IN THE SUPREME COURT OF JUDICATURE OF JAMAICA

CIVIL DIVISION

CLAIM NO. 2012 HCV 06568

BETWEEN	**NEVILLE KNOWLES, JNR (Administrator of the estate of Neville Knowles)**	**CLAIMANT**
AND	**SOUTH EAST REGIONAL HEALTH AUTHORITY**	**1ST DEFENDANT**

Mr. Nigel Jones and Ms. Lianne Chung instructed by Nigel Jones & Co. for the Claimant

Ms. Tamara Dickens instructed by the Director of State Proceedings for the Defendants

Heard: July 24, 2018 and January 11, 2019

NEGLIGENCE – MEDICAL NEGLIGENCE – LAW REFORM (MISCELLANEOUS PROVISIONS) ACT – FATAL ACCIDENTS ACT

WINT-BLAIR, J

[1] This claim has been decided after a considered review of the documents filed by each party, the viva voce evidence and the written submissions of counsel. I am grateful for the industry of counsel appearing in the matter for agreeing all the evidence in the matter, as this assistance has been invaluable. There is certainly no intent to disregard the comprehensive written submissions filed at each and, every point raised has not been reproduced here. This decision does not attempt

to capture all that has been presented in the way that it has been and is instead issue based.

[2] The claimant is the son of the deceased Neville Knowles. By way of an Amended Claim Form filed on February 26, 2016, the claimant sought;

a. Damages under the Law Reform (Miscellaneous Provisions) Act on for the estate of the deceased;

b. Damages under the Fatal Accidents Act on behalf of the Dependant;

c. Special damages amounting to in excess of $20,000.00, along with sums spent for funeral expenses.

d. Interest thereon as at such rate and for such period as may to the Court seem just pursuant to the Law Reform (Miscellaneous Provisions) Act.

[3] In his Amended Particulars of Claim, the Claimant pleaded that Neville Knowles died as a result of the negligence of the Second Defendant as at all material times he was under their care. The Claimant set out particulars of breach of contract and or breach of statutory duty and or negligence as follows:

- *Failing to adopt the correct/ appropriate medical procedure on Neville Knowles in the circumstances;*

- *Failing to commence venous thromboembolism prophylaxis on Mr. Knowles upon admission;*

- *Failing to realize that the administration of venous thromboembolism prophylaxis may have reduced the possibility of deep venous thrombosis and thereby a fatal pulmonary embolism;*

- *Failing to take Neville Knowles' risk factors into consideration in deciding the medical procedure to adopt*

- *Failing to realize that Mr. Knowles had the following risk factors: age, comminuted fracture of the femur and a delay between injury and surgical procedure;*

- *Failing to provide surgical procedure on the deceased until 11 days after the he received the gunshot;*

- *Causing Mr. Neville Knowles to die from pulmonary embolus;*

- *Failing generally to provide adequate and reasonable care to Neville Knowles;*
- *Failed to advise Mr. Knowles that a delay in the surgery can cause serious complications and can cause him to die;*
- *Failed to explain to Mr. Knowles that the he had other risk factors that could cause him to die.*

[4] Both sides very helpfully agreed all the evidence in this case with brief cross-examination of two witnesses. Both sides also agreed that this case would turn on the applicable law.

[5] The claimant gave evidence via live link and said that his father was sixty-three years old and a retired police officer earning a monthly pension of $35,000 per month when he died. Mr. Knowles had been admitted to the Kingston Public Hospital ("KPH") on November 20, 2009 with a self-inflicted gunshot wound. He was taken into surgery on December 1, 2009 and died on that day at 1:38pm. The agreed post mortem examination report of Dr. Dinesh Rao, Consultant Forensic Pathologist, dated December 10, 2009, under the heading cause of death listed the following;

I. (a) Acute pulmonary emboli

(b) Deep vein thrombosis

(c) Left ventricular hypertrophy

(d) Chronic ischemic heart disease

II. (a) Gunshot wound to the leg

(b) Artherosclerosis

[6] The claimant claims that the death of the deceased was caused by the negligence of the first defendant, their servants and or agents in that they failed to provide proper or appropriate treatment to Neville Knowles, which caused his death. The claimant asserts that the recommended protocol for an individual with

the deceased's risk factors was to commence venous thromboembolism prophylaxis ("VTEP") on admission and that this had not been done.

The Evidence

[7] Mr. Knowles was examined at approximately 8:30pm on November 20, 2009 by Dr. Jason Copeland, junior surgical resident, orthopaedic rotation. The significant clinical findings upon examination revealed:

> *"His scrotum was swollen and tender with blood oozing from two wounds to his scrotum; the wound to the left half of the scrotum a likely entry wound and to[sic] one to the right half a likely exit wound. Two wounds were noted to the right thigh; one to the upper medial third a likely exit wound. Two wounds were noted to the right thigh; one to the upper medial third a likely entry wound and another to the medical[sic] aspect of the proximal right knee a likely exit wound. These wounds were also noted to be oozing blood a non-expanding haematoma was appreciated around the wound to the upper right thigh…*
>
> *…His admitting blood results were: haemoglobin of 13.8g/dl, a white blood cell count of 6.0 and a platelet count of 179. The follow up complete blood count revealed a fall in his haemoglobin level to 11.7g/dl confirming the loss of blood from his injuries."*

[8] The following morning, Mr. Knowles was seen by Dr. Melton Douglas, orthopaedic consultant. Dr. Copeland reviewed his findings with his senior, Dr Douglas. The decision was taken not to commence the administration of anticoagulant drugs to include Heparin as they are contraindicated in a trauma patient with ongoing blood loss.

[9] The agreed medical report of Dr. Melton Douglas, orthopaedic consultant, dated December 30, 2009, stated that Neville Knowles was admitted to the Steventon

Ward of the KPH on November 20, 2009 following a gunshot wound. The salient portions are as follows:

> *"The bullet went through the scrotum before entering the right lower thigh. …Entry and exit wounds were noted to the scrotum and right thigh and were also swollen…X-ray of the right thigh confirmed a comminuted fracture of the right lower third of the femur. Mr. Knowles is a known hypertensive on medication…*
>
> *His blood studies showed Hb = 13.8, WBC = 6, Platelet 179 on November 20, 2009. The repeat blood test done the following day showed a Hb of 11.7. He was prescribed antibiotic Rocephin for 3 days, Voltaren and Panadol for pain, Enalapril for his blood pressure, and Federgel as a replacement for Zantac that was unavailable. He was not on Heparin.*
>
> *The life threatening injuries done on the emergency list would make it impossible to have his surgery done on the emergency list on the day of admission.*
>
> *Skeletal traction was applied through a tiabial[sic] pin that was inserted on November 20, 2009. Mr. Knowles was taken to the Operating Theatre on November 22, 2009 by Dr. Dunbar, the Urologist and under general anaesthesia had the left testes removed. His orthopaedic surgery could not be done at the same sitting because the locked intramedullary nails costing over one hundred thousand dollars are not available in the hospital for routine use. They would have to be acquired through the hospital procurement procedure or by the relatives.*
>
> *He was advised surgery to the right femur. A retrograde locked intramedullary nail was needed for the surgery to fix his fractured femur. The request was sent to the procurement office of the KPH. The relatives and the procurement officer met and the nail was made available. His*

ECG was done on November 26, 2009 Mr Knowles was schedule[sic] for surgery on November 27, 2009 but the operating time was exceeded before we could get to him. He was rescheduled for December 1, 2009.

