THE REPUBLIC OF TRINIDAD AND TOBAGO

IN THE HIGH COURT OF JUSTICE

CLAIM NO: CV2014-00578

BETWEEN

BEVON DOLLARD

CLAIMANT

AND

THE NORTH CENTRAL REGIONAL HEALTH AUTHORITY

DEFENDANT

Before the Honourable Madame Justice Quinlan-Williams

Appearances: Mr. Richard Jagai instructed by Mr. Kent Samlal for the Claimant

Mr. Rishi P. A. Dass instructed by Ms. Marina Narinesingh for the Defendant

Date of Delivery: 9th September 2019

JUDGMENT

Procedural History

1. This action was commenced by claim form and statement of case filed on the 14th February 2014. The claim is for damages and consequential loss for medical negligence as a result of the defendant's servants and/or agents in the management and or care of the claimant's injuries which occurred on the 15th February 2010.

2. The defendant filed its defence on the 15th October 2014. Thereafter, a reply to the said defence, was filed on behalf of the claimant on the 9th January 2015. On the 26th June 2015 the claimant filed an amended statement of case. Subsequently, by order dated the 29th June 2015 the defendant was granted leave to file and serve an amended defence which was effected on the 29th September 2015.

3. The claimant by notice of application dated the 24th March 2016 sought the court's permission to adduce expert evidence from Dr. Stephen Ramroop who produced a medical report on the 4th May 2015. Additionally, on the said 24th March 2016 the defendant also filed a notice of application seeking the court's permission to call Mr. Dean Baiju as an expert witness at the trial of this matter.

4. Subsequently, the both parties on the 27th June 2016 presented a consent order proposing the appointment of Mr. Dean Baiju as a joint expert in this matter. It was also agreed, that the joint expert witness would be instructed by both parties. Accordingly, on the 26th July 2016 the Honourable Mr. Justice Andre des Vignes (as he then was) granted the order appointing Mr. Dean Baiju as the joint expert in this matter.

5. On the 6th August 2018 the defendant filed its evidential objections. Contained therein, the defendant stated that paragraph 55 of the claimant's witness statement was inadmissible on the grounds that Dr.

Stephen Ramroop is not an expert within the meaning of Part 33 of the Civil Proceedings Rules 1998 as amended and a joint expert was already appointed. The court delivered its ruling regarding the defendant's evidential objections on the 17th October 2018. However, the court determined that the objection in relation to paragraph 55 of the claimant's witness statement would be addressed at a later stage in the proceedings.

6. The matter was fixed for trial on the 3rd April 2019. Bevon Dollard gave evidence for the claimant while Dr. Malachy Ojuro and Dr. Anil Kumar gave evidence for the defendant. Mr. Baiju's expert report was filed and forms part of the evidence.

7. The main issue for the court to decide is whether the defendant, through its servants and agents, failed to exercise the ordinary skill of ordinary competent doctors and health care professionals during the management and or care of the claimant thereby causing the claimant to suffer injuries and other related consequential loss such that the defendant should be responsible for making recompense to the claimant.

8. In making the findings relating to the main issue, the judgment will be ordered as follows:

   a. Resolving the outstanding evidential issues;
   b. Finding the facts relating to the main issues; and
   c. Duty of care, causation and liability

a. Outstanding Evidential Issues

Dr. Stephen Ramroop's evidence

9. Two issues as it relates to the expert evidence in the matter arises before

the court. A single joint expert was appointed by the court to give evidence. However, the claimant is attempting to rely on opinion evidence of other experts through other means. Firstly, the claimant has attached the expert report of Dr. Stephen Ramroop to his amended statement of case and witness statement. Secondly, under cross-examination the claimant sought to elicit opinion evidence from the defendant's witness Dr. Anil Kumar as to whether the allegations of negligence have been made out.

10. On the 24th March 2016, the claimant sought leave of the court to rely on Dr. Stephen Ramroop's medical report at trial[1]. A copy of Dr. Ramroop's report was attached to the claimant's amended statement of case filed on 26th June 2015 and his witness statement filed on the same day of the 24th March 2016.

11. By the order of the Honourable Mr. Justice des Vignes (as he then was) dated 26th July 2016, a single joint expert Mr. Dean Baiju was appointed pursuant to Part 33 of the Civil Proceedings Rules ("CPR"). A core statement of agreed facts was set out and the single joint expert was afforded access to the pleadings and bundles of documents. Joint instructions were also provided to Mr. Baiju for the production of his report. As part of the instructions, the claimant presented the medical report of Dr. Ramroop, instructing Mr. Baiju to make his own independent assessment and conclusions in light of the material presented to him. Upon completion of the report, the claimant filed same as a Notice on the 12th June 2017.

12. Despite the appointment of the single joint expert, the claimant purports to rely on the expert report of Dr. Ramroop for several aspects of his claim including the particulars of the injuries suffered,

[1] Trial Bundle 1 at page 357

the appropriate standard of care in treating with his injuries and damages as it relates to the cost of future surgery.

13. The defendant takes issue with the course adopted by the claimant for several reasons. The defendant avers that Dr. Ramroop did not provide a witness statement in this matter and as such it was denied the opportunity to cross-examine same. Before the trial of this matter, the defendant in its evidential objections filed on the 6th August 2018, objected to Dr. Ramroop's expert evidence as he was not an expert within the meaning of Part 33 of the CPR (the single joint expert), rendering the opinion of any other expert inadmissible.

14. In the case of *Kelsick -v- Kuruvilla* Civil Appeal No. P 227 of 2012 Jamadar JA (as he then was) provided guidance as to the appointments of experts and the considerations that must be afforded when admitting expert evidence under Part 33 of the CPR:

> "7. The principle to be applied in determining whether or not permission ought to be granted to allow expert evidence is as provided for in Part 33.4, CPR, 1998: "Expert evidence must be restricted to that which is reasonably required to resolve the proceedings justly". In this regard, the overriding objective is an aid to analyzing the legitimate considerations that impact on deciding what dealing justly with a case involves.
> …
> 11. In summary, for expert evidence to be appropriate in light of the CPR, 1998, and for permission to be granted to use it, that evidence ought to be relevant to matters in dispute, reasonably required to resolve the proceedings and the proposed expert must be impartial and independent and have expertise and experience which is relevant to the issues to be decided. In addition, the use of expert evidence must also be proportionate in light of the factors set out in Part 1.1, CPR, 1998. Economic considerations, fairness, prejudice, bona fides and the due administration of justice are always matters that may have to be considered depending on the circumstances of each case.
> …
> 24. The trial judge is the primary finder of fact in a case such as this. Before issues of negligence can be considered the relevant findings of fact and conclusions of inference on issues such as causation must be determined. Where (as in this case) there are

multiple potentially overlapping options, and the medical evidence and derived inferences are critical to liability, and the Defendants are all potentially implicated, a trial judge can only benefit from an impartial and relevant medical expert whose primary duty is to assist the court in objectively resolving these issues. In our opinion, on the basis of the various claims and defences, and on the respective cases stated, denied and implied, and also on the basis of the medical reports and correspondence intended to be relied upon or agreed, this case is a fit case for the use of a relevant medical expert witness and of medical expert evidence.

…

32. Part 33 provides for the calling of expert evidence and the use of expert reports only with the permission of the court and only when it is reasonably required to resolve the proceedings justly. An expert witness and an expert report, though solicited by a party, are in effect a witness and report of the court. Part 33.1 provides that the duty of an expert is to impartially help the court on matters relevant to his/her expertise. Part 33.2 states that this duty "overrides any obligations" to any other party, including those from whom the expert has received instructions (and payment). Part 33.2 says that the expert evidence and report must be an "independent product … uninfluenced as to form or context by the exigencies of the litigation", and that the duty of the expert is to "provide independent assistance to the court by way of objective unbiased opinion". This duty to the court is reinforced by Part 33.15, which provides that an expert appointed by the court "may be cross-examined by any party", suggesting that an expert is the court's witness. Moreover, Part 33.5 suggests that, consistent with the extensive powers of the court at case management, the court may with or without an application call an expert witness. Part 33 exists for the benefit of the court and as an aid to the mandate to determine cases justly.

