REPUBLIC OF TRINIDAD AND TOBAGO

IN THE HIGH COURT OF JUSTICE

Claim No CV 2008-02135

BETWEEN

DEONATH RAMKISSOON
(LEGAL PERSONAL REPRESENTATIVE OF THE ESTATE OF THE LATE AARON RAMKISSOON)

First Claimant

DENECIA SOOKRAM

Second Claimant

AND

THE EASTERN REGIONAL HEALTH AUTHORITY

Defendant

Before the Honourable Mr. Justice Vasheist Kokaram
Date of Delivery: 16th December 2009
Appearances:
Mr. A. Ramlogan, Ms. M. Ramsundar for the Claimant
Mr. K. Sagar for the Defendant

JUDGMENT

Introduction:

1. Mrs. Denecia Sookram was admitted to the Sangre Grande Hospital ("the hospital"), an institution under the management of the Defendant on the 11th January 2005. At that time she was then 38 weeks pregnant and was in very early labour. On said day at 11:16am Mrs. Sookram eventually gave birth to Aaron Sookram who for convenience I will refer to as "the mother" and "the baby" respectively. All was not well as the baby had an APGAR score of 7

at birth and a score of 9 five minutes after birth[1]. No further tests or X-rays were ordered at that time. At 3:30a.m on the following day a problem was detected with the baby. The baby was observed to be cyanosed, meaning that not enough oxygen was going into the baby's lungs. The baby at that time was being breast fed by the mother who contends that before she was allowed to burp the baby, he was taken away from her and placed in an incubator. After the baby was taken from his mother and between the hours of 3:30a.m and 11:30a.m, the baby was under the care and management of the hospital staff. The next occasion, on which the mother was allowed to see her baby, he was in the incubator cold and lying still, was no longer breathing and had subsequently died.

2. Both parents have commenced this action against the Defendant for damages in negligence. The First Named Claimant, the father of the baby brings the action on behalf of the estate of the baby under the Supreme Court of Judicature Act Chp.4:01.

3. The mother brings her claim for general damages for negligence attributed to the staff of the hospital in their treatment of her baby during the course of the delivery of her baby and nervous shock as a result of death.

4. Both parties in this action accept the standard to be applied in assessing the treatment of the baby by the medical staff as explained by MC Nair J in **Bolam v Friern Hospital Management Committee** [1957] 2 All ER 118 at page 121:-

> "Before I turn to that, I must explain what in law we mean by "negligence". In the ordinary case which does not involve any special skill, negligence in law means this: Some failure to do some act which a reasonable man in the circumstances would do, or doing some act which a reasonable man in the circumstances would not do; and if that failure or doing of that act results in injury, then there is a cause of action. How do you test whether this act or failure is negligent? In an ordinary

[1] An APGAR score: "This is used to measure the baby's general condition at birth. It records the baby's grimace, colour of baby, limbs, cry, grasp, breathing and later is reviewed by the Doctor. The APGAR are 5 factors and 2 marks are allocated for each factor. The baby had an APGAR score of 7 at birth and 9, about 5 minutes later. This would have meant that even though the baby cried at birth it was not lustily or for a long period. A 7-9 score would mean that all was not well with the baby." See evidence in chief of Nurse Mills.

case it is generally said, that you judge that by the action of the man in the street. He is the ordinary man. In one case it has been said that you judge it by the conduct of the man on the top of a Clapham omnibus. He is the ordinary man. But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. I do not think that I quarrel much with any of the submissions in law which have been put before you by counsel. Counsel for the plaintiff put it in this way, that in the case of a medical man negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if a medical man conforms with one of those proper standards then he is not negligent. Counsel for the plaintiff was also right, in my judgment, in saying that a mere personal belief that a particular technique is best is no defence unless that belief is based on reasonable grounds. That again is unexceptionable. But the emphasis which is laid by counsel for the defendants is on this aspect of negligence: He submitted to you that the real question on which you have to make up your mind on each of the three major points to be considered is whether the defendants, in acting in the way in which they did, were acting in accordance with a practice of competent respected professional opinion. Counsel for the defendants submitted that if you are satisfied that they were then it would be wrong for you to hold that negligence was established."

5. It is true that doctors much like lawyers cannot guarantee a favourable outcome from their efforts. This is far from saying however that a professional owes no duty to expend all reasonable efforts to secure a favourable outcome. I must say from the outset that whereas the Claimant has advanced one school of medical opinion on the failure to burp a new born

baby and the treatment of a cyanosed baby, the Defendant has failed to provide to this court with any reliable evidence to support any other competing standard. The only evidence adduced by the Defendant in the field of pediatrics was a witness statement of Dr. Selwyn Beharry. However Dr. Beharry was unable to attend the trial having suffered a stroke and the statement was admitted under the exception to the hearsay rule. His testimony did not therefore come under cross examination and very little weight can be placed on it. Further, he was not the attending pediatrician during the critical time period of 3:00a.m to 11:30a.m. His services were engaged days after the death to review the hospital notes. It is lamentable that Dr. Beharry's evidence in chief states that the appropriate treatment of the baby is to place it in "a respirator in a warm environment, suctioned and observed". However, there is very little said by the Defendant in this case of any observation of this baby by any medical staff during the critical time period.