He was taken to the Operating Theatre on December 1, 2009 at 11:30am. and under general anaesthesia had a retro=grade[sic] locked intramedullary nail inserted. The blood loss was relatively low. Near to the end of the surgery the anesthetist expressed concern over his unstable vital signs. The surgery was completed while the anesthetists were assessing and treating him. The details would be best reported by the anesthetist, but in essence had a fall in blood pressure and a suspicion of pulmonary embolism made. Attempts at resuscitation with a full complement of anesthetic[sic] consultant[sic] and staff and the Orthopaedic team failed to resuscitate him. Drugs, deffrillator[sic], cardiac massage, were all utilized in his resuscitation. The resuscitation went on for 30 minutes but failed. He was pronounced dead at 1:38p.m. on December 1, 2009.

A post mortem was requested to confirm the cause of death."

[10] The claimant relied on the expert evidence of Dr. Christopher Rose, consultant orthopaedic surgeon, who produced a medical report dated December 16, 2010. In his report, Dr. Rose set out the medical history of the patient pertinent to his admission at the KPH and that he had reviewed the report of Dr. Melton Douglas. The report authored by Dr. Rose significantly stated that:

"On admission, appropriate blood investigations were requested and he was placed on parenteral Rocephin for three days as well as analgesics. No venous thromboembolism prophylaxis was commenced according to the medical report submitted by Dr. Melton Douglas."

TREATMENT

…The post mortem revealed a thrombus in the posterior tibial vessel and thromboemboli in the pulmonary artery of the right lung. The cause of death as stated in the post mortem report was a pulmonary embolus.

COMMENT

Venous thromboembolic disease is a leading cause of death and morbidity (1,2). For the orthopaedic surgeon this disease has special importance, because it is the most fatal complication following surgery or trauma involving the lower extremities. Patients undergoing major orthopaedic surgery, which includes hip and knee arthroplasty and hip fracture repair represent a group that is at particularly high risk for thromboembolism and routine thromboprophylaxis has been the standard of care for many years (3,4,5,6,)

There are two general approaches to making thromboprophylaxis decisions. One approach is to consider the risk of venous thromboembolism in each patient, based on their individual predisposing factors and the risk associated with their current illness or procedure. Examples of individual risk factors include: immobility, malignancy, cancer therapy, previous venous thromboembolism, increasing age, heart or respiratory failure, obesity, smoking, varicosities, nephrotic syndrome, to name a few.

The second approach involves the implementation of group specific prophylaxis routinely for all patients who belong to each of the major target groups. Patients undergoing hip fracture surgery are at very high risk of venous thromboembolism. Additional factors for venous thromboembolism is [sic] advanced age and delayed surgery. Symptomatic venous thromboembolism and fatal pulmonary embolus after hip fracture surgery

can be significantly reduced and many authors report that is[sic]can be prevented with thromboprophylaxis.

Mr. Knowles had certain risk factors: age, comminuted fracture of the femur and a delay between injury and surgical procedure. The recommended protocol for such an individual is commencement of venous thromboembolism prophylaxis on admission. It is not stated in the medical report by Dr. Douglas whether there was a contraindication to Mr. Knowles' receiving thromboembolism prophylaxis. The administration of venous thromboembolism prophylaxis may have reduced the possibility of deep venous thrombosis and thereby a fatal pulmonary embolism."

[11] Dr. Jason Copeland, junior surgical resident to Dr. M. Douglas, orthopaedic rotation gave evidence on behalf of the defendants. He testified as an ordinary witness. His evidence was that he disagreed with Dr. Rose's conclusion. The witness said that Mr. Knowles had been bleeding on admission and had been taken into the operating theatre ("OR") two days after his admission for definitive control of the bleeding by a urologist. To assist in controlling the bleeding, the patient's testes had been removed. Mr. Knowles' blood haemoglobin count thereafter fell until November 27, 2009.

[12] Dr. Copeland said that for an intra-medullary procedure it would be normal to administer VTEP. Venous thrombo embolism prophylaxis – prophylaxis means prevention of, venous thrombo embolism is a clot within the blood vessel, VTEP means the prevention of a clot forming in the blood vessel.

[13] In his witness statement at paragraph 5, Dr. Copeland said that Heparin and other anticoagulant drugs are contraindicated in a trauma patient with ongoing blood loss. In evidence at trial, Dr. Copeland said Mr Knowles presented with multiple injuries some of which were actively bleeding. In the multiple trauma patient who is actively bleeding there is a contra-indication to administering anti-coagulants which in this case was VTEP. He said they would administer the

prophylaxis once there is no contra indication to receiving VTEP. At the time Mr. Knowles was actively bleeding so anti-coagulation would have worsened his blood loss and it is a contra-indication to a patient who is bleeding. Heparin is an anticoagulant drug used to prevent clotting of the blood. It is one of the drugs used for VTEP. It is contraindicated in trauma patients, which means it is likely to cause more harm than benefit.

[14] It was for this reason that VTEP was not commenced. At paragraph 7 of his witness statement, Dr. Copeland said that on November 27, 2009 it was noted that the blood results from the previous day (November 26, 2009), indicated a further fall in the haemoglobin levels of 2g/dl to 9.7g/dl therefore Heparin was again withheld. Mr. Knowles was instructed to do calf muscle exercises instead.

The availability of the intramedullary nail

[15] The witness statement of Dr. Copeland at paragraph 6 said that the relatives of Mr. Knowles were advised that there was a need to procure the intramedullary nails which were not stocked at KPH. They were then advised that this would cause a delay in the surgery. This was undisputed.

Delay in operating

[16] On November 20, 2009 the decision was taken for intramedullary nail fixation of the femoral fracture of Mr. Knowles. The OR had been booked with emergency cases ahead of Mr. Knowles'. He was taken to the OR on November 22, 2009 by the urology team for scrotal exploration with the evacuation of blood clots and right orchidectomy. At this point, the agreed evidence disclosed that there was no intramedullary nail as yet available. Dr. Copeland testified that had the nail been available on the 22nd November, 2011, the intra-medullary procedure would have been performed then despite the ongoing blood loss.

[17] On a date unknown, surgery for the retrograde intramedullary nail fixation of the fractured right femur was scheduled for November 27, 2009. That surgery as

scheduled was postponed as the operating time had expired, there being other emergency cases on the operating list before that of Mr. Knowles'. The next available list for a procedure such as that to be performed on Mr. Knowles was on December 1, 2009 and he was taken to the OR on that date.

