TRINIDAD AND TOBAGO

IN THE COURT OF APPEAL

CV APP. #60 OF 2008
HCA NO. #555 OF 2003

BETWEEN

SOUTH WEST REGIONAL HEALTH AUTHORITY

APPELLANT

AND

SAMDAYE HARRILAL

RESPONDENT

PANEL
MENDONÇA, JA
JAMADAR, JA
BEREAUX, JA

APPEARANCES: Mr. E. Koylass SC & Ms. D. Roopchan for the Appellant
Mr. A. Ramlogan for the Respondent

DATE DELIVERED: 12TH MAY, 2011

REASONS

[1] On 25th January, 2010, we dismissed this appeal on the question of liability but on the question of damages allowed the appeal in part, reducing the general damages awarded to the respondent from one hundred and forty thousand dollars ($140,000.00) to one hundred and twenty thousand dollars ($120,000.00). We promised to give our reasons subsequently. We do so now and deeply apologise for the delay. The issues raised in this appeal are of great public interest, moreso because, ultimately, the cause of action may have resulted from unprecedented industrial action taken by medical doctors at a public hospital. Additionally, our reasons are being published at a time of great public anxiety about the quality of medical care being given to members of the public, (most of whom cannot afford private care) at our public medical institutions and particularly so in respect of maternity cases. We have thus sought to set out the law as fully and clearly as possible. We consider the facts and circumstances of this case to have been unfortunate and it is our hope that this will remain a rare and exceptional, if not isolated case.

[2] The respondent had given birth to a stillborn male child at the San Fernando General Hospital on 23rd April, 2002. She alleged that the stillbirth was due to the negligence of the appellant, its servants or agents and claimed damages for the loss of her child, as well as damages for distress, anxiety and inconvenience. The respondent set out numerous particulars of negligence of which the most relevant were:

- failing to have a competent, or any doctor available to respond and attend to the respondent's deteriorating condition;
- failing to take any or any sufficient measures to safeguard the interest, life and welfare of the baby;
- failing to transfer the respondent to a suitably staffed institution which was properly equipped to handle her case;

- failing to use reasonable care and diligence in the treatment given to the respondent;

- admitting the respondent to the hospital when it was not suitably staffed to handle the respondent's case.

Facts

[3] The following facts, given in evidence by the respondent, were not disputed by the appellant. The respondent was nine months pregnant. She had had an uneventful pregnancy and, although she suffered from a congenital heart condition known as Ventricular Septal Defect (VSD), was expected to have had an uncomplicated delivery. Her medical condition could suitably have been managed by the administering of antibiotics during labour. The respondent had done her ante-natal care at the San Fernando General Hospital. Her medical condition had been noted in red in her patient notes, with the instruction that antibiotics be administered during labour. It would have been noted by the nurses on the ward.

[4] On 22nd April, 2002, at about 8.00 am, the respondent went to the hospital because she thought that her amniotic sac had burst and that her baby's birth was imminent. The child's birth had in fact been three days overdue. It was accepted that the senior doctors at the hospital had taken an industrial action by withholding their services. It was also not disputed that at the time of the respondent's admission, there was no obstetrician on duty. Indeed, none of the three wards to which the respondent was sent, had any obstetrician on duty, they were manned by nurses and midwives only. According to the respondent's evidence however, she was told only that there was no doctor in the emergency department. She was sent to Ward 13A, where, upon admission to the ward, a nurse examined her and told her that the baby's heart beat was *"all right"*. She sat on a bench for two and a half hours, after which she was taken to Ward 13B, there she waited on another bench for a further two hours before eventually being assigned a bed.

[5] Up until her admission at 10.55 am on 22nd April, 2002, the respondent had felt no labour pains. Pain started sometime after 6.00 pm. She informed the nurse who advised her to lie

down or keep pacing up and down the corridor. She chose to pace. When the pain grew stronger, the nurse made her lie down. She *"checked the baby"* and said that everything was *"all right*". The respondent asked to see a doctor. She said that *"I did so because I have a heart problem and with previous births when I go into labour I have to get an antibiotic injection"*. The nurse told her that an injection could not be administered without a doctor's permission.

[6] By 10.00 pm, the respondent was in *"overbearing"* pain. She again asked for a doctor. A nurse tried to contact a doctor but told her that *"no doctor would come"*. The respondent was taken to an examination room and the baby's heart rate was read. The respondent felt she was getting really strong labour pains. She asked once again for a doctor. At 10.30 to 11.00 pm, she was given an antibiotic injection (although there was no doctor in attendance). The respondent's patient notes, which were admitted into evidence, show that the nurse contacted a doctor by telephone and he authorized the administering of the antibiotic. At 12.20 am on 23rd April, 2002, monitoring of the foetal heart rate revealed that there was deceleration, a sign of foetal distress. The doctor was again informed but still he did not come. At 12.30 am, a marked deceleration of the foetal heart rate was noted on the monitor together with the draining of meconium stained liquor, a further sign of foetal distress. She was transferred to the labour ward *"for further management"*. At 12.35 am another test detected no foetal heart rate.

[7] The respondent eventually delivered the stillborn male infant at 1.06 am. A paediatrician arrived at the labour ward at the same time of the birth and attempted resuscitation. The child was pronounced dead at 1.40 am on 23rd April, 2002. The cause of death, as set out in the medical certificate of death was *intra partum asphyxia,* although the post mortem revealed no cause of death. At no time during her stay at the hospital, from admission to delivery of her child, was the respondent seen or treated by a doctor.

The defence

[8] In its defence, the appellant, as a general response to the respondent's claim, contended that doctors in its employ had withdrawn their services from the San Fernando General Hospital and would, without notice, or at very short notice, not take up duty as rostered. It

contended that in those circumstances, it made use as best as it could, of its available personnel and gave public advisories as to its limited and compromised ability to provide or guarantee medical services to the public at large. It alleged that it sought assistance from doctors not within its employ in an effort to keep the hospital open to the public and that in those circumstances, it did all that was reasonable in seeking to discharge its statutory duties. The appellant alleged further that the care given to the respondent by the midwives, in the delivery of her baby, was proper in all respects.

[9] Having proffered those facts by way of general defence to the respondent's allegations, the appellant then pleaded to specific allegations in the statement of claim not all of which need be repeated here. The appellant asserted it was not negligent in the death of the infant because:

(i) death was due to *intra partum asphyxia "which could have and did occur without negligence"* due to:

(a) congenital defect;
(b) an inherent and unavoidable risk of childbirth;
(c) the stress of labour;
(d) ingestion of liquor;
(e) lack of oxygen in the foetal descent along the birth canal.

(ii) at the time of admission, the respondent was not in labour and was kept for observation under the care of nurses and midwives competent and capable of carrying out the delivery of a baby *"if such necessity arose"*.