6. In my assessment of the evidence I find that the mother's version of the events of the critical time period to be credible and that the Defendant by the testimony of its own witnesses have accepted that the standards of the ordinary competent practitioner were not met. My conclusions can be summarized as follows:

    a. The baby was taken away from the mother at 3:30a.m immediately after feeding him and while the mother was in the process of burping him.

    b. Burping is a standard practice with known medical benefits for a new born infant. It releases air from the lungs and prevents the regurgitation of stomach contents and mucus.

    c. The cause of the baby's death was due to respiratory failure caused by asphyxia following feeding. The cause of death is not due to a premature lung as contended by Dr. Beharry. The cause of death is consistent with the baby's regurgitation of stomach content.

    d. The failure to burp the baby is consistent with the cause of death, "asphyxia following feeding" and the findings of Dr. Wayne Mohammed, the pathologist that performed the autopsy on the child.

e. Even if the failure to burp the child was not the cause of the baby's death, the duty nurse and doctor failed to exercise the proper care and skill in the treatment of the baby during the critical period.

f. The duty doctor failed to respond in a timely manner or at all for that matter to the call from the nurses for help and the special needs of the baby which was low birth weight and exhibiting signs of cyanosis.

g. The duty nurses failed to monitor the baby on regular intervals and left the baby unattended or without any medical treatment during the critical period. Conducting X-Rays of the baby at 10:30a.m when it was in respiratory distress since 3:30a.m was too little too late.

h. The medical staff displayed a remarkable indifference to the needs of this baby which the Defendant admits exhibited all the tell tale medical signs of one that deserved careful and urgent medical attention.

i. There is no body of opinion to support the Defendant's handling of the baby and the opinions of the Defendant's nurse and Dr. Beharry with regard to this cyanosed baby cannot withstand any logical analysis.

j. The first Claimant is entitled to damages for negligence by the Defendant in the treatment of the baby leading to his death.

k. There was no negligence by the Defendant in the treatment of the hospital staff in the delivery of the baby. The mother is not entitled to damages for the recovery of pain and anguish attendant on the loss of her baby.

The agreed chronology:

7. The parties submitted an agreed statement of facts and agreed chronology which set out the events and timelines leading up to the death of the baby. The chronology was based upon the notes and records of the hospital. In essence the agreed chronology of events are as follows:

DATE	TIME	EVENT
11.01.05	2:20am	Second Claimant admitted to Sangre Grande Hospital.
	6:30am	Patient began having contractions.
	8:00am	Patient taken over to the Delivery Room having contractions of 1-3 moderate.
	11:16am	Labour progressed to a spontaneous vaginal delivery of a live term male infant. APGAR 7^{1} 9^{5}.
	3:00pm	Infant was breastfed.
	6:00pm	Infant breastfed.
	8:30pm	Infant breastfed. Infant reported to be feeding well.
12.01.05	3:00am	Infant crying and mother encouraged to breastfeed. Infant breastfed.
	3:30am	Infant very muffled – groaning and grunting. Infant skin cyanosed. Oxygen 2-3g given via face mask.
	6:00am	Infant still grunting and crying. Oxygen continued. Skin pink.
	6:15am	Duty doctor informed of need to review the baby.
	8:00am	Infant was seen by Duty Doctor and an X-Ray was ordered. X-Ray commenced.
	9:35am	Infant taken to the X-Ray Department and an X-Ray performed.
	10:30am	X-Ray reviewed by Dr. O Ewedemi with instructions that the infant be monitored frequently.
	11:20am	Infant appeared to be not breathing and Duty Doctor informed to see infant. Infant nursed in incubation with Oxygen 5g via tubing. Infant's skin colour mildly pink. H R nil. R R Nil.
	11:35am	Infant reviewed by Dr O Ewedemi, certified dead. Dr. Ewedemi informed Second Claimant. Second Claimant signed form for Pist Mortem.
	1:30pm	Second Claimant discharged home with necessary documents and advice.

The plea of negligence:

8. From the outset, it is important to note that the Claimants' claim as set out in their Claim Form and Statement of Case is for damages for medical negligence for the death of the baby and not for the alleged ill treatment of the mother during the course of her delivery. The particulars of negligence pleaded are confined to the alleged lack of care in the treatment of the baby and are set out verbatim as follows:

   "By reason of the matters aforesaid and due to the negligence of the Defendant his (sic) Servant and/or Agents the Claimants suffered loss and damage.

Particulars of Negligence

a) Failing to take any or any sufficient measures to safeguard the interest, life and welfare of the Claimants' baby;
b) Failure on the part of the duty nurse to allow the Second Claimant to burp her baby soon after breast feeding;
c) Failure on the part of the duty nurse to burp the Claimants' baby soon after the baby was breast fed;
d) Failure on the part of the duty nurse to take special care when dealing with the Claimants' low birth weight baby;
e) Failure to staff the Hospital with suitably skilled, experienced, qualified and/or competent staff;
f) Failure on the part of the duty nurse to apply the correct procedures in dealing with the Claimants' low birth weight baby soon after breast feeding;
g) Failing to use reasonable care, diligence in and about the treatment and/or attendance given to the Claimants' baby;
h) Failing to exercise reasonable care and skill in the treatment of the Claimants' baby by both the duty doctor and duty nurse;
i) Failure on the part of the duty doctor to respond in a timely manner to the needs of the Claimants' baby in distress;
j) Treating the Claimants' baby inexpertly;
k) Failing to provide suitable skilled and experienced staff to deal with the Claimants' baby;
l) Failing to provide a system and/or any adequate system and/or procedures to deal with a situation where the nurse on duty could not provide adequate care and attention to the Claimants' baby."

