IN THE REPUBLIC OF TRINIDAD AND TOBAGO

IN THE HIGH COURT OF JUSTICE

Claim No. **CV 2013-05017**

BETWEEN

MARY LONDON

(The Administratrix of the Estate of deceased Kennis London)

Claimant

AND

NORTH CENTRAL REGIONAL HEALTH AUTHORITY

Defendant

Before the Honourable Madame Justice Quinlan-Williams

Appearances:

Claimant: Mr. Keith Scotland instructed by Ms. K. Kidd Hannibal for the claimant

Defendant: Mr. Ravindra Nanga instructed by Ms. Alana Bissessar

Date of Delivery: 18th January, 2018.

DECISION ON LIABILITY

HISTORY

1. This action was commenced by Claim Form and Statement of Case filed on the 6th of December 2013. The claim is for damages pursuant to the **Compensation for Injuries Act**[1] and the **Supreme Court of Judicature Act**[2], following the death of Kennis London (London). The Defendant filed a Defence on the 13th of March 2014.

[1] Chapter 8:05.
[2] Chapter 4:01

2. In brief, the Claimant alleges that London, a known sickle cell patient, was admitted to the Eric Williams Medical Sciences Center (the hospital) and provided with improper care which led to his death.

3. At the trial, the Claimant called three witnesses in support of the claim, namely the Claimant, Darnell Orr and Dr. Mathura. The Defendant did not call any witnesses.

THE ISSUES

4. The issues that fall for determination are:
    i. Was the Defendant negligent?
    ii. If yes, did the medical negligence of the Defendant or London's known medical condition of sickle cell disease cause the Defendant's death?

THE LAW

5. The test for medical negligence, the Bolam Test[3], is the standard that was given in the direction to the jury by McNair J in **Bolam and Friern Hospital Management Committee**[4]

> *In the ordinary case which does not involve any special skill, negligence in law means a failure to do some act which a reasonable man in the circumstances would do, or the doing of some act which a reasonable man in the circumstances would not do; and if that failure or doing of that act results in injury, then there is a cause of action. How do you test whether this act or failure is negligent? In an ordinary case it is generally said you judge it by the action of the man on 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, the test as to whether there has been negligence or not 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; it is well established law that it is sufficient if he exercised the ordinary skill of an ordinary competent man exercising that particular art…in the case of a medical*

[3] This test has been applied by the Court of Appeal in Deonarine and Ramlal CA APP No. 28 of 2003
[4] [1957] 1 WRL 582

man, negligence means failure to act in accordance with the standards of reasonable competent medical men at the time…as long as it is remembered that there may be more or more perfectly proper standards; and if he conforms with one of those proper standards, then he is not negligent. (page 4)

Later, in the direction to the jury McNair J said

…he 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…it is just a different way of expressing the same though. Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice merely because there is a body or opinion who would take a contrary view. (page 5)

6. The Bolam test was applied, with refinement in **Bolitho and City and Hackney Health Authority**[5], where it was held that when medical professionals perform their functions in conformity with an accepted practice if that practice is demonstrated to be inherently wrong or illogical then it would not serve as an escape route upon the Court scrutinizing the practice and declaring it negligent.

7. Negligence is established where there is a departure from the normal practice. In the case of **Hunter and Hanley**[6] the action was against a medical practitioner, who had administered an injection to a patient. During the course of that procedure the hypodermic needle broke in the patient. The issue and question raised was whether the practitioner failed or departed from the normal and usual practice of general practitioners. If there was a failure, could it be reasonably described as gross negligence, the Lord President said in the judgment:

To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care. There is clearly a heavy onus on a pursuer to establish these three facts, and without all three his case will fail.

[5] [1997] 4 ALL ER 771
[6] 1955 SC 200

8. It is settled law that a hospital is liable for the acts of negligence of its professional servants which occurred during the course of their employment. In **Cassidy and Ministry of Health**[7] Denning L.J said

