**THE REPUBLIC OF TRINIDAD AND TOBAGO**

**IN THE HIGH COURT OF JUSTICE**

**CV2011-01750**

BETWEEN

**HARDEO MASNAN**

**(in his personal capacity and as Administrator of the Estate of Veena Masnan, deceased)**

**ASHVINI MASNAN**

**AASHIQUI MASNAN**

**Claimants**

And

**MEDCORP LIMITED**

**First Defendant**

**PROFESSOR VIJAY NARAYNSINGH**

**Second Defendant**

**DR. BRUCE MC INTOSH**

**Third Defendant**

**BEFORE THE HONOURABLEMADAME JUSTICE JOAN CHARLES**

## Appearances:

| | |
|---|---|
| Claimants: | Mr. Robin Ottway led by Mr. Douglas Mendes S.C. instructed by Mr. Kern Saney |
| First Defendant: | Mr. Neil Bisnath instructed by Ms. Annabelle Sooklal |
| Second Defendant: | Mr. Terrance B. Neale |
| Third Defendant: | Mr. Jonathan Waller instructed by Ms. Debra Thompson |
| Date of Delivery: | 15th June 2021 |

# JUDGMENT

## THE CLAIM

[1] The First Claimant, Hardeo Masnan ("Hardeo" or "the First Claimant"), is the widower of Veena (the deceased)and also the Administrator of her estate. He brings this action in his capacity as the legal personal representative of Veena's estate, as well as in his personal capacity as an alleged dependent of Veena. The Second and Third Claimants, Ashvini and Asshiqui Masnan ("Ashvini" and "Aashiqui" respectively) are the children of Hardeo and Veena, and they bring this action in their personal capacity as alleged dependents of Veena.

[2] The Claimants have brought this claim on the basis of negligence that they say was committed by three persons, Medcorp Limited "Medcorp" or "the First Defendant"), Professor Vijay Naraynsingh ("Prof Naraynsingh" or "the Second Defendant") and Dr. Bruce McIntosh (Dr. McIntosh" or "the Third Defendant").

[3] The Claim is brought by the Claimants on behalf of the Estate of the Deceased and as dependents pursuant to the **Section 27** of the **Supreme Court of Judicature Act**[1]and the **Compensation for Injuries Act.**[2]

[4] The remedies sought by the Claimants as set out in their Re-Amended Statement of Case are as follows:

a. Special Damages for various medical and funeral expenses[3].

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[1]Cap. 4:01
[2] Cap. 8:05.
[3]Para 11 of the Re-Amended Statement of Case:

| | |
|---|---|
| a. Nursing care from 07/05/07 to 24/03/11 | $1,564,784.00 |
| b. Therapy from 07/05/07 to 24/03/11 | $254,600.00 |
| c. Medical Supplies from 07/05/07 to 24/03/11 | $36,175.62 |
| d. Hospital, clinic and laboratory expenses | $803,707.58 |
| e. Miscellaneous supplies and drugs from 07/05/07 to 24/03/11 | $2,045.52 |
| f. Medical equipment and adjustments made at home (including purchase of hospital bed, bed alternating pressure pad and pump, Oxygen concentrator, suction machine, ripple mattress) | $34,300.00 |
| g. Nursing and medical and related (including ambulance transfers to St. Clair Medical Centre at $1200 per round trip and for Doctor's house calls at $300 per session) from the 7/05/07 to 24/03/11 | $26,400.00 |
| h. Doctor's fees | $112,200.00 |
| i. Ambulance | $5,900.00 |

b. General Damages for medical negligence and/or breach of contract in the provision of medical services

c. General Damages for negligence for loss of expectation of life and n respect of the loss years and/or under the Compensation for Injuries Act Cap. 8:05

d. General Damages for the loss of society of the deceased

e. General Damages pursuant to Section 27 of the Supreme Court of Judicature Act Cap. 4:01 for the death of the deceased and/or on behalf of her Estate

f. General Damages for pain and suffering, shock and trauma endured by the Claimants, or any one of them

g. Aggravated and/or exemplary damages

h. Interest pursuant to Section 25 of the Supreme Court of Judicature Act Cap. 4:01.

i. Costs.

[5] Medcorp is the owner and operator of the St. Clair Medical Centre (SCMH), the medical facility where the operation was conducted. It was responsible for, inter alia, providing some of the equipment and nursing care for the surgical procedures performed on Veena on 6th May 2007 and her aftercare.

[6] The Second Defendant is a medical practitioner and a consultant vascular surgeon duly registered to practice medicine in Trinidad and Tobago.

[7] Dr. McIntosh is the anaesthetist who was responsible for administering the anaesthetic to Veena (so as to enable the surgical procedures to be performed) as well as for monitoring her vital signs during the operation and then reviving Veena once the surgery was completed. The Third Defendant is a consultant anaesthetist with practicing privileges at the Clinic.

[8] On May 6 2007, the Veena Marsan (“the patient”) was admitted at Medcorp Limited (SCMH) for elective surgical procedures to be done on the following day. The consent form referred to her doctors as being Dr. Gopeesingh (her brother-

in-law) and ProfessorNaraynsingh, the Second-named Defendant. The consent form referred to dilation and curettage and a cholecystectomy as the procedures to be done. However, a haemorrhoidectomy was also done during surgery.

[9] The primary background facts are not in dispute. They are as follows:

i. One month prior to 6thMay 2007, an attempt had been made to perform these procedures, but this had been abandoned due to the anaesthetist experiencing difficulty in intubating Veena.

ii. At the time of the operation Veena was 55 years old and she had a prior operation to correct scoliosis and had a Harrington rod inserted in the area of her neck and a receding jaw.

iii. On 7th May 2007 she was operated on by Professor Naraynsingh and Dr. Gopeesingh. These operations were uneventful and proceeded without complication.

iv. The operations were performed between 7:50a.m and 9:50a.m. Upon completion of the operations, Dr. Mc Intosh reversed the effects of the anaesthesia and at 9:50a.m. Veena was transferred to the recovery room where she was extubated by Dr. Mc Intosh.

v. At that time Veena had 100 percent oxygen saturation with oxygen being given via face mask and her blood pressure and pulse were unremarkable.

vi. When Veena was fully alert in the recovery room and waiting to be transferred to her room on the ward, Dr. Mc Intosh left her in the care of the recovery room nursing staff and left the premises to go to another nursing home.

vii. The directions for Veena's post-operative care were written up by Professor Naraynsingh, the Second Defendant.

viii. Veenawas taken to her room on the ward at 10:40a.m. where she met with her family and was periodically monitored by Medcorp's nursing staff.

[10] It was a live issue in the trial as to whether in fact the patient was monitored at twelve noon and 12:30p.m. but it is the First Defendant's case that the patient

was monitored at those times and her vital signs recorded by the nursing staff at SCMH. At 11:30a.m Nurse Melba Espinoza administered intramuscularly 15mg of morphine to the patient. The patient's vital signs were checked and recorded in the Frequent Vital Signs Graphic Record at 11:30am and thereafter at 11:45a.m, 12 noon and 12:30p.m. The patient's vital signs were normal/stable on each of those occasions. When checked at 12:30p.m. the patient's blood pressure was 121/70, her pulse rate was 59 and her respiratory rate was 22.

[11] At 1:00pm, the patient was found to be unresponsive with no pulse. Immediately thereafter, in accordance with standard procedure, a "Code Blue" was called and medical professionals present in SCMH immediately attended upon the patient and treated her. The patient was resuscitated but never regained consciousness. She passed away on March 24 2011.