9. By reason of the alleged negligence the Claimants plead that they suffered pain injury and damage. The particulars of the injuries suffered as pleaded by the Claimants are:
    - Extreme Pain and suffering
    - Mental anguish
    - Nervous shock

10. The mother also contends that by reason of the negligence of the Defendant, its servants and/or agents, she suffered the loss of the child, great distress, anxiety and inconvenience. Again it must be noted that whereas in this case there is evidence of the loss of the child and attendant grief, distress and anxiety, there is no evidence of damage in the form of nervous shock or psychiatric illness caused by the loss of the child.

11. The Defendant contends that the baby was born under weight and with under developed lungs which was contributed or caused by the fact that the mother was anemic. No evidence was led in this case to support this plea. The Defendant also contends that the baby was taken away to be given oxygen support as a result of under developed lungs. There is no evidence advanced in this case to demonstrate that the difficulty experienced by the child was as a result of under developed lungs. The Defendant further contends that it exercised the standard of the ordinary skilled person in performing their functions and duty to the infant.

12. The Defendant contended that:
    (a) At all material times the Defendant's nurses took sufficient measures to care /to safeguard the life of the said baby.
    (b) At all material times the hospital was suitably staffed with skilled and experienced personnel who in the performance of their duty exercised the care and skill required of them as the ordinary skilled person exercising and professing to have that special skill as, nurses, nursing assistants and doctors.
    (c) The duty nurse did apply the correct procedure in dealing with the said baby as was prescribed and obtained at the material time.
    (d) At all material times the duty doctor did respond in a timely manner to the needs of the said baby and in fact exercised the care and skill required of him towards the infant.

13. The Defendant further contended as follows:
    (a) The said baby was born on the 11th January, 2005 under normal weight 2070 grams and with under developed lungs. For the First day the baby was breast fed and observed to be doing well.

(b) The said baby was observed breathing abnormally and skin cyanosed at about 3:30a.m on the 12th January, 2005 and was thereupon taken from the mother and placed in the respirator and given oxygen via a face mask which was the normal and accepted treatment at that time.

(c) At all material time if the baby was not burped (which is not admitted) he was placed in the respirator to lie on his side with a towel/blanket rolled in a cylindrical manner along his back to keep him in the side position so that if he vomits it would run out at the side of his mouth, which was also the normal and accepted treatment at the material time.

(d) The said baby was taken for X-Ray on the shift of Nurse Mills that is from 8:00am on the morning of the 12th January, 2005 in accordance with, normal, accepted practice.

(e) After the X-rays were taken the said baby was constantly monitored by competent staff in the nursery until the baby died at about 11:35am the said day.

(f) At all material times during the shift of Nurse Mills the Doctor on duty duly examined the X-ray report and ordered that the baby be given oxygen and properly monitored in the incubator.

(g) At all material times also the accepted practice for treatment for a cyanosed condition in an infant is for the baby to be given oxygen, placed in an incubator and wrapped in a blanket to keep warm all of which was done in his case.

14. As will be seen in the analysis of the evidence led in this case, there is no evidence adduced to demonstrate the position of the baby during the hours of 3:30a.m to 8:00a.m on 12th January 2005. There is no evidence that the baby was "constantly monitored" during the critical time period as alleged by the Defendant. For the purpose of satisfying the *Bolam* test the Defendant contends that the acceptable practice for the treatment of a cyanosed baby is for it to be "given oxygen, placed in an incubator, wrapped in a blanket to keep warm." The Court must be astute to determine whether any expert evidence has been led to support this practice and ultimately determine rather than accept this on face value in the context of this case to analyze the underlying logic of this practice to determine the reasonableness of this standard.

The agreed issues:

15. The parties set out the following issues for determination in this action:

1. Whether the Defendant, its servants and/or agents failed to take any or any sufficient measures to safeguard the interest, life and welfare of the Claimants' baby.
2. Whether burping the baby was a standard medical practice and whether the duty nurse had a duty to burp the Claimant's baby. Whether the duty nurse, failed to allow the Second Claimant to burp her baby soon after breastfeeding, if special care was required at the material time.
3. Whether the duty nurse failed to burp the Claimants' baby soon after the baby was breastfed.
4. Whether the duty nurse failed to take special care when dealing with the Claimants' low birth weight baby.
5. Whether the Defendant, its servants and/or agents failed to provide suitably skilled, experienced, qualified and/or competent staff to care for the Claimants' baby.
6. Whether the duty nurse failed to apply the correct procedures in dealing with the Claimants' low birth weight baby soon after breast feeding.
7. Whether the Defendant, its servants and/or agents failed to use reasonable care and diligence in the treatment and/or attendance given to the Claimant's baby.
8. Whether the duty nurse failed to exercise reasonable care and skill in the treatment of the Claimants' baby.
9. Whether the duty doctor failed to exercise reasonable care skill in the treatment of the Claimants' baby.
10. Whether the duty doctor failed to respond in a timely manner to the needs of the Claimants' distressed baby or whether having regard to the prevailing circumstances he acted reasonably and with the required degree of skill and care.
11. Whether the Defendant, its servants and/or agents treated the Claimants' baby inexpertly.
12. Whether the duty nurse provided adequate care and attention to the Claimant's baby and whether in the prevailing circumstances the Defendant, its servants and/or agents provided a system and/or adequate system and/or procedures to deal with the situation.

13. Whether the Defendant, its servants and/or agents failed in their duty to commence resuscitation of the Claimants' baby at the material time, and if resuscitation was necessary or required then.
14. Whether the failure to burp the baby caused the said Asphyxia which led to the death of the Claimants' baby and whether the burping of the baby was accepted standard medical practice.
15. Whether the Defendant, its servants and/or agents were negligent in the treatment of respiratory distress and cyanosis of the Claimants' baby.