(iii) between 12.20 am, when deceleration of the foetal heart rate was observed and 12.35 am, when the respondent was in established labour, the available forms of proper and established medical treatment involved performing a caesarean section or hastening the respondent's delivery per vagina. The option of caesarean section

was not available due to the short time frame within which the respondent was in established labour and during which time no foetal heart rate was heard on the monitor at 12.35 am.

(iv) due to the respondent's presented condition, including the drainage of meconium stained liquor (noted at 12.30 am), hastened delivery per vagina was the only and preferred viable procedure which was attempted. The respondent, during the period of delivery, was not herself in distress. The time frame within which the respondent experienced established labour did not allow for any other mode of intervention for her care or that of her foetus and the death of the foetus occurred without negligence, by act or omission, of the appellant, its servants or agents.

(v) arrangements were being made for the respondent's transfer to another medical facility but were overtaken by the delivery.

Findings of the judge

[10] The trial judge found that the appellant was in breach of its duty of care to the respondent. We have summarized his reasons thus:

(i) no option was given to the respondent to attend another medical facility staffed with doctors, in the event that one would be required.

(ii) there were no doctors available in the hospital to attend to the respondent at the earliest possible time, should there have been an indication that something may have gone wrong with the baby's heart rate.

(iii) there was a delay in the administering of the antibiotic to the respondent because the nurse had to obtain authorization of a doctor via the telephone.

(iv) the respondent had been in excruciating pain and had requested a doctor to attend to her but none was available.

(v) there was no monitoring to decide whether to do delivery via caesarean section.

(vi) the lack of availability of doctors on the labour ward, eliminated all possibility of delivery by forceps or caesarean section, since this was a decision to be made at the ward by doctors on duty.

(vii) the very fact that the respondent suffered from VSD and that something could have gone wrong should have put the nurses on guard. They should not have taken the responsibility of accepting a VSD patient themselves. The fact that she suffered from VSD made her a high risk patient.

(viii) the baby was three days overdue. This meant that the pregnancy had entered a danger zone. An obstetrician should have seen the respondent so as to make a considered judgment long before any kind of serious labour started.

[11] The judge awarded the respondent the sum of one hundred and forty thousand dollars ($140,000.00), together with interest at 6% per annum from 15th April, 2003. Included in this sum was an award of exemplary damages, (which was not specified), for what the judge considered to be oppressive, arbitrary and unconstitutional acts by the appellant. He also appears to have awarded damages for the respondent's distress, anxiety and inconvenience.

[12] The appellant, in its notice of appeal, lodged multiple complaints against the judge's decision. It alleged, *inter alia,* that the judge failed to analyse its defence; was *"overpowered by sympathy for the respondent"* and failed to give weight to the fact that it was blameless for its doctors' absence from the hospital; that the decision was against the weight of the evidence and that, while the judge stated different heads of claim in respect

of the award of damages, he did not relate such matters to this case or showed how they applied to it. The appellant also contended that the judge wrongly compensated the appellant for nervous shock when there was no evidence of her having suffered it and was also wrong to have awarded exemplary damages. The questions on appeal, therefore, were whether the judge's finding of liability consequent upon a breach of duty was justified and whether there was legal justification for the quantum of damages granted.

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

[14] The route by which the trial judge arrived at his findings and conclusions was not immediately clear. There was no specific acceptance of the evidence on behalf of the respondent. We are left to deduce from his conclusions that there was such an acceptance. His findings appear to relate primarily to a breach of duty of care as opposed to causation. With those findings, we have no specific quarrel except for those at para 10(iii) above, which, as the medical evidence demonstrated, had no bearing whatever on the stillbirth.

[15] The judge did not specifically relate his findings to the issue of causation. Indeed, he set out no sufficient analysis of the medical evidence before him nor did he relate his findings to the medical evidence. Our examination of the evidence however, has led us to conclude that he in fact accepted the evidence of Doctors Ralph Hoyte and Neil Sampath who testified for the respondent and that it was upon their evidence that his conclusions and findings were based. Because the judge did not relate his findings to the medical evidence, it was necessary for us to examine the medical evidence afresh and to consider whether there was any basis upon which the judge could have concluded as he did.

[16] As to the quantum of damages however, the appellant's criticisms of the award were well founded. There was no basis for awarding exemplary damages. We also agree with counsel for the appellant that the judge wrongly compensated the respondent for nervous shock, when there was no evidential basis upon which to do so. For these reasons, we reduced the quantum of damages from one hundred and forty thousand dollars ($140,000.00) to one hundred and twenty thousand dollars ($120,000.00)

Issues

[17] We broach the broad issues in this appeal thus:

(i) was the hospital negligent in its treatment of the respondent during her period of admission, more so during the delivery of her baby,

(ii) was the hospital's negligence the cause of the stillbirth; and if yes,

(iii) what was the appropriate measure of damages?

Issues (i) and (ii) were determinative of the question of liability and we answered both questions in the affirmative;

[18] The question of negligence, having regard to the pleadings, turned on the following specific issues:

[a] did the hospital use reasonable care in the treatment of the respondent?

[b] was the hospital negligent in failing to have a doctor skilled in obstetrics respond and attend to the respondent during the course of labour?

[c] should the hospital have transferred the respondent to a suitably staffed institution which was then better equipped to handle her case?

All of these sub-issues revolved around the single fact that there was no doctor available to attend to the respondent during the period of her admission and in particular, when the deceleration of the foetal heart rate had first been detected. Indeed, it was this latter period which was critical to the question of liability. Having considered the evidence in this case, we answered question (a) in the negative, and questions (b) and (c) in the affirmative.

The Law

[19] It is now quite settled that a medical practitioner is not obliged to achieve success in every case he treats. His duty is to exercise reasonable skill and care in his treatment of the patient. See **Deonarine v Ramlal**, Civ. App. #28/2003 where **Mendonça J A**, applying the dictum of **Mc Nair J** in **Bolam v Friern Hospital Management Committee** [1957] 2 All E R 118, said:

> ***"The principle has been restated over the years but perhaps the most often quoted formulation is the direction of Mc Nair J. to the jury in Bolam v Friern Hospital Management Committee [1957] 2 All E R 118 which is now commonly referred to as the Bolam test. In that case Mc Nair J stated (at p. 121-122).***
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> > ***'How do you test whether this act or failure is negligent? In an ordinary case it is generally said, that you judge that by the action of the man in the street. He is the ordinary man. In one case it has been said that you judge that by the conduct of the man on top of the Clapham omnibus. He is the ordinary man. But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on top of the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient***

that he exercises the ordinary skill of an ordinary competent man exercising that particular art … A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art … Putting it the other way around a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view."

[20] It is also settled that a hospital is liable for the negligent acts of its professional servants which occur in the course of their employment; see in particular, the judgment of **Denning L.J.** in **Cassidy v Ministry of Health** [1951] 1 All E R 574.

"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 services 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 is anyone else who employs others to do his duties for him."

[21] 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..

[22] 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. See **Lord Alness** in **Vancouver General Hospital v Mc Daniel** (1934) 152 L T 56 at 57.