[12] The Evidence in this case is to be found in the various witness statements and expert reports filed by each of the parties as well as the agreed bundle. In so far as the factual witnesses are concerned, the relevant witness statements are:

For the Claimants:

(i) Hardeo Masnan;

(ii) Ashvini Masnan;

(iii) Aashiqui Masnan; and

(iv) Kamini Gopeesingh

For Medcorp:

(i) Susan Berkeley; and

(ii) Melba Espinoza

While the Second and Third Defendants each testified on behalf of themselves.

[13] As to the experts, the Claimants relied on three experts – Dr. Frank Cross, Dr. Annmarie Rollin and NurseJanine De Massey; while Medcorp relied on Dr. Denaesh Ariyanayagam; Professor Naraynsingh relied on two experts, Professor Winslet and Professor Walley and similarly Dr. Mc Intosh relied on two experts namely Professor Alan Aitkenhead and Dr. Derrick Lousaing.

**BACKGROUND FACTS**

[14]a. the First Claimant is a retired police officer and the widower of the deceased having gotten married on March 30 1980.

b. at the time of the filing of the Claim, the Claimants had not obtained a grant of Letters of Administration to act on behalf of the Estate of the deceased.

c. The First Claimant however obtained a grant of Administration in respect of the Estate of the deceased on October 21 2011.

[15] On 23rd April 2007, some two weeks prior to her admission to the hospital, a previous attempt had been made by the Second Defendant at the Medical Associates Hospital to perform a cholecystectomy and haemorrhoidectomy on the Deceased. These were the same procedures which were eventually performed on her on the 7th May 2007. The Consultant Anaesthetist involved in that aborted procedure, Dr. Aroon Naraynsingh, whom the Second Defendant under cross-examination described as "highly competent" failed in his attempt to perform an anaesthetic induction upon the Deceased. According to Dr. Aroon Naraynsingh's notes: *"Patient known to me. Was impossible for me to intubate in the past – a few years for C/S. Had Dr. Clyde Teeluckdharry for standby for fiber optic intubation."* Those notes continue as follows: - *"Attempts to intubate failed. Dr. Teeluckdharry attempt to fiber optic intubation also failed. Patient awake and sent back to ward. Patient advised to have tracheotomy for this surgery because of airway risk. Must have tracheotomy apparatus (?) for safe anaesthetic." "Operation performed. Failed intubation."*

[16] On admission to the Surgical Ward of the Clinic on May 6th 2011, the Deceased completed a questionnaire for anaesthesia. In the completed questionnaire the Deceased denied any exceptional sensitivity to local or general anaesthetics.

**PRELIMINARY POINTS**

[17] All three Defendants contended that the Second and Third Claimants have no capacity to pursue these proceedings as Defendants since the action on their behalf was commenced before the expiry of the six months period after the death of the deceased and in breach of **Section 4** of the **Compensation for**

**Injuries Act**[4](the Act). It was submitted that the First Claimant had no capacity to bring the Claim in the circumstance where he obtained the Grant of Letters of Administration on 21st October 2011, while the Claim was begun on 9th May 2011.I note that in the original Claim the First Claimant brought the action as a dependent of the deceased and not in a representative capacity on behalf of the estate. In the Re-amended Statement of Case filed on the 13th December 2011, more than six months after the death of the deceased on 24th March 2011 and prior to the first Case Management Conference (CMC), the First Claimant was added as a new party as Administrator of the Estate of the deceased. The remaining Claimants instituted this Claim as dependents. Their claim was premature since Section 4 of the Act required that they wait six months before instituting proceedings if the Executor or an Administrator failed to do so.

[18] In **Austin v Hart**[5] before the six month period had expired, the Plaintiff issued a writ against the Defendant alleging negligence and claiming damages for the resultant death of the Deceased. During the six months following the death, no Executor or Administrator had begun proceedings against the Defendant. The Privy Council there held that **Section 8:02** of the **Compensation for Injuries Act** (the predecessor of Section 4 supra) did not invalidate any action by a dependent within six months of the death, if at the date of the writ there exists an Executor or Administrator. In this case there was no Executor and the First Claimant was entitled to apply for administration of the estate. The Court held that the premature filing of a claim was an irregularity which could not nullify the proceedings if no injustice was caused the Defendants. On the facts of this case I hold that Section 4 of the Act does not expressly invalidate any proceedings brought by the dependants within six months of the death of the Deceased. In the circumstances, the claims filed by the Claimants are valid and do not amount to a nullity.

[4]Cap 8:05(4) Every action in respect of any personal injury resulting in death shall be for the benefit of the dependants of the person whose death has been so caused and shall be brought by and in the names of the executor or administrator of the deceased person; but, if within six months of the death, no such action has been taken by and in the name of the executor or administrator, then an action may be brought by and in the name of any of the dependants of the deceased person.

[5] In 1983 2 AC 640

**THE FIRST DEFENDANT**

**Particulars of Negligence against the First Defendant**

[19] The specific allegations made against the first Defendant were that it:

a. failed to provide a safe or adequate system and/or process for the provision of satisfactory health care;

b. failed to provide the sufficient number of properly trained, skilled, experienced, qualified and competent medical personnel including doctors, nurses and other healthcare givers including continuous monitoring by an experienced and qualified nurse while the deceased was in the recovery room or the surgical ward and/or a full "Blue Code" team including a consultant anaesthetist and an Accident and Emergency Specialist, immediately as the deceased went into respiratory and/or cardiac arrest and /or to take and/or implement in a timely manner appropriate and urgently required methods such as the performance of a tracheotomy upon the deceased, to ensure that the surgery could be safely performed upon the deceased and/or safe recovery post-operatively therefrom, and or failed to have the deceased monitored properly and/or carefully and/or continuously on a 24 hour per day basis by an experienced and/or qualified member of the First Defendant's nursing staff;

c. failed to provide all necessary facilities, equipment and material, including but not limited to a post surgical "step down" unit or facility and/or a pulse oximeter and/or devices designed to monitor the deceased's breathing, levels of consciousness and blood pressure post-operatively to ensure that the surgery cold be safely performed upon the deceased and her successful and complete post-operative recovery;

d. failed to ensure that the deceased was continuously and/or frequently and/or regularly monitored or properly monitored during the post-operative period by appropriate numbers of experienced and qualified nurses, including in particular when she was taken to and left in the Clinic's surgical ward and/or putting the deceased into a room in the surgical ward furthest away from the closest nurses station thereto;

e. failed to use reasonable care, skill and diligence in the care and treatment of the Claimant during and immediately after the surgery;

f. failed to take any or any sufficient measures to safeguard the interests and welfare of the deceased;

g. failed to put the deceased postoperatively to sit or recline in a sufficiently comfortable position to assist her in breathing;

h. administered sedatives and/or narcotics and in particular morphine immediately before and/or while the deceased into respiratory arrest which had the effect of suppressing her breathing and/or causing serious deoxygenation, loss of consciousness and serious braindamage;

i. failed to sound an alarm and/or summon appropriate professional and/or emergency medical assistance with urgency when the deceased went into distress and/or respiratory and/or cardiac arrest;

j. failed to keep full and/or accurate and/or reliable and/or consistent notes, and/or in a proper sequence or order, as to what took place following the discharge of the deceased from the operating theater, and in particular when she was in the surgical ward.

[20] In relation to this Defendant, the issues that fall to be determined are:

Does the evidence of the Claimants establish –

a. a breach of the duty of care to the patient by nursing staff of SCMH and;

b. a causative link between the action of the nursing staff of SCMH and the patient becoming unresponsive without a pulse on May 7 2007.

[21] In order to succeed in their claim against the First Defendant in negligence, the Claimants had to establish the following:

a. that the Claimant was owed a duty of care by the Defendant

b. that the Defendant breached that duty by failing to exercise reasonable care

c. that the Claimant actually sustained injuries

d. that the breach of duty caused the claimant's injury[6].