> *If a man goes to a doctor because he is ill, no one doubts that the doctor must exercise reasonable care and skill in his treatment of him, and that is so whether the doctor is paid for his service or not. If, however, the doctor is unable to treat the man himself and sends him to hospital, are not the hospital authorities then under a duty of care in their treatment of him? I think they are. Clearly, if he is a paying patient, paying them directly for their treatment of him, they must take reasonable care of him, and why should it make any difference if he does not pay them directly, but only indirectly through the rates which he pays to the local authority or through insurance contributions which he makes in order to get the treatment? I see no difference at all. Even if he is so poor that he can pay nothing and the hospital treats him out of charity, still the hospital authorities are under a duty to take reasonable care of him just as the doctor is who treats him without asking a fee. In my opinion, authorities who run a hospital, be they local authorities, government boards, or any other corporation, are in law under the self-same duty as the humblest doctor. Whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves. They have no ears to listen through the stethoscope and no hands to hold the knife. They must do it by the staff which they employ and, if their staff are negligent in giving the treatment, they are just as liable for that negligence as anyone else who employs others to do his duties for him*

9. A public hospital according to Halloran JA in **Fraser and Vancouver General Hospital**[8] is a place where:

> *The operation of a public hospital is for the public good; the carrying on of an emergency ward therein is a general invitation to the public without unreasonable limitations or reservation, and thus it is bound to the utmost extent to serve the public with that skill and professional knowledge the hospital holds out to the public that it possess without negligence*

10. The liability of the hospital maybe vicarious as where the hospital doctors and staff are negligent but it may also be direct where there are inadequate systems and procedures in place and the result is that the patient is injured or dies. In **Bull and Devon Area Health Authority**[9] it was held that:

[7] [1951] 1 ALL E R 574
[8] [1951] 3 WWR 337
[9] [1993] 4 Med L R 117

I have no means of making a finding as to what went wrong with the system on this occasion. It is sufficient for me to find, as I do, that a properly working system would not have left this Plaintiff unprotected by inexperienced doctors for such a long time at such an important stage. In my judgment the system was inefficient or some member of the administrative staff failed properly to carry out his or her duty in securing the registrar's attendance. The Defendants were negligent in that respect.

11. On the issue of negligence by the hospital in the care and treatment of a patient, the authority of **South West Regional Health Authority and Samdaye Harrilal**[10] is instructive, Mendonca JA said:

> *In the case of a public hospital, such as the San Fernando General Hospital, such a duty of care is beyond question. Indeed, it has been expressed as a fundamental proposition that the operation of a public or general hospital is "affected with a public interest". See Fraser v Vancouver General Hospital [1951] 3WWR 337 at 339 to 340 where O' Halloran J A said: "The operation of a public hospital is for the public good; the carrying on of an emergency ward therein is a general invitation to the public without unreasonable limitations or reservations, and thus it is bound to the utmost extent to serve the public with that skill and professional knowledge the hospital holds out to the public that it possesses and without negligence."*
>
> *The same is to be said of the operation of the San Fernando General Hospital and indeed all public health facilities in Trinidad and Tobago. Since the hospital authorities themselves do not treat patients, the applicable standard by which any negligence of its servants will be judged and for which the hospital authorities will be vicariously liable is the Bolam standard. Where, as in this case, a claimant alleges that the negligence is due to the fault of the hospital authority itself, the liability is direct and not vicarious.*

12. With respect to the use that the court can make of the medical notes, admitted with the evidence of the Claimant as well as with the evidence of the Claimant's expert. The court considered that the medical notes were notes that were provided by the Defendant to the Claimant. The use that the court can make of medical notes; whether admitted as evidence for the truth of the contents or as recitals for what is stated therein has been judicially considered. The court held in **Gulf View Medical Centre Limited and Crisen Jendra Roopchand and Karen Tesheira**[11]

[10] CA APP #60 OF 2008. Delivered on the 12th May, 2011
[11] CA Nos. 087 and 093 of 2005

In the absence of evidence on behalf of the appellants. And a credible reason for not adducing evidence on what occurred on that date, the judge was entitled to draw reasonable inferences adverse to the appellants that had the effect of strengthening the respondent's case. One of these inferences was that what was stated in the progress notes was true and that the medical records accurately reflected the factual position at the time.

Accordingly, despite the fact that when admitted the notes could only properly have been admissible to show that this was what was said at the time by the persons responsible for the deceased's medical treatment, in the circumstances that applied in this case the judge was entitled to come to the conclusion, as he clearly did, that what was said in the medical notes was a true representation of what in fact occurred on that date and that the medical records comprised an accurate and complete record of the treatment accorded to the deceased on that date…

In the circumstances that transpired the judge was entitled to consider the contents of the medical records, and in particular the medical notes, for the truth of what was stated in them. Insofar as he accepted the contents of the medical notes as true and the medical records as containing a complete and accurate record of what transpired on that day the judge cannot be faulted

13. In this case the Claimant has an expert witness, Dr. Ramesh Mathura. The expert's evidence was admitted pursuant to the **Civil Proceedings Rules, Part 33** (as amended). This sets down the parameters for the expert's overriding duty, the general duty to the court and the parties and the contents of the expert's report. The expert's overriding duty is to "help the court impartially on the matters relevant to his expertise". This duty, may override any duty that the expert perceives or believes he has to any party.