[23] The decided cases are also clear that hospital authorities will be held liable, not just for the negligence of their staff, including doctors and nurses but also for inadequate systems and procedures which result in injury to its their patients. In **Bull v Devon Area Health Authority** [1993] 4 Med L R 117 a hospital offering obstetric services was held to have a

duty to provide an adequate system for securing the attendance, within a reasonable time, of doctors with sufficient expertise to deal with an emergency during the course of delivery. (This principle will be equally applicable to any service offered by a hospital in which a forseeable duty may arise.) In **Collins v Hertfordshire County Council** [1947] KB 598, a hospital was held to owe a duty of care to establish adequate procedures to safeguard patients from the risk of errors in the administration of drugs. In that case, there was a failure to bring to the attention of an unqualified junior medical officer, the requirement of having a written prescription signed by a qualified member of staff. This was a routine requirement set out in the hospital's administrative procedures. The failure to bring it to the intern's attention led to a patient being injected with a lethal mixture of cocaine and adrenalin on the operating table, causing his death. **Hilbery J**. in finding the hospital negligent, said:

> ***It is clear to my mind … that the hospital was on this occasion permitting a system to be in operation which was dangerous and negligent. Miss Knight [the intern] was enabled, under the system that they allowed, to take an order for a dangerous drug in an extraordinary quantity to the pharmacist to be dispensed, she being an unqualified person, and to get it dispensed without it being ordered on a prescription in writing or any prescription or order signed by a qualified person. She told me she did that as a matter of course and that she had done it in respect of other dangerous drugs, such as morphia. The system which was being operated at the hospital was such that the pharmacist accepted that order and dispensed the drug in sterile form for an injection, knowing that it was for a patient who was to be operated on, and sent it up, and he did all that without having any qualified person's signature ..***
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> ***… I am satisfied that the hospital negligently failed to bring to the mind and attention of Miss Knight, when they appointed her, the regulations that they regarded as necessary for the management of***

the hospital; they had not brought to her particular attention the requirements of their routine procedures or that she was bound to adopt them, and they were permitting a state of affairs where a dangerous drug in an extraordinary quantity was to be made up in a solution with a very high fraction of another drug, which thereupon became a deadly poison. If they had had a proper system in operation, this solution could not have arrived at the theatre, let alone arrived at the body of the unfortunate patient."

[24] Finally, there is the obiter dictum of **Brown-Wilkinson V C** in **Wilshere v Essex Area Health Authority** [1987] QB 730, 778 to the following effect:

"… a health authority which so conducts its hospital that it fails to provide doctors of a sufficient skill and experience to give the treatment offered at the hospital may be directly liable in negligence to the patient. Although we were told in argument that no case has ever been decided on this ground and that it is not the practice to formulate claims in this way. I can see no reason why, in principle, the health authority should not be so liable if its organisation is at fault."

Did the hospital owe a duty of care and was it provided?

[25] As to the question whether the hospital owed a duty of care to the respondent while she was a patient at the hospital and if yes, what was the nature of that duty, the answer to the first part of that question was clearly in the affirmative. As to the second, we readily adopt the following submission approved as a broad statement of principle by **Slade L J** in **Bull & Another -v- Devon other Health Authority** [1993] 4 Med L R 117, at page 126, in respect of the nature of the duty of care:

"The duty of a hospital is to provide a woman admitted in labour with a reasonable standard of skilled obstetric and paediatric care, in order to ensure as far as reasonably practicable, the safe delivery

of the baby or babies and the health of the mother and offspring thereafter. The duties of each of the individual members of the hospital's staff are to carry out the functions of his or her post to the standard reasonably required of a professional person occupying that post."

The question then was whether the respondent was provided with the necessary standard of obstetric care in this case. In light of the stillbirth, the issue of paediatric care does not arise but in any event, the evidence discloses that a paediatrician arrived on the ward at the same time of the stillbirth and was able to apply emergency resuscitation techniques to the baby but to no avail. With respect to the provision of a reasonable standard of obstetric care, however, we do not believe that by any stretch of the imagination it can be said that the respondent received any such standard of care.

The evidence

[26] Three persons, including the respondent, testified for the respondent. The two witnesses for the respondent were Dr. Ralph Hoyte, a specialist obstetrician with over sixty-two (62) years medical experience (fifty-one (51) years of which were as an obstetrician) and Dr. Neil Sampath, a medical doctor, who was, at the time of giving evidence, completing a specialist degree in surgery. Dr. Sampath had only limited experience in obstetrics and gynaecology, having worked in the ob-gyn ward of the Port of Spain General Hospital from July 1997 to December 1998 as an intern. Four witnesses testified on behalf of the appellant, Sumintra Mathura, Dolores Ferguson, Ann-Marie Dickie, all of whom were midwives on duty at the hospital during various periods on the 22nd April, 2002 and Dr. Martin Trotman, gynaecologist. None of the doctors who testified had ever treated the respondent, nor were they on duty at the relevant time. Indeed, none of them had known or treated the respondent during her pregnancy or even after the stillbirth. They all relied on the respondent's patient notes which had been made by the midwives on duty. Dr. Hoyte however, relied on a statement given to him by the respondent sometime after the stillbirth and had only seen the patient notes of the respondent on the morning of the trial.

The respondent's evidence

[27] The respondent's evidence has already been summarized at paragraphs [2] to [6] of this judgment. The critical period with respect to the stillbirth was the period 10.00 pm on 22nd April, 2002 to 1.06 am on 23rd April, 2002. However, the judge's note of the respondent's evidence bears full reproduction. The relevant time frame under consideration began at 6.00 pm on 22nd April, 2002. At about that time, a nurse had checked the respondent and said *"everything was alright, it had a good heart beat"*. She had checked her blood pressure and said that it was *"alright"*. The rest of the respondent's evidence, in so far as it is relevant, was as follows:

> ***"My husband left about 6. I had dinner. Then I started to get some pain. I went to the nurses' station and informed the nurse. She told me I could go and lie down or keep pacing up and down the corridor. I started to walk and the pain started to get stronger. I told the nurse, she put me to lie down and she checked the baby and my pressure. She said everything was all right.***
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> ***I asked to see a doctor. I did so because I have a heart problem and with previous births when I go into labour I have to get an antibiotic injection. This was written in red on my file. The hospital knew of this…***
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> ***The nurse said she would try and get the doctor. She could not give an injection without the doctor's consent. I had told them about this condition when I went to the nurses' station. One of the nurses said it was written on the file and so they know they have to give it to me. One of the nurses tried to get the doctor by phone. About 10 in the night, I had overbearing pain and I asked to get a doctor. A nurse tried but she said no doctor would come.***
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> ***A nurse took me to the examination room. I was made to lie on the bed. She took my blood pressure, she tied a belt across my tummy, a***

monitor kept reading the baby's heart beat. I remained there for a while. The pain was really strong. She told me to turn to the side so I can breathe a little easier. I felt I was getting strong labour pains. I asked to see a doctor. Finally, a nurse came and gave me the antibiotic injection on my hand. This was about 10.30 to 11.00 pm.