33. Even though in this appeal the specific question of whether a court can call an expert on its own initiative does not arise for determination, the above analysis is important. This is because the trial judge considered the Claimant's alleged failure to call medical evidence and the fact that the application to call Dr. Rennie was made by the First Defendant, in the context of the "adversarial nature" of proceedings, of significance to his decision.

34. In our opinion the trial judge may have, in so doing, lost sight of the real purpose and value of expert evidence and reports under the CPR, 1998. Expert evidence and reports are not

simply partisan, however they come into being. They are only and always primarily for the benefit of the court. In this regard, it matters not who seeks permission to obtain expert evidence or reports. What matters is whether the evidence and reports are reasonably required (Part 33.4) to help the court (Part 33.1 (1)) resolve the proceedings justly (Part 33.4).

…

36. On the issue of the timing of the application, it is clear that the general rule is that a court ought to consider whether to use expert evidence and reports at the stage of case management. However, this is not an absolute rule. Flexibility must be applied by the court because an expert is there primarily to assist the court. In this case, the fact that the application was made in October, 2012, five months before the date scheduled for trial, was in and of itself of little consequence. What mattered were the considerations of cogency, usefulness and proportionality, applied to the circumstances of the case, as have been discussed above. Always, an underlying consideration for the trial judge ought to be: Can this expert evidence and report help in determining the issues I am called upon to resolve? The question must be posed and held in a neutral way and considered from the court's perspective and responsibilities – not solely from the parties.

37. The general rule that the use of expert evidence ought to be considered at case management is there for guidance and as a matter of common sense, given the judge driven case flow management process that now operates in civil litigation. However, whenever an application to use expert evidence is made, the approach should be to consider admissibility, cogency, usefulness and proportionality, together with, when relevant, fairness, prejudice, bona fides and the due administration of justice. These must be weighed and balanced, and the tension that will sometimes arise between what is 'reasonably required' to resolve issues and the 'just resolution' of proceedings worked out on a case by case basis."

15. Likewise, the recent Privy Council judgment *Bergan -v- Evan (St Christopher and Nevis)* [2019] UKPC 33 expounds on the general requirement of the court's permission when admitting expert reports into evidence. In that case the trial judge admitted into evidence a medical report which was attached to the claimant's claim form and which was also the subject of a previously denied application. The Rule 10.6 of St. Kitts and Nevis' CPR mandates the defendant to state which

parts of the medical report is agreed and which are disputed, in default of which, the defence is rendered defective. This was the circumstances of the case as the appellant/defendant failed to dispute any part of the medical report. In addition, section 163 of St. Kitts and Nevis' Evidence Act renders the written report of a medical practitioner admissible as documentary evidence in civil proceedings. Therefore, the trial judge interpreted section 163 to be an entirely separate route by-passing rule 36.2 of the CPR, which requires the court's permission before any expert report is admitted into evidence. The Board disagreed with the trial judge's findings in both regards affirming that the court's permission is still required in both cases to deploy expert evidence under Rule 32.6. It held at paragraph 35 that:

> "It would be an extraordinary restriction upon the court's duty and power to limit expert evidence to that which is reasonable required to resolve the proceedings justly if the claimant could secure the right to deploy any number of experts of her choice, merely by attaching their report to her claim form."

16. The law as it relates to an appointed single joint expert is that he is not usually called upon testify as there is no general basis to contradict him upon any point[2]. In many cases (in particular those involving a single joint expert) all of the expert evidence is given by report alone and thus examination in chief and cross examination does not arise. Hodgkinson notes at paragraph 5-011:

> "SJEs do not normally give oral evidence at trial because: (a) any clarification of the report of a SJE should be obtained by asking written questions, and (b) where a party is dissatisfied with the report of a SJE (including any answers to written questions), the remedy is to apply for permission to put in own-party expert evidence. Where the SJE does give oral evidence, he is usually called by the judge and cross-examined by both parties unless the report is favourable to one party in which case that party usually calls the SJE as his own witness."

[2] Expert Evidence: Law and Practice 4th Edition (2015) Tristram Hodgkinson Sweet & Maxwell, at paragraph 8-012

17. Furthermore, if a party is dissatisfied with the view of a single joint expert, the court has a discretion to accede to a request for a party to rely upon a further expert report. However, there are strict limitations upon this approach and it must be done well in advance of trial[3].

18. Firstly, Dr. Stephen Ramroop is a Specialist Surgeon in Orthopedic Surgery who examined the claimant on two occasions, 16th May 2014 and 2nd May 2015. The medical report was dated the 4th May 2015 which detailed the circumstances around the claimant's injury, the physical examination findings and Dr. Ramroop's assessment and conclusions. Upon an examination of the report, it is evident that the claimant relied on Dr. Ramroop's report to prepare his amended statement of case filed approximately one month later on the 26th June 2015. It appears that the major changes made to the statement of case was as a result of this report. The particulars of negligence, particulars of injuries and the particulars of special damages and general damages were all amended to reflect what was contained in Dr. Ramroop's report. The medical report was not attached to the amended statement of case but annexed to the witness statement of Bevon Dollard.

19. Dr. Ramroop concluded that based on the injuries suffered by the claimant, there is clear evidence from the Journal of Bone and Joint Surgery articles "that there is a much better prognosis in young patients, if surgery is minimally invasive and if done earlier in the post injury period." As a result, it was his view that the option of surgery should have been contemplated and discussed with the claimant. Furthermore, he opined that the claimant received an extremely poor standard of care from the clinicians attending to him at all levels. The record keeping was poor and the standard of care fell well below what

[3] Expert Evidence: Law and Practice 4th Edition (2015) Tristram Hodgkinson Sweet & Maxwell, at paragraph 5-005

was acceptable for a fracture of this type; there were no attempts to classify the fracture and plan treatment despite the availability of CT scans in the Centre of Excellence where the claimant was warded. As it relates to future surgery Dr. Ramroop opined that at present, the clinical condition has stabilised and the claimant is not likely to improve with surgical intervention or any other active medical treatment. Surgery is however urgently required amounting to the sum of TTD$80,000.00 in the private sector.

20. The case law outlined above provides that the overriding principle which determines and guides the court as to the grant of its permission in the admissibility of expert evidence is hinged upon what is reasonably required to resolve the proceedings justly. While this is true, the case of *Bergan -v- Evan* [supra] emphasizes the need for the court's permission in such cases. *Bergan -v- Evan* [supra] is analogous to the instant matter. In both cases an application was made to adduce a medical report into evidence which was refused. Nevertheless, the refused medical reports were attached to the claim form in *Bergan -v- Evan* [supra] and to the amended statement of case and witness statement of Bevon Dollard in the instant proceedings. The Privy Council, overturning the trial judge's decision stressed the importance of the court's permission for reliance to be placed on medical reports as, it would undermine the court's power if such expert reports could be admitted into evidence simply by attachment.

21. The case of *Kelsick -v- Kuruvilla* [supra] highlights the various criteria by which a judge must address his/her mind to when making a decision to grant permission to use expert evidence. For permission to be granted so that the overriding principle is achieved, the independence, expertise and experience of the expert must be assessed to determine if their opinion is relevant to the issues to be decided. This is because in cases of negligence the relevant findings of fact are crucial in the

determination of issues such as causation. As the judge is the primary finder of fact, this is why it is essential that the judge is satisfied that the expert is sufficiently qualified, experienced and impartial when deciding to permit expert evidence. The judge must be contented that expert can fulfill his/her duty in providing independent assistance to the court by way of objective unbiased opinion irrespective of whom the expert has received instructions or payment.