The evidence:

16. In my analysis of this case I have considered both the documentary and oral evidence. With regard to the documentary evidence, the parties agreed a core bundle of documents.

17. The Claimant adduced oral evidence through the Claimant and Dr. Hoyte. The Defendant called two witnesses, Nurse Mills and Dr. Wayne Mohammed, the pathologist. Dr. Beharry's witness statement was adduced into evidence under the exceptions to the hearsay rule by notice dated and filed 26th October 2009. I now assess the evidence before me in turn.

Mrs. Deneica Sookram (the mother):

18. The mother was a simple lady and her evidence was uncomplicated. By her demeanor and responses in cross examination she appeared to be frank and truthful. Under cross examination her account of the critical time frame was instinctive and credible. In essence her evidence can be summarized briefly as follows.

19. She went into the delivery room at the Sangre Grande Hospital around 10:00a.m on January 11, 2005. The experience in the delivery room with Nurse Mills was not a pleasant one as she was yelled at by the nurse and was slapped on her arms and legs. Although denying this rough treatment Nurse Mills recorded in the notes that the patient was "uncooperative". The mother delivered her baby at 11:16a.m. She was shown that he was a boy and the mother was happy about her delivery but Nurse Mills broke her mood by screaming "this is the worst delivery in all my years". Shortly after leaving the delivery room she breastfed the baby, burped him and he fell asleep. Around 2:30a.m the following day baby awoke and she breastfed him, he then started to cry and so she put him on her shoulder to burp him. Before

she could burp the baby, she alleges that Nurse Mills stormed in the room and shouted at her and took the baby away. She alerted to Nurse Mills that she had not yet burped him.

20. There are two difficulties with this evidence. First the hospital notes records that the baby was taken at 3:30a.m and not 2:30a.m. This discrepancy however in my view is not material as there is no denial that the baby was taken from the mother early that morning. Whether it was 2:30a.m or 3:30a.m the fact remains that the mother stoutly maintained in cross examination that she was not allowed to burp the child after having breast fed him. This testimony remained unshaken. According to her, the process of burping her baby took 4 to5 minutes. This is confirmed by other evidence adduced in this case through Dr. Mohammed and Dr. Hoyte. Accepting this, it must mean that when the baby began to cry she placed the child on her shoulder preparing to burp him. The nurse on duty entered the room, took the baby from her and placed him in an incubator.

21. Second, there is simply no evidence to contradict the mother's version of events. There is no record in the hospital notes of exactly when the child was taken from the mother. Dr. Beharry draws the following conclusion from the hospital note:

    - "3:30a.m Infant cry muffled on checking. Infant skin cyanosed groans and grunting". The mother was quite clear in her evidence that when the baby was taken away from her it was not grunting or groaning it was crying. Nurse Mills was adamant that she was not on duty at that time and that her shift ended at 3:00p.m on the previous day.

    - The hospital records do reveal that one C. Mills last signed the notes at 12:00p.m on 11th January 2005 and then at 8:00a.m on 12th January 2005. Whether the mother was mistaken as to the identity of the nurse on duty at 3:00a.m on the morning of January 12, 2005, is in my view immaterial.

    - The child was taken away from the mother before she had the opportunity to burp the child. She then went back to sleep. This remains un-contradicted.

    - It is also probable that the child was taken away while it was crying, the mother not hearing any muffled noises from her baby. There is no evidence from the Defendant to demonstrate that the muffled noise from the baby was observed while it was with

the mother or when it was already taken away from the mother and placed in an incubator. In any event I accept the mother's evidence that the baby was taken away from her before she had the opportunity to burp him.

22. In cross examination the mother admitted that she saw her child with an oxygen mask placed over his face but was not told what was happening to him and that she should go back and lie down. She also saw him going for an X-Ray later that morning but was told that he had difficulty breathing.

23. After 11:00a.m on the morning of January 12, 2005, she was told that her baby died and she was then allowed to view the body. She began to cry and became beside herself with grief. On 13th January she arrived at the mortuary in time to collect her baby's body before it was disposed of despite her previous request that she should be allowed to collect and bury her son. Her anguish affected her relationship with her husband. She slept separately from her husband for several months. She could not look at children as she felt sad that she herself lost her child. She however became pregnant again in 2005 and successfully delivered her second child.

The medical evidence:

Dr. Hoyte

24. The medical evidence in this case in the field of pediatrics was given for the Claimant by Dr. Ralph Allan St. Clair Hoyte and for the Defendant by Dr. Beharry, with the limitations already observed earlier in this judgment.

25. Dr. Hoyte is a specialist obstetrician and gynecologist. He worked in maternity departments in hospitals in Scotland, Jamaica, Trinidad and Tobago and Dutch Gold Coast West Africa. He has had an impressive career in the field of medicine in this country and was awarded the Chaconia Medal Gold in recognition of his service. He is intimately familiar with the hospital as he was at one time in charge having set up systems and procedures in place for the maternity ward. I remain cautious in assessing his evidence as it was based upon a statement given to him by the mother which he wholeheartedly accepted. The following elements of his evidence are however useful:

(a) There is a medical benefit to the infant baby of burping after feeding. It releases air which is sucked in by the baby when it is feeding. If not burped properly the baby can regurgitate milk and mucus and drown.

(b) Burping is a standard and common procedure but not necessarily a medical procedure.

(c) He expressed alarm that the nursing staff would not have allowed the mother to complete the process of burping.

(d) The symptoms of cyanosis were consistent with the failure to burp the baby.

(e) There are two procedures to treat cyanosis: administer oxygen and remove the blockage. He maintains however that removing the blockage would entail burping the child.

