolonged and that the defendant breached its duty of care. Dr. Hardie testified that the delivery time was standard. However, he also gave evidence that the normal time from decision to incision is thirty (30) minutes. The decision was made at 1:40 am and the first incision was done at 2:13 am. So in Miss Martin's case it took thirty three (33) minutes. Dr. Hardie stated that he would not hold three (3) minutes against the defendant.

[261] The decision to incision was a bit delayed. One cannot ignore this fact. However, Dr. Palomino-Lue did not present evidence to the Court concerning the possible effect of the delay on the claimant. It was not revealed that the delay of three (3) minutes was substantial and that it is more likely than not that the claimant suffered injury as a result of the delay. In other words, the claimant did not present any evidence to establish a causal connection between the delay and the damage.

[262] Based on his evidence, Dr. Hardie seemed to be of the view that the delay in this case was insubstantial and I am so persuaded.

[263] Evidence was not presented by the claimant that it is unlikely that Miss Martin's pre-existing conditions could have exposed the claimant to the injury suffered and it is difficult, given the state of the evidence, to say that it establishes on a balance of probabilities, that any act or omission of the defendant's servant/agent caused or materially contributed to her injury. In fact, Dr. Palomino-Lue admitted that Miss Martin's pre-existing conditions could have resulted in the claimant's injury.

[264] Dr. Hardie went so far as to give an indication that placental insufficiency as a result of the mother's pre-existing conditions cannot be ruled out because the notes themselves reveal that fatty deposits were seen on both the maternal and foetal surface of the placenta which he said could result in the condition.

[265] Dr. Hardie also stated that Miss Martin's diabetes would increase the risk of her having an abnormal baby. He gave further evidence that diabetes is one of the causes of microcephaly manifesting itself after delivery. This evidence remains uncontradicted.

[266] Mr. Page quite cleverly submitted that if Miss Martin's conditions were well controlled it seems less likely that the claimant would suffer injury as a result.

[267] Interestingly, when asked about whether diabetes in a mother can cause or lead to cephalopelvic disproportion. Dr. Hardie said *"yes"*. He went on to say:-

"That is the reason why so much care was taken to control her diabetes, which I must say, that the University did an excellent job. There is no entry in her docket of an abnormal blood sugar reading for the entire pregnancy that I saw. ***Now, that does not change what might have happened during pregnancy, because her diabetes predated the pregnancy***.*"*

[Emphasis added]

[268] From this statement it appears that Dr. Hardie was saying that although Miss Martin's diabetes was well controlled during her pregnancy, it did not guarantee that all would have been well because her condition existed before she was even pregnant.

[269] Dr. Hardie also gave evidence that the degree to which either or both conditions would impact on a particular pregnancy will vary from patient to patient. When Dr. Hardie spoke about the blood vessels and the inadequate supply of oxygen, he also said that it could have been happening for a sustained period during the

pregnancy undetected because there may not have been changes that would have been obvious from the usual parameters that one uses to monitor the pregnancy. Clearly the inference from Dr. Hardie's evidence is that even though there may have been a problem a foetal test could still yield normal results.

[270] The defendant has presented evidence that the way its servants/agents dealt with the claimant was in accordance with acceptable practice and it could not be said that the views of Dr. Hardie were illogical or irresponsible. Dr. Hardie gave reasoned, considered views with appropriate regard to the factual evidence.

[271] Bearing in mind the ***Bolam*** test it could not be said that the claimant presented evidence that emanated from responsible medical men *skilled in that particular art.* Dr. Palomino-Lue gave no evidence to suggest that she was an expert in obstetrics generally and specifically and she gave no evidence indicating an expertise in the treatment and management of high risk pregnant mothers. By virtue of being a paediatrician and not an obstetrician, Dr. Palomino-Lue's limitations were evident. This undoubtedly placed the claimant's case in a significantly weakened position as there is no reliable evidence to contradict or cast doubt on what Dr. Hardie has said. Doctors Hardie and Samuels are on the other hand qualified in the field of Obstetrics. Dr. Palomino Lue's area of specialization is not one which would allow this Court to say her evidence is more reliable than that of Dr. Hardie. (See ***Paula Whyte*** (supra) and the Privy Council decision of ***West Indies Alliance Insurance Company Limited v. Jamaica Flour Mills Limited*** [1999] Lexis Citation 2860 which espouses a somewhat similar view)

[272] The facts of this case are no doubt tragic. Young Cheavela Smith suffered a great deal immediately after birth and as a victim of cerebral palsy she will remain disabled to a very severe degree. Her injuries are such that it would invoke the sympathy of anyone, even one with the most hardened heart. However, I am simply not satisfied that the evidence in this case is sufficient to make a finding that the servants/agents of the defendant were negligent.

Conclusion

[273] The claimant has not successfully established that the servants/agents breached the duty of care owed to her. Even if it could be said that the duty of care was breached (having regard to the delay in decision to incision time), I am not satisfied that the evidence is sufficient to make a finding in the claimant's favour on the question of causation. Therefore, two essential components of the tort of negligence have not been satisfactorily established and the claimant's claim must fail.

[274] In the circumstances, judgment is entered in favour of the defendant with costs to be taxed if not agreed.