22. Therefore, when the judge considers an application the underlying consideration that must always be kept in mind is "can this expert evidence and report help in the issues I am called upon to resolve?" The question must be posed and held in a neutral way taking into account the perspective and responsibilities of both the court and the parties. As a result, the approach that should be adopted is a balancing exercise administered on a case by case basis, considering the admissibility, cogency, usefulness and proportionality together with, when relevant, fairness, prejudice, bona fides and the due administration of justice.

23. It is clear from the facts of this case that permission was not granted to the claimant to adduce the expert report of Dr. Ramroop into evidence. In fact, when the application was made to admit Dr. Ramroop's report, Justice des Vignes (as he then was) refused the application as he thought a single joint expert was suitable in these circumstances. If the claimant did not agree, it was open to the claimant to appeal the decision. It therefore appears that the claimant had no issue with the course adopted, choosing to accept and abide by the opinion of a single joint expert, especially since same was appointed by consent of both parties. In any event, there were other appropriate means the claimant could have adopted if the medical report was not favourable to him and he still desired to rely on the expert report of Dr. Ramroop. In accordance with the learning of

Hodgkinson, it was open to the claimant to make an application to adduce further expert evidence; request permission to adduce questions of clarification to the expert; or have the expert attend trial for further questioning. However, none of these were adopted by the claimant.

24. Based on the abovementioned, the case of *Bergan -v- Evan* [supra] and the overriding principle as explained in *Kelsick -v- Kuruvilla* [supra], the court rejects the expert report of Dr. Ramroop. While the report does address the issues to be resolved in this matter, the court was deprived the opportunity to assess the independence and expertise of this expert, relevant to the findings of fact and causation in this case of clinical negligence. The fact that the claimant relies on this evidence to prove what he considers to be material parts of his claim does not make the evidence admissible.

25. On the other hand, it would be unfair and prejudicial to the defendant. The defendant would be denied the opportunity of cross-examining Dr. Ramroop to assess what weight, if any, the court should attach to Dr. Ramroop's opinion. The defendant would also be denied the opportunity of adducing their own evidence to impeach Dr. Ramroop's expert opinion. The objection to Dr. Ramroop's evidence is upheld and his report which is attached the claimant's witness statement is struck out as being inadmissible.

Dr. Kumar's evidence

26. As it relates to Dr. Kumar, he is a Consultant Orthopedic Surgeon with the Orthopedic Department at the Eric Williams Medical Sciences Complex (herein after referred to as "EWMSC"). Despite his position, he was not involved in the claimant's treatment. Dr. Kumar was called as a witness to give evidence explaining the medical records which

were prepared by members of staff responsible for the care of the claimant. Nevertheless, the claimant under cross-examination attempted to put its case to Dr. Kumar who generally agreed with the case put, that the standard of care in relation to the claimant fell below the requisite medical standard.

27. The claimant submitted that Dr. Kumar was a witness of fact because it was revealed under cross-examination that he was the Consultant Orthopedic Surgeon on duty on the days that the claimant initially presented at EWMSC i.e. 15th - 16th February 2010. Additionally, he is a witness with expertise on issues directly relevant to the court. As a result, the claimant avers that his expert opinion ought to be admitted as they are relevant to the issues to be determined. The claimant relied on the evidential rule permitting opinion evidence as set out in the case of *Sherrard -v- Jacob* [1965] NI 151 at page 12 which states:

> "I find in the judgment of Kingsmill Moore J. a statement of the principles which I have found expressed in the leading text-books and in judgments. The passage n4 is as follows: "It is a long standing rule of our law of evidence that, with certain exceptions, a witness may not express an opinion as to a fact in issue. Ideally, in the theory of our law, a witness may testify only to the existence of facts which he has observed with one or more of his own five senses. It is for the tribunal of fact – judge or jury as the case may be – to draw inferences of fact, form opinions and come to conclusions. The witness, as far as possible, puts the judge and jury in the position of having been present at the place and time when the fact deposed to occurred, and having been able to make the observations. The witness may be lying, his powers of observation may be deficient, his ability to express clearly what he observed may be inadequate, his memory may be faulty. These are inescapable hazards. But it is possible to avoid the further hazards of prejudice, faulty reasoning and inadequate knowledge, which would be introduced if a witness were allowed to give his opinion, and the tribunal of fact were allowed to act upon it. To this ideal rule exceptions have been introduced for reasons of necessity and practical convenience. The nature of the issue may be such that even if the tribunal of fact had been able to make the observations in person he or they would not have been possessed of the experience or the specialised knowledge

> necessary to observe the significant facts, or to evaluate the matters observed and to draw the correct inferences of fact. Questions of this nature are usually compendiously referred to as 'matters of science and art', and in such matters the tribunal may be assisted by the evidence of persons qualified by experience, training and knowledge, to guide the tribunal to the correct conclusions. Such persons, generally described as experts, may express their opinions and conclusions, and such opinions and conclusions may be based not only on their own observations but on the observations of other witnesses who have given evidence. No question of expert evidence arises in the present case."

28. The defendant on the other hand disagreed. There is no suggestion that Dr. Kumar actually observed anything in respect of the claimant's treatment and at no point did he actually treat the claimant. Furthermore, it was submitted that Dr. Kumar was not appointed as an expert in this matter to evaluate and express his opinion about the standard of care meted out the claimant. This was the purpose of the single joint expert consented to by both parties and thus appointed by the court. The claimant in his cross-examination did not even raise questions with Dr. Kumar in response to the expert evidence of the single joint expert in this case. As a result, the defendant submits that it will be wholly inappropriate and an abuse of process to admit his opinions into evidence.

29. The issue with regard to Dr. Kumar's evidence, in the court's opinion are not directly and simply confined to permission given to adduce expert evidence pursuant to Part 33.

30. Dr. Kumar was a witness for the defendant whose evidence in chief explained the medical notes pertaining to the claimant. However, Dr. Kumar was not only cross-examined on his evidence in chief but also on matters relating to the standard of care meted out to the claimant. He was not an attending doctor involved in the claimant's treatment

observing facts with his own five senses. Nevertheless, he was asked questions about his opinion on record keeping, the competence of the staff, whether the claimant ought to have been warded when initially presented, along with other matters regarding the standard of care at EWMSC which did not form part of his evidence in chief in his witness statement.

31. Dr. Kumar has been a Consultant Orthopedic Surgeon for over 13 years and has held this position at the Orthopedic Department of the Hospital for the past eight years[4]. Based on his experience, he is also knowledgeable about the internal workings of the Hospital, familiar with the records, staff and culture of the organization. Since he did not view the patient, in accordance with the case of *Sherrard -v- Jacob* [supra], he is not a witness of fact as it relates to the treatment and care of the claimant. Dr. Kumar however, is a witness of fact regarding the medical notes and what he knows about EWMSC by virtue of his position. As a result, Dr. Kumar is a witness of fact, who is capable of assisting the court by way of his opinion on certain issues.

32. The fact is that he is a medical doctor and therefore would, in the usual cause of events, be considered competent to express expert opinion. As a witness called by the defendant to give formal evidence, one cannot divorce his expertise and experience when he is cross-examined.

33. His opinions were elucidated through cross-examination by counsel for the claimant. What then is the effect of evidence divulged through cross-examination? According to the Halsbury of Laws England[5], cross-examination is directed to (1) the credibility of the witness; (2) the facts to which he had deposed in chief, including the cross-examiner's

[4] At the time of filing his witness statement dated 24 March 2016
[5] Volume 12 (2015) at paragraph 846

version of them; and (3) the facts to which the witness has not deposed but to which the cross-examiner thinks he is able to depose.