14. The expert must give a factual or scientific criteria for his opinion. It is important to note therefore that the expert's evidence, upon which the court may be assisted in arriving at a determination about negligence in not limited to scientific criteria. In **Moonsammy and Ramdhanie & Anor**[12], the expert's evidence gave neither criteria and the court held:

It is important to observe that Dr. Bedaysie gives not factual nor scientific criteria for his opinion that the appellant would have to retire in about five

[12] Civ. App No. 62 of 2003

years time. It is not apparent from the report that Dr. Bedaysie was aware of the occupation of the appellant nor what his job entailed

CLAIMANT'S CASE

15. The Claimant's case, is that London was admitted to the Eric Williams Medical Science Center on the 8th of August 2010 around 6:00am. He was registered as a patient, transferred to the emergency department and placed on a stretcher in the corridor of the said emergency department. London died on the 10th of August 2010 due to the negligence of the hospital.

THE DEFENDANT'S CASE

16. The Defendant submits, inter alia, that the Claimant has led no evidence to establish causation; that London's death was not due to the negligence of the Defendant. The Defendant submits that the court must ask "whether Dr. Mathura has been able to establish his expertise in treating sickle cell patients? It is clear from Dr. Mathura's curriculum vitae, that no mention is made as to his qualifications(s) to treat sickle cell disease, nor as to his experience treating (cell) sickle cell disease." (paragraph 12 of Defendant's submission). The Defendant further submitted that Dr. Mathura provided conclusions without providing the necessary scientific criteria for testing the accuracy of these conclusions. Further, the Defendant submitted that the Claimant has not adduced any evidence to show what was the reasonable standard of care necessary for a patient suffering with sickle cell disease.

EVIDENCE

17. The Claimant called three witnesses. The evidence of in chief of those witnesses was deemed to be their witness statements. The witnesses were presented for cross-examination by the Defendant. The Defendant did not call any witnesses.

18. Mary London, the mother of the deceased London, was the first witness. She is the Claimant as Administratrix in the estate of her son Kennis London. The Claimant's evidence is that her son was experiencing unbearable stomach pains on the morning of the 8th of August 2010. She took London to the Eric William Medical Science Center (the hospital) around 6:00am that said morning. He was placed on a stretcher in the corridor of the Emergency Department and given intravenous fluids and an injection.

19. About 8:00am on the 9th of August 2010, the next time the Claimant saw London, he was on the same stretcher in the corridor of the Emergency Department and he was still experiencing severe stomach pains. He reported that around 3:00am on the 9th of August 2010 he was visited by a team of Doctors including Dr. Aleong and was taken for an x-ray and a blood test was conducted.

20. Later that day, London called the Claimant and reported that he had overheard that his file was lost. The Claimant returned to the hospital in the afternoon of the 9th August, 2010 and was informed by Dr. Zani that London's files which contained his registration and test results could not be located.

21. The Claimant, upon instructions to do so, physically took London to re-register. He also had to be re x-rayed and another blood test had to be done, a process called a 're-check'.

22. Thereafter, Dr. Zani informed the Claimant that her son had developed pneumonia and had fluid in his lungs. The Claimant personally attempted to get a ventilator and even suggested that London should be transferred to another health institution. The Claimant did not get a ventilator nor were her request about the transfer heeded.
23. During this time, the afternoon and evening of the 9th of August 2010, London was complaining of sever pains and he was administered morphine although his records had not been found. Thereafter, London's breathing became abnormal – very fast and he had frothing at the mouth.
24. The Claimant immediately contacted the Doctor on duty, Dr. Ahmed, who indicated that the Doctors who treated London earlier should arrive in about twenty (20)

minutes. Dr. Seuratsingh also indicated that he could not attend to London as he had not seen him initially and did not have London's file as it could not be found.

25. Around 10:00 pm on the said 9th of August 2010, the team of doctors including Dr. Zani and Dr. Aleong arrived and examined London and he was rushed to a critical area.