I was still in the examination room, The baby's heart beat started to drop. A nurse went and got a midwife to come. She did vaginal exam and said the baby was in distress and she needed to get me to the labour room immediately. I was in too much pain. The nurse said a hot bath will help. She assisted me to the bathroom where I had a warm standing bath. While bathing I started to bleed. She helped me dry and put on a nightie and took me to a bed in the labour room. The midwife came and checked the baby's heart beat. She was not getting any. One of the nurses try to get a doctor to come but none was coming. My pain ease a little. The nurse told me when a pain come to push.

I got a slight pain and I pushed. She told me I had to push a little harder. I made several tries and about 1.06 the baby was born. It was a boy. I eventually found out he was 7-1/2 lbs. The nurse put the baby in a baby cot next to bed. They told me nothing. I did not hear the baby cry. The nurse started to pass his chart and then a doctor came. He stuck something inside of the baby's mouth and keep pumping and green stuff came out through the tube. I saw the doctor gave him an injection in his feet. I felt numb on seeing all of this. I felt my life had ended too. The doctor just left. He did not even come across by me and say anything. He just left. I thought at that point the baby was not alive but nobody told me so.

I then asked and the nurse told me the baby is not alive. I asked to hold the baby. She said he was not alive. I told her I still wanted to

hold him so she wrapped him in a green cloth and gave him to me. I wanted to keep him. I had made preparation for this child. I had bought clothes, a crib, fixed a room for him. My other three children were looking forward to having a baby home."

[28] The patient notes of the respondent taken by the nurses, starting with her admission, were as follows:

22nd April, 2002

10.55 am:	Admission procedure carried out. Findings recorded on Admission sheet. Taken to Ward 13B.
4.00 pm	Patient was taken over awake in bed experiencing slight discomfort in lower back. Is being closely observed.
5.00 pm	Experiencing stiffening sensation otherwise ambulant, continues to be monitored.
10.15 pm:	Patient taken over in labour having 1-7 mild contraction. Dr. T... informed of patient's cardiac status. Antibiotics in labour; Amprec 500 mg.
10.55 pm:	Full dose of ampicillia given.

23rd April, 2002

12.20 am:	Non stress test (NST) in progress Foetal heart rate – deceleration. Dr. T... informed, office informed.
12.30 am:	Marked deceleration noted on non stress test (NST), VE done. Os 6 cm dilated. MSCT blood draining, transferred to ICU for further management.
12.35 am:	Enema and hot bath given. O2 therapy commenced. No foetal heart rate heard when CTG monitoring attempted.

> **1.06 am:** Progressed to normal delivery of term, male stillborn infant. Paediatrician in attendance. Resuscitation attempted. Pronounced dead at 1.40 am. Mother reassured and left resting ...

[29] We do not consider, that by any measure, the respondent can be said to have received the reasonable standard of skilled obstetric care required to ensure as far as reasonably practicable, the safe delivery of the baby and the health of mother and offspring thereafter. In fact there was no obstetric care given to the respondent at all. The negligence was compounded by the fact that the respondent (as Dr. Trotman testified) was a high risk patient with a congenital heart condition who required antibiotic treatment under supervision by a doctor. This also did not occur.

[30] Both the respondent's evidence and the nurse's patient notes indicate that in the critical period between 12.20 am and 12.35 am when obstetric care was required, there was no doctor available to the respondent. Indeed that was not in dispute. A decision had to be made as to what kind of treatment was required to save the foetus but there was no obstetrician available to do so. A doctor was informed at 12.20 am but (for reasons unknown) he did not come. It was also clear from the respondent's evidence and her patient notes, that a decision as to the administering of antibiotics to the respondent was necessary. There was no doctor immediately available and the same doctor had earlier been contacted by phone (at 10.15 pm on the 22nd) but he did not come to the hospital. Even when the injection was authorized, no doctor was available in the event that there were complications. (We have edited full reference to the name of the doctor who was contacted because we have not heard his reasons for not coming and it was not immediately clear whether he was actually employed at the hospital).

[31] In our judgment, there was a proper evidential basis for the judge's finding of a breach of duty of care. The evidence of Dr. Ralph Hoyte supported such a finding. He has a very distinguished history as a doctor. He had been an ob-gyn specialist for fifty-one (51) years, was a specialist in the Ministry of Health hospitals at Port of Spain, San Fernando and Mt. Hope Women's hospital for twenty-five years. He was also Deputy Director of

Medical Services in charge of hospitals. In that position he and other specialists had laid down the rules of procedure and practice in the labour ward, two of which were:

(i) that a doctor was to be appointed to be in charge of the labour ward for 24 hours;

(ii) that he or she should be on immediate emergency call.

[32] It was obvious that those rules of procedure were breached in this case. Dr. Hoyte spoke quite bluntly. The judge's note records the following testimony:

> ***"I have reviewed the patient notes of the respondent. I am greatly surprised the South West Regional Health Authority has allowed this matter to come to court. The plaintiff went to the hospital for medical attention and from the time she entered and until the baby was born dead she was never seen by a doctor. Although the nurses on duty tried repeatedly to contact him and could not do so."***

He added:

> ***The nurse's care indicated the following:***
> ***Blood pressure and urine, and the heart monitor which showed the child's heart beat to be present and normal. A 2nd application of the monitor gave the same result. A 3rd application of the monitor shows the heart beat to be "nice". A 4th application of the monitor showed the baby's heart to be in distress. The patient herself heard the nurses say this. A 5th application of the monitor showed the child's heart beat absent. Shortly thereafter, after midnight on the 22nd – 1.06 am the patient gave birth to a dead child.***
>
> ***When during labour there is distress of child or mother, urgent or emergency treatment is called for, this patient received no such treatment from any doctor in spite of a number of attempts by the nurses to contact the doctor."***

[33] Certainly, at the close of the respondent's case, there was a prima facie case of breach of duty raised against the hospital. It was then for the appellant to have led evidence to rebut it. In our judgment, having regard to the defence pleaded, this was well neigh impossible. It was no defence to the allegation of negligence to say that there was industrial action taken by the doctors, unless it was to shift blame to the body of doctors themselves for taking such action. [The doctors' association was not joined as a party to this action.] However, the appellant chose to keep the hospital open to members of the public and to admit pregnant women to the maternity ward. In so doing, it held out to its patients and to members of the public that its medical facility was competent to deal with not just normal deliveries but whatever emergencies which may have arisen during the course of labour and childbirth; that is to say, the appellant held out to members of the public that the hospital was possessed of medical staff competent and available to administer all aspects of the medical treatment which might become necessary during labour and childbirth.