**THE LAW**

[22] Breach of Duty: Law - **The Bolam Test**

This test was applied by the Court of Appeal in the local cases of **Deonarine v Ramlal[7]**and in **South West Regional Health Authority v HarrilalSamdaye[8]**.

[23] In **Deonarine v Ramlal[9]**, the HonourableMendonça JA, applying the dictum of Mc Nair J in **Bolam v Friern Hospital Management Committee[10]**, stated[11]-:

> *"The principle has been restated over the years but perhaps the most often quoted formulation is the direction of Mc Nair J. to the jury in Bolam v Friern Hospital Management Committee [1957] 2 All E R 118 which is now commonly referred to as the Bolam test. In that case Mc Nair J stated (at p.121-122). 'How do you test whether this act or failure is negligent? In an ordinary case it is generally said, that you judge that by the action of the man in the street. He is the ordinary man. In one case it has been said that you judge that by the conduct of the man on top of the Clapham omnibus. He is the ordinary man. But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on top of the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. 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 that he exercises the ordinary skill of an ordinary competent man exercising that particular art … A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art … Putting it the other way around a doctor is not negligent, if he is acting in accordance with*

[6] Linda Rajkumarsingh v Gulf View Medical Centre Limited CV 2010-01958
[7] Civ. App. No. 28/2003
[8] C.A.CIV.60/2008
[9]Civ. App. 28/2003
[10][1957] 2 All E R 118
[11]stated at paragraph 19

*such a practice, merely because there is a body of opinion that takes a contrary view."*

[24] It has been said that the Bolam Test is applicable to all aspects of a medical practitioner's work.[12]

[25] In accordance with the Bolam Test, for a plaintiff to succeed he must show that the medical practitioner failed to exercise a reasonable degree of skill and care. The medical practitioner can therefore be held liable if he failed to act in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art. However as is evident from the passage quoted from the Bolam case, it is not sufficient for the plaintiff to adduce evidence to show that there is a body of medical opinion that considers the practice adopted by the medical practitioner to be wrong if there also existed a body of equally competent opinion that considered it acceptable[13] In **Sidaway v The Board of Governors of the Bethlem Royal Hospital**, supra, Lord Scarman put it this way[14]:

*"A doctor is not negligent if he acts in accordance with the practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice."*

[26] The case against the First Defendant alleges negligence against its nursing staff in failing to monitor the deceased post operatively as required, and failing to determine that she was in respiratory distress at any time before 1:00p.m. when she was found unresponsive. Where, as in this case, the issue to be determined involves the use of some special skill or competence then the test is *"the standard of the ordinary skilled man exercising and professing to have that skill…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"[15].*

[27] While it is noted that the nursing support staff at Medcorp are not medical practitioners, their nursing skill and knowledge fall within the parameters of Bolam, by dint of the fact that nursing is a skill requiring specialized knowledge and training.

[12]Sidaway v The Board of Governors of the Bethlem Royal Hospital [1985] A.C. 871
[13] Maynard v West Midlands Regional Health Authority [1985] 1 All E.R. 635
[14] at Sidaway supra at page 881F
[15]Bolam v Friern Hospital Management Committee (1957) 2AER 118

[28] The First Defendant argued that the decision as to a patient's post operative care and whether that care takes place in the surgical ward, ICU to HDU lies solely with the patient's physicians and not the hospital. This Defendant argued further that the Second and Third Defendant would know that the patient would receive much closer monitoring in the ICU and HDU wards – they did not however exercise either option for the deceased.

[29] It was submitted that the First Defendant's nursing staff carried out the standard monitoring for a patient on a surgical ward – every fifteen minutes for the first hour after surgery, then every thirty minutes for the next two hours, and every thirty minutes thereafter. Additionally, the standard procedure following surgery at SCMH is to put the patient to lie flat on the bed with a pillow under their head unless specific instructions to the contrary are given by the physician. In the case of this patient no instructions were given by any of her physicians to SCMH staff to place the patient in a position other than the standard procedure followed by SCMH.

[30] The First Defendant asserted that the patient's vital signs were checked by a nursing assistant at twelve noon and by Nurse Melba Espinoza at 12:30p.m; her vital signs were normal on those occasions as well as at 11:00a.m, 11:15a.m, 11:30a.m, 11:45a.m as noted on the Frequent Vital Sign Graphic Record(FVSGR). The FVSGR showed that the condition of the patient was normal.

[31] The Nurse's Progress Report records that the pain medication was given at 11:30a.m but this was listed as a late entry after the 12 noon and 12:20p.m entries. It was then recorded that the vital signs were checked and recorded at 12 noon and at 12:30p.m.

[32] The Claimant's expert witness, Dr. Frank Cross, opined in his witness statement[16] that it would have been a wise precaution to send the patient to a High Dependency Unit given her history of a difficult airway, or at least be assigned a nurse in constant attendance[17]. It was his view that had the

[16] Paragraph 40
[17] Paragraph 45 of his witness statement

deceased been put in a HDU, her difficulty would not have gone unobserved and steps could have been taken to prevent deterioration and cardiac arrest[18].

[33] I note that in answer to Mr. Bisnath for Medcorp, Dr. Cross asserted that it was for the surgeon or Anaesthetist to decide where the deceased be placed post surgery – the ICU, HDU or Surgical Ward[19]. The hospital does not make that decision. He also agreed that since the cost for care in the ICU or HDU was higher than the cost of the surgical ward it was for the patient and/or her relatives to decide whether to incur such costs.

[34] Significantly, Dr. Cross also agreed that specific orders about the positioning of the patient must be given by the physician; in the absence of such specific orders the standard procedure post surgery is to put the patient to lie flat with a pillow under her head. No such instructions were given in this case by Professor Naraynsingh. It should also be noted that neither Dr. Mc Intosh nor Professor Naraynsingh gave any instructions to have the deceased placed in the ICU, HDU or under the constant monitoring of a nurse.

[35] Another of the Claimant's experts, Dr. Rollin agreed with Dr. Cross that the deceased should have been placed in a HDU, under close nursing supervision port operatively on the instruction of her doctors.

[36] Another of the Claimant's witnesses, Janine De Massey, a nurse, testified as to what was required of the nursing staff at Medcorp relative to the postoperative care of the deceased. She too noted that there were no *"clear post-operative instructions or areas of concern indicated (her airway) for them to keep a closer eye once Mrs. Masnan returned to the ward. Without this information provided, the surgical post-op Nursing Team would have no knowledge the issues faced by the theatre teams and so would treat Mrs. Masnan as a routine, low risk patient that day."*[20]

[37] Nurse De Masseydetermined that as a result of this omission by the attending physician of the deceased, the latter was treated as a routine post operative patient on the ward[21]. Nurse De Massey was also of the view that Medcorp's

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[18] Paragraph 41 of the witness statement of Dr. Cross
[19]Para 40 of the Report of Dr. Cross
[20] Page 13 of the Report of Jenine De Massey
[21] Page 14 of Nurse De Massey's Report

staff responded appropriately to the Code Blue alarm when the deceased was found unconscious at 1:00p.m.

[38] The breaches of duty relied on by the Claimant against the First Defendant[22] are not made out on the evidence since many of the grounds relied up really fall within the domain of the deceased's attending physicians and not the hospital. As noted above, in the absence of any instructions for the deceased's surgeons/anaesthetist, the placement of the patient in a surgical ward as opposed to a HDU or ICU cannot be blamed on Medcorp.

[39] I therefore hold that the Claimant has not established that the First Defendant breached its duty of care toward the deceased by failing to put her under continuous monitoring by a nurse while in the surgical ward, or failing to put her in the HDU/ICU, or failing to put her in a sitting position post operatively. There was no breach of duty in relation to the administration of morphine to the patient; this was done on the physician's orders as is usual. The nursing staff at the hospital was required to administer medication as prescribed by the physician and this was done in this case. In any event, this fact is not disputed. I also hold that the Claimant has not established that the First Defendant was negligent insofar as their response to the code blue alarm; indeed their own witness gives evidence to the contrary.