[18] The exact date the intramedullary nail was made available to the hospital by the relatives of Mr. Knowles is unknown. The inference can be drawn that it had not been available on November 22, 2009 and it would have been improbable that the intramedullary procedure, which had been scheduled for November 27, 2009 would have been without it. The procedure was not performed on November 27, 2009 and the next available date was December 1, 2009. There is nothing before this court by way of evidence or law to suggest that South East Regional Health Authority ("SERHA") breached its duty of care to this particular patient by failing to stock the locked retrograde intramedullary nail which contributed to the delay in operating on Mr. Knowles.

Submissions

[19] It was the submission of Mr. Jones that a settlement had been reached between the claimant and Dr Melton Douglas. A copy of which was tendered and admitted as Exhibit 8. Counsel submitted that having settled with Dr. Douglas, the claim against SERHA and the Attorney-General ("AG") could continue arising from the same loss. Both parties would be jointly and severally liable for any loss sustained. Mr. Jones for the claimant relied on section 3(1)(a) of the Law Reform (Tort-feasors) Act:

> "(1) *Where damage is suffered by any person as a result of a tort (whether or not such tort is also a crime)-*
>
> *(a) Judgment recovered against any tort-feasor liable in respect of such damage shall not be a bar to an action against any other*

> *person who would, if sued, have been liable as a joint tort-feasor in respect of the same damage."*

[20] Counsel relied on **Jameson v Central Electricity Generating Board** [2000] 1 A.C. 455, where the Court having considered the issue of whether a settlement with one party discharged the other party from liability stated that:

> *"So the acceptance by a plaintiff of payment into court by one concurrent tort-feasor does not operate as a bar to proceedings against other concurrent tort-feasors, unless the plaintiff has recovered the whole of his loss. Exactly the same applies where judgment has been entered in respect of the amount paid into court (as happened in Townsend v. Stone Toms), or where a claim is settled without any payment into court; and exactly the same applies whether the claims against the other tort-feasors are made in the same set of proceedings or in subsequent proceedings."*

[21] The claimant's counsel further submitted that a hospital has a non-delegable duty of care which can either be vicarious or direct. He relied on the case of **Cassidy v Ministry of Health (Fahrni, Third Party)** [1951] 1 All ER 574, a decision of Somervell, LJ (whose judgment was read by Denning, LJ). Mr. Jones argued that there was a non-delegable duty of care owed by the hospital authorities to Mr. Knowles. The claimant in the case at bar having settled the claim against Dr. Melton Douglas presented a prima facie case against the hospital authorities on the grounds of vicarious liability, as he was then an employee of the SERHA.

[22] The defendants called Dr. Jason Copeland who asserted that any injury suffered by Neville Knowles was consistent with due care on the part of the medical staff. Dr. Copeland gave evidence of the course of treatment administered to Mr. Knowles. The defendants did not call any senior medical personnel or expert in support of their position.

[23] The defendants were represented by counsel Ms. Dickens, who submitted that the evidence of Dr. Copeland pointed to the ongoing blood loss resulting from the gunshot wounds sustained by Mr. Knowles. She argued that this was the reason that Heparin and other anticoagulant drugs which were contraindicated in a trauma patient with ongoing blood loss such as Mr. Knowles, were not

administered. Further, that this situation also prevented VTEP from being commenced as this would have worsened the bleeding.

[24] Counsel further submitted that the delay in operating on Mr. Knowles was not due to the unavailability of the intramedullary nail which is not stocked by the hospital. The hospital did not procure the nail and it was the relatives of the patient, who having met with the hospital, procured it themselves. She addressed the delay attendant upon emergency cases listed ahead of Mr. Knowles by saying that the emergency list at the KPH prioritizes life threatening emergencies. The repairs of fractures are treated as electives and are placed on an elective list. The patient list at the hospital exceeds the available resources. Emergencies to include fractures are done on average three weeks after admission. I note that there was no evidence to support these submissions regarding hospital resources nor was evidence said as to the system operated by KPH with regard to priority of assignment of cases and the claimant did not concede any of these points on the issue of surgical delay.

[25] Counsel relied on the test set out by McNair, J in **Bolam v Friern Hospital Management** [1957] 2 All ER 118:

> *"the test is the standard of the ordinary skilled man exercising and professing to have that special skill…it is well established law that it is sufficient if 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 of medical men skilled in that particular art."*

Counsel relied on page 122, where McNair, J said:

> *"a doctor is not guilty of negligence if he has acted in accordance with a practice that is accepted as proper by a responsible body of medical men skilled in a particular art… putting it the other way round, a doctor is not negligent, if he is acting in accordance with such practice merely because there is a body of expert opinion that takes a contrary view."*

[26] Ms. Dickens relied on Halsbury's Laws of England (4th Edition), Volume 30, paragraph 35 which states:

> *"The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence, judged in the light of the particular circumstances of each case, is what the law requires, and a person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment, or operated in a different way; nor is he 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, even though a body of adverse opinion also existed among medical men."*

Expert Evidence

[27] The claimant relied on the medical report of Dr. Christopher Rose, orthopaedic surgeon who had been appointed an expert by the order of K. Laing, J on June 28, 2016. That medical report did not address the continued blood loss suffered in a situation specific to a gunshot wound or other trauma. In order to clarify the medical evidence, the Defendants posed questions to Dr. Rose. With regard to question five which reads:

> *"Is it likely that if the deceased was administered thromboembolism prophylaxis that he would have still developed pulmonary emboli and deep vein thrombosis."*

Dr. Rose said:

> *"Even with adequate anticoagulant prophylaxis, deep venous thrombosis can and does develop." There is a 14% incidence of venous thromboembolism following major orthopaedic procedures such as hip and total knee arthroplasties, pelvis, hip and lower limb fractures in which standard prophylactic measures had been applied."*

[28] It is evident from the report and responses of Dr. Rose that he is not purporting to espouse qualifications in any other specialty other than that of orthopaedics. He quite properly made no finding as to the effect of Mr. Knowles' ongoing blood loss in a trauma patient pre-surgery or of the patient's declining haemoglobin levels. Dr. Rose was only given the report penned by Dr. Douglas' which Ms.

Dickens correctly described as written at a time when litigation was not being contemplated. The report of Dr. Douglas contained far less details than those which emerged at the trial and the findings and conclusion of Dr. Rose were based solely on the report of Dr. Douglas.

[29] The report of Dr. Rose sets out two approaches. I accept that the medical team employed the first of those and considered the risk of venous thromboembolism in the patient, based on his individual predisposing factors and the risk associated with his current illness. I am able to come to this position as, in my view, the specific factual circumstances of this case did not just involve the risk factors of a comminuted fracture of the femur, age, delay between injury and surgery but also the trauma suffered by the patient, the nature of the injury which led to the fracture, the ongoing blood loss and the continued fall in haemoglobin levels. All of these factors had been assessed by the medical staff as set out in the report of Dr. Douglas and the evidence of Dr. Copeland.