[34] The nurses' evidence and in particular that of Nurses Ferguson and Dickie, was that no obstetrician was available to the respondent at all. The respondent testified that upon her admission, she was not told that obstetricians were not available at the maternity wards. Nurse Ferguson' evidence, as noted by the judge, does not make clear what information about the impasse had been made known to the public. But in our view, whatever the information, it was of no consequence, because the hospital continued to admit patients, including a high risk patient. The duty to deliver reasonable obstetric care would have arisen in respect of each maternity patient admitted to its wards and was an ongoing duty so long as the patient remained admitted to the hospital. That duty could not be avoided by any form of public disclaimer. There are many persons in Trinidad and Tobago who, in any event, cannot afford private medical care and would have had little choice but to have subjected themselves to the health care then available at the hospital, however capricious.

[35] The appellant also contended in its defence that the nurses and midwives were competent and capable of delivering a baby *"if such necessity arose"*. That, in our judgment, was not the issue. There was no question as to the ordinary competence of the nurse and midwives in this case. The evidence was clear however that they were not competent to handle any medical emergency which may have arisen with respect to the respondent's congenital

heart condition or the medical emergency which arose in respect of the respondent's baby. The evidence was also clear that the nurses did all that they could have done for the respondent but that there was obvious need for a doctor's intervention during the critical period between 12.20 am and 12.35 am.

[36] The evidence of Nurse Ferguson is apt. She worked the 10.00 pm to 6.00 am shift on 22nd April, 2002 to 23rd April, 2002. The 10.15 pm entry in the patient notes was hers, as was the 12.20 pm entry which noted that the infant's heart rate was decelerating. She said that she called Dr.T at 10.15 pm and he ordered an antibiotic to be administered to the respondent. Dr. T was also informed at 12.20 am of the deceleration of the infant's heart rate. The judge's record of her evidence was as follows:

> ***"We were told Dr. T was the doctor on call and he was informed at 12.20 am. The office was also informed. This is the nursing supervisor's office. There were no doctors around. No doctor came on the ward."***
>
> ***I looked at the NST (Non stress test) –there was marked deceleration, it was worsening, she had dilated 6 c.m. A forceps delivery is not possible at 6 cm dilation. I called the labour ward and told them of the history and was transferring the patient to the patient to the labour ward… Up to the time the patient left 13B, the nurses did everything they should have done. There was nothing I could have done that I did not do. At this stage, there was need for doctors' intervention and nurse's intervention".***

She also said that in an emergency, it would take half an hour to prepare a pregnant patient for a C-section.

[37] Under cross-examination by Mr. Ramlogan, Nurse Ferguson added:

> ***"The patient was in labour at 10.15 pm, but I cannot say if it is established labour. From 10.15 she would need to be checked every 30 minutes at maximum for foetal heart beat. At 12.20 when I***

***detected a deficiency I reported to Dr. T and the office. A baby was in near distress. There was nothing now the nurses could have done. It was an emergency situation. We were told that there were things in place to transfer the patient, when an emergency occurs, the patient would be transferred to a private nursing home. Dr. T should have been available when called and responded quickly if not immediately. There was no firm in place to manage this patient*.**"

This was the evidence of the appellant's witness. The absence of a medical doctor to address such an emergency amounted to negligence on the hospital's part. Dr. Trotman's evidence provided no rebuttal of the respondent's case on negligence but went instead, to causation.

[38] In our judgment, if there were no doctors available to deal with medical emergencies, then patients such as the respondent who were high risk (in the respondent's case, due to her medical condition and to the fact that she was overdue), should have been re-directed to private hospitals or, once admitted, transferred to a private institution, when it became obvious that no doctor was available. The particulars of negligence which we have set out at paragraph 2 of this judgment were proven.

Causation

[39] I turn to the more difficult question of causation, that is to say, whether the hospital's negligence was the cause of the stillbirth. The fact of a stillbirth does not necessarily mean that a hospital is negligent. It turns on the evidence. The medical evidence in this case was less than satisfactory and the basis of any conclusion that such negligence was the cause of death was inferential. But in our judgment, there was sufficient evidence on which to conclude, on a balance of probability, that the negligence of the hospital, in not having a doctor available to deal with the emergency, led to the stillbirth.

[40] The respondent had to discharge her onus on a balance of probability and the evidence of Dr. Hoyte also provided a sufficient discharge of that onus. His evidence was that the absence of a doctor eliminated any of the medical options available for saving the baby.

His evidence in chief quite clearly tied the death of the child to a lack of treatment of the respondent by a doctor. He said:

> ***"When during labour there is distress of child or mother, urgent or emergency treatment is called for, this patient received no such treatment from any doctor in spite of a number of attempts by the nurses to contact the doctor.***
>
> ***Quite apart from the doctor making a routine visit, he should have been available when called. The proper treatment could have been to terminate the labour as quickly as possible for… both the mother and child. Such termination may call for manipulation to shorten the labour or forceps delivery for the same reason or caesarean section. These three could only have been done by a doctor. If any of these had been done it is most likely that the baby would have been delivered alive. The vitals signs were there. A midwife or a nurse does normal delivery, not forceps or C-section. None of these options were even attempted as the doctor was not there.***
>
> ***If any of these options had been done to Mrs. Harrilal, the chances would have been good that the child would have been born alive. The cause of death is said to be intra partem asphyxia.***

Later in cross-examination he said:

> ***"A stillbirth is not always due to negligence. If I was told a person had a stillborn baby I would come to no conclusion. I would need [the] history. I had information that the plaintiff was in good condition when she went to the hospital. The document says that she had nil contractions on entry. All the questions came after the question, 'where was the doctor during all this'.***

[41] Dr. Hoyte's view was that even though there was a short fifteen minute window between the detection of deceleration of the baby's heart rate and its apparent death, that was

sufficient time to prepare the respondent for a C-section and to complete the surgery such as to save the child. He said:

> ***"It would take a few minutes to prepare the patient for a caesarean section. Also signs a consent form, given an injection, a catheter is placed to empty her bladder and taken to the theatre. It has to be done quickly if the baby is in danger." There must be an operating theatre. When there is a crisis, the theatres are full but most of the time we manage. At 12.00 on the night, a theatre should be available. There is an anaesthetist on call all the time."***

[42] The appellant in its defence put forward five possible causes of the *intra partum asphyxia*.

(a) congenital defect;

(b) an inherent and unavoidable risk of childbirth;

(c) the stress of labour;

(d) ingestion of liquor

(e) lack of oxygen in the foetal descent along the birth canal.

[43] It also disputed that the respondent was in labour at the time of admission. This would of course have affected the type of treatment she could have gotten at that time. None of these allegations was proven by the appellant. As to the question whether the respondent was in labour or not, Dr. Hoyte did not appear to attach any significance to *"established labour"* as opposed to labour *simpliciter*. He stated that the respondent was most likely in labour from the time of admission and that this was heightened by the fact that she was experiencing pain. Certainly, on the evidence, she appeared to be in labour from about 10.00 am. This seemed to be confirmed by the fact that the doctor to whom Nurse Ferguson spoke by phone, ordered the administering of antibiotics from about 10.15 pm. The evidence was that such medication was to be given during labour. The fact that the doctor saw it fit to have it administered (albeit, with no doctor present) suggested to us that he too was satisfied that the respondent was in labour.