(f) He surmises that the baby was placed face down in the incubator.

(g) He noted as well a critical lull in the nursing activities from his experience around 7:00a.m. He also pointed out that the baby was in obvious distress and there is a critical lull in activity in monitoring this child between 6:15a.m and 8:00a.m.

(h) His evidence however is consistent with the cause of death as asphyxia following feeding. The low birth weight of the child was not the main cause of death.

26. It is the critical lull in activity of the nursing staff referred to by Dr. Hoyte which will ring true with the evidence of the Defendant's own witnesses.

Dr. Beharry

27. Dr. Beharry is a qualified pediatrician. Very little weight can be placed on his statement untested in cross examination. Further the evidence is based upon a review of the notes in this matter. However many statements have been made without support from the notes adduced into evidence in this case such statements include:

(a) That the baby was taken from the mother's side and placed in the nursery with oxygen by face mask and observed.

(b) That the baby was reviewed by a doctor at 7:00a.m.

(c) The baby had an episode of cyanosis and respiratory distress which was apparently resolved with oxygen therapy and warmth. This is not consistent with his own notes that there was peripheral sign of cyanosis at 9:30a.m. Further Nurse Mills' observations revealed she saw the child as cyanotic when she assumed duties at 7:00a.m.

(d) That the baby died from a premature lung.

28. Dr. Beharry certainly supports Dr. Hoyte on the critical lull of inactivity in the monitoring of the baby. At 3:30a.m the baby was in distress. The nurse however calls the doctor on duty three hours later. The baby was reviewed some three hours later at 9:30a.m. The plan according to him was to observe the baby carefully; however there is no recorded notes of regular or careful observations of the baby between 3:30a.m to the hours of its demise at 11:30a.m. The recorded observations or comments on the child's recovery were sporadic. This sequence of events contradicts the notion put forward that the recommended standard in relation to the care offered to the baby was in fact observed, that is that the baby was: "placed in a respirator, in a warm environment, suctioned and observed."

General Practice:

29. Both Nurse Mills and Dr. Wayne Mohammed provide useful testimony as to the general practice in the assessment of this case. I made the following observations of their evidence.

Nurse Mills:

30. In her testimony she stated that she was unable to say what position the baby was placed before 7:00a.m. She observed the child as still being cyanosed. This in spite of the notes saying the child was pink at 6:00a.m. Clearly the distress of the child had not yet alleviated when Nurse Mills took up duty. She contends that the only procedure for the cyanosed child is oxygen therapy. This is unsupported by Dr. Beharry, Dr. Hoyte and Dr. Mohammed.

Dr. Mohammed:

31. Dr. Mohammed is not employed by the Defendant. He also stated his qualifications as a medical practitioner and spent time in his training on pediatric wards. He is a pathologist who conducted the autopsy of the baby subsequent to its demise. His conclusion of the autopsy

revealed the child died of asphyxia in a preterm neonate with associated umbilical sepsis. He also listed immature lungs as a contributing factor.

32. Significantly he noted that this was a baby that deserved special treatment.

> "There could have been many different causes for the asphyxia leading to the obstruction of the baby's breathing some examples being regurgitation of stomach content, bedding obstruction, excess mucus in nostrils causing blockage. At the time of the post mortem I did not have details as to position that the baby was placed in on the bed so that I was not able to provide any specific cause for the asphyxia. It should be noted that this baby was pre term with immature lungs. Such babies are less likely to survive asphyxia because they would already have breathing problems due to immaturity of the lungs. Any obstructions of the breathing would aggravate their condition."

33. In his cross examination he made several concessions and corroborated the evidence of the Claimant. He conceded that the baby did not die of congenital heart disease which was suggested by the doctor. Also he stated that the baby became cyanotic after feeding. The cyanotic state of the baby could have been caused by "a number of reasons sever congenital heart disease or if some reason the food went down the wrong passage". This baby being a pre term baby needed special attention, since he was considered as being at risk. He commented "they are at risk you need careful monitoring support and care. They need special treatment." He made mention of the fact that cyanosis is not fatal however it is a sign that there is respiratory distress. As such the appropriate ventilator support which would include oxygen should be administered by incubator or a tube to the baby in distress. Further he highlighted that a proper examination is needed to detect the underlying cause of the respiratory distress. This included physical examination of the oral cavity to determine blockages which are occurring in the baby.

34. Dr. Mohammed was adamant in stating that underdeveloped lungs will not lead to sudden death. However no matter what position the baby lies in after being fed, the risk of regurgitation is present if the baby is not burped. With food in the lungs it can cause the baby to die instantly or the food can get down in the lungs and set up a reaction over a period of hours sometimes days.

35. With respect to the treatment meted out by the hospital staff, Dr. Mohammed found that there is a deficiency in the records.

> "It is an infant. You must record physical condition of the respiration system. This has to be done very often. This baby has to be continuously monitored for pulse rate, respirator rate pulse rate physical appearance."

Q: *By whom?*

A: The attending medical personnel. I normally include everyone.

Q: *Would you expect a doctor to be actively involved?*

A: Yes not necessarily continuous monitoring. But present at the bed side I don't expect him to be taking the vital signs but should be available on site.

Q: *But after detecting when the skin was pink there was no underlying cause because it was pink?*

A: The skin turned pink and the infant grunting or crying it means they were buying time.

The law:

36. In analyzing the law of medical negligence. The starting point is the *Bolam* test which has been restated in many cases, most recently dealt with in the Court of Appeal in **Deonarine v Ramlal** CA Civ 28 of 2003:

> "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."