26. The Claimant was informed by one of the doctors that London was in a critical condition and had to be taken to the Intensive Care Unit (ICU) department or the High Dependency Unit (HDU). The Claimant was also informed that London needed a ventilator to help his breathing but that none was available.

27. The Claimant was informed that her son needed an electrocardiograph to determine the cause of the fluid leaking into his lungs, but that the electrocardiograph machine was not working, there was no one present to administer the test and that the door to the electrocardiograph machine was locked.

28. The Claimant's evidence is that London was administered oxygen vial an oxygen tank while awaiting a bed or for a patient to leave the ICU department. After some time, room was made for London in the ICU.

29. After being told this, the Claimant waited in the same critical area with her son London, for approximately three hours and left when his labored breathing evidenced by his gasping for breath and frothing at the mouth became too much for her to bear. There was not assistance given to him by any doctor, the only treatment was oxygen from an oxygen tank.
30. While the Claimant was unable to see her son in the state he was in, her other, son Darnell Orr and her husband Dustan Orr went into the area with London. Eventually, the Claimant was later informed that while they were transferring London to the ICU, he died.
31. The medical records and the post mortem examination report were attached to the Claimant's witness statement.

32. The Claimant was cross-examined. She was cross examined about her evidence that the patient's notes referred to the results of an ECG (long name), the Claimant maintained that she was told London needed and did not get an electrocardiogram, not an ECG.

Post Mortem Examination Report

33. The post mortem examination was performed by Dr. Chunilal Ramjit's[13], a Consultant Pathologist. His opinion was that Londons' death was due to three factors: bilateral pulmonary thrombo-embolism with marked pulmonary oedema, bilateral bronchopneumonia with pleural adhesions and complications of sickle cell disease.

34. The Claimant was cross-examined. The cross-examination included a suggestion the patient's notes referred to the results of an ECG. She maintained that she was told London needed an electrocardiogram, not an ECG, and that he did not get an electrocardiogram.

Darnell Orr

35. Darnell Orr (Orr) is London's brother. His evidence is that he arrived at the hospital around 5:00pm on the 9th of August 2010. He went to and saw London in the emergency department. He immediately observed that London was unable to breathe properly as he was gasping for breath. Orr said he asked about the possibility of moving London to another hospital and a Doctor told him it was too risky.

36. Orr noticed that over time, London's shortness of breath worsened. He also testified that there was a nurse "trying" to administer oxygen. He said he overheard that the oxygen in the tank had finished and (that) the apparatus on the other tank was not functioning. Orr observed that the nurse fiddled for some time with the oxygen tank. Eventually Orr was asked to leave.
37. Sometime between 1:00 a.m. and 2:00 a.m. on the 10th of August 2010, a female Doctor informed the family that London "did not make it".

[13] Consultant Pathologist

38. Orr was not cross-examined.

Dr. Ramesh Mathura/The Expert Witness.

39. The Claimant called, as her expert witness, Dr. Ramesh P. Mathura. The curriculum vitae attached to the witness' statement sets out his professional qualifications and experience.

40. After reviewing the hospital medical records for the patient London, Dr. Mathura rendered his opinion firstly in a letter dated 17th of January, 2011. In that letter Dr. Mathura formed the opinion that "there are many grounds of negligence".

41. In a second letter dated 25th November 2013, Dr. Mathura expanded on the grounds of negligence by listing eight (8) factors to support his finding:

    I. the patient was known to suffer from sickle cell disease and there is a high risk of developing an Acute Chest Syndrome;

    II. a Hematologist was not called for an expert opinion. There was no Registrar to advise the young doctors on proper management;

    III. the unavailability of absolute necessary expertise and equipment in this case were totally inaccessible: Echocardiogram machine, ICU bed and ventilator;

    IV. misplacement and losing of his files on admission;

    V. mismanagement medically in spite of Dr. Aleong's wish and request to send this patient to the ICU. The length of time he remained on a bed in the corridor for days;

    VI. inappropriate use of some drugs and failure to institute expert treatment;

    VII. a failure in the Autopsy report which states that he had a Splenectomy; and

VIII. Failure to provide a Hematology Unit for patients with many hematological disorders requiring treatment.

42. Among the professional qualifications and designation used after Dr. Mathur's signature is one as a "Pediatric and Adult Hematologist/Oncologist". Based on Dr. Mathur's curriculum vitae and his evidence, the court was satisfied that the witness is competent to give evidence and assist the court with respect to patients needing hematologist care.