[44] Dr. Trotman on the other hand, was not prepared to say when he felt the respondent had gone into labour but was satisfied that she was in *established* labour at 12.30 am. There

was no conflict of medical opinion and in our view the weight of the medical evidence was that the respondent was certainly in labour from 10.15 pm when the antibiotic was first administered.

[45] In our judgment, Dr. Hoyte's evidence certainly raised a prima facie case that the failure of the hospital to provide a doctor more than likely caused the baby's stillbirth, because there was no doctor available to perform a C-section which could have saved it. The burden of proof thus shifted to the appellant to show that the hospital's negligence in not providing a doctor to treat the respondent was not the cause of the stillbirth. It was incumbent of the appellant, in those circumstances, moreso in light of its defence, to produce evidence supporting the causes of death put forward in its defence and rebutting the evidence of Dr. Hoyte. There was nothing in Dr. Trotman's evidence which supported any of these possible causes. On the contrary, it was Dr. Hoyte, in his evidence in chief who sought to disprove any likelihood that any of those possible causes may have resulted in the baby's death. He said:

> ***"The cause of death is said to be intra partem asphyxia. Asphyxia means no breath. Intra partem means during pregnancy the cord may get tangled and the baby dies.***
>
> ***There was a post mortem examination of the infant which revealed no cause of death. There was no [congenital] defect. This is one cause we can dispense with – none was found.***
>
> ***The child is fed with oxygen and nutrition through the umbilical cord. At the time of delivery there was nothing to suggest pressure on the cord to affect the baby.***
>
> ***As to inherent and unavoidable risk of child birth – this should have been very small. Our foetal mortality rate in Port of Spain is better than in the U S A, as well as our maternal mortality. We have the ability to cope with the inherent risk of child birth.***

> ***As of the stress of labour – every labour has stress and this does not kill babies. The stress should become less with more children. Sometimes a big baby can cause stress but this was not the case here.***
>
> ***Liquor is the fluid in which the baby has lived for 9 months. When the child is born the fluid is gotten rid of by a suction pump. The heart stopped during the period of labour.***
>
> ***As to lack of oxygen on the foetal descent along the birth canal, the child is still getting oxygen through the umbilical cords. It does not matter how long the head takes to come down the child is still getting oxygen through the cords. In the case of a breach delivery the cord can be compressed but in this case the head came out first.***

[46] Except for the fact that Dr. Hoyte refers to the mortality rate at the Port of Spain General Hospital, that evidence was direct and to the point. In contrast, Dr. Trotman's evidence, given on the appellant's behalf, did not support the possible causes of the *intra partem asphyxia*. His evidence in chief skirted the issue of cause of death, stating merely that *intra partem asphyxia* meant that the baby was starved of oxygen *"at some point during labour"*. Dr. Trotman stated that 12.20 am was the time to have called a doctor because that was when deceleration of the infant's heart rate was detected. He added that given that the respondent was *"only 6 cm dilated"* an immediate vaginal delivery was not possible and a doctor would have requested a caesarean section. This evidence was inconsistent with the appellant's pleading that the short time frame within which the respondent was in *established labour* did not allow for any form of delivery other than delivery per vagina. Rather, it was consistent with Dr. Hoyte's evidence and narrowed the issue to whether the presence of a doctor would have facilitated a C-section which would have saved the child.

[47] Whereas Dr. Hoyte was of the view that *"it would take a few minutes to prepare the patient for a caesarean section",* Dr. Trotman testified that at the hospital, it would have taken at least forty-five minutes to an hour to get the respondent to the theatre and deliver

the baby but that at 12.35 am, no heart rate having been heard, it meant that the baby had died. We note that the nurses' evidence as to the period of preparation for C-section surgery ranged from half hour (per Nurse Ferguson) to between half hour to forty-five minutes (per Nurse Dickie). There was thus some conflict between Dr. Hoyte's evidence and that of Dr. Trotman (and the nurses) as to whether there was sufficient time to prepare the respondent for surgery and to deliver the child alive, given the fifteen minute window between deceleration and apparent death of the baby. The court's approach in the face of a conflict of medical opinion was explained in **Deonarine** (supra) by **Mendonça J A**. In applying the *Bolam* test, a court would have to be satisfied, before accepting a body of opinion as being responsible, reasonable or respectable, that in forming their views, the experts had directed their minds to the question of comparative risks and benefits and had reached a defensible conclusion on the matter. (See **Deonarine** at para 39 page 16 applying the speech of Lord Brown-Wilkinson in **Bolitho v City & Hackney Health Authority** [1997] 4 All E R 771).

[48] In this case however, the conflict was not a conflict of medical opinion. Rather, it was a conflict as to the practice in preparing a patient for emergency C-section surgery. It was a simple evidential question. The judge would have been entitled to accept the evidence of Dr. Hoyte in this regard. In any event, we find it unreasonable (if not scandalous), that it should have taken thirty minutes, forty-five minutes or even an hour to prepare a patient in labour for C-section surgery in circumstances of emergency in which the life of the child is at immediate risk. We say further that, if such were the case, then the system at the San Fernando General hospital which was set up to deal with emergency C-section surgeries was an inefficient and inadequate system which in all probability would have resulted in the death of the child. We accept the evidence of Dr. Hoyte that in circumstances of emergency where the life of the child is at risk, a fifteen minute window is sufficient time within which to perform an emergency C-section to save the child.

[49] But by either equation, causation was established. Dr. Hoyte's evidence pointed to the absence of a doctor to perform a C-section given that there was sufficient time to perform an emergency C-section to save the baby. Dr. Trotman's evidence and the nurses' evidence, pointed, in any event, to an inefficient emergency preparation procedure on the

hospital's part which, by any standard, is highly unacceptable and which would also have resulted in the baby's stillbirth, even if a doctor were available.

[50] Before turning to the issue of quantum, we must address the judge's finding *"that there was no monitoring in order to decide whether to do delivery via caesarian section"*. It is unclear what he meant by it since there was no explanation for the basis of that finding. We believe that this was an acceptance of Dr. Sampath's opinion that there was no monitoring by the nurses of the foetal heart rate until some thirteen hours after admission. Respectfully, we consider that opinion to have been highly unreliable, having regard to the entire evidence in this case.

[51] The respondent's own evidence showed that there had been monitoring of the foetal heart rate on several occasions. Dr. Hoyte, in his evidence, spoke of at least five occasions on which there was monitoring of the heart rate. Nurse Ferguson's evidence suggested that she had checked the heart rate of the infant every thirty minutes. However, the extract of the patient's notes, which we have set out at para. 29, shows that only one note of the foetal heart rate was made despite the fact that other monitorings had occurred. The notes therefore did not truly reflect the fact of monitoring. Indeed in cross-examination, Dr. Sampath conceded that it was common for *"nurses to do things"* and not record it and that it was quite possible that a patient could have been given care but it is not recorded. We believe that this is precisely what occurred here. The evidence of both Dr. Hoyte and Dr. Trotman was that the nurses cannot be faulted**.** We agree.