[30] It seems to me to be common sense that an anti-coagulant would worsen the bleeding in a patient with ongoing blood loss. It is therefore a simple matter to accept the evidence of Dr. Copeland as to why VTEP would not have been commenced on admission nor if the patient had continued to suffer from falling haemoglobin levels.

[31] In my view, there was therefore no need for Dr. Rose to rely on the absence of a statement in the report of Dr. Douglas as to whether there was a contraindication to Mr. Knowles' receiving thromboembolism prophylaxis, as this would have been clear from the type of injury sustained by the patient; the fact of the ongoing blood loss and the falling haemoglobin levels which were set out in the report of Dr. Douglas, both of which point to bleeding on the part of the patient.

[32] In fact, it was the position of Dr. Rose that even if VTEP had been commenced, "deep venous thrombosis can and does develop." He said that the incidence of post-surgical venous thromboembolism is 14%. The report of Dr. Rose does not

assist the claimant or the court in determining the issues before it as the risk factors specific to the injury suffered by Mr. Knowles have not been addressed in it. In addition, Dr. Rose did not address any other of the five factors listed in the post mortem examination report under the heading 'cause of death', but confined his reasoning solely to the pulmonary embolism. I therefore have declined to accept the report of Dr. Rose in relation to the specific medical situation in which Mr. Knowles found himself.

Duty of care

[33] In the case of **Caparo Industries plc v Dickman** [1990] 2 A.C. 605 Lord Bridge of Harwich stated as follows:

> *"What emerges is that, in addition to the foreseeability of damage, necessary ingredients in any situation giving rise to a duty of care are that there should exist between the party owing the duty and the party to whom it is owed a relationship characterised by the law as one of "proximity" or "neighbourhood" and that the situation should be one in which the court considers it fair, just and reasonable that the law should impose a duty of a given scope upon the one party for the benefit of the other."*

[34] In the law of torts, a duty of care is owed to anyone you may reasonably foreseeably injure. There is therefore little difficulty in finding that the KPH owed a duty of care to the claimant.

Negligence

[35] The claimant submitted that as part of the pre-surgery preparation for the intramedullary procedure, VTEP was not commenced. This was supported by the evidence of Dr. Copeland who said in cross-examination: "generally speaking for procedures like that we would normally administer VTEP." The amended particulars of claim at paragraph 8(ii) states that the first defendant failed to commence venous thromboembolism prophylaxis on Mr. Knowles upon admission. There was therefore a departure from the pleadings here as well as for the submission that the first defendant was negligent in its failure to provide

the appropriate medical equipment. The claimant cannot rely on the allegation that there was failure to provide medical equipment.

[36] Pleadings set out the framework of the case that is being advanced by each party. They define the issues, the extent of the dispute between the parties and identify the general nature of the case of each party. Rule 8.9A of the Civil Procedure Rules under the heading "Consequences of not setting out case" provides that:

> *"The claimant may not rely on any allegation or factual argument which is not set out in the particulars of claim, but which could have been set out there, unless the court gives permission."*

[37] The claimant relied on the report of Dr. Rose which said:

> *"On admission, appropriate blood investigations were requested and he was placed on parenteral Rocephin for three days as well as analgesics. No venous thromboembolism prophylaxis was commenced according to the medical report admitted by Dr. Melton Douglas.…The recommended protocol for such an individual is commencement of venous thromboembolism prophylaxis on admission.* (emphasis mine.)

[38] The claimant did not seek permission to depart from the pleadings in this manner and this triggered Rule 8.9A. However, in order to apply the overriding objective to this case, I would consider that paragraph 8(i) of the particulars of claim which states "failing to adopt the correct/appropriate medical procedure on Neville Knowles in the circumstances;" encompasses the period in the enquiry sought by Mr. Jones in cross-examination. The question raised was why was VTEP not commenced before the intramedullary procedure? Implicit in that question would be a presumption that the patient would have been considered stable and ready for surgery.

[39] The evidence from the defendants to answer this question came from Dr. Copeland in cross-examination. He said that on the 22nd, November 2009 the intramedullary procedure could have taken place had the nail been available. Active blood loss would not have been a factor then as both the urologist's team and orthopaedic team would have performed their respective parts of the operation. It was therefore the procurement of the intramedullary nail, which caused a delay in the surgery to repair the fracture. There was agreed evidence that the OR was scheduled for emergency cases ahead of Mr. Knowles' on November 27, 2009. There was no commencement of VTEP when the patient was considered ready for surgery on November 27, 2009 as his haemoglobin levels were still falling. There was no evidence as to what transpired between November 27, 2009 and December 1, 2009, nor any evidence as to the patient's condition going into the intramedullary procedure on the latter date. What is clear is that VTEP was not commenced on December 1, 2009 and there has been no explanation for the decision.

[40] There remains a critical unanswered question. The intramedullary procedure had been postponed due to the unavailability of operating theatres at the hospital. Why was VTEP not commenced? The patient remained in the care of the hospital between November 27 and December 1, 2009. The period between these dates is indivisible from the duration of Mr. Knowles' admission. The claimant has argued and Dr. Copeland has agreed, that VTEP is standard for an intramedullary procedure. There was a clear departure from that standard on the evidence.

[41] The claimant argued that KPH was negligent in the treatment of his father and relied on the case of **Tahjay Rowe (A minor, suing by Tasha Howell, His mother and next friend) v The Attorney General for Jamaica and The South Eastern Regional Health Authority** [2015] JMSC Civ. 177. The case of Tahjay Rowe can be distinguished from the instant case. In **Tahjay Rowe** Lindo J, found that the hospital staff was negligent in the post-natal care of the infant claimant.

On the evidence, the delivery itself was normal yet the defendant was unable to explain how the claimant suffered brain damage. Consequently, it was the hospital's management of the claimant that was under scrutiny. Expert evidence was presented to show that the record-keeping of the claimant's care and management was inadequate and no investigations had been carried out to determine the reasons behind the infant's continuous crying and lack of feeding after birth. In the instant case, I am of the view that the absence of documentation or medical records is not a factor in the case at bar.

[42] I rely on the portions of the judgment of Lord Somervell in the case of **Cassidy v Ministry of Health (Fahrni, Third Party)** as set out below:

> *"The plaintiff, a general labourer, now some fifty-nine years of age, was suffering in the early part of 1948 from a contraction of his third and fourth fingers. He consulted a Dr. Flanagan, who diagnosed the condition as one known as Dupuytren's contraction. The doctor sent the plaintiff with a note to Walton Hospital for examination. He was seen by Dr. Fahrni, the third party in these proceedings. Dr. Fahrni was a whole-time assistant medical officer of the Walton Hospital. That hospital was at that date a hospital of the city of Liverpool, the original defendants to these proceedings…Dr. Fahrni confirmed Dr. Flanagan's diagnosis and recommended an operation. The plaintiff agreed to the operation and it was carried out on 8 April 1948. The nature of the operation involves in the ordinary course the hand and lower arm being kept rigid, or practically rigid, in a splint for some eight to fourteen days. When the plaintiff's hand was finally released after some fourteen days, the condition of all the four fingers was very bad…it will be seen that it is not alleged that the operation itself was negligently conducted. The plaintiff called Dr. McAustland who saw the hand in August, 1948 and described its condition. There was stiffness and swelling of all the fingers, scars and abrasions and marks on the flesh. He gave as his opinion of the cause:*

> *"Too tight and too prolonged bandaging in that splint. Too tight immobilisation and too prolonged immobilisation in that splint."*

He considered that in view of the plaintiff's bitter complaints, the bandage ought to have been removed to see whether some destructive process was going on which gave the man more pain than one would expect to have from the operation."

