[2018] JMSC. Civ. 95

IN THE SUPREME COURT OF JUDICATURE OF JAMAICA

IN THE CIVIL DIVISION

CLAIM NO. 2013HCV04203

BETWEEN	**CAROL BLAKE**	**CLAIMANT**
AND	**UNIVERSITY HOSPITAL BOARD OF MANAGEMENT**	**DEFENDANT**

IN OPEN COURT

Mr. Kevin Page instructed by Page & Haisley for the Claimant

Mr. Christopher Kelman and Ms. Stephanie Ewbank instructed by Myers, Fletcher & Gordon for the Defendant

Heard: April 23 and 24, 2018, May 15, 2018 and June 12, 2018

Negligence – Medical negligence – **Negligence not established on the evidence**.

LINDO, J.

[1] This is a claim which arose from the alleged negligence of medical personnel employed to the defendant and carrying out duties at the University Hospital of the West Indies (UHWI). The action is brought by Carol Blake who was taken to the UHWI on February 28, 2012 after sustaining injury to her left ankle when she fell from a tree.

[2] Ms. Blake by her claim originally filed on July 19, 2013 and subsequently amended, is claiming that on or about February 28, 2012 she was a patient at the UHWI "when as a result of the negligence of the servants or agents of the defendant was injured, suffered loss and damage and incurred expense".

[3] In her amended Particulars of Claim she states the following particulars of negligence:

> *a) Negligently treating the Claimant's broken ankle;*
>
> *b) The defendant's servants and/or agents failed to recognize the risk of the development of infection of the wound or alternatively recognised the risk but went on to take it, causing the infection to further spread;*
>
> *c) Failed to pay any or proper attention to the symptoms being experienced by the claimant whilst under their care;*
>
> *d) Failed to take any or adequate account of the further symptoms of the wound;*
>
> *e) Creating large and unsightly scars which represent a permanent and unnecessary cosmetic disfigurement;*
>
> *f) Failed to provide any or proper medical care in the management of the Claimant's condition;*
>
> *g) Failed in the circumstances to take reasonable care for the safety of the Claimant;*
>
> *h) Exposed the Claimant to an unnecessary risk of injury."*

[4] The defendant in a defence filed on October 25, 2013, while admitting that Ms Blake was "an in-patient at the Defendant's hospital between February 28 and June 2, 2012", denies the allegations of negligence enumerated in the particulars of negligence and asserts that at all material times the Claimant's management and treatment at the Defendant's hospital accorded with good, approved and acceptable medical and surgical practice in Jamaica in 2012.

The Claimant's Case

[5] At the trial, Ms. Blake's witness statement filed on September 25, 2017 stood as her evidence in chief after she was sworn and it was identified by her. She was cross examined.

[6] Her evidence is that she is 46 years old and that on February 28, 2012, she fell from a mango tree and "twisted and broke her left ankle" and that she was taken

to the UHWI where she was diagnosed as having an open fracture and was admitted and taken into surgery which was done “about 18 hours” after she was admitted.

[7] She states further that after the surgery her wound was inspected and the doctors told her they were “satisfied with the progress of the wound” and about five days after, she “developed a sepsis in the wound”. She says she had to do at least four operations and these were performed by Dr. Vaughan, Dr. Samuels and Dr. Williams and that “sequential debridement of her wound was carried out in one of the operations” and she spent about three months as an in-patient at the hospital.

[8] Ms. Blake adds that up to about three days after the operation, her ankle looked normal and on the fourth or fifth day it was wet and the skin looked wrinkled. She states that “the hospital staff had not dressed the wound frequently up to that time...the staff of the university of the west Indies hospital did not do frequent checks on me...”. She also states that she incurred medical and transportation expenses and is unable to afford further medical treatment.

[9] In cross examination by Mr. Kelman, she indicated that she fell from the tree “before 5:30, minutes to 6” and that she arrived at the hospital “after 6” and was taken to the operating theatre at “3 o’clock on the 29th”. When it was suggested to her that it was not eighteen hours after she arrived at the hospital that she was taken to the theatre, she admitted that it could not be 18 hours.

[10] Ms. Blake agreed that the first time there was evidence of infection was on March 5, and indicated that she was monitored between the date of the operation and March 5, but said, “I am maintaining that the hospital didn’t do frequent checks on me”. However, when confronted with (Exhibit 74) the ‘Nurses Notes’ and ‘Focus Notes’ for the period February 29 to March 5, she agreed that in light of the information contained in the notes, she was prepared to agree that her entire evidence that “I found it strange that the staff did not dress the surgical site of the

wound more frequently. The staff at the University of the West Indies Hospital did not do frequent checks on me", was false.

[11] When it was put to her that her inability to afford further medical treatment is not the only reason her condition is not better, but that she refused advice to undergo further medical treatment, she stated that she did not refuse treatment but that she was scared, as she went to the hospital with "a break leg and one scar and came out with three".