37. It is not sufficient for a Claimant to succeed to simply show that there was a body of opinion that may not have approved of the practice of the medical practitioner if there also existed a

body of equally competent opinion that supported it. This Court is not bound to hold that a defendant escapes liability for negligence just because he leads evidence from a number of medical experts who support the decision taken by the defendant. This was held to be so in **Bolitho v City and Hackney Health** [1997] 4 All ER 771:

> "…the Court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. "In Bolam's case … Mc Nair J. stated that the defendant had to have acted in accordance with the practice accepted as proper by 'responsible body of medical men'. … Later he referred to a 'standard of practice recognised as proper by a competent reasonable body of opinion' …. Again, in the passage which I have cited from Maynard's case, Lord Scarman refers to a 'respectable' body of professional opinion. The use of these adjectives – responsible, reasonable and respectable – all show that the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."

38. The Court of Appeal in **Deonarine** commended the approach as determining whether in the face of competing opinions whether the opinion of the Respondent is indeed a defensible conclusion. The issue in this case therefore was whether the decision to not burp the baby was a defensible proposition. In the circumstances of this case and in light of the evidence adduced, it is not. There is a link to the failure to burp and the regurgitation of stomach contents leading to the aggravation of the trachea. There is no one who gave evidence in this court who observed the baby between the hours of 3:00a.m to 7:00a.m, the critical time period. At that time Nurse Mills would have noticed the child as still cyanosed until it died. Oxygen therapy clearly was not adequate as it temporarily relieved the baby at 6:30a.m only to be cyanosed again at 7:00a.m. This dramatic inadequacy of oxygen treatment was demonstrated at the very last moment when oxygen was administered, the baby turned pink and then it died.

39. Furthermore it is unsatisfactory in this case for the baby to have exhibited all symptoms of distress and yet no one monitored the baby regularly nor did the doctor himself see it fit to review the baby until hours after he went into distress. Even at that point in the notes Dr. Mohammed noted conversations being had about conducting an X-ray but no such conversation was had concerning the state of the infant.

40. In the circumstances, the Defendant's failed to pay regard to the obvious signs of distress of the baby. In accordance with the opinions expressed by Dr. Hoyte and Dr. Mohammed, the baby was exposed to obvious risks that could have been guarded against had regard been paid to the need to detect the underlying cause of the cyanosis, the respiratory difficulty. The continued cyanosis in a low birth weight child with immature organs vulnerable to respiratory difficulties should have prompted more aggressive and more proactive action before leisurely embarking simply upon a course of oxygen treatment.

41. From all accounts expressed by all the witnesses, this baby was unsupervised and not monitored properly at all for hours. Further based on the admission of Nurse Mills the intervention of the doctor was needed urgently.

42. I find therefore that the Defendant was negligent in its treatment of the baby.

43. It is now necessary to consider whether this negligence caused the death. The answer to that question is pellucidly yes. A doctor would have reviewed the baby in the early morning when he was called. A physical examination would have revealed the inflamed trachea. Alternative methods of administering oxygen could have been utilized such as inserting a tube into the lung. Quite apart from the lack of foundation for the standard advanced by Dr. Beharry, this case unlike in **Bolitho** can be resolved without substituting my views with the medical opinion, as the medical opinion in this case has consistently pointed out key signposts of a breach of care. These include no effective monitoring of the baby; no response by the doctor on call; an x-ray which was performed 7 hours after there were signs of respiratory distress; all of which lending to the cause of death "asphyxia following feeding".

44. The Defendant contends in this case, that what was done with this child was standard nursery practice. No effective monitoring, the failure of doctors to respond to calls of distress, the

failure to detect early underlying causes of cyanosis, the over reliance on one treatment which clearly after 4 hours was not working; as Dr. Mohammed stated the obsession with talk about doing something without actively managing the child cannot in my view logically be defended as "standard nursery practice". Accordingly I find that the Defendant's negligence in the management of the baby resulting in its death.

Damages:

45. The first Claimant brings this claim in his capacity as the Legal Personal Representative of the estate of the baby for the benefit of the baby's estate under the Supreme Court of Judicature Act Chapter 4:01. There is no claim under the Compensation for Injuries Act Chapter 8:05. No submissions were made by the Claimant's attorney at law in support of its claim for damages under the Supreme Court of Judicature Act. However it is trite law that the estate of the baby is entitled to recover special damages; damages for pain and suffering; a conventional sum representing the deceased's loss of expectation of life and loss of earning which would have accrued to the deceased in the "lost years". See P**ickett v British Rail Engineering** [1979] AER 799.

Pain and Suffering:

46. Such damages are usually small as death so often follows quickly upon the injury. In **Hicks v Chief Constable of South Yorkshire Police** [1992] 1 AER 690, Parker LJ stated:

> "When unconsciousness and death occur in such a short period after the injury which causes death no damages are recoverable. The last few moments of mental agony and pain are in reality part of the death itself."

That type of case as contemplated by Parker LJ in which no damages are recoverable are those where unconsciousness has relieved the victim of any physical pain or where the moments of agony immediately precede the death or where the circumstances surrounding the death are unknown.

47. In **Hicks,** the death of the victims in the horrifying crush in the Hillsborough Stadium was caused by asphyxia. However there was no indication of the manner in which the asphyxia was brought on "whether for example by a slow but steady increase in pressure in the press of bodies or by sudden pressure against a barrier or by being under a heap of other people the

combined weight of which produced the asphyxia from which death resulted. In any event the episode occurred within a half hour time frame."