[43] *Denning, LJ read:*

> *"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…in my opinion, authorities who run a hospital, be they local authorities, government boards, or any other corporation, are in law under the selfsame 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 him the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him. What possible difference in law, I ask, can there be between hospital authorities who accept a patient for treatment and railway or shipping authorities who accept a passenger for carriage? None whatever. Once they undertake the task, they come under a duty to use care in doing it, and that is so whether they do it for reward or not…Where, however, the doctor or surgeon, be he a consultant or not is employed and paid, not by the patient, but by the hospital authorities, I am of the opinion that the hospital authorities are liable for his negligence in treating the patient. It does not depend on whether the contract under which he was employed was a contract of service or a contract for services. That is a fine distinction*

which is sometimes of importance, but not in cases such as the present where the hospital authorities are themselves under a duty of care in treating the patient.

I take it to be clear law, as well as good sense, that, where a person is himself under a duty of care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for services.

The hospital authorities accepted the plaintiff as a patient for treatment and it was their duty to treat him with reasonable care. They selected, employed and paid all the surgeons and nurses who looked after him. He had no say in their selection at all. If those surgeons and nurses did not treat him with proper care and skill, then the hospital authorities must answer for it, for it means that they themselves did not perform their duty to him."

[44] The defendants are liable in negligence if the surgeons and nurses employed by SERHA did not treat Mr. Knowles with proper care and skill. Therefore, it is for the claimant to establish that there was a failure to treat his father with proper care and skill on the evidence as presented to the court in all the circumstances of the case. The defendants have presented evidence that the way its servants/agents dealt with the claimant was in accordance with acceptable practice and it could not be said that the evidence of Dr. Copeland was anything other than considered and reasoned giving due regard to the professional standard for trauma patients.

[45] However, establishing a causal link between negligence and damage does not necessarily mean that liability will follow. The court still has to decide whether the defendant ought to be held liable for the damage in question. In the case of

Kuwait Airways Corpn v Iraqi Airways Co (Nos 4 and 5) [2002] 2 AC 883, 1090-1091, Lord Nicholls explained the position in this way:

> *"69. How, then, does one identify a plaintiff's 'true loss' in cases of tort?... I take as my starting point the commonly accepted approach that the extent of a defendant's liability for the plaintiff's loss calls for a twofold inquiry: whether the wrongful conduct causally contributed to the loss and, if it did, what is the extent of the loss for which the defendant ought to be held liable. The first of these inquiries, widely undertaken as a simple 'but for' test, is predominantly a factual inquiry.*
>
> *70. The second inquiry, although this is not always openly acknowledged by the courts, involves a value judgment ('ought to be held liable'). Written large, the second inquiry concerns the extent of the loss for which the defendant ought fairly or reasonably or justly, to be held liable (the epithets are interchangeable) … The law has to set a limit to the causally connected losses for which a defendant is to be held responsible. In the ordinary language of lawyers, losses outside the limit may bear one of several labels. They may be described as too remote because the wrongful conduct was not a substantial or proximate cause…The defendant's responsibility may be excluded because the plaintiff failed to mitigate his loss. Familiar principles, such as foreseeability, assist in promoting some consistency of general approach. These are guidelines, some more helpful than others, but they are never more than this.*
>
> *71. in most cases, how far the responsibility of the defendant ought fairly to extend evokes an immediate intuitive response. This is informed common sense by another name. Usually, there is no difficulty in selecting from the sequence of events leading to the plaintiff's loss, the happening which should be regarded as the cause of the loss for the purpose of allocating responsibility. In other cases, when the outcome of the second inquiry is not obvious, it is of crucial importance to identify the purpose of the relevant cause of action and the nature and scope of the defendant's obligation in the particular circumstances. What was the ambit of the defendant's duty? In respect of what risks or damage does the law seek to afford protection by means of the particular tort?"*

This court has adopted the approach enunciated by Lord Nicholls.

Causation

[46] The claimant must prove not only negligence or breach of duty but also that such fault caused or materially contributed to the death of Mr. Knowles in this claim. The claimant must, as in all cases prove his case by the ordinary standard of

proof in civil actions; that on a balance of probabilities the breach of duty caused or materially contributed to his injury.

[47] The law, requires proof of fault causing damage as the basis of liability in tort. On the general question of causation in the speech of Lord Shaw of Dunfermline in **Leyland Shipping Co. v. Norwich Union Fire Insurance Society** [1918] A.C. 350. said at p. 369:

> *"To treat proxima causa as the cause which is nearest in time is" out of the question. Causes are spoken of as if they were as distinct from" one another as beads in a row or links in the chain, but—if this meta-" physical topic has to be referred to—it is not wholly so. The chain of "causation" is a handy expression, but the figure is inadequate. Causation is not a chain, but a net. At each point influences, forces, events, precedent and simultaneous, meet; and the radiation from each point extends infinitely. At the point where these various influences meet it is for the judgment as upon a matter of fact to declare which of the causes thus joined at the point of effect was the proximate and which was the remote cause."*

The multiplicity of causes which were listed on the post-mortem examination report places the instant case squarely within the net rather than the chain. There were several factors which converged from the starting point of admission to the KPH.

[48] On the issue of causation, the claimant relied on surgical delay and failure to commence VTEP. In the case of **Bolitho v City & Hackney Health Authority** [1997] 4 All ER 771, ("Bolitho") cited by both sides, two separate questions relating to liability for medical negligence were raised by the court. The first related to the proof of causation when the negligent act is one of omission. The second related to the approach to professional negligence laid down in **Bolam v. Friern Hospital Management Committee** [1957] 1 W.L.R. 583 ("Bolam"). The claimant has relied on Bolitho in arguing this case on the first question. The defendants have relied on the test in Bolam, which Ms. Dickens submitted was modified in Bolitho in respect of the second question.