[40] With respect to the allegation that the First Defendant failed to keep full and/or accurate and/or reliable and/or consistent notes, and/or in a proper sequence or order, as to what took place following the discharge of the deceased from the operating theatre, and in particular when she was in the surgical ward, the evidence needs to be assessed in light of the suggestion that the deceased's respiratory rate was not checked at 12 noon and 12:30p.m.and that entries in the Nurses' Progress Record at those times were made after the fact.

[41] The issue as to whether the deceased was monitored by the First Defendant's nurses after 11:30a.m arises for the following reasons:

i. An entry at 11:30a.m. in the Nurses' Progress Record was made after the 12 noon entry.

[22] Para 9 (b) – (i)

ii. A handwritten notation in the data column stated that the 11:30a.m. entry was a late entry.

iii. Nurse Espinoza admitted during cross-examination that the 11:30a.m. entry was made 'sometime after 12 noon;' when pressed as to the time her answer was that she could not recall exactly.

[42] Under cross-examination, Nurse Espinoza indicated that the entry in the Nurse'sProgress Record at 10:40am was made by her. The 11:20am entry was not hers.It was made by Nursing Assistant Gail. According to that note, the Deceased hadcomplained of pain and Nursing Assistant Gail informed Nurse Espinoza, who isthe Registered Nurse referred to in the note.

[43] The next entry at 12:00 noon read: "*patient appears to be asleep, nursing observation continued*", which Nurse Espinoza said was also made by Nursing Assistant Gail.

[44] Nurse Espinoza accepted that the Deceased's vital signs ('VS' in the notes) were recorded in the Vital Signs Graphic Record,[23]and accepted that the vital signs there recorded were: Pulse rate,respiration rate, blood pressure and temperature. Oxygen saturation was neverchecked.

[45] The Vital Signs Record shows that the Deceased's vital signs were taken at 11am,11.15am, 11.30am, 11.45am, 12noon, and 12.30pm. However, theentries for 11am, 11.15am, 11.30am and 11.45am are not recorded or referenced in the Nurses' Progress Record;interestingly the entries for 12noon and 12.30pm are referenced and recorded in the Nurses ProgressRecord.

[46] Both the Claimants and the Third Defendant submitted that it was significant that the Vital Signs Record showed that there was no recordmade for the Deceased's respiratory rate at 12noon and 12.30pm. It was further submittedthat given that theVital Signs Record is the place designated for recording vital signs, this omissionsuggestedthat the Deceased's respiratory rate was not taken at12noon and 12.30pm. Nurse Espinoza recorded the deceased's respiratory rate as 22 at 12:30p.m, which, if true, was satisfactory. Her explanation for the omission of the respiratory Rate Record in the Vital

[23]Exhibit "ME6" to her Witness Statement Page 128, Volume IV.

Signs Graphic Record was that it was recorded in her nurse's notes which were not disclosed in these proceedings.

[47] No explanation was given by Nurse Espinoza or any other witness for the discrepancy and/or omission noted above.

[48] It is clear that the post operation monitoring of VeenaMasnan was important. According to the First Defendant's own standard operating procedure, she had to be monitored every fifteen minutes for the first hour after surgery then every thirty minutes for the next two hours and every thirty minutes thereafter. Based on the evidence that Veenawas returned to the ward about 10:40 a.m. – she ought to have been monitored every fifteen minutes between 10:40 a.m. to 11:40.a.m. then every thirty minutes from 11:40a.m to 12:40p.m. and every thirty minutes thereafter. The actual record shows that she was monitoredevery fifteen minutes from 11:00a.m. to 12 noon and thereafter every thirty minutes after 12 noon at 12:30p.m. and 1:00p.m.

## CAUSATION

[49] In **South West Regional Health Authority vSamdayeHarrilal**[24] the Court there opined:

> *"The question of liability, ought, in our judgment, to have been approached from two perspectives, firstly, whether the hospital was negligent in its treatment of the respondent during the course of her stay and particularly, during the delivery of her baby and if yes, whether such negligence was the cause of the stillbirth. The first issue necessarily involved finding the existence of a duty of care to the respondent and considering whether there was a breach of that duty. The second issue, being one of causation turned on the medical evidence."*

[50] There is no evidence before me by which I could find that the failure to record Veena's respiration rate at 12 noon and 12:30p.m. caused or contributed to her death. In any event, I make no such finding having accepted the evidence of Nurse Mendoza that in fact the respiration rate was taken at 12 noon and 12:30p.m. and entered as a late entry. The First Defendant, in accordance with

[24] CV APP. #60 OF 2008

accepted practice, monitored the deceased every thirty minutes after the first hour, and she did not appear to be in any distress at 12:30p.m. Her collapse clearly occurred sometime between 12:30p.m and 1:00p.m when she was observed to be in distress. There is no causal link between the care of the nursing staff of the First Defendant and the eventual deterioration of the deceased.

[51] In the circumstances, I hold that the First Defendant is not liable for negligence in the post-operative care of the deceased.

**THE SECOND DEFENDANT**

[52] The particulars of Negligence pleaded against Professor Naraynsingh were that he:

i. failed to inform and/or warn the deceased and the other medical staff and caregivers pre-operatively or at all of the risks of using and/or of her sensitivity to sedatives and/or narcotics and in particular morphine and/or combination of pain killing drugs and narcotics.

ii. failed to inform and/or warn the Third Defendant and/or Dr. Chang or either of them of the full implications of the deceased's history and/or medical and/or physical condition, including the fact that the difficulty in intubating her pre-operatively would cause trauma and/or swelling and/or oedema in the area of the deceased's vocal cords and neck and thereby caused her difficulty in and/or suppressed her breathing, considering in particular the nature of the surgery performed by or under the control or direction of the Second Defendant at the material time, and in particular of the risks and/or dangers of administering pain killing drugs and/or sedatives and/or narcotics, and in particular Morphine, having knowledge of her poor anaesthetic history.

iii. allowed and/or failed to stop the Third Defendant and/or Dr.Chang and/or the other medical and nursing staff involved in the treatment and/or care or any of them, from administering an excessive dosage of pain killing drugs and/or sedatives and/or narcotic and in particular morphine, before and/or during and/or after the surgery.

iv. failed to monitor and/or supervise and/or control the amount of pain killing drugs and/or sedatives and/or narcotic, and in particular morphine administered while he was or ought reasonably to have been aware of the dangers and/or risks of so doing.

v. failed to 'red flag' the patient on his chart or other medical records used for the purpose of and/or during and/or following the subject operation in order to alert any other doctor, and in particular the Third Defendant and/or Dr. Chang and/or the nursing and other staff of the First Defendant or any of them to the risks and/or dangers associated with administering or using upon the patient sedatives pain killing drugs and/or narcotics and in particular morphine prior to, during and/or following the surgery, considering in particular the difficulty in intubating the patient and the consequences thereof as detailed at sub-paragraph (ii) hereinabove;

vi. failed to remain within or in the vicinity of the operating theatre and/or recovery room and/or clinic until the patient's return to full consciousness and/or complete recovery from anaesthetic and/or other drugs administered during the surgery.

**Allegations (i), (iii), (iv) and (v)**

[53] I propose to deal with the allegations above, since they all involve the administering of morphine and other painkilling drugs to the Deceased during and post-operation.