34. The claimant was well within his right to cross-examine Dr. Kumar on facts that they believe Dr. Kumar can express an opinion on regarding his knowledge of the EWMSC. Based on Dr. Kumar's position at the EWMSC, the questions posed to Dr. Kumar in cross-examination were proper. The fact that the defendant believes that answers were not favourable to their case are not grounds for excluding Dr. Kumar's evidence in these circumstances. The questions posed and the answers elicited are as a result of the skill of the cross-examining attorney.

35. The court has the evidence in chief of Dr. Kumar and the court also had the opportunity of viewing Dr. Kumar in the witness box. The court also has the benefit of all the evidence elicited in the trial. In so doing, the court will make an assessment of the credibility of Dr. Kumar by checking his demeanor, considering the contemporary records annexed to his witness statement, examining the pleaded case and weighting the probability or improbability of rival contentions in light of the facts of this case[6]. Hence, collectively, the court was able to assess the independence, expertise and experience of Dr. Kumar. The court was also able to consider the opinions expressed by Dr. Kumar and to apply what weight if any, it considered appropriate.

36. The court is satisfied that based on Dr. Kumar's experience, expertise and independence, his opinions elicited during cross-examination are admissible without any permission being sought or granted by the court pursuant to Part 33.

[6] Privy Council decision of Reid -v- Charles No. 36 of 1987

b. Facts Relating to Main Issues

37. Having reviewed all the evidence, the court has determined, on a balance of probabilities, the facts of this case. The facts are that on the 15th February 2010, at or around 2:30pm, the claimant was on a building, two to three storeys up. The claimant jumped from that height, landed on his feet and then fell over in pain and discomfort. He was subsequently taken to the EWMSC. At the EWMSC, the claimant was placed in a wheel chair, after which he was registered. The Nurse's notes on admission, record that the claimant was suffering from "pain and swelling to both ankles Patient was attacked by a group of armed men and then he jumped from the 2nd floor of a building …he suffered severe pain & swelling to both ankle joints with assoc difficulty in movements…& inability to walk".

38. The claimant was later taken to be X-rayed. The X-ray report noted that there was (R) calcaneal fractures with a queried left distal fibula fracture and an old injury caused by a bullet. When the doctor (Dr. Andrew) examined the patient, he also recorded in the doctor's notes that the patient jumped from a building and landed on both feet.

39. A plan for the claimant's treatment was reviewed with the House Officer on call and prescribed as follows:
    - **a.** below knee back slab bilaterally;
    - **b.** non-weight bearing;
    - **c.** orthopaedic patient clinic referral;
    - **d.** ibuprofen; and
    - **e.** tramacet po tab

40. The claimant was fitted with casts on both legs and discharged from the EWMSC on 16th February, 2010. Before being discharged, the claimant was referred to the Orthopedic Out Patient Clinic. The

referral to the Orthopedic Out Patient Clinic was initially scheduled for the 1st March. The claimant did not report to the clinic on the 1st March and a new date was given for the 8th of March 2010.

41. The claimant presented himself to the Arima Health Facility on the 7th April 2010 with complaints of pain. The nurse noted that the "Patient had bilateral fracture over the carnival and had casts placed to both legs. Removed casts 2 weeks ago for himself. Presently having pain to both legs." On examination the doctor noted the patient's history of "calcaneal fractures bilateral, seven weeks prior".

42. On the following morning, the examining doctor noted that the patient "complained of severe pain to both ankles for the past two weeks post removal of cast bilateral". It was also noted that the patient was in severe pain to both ankles and that puncture wounds were seen to both heels. The patient was diagnosed as suffering from osteomyelitis. The treatment plan included medication, X-ray of both ankles (anterior and lateral) and transfer to the Adult Priority Care Facility at EWMSC.

43. There are no records from the Arima Health Facility or the EWMSC about the claimant's transfer and admittance between both health facilities. The claimant, later attended his outpatient clinic on the 19th April 2010. On that day, the doctors at the clinic determined that the claimant was from Dr. Kumar's clinic and gave him a referral to attend Dr. Kumar's clinic. According to the hospital records, the claimant attended Dr. Kumar's clinic on the 22nd April 2010.

44. The outpatient clinic notes revealed that the claimant had been weight bearing for the past two months. That would mean that the claimant was weight bearing shortly after he sustained his injury. The notes also questioned the account given that the claimant's casts had been removed by a doctor in emergency. The treatment plan was for casts,

acceptance to ward and non-weight bearing. The patient was admitted to the Adult Surgical Ward. Once warded, Dr. Quan Soon's treatment plan included medication and bed rest. The progress notes for the claimant showed that the casts were on both feet and that the claimant was comfortable and moving via wheel chair. The treatment plan evolved that the patient be discharged on the 27th April 2010. The claimant was however not discharged and he was allowed to remain on the ward as he had no wheel chair or family to assist.

45. On the 4th May 2010, the patient was not seen on the ward and was later found in the corridor. On examination, the doctor noted that the claimant had nil complaints and that his family had acquired a wheel chair. The treatment plan was for discharge and the claimant was to be seen at the Orthopedic Out Patient Clinic in three weeks and new X-rays were to be done. The claimant left the EWMSC on the 4th May 2010.

46. On the 13th May 2010, the claimant attended clinic and the new X-rays showed that there was still a calcaneal fracture. He was advised to continue the use of a wheel chair and non-weight bearing. On the 29th July 2010 the claimant attended clinic again, the new X-rays showed that the ankle joint was intact and that there was a severe calcaneal fracture and spurs. The treatment included continued physiotherapy and a return to the clinic in two weeks. There are no records of the patient returning in two weeks, instead he returned just shy of two years on the 25th May 2012.

47. On the 25th May 2012 the notes showed that the claimant had bilateral calcaneal fractures for three years. The X-rays showed a collapse of the height of the calcaneal bone, a loss of articulation of the talus and that the calcaneaus were painful. He was assessed as having a

permanent disability of 15%. After the visit on the 25th May 2012, the claimant has not attended the clinic.

Resolving disputes in the evidence

48. There were matters of dispute and discrepancies that emerged from the evidence. Some of those matters affected the credibility of the witnesses, particularly the claimant. In cases of fact finding, the Privy Council in the case of *Reid -v- Charles* No. 36 of 1987 sets out the approach of a trial judge in assessing the evidence of a witness:

> "…where there is an acute conflict of evidence between neighbours, particularly in rights of way disputes, the impression which their evidence makes upon the trial judge is of the greatest importance. This is certainly true. However, in such a situation, where the wrong impression can be gained by the most experienced of judges if he relies solely on the demeanour of witnesses, it is important for him to check that impression against contemporary documents, where they exist, against the pleaded case and against the inherent probability or improbability of the rival contentions, in the light in particular of facts and matters which are common ground or unchallenged, or disputed only as an afterthought or otherwise in a very unsatisfactory manner. Unless this approach is adopted, there is a real risk that the evidence will not be properly evaluated and the trial judge will in the result have failed to take proper advantage of having seen and heard the witnesses."

49. While the court agrees with the claimant's submission that Bevon Dollard is a simple man who was not afforded the benefit of higher learning, his simplicity was not decisive in the findings about his credibility.

50. The first matter that required resolution was whether the claimant jumped or fell from the building on the day he suffered the injury. While that fact, in and of itself is not relevant to the nature of the claimant's injuries, resolving that discrepancy has assumed great

importance on the issue of the claimant's credibility and the fact finding exercise. That discrepancy emerged on the claimant's case. The claimant pleaded and gave evidence that he fell from the building. However, the medical records on which the claimant relies, tells a different tale.