[49] Bolitho concerned the treatment received by Patrick Nigel Bolitho at St. Bartholomew's Hospital on January 16 and 17, 1984, he was then two years old. Patrick suffered catastrophic brain damage as a result of cardiac arrest induced by respiratory failure. Negligence having been established, the Court had to determine the question of causation which was set out in this way: "*would the cardiac arrest have been avoided if Dr. Horn or some other suitable deputy had attended as they should have done."*

[50] Lord Browne-Wilkinson in delivering the judgment of the House of Lords distinguished between an omission to act on the part of medical professionals and an act which ought to have been done. The learned judge said as follows:

> *"Where, as in the present case, a breach of a duty of care is proved or admitted, the burden still lies on the plaintiff to prove that such breach caused the injury suffered: Bonnington Castings Ltd. v. Wardlaw [1956] AC 613; Wilsher v. Essex Area Health Authority [1988] AC 1074. In all cases the primary question is one of fact: did the wrongful act cause the injury? But in cases where the breach of duty consists of an omission to do an act which ought to be done (e.g. the failure by a doctor to attend) that factual inquiry is, by definition, in the realms of hypothesis. The question is what would have happened if an event which by definition did not occur had occurred.…Therefore, in the present case, the first relevant question is "what would Dr. Horn or Dr. Rodger have done if they had attended?..."*
>
> *"…Therefore, the Bolam test had no part to play in determining the first question, viz. what would have happened? Nor can I see any circumstances in which the Bolam test could be relevant to such a question.*
>
> *However, in the present case the answer to the question "what would have happened?" is not determinative of the issue of causation. At the trial*

the defendants accepted that if the professional standard of care required any doctor who attended to intubate Patrick, Patrick's claim must succeed. Dr. Horn could not escape liability by proving that she would have failed to take the course which any competent doctor would have adopted. A defendant cannot escape liability by saying that the damage would have occurred in any event because he would have committed some other breach of duty thereafter. I have no doubt that this concession was rightly made by the defendants. But there is some difficulty in analysing why it was correct. I adopt the analysis of Hobhouse L.J. in Joyce v. Merton, Sutton and Wandsworth Health Authority [1996] 7 Med. L.R. 1. In commenting on the decision of the Court of Appeal in the present case, he said, at p. 20:

> *"Thus a plaintiff can discharge the burden of proof on causation by satisfying the court either that the relevant person would in fact have taken the requisite action (although she would not have been at fault if she had not) or that the proper discharge of the relevant person's duty towards the plaintiff required that she take that action. The former alternative calls for no explanation since it is simply the factual proof of the causative effect of the original fault. The latter is slightly more sophisticated: it involves the factual situation that the original fault did not itself cause the injury but that this was because there would have been some further fault on the part of the defendants; the plaintiff proves his case by proving that his injuries would have been avoided if proper care had continued to be taken. In the Bolitho case the plaintiff had to prove that the continuing exercise of proper care would have resulted in his being intubated."*

There were, therefore, two questions for the judge to decide on causation: (1) What would Dr. Horn have done, or authorised to be done, if she had attended Patrick? and (2) If she would not have intubated, would that have

been negligent? The Bolam test has no relevance to the first of those questions but is central to the second.

There can be no doubt that, as the majority of the Court of Appeal held, the judge directed himself correctly in accordance with that approach… Accordingly the judge asked himself the right questions and answered them on the right basis.

[51] Adopting the reasoning of the House of Lords in Bolitho, there are two questions that this court should ask itself on the issue of causation: (1) Should the medical staff have commenced VTEP? (2) If they had not, would they have been negligent? The Bolam test has no relevance to the first of those questions but is central to the second.

[52] In a case where the breach of duty consists of an omission to do an act which ought to be done, I interpret this to mean that VTEP ***ought*** to have been done in an intramedullary surgical procedure. There is agreement on this point when one looks at the medical reports of Dr's. Rose and Douglas and the evidence of Dr. Copeland. The question then, is, within the context of these facts, was there an omission to do that which ought to have been done? The explanation given by Dr. Copeland assumes that there was a risk to the patient if VTEP was not commenced. However, there is also the question of the trauma patient whose intramedullary surgical procedure is non-typical, in that, it was not the repair of a fracture in the ordinary sense, void of other complications such as ongoing blood loss, chronic ischemic heart disease, artherosclerosis and the nature and specificity of the injury suffered by the patient in the case at bar.

[53] This court has been asked by the claimant to embark upon a factual inquiry based on the hypothesis. "What would have happened if an event which did not occur had occurred," the Bolam test as has been indicated in Bolitho has no relevance to this question.

[54] The claimant in Bolitho failed to prove that the continuing exercise of proper care would have resulted in his being intubated. The claimant in the instant claim would similarly have to prove that the continuing exercise of proper care would have resulted in Mr. Knowles undergoing VTEP.

[55] To attempt to answer this hypothetical first question, in the present case, I accepted the evidence of Dr. Copeland that VTEP ought to have been but could not have been commenced on admission given the patient's ongoing blood loss and falling haemoglobin levels. By inference, although not expressly, I must also accept that Dr. Douglas also would not have caused VTEP to be commenced. In other words, as a surgical resident, Dr. Copeland would not have commenced VTEP without the approval of his senior and orthopaedic consultant who was Dr. Douglas. There was no evidence before the court from any expert or independent medical professional as to what would have happened in a case such as that presented by Mr. Knowles upon admission. The only expert evidence came from Dr. Rose whose report did not consider the hypothetical question nor address the risk factors attendant upon issues of the irrefutable ongoing blood loss and trauma suffered by the patient on admission. Applying the reasoning of the Lord Browne-Wilkinson as the Bolam test could not be said to be relevant to the first question as to what would have happened. "What would have happened or what should have happened" - is therefore not determinative of the issue of causation.

[56] Common to both sides is the recognition that I must decide whether the orthopaedic team should have commenced VTEP, and, even if they would not, or had not, whether such a failure would have been contrary to accepted practice in the profession.

[57] On the second question, I rely on the judgment of the House of Lords in Bolitho which demonstrates the need for reliable medical evidence which can be weighed by the court.

"In the Bolam case itself, McNair J. stated [1957] 1 W.L.R. 583, 587, that the defendant had to have acted in accordance with the practice accepted as proper by a "responsible body of medical men." Later, at p. 588, he referred to "a standard of practice recognised as proper by a competent reasonable body of opinion." Again, in the passage which I have cited from Maynard's case, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives -responsible, reasonable and respectable--all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."

[58] Bearing in mind the Bolam test it could not be said that the claimant presented evidence that emanated from responsible medical men skilled in that particular art. Dr. Rose gave no evidence to suggest that he was an expert in cardiology or venous insufficiency. This undoubtedly placed the claimant's case in a significantly weakened position as there was no reliable evidence to contradict or cast doubt on what Dr. Copeland has said as regards the ongoing blood loss. (See the Privy Council decision of West Indies Alliance Insurance Company Limited v. Jamaica Flour Mills Limited [1999] Lexis Citation 2860.)

[59] The defendants did not call any expert witnesses. Dr. Copeland testified as an ordinary witness. In the case of **Wilsher v. Essex Area Health Authority** [1988] AC 1074. The claimant sued the Essex Area Health Authority ("the authority") claiming that the new born patient suffered from retrolental fibroplasia ("RLF"), an incurable condition of the retina which caused total blindness in one eye and severely impaired vision in the other. This RLF was said to have been caused by

an excess of oxygen tension in the infant's bloodstream in his early weeks and was attributable to a want of proper skill and care in the management of his oxygen supply. In a trial which lasted 20 days the judge heard evidence from the medical and nursing staff at the hospital, expert evidence from two paediatricians and two ophthalmologists called for the plaintiff and from three paediatricians and one ophthalmologist called for the authority. All were highly qualified and distinguished experts in their respective fields. In addition, no less than 24 articles from medical journals about RLF were admitted into evidence.