[54] I agree with the Claimant's submission that the Second Defendant acted as a specialist or consultant general surgeon whilst performing haemorrhoidectamy and cholesystectomy on the deceased; in the circumstances he had to be judged by the standards of this specialty and not that of a vascular surgeon. In assuming the responsibility to write up the post operative notes and prescribe morphine to deal with post operative pain management, he also took on the role of a professional in the field of post operative pain management, namely a Consultant Anaesthetist.

[55] The Claimants contended that the Second Defendant was under a duty to warn the deceased and other medical staff of the risks of using morphine and other narcotics because of her sensitivity to such drugs. The evidence in the matter is that a caesarean section was performed on the deceased at Medical Associates in 1989. After the surgery the deceased was administered post operatively with 100mg Pethidine (the equivalent in opioid effect to 10mg of morphine) and did not demonstrate any signs of sensitivity to narcotics.[25]

[56] There is no evidence before me relating to the deceased's sensitivity to morphine either from her medical history or the instant surgery and hospitalization. None of the experts, including the Claimants'were able to point to any evidence in support of this ground. Indeed the Claimants accepted that based on the evidence of their own witnesses *"that any case based on the deceased's sensitivity to morphine or on an overdose of morphine can no longer be maintained."*[26]It was also agreed by the Claimant that their witness Dr. Rollin in her expert report accepted that their use of morphine post-operatively was appropriate.[27]

[57] In the circumstances, this ground of the Claimants' case fails.

[58] **Second Allegation**

***Failing to inform and/or warn the Third Defendant and/or Dr. Chang or either of them of the full implications of the deceased's history and/or medical and/or physical condition, including the fact that the difficulty in intubating her pre-operatively would cause trauma and/or swelling and/or oedema in the area of the deceased's vocal cords and neck and thereby caused her difficulty in and/or suppressed her breathing, considering in particular the nature of the surgery performed by or under the control or direction of the Second Defendant at the material time, and in particular of the risks and/or dangers of administering pain killing drugs and/or sedatives and/or narcotics, and in particular Morphine, having knowledge of her poor anaesthetic history.***

[59] There was no need for the Second Defendant to warn Dr. Chang of any difficulty with intubating the deceased since he was not involved in her post operative care until she suffered cardiac arrest. There was also no need for the Second Defendant to warn the Third Defendant of the deceased's medical history with

[25] Paras 31 and 44 of the Walley Report- TB Vol vi pgs 46 and 48
[26] Para 65 of the Claimants' submissions filed 3rd Aug 2020
[27] Para 66 of the Claimants' submissions filed 3rd Aug 2020

respect to her difficult airway or the difficulty in intubating her since Dr. Mc Intosh was well aware of both facts before the surgery. Indeed, he enlisted the help of an ENT Specialist, Dr. Shim to assist with intubating the patient by using a flexible intubation laryngoscope[28]. I therefore hold that there was no breach of duty of care to the deceased by Professor Naraynsingh on this ground. Accordingly this limb of the Claimant's case fails.

[60] **The Sixth Allegation**

***Failing to remain within or in the vicinity of the operating theatre and/or recovery room and/or clinic until the patient's return to full consciousness and/or complete recovery from anaesthetic and/or other drugs administered during the surgery.***

[61] The Second Defendant submitted that there was no evidence that any breach of duty by the Second Defendant caused the death of the deceased. He submitted that the fact Maxolone, a safe antagonist to morphine, was not administered to the patient after her cardiac arrest is evidence that doctors at the scene did not consider that a morphine related adverse effect likely. He also relied upon the evidence of Nurse Espinoza that she monitored the patient at 12:30p.m. and 12 noon and the latter seemed to be resting.

[62] The Second Defendant, in answer to Mr. Mendes, opined that all post operative care of the patient lies with the Anaesthetist, including whether that patient be placed in the ICU, HDU or ward. He further asserted that the hospital also shares responsibility for the post operative care of said patient. He agreed with Counsel that responsibility for instructions that patient be put to lie in any position lay with the Anaesthetist or surgeon, failing which the patient would be put in the standard lying position on the bed. Dr. Gopeesingh also agreed with this opinion.

[63] The Second Defendant testified that[29]:

> *"17. After closing the Patient I satisfied myself that the Patient was stable by checking with Dr. Mc Intosh and reviewing her state. I then left the*

[28] Paras 4 and 8 of the witness statement of Dr. Mc Intosh ; paras 6 – 9 of the witness statement of Dr. Naraynsingh
[29] Paras 17-18 of the Witness Statement of Professor Naraynsingh

*Patient in the care of Dr. Mc Intosh. The Patient had not yet awakened. I wrote up my "Physician's Orders" and left instructions that post operatively the Patient was to be given 15 mg of Morphine IM (intra muscular) at 4 hourly intervals for pain if necessary, oral fluids and Rocephin or Oframax 1g twice daily for 2 days. I also left instructions for changing the Patient's dressings.*

*18....I completed my notes on the Patient's records, checked on the Patient in the recovery room and there being no issue concerning the Patient's recovery from the surgeries, I left St. Clair at approximately 11a.m."*

[64] I am of the view that this ground is not made out having regard to the undisputed evidence that Veena had returned to full consciousness after the surgery. She conversed with her relatives after she was taken to the ward and had been observed for some time after the surgery by the nursing staff of the SCMH and had appeared to be progressing normally. Professor Naraynsingh, having completed his surgery and handed over the patient to Dr. Mc Intosh after she had recovered in the recovery room, I therefore hold that there is no negligence that can be attributed to Professor Naraynsingh on this ground since the patient had clearly recovered from the anaesthetic drug of 100mcg of Fentanyl post surgery. The evidence of Professor Walley is that this drug, administered at the start of the operation would have worn off by the time the surgery was completed.[30] This drug therefore played no part in the Deceased's eventual cardiac arrest some two hours later.

[65] Even if I am wrong on the issue of the breach of duty of care, the Claimants had to show that if there was a breach of duty of care that it was this breach which caused the death of the deceased.[31] The main thrust of the Claimants' case against this Defendant was that the Deceased's cardiac arrest was caused by the Second Defendant's prescription of morphine and or narcotics to her; as had been discussed above, it is clear that there is no causal link on the evidence between the administration of morphine to the deceased and her cardiac arrest. Indeed Professor Walley[32] opined that morphine *"could not be responsible for the patient being found in an unresponsive state at 1:00p.m. on*

[30] Para 39 of the Report of Prof. T. Walley

[31] Southwest Regional Health Authority v HarrylalSamdaye CA 60 of 2008 ; Linda Rajkumarsingh v Gulf View Medical Centre Ltd. CV 2010-001958

[32] Trial Bundle Volume 6 pg 48 para 40

*7th May 2007 or that it could have caused upper airway obstruction."* He further opined that the postoperative nursing observations were inconsistent with any suggestion of any adverse effect to morphine, *"in particular well maintained blood pressure and no suggestion of decreased respiratory rate."*

[66] I have taken into account the authorities which indicate that the court should only reject the opinion of an expert witness if it was one which no responsible expert in a comparable position could reasonably hold.[33]

[67] I also note that all the medical experts agree that the cause of the Claimant's cardiac arrest could have been due to several possibilities.[34] There was no post mortem report in this case and so several possible causes were discussed including:

a. undiagnosed cardiac disease

b. respiratory depression due to morphine

c. upper airway oedema causing airway obstruction

[68] As noted above there was no evidence to support either (a) or (b) and a fuller discussion in relation to (c) would be embarked upon in relation to the Third Defendant. There was no definite statement as to the cause of death by any of the experts; they all gave an opinion but pointed to the fact of the absence of a post mortem report which would have allowed them to state with some degree of certainty what the cause of death was.