51. The claimant's version of events as to cause of his injuries is that on the 15th February while having obtained a private job, painting the outside portion of the third storey of a building, he suddenly fell off the scaffolding. He fell three stories down and landed in a standing position on his feet. The nurse's notes on his admission form states:

> "…pain and swelling to both ankles. Patient was attacked by a group of armed men and then he jumped from the 2nd floor of a building."

52. Additionally, Dr. Andrew later that day at 8:44pm recorded:

> "Pt jumped from a 2 storey building and landed on both feet."

53. The court had to choose a version between the claimant's witness statement made on the 11th March 2016 made well over six years from the date of the injury and the contemporaneous account. The court has chosen the contemporaneous account. The difference in accounts, in my view, cannot be attributed to, memories fading and details becoming blurred over time. The court does not believe the claimant in this regard and is of the view that he is telling an untruth.

54. The court is satisfied that the claimant was attached by men and he jumped from a height of two or three storeys to escape the attackers. He fell on both feet and toppled over as a result of the injuries sustained from the jump. On his admission to EWMSC, at the first opportunity to recount what brought him to the hospital, he gave an accurate account. There would be no reason for the claimant, while in excruciating pain, to lie to the nurse as well as the doctor. Similarly,

there would be no reason for the nurse and the doctor to make up an account as to the manner in which a patient received his injuries. Now, six years later, the claimant may feel that a sanctified version is more favourable to his case. For these reasons, the court accepts that records from the nurses and doctors at the EWMSC are independent and accurate records of the account given by the claimant and that account is how the claimant came to suffer his injuries.

55. Secondly, it is the defendant's case that when the claimant visited the Adult Priority Care Clinic on the 23rd February 2010 he was given the date of the 1st March 2010[7] to be seen at the Orthopedic Outpatient Clinic. However, there are no medical records to show that the claimant did in fact visit the said clinic on that day. The claimant however in response[8] stated that he did attend the outpatient clinic on the 1st day March 2010 but was advised that he had not been listed for the clinic on that date. As a result, he was given a new appointment date for the clinic on the 8th March 2010.

56. The court finds difficulty with believing the truth of this statement. The claimant filed a claim form and statement of case on the 14th February 2014. Subsequently, the defendant filed its defence on the 15th October 2014, which the claimant replied to on the 9th January 2015. An amended statement of case was filed on the 26th June 2015 and an amended defence was then filed on the 29th September 2015. No subsequent reply was filed by the claimant, and the information relating to his visit to Out Patient Clinic on the 1st March 2010 is only mentioned in that reply as it is not contained in the amended statement of case.

[7] At paragraph 12 of the Defence filed on the 15th October 2014 and the Amended Defence filed on the 29th September 2015

[8] Reply to Defendant's Defence filed on the 9th January 2015 at paragraph 2

57. Significantly, the claimant failed to detail in his witness statement that he attended the outpatient clinic on the 1st March 2010 and was given a new date. After he speaks of his visit to the Facility on the 17th February 2010, the claimant states[9]:

> "After leaving the Health Facility I returned home because I could not bear to be rejected by the Hospital again. I remained there in pain for the next three weeks until my appointment at the Hospital scheduled for the 8th day of March 2010 to see a Dr. Young Pong."

58. In both the claimant's witness statement and amended statement of case the claimant is explicit that he remained at home in pain from the 17th February 2010 to the 8th March 2010. The court is of the opinion that it cannot overlook this deficiency in the claimant's witness statement and that it amounts to an inconsistency in his pleaded case. Such information is crucial to the claimant's case as it goes to defendant's pleadings of contributory negligence i.e. the claimant failed to attend promptly or at all the orthopedic outpatient clinic on the 1st March 2014.

59. Additionally, when the claimant states that he remained at home in pain from the 17th February 2010 to the 8th March 2010 the court finds this statement to be wholly untrue. The contemporaneous interspeciality referral letter dated the 23rd February 2010 reflects that the claimant visited the Hospital on that date and received an appointment for the 1st March 2010. For those reasons, the court finds that the claimant's pleaded case is inconsistent with the evidence which goes to the claimant's credibility.

60. Thirdly, the removal of the casts and transfer from the Arima Health Facility to the EWMSC. The claimant scolds that an adverse inference should be drawn against the defendant, stating that the medical

[9] At paragraph 24 of the witness statement of Bevon Dollard filed on the 24 March 2016

records for the period of the 8th April 2010 to the 19th April 2010 were missing. The claimant relied on the case of CV2010-04502 *Ijab Ojah Brathwaite -v- The Attorney General of Trinidad and Tobago* where Justice Rajkumar (as he then was) stated:

> "49. The non-disclosure of this report was material. The law on this matter is clear. Where a party has failed to provide proper disclosure it is open to the Court to draw adverse inference at the trial in relation to the absence of those documents."

61. The court has taken an entirely different view of the claimant's evidence and what occurred over this period.

62. There is no dispute that the claimant attended the Arima Health Facility on the 7th April 2010. The nurses' notes detailed:

> "Patient had bilateral fracture over the Carnival and had cast placed to both legs. Removed cast 2 weeks ago for himself. Presently having pain to both legs."

63. The 7th April 2010 was a few weeks after the claimant was discharged and given a treatment plan that included casts on both legs and a directive to be non-weight bearing. Clearly the patient did not follow the treatment plan. The court is satisfied on a balance of probabilities that the claimant himself, removed the casts from both legs. The claimant told the nurses that he did removed the casts, and the nurses were careful to take a note of the claimant's account. Clearly that was relevant and important information for his diagnosis and care. Why would the claimant remove his casts, if not to use his feet and therefore to weight bear in direct contradiction to the treatment plan given to him by the medical professionals at EWMSC. The court is satisfied that the pain to both legs that the claimant complained about at Arima Health Facility, was caused by or exacerbated by the behaviour of the claimant in removing his casts and weight bearing.

64. At 4 am on the 8th April 2010, Dr. Rampersad as part of his treatment plan indicated that the claimant be transferred to the Adult Priority Care Facility which is located at EWMSC. The claimant in his witness statement is silent on how he got to the EWMSC. The court notes that on all other occasions the claimant was explicit about how he was transported to the various places where care and treatment was administered. This omission is significant because the claimant alleged that it was Dr. Andrews who removed the casts at EWMSC:[10]

> "I was then taken to the Hospital where he was again met by "Dr. Andrews" who ordered that the Claimant undergo a second X-Ray. This was another painful experience as the attendants roughly placed me on the X-Ray table. The "casts" on my feet were removed and a second X-Ray was done."

65. The court, is satisfied on a balance of probabilities that the claimant did not go to the EWMSC as Dr. Rampersad directed. It is for this reason only that there are no notes about his admission, no medical records, no copies of X-ray reports and no details about any treatment plan. They were not missing because they never existed. No medical records were ever made because the claimant was not at the facility during that period. The only adverse inference to be drawn is on claimant's veracity.

66. That is why the next available record provides continuity from the observations made at the Arima Health Facility on the 7th and 8th April 2010 regarding the removal of the claimant's casts. On the 19th April 2010 the claimant attended the Out Patient Clinic. It appears to the court that rather than going the EWMSC as per the order of the doctor at the Arima Health Facility, the claimant waited on his clinic date for the 19th April 2010.

[10] At paragraph 30 of the witness statement of Bevon Dollard filed on the 24th March 2016

67. At the Out Patient Clinic on the 19th April 2010, Dr. Young Pong ascertained that the claimant was for Dr. Ali's clinic and referred him to Dr. Ali for the 22nd April 2010.

68. On the 22nd April 2010 at the Dr. Ali's clinic, the progress notes questioned the whereabouts of the claimant's casts and noted that the claimant had been weight bearing. By then the claimant had been without his casts for about a month; from two weeks prior to the 7th April 2010 (by this count since sometime in May 2010) to the 22nd April, 2010.