[60] I cite the case of Wilsher to emphasise just how much assistance could have been given to the court on the medical issues to be determined. This court would have desired to have had before it, the views of a body of experts who would have set out their professional opinions as part of the record. In my view the Bolam test does not require the court to simply accept the views of any expert if they are not persuasive. Ultimately, it is for the court, not for medical opinion, to decide what was the standard of care required of a professional in the circumstances of a particular case. However, the court ought to be able to come to this conclusion having reviewed what is **said** to be the accepted practice in the field and only the experts can **say** this.

[61] In the speech of Lord Scarman in **Maynard v. West Midlands Regional Health Authority** [1984] 1 W.L.R. 634, 639 the learned judge said:

> *". . . I have to say that a judge's 'preference' for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his judgment he stated the law correctly. For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate speciality, if he be a specialist) is necessary." (Emphasis added.)"*

[62] There are decisions, which demonstrate that the judge is entitled to approach expert professional opinion on this basis. In **Hucks v. Cole** [1993] 4 Med. L.R. 393), a doctor failed to treat with penicillin a patient who was suffering from septic places on her skin though he knew them to contain organisms capable of leading to puerperal fever. A number of distinguished doctors gave evidence that they would not, in the circumstances, have treated with penicillin. The Court of Appeal found the defendant to have been negligent. Sachs L.J. said, at p. 397:

> *"When the evidence shows that a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then, however small the risk, the court must anxiously examine that lacuna--particularly if the risk can be easily and inexpensively avoided. If the court finds, on an analysis of the reasons given for not taking those precautions that, in the light of current professional knowledge, there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact and where necessary to state that it constitutes negligence. In such a case the practice will no doubt thereafter be altered to the benefit of patients. On such occasions the fact that other practitioners would have done the same thing as the defendant practitioner is a very weighty matter to be put on the scales on his behalf; but it is not, as Mr. Webster readily conceded, conclusive. The court must be vigilant to see whether the reasons given for putting a patient at risk are valid in the light of any well-known advance in medical knowledge, or whether they stem from a residual adherence to out-of-date ideas."*

[63] On the second question which concerns professional negligence, I hold that it would be difficult for a trial judge to form the view that the professional opinion genuinely held by a competent medical expert is unsound; as the judge is ill-equipped to himself or herself assess medical risks and benefits and would rely upon expert evidence for the process of clinical decision-making in a hospital setting. It is only where a judge can be satisfied that the weight of expert opinion cannot be logically supported on the evidence presented at the trial that such expert opinion will not provide a bench mark by which the defendant's conduct may be assessed.

[64] In my judgment it was for this court to assess the truth of the evidence on both questions. If the court finds, on an analysis of the reasons given for not commencing VTEP, in the light of current professional knowledge, and there was

no proper basis for the failure so to do, and that it was definitely not reasonable that those risks should have been taken, then the duty of the court is to state that fact and that it constitutes negligence.

[65] In the case at bar, there has not been placed before the court a body of expert medical opinions. The only expert evidence came from Dr. Rose. However, Dr.'s Rose, Douglas and Copeland all agree that VTEP ought to have been commenced where there is to be an intramedullary procedure. This was the accepted, established standard. I accept that firstly, VTEP ought to have been commenced between November 20, 2009 and November 27, 2009 but could not have been because of the patient's ongoing blood loss. There was no evidence that VTEP was commenced between November 27, 2009 and the date of the intramedullary procedure which was December 1, 2009. The risks outlined in the report of Dr. Rose would have been a sufficient reason to commence VTEP between those dates. There was no evidence placed before this court as to the condition of Mr. Knowles between the dates of November 27, 2009 to December 1, 2009 as indicated above. The presumption that he was stable enough for the procedure to be performed has not been rebutted by the defendants. The defendants therefore have breached their duty of care owed to Mr. Knowles, as this was a foreseeable consequence of the omission to commence VTEP in a patient with his risk factors coupled with surgical delay at the instance of the KPH.

[66] In the instant case, the patient was admitted to the hospital suffering from a gunshot wound which entered the scrotum and exited the femur. His ongoing blood loss was stemmed by surgical intervention on November 22, 2009 when his testes were removed. He was stable but continued to suffer from falling haemoglobin levels until November 27, 2009. The fracture to repair the femoral bone was successfully performed on December 1, 2009, yet most unfortunately Mr. Knowles did not survive. It was noted by Dr. Douglas that Mr. Knowles was hypertensive and on medication for that condition. The first four paragraphs of

the post mortem examination report under the heading cause of death list what essentially are blood clots, which travelled to the lung and caused damage to the heart contributed to, by the pre-existing condition of hypertension. The hospital ought to have been managing the hypertension and ensuring the administration of blood thinners once the bleeding had been controlled to prevent blockage to the arteries and possible death. This was particularly so as none of the undisputed risk factors outlined by Dr Rose had been diminished while Mr. Knowles was waiting for an available OR. This was a function of patient care, particularly as the patient had been through no fault of his own, made to wait for an available OR. VTEP was crucial in the case of Mr. Knowles and the failure to administer anticoagulants contributed materially to his death. The answer to the second question can be answered on the totality of the evidence in the affirmative.

[67] I find that there was a convergence of surgical delay and the failure to commence VTEP which materially contributed to the death of Mr. Knowles. The hospital had time to properly treat Mr. Knowles so as to avoid any permanent harm. The harm caused was closely related to the cause of death and cannot be declared to be remote. I rely on the cases set below for the common sense approach to be taken to ascertaining the cause from a combination of factors

[68] In **Yorkshire Dale Steamship Company Ltd. v. Minister of War Transport** [1942] A.C. 691 at p. 698 Viscount Simon L.C. said:

> *"The interpretation to be applied does not involve any metaphysical or scientific view of causation. Most results are brought about by a combination of causes, and a search for ' the cause ' involves a selection of the governing explanation in each case." Lord Wright said at p. 706: " This choice of the real or efficient cause from out of the whole complex of the facts must be made by applying common sense standards."*

[69] In **Cork v. Kirby Maclean Ltd.** [19521 2 All E.R. 402 at p. 407 Denning L.J. said:

> *"It is always a matter of seeing whether the particular event was sufficiently powerful a factor in bringing about the result as to be properly regarded by the law as a cause of it."*

[70] In light of the foregoing, I find that the claimant has proven on a balance of probabilities that there was negligence on the part of SERHA.

The Fatal Accidents Act

[71] It is trite that claims under the Fatal Accidents Act ("FAA") are based upon financial loss to the near relations/dependents of a deceased person on account of his wrongful death caused by the Defendant, which is referred to as the "dependency."