[69] In **Wilsher v Essex Area Health Authority**[35] the Court held that:

> *"Where a plaintiff's injury was attributable to a number of possible causes, one of which was the defendant's negligence, the combination of the defendant's breach of duty and the plaintiff's injury did not give rise to a presumption that the defendant had caused the injury. Instead the burden remained on the plaintiff to prove the causative link between the defendant's negligence and his injury although that link could be legitimately inferred from*

[33] Bolitho v City and Hackney Health Authority 13 ButterworthsMedico-Legal Reports] [BMLR] 111
[34] Prof Aitkenhead's Report pg 91 para 24 ; Prof Walley's Report TB VI pgs 46-49 para 34-45; Dr. Cross TB Vol V pgs 14 -15 para 38
[35] [3 BMLR] pages 37 – 38

*the evidence. Since the plaintiff's retinal condition could have been caused by any one of a number of different agents, and it had not been proved that it was caused by the failure to prevent excess oxygen being given to him, the plaintiff had not discharged the burden of proof as to causation."*

Taking into consideration the fact that the surgeries performed by ProfessorNaraynsingh were successful and the patient had recovered post-operatively, I hold that there was no breach of duty in Professor Naraynsingh prescribing morphine post-operatively for pain management and there is no evidence as to the cause of Veena's cardiac arrest. I therefore hold that there is no causal link between Professor Naraynsingh's treatment and her arrest. It should also be noted that the surgeries, having been successfully completed, and the patient having had an unremarkable recovery post surgery,in the absence of evidence as to why she arrested two hours later, in my view it would be speculative to find that it was the failure to order that she be placed in a reclined position or in a HDU which led to her death. In the circumstances, I conclude that there is no evidence that the actions of Professor Naraynsingh amounted to a breach of duty of care or caused the arrest of the deceased.

**THE THIRD DEFENDANT**

[70] The Particulars of Negligence against the Third Named Defendant are that he:

a. failed to conduct any or any proper and/or systematic pre-operative assessment and/or to take full information or particulars of the full nature of the deceased's history and/or condition and/or of the nature of the Surgery then due to be performed.

b. failed to inform and/or warn the patient pre-operatively of the risks of using and/or sensitivity to painkilling drugs and/or sedatives and/or narcotics and in particular morphine.

c. failed to "red-flag" the patient and/or to make any or any proper note pre-operatively and/or during the Surgery and/or immediately thereafter on his chart in order to warn any other doctor and in particular the Second Defendant and/or Dr. Chang and/or the nursing and other staff

of the First Defendant, or any of them, of the serious and/or significant risks associated with administering or using upon the deceased painkilling drugs and/or sedatives and/or narcotics including morphine during and/or immediately after the Surgery, including the fact that the difficulty in intubating her pre-operatively would have caused trauma and/or swelling and/or oedema in the area of the deceased's trachea, airways and/or vocal cords and her neck which would lead to her having difficulty in and/or the suppression and/or cessation of her breathing.

c (i). failed to perform a tracheotomy pre-operatively by which to administer anaesthetic to the deceased by that means, instead of by intubation.

d. failed to take any steps such as would have notified of and/or alerted Dr. Chang or any other doctor or medical care giver to the full nature of the deceased's condition and in particular her sensitivity to painkilling drugs and/or sedatives and/or narcotics and in particular morphine, which should not have been administered to her in the manner and/or to the extent and/or at the times which they were performed.

e. failed to monitor and/or supervise and/or control the amount of pain killing drugs and/or sedatives and/or narcotic administered while being aware of the dangers and/or risks of so doing to the deceased.

f. administered or allowed the administration of an excess and/or improper dosage and/or an overdose of morphine and/or pain killing drugs post-operatively thereby causing serious deoxygenation, loss of consciousness and serious brain damage.

g. failed to remain within or in the vicinity of the operating theater and/or recovery room and/or clinic until the patient's return to full consciousness and/or complete recovery from the anaesthetic and/or other drugs administered during the surgery.

h. handed over and/or delegated immediately after the operation and/or prior to the deceased's full and complete recovery from the anaesthetic and other drugs and/or return to full and pain-free consciousness, improperly to another Consultant Anaesthetist and/or failing to give the

latter sufficient information to allow him to properly and/or safely handle the deceased's post-operative recovery.

i. failed to inform the First Defendant and/or Dr. Chang of the amount of sedative and/or narcotics, and in particular morphine, administered before and/or during and/or following the surgery prior to handing over the deceased Dr. Chang and/or of the swelling and oedema in the area of the deceased's trachea, airway, vocal cords and her neck which would have caused her difficulty in and/or suppressed her breathing and/or the caused the cessation of breathing.

j. failed to resuscitate the deceased after the administration of morphine post-operatively even though all facilities and personnel needed to do so were readily available and/or immediately at hand, and/or alternatively, failing to ensure that such facilities and/or equipment and sufficiently trained and/or experienced personnel were in fact so available before the subject operation was commenced.

k. failed to direct or instruct any other member of the surgical team and/or any experienced and qualified nurse or other member of the First Defendant's staff that the deceased should not be administered any Morphine and/or sedative and/or narcotic drug post-operatively and/or that she should be continuously monitored on a 24 hour per day basis and placed in the First Defendant's "step down" facility and/or in a room in the surgical ward right next to the nearest nurses station for close observation and/or that she be placed in a comfortably reclined position to assist her in breathing and/or that a pulse oximeter and/or appropriate monitoring devices to monitor the patient's breathing and blood pressure be attached to the deceased from the time she left the operating theatre and/or recovery room until she fully recovered consciousness.

[71] For the sake of convenience I propose to deal with the particulars of negligence alleged against the Third Defendant in the following manner:

**Allegation (a)**

***failed to conduct any or any proper and/or systematic pre-operative assessment and/or to take full information or particulars of the full nature of the deceased's history and/or condition and/or of the nature of the Surgery then due to be performed.***

[72] There is no evidence to suggest that the Third Defendant failed to conduct a pre-operative assessment of the deceased or was unaware of her medical history or the surgeries to be performed on her on the 7th May 2007. Indeed what is clear is the fact that he had been advised of the difficulty in intubating the deceased and took steps to treat with this issue including retaining the services of an ENT Specialist, Dr. Shim to assist him.[36] He also testified[37] that he was aware of her history including the previous failed attempt to intubate her by another anaesthetist. This led him to consult with Dr. Dexter Shim an ENT surgeon; he asked Dr. Shim to bring to the hospital a flexible intubation laryngoscope, which is a tool used in challenging intubations in order to facilitate the intubation of Mrs. Masnan. He also testified that he spoke to Mrs. Masnan the night before her surgery, and discussed with her the process for administering the anaesthetic, the potential difficulty of intubation, and the fact that he had spoken to Dr. Shim with a view to using a flexible laryngoscope for her intubation. Dr. Mc Intosh asserted that Mrs. Masnan consented to the intubation processthat he described to her.[38]Indeed the Claimants' expert Dr. Anna-Maria Rollin accepted that there was contemporaneous evidence in the clinical record, that Dr. Mc Intosh did conduct a pre-operative assessment and that the details of this assessment are included in the anaesthesia records.[39]

[73] I accepted this evidence from the Third Defendant and in the circumstances this ground was not made out.