Damages

[52] We turn then to the quantum of damages awarded in this case. We found this issue to be by no means an easy one. The respondent sought damages for distress, anxiety and inconvenience resulting from the stillbirth. She also sought damages for loss of the child. We say at the outset that such damages are generally irrecoverable. The dictum of **Lord Oliver** of Aylmerton in the case of **Alcock v Chief Constable of S. Yorkshire** (H.L.E.) [1992] 1 AC 310 at 416 is a good starting point. He said:

> ***"Grief, sorrow, deprivation and the necessity for caring of loved ones who have suffered injury and misfortune must, I think, be***

considered as ordinary and inevitable incidents of life which, regardless of individual susceptibilities must be sustained without compensation."

[53] This is a principle universally applied throughout common law jurisdictions. See the decision in **McKenzie v Lichter & Ors** [2005] VSC 61 given by the Supreme Court of Victoria, Australia, per Gillard J. in which the father of a stillborn child sought damages for grief and distress suffered as a result of the stillbirth. At paragraph 12 page 4 of the transcript Gilliard J. stated that:

"it is important to emphasise that "save in exceptional circumstances, the person is not liable, in negligence for being a cause of distress, alarm, fear, annoyance or despondency, without any resulting recognised psychiatric illness" – per Gleeson C J in Tame v NSW (2002) 211 CLR 317 at 329. This means that compensation is not payable in the present case because of the grief and upset flowing from the death … Compensation is payable for the psychiatric injury due to the consequences of the negligent act and all that flows from that injury, not the grief and sorrow short of psychiatric injury."

[54] Nor is compensation payable for death of the foetus. Legally, the foetus is not considered to have a life of its own until delivered alive from its mother. There has been much discussion and debate on whether this is a correct approach and whether the foetus, *in utero*, has a life of its own such as to justify the award of compensation to the parents for the loss of its life when medical negligence results in its stillbirth. The law however remains unchanged. Damages are recoverable only in respect of a child who is delivered alive and is either physically impaired or dies, due to medical negligence.

[55] The Canadian decision of **Martin v Mineral Springs Hospital** [2001] ABQB 58 puts in perspective the paradox courts face when dealing with a claim in damages for a stillbirth as opposed to a child who succumbs shortly after birth. It also illustrates the difficulties in assessing pecuniary loss in respect of child deaths. That was a case in which the parents of

a stillborn baby girl sought to recover damages, inter alia, for the loss of the foetus and for loss of her companionship. At page 5 of the transcript of the judgment, Rowbotham J said:

> ***"[17] The Supreme Court of Canada in Winnipeg Child and Family Services (Northwest Area) v DFG [1997] 3 S C R 925 determined that a foetus has no legal status until it is a child, born alive and viable. Once a child is born, its existence before birth can be recognised for certain purposes such as estate matters or injuries sustained in utero. Any rights that may accrue from a foetal existence crystallize only upon a live birth***
>
> ***[18] The plaintiffs' claims are somewhat inconsistent in that they claim for the loss of enjoyment of a relationship with Kelsey Lee, while at the same time submitting that Cindy Martin should at the very least be compensated for the loss of the foetus, as part of the mother. They submitted that a plaintiff is entitled to damages for loss of a body part resulting from a defendant's negligence and it follows that there ought to be compensation for the loss of a foetus.***
>
> ***[19] The anomaly in this case is that if Kelsey Lee Martin had been born alive and died at any time thereafter due to negligence, Cindy and Stephen Martin would have a claim pursuant to the Fatal Accidents Act, R S A 1980, c F-5 ("the F.A.A."). They would be entitled to pecuniary loss plus forty-three thousand dollars ($43,000.00) (to be shared equally) for the bereavement. The harsh reality of assessing pecuniary loss to the parents upon the death of a child often results in there being no award for pecuniary loss. The point is clearly made by Robins, J A in <u>Mason v Peters</u> (1982) 139 D L R (3d) 104 (Ont. C.A.) at 111.***
>
> > ***"... scrupulous adherence to the pecuniary loss requirements would make it difficult, if not impossible, save in rare cases, to find any actual or prospective economic loss flowing from a***

> ***child's death. Given the realities of modern family life, the probable cost of raising and educating a son or daughter today exceeds by far the probable pecuniary value of any … financial contributions they may make in the future of parents or relatives. Whatever the situation may have been in earlier times when children were regarded as an economic asset, in this day and age, the death of a child does not often constitute a monetary loss or one measureable in pecuniary terms."***

[56] The law on medical negligence in Trinidad and Tobago is still in the early stages of development and no case has yet been brought on behalf of any child injured by antenatal medical negligence, or during childbirth. Certainly, the provisions of the Compensation for Injuries Act, Chap. 8:05 permit such actions. The difficulty has always been in obtaining medical evidence. In the present case, the foetus died in utero and had no legal status. But the respondent carried a healthy foetus to full term, only to lose the child during childbirth due to the negligence of the hospital. On the law as stated, she was however entitled to no damages for the loss of the foetus nor was she entitled to damages for distress, despondency or even depression, unless they were the result of some psychiatric illness. No such illness has been proven here. How then were damages to be measured, if at all?

[57] We considered the approach of **Simon Brown J** in **Bagley v North Herts Health Authority** [136] NLJ 1014 to be appropriate, helpful and commendable. In that case the plaintiff gave birth to a still born baby due to the negligence of the hospital in the treatment of a medical condition from which the plaintiff suffered. As a result of the stillbirth, the plaintiff suffered severe depression and her marriage was adversely affected. Had the hospital not been negligent, there was a 95% chance of her giving birth to a normal child. In the course of his judgment, Simon Brown J sought to come to grips with the law on the subject. He said:

> ***"it is convenient first to identify those consequences of the plaintiff's misfortune for which damages are clearly not recoverable in law. First, it is trite law that general damages are not recoverable for***

grief and sorrow. The most authoritative recent statement of this principle is to be found in the House of Lords decision in McLaughlin v O'Brian [1982] 2 All ER 298, in particular the passage in Lord Wilberforce's speech at 301-302.

Second, there is at common law no claim for loss of society as such the old claims for loss of consortium have now been abolished. They were in any event never available to the parents of deceased children. The only form of claim available to reflect losses of this general character is the recently enacted statutory provision for damages for bereavement. This was introduced by the Administration of Justice Act 1982 into the Fatal Accidents Act 1976 in the fixed sum of £3,500. Although bereavement is not defined within the legislation, to my mind it clearly encompasses both consolation of grief and sorrow and compensation for loss of society. It is, however, a right conferred only on a limited class of claimants and in specific circumstances. Although it can benefit parents, it does so only when a live child is tortuously killed. The hospital's negligence in the present case did not of course kill a live child; rather it caused the child to be born dead. That critical distinction here precludes any claim under the statute."