48. In the instant case the baby was in obvious distress for a period of some 7 hours between 3:30a.m to its ultimate demise at 11:30a.m. It began with the baby grunting and groaning and exhibiting cyanotic symptoms. Dr. Mohammed explained that the baby's trachea was inflamed which suggested the regurgitation of stomach content. The baby's colour turned blue even before he died according to the testimony of Dr. Mohammed. I am satisfied that in this case that the baby was in a degree of pain and difficulty. Dr. Mohammed explains that death was a result of asphyxia following feeding which took place around 3:00a.m.

49. There is no firm evidence however of the baby's condition throughout the 7 hour period. I would award a notional award for pain and suffering in the sum of $7,000.00.

Loss of expectation of life

50. I will award the conventional award for loss of expectation of life in the sum of $15,000.00 for the estate of the baby. See HCA 1742 of 1993 **V Ramsingh v Butcher**.

The lost years

51. I agree with the Defendant that no award is to be given for loss of earnings in the lost years. To do so would be engage in a speculative and fanciful exercise. The baby was merely a few hours old. The loss of earning capacity is so distant that an assessment of such will merely be speculative. No estimate is possible in the circumstances and not even a conventional award should be made. In any event there is no evidence to support any claim under this head.

Special Damages

52. No claim has been made for special damages and therefore none will be awarded. Counsel submitted that the case of **Tota Maharaj** H.C.A 46 of 2003 is still under appeal.

53. The first Claimant is entitled to damages therefore in the sum of $22,000.00. There would be no award for exemplary or aggravated damages as the facts do not warrant any such award.

The second Claimant's claim:

54. There is no doubt that the mother suffered pain and grief over the loss of her child. There is no doubt that she viewed the body immediately after the death and can be considered to be within the immediate aftermath of the death. An interesting academic debate was raised in this case as to whether this Court could award the second Claimant damages for nervous shock which falls short of a psychiatric illness. That debate was necessarily engaged by the parties as the Claimant led no medical evidence to prove any known medical illness as having been sustained as a result of the death of her baby. I say it is academic as firstly the common law developed in most of the Commonwealth is very clear, no award for damages can be made for nervous shock which is a psychiatric illness in the absence of evidence. Charlesworth and Percy on Negligence 10th Ed. paragraph 2-78 states that:

> "The first limiting mechanism is the type of symptoms that can attract compensation. It has long been recognized that there is no recovery of damages in tort otherwise that certain specialized types of claims for mere injury to feelings. Only where the injury which arises is so intense or potent in its symptomatology that it can be regarded as an illness can the claim be entertained. Claims for symptoms which cannot be characterized as "psychiatric illness" should fail at the outset."

55. For secondary victims such as the mother, a person witnessing a horrifying event their claims in tort are subject to control mechanisms. Some of the applicable principles are set out by Lord Ackner in **Alcock** [1992] AC at p 400:

> "1. Even though the risk of psychiatric illness is reasonably foreseeable, the law gives no damages if the psychiatric injury was not induced by shock. Psychiatric illnesses caused in other ways, such as by the experience of having to cope with the deprivation consequent upon the death of a loved one, attracts no damages. Brennan J in Jaensch v Coffey, 155 549, 569, gave as examples, the spouse who has been worn down by caring for a tortuously injured husband or wife and who suffers psychiatric illness as a result, but who, nevertheless, goes without compensation; a parent made distraught by the wayward conduct of a brain-damaged child and who suffers psychiatric illness as a result also has no claim against the tortfeasor liable to the child.

2. Even where the nervous shock and the subsequent psychiatric illness caused by it could both have been reasonably foreseen, it has been generally accepted that damages for merely being informed of, or reading, or hearing about the accident are not recoverable.
3. "Shock," in the context of this cause of action, involves the sudden appreciation by sight or sound of a horrifying event, which violently agitates the mind. It has yet to include psychiatric illness caused by the accumulation over a period of time of more gradual assaults on the nervous system."

56. In **Vernon v Bosley** [1997] 1 All ER 577 Evans LJ summarized the condition that had to be satisfied as:

"The person who seeks to recover damages must prove that he or she has suffered mental illness (nervous shock) as the result of the traumatic experience."

57. In **Hinz v Berry** [1970] 2 Q.B. 40 Lord Denning M.R. said:

"Damages are, however, recoverable for nervous shock or, to put it in medical terms, for any recognizable psychiatric illness caused by the breach of duty by the defendant."

58. It was in the landmark decision of **McLoughlin v O'Brian** [1983] 410 which advanced the law on nervous shock that Lord Wilberforce observed:

"There can be no doubt that these circumstances, witnessed by the appellant, were distressing in the extreme and capable of producing an effect going well beyond that of grief and sorrow." That effect was described as "severe shock, organic depression and a change of personality."

59. Brennan J usefully makes the observation that not only is the notion of a psychiatric illness important but perception as distinct of mere knowledge of a distressing fact is compensatable. In **Jaensch v Coffey**, 155 C.L.R at p. 566/7 where he said:

"The notion of psychiatric illness induced by shock is a compound, not a simple, idea. Its elements are, on the one hand, psychiatric illness and, on the other, shock which causes it. …I understand "shock" in this context to mean the sudden sensory perception – that is, by seeing, hearing or touching – of a person, thing or event, which is so distressing that the perception of the phenomenon affronts or insults the plaintiff's mind and causes a

recognizable psychiatric illness. A psychiatric illness induced by mere knowledge of a distressing fact is not compensable; perception by the plaintiff of the distressing phenomenon is essential."