69. Clearly the claimant's account that his casts were removed by a doctor on the 8th of April 2010 to facilitate X-rays of the claimant's legs, did not make sense causing the doctor who attended to the claimant on the 22nd April 2010 to question that account.

70. Based on the aforementioned inconsistencies and fabrications in the claimant's evidence it is difficult for the court to believe his version of events especially when the contemporaneous records portray a different scenario. The court finds that there was no reason for the nurse at the Arima Health Facility to construct a story that the claimant removed the cast himself. In addition, based on the evidence and the manner in which the defendant's staff documented patient's notes, the court does not form the view that Dr. Andrew would have removed the claimant's casts and X-Ray his feet without at least documenting that an X-Ray was done on that day.

71. Lastly, another minor inconsistency was observed in the claimant's evidence and the contemporaneous evidence as it relates to the appointment he was given on the 19th April 2010 when he visited Dr. Young Pong. The claimant at paragraph 39 of his witness statement avers that he was given another outpatient clinic appointment for the

21st April 2010 which is inconsistent with the contemporaneous records. Both Dr. Young Pong's referral letter and the registration form detail the 22nd April 2010 as the date of the appointment.

c. Duty of Care, Causation and Liability

72. It is the undisputed evidence of both parties to the instant proceedings that the injuries sustained by the claimant, however caused, was no fault of the defendant. The claimant under cross-examination admitted that it is not his case that his legs were broken by the doctors at the Hospital. Instead, the claimant contends that the main issue to be determined by the court is whether the treatment and care administered in respect of his injuries fell beneath the requisite standard of care.

73. The claimant in establishing his case of medical negligence relied on paragraphs 5-12 of the judgment *Mary London (The Administratrix of the Estate of the deceased Kennis London) -v- North Central Regional Health Authority*[11]. The case sets out the law as it relates to the *Bolam test* for medical negligence, its refinement and a public hospital's liability for the acts of negligence by its professional servants in the course of employment as follows:

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

[11] CV2013-05017

> 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 medicalman, 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**, 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** 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.

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** 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** 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** it was held that:

> 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** 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**:

> 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"

74. It is the defendant's case that the single joint expert did not identify any treatment provided by it which fell below the standard of care of

a medical professional. In reliance on the *Bolam Test* the defendant reiterated that professionals need not possess the highest expert skill. Consequently, there is no breach of care simply because there is mere evidence that a different or superior treatment was possible. This principle has always been the law in this area and was established in the case of *Rich -v- Pierpont* (1862) 176 ER 16:

> "A medical man was certainly not answerable merely because some other practitioner might possibly have shown greater skill and knowledge; but he was bound to have that degree of skill which could not be defined, but which, in the opinion of the jury, was a competent degree of skill and knowledge. What that was the jury were to judge. It was not enough to make the Defendant liable that some medical men, of far greater experience or ability, might have used a greater degree of skill, nor that he might possibly be used some greater degree of care."

75. Additionally, the defendant submitted that there were serious and fatal errors in the manner in which the claimant framed his pleaded case of clinical negligence. The defendant contended that within the pleadings, there are no allegations of causation. The claimant does not plead that his injuries was caused by the defendant nor does he identify any treatment administered by the defendant which led to the claimant's injuries.

76. The defence states that such errors were brought to the attention of the claimant in the early stages of the proceedings. Firstly at paragraph 7 of the defence[12] and then at paragraph 7 of the amended defence[13]:

> "The Defendant denies paragraph 34 and that it is responsible for the particulars of injuries as pleaded thereunder. In particular the Defendant notes that these injuries were referable to and solely caused by the fall which the Claimant admits and for which it cannot accordingly be held liable. No injury nor any special damage there pleaded is or can be referable to or caused by any treatment provided to the Claimant by the Defendant. Instead these injuries are consistent

[12] Filed on the 15th October 2014
[13] Filed on the 29th September 2015

with the admitted accident of the Claimant prior to treatment by the Defendant and could not have been precluded nor ameliorated by appropriate medical treatment (which the Defendant maintains was in any event administered)."

77. As a result, the defendant maintains that claimant had ample opportunity to change his litigation strategy if he saw fit. In failing to do so, the claimant's claim is without merit due to the deficiencies in the pleadings. The defendant guides the court as per Dyson LJ (as he then was) quoting from the case of *Al-Medinni -v- Mars UK Ltd* [2005] EWCA Civ 1041 as to the consequence of a party to litigation choosing to run a case in a particular way may that:

> "the judge is compelled to reject a claim on the basis on which it is advances, although he or she is of the opinion that it would have succeed if it had been advanced on a different basis."

78. Moreover, the defendant avow that there is also no evidence of any causation of any harm through any action of the defendant or its servants and/or agents. Such evidence is particularly crucial in a case of negligence. Lord Phillips in the case of *Sienkiewicz -v- Greif (UK) Ltd* [2011] UKSC 10 noted:

> "[7] Where the court is concerned with a speculative question— 'what would have happened but for a particular intervention' it is likely to need to have regard to what normally happens. A good example of such a situation is the task of estimating the loss of expectation of life of a person whose death has been caused by negligence or breach of duty. In such a situation the evidence upon which the court will reach its conclusion is likely to be provided, at least in part, by a statistician or an epidemiologist. Medical science will identify whether the deceased had any physical characteristic relevant to his life expectancy. Epidemiology will provide statistical evidence of life expectancy of the group or cohort to which the deceased belonged. With this material the court answers the hypothetical question of the length of the life that the victim would have enjoyed but for the breach of duty of the defendant.
>
> …
>
> [16] It is a basic principle of the law of tort that the claimant will only have a cause of action if he can prove, on balance of probabilities, that the defendant's tortious conduct caused the

damage in respect of which compensation is claimed. He must show that, but for the defendant's tortious conduct he would not have suffered the damage. This broad test of balance of probabilities means that in some cases a defendant will be held liable for damage which he did not, in fact, cause. Equally there will be cases where the defendant escapes liability, notwithstanding that he has caused the damage, because the claimant is unable to discharge the burden of proving causation."

79. Lord Phillips illustrated the difficulty which was involved in cases dealing with treatment following injury by reference to the case of *Hotson -v- East Berkshire Area Health Authority* [1987] AC 750:

> "[27] In Hotson v East Berkshire AHA [1987] 2 All ER 909, [1987] AC 750 causation again caused a problem. The plaintiff, aged 13, had fallen out of a tree and sustained injury which reduced the flow of blood to cartilage in his hip joint. In breach of duty the defendants failed to diagnose this for five days. He suffered permanent disability of the hip joint. The issue was whether the injury itself was so severe that the subsequent disability of the hip joint was inevitable or whether, but for the five-day delay, it would have been possible to prevent that disability. The medical evidence was that there was a 75 per cent likelihood that the former was the case, but a 25 per cent possibility that the delay in treatment was critical. At first instance ([1985] 3 All ER 167, [1985] 1 WLR 1036) Simon Brown J held that the defendant's breach of duty had robbed the plaintiff of a 25 per cent chance of avoiding the disability. The House of Lords held that this analysis was erroneous. The plaintiff was not robbed of a chance of avoiding the disability. The die was cast as soon as he had sustained his injury. Either the disability was inevitable or it could, with due skill and care, have been avoided. On balance of probability, estimated at 75/25, the former was the position, so the plaintiff had failed to prove causation."

80. The learned authors Michael Powers QC and Anthony Barton[14] underscored that the breach must be causative and relevant in clinical negligence cases:

> "In the context of clinical negligence, issues of causation pose particular difficulties. The claimant will usually ex hypothesis

[14] Clinical Negligence, Fifth Edition (2015) at Chapter 1

> have been suffering from illness in the first place. Further, through breach of duty may be held to have occurred, that particular breach of duty may be held in the particular time-sensitive circumstances of the case not to have been causative of the damage suffered. *Anderson v Milton Keynes General NHS Trust and Oxford Radcliffe Hospital NHS Trust* concerned a Claimant who had suffered injury due to his accident at work, and who after contracting MRSA was left with significant disability in, and pain and shortening of, the left leg. It was held that although there was an admitted breach of duty in that the presence of MRSA had not be notified in time to the plastic surgeons, on the balance of probabilities the bacteria would by the relevant time have been immune to attack, and further reconstructive surgery to the Claimant's leg would have been required in any event, so that the hospital was not liable in damages."