He then went on to set out three heads of damage which he considered appropriate:

"What then are the recoverable heads of damage? There are essentially three, although it would be a mistake to regard each as wholly and strictly self-contained. In reality there is a measure of interaction, and even perhaps to some degree overlap between them. The three are as follows:

> ***(1) The plaintiff's loss of the satisfaction of bringing her pregnancy, confinement and labour to a successful, indeed joyous, conclusion. It is, accepts counsel for the***

health authority in his most helpful and able submissions, the reward which every woman hopes for at the end of her labour. This plaintiff was denied it. On the contrary, she underwent the burdensome, laborious process of carrying and bearing her child, only to be deprived at the final hour of her hopes and expectations of success and fulfillment. One needs but little imagination to appreciate something of the depths of her disappointment and distress. I accept entirely the submission of counsel for the health authority that the plaintiff cannot be compensated for the discomfort and inconvenience of carrying the child. That would, of course, have been suffered even had the Hospital not been negligent – even, that is, had the pregnancy been brought to a happy end. For this reason, Udale v Bloomsbury Area Health Authority [1983] 2 All ER 522, and other authorities concerned with failed sterilization or vasectomy, namely, with the failed prevention of childbirth, cannot assist me. But that is not to say that I must ignore that the disappointment, the lack of a sense of accomplishment at the end of the pregnancy, is not the more acute through a realization of the needless struggle and the dashed hopes that were increasingly built up throughout the entire period of pregnancy.

(2) The loss associated with the physical loss of the child. Counsel again fairly concedes that the hospital's negligence frustrated this plaintiff's plans to enlarge her family; and that her loss in this regard is rendered the more poignant by what he accepts to be her reasonable decision not to attempt a further pregnancy. Thus she

has no hope of replacing the lost child and thereby repairing her shattered family plan. I have no doubt whatever that this plaintiff falls to be compensated on the basis that she will not now have another child; indeed, were she to attempt it and fail, then the aggravation of her suffering would in my judgment at least equal such alleviation of frustration as she could hope to achieve any success. As it is, both the plaintiff and her husband have taken the view that the plaintiff would probably not be able to recover from an unsuccessful further pregnancy.

(3) Damages for the physical illness brought on the plaintiff by her grave misfortune. She has plainly suffered a great deal over the last four years. This suffering is moreover likely to continue, although I believe that with the psychiatric treatment which I understand she is now prepared and intending to undergo, it will at least diminish and may very well one day, one hopes sooner rather than later, finally resolve. These three aspects of loss I shall hereafter call simply heads 1, 2 and 3. What guidance is offered by the authorities to the assessment of these various aspects of loss? Undoubtedly some – and I am grateful to counsel for their researches – but I have no doubt that counsel for the health authority is right to counsel me against relying too heavily on assessments arrived at in other cases, sometimes in years gone by, in significantly different circumstances, and in an area of human experience and suffering where the scope for variation is limitless, and the subjective element is immense."

[58] We considered that these three heads of damage were appropriate in cases such as this. Counsel for the appellant, (who cited **Bagley** before us) submitted that the respondent was entitled to minimal damages at best and entreated that we consider the criticisms of the Bagley decision by **Ognall J** in **Kerby v Redbridge** (unreported) QBD, 4th February, 1992. **Ognall J** said that as to the first head of damage set out by **Simon Brown J:**

> ***"I regret that I am unable to reach the same conclusion as did Simon Brown J in that case. I consider that Mr. Laghlan is correct in his submissions that, were I, as I have been asked, to award any sum under the heading of Bagley (1) the dashed hopes – I would indeed be either awarding damages for bereavement twice or awarding damages for a head of claim not recognised by English law."***

[59] We do not share that view. Rather, we consider this to be an area of law which requires a different approach to the assessment of loss because the traditional approach has produced unsatisfactory results. We accept that with a stillbirth there will be the resulting grief, distress and anxiety and that these may all be manifestations of the process of bereavement for which damages are not recoverable at common law.

[60] Moreover, in Trinidad and Tobago, neither the Compensation for Injuries Act, Chap. 8:05 nor the Supreme Court of Judicature Act, Chap. 4:01, provides for damages for bereavement. As such, damages for bereavement are not at all recoverable in Trinidad and Tobago. We disagree however that head 1 of ***Bagley*** is akin to bereavement damages.

[61] The birth of a child is very much a matter of great anticipation, joy and celebration. It is a significant event in the life of both parents and as well, in Trinidad and Tobago, the extended family of grandparents, aunts, uncles and cousins. The arrival of the new born baby is celebrated by the extended family, the neighbourhood and in many rural areas, the village. Its baptism or other initiation into religious life is usually a cause for much feting and celebration, at which the child is triumphally introduced and presented by mother and father, almost trophy-like, to family members and well-wishers. It is in fact a celebration of the renewal of life and indeed, the baby's presentation is very much representative of the

successful conclusion of a long, confining and sometimes painful pregnancy. The satisfaction which comes from such a successful conclusion is real and distinct; so too is the loss of that satisfaction when a stillbirth occurs and though intangible, the latter is more than merely emotive.

[62] Further, we do not consider that the loss of a child whether in utero or after birth can be measured solely from the pecuniary benefits he or she may have brought to the parent in later years. The nurturing of a child from pregnancy to infancy to adulthood brings with it, its own peculiar and immeasurable levels of joy and satisfaction. The vast majority of persons do not venture into the difficult task of parenthood with pecuniary benefits in mind. Far from it. It is a response to the basic human impulse and need for love, community and security which, in most cases, are met within the context of the family unit.

[63] As to head 1 of ***Bagley***, we considered the respondent's loss of the satisfaction of bringing her pregnancy to a successful conclusion to be a loss which was not insubstantial, having carried her pregnancy to full term only to lose the child through the negligence of the hospital. So too, is the loss associated with physical loss of the child. The respondent spoke of her having planned for her baby and of her frustrated efforts to replace that child with another. She was subsequently twice pregnant but suffered miscarriages. This would have rendered her loss all the more poignant.

[64] We therefore considered that the sum of one hundred and twenty thousand dollars ($120,000.00) was a sufficient measure of damage in respect of heads (1) and (2) of ***Bagley***. We did not consider that the respondent proved any damage in respect of head (3) and made no award in respect of it.

[65] The appellant, no doubt, pursued this appeal because it considered that, ultimately, it was not the perpetrator of the injury which occurred in this case and that it had sought, conscientiously and under difficult circumstances, to fulfill its statutory duty to provide proper health care to members of the public. Good conscience should always inform any decision in which innocent members of our citizenry are likely to be adversely affected and to that extent the appellant's efforts were commendable.

As to whether good conscience (if not the Hippocratic oath) informed the decision making process of the doctors who took the industrial action which affected the appellant's ability to provide the appropriate medical care to the public, it seems to us that the facts of this case eloquently speak for themselves.

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A. MENDONÇA, J A

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P. JAMADAR, J A

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N. BEREAUX, J A