[36] Para 10 and 20 of the 3rd Defendant's Defence filed 16th Feb 2012
[37] Paras 6-8 of the Witness Statement of Dr. Mc Intosh
[38] Para 9 of the Witness Statement of Dr. Mc Intosh
[39] Para 129(a) of the report of Dr. Anna-Maria Rollin filed 23rd October 2018

**Allegations (b),(c), (d), (e),(f), and(i)**

**(b)** ***failed to inform and/or warn the patient pre-operatively of the risks of using and/or sensitivity to painkilling drugs and/or sedatives and/or narcotics and in particular Morphine.***

**(c)** ***failed to "red-flag" the patient and/or to make any or any proper note pre-operatively and/or during the Surgery and/or immediately thereafter on his chart in order to warn any other doctor and in particular the Second Defendant and/or Dr. Chang and/or the nursing and other staff of the First Defendant, or any of them, of the serious and/or significant risks associated with administering or using upon the deceased painkilling drugs and/or sedatives and/or narcotics including Morphine during and/or immediately after the Surgery, including the fact that the difficulty in intubating her pre-operatively would have caused trauma and/or swelling and/or oedema in the are of the deceased's trachea, airways an/or vocal cords and her neck which would lead to her having difficulty in and/or the suppression and/or cessation of her breathing.***

**(d)** ***failed to take any steps such as would have notified of and/or alerted Dr. Chang or any other doctor or medical care giver to the full nature of the deceased's condition and in particular her sensitivity to painkilling drugs and/or sedatives and/or narcotics and in particular Morphine, which should not have been administered to her in the manner and/or to the extent and/or at the times which they were performed.***

**(e)** ***failed to monitor and/or supervise and/or control the amount of pain killing drugs and/or sedatives and/or narcotic administered while being aware of the dangers and/or risks of so doing to the deceased.***

**(f)** ***administered or allowed the administration of an excess and/or improper dosage and/or an overdose of Morphine and/or pain killing drugs post-operatively thereby causing serious deoxygenation, loss of consciousness and serious brain damage.***

**(i)** ***failed to inform the First Defendant and/or Dr. Chang of the amount of sedative and/or narcotics, and in particular Morphine, administered before and/or during and/or following the surgery prior to handing over the deceased Dr. Chang and/or of the swelling and oedema in the area of the deceased's trachea, airway, vocal cords and her neck which would have caused her difficulty in and/or suppressed her breathing and/or the caused the cessation of breathing.***

[74] As indicated above, the Claimant has not established that the morphine which had been administered to the deceased post surgery for the management of her pain amounted to a breach of duty or was a causative factor in her cardiac arrest. In any event, morphine was not administered during surgery nor was Dr. Mc Intosh involved in prescribing this drug to Veena. In the circumstances these grounds of negligence must fail.

**Allegation (c)**

***Is there any evidence that the difficulty in intubating the deceased caused trauma and/or swelling and/or oedema in the area of the deceased's trachea airway and/or vocal cords which would lead to her having difficulty in/or suppress and/or prevented her from breathing?***[40]

[75] The Third Defendant denied that there was any trauma and/or swelling and/or oedema in the area of the deceased's trachea and the airway.[41] He pleaded that he had secured the use of a flexible laryngoscope to facilitate her intubation in anticipation of a potentially difficult intubation and was able to complete the procedure without causing any trauma, swelling or oedema to the Defendant's trachea. He testified[42] that during the intubation process he did not observe any trauma or swelling or oedema in the area of Mrs. Masnan's trachea or airway.

[76] I agree with the Third Defendant's submissions that there was no physical evidence of swelling or oedema in the area of the deceased's trachea or airway either during or after surgery. Dr. Mc Intosh had testified during cross-

[40] Para 70 (c) above
[41] Para 10 of the Third Defendant's Defence
[42] Para 14 of the Witness Statement of Dr. Mc Intosh

examination that there was no swelling or oedema before or after the operation. Dr. Rollin however was of the view that the intubation process, which was quite intrusive, may have caused swelling post operation, after extubation.In answer to Mr. Mendes, Dr. Mc Intoshat first testified that he did not examineVeena's larynx using the laryngoscope. He later said that he did. This seeming inconsistency however, was not sufficient to establish that there was swelling or oedemain the area of Mrs. Masnan's airway or trachea either during or after surgery or that any such swelling or oedema was the cause of her cardiac arrest. The opinion of the experts on this point is as a result speculative. I have also taken into account Professor Aitkenhead's opinion that *"the onset of upper airway obstruction related to traumatic tracheal intubation is a slow process. It does not cause sudden total airway obstruction. It is preceded by increasing stridor, distress and clinical signs, usually for several hours before total obstruction occurs, and patients are perfectly capable of calling for help long before that."*There is no evidence before me of Mrs. Masnan indicating that she was in any such distress before she was eventually found unresponsive. Indeed, the Claimants' own expert Dr. Frank Cross opined that a laryngeal oedema and or spasm would induce respiratory distress, but the patient would have had time to ring the emergency bell, "unless she were already unconscious".[43]It was Dr. Cross' opinion that the circumstance under which the deceased would have become unconscious would have been as a result of the morphine injection administered to her. It has already been established that the administering of morphine post surgery did not have this adverse effect on the patient; Dr.Cross is therefore in agreement with Professor Aitkenhead's opinion that the onset of upper airway obstruction related to traumatic tracheal intubation is a slow process since he is of the view that Mrs. Masnan would have had time to ring the emergency bell. This did not happen. As well, Dr. Rollin opined "it is likely but by no means certain that there was some oedema as a result of difficult intubation, it is also likely that this would increase over the ensuing few hours further compromising the airway"[44], thereby fortifying my view that there is no evidence before me that this was the cause of the deceased's collapse.

[43] Para 38(2) of Dr. Cross' Report filed 3rd March 2017
[44] Para 142 of Dr. Rollin's Report

**Allegation *c (i)***

***failed to perform a tracheostomy pre-operatively by which to administer anaesthetic to the deceased by that means, instead of by intubation.***

[77] I note that the Claimants' own expert Mr. Frank Cross was of the view that an elective tracheostomy was not a good recommendation for further surgery after the initial failed intubation.[45] Mr. Cross went on to state that this procedure is a *"fairly drastic manouveur"* which may be carried out for emergency or life saving surgery but not for elective surgery.[46]The Claimants' other expert Dr. Rollin agreed with Mr. Cross that a tracheostomy was not appropriate on the facts of this case since it carried significant long and short-term risks. She concluded that the expert use of a fiber-optic flexible scope was safer and less traumatic to carry out a controlled intubation.[47]Additionally, Professor Aitkenhead was also of the view that there was no indication that a tracheostomy should have been performed on the deceased; he stated that this procedure should only be adopted if more conservative attempts at tracheal intubation had failed and only after the consent of the patient had been obtained. For these reasons this ground also fails since there was no negligence in the failure to perform a tracheostomy and no causative link was established that the anaesthetist's choice of laryngeal intubation over a tracheostomy led to Mrs. Masnan's cardiac arrest.[48]

[78] I hold that this allegation was not made out by the Claimant since there is no evidence to support this allegation by any of the experts who testified in this matter. Further, Professor Aitkenhead opined that the flexible fiber optic laryngoscope used by Dr. Mc Intosh to intubate Veena*"is of very narrow diameter and, because it is small and flexible, results in very little trauma to tissues."*[49]He opined further that there was no reason to red flag Mrs. Masnan or warn medical or nursing staff about a high risk of airway obstruction post-operatively. He also stated that the predictable risks of airway obstruction after consciousness had been regained were no greater than the risks for any fit patient after abdominal or pelvic surgery. It was also his view that since the

[45] Para 42 of the Report of Mr. Frank Cross
[46] Para 42 supra
[47] Para 134 of the Report of Dr. Rollin
[48] Para 16 of Prof Aitkenhead's Report
[49] Para 15 of Prof Aitkenhead's Report

surgery did not involve the thorax, head or neck there was little chance of swelling or oedema[50].