43. Dr. Mathura was cross examined on his expert opinion. This opinion he formed from the hospital reports he had access to. Dr. Mathura's opinion is quite clear; there was a lack of specialize services available to threat London. This was below the proper standards for treating patients such as London. The delays in getting things done to treat London was also below the proper standards necessary treating patients like London. What should have been done urgently to treat a patient like London was not done and this too was below the proper standards for treating patients like London.

44. The medical records show that London was first registered as a patient at 5:30am on the 8th of August 2010 and then he was re-registered at 4:00pm on the 9th of August 2010. What happened that necessitated this re-registration and how it affected the patients care is unexplained by the Defendant, but it does support the opinion that there was a lack of services or delays in getting things done that was below the standard of care expected in the circumstances, as per **Bull and Devon Area Health Authority (Supra).**

45. Dr. Mathura's opinion was that the Defendant did not have the appropriate medical doctors present to see the patient, London, the appropriate specialist, the advice and machinery available to treat with the patient. His position was or became acute and he died because there was a failure at every level of this case. Further the Defendant did not follow known standards according to international protocol. He specifically referenced that there was no bed or expert help or team in this particular case and his opinion is that London's death could have prevented.

46. He referred for instance, the medical report where the test which was required to be done on the London was not done. This supports the evidence of the Claimant that the test was not available to London as she said she was told. Dr Mathura explained that an echocardiogram, it echoes any abnormality within the chambers of the heart and it is used to see the flow of the blood in the heart. It could also record the amount of blood coming-out of the chambers. While an electrocardiogram is a tracing of the electrical conduct in the heart and it records the electrical conducting and speed and timing of the heart the regularity of the heart and if there is any blockage. This is the basic test done to detect a heart attack. The two test are significantly different and what was ordered to be done was not done on the patient London.

47. Dr. Mathura further testified that there was no hematologist available at the hospital - so because of that I assumed that none was called. His assumption was confirmed by a conversation he had with Dr. Aleong where he was informed that no hematologist was called.

48. Dr. Aleong informed him that he wanted the London (patient) to go to ICU. Dr. Mathura said he advised him strongly that that was required. This conversation occurred when Dr. Mathura called Dr. Aleong. Dr. Mathura said he called Dr. Aleong and we spoke about the patient. Dr. Mathura had known the patient and was familiar with his medical history.

49. Dr. Mathura stated in cross-examination that "I am a hematologist".

50. Dr. Mathura was firm in his opinion that London did not die from sickle cell. But that under the circumstance of the case and the care he received at the hospital, that he died from poor management considering that he had sickle cell.

51. The court understood that Dr. Mathura's opinion was that London (the patient), admitted as he was with sickle cell disease, was required to be cared in a certain known manner. This included attention to detail and alacrity, since his condition made

him vulnerable to certain known conditions. Since sickle cell is a disease of the blood, a hematologist is required and that the patient should be cared at the ICU. Further the patient needs access to specialist skill and test.

52. In this case, Dr. Mathura's opinion is that factually and scientifically, the care fell below that standard of care expected (as per the Bolam Test). The hospital's medical staff failed to act in accordance with the standards of reasonable competent medical men. The hospital's resourced failed to be in accordance with the standards reasonably expected of hospitals who accepted patients in their care.

Medical Records

53. The court was able to make use of the medical records and rely on them as the truth of the contents contained therein (**Gulf View Medical Centre Limited and Crisen Jendra Roopchand and Karen Tesheira Supra)**. The patient's notes for London, reveal that by 5:43pm on the 9th of August 2010 the expert opinion was that London was experiencing a "Sickle Cell Crisis" and that the "Plan" for the patient's care included "oxygen via face mask" and the patient was for "Hematology consult and for possible transfer to Hematology". It is unclear if this crisis existed earlier or could have been detected earlier since London's notes were missing for some period of time between the 8th and 9th of August 2010.

54. Dr. Aleong was not able to administer the test he wanted to administer and noted it was "locked" with "no access to Machines".

55. At 6:45pm on the 9th of August 2010, the "HO" for Dr. Aleong noted that:
    i. the patient had "sickle cell disease";
    ii. that he attempted to obtain a portable Echo machine but the department was locked;
    iii. For ICU to decide on need to support ventilation;
    iv. For close nursing supervision preferably in ICU or HDU;

v. Dr. Aleong asked the Thoracic Medical Dr. to assist in the management of the young "sickler" and to "Please take over the management of his pulmonary complaint".