[12] She agreed that the reference (in Ex 74) in the orthopaedic clinic's notes of September 7, 2012 and September 21, 2012 that the "patient was still not sure" and "patient not willing to have frame" was reference to the 'frame' she was recommended. She indicated that she was not sure if June 14 was the last date she attended the orthopaedic clinic but that she asked for a medical report as she wanted a second opinion and she is yet to receive the report. After much pressing, she agreed that she did not accept the recommendation of UHWI to put on the frame and she also agreed that Dr. Dundas had similarly recommended a 'frame' for her foot.

[13] Ms. Blake, in support of her claim that the staff at the defendant's hospital were negligent in their treatment towards her during the period she was under their care, called Dr. Grantel Dundas, Consultant Orthopaedic Surgeon and Dr. Akshai Mansingh, Consultant Orthopaedic Surgeon as expert witnesses and their medical reports dated May 27, 2013 and September 28, 2014, respectively, were admitted in evidence in support of her claim without them attending.

[14] Ms. Blake was seen by Dr. Dundas for the first time on October 18, 2012 and she gave him information in relation to her injury and subsequent treatment at the UHWI both as an in-patient and an out-patient. His report indicates that on examination there were "scars related to the Rectus addominus muscle transfer... extensive skin grafting...the ankle was internally rotated and adducted. There were ulcers on the anterior lateral aspect of the distal third of the leg". The

diagnoses entertained were “Left ankle disarticulation. Status post septic left ankle”.

[15] Dr. Dundas’ report further states that he recommended that she should have “Ilizarov rings for bone transport and eventually arthrodesis of the ankle” and that he saw her again in February 2013, “the ankle was significantly deformed and in equinus but her pin tracts were dry” and that he recommended the removal of the pins and further suggested the use of “a Taylor Spatial Frame for correction of the equinus deformity and possibly for the stabilization of her ankle.”

[16] The medical report of Dr. Mansingh indicates that he first saw Ms. Blake on August 29, 2014 and that she gave a history of sustaining the injury and having gone to the UHWI where she was admitted and taken to surgery, and that she developed post operative infections which resulted in four further surgeries.

[17] Dr. Mansingh’s report states that on examination “significant findings were in her left ankle which had notable scars from a split skin graft (SSG) along the lateral aspect up to the knee”. His diagnosis is stated as follows: “Osteomyelitis of left ankle (distal tibia and fibula) secondary to an open fracture. Comcomitant osteoarthritis of the ankle joint with fixed flexion deformity”. Additionally, the report states “the surgeries described by the patient are in keeping with a severe bony infection (osteomylitis) which required multiple debridement and ultimately resection of the lateral malleolus and plastic surgery”.

The Defendant’s Case

[18] Dr. Kenneth Vaughan, Consultant Orthopaedic Surgeon, was called as a witness for the defendant and his witness statement, consisting of twelve pages and dated June 30, 2017, was admitted as his evidence in chief.

[19] In amplification, Dr. Vaughan stated that based on his review, Ms Blake was seen in the emergency room between 6:15 and 6:30 pm on February 29, was admitted about 9 pm and got to surgery in about 8 – 9 hours. He said that the wound was inspected 48 hours after surgery and found to be healing well and

that it was inspected daily thereafter and nothing was found, but, that on the 5th day of March it was noted that a green discharge was coming from the wound. He stated that after every inspection the wound was dressed and checks are done frequently by nurses, adding that vital signs are done at least four times per day, and about eight hours after surgery.

[20] In relation to Dr. Dundas' recommendation for the use of a Taylor Spatial Frame for correction of the equinus deformity, Dr. Vaughan explained that it is a form of external fixation used to correct deformities, correct malunion or give a stable foot to walk on.

[21] With regard to Dr. Mansingh's report which stated, "It is recommended that a formal ankle arthrodesis (fusion) be considered to improve her function", Dr Vaughn said it is a fusion of the ankle joints, as, by then, the claimant had lost a portion of the lower end of her tibia which forms part of the ankle joint and so it would be to bring the bone down to achieve a fusion.

[22] Dr. Vaughan stated that the recommendation by Doctors Dundas and Mansingh are similar to the recommendation from the UHWI and that where the claimant said she came in with one scar and came out with three, it is that she came in with an open fracture, "a Grade 3A open fracture" and the implication is that you are at risk for infection so she had surgery early in the morning following admission having had the wound cleaned as best as it could and at surgery further cleaning and further debridement, "i.e. removal of tissue, dirt etc" and he explained that she had a wound, she had broken bones, one on the outside and one on the inside...she had one on the left.". He added that subsequent plastic surgery procedure would have accounted for the third one.

[23] He explained that the "6 hour rule" was thought to be the benchmark for treating open fractures but in relation to getting to the operating room and dealing with the fracture, it has been shown that the most important thing is the administering of antibiotics "which is crucial in minimizing the risk of infection". He stated that antibiotics were administered as soon as Ms. Blake got to the emergency room

and he pointed out that it was recorded that she was given antibiotics at 6:30 and that this was “broad spectrum antibiotics” and she was also given immunization against tetanus. He added that antibiotics were continued during the entire period of time that Ms. Blake was in the hospital and after.