Pursuant to section 4 of the Fatal Accidents Act, the dependents of a deceased person can claim losses they would have incurred as a result of the death of Neville Knowles.

[72] Section 4(4) provides that:

> *"(4) If in any such action the court finds for the plaintiff, then, subject to the provisions of subsection (5), the court may award such damages to each of the near relations of the deceased person as the court considers appropriate to the actual or reasonably expected pecuniary loss caused to him or her by reason of the death of the deceased person and the amount so recovered (after deducting the costs not recovered from the defendant) shall be divided accordingly among the near relations."*

[73] Further, Section 4(5) provides that:

> *"(5) In the assessment of damages under subsection (4) the court- (a) may take into account the funeral expenses in respect of the deceased person, if such expenses have been incurred by the near relations of the deceased person; (b) shall not take into account any insurance money, benefit, pension, or gratuity which has been or will or may be paid as a result of the death; (c) shall not take into account the remarriage or prospects of remarriage of the widow of the deceased person."*

Dependents are only able to benefit under the FAA if their dependency under this head exceeds that of the LRMPA. There were no pleadings under the FAA, setting out evidence of financial loss or expenditure from the claimant pursuant to section 5 of the FAA. Pensions are also specifically excluded under section 4(5) of the FAA, I therefore decline to make an award under the FAA.

The Law Reform (Miscellaneous Provisions) Act

[74] In the case of **Vinston Miller (Administrator of the Estate of Weston Miller, the deceased) and Caribbean Producers Jamaica v. Kirk Hillary** [2015] JMSC Civ. 250, Campbell J set out the applicable law under this head:

> *"At common law, the death of either the tort-feasor or his victim would normally extinguish the possibility of an action. The Law Reform (Miscellaneous Provisions) Act, 1955, changed the common law by providing that; on the death of any person, all causes of action (with few exceptions) subsisting or vested in him should survive for the benefit of his estate.*

Section 2(1) of the Law Reform (Miscellaneous Provision) Act provides:

> *Subject to the provisions of this section, on the death of any person after the commencement of this Act, all causes of action subsisting against or vested in him shall survive against, or, as the case may be, for the benefit of, his estate:"*

[75] Further, Section 2(2)(c) of the Law Reform (Miscellaneous Provisions) Act provides;

> *"where the death of that person has been caused by the act or omission which gives rise to the cause of action, shall be calculated without reference to any loss or gain to his estate consequent on his death, except that a sum in respect of funeral expenses may be included."*

[76] From section 2 of LRMPA, it is clear that the law will allow damages claimed for (1) special damages, (2) loss of expectation of life, (3) funeral expenses and (4) lost years/ loss of future earnings. It should be noted that funeral expenses can be recovered under this head or under the section 4(5) of the FAA.

[77] The approach of the Court in the assessment of damages under the LRMPA is a practical one, "there is no room for sentimental agonizing," it is a hard matter of "dollars and cents subject to the element of reasonable future probabilities." (Per Harrison J (Ag), **Doris Fuller (Administrator Estate Agana Barrett, dec'd) v Attorney General** CL 1993/F152 delivered on 5th July 1993.

Loss of Expectation of Life

[78] The award under this head is a conventional or moderate award. Damages for the loss of expectation of life are in respect of loss of life and not of loss of future pecuniary prospects. There is no regard that can be had to financial losses or gains during the period, which the victim has been, deprived (See; Benham v Gambling [1941] 1 All E.R. 7).

[79] In the instant case the claim was for loss of expectation of life for which the conventional sum of $150,000.00 was submitted by Mr. Jones as being an appropriate sum. The claimant relied on **Gifton Alexander & Gardeon Alexander v Morris Hill Ltd.** [2016] JMSC Civ. 223 in which the award of $100,000.00 was made to a 79-year-old truck driver. The claimant submitted that Mr. Knowles was younger in age and therefore $150,000.00 was an appropriate sum.

[80] In **Hill v Administrator General Jamaica and The Attorney General**, [2014] JMSC Civ. 217, delivered on 19th December 2014, Lindo, J. (Ag), as she then was, cited the case of **Rose v Ford** [1937] AC 826, wherein the court stated;

> *"…settled law that a claim for loss of expectation of life is maintainable on behalf of the estate of the deceased. A conventional sum is usually awarded under this head of damages, as such a loss is incapable of*

> *quantification using any known arithmetical formula. I have considered the cases cited by Counsel (Gordon & Others v The Administrator General 2006HCV1878, unreported, delivered January 6, 2011, in which the sum of $150,000.00 was awarded and The Attorney General of Jamaica v. Devon Bryan (Administrator for the estate of Ian Bryan) 2013 JMCA Civ. 3 where the Court of Appeal reduced an award of $250,000.00 made in 2007 to $120,000.00).”*

[81] In **Bryan v. AG** (unreported) – CL 2001 B 088, Sinclair-Haynes J. (as she then was) also stated that the figure under this head of damages should be a conventional or moderate figure and recognized that there has been much controversy with regard to this sum. Sinclair-Haynes J. also stated that the massive devaluation of the Jamaican dollar required that the figure be adjusted proportionate to the change in the dollar value. Brown, J. took a similar approach in Gordon et al. v. Administrator General (Gordon, deceased) (unreported) – 2006 HCV 01878. In that case, both claimants and defendants presented recent awards granted by the Supreme Court that ranged from $50,000.00 to $175,000.00 Brown, J. having acknowledged the variance resulted from the devaluing Jamaican dollar, considered the claimant proposed sum of $150,000.00 to be reasonable. The loss of expectation award should therefore be updated to match the devaluation of the dollar.

[82] The defendants submitted that the case of **Tyler Horatio Wedderburn v The Attorney General & Police Constable Vernon Ellis** [2013] JMCA Civ. 153, in which Fraser, J awarded the sum of $180,000.00 to the deceased’s as a conventional award. Miss Dickens submitted that an appropriate conventional award in the instant case was the sum of $120,000.00 based on the case of **The Attorney General of Jamaica v Devon Bryant** [2013] JMCA Civ. 3 in which the Court of Appeal held the conventional sum for a loss of expectation award to be $125,000.00.

[83] The court makes the following orders:

1. Judgment for the claimant.

2. Costs to the Claimant to be taxed if not agreed.

3. The Defendants are jointly and severally liable to pay the following sums to the claimant pursuant to the Law Reform Miscellaneous Provisions Act:

    a.) Special damages in the sum of $20,000.00 with interest at the rate of 3% per annum from December 1, 2009 to the date of judgment.

    b.) Loss of expectation of life in the sum of $150,000.00 as a conventional award, Interest on loss of expectation of life from the date of filing of the claim to the date of judgment at a rate of 3% per annum.

[84] The settlement between Dr. Douglas and the claimant has extinguished the awards made at paragraph 83. The sum of $950,000.00 having been accepted by the Claimant satisfies the claim herein, the defendants are therefore not liable to pay the awards made at paragraphs 3(a) and (b) but shall pay costs of this action as indicated at order number 2.