81. The issues relating to the claimant's injuries, the appropriate standard of care and whether the treatment fell below that standard of care is a matter which requires the opinion of a skilled competent professional pursuant to the *Bolam Test* as outlined above. As a result, Mr. Baiju was appointed to assist the court as to the proper standards of a reasonable competent medical man when treating and managing injuries as presented by the claimant. Mr. Baiju's findings were as follows:

> "Both Feet - He has bilateral varus hind feet swelling with widened heels.
> There is associated swelling with tenderness on palpation both the ankle and calcaneal region.
> He has 0^{o}-20^{o} movements at the ankle but no movement at the subtalar joint. His mid foot is normal. Neurovascular normal.
> **Initial X-rays (15/02/2010)**:- Both Feet - severe comminuted intra-articular calcaneal fractures
> **Final X-rays (30/08/2016)**:- Healed calcaneal fractures"

82. Based on these findings, Mr. Baiju concluded that due to the nature of the claimant's fractures he was always at risk of developing subtalar arthritis (100%) regardless of what treatment was instituted. The evidence and the court's findings are that the fractures were not caused or exacerbated by the hospital staff or agents. The injuries

occurred during the process of the claimant eluding attack and they were exacerbated by the claimant's behaviour in not following his treatment plan in significant ways. As per *Hotson -v- East Berkshire Area Health Authority* (supra), the die was cast as soon as the claimant jumped off the two or three story building.

83. Mr. Baiju also found that treatment could have been more refined to relieve some of the suffering experienced by the patient "He should have been admitted to the hospital on the day of presentation and kept non-weight bearing at least until comfortable (2-5 days)". The claimant on the day of presentation was kept 1-2 days instead of 2-5 days. The important aspect of the expert's recommendation was for the patient to be non-weight bearing for a further 12 weeks. The court is of the view that there was no material departure from what the expert opined was the appropriate standard of care. He was discharged after two days with pain medication to treat his pain and instructed not to weight-bear. Based on the court's findings of fact, it was the claimant who is at fault by not following his treatment plan and by lying about it. The fact that the treatment plan could have been "more refined to relieve some of the suffering" when viewed with the facts as the court has found them, do not amount to negligence on the part of the defendant's servants or agents.

84. Mr. Baiju also found "The failure to properly diagnose or treat the injury at initial presentation does not affect the final outcome" as it relates to the injuries or the effects of those injuries that persist to today. The claimant feet; his bilateral varus hind feet, have widened heels. At the initial presentation, the only surgical intervention that could have been recommended, according to Mr. Baiju, was a primary subtalar fusion. However, the complications of such surgical intervention at the initial presentation, in the opinion of the expert, far outweighed any benefits that could have resulted from that

surgery. The same option for a surgical intervention still exist. There is no evidence that not performing the surgery at the initial presentation was negligent – in fact, it appears that it was be medically preferred option.

85. In making that assessment, Mr. Baiju did not have the facts that the patient did not follow the doctor's orders; that he removed the casts on his own, as well as he was weight-bearing within a few weeks of suffering the injuries. Mr. Baiju's opinion is that the treatment could have been more refined. This resulted in flattening of the calcaneal even more and reduction of the bone stock thereby making subtalar fusion surgery a little more difficult. However the court has found that these effects may be a result of the nature of the injury suffered and the claimant not following his treatment plan. The flattening of the calcaneal was not caused by the negligence on the part of the defendant's servants and agents.

86. A manipulation during admission may have reduced the width of the claimant's heels and may have aided the wearing of shoes when the fracture healed. However, the effects of such a surgery may have been more detrimental to the claimant.

87. Dr. Kumar was cross-examined and his opinion on certain issues was elicited and admitted into evidence.

88. The defendant in its amended defence[15] denied that it employed a medical professional known as "Dr. Andrews". However, Dr. Kumar revealed that there was a House Officer called "Dr. Andrew" in the employ of the defendant at the time. Dr. Kumar also apprised the court that he was the Consultant Orthopedic Surgeon on duty during

[15] Filed on the 29th September 2015 at paragraph 13

the 15th-16th February 2010 and was the person in charge on that day. Therefore, on the 15th February 2010 when the claimant was referred to the orthopedic outpatient clinic for further management of his injuries, Dr. Kumar stated that this was the reason why Dr. Andrew signed the referral on his behalf that day. The court found that the defendant was being pedantic on the issue of not knowing a Dr Andrews. However at the end of the day, nothing decisive turned on the fact that the attending physician was Dr. Andrew and not Dr. Andrews.

89. Under cross-examination, Dr. Kumar told the court that he did not review the claimant before discharge; based on his interpretation of the patient notes he could not tell whether the claimant's patient notes or treatment plan was reviewed or assessed by any senior surgeon in the department before Dr. Andrew discharged him. Dr. Kumar agreed with counsel for the claimant that from the medical records, it was apparent that the patient plan for the claimant was not discussed with the Registrar Dr. Ali, but instead was discussed between Dr. Andrew and another House Officer, Dr. Singh.

90. Additionally, Dr. Kumar accepted that the claimant was not warded and that he ought to have been warded at initial presentation. Dr. Kumar's opinion on this issue is assessed in context that he did not examine or see the claimant when he initially presented or was warded initially. The fact that the claimant was discharged without being warded for a longer period of time and without a review by a senior surgeon does not, without more, amount to negligence. That Dr. Kumar may have made different decisions regarding the warding and review of the claimant does not make the attending physician's care negligent. The expert's opinion is that based on the nature of the claimant's injuries, the outcome was set and would have been the same.

91. Dr. Kumar's evidence under cross-examination is that the progress notes were deficient as it failed to mention any reason why the claimant was not warded. There is no evidence that this amounted to negligence; there is no causation between this deficit and any injury suffered by the claimant.

92. Dr. Kumar highlighted what he considered to be further deficiencies in the record keeping at the Hospital. When the claimant was transferred from the Arima Health Facility by Dr. Rampersad to the Adult Priority Care Facility on the 8th April 2010, Dr. Kumar averred that from the patient notes he could not determine whether in fact the transfer was effected, as there were no patient records for the claimant between the periods 8th April 2010 to the 19th April 2010. The court has found that there were no notes because the claimant did not attend the EWMSC from the Arima Health Facility, therefore, in this regard there were no deficiencies.

93. Also, the medical records and notes of the Hospital do not reveal that an evaluation of the claimant's fractures was made with a view for surgery nor was the option of surgery discussed with the claimant. Again there is no evidence that this affected the outcome of and the effects of the injuries.

94. Dr. Kumar accepted that at this time surgical intervention in the form of reconstructive surgery was required by the claimant which could amount to $80,000.00 if done privately. In addition, he accepted that the pain the claimant experienced and continues to experience was likely to persist with or without this surgery. These facts do not support the claimant's claim that the defendant was negligence.

95. When the claimant's case was put to Dr. Kumar as to whether: the patient received an extremely poor standard of care after initial

presentation by the clinicians attending to him; the claimant ought to have been warded following his injury; the record keeping was poor; the level of care fell below the acceptable standard for this type of fracture; the staff failed to properly diagnose and treat the claimant; the defendant failed to provided suitably skilled or competent staff to treat the claimant; and whether the defendant failed to have sufficient levels of specialist consultation or decision making in relation to the claimant, Dr. Kumar answered in the affirmative.