***Allegation (g)***

***failed to remain within or in the vicinity of the operating theater and/or recovery room and/or clinic until the patient's return to full consciousness and/or complete recovery from the anaesthetic and/or other drugs administered during the surgery.***

[79] Dr. Mc Intosh's evidence is that he did not leave the hospital until Veena had made a full recovery in the recovery room by which time the effects of the anaesthesiahad been fully reversed and she was alert and conscious. The Claimants' expert Dr. Rollin agreed that given the condition of the patient post-surgery of being alert at the time of her return to the ward, it was appropriate for Dr. Mc Intosh to leave the hospital.[51] This evidence was not disputed in any way and indeed the Claimants confirmed that when Veena was taken to the ward, she was conscious and they were able to speak with her. Accordingly, this allegation also fails since there is no evidence to support it.

**Allegation (*i*)**

***failed to inform the First Defendant and/or Dr. Chang of the amount of sedative and/or narcotics, and in particular Morphine, administered before and/or during and/or following the surgery prior to handing over the deceased Dr. Chang and/or of the swelling and oedema in the area of the deceased's trachea, airway, vocal cords and her neck which would have caused her difficulty in and/or suppressed her breathing and/or the caused the cessation of breathing.***

[80] The allegation in (i) is not made out; in any event, the case against the Defendant was erroneously premised upon the fact that Dr. Chang had been involved in the surgical procedures on the 7th May 2007. This allegation was not pursued and therefore is not made out.

[50] Para 15 of Prof Aitkenhead's Report
[51] Para 139 of the Report of Dr. Rollin

**Allegation (j)**

***failed to resuscitate the deceased after the administration of Morphine post-operatively even though all facilities and personnel needed to do so were readily available and/or immediately at hand, and/or alternatively, failing to ensure that such facilities and/or equipment and sufficiently trained and/or experienced personnel were in fact so available before the subject operation was commenced.***

[81] The evidence in relation to this ground is that after the deceased went into cardiac arrest a 'Code Blue' was alarmed and Dr. Chang and other doctors at the hospital resuscitated the deceased. The Claimant's own witnesses found no fault with the SCMH's handling of the medical crisis.[52] This Defendant was not involved in the resuscitation and therefore this ground also fails.

**Allegation (k)**

[82] This ground contains several allegations against the Third Defendant as follows:

i. that he should have instructed the staff of the SCMH that Veena should have not been administered Morphine post operatively.

ii. that Veena should have been continuously monitored on a 24 hour daily basis and placed in the First Defendant's step down facility or in a room next to the nursing station for close observation.

iii. that Veena should have been placed in a comfortably reclined position to assist her in breathing.

iv. a pulse oximeter and/or appropriate monitoring device should have been attached to Veena in order to monitor her breathing and blood pressure from the time that she left the operating theatre and/or recovering room until she fully recover consciousness.

[83] On the facts of this case, Professor Naraynsingh agreed to write up the post operative notes and it was his decision to prescribe morphine for the patient. It has already been shown that the morphine thus administered to the patient did not cause her cardiac arrest. In any event, Professor Naraynsingh, having

[52] Para 143 of Dr. Rollin's Report

assumed the responsibility, quite properly wrote up the post operative notes and issued the instructions to the hospital. No breach of duty can be ascribed to this Defendant in relation to those instructions.

[84] On this issue, the evidence before me is that the surgical procedures performed on the deceased had been successful as was her intubation. She appeared to have regained consciousness after the surgery, and her recovery from the anaesthesia was uneventful. As noted above, when she was returned to the ward, she was able to speak to her relatives. Dr. Mc Intosh maintained that he saw no evidence of swelling or oedema in Veena's trachea or airways to suggest that she needed special 24 hour monitoring or placed in a high dependency ward.As stated above, there is no evidence as to the cause of the deceased's cardiac arrest. The Claimants' experts including Dr. Cross acknowledged this and gave possible reasons for her collapse.[53] In any event, the Claimants alleged that the Third Defendant's breach of duty of care involved the period from the time she left the operating theatre until she fully recovered consciousness. The evidence is that she did fully recover consciousness.

[85] There is no evidence before the Court as to the position to which the deceased had been placed when she was taken to the ward post surgery. In the circumstances, the Claimant has failed to establish on a balance of probability that there was a failure to position the deceased in a comfortably reclined position, or if such failure existed that it led to the Deceased's arrest.

[86] The Claimants alleged that a pulse oximeter and/or appropriate monitoring devices to monitor the patient's breathing and blood pressure should have been attached to her to monitor her breathing and blood pressure until she fully recovered consciousness. As noted above, the Claimant had fully recovered consciousness when taken to the ward. The evidence before me is that she was monitored every fifteen minutes during the first hour after she was warded during which her oxygen saturation level and blood pressure level were noted. Thereafter at half hour intervals notes were made with respect to her blood pressure and oxygen saturation. There was no indication that the patient had been having any difficulty until she was discovered in cardiac arrest at 1 p.m. The Claimant's pleading is limited to the period when the deceased would have

[53] Para 38 of the Report of Dr. Cross

regained consciousness; however, the evidence from the experts covered a broader period which fell outside the pleaded case. I also note that Professor Aitkenhead was of the view that there was no need for Mrs. Masnan to be continuously monitored after she regained consciousness.[54]

[87] The Claimant's own expert, Dr. Cross, opined that specific orders regarding the positioning of a patient must be written up by the surgeon. While Dr. Rollin[55] stated that there ought to have been collaboration between Professor Naraynsingh and Dr. Mc Intosh before Professor Naraynsingh wrote up the post operative directions, this was not the case advanced by the Claimantagainst this Defendant. This is a serious allegation which ought to have been pleaded so as to afford both doctors the opportunity to answer the plea. Additionally, it is clear from the evidence that Professor Naryansingh was very familiar with thispatient and had been present during a previous attempt to intubate her. There were no complications arising from the surgical procedures performed on the 7th May 2007; in the circumstances, the failure to consult with Professor Naraynsingh cannot in my view amount to a breach of duty of care by Dr. Mc Intosh nor does it establish a causative link between this failure to consult and the Deceased's cardiac arrest. As noted above, there being no evidence relative to the cause of Veena's cardiac arrest, on the facts of this case, I do not consider that the failure to consult with Professor Naraynsingh with respect to the post-operative instructions caused said arrest.

[88] I note that Professor Aitkenhead did not consider such consultation to be either normal or necessary. Dr. Aitkenhead went on to say that *"the predictable risks in the post-operative period were no different in Mrs. Masnan's case to the risks in any fit adult patient who has undergone abdominal and pelvic surgery."*[56]

[89] Professor Aitkenhead after considering the medical reports and the evidence of the physiciansconcluded*"that, in all respects, the care which he, (Dr. Mc Intosh) provided was of a standard which would be regarded as proper by reasonable and responsible body of anaesthetists."*[57]

[54] Para 15 of Prof Aitkenhead's Report
[55] Para 132 of the Report of Dr. Anna-Maria Rollin
[56] Para 21 of Prof. Aitkenhead's Report
[57] Para 26 of The Report of Prof. Aitkenhead

[90] In my analysis of this case, I found that the opinions of the medical experts called on behalf of all of the Defendants to be reasonable and ones which the responsible experts in a comparable position could reasonably hold.

[91] In the circumstances, I hold that there was no breach of duty of care by Dr. Mc Intosh in his care of the deceased. Further, there is no causative link in the evidence between any of his actions before, during and after the surgical procedure and the cardiac arrest of Mrs. Masnan. Accordingly I hold that he is not liable in negligence for the arrest and subsequent death of Mrs. Masnan.

[92] As noted earlier, the burden of proof lay with the Claimants to establish a breach of duty of care on the part of each Defendant and that that breach of duty caused the death of the deceased. I hold that the Claimant has failed to discharge that burden of proof on a balance of probability against all the Defendants.

[93] Accordingly,

a. The Claimants' case is dismissed against all the Defendants;

b. The Claimants to pay to the Defendants two-thirds of their prescribed costs to be assessed by the Registrar in default of agreement.

**Joan Charles**
**Judge**