60. In Australia **Wilson v Lund** [1971] 80 Wash 2d 91, 491 p2d 1287, supra 3[b], in which the court stated that for purposes of proving grief, mental anguish, or suffering of a surviving parent, expert psychiatric testimony will often be useful and proper, if not absolutely necessary, in action by surviving parents for the death of children to provide a reasonably reliable basis for considering an award of mental anguish damages, to prevent the trier of fact from falling into the realm of mere speculation and conjecture, and to prevent the trier of fact from resorting to legal assumptions and conclusions which have little or no supporting medical or other reasonably reliable data.

61. Second on the evidence the mother was informed of the death of the child rather than being a witness to a horrifying experience. What she witnessed between 3:00a.m to 11:00a.m was not any distress or perceived distress of the baby beyond the norm. As far as she was aware the baby had cried and she had hoped that the nurse would have burped the baby. Her knowledge of the child being sent for an X-ray and being placed under an oxygen mask did not give rise to any anxiety on her part.

62. Third I am satisfied that based on the evidence adduced by the second Claimant in this case there is no justification at least in this case to call for the review of the treatment of nervous shock cases in this jurisdiction. I have reviewed the line of Canadian authorities referred to me by counsel for the Claimant **McDermott v Ramadanovic Estate** [1988] 27 BCLR (2d) 45; **Rhodes v Canadian National Railway** [1990] 75 DLR (4^{th}) 248; **Cox v Fleming** [1993] 13 CCLT (2d) 305; and **Anderson v Wilson** [1999] 175 DLR (4^{th}) 409. These cases approved of Southin J's analysis that the current law on actionable nervous shock makes an artificial distinction of intense human suffering:

"But what is the logical difference between a scar on the flesh and a scar on the mind? If a scar on the flesh is compensable although it causes no pecuniary loss, why should a scar on the mind be any the less compensable? In both cases, there are serious difficulties of assessment. That has not been allowed to stand in the way of the court's making awards

for non-pecuniary losses. Nor has it prevented awards for pain caused by physical injury which is, to use Mr. Fleming's words, "a bad memory"."

In these cases the secondary victims bore witness to the suffering of the deceased. The nature of the evidence adduced by the mother in this case as to any severe shock on the system as discussed in those cases is negligible.

63. The second Claimant in my view simply did not suffer any damage beyond the ordinary grief attendant on learning of the death of her child. As tragic as learning about the death of the child was for the second Claimant it cannot give rise to an award of damages associated with a psychiatric illness as to do so in the absence of any evidence would be to remove the recognizable bounds of liability in tort.

64. In this case I am not convinced of the mother's alleged depression. She states as follows:

"16. The Same Nurse Mills who had been so horrible throughout my stay in the Hospital was suddenly very nice and assured me it was my right to see the child. I went to see my baby and he was just cold and lying still. I began to cry and became beside myself with grief as I could not understand how my healthy baby could be lying there dead."

"23. Following the death of my baby boy I suffered severe depression. I constantly cried and could not eat or sleep. I fell into such a deep depression that I stopped talking with everyone, even my husband. Our relationship suffered considerably as a result of our baby's death. I could not bear to share the marital bed with my husband and we slept separately for several months.

24. Approximately 3 months after the death of my baby, my husband's cousin had a baby boy. I could not bring myself to visit as the thought of seeing another baby boy brought on the depression even more. Even in this day I cannot look at any boy child aged 3-4 years old and not feel sad that my child would have been that age if alive.

25. Later in 2005 I became pregnant again, this time I had a healthy baby girl. I was very afraid of losing this baby. Even up to admittance to the Sangre Grande

Hospital, I feared Nurse Mills would be there and I would go through the same pain and depression all over again."

65. In summary her evidence simply was that she "was beside herself with grief". In cross examination she stated she did not seek professional help as she was afraid to go to any doctor. Yet three to four months later she claimed "everything was back to normal". She got pregnant again a few months after the incident and she returned to the Defendant again where she gave birth to her second child. On the evidence I am not convinced that this Claimant suffered any clinical depression, nervous shock or anxiety beyond normal grief on seeing her dead son.

66. On the facts therefore this case is distinguishable from **Grace Prima v AG** HCA 6501/85 and **Harrilal v SWRHA** S555/03. In those cases the claimant endured physical pain and suffering from the ill treatment and negligence of the medical staff. In the case of **Harrilal** there was extreme pain waiting for assistance from the medical personnel. In the case of **Grace Prima** the claimant's uterus was removed. It is doubtful whether any award would have been made in those cases were it simply the death of the baby without any physical injury to the mother.

67. I would say that plainly in the absence of medical evidence or a psychiatric illness there may be grounds for an award of damages so long as the injury proven is severe enough that is greater than the acceptable grief and anxiety associated with the death. This is the common thread in the controversial Canadian and American authorities. To allow a claim such as this one will make light of the limitations in recovery of damages in negligence and certainly unnecessarily open the floodgates in this area of the law.

68. The second Claimant's claim for damages therefore fails.

Conclusion:

69. There will be judgment for the First Claimant against the Defendant. Damages are assessed for the first Defendant in the sum of $22,000.00 with interest thereon at the rate of 12% per annum from 10th June 2008 to the date of payment.

70. The second Claimant's claim is dismissed with no order as to costs.

71. At the case management conference a budget was fixed by this Court in the sum of $110,000.00. I am satisfied that all of the items claimed in the bill are recoverable having regard to the nature of the case. The sum I can say at this stage was proportional to the matter. However having regard to the final disposition in which only the first Claimant was successful I will order that the costs be reduced by 50%. The Defendant do pay to the First Claimant costs in the sum of $55,000.00.

Vasheist Kokaram

Judge