96. Dr. Kumar's opinion proffered in cross-examination did not satisfy the court that the defendant's servants or agents were negligent. Dr. Kumar, as noted, did not examine the claimant. Based on the medical notes, Dr. Kumar may have made different decisions about the treatment and care plan for the claimant. However, that difference in expert opinion, without more, does not establish negligence. The claimant did not adduce any evidence to establish any more than those differences in opinion.

97. However, Mr. Baiju in his expert report, opined that despite the diagnosis or treatment proffered by the defendant, it would not have made a difference to the final outcome of the claimant's injuries. He would have always developed subtalar arthritis because of the nature of his fractures. This is akin to the case of *Hotson* [supra] as the die was cast from the time he sustained his injury. Therefore, the diagnosis or treatment did not cause the claimant to develop arthritis and the defendant is consequently not liable for this condition.

98. The evidence that is required to establish a breach in the duty of care, is evidence showing that the diagnosis was incorrect in terms of the fracture. It also required evidence demonstrating that the treatment provided caused the claimant to suffer injuries different from that

sustained from the fall and that the claimant endured more pain than was expected from injuries of the kind sustained.

99. There is no evidence that the diagnosis was incorrect. The claimant suffered all the injuries diagnosed on his presentation. The claimant did not sustain and suffer injuries different from those diagnosed when he was admitted to the EWMSC for treatment on the 15th February 2010. Further the expert's uncontroverted evidence is that the injuries sustained and the effects of those injuries were consistent with the jump and that the outcome would have been the same even if the claimant's injuries were managed differently – including hospitalization for a longer period at the initial stage of his presentation at the EWMSC.

100. It is pellucid from the evidence that the claimant was in extreme pain. The medical notes on the day of initial presentation, 15th February 2010, detail on two occasions that the claimant was in severe pain to the extent that he was screaming and shouting in pain. The medical notes of the EWMSC on the 7th and 8th April 2010 also recorded pain to both legs and indicated that the claimant was in painful distress as his ankles were swollen, warm, tender to the point that he was unable to move them.

101. As part of the treatment, the expert and Dr. Kumar opined that the claimant ought to have been warded at the Hospital on the day of initial presentation. Mr. Baiju further stated that the claimant on initial presentation should have been kept non-weight bearing at least until comfortable, around two to five (2-5) days. This fact, by itself, does not amount to negligence. What the evidence showed is that the claimant was weight bearing soon after his injury, he removed his casts and he did not attend at the Out Patient Clinic.

102. The claimant's warding on the 22nd April 2010 became necessary as a direct consequence of the claimant's behaviour in not following the doctors' orders and the concomitant deterioration of his circumstances.

103. The treatment plan included medication for pain management and direction to be non-weight bearing. It is impossible for the court to determine how much of the pain the claimant suffered and still suffers is as a result of his own behaviour by not complying and following his doctors' directions.

104. It is accepted that the medical professionals ought not to possess the highest expert skill in line with the *Bolam Test* or adopt a superior treatment. Warding a patient who was screaming out in pain on his admission and discharging him on the second day does not mean that the claimant was in the same pain as when he was admitted. The court would have to find the claimant a credible witness to be satisfied on a balance of probabilities, that the claimant was in the same or similar pain when he was discharged than when he was admitted. It appears reasonable for the court to find as a fact that upon being admitted and treated, the doctors were satisfied that with medication to manage his pain, the claimant could have been discharged. The claimant was instructed not to weight bear. It appears that the major part of the treatment for his claimant was non-weight bearing and rest. There appears to be no difference in non-weight bearing home and non-weight bearing at the hospital in the circumstances of this case and the claimant's injuries.

105. The court does not find that discharging the claimant, as opposed to warding him, was unreasonable treatment and care for the claimant's injuries under these circumstances. There is no evidence that he could not do at home what was required to be done and there is no evidence

that the treatment plan amounted to negligent care or that the treatment plan caused the claimant to suffer any injuries.

106. Additionally, the court does not find incompetence with the medical professionals employed by the defendant in failing to have sufficient levels of specialist consultation or decision making in relation to the claimant. The evidence of Dr. Kumar is that on the 15th February 2010 based on his interpretation of the patient notes, he could not tell whether the claimant's patient notes or treatment plan were reviewed or assessed by any senior surgeon in the department before Dr. Andrew discharged him. Instead, Dr. Andrew a House Officer held discussions with another House Officer Dr. Singh, both at the lowest rank in the chain of command. Dr. Andrew did not seek the opinion of a more experienced doctor including the Registrar Dr. Ali, nor Dr. Kumar Consultant Orthopedic Surgeon who was in charge on that day.

107. Nothing turned on the defendant not having the claimant reviewed by a senior surgeon. Mr. Baiju opined that as part of the treatment a manipulation during admission may have reduced the width of his heel and may have aided in the wearing of shoes when the fracture healed. The court does not know if the claimant removing his casts and being weight-bearing soon after receiving his treatment plan, caused the increased width of the heel. In any event, Mr. Baiju's evidence is that such surgical intervention on presentation carried more risks than any expected benefits.

108. There is no doubt that the defendant owed a duty of care to the claimant. The court is satisfied that the defendant discharged the duty of care owed. The claimant also owed to himself a duty to take care. The claimant did not discharge his duty to himself and he cannot place that additional burden on the defendant.

109. The claimant's early discharge, is not indicative of poor management of the injury on the defendant's part as discussed above, the evidence is that the claimant in turn, removed his casts and placed weight upon his injured heels. Weight bearing has certainly caused more pain and would cause flattening of the calcanei even more reducing bone stock.

110. The claimant in his reply stated that he did remain off his feet receiving assistance from family and friends. According to the claimant that assistance was to move about at home and he used crutches and subsequently a walking stick to get around. Because the credibility of this witness was compromised by the inconsistencies and falsities within his evidence, the court agrees with the opinion of the expert that weight bearing has certainly caused more pain and would cause flattening of the calcanei even more reducing bone stock.

111. Along with placing weight on his heels subsequent to treatment and in breach of medical direction, the defendant in its amended defence pleaded that the claimant also contributed to his injuries when he failed to attend promptly or at all the Orthopedic Out Patient Clinic on the 1st March 2010. The claimant replied to these allegations against him stating that he did attend the Out Patient Clinic on the 1st day March 2010. However, he was advised that he had not been listed for the clinic on that date and was then given a new appointment date to return to the clinic on the 8th March 2010.

112. However, as previously discussed, the court did not believe this evidence. The court is of the view that the claimant did not visit the Out Patient Clinic on the 1st March 2010 as he claims. Based on the court's interpretation of the evidence, it appears that the claimant mixed up the dates for his appointment and did not show up for is scheduled appointment on Monday 1st March 2010. Instead he showed up on Monday 8th March 2010 as he stated in his evidence.

This is the reason why his name was not on the list and was subsequently told to return on the 19th April 2010 as reflected on the interspeciality referral letter and witness statement.

113. Therefore, the court is satisfied that the claimant contributed to his injuries when he removed the casts and placed weight on his injuries subsequent to treatment in breach of medical direction and failed to attend promptly or at all the Orthopedic Out Patient Clinic on the 1st March 2014.

114. However, while the option of surgery should have been discussed, by not doing so the defendant did not breach its duty of care to the claimant. At present, Dr. Baiju opined that the option of surgery is still available, though may be a bit more difficult as a result of the reduced bone stock. If the surgery was not available at this point then the outcome of this decision would have been different. It cannot be proven that but for the defendant's failure to discuss the option of future surgery with the claimant, he has suffered loss.

Disposition

115. The claimant's claim against the defendant is dismissed. The claimant shall pay the defendant's cost as prescribed, in the amount of $14,000.00.

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Justice Avason Quinlan-Williams

JRC: Romela Ramberran