56. At 9:00pm it was noted that the patient's "yesterday's notes were missing". The patient's notes continued that the "patient ideally needs HDU/ICU management".

57. At 11:05 pm on the 9th of August 2010, the notes revealed that the patient was in "resp distress" and there was a notation about ICU as well.

58. There was also a notation made after the London's death "written in retrospect" made at 2:00am notes:

- *Pt. being prepared for transfer to HDU*
- *Suddenly collapsed and went asystotic*
- *Taken straight to …*
- *CPR commenced*
- *Pt certified at 1:28am*
- *For possible PM after discussion ..Dr. G. Aleong*

59. The "Observation Record" for the patient commences on the 9th of August 2010 at 8:25pm and ends at 1:22am on the 10th of August 2010. There are no records before that, although the patient was admitted on the morning of the 8th of August 2010.

60. The Nurse's Notes record commences at 1:30pm on the 9th of August 2010. At 4:00pm, the notes record that "Dr…informed that patients file was is missing + patient in painful distress. Mother went to register again the patient".

61. The Nurses Notes show that at 12:50am on the 10th of August 2010 "Patient is being prepared for transfer to HDU ward".
62. Meanwhile according to the Progress Notes, by 7:11pm, on the 9th of August 2010, the patient was noted to be in a deteriorating state, he was noted to be having "increasing respiratory distress". No Cardiac …Monitor was available.
63. The court considered London's medical records and that the contents thereof represented the truth of what occurred during the time London was at the hospital

(as per **Gulf View Medical Centre Limited and Crisen Jendra Roopchand and Karen Tesheira**, supra). In my opinion the evidence, from the medical records, supports Dr. Mathura's opinion that there was negligence by the defendant in this case.

The Standard of Care Necessary in This Case

64. The standard of care required for a patient suffering from sickle cell and in London's condition is apparent from the patient's notes and what the doctors who attended to him stated to be the appropriate care required in his case. London's patient notes are also evidence that the standard of care required was not given and that there was negligence.

65. Firstly, the patient needed to be properly admitted to the hospital. On the evidence it took two attempts before the London was admitted. London was first registered at 5:30 a.m. on the 8th of August 2010. Then again, at 4:00pm on the 9th of August 2010 when the Claimant had to physically take London to be registered again. This delayed the care that was required as what had already been done had to be redone.

66. Secondly, proper patient notes needed to be made and kept for the proper care of London. In this case the London's medical notes were lost.

67. Thirdly the patient needed to have an electrocardiogram test performed on him. In this case, London did not have such a test performed because the room was locked, there was no technician available and there was no portable machine available.

68. Fourthly, the patient needed to have assistance with breathing. There was trouble with the machines. At 5:43pm on the 9th of August 2010 London was supposed to have been assisted with his breathing by oxygen via face mask. Orr's evidence which, the court accepts, was that he heard the nurses speaking about no oxygen in one tank and another malfunctioning. He was not cross-examined about this evidence.
69. Fifthly, the patient needed to be closely monitored. In this case London remained on a stretcher in the corridor of the hospital for many many hours.

70. Sixthly, the patient needed to have the specialist care available on the ICU or HDC wards. In this case it took many many hours for such arrangements to be made, London did not get to the ICU alive. The nurses commenced arrangement to transfer London to the ICU at 12:50am on the 10th of August 2010 and he died at…….before arriving at ICU.

71. Seventhly, the patient needed the care of specialist such as hematologist. None was either available or called.

72. Eighthly, the patient needed to be specially monitored with special machines. In this case no cardiac monitor was available.

73. Accordingly, the issues raised in the case can thus be answered as follows:
    1) Was the defendant negligent? The court is satisfied from the factual and scientific evidence that the Defendant was negligent.

    2) Did the medical negligence of the Defendant or London's known medical condition of sickle cell disease cause his death? The court is satisfied that the medical negligence of the defendant caused the death of London.

74. The court therefore finds that the defendant is liable for the death of Kennis London who died on the 10th of August 2010 at the Eric Williams Medical Sciences Hospital.

75. On the issue of damages, the parties are to file submissions on or before the 9th February, 2018 and any replies to those submissions are to be filed and served on or before 21st February, 2018.

76. The case stands adjourned to 7th March, 2018, on this date the court would determine the issue of damages.

Dated this 18th, January, 2018

Avason Quinlan-Williams

Judge

(Leselli Simon-Dyette, Judicial Research Counsel)