[24] Dr. Vaughan said that literature shows that the correct consensus in relation to the treatment of a person with an open fracture is that it is the timing of the antibiotics rather than getting the patient in surgery within six hours. He explained that the infection discovered on March 5 was a necrotizing fasciitis which is a peculiar type of infection which can arise from trivial injuries and stated that it is very dangerous and can cause loss of limb “or indeed life”.

[25] Under cross examination by Mr. Page, Dr. Vaughan indicated that he personally treated Ms. Blake and he agreed that she was prepared for surgery and the operating room did not become available until 2:35 am. He said the surgery was carried out by Senior Resident, Dr. Orville Samuels and she was given further antibiotics between 9pm and 2:35, am but her wound was not cleaned during that period.

[26] He explained that the surgical procedure carried out at 3 am was a “debrino wound irrigation and fixation of fracture of the tibia”. He indicated that that was not the first time the wound was cleaned, but that it was cleaned in the emergency room when she came in initially, and that when he said all dirt and debris was removed, it would be all that can be seen with the naked eye. He said that it was not likely that some dirt and debris could remain after surgery, as the operating room is where you have a “controlled environment, adequate lighting, adequate anaesthesia of patient and all facilities available to clean and debride”

[27] He admitted that the inspection carried out on March 5 was by the doctors on the team and that inspection was carried out daily between the 2nd to the 5th of March but that there was no inspection by any doctor until 48 hours after the surgery, as it was a clean surgical wound and having done the debridement, protocol is that you inspect it 48 hours after. He said no inspection is done by the nurses either.

[28] Dr. Vaughan agreed that on the day after the infection was discovered he conducted the surgical procedure and found fascial tissue which extended from the ankle to the knee. He explained that what she had was necrotising fasciitis, which can spread rapidly and that the development of the infection could "possibly" have taken place between the 2nd and 5th of March, but was "not likely" to be in the 48 hours between the first surgery and when it was inspected on March 2. When asked why an infection was not picked up between the 2nd and 5th March, he indicated that bacteria multiply despite being on antibiotics and it was "not an ordinary wound infection it is a necrotising fasciitis".

[29] He stated that "vital signs, complaint of pain and wound drainage" is what would be used to detect infection and he indicated that necrotising fasciitis spreads rapidly and he is not aware of any defined time within which it would travel "six inches up the leg", and indicated that the purpose of the surgery on March 7 was the need to be aggressive in exploring the wound to ensure no further spread of the infection. He explained that a reason the inspection on March 4 did not reveal the infection, but it was seen on March 5, is that Ms. Blake was on antibiotics which would suppress any sign of infection and further it is not until you make the incision you realize you are dealing with a necrotising fasciitis. He agreed that the wound was left exposed after the operations on March 6 and 7 as there was no sufficient tissue to close it and that it would be from the ankle "all the way up to the knee"

[30] He explained that plastic surgery procedures had to be done and that there was no time to cover the wound and they had to ensure it was cleared of all the infection before anything further can be done. He agreed that she was not seen by a plastic surgeon until March 17 and stated that the wound "would have to settle down before Plastic Surgeon could do anything". He said in his opinion dealing with this type of infection the period between March 7 and 17 was reasonable time.

[31] He pointed out that the claimant was seen by a plastic surgeon on March 17 and surgery was scheduled for March 23 but had to be postponed as Ms. Blake had 'tachycardia' which is a very high heart rate. He admitted that one of the antibiotics was discontinued as it was thought that her vomiting was a reaction to it, but not that it was ineffective.

[32] Dr. Vaughan stated that, in relation to the fever Ms. Blake developed after the surgery on April 6, it was evident she had an infection not only in the fascial tissue but in the bone, and that is why she had to be taken to the theatre and the infected end of the bone had to be removed. He noted that she was discharged from the hospital on June 2 with 'out-patient follow –up' and he denied all allegations of negligence put to him by Counsel for the claimant and disagreed that the defendant is responsible for the claimant picking up the infection.

Claimant's Submissions

[33] In his written closing submissions filed on May 15, 2018, Counsel for the claimant outlined the claimant's case and submitted that the doctors at the defendant's hospital owed an "established standard of care to the claimant by virtue of the relationship" and that they fell below the required standard "established by case law in the House of Lords decision of **Bolitho v City and Hackney HA** [1997] 4 All ER 77."

[34] Counsel also submitted that the doctors failed to "properly clean the wound, failed to perform the surgical procedure in a timely manner and failed to properly treat and dress the wound after the initial surgery" and "took an inordinately long time to cover the wound".

[35] Reliance was placed on the medical report of Dr. Akshai Mansingh for the proposition that the defendant breached their non-delegable duty of care in their deficiencies in the treatment and management of the claimant where Dr. Mansingh states: "...developed post operative infections..."

[36] Counsel also placed reliance on the medical report of Dr. Grantel Dundas, where he states: "...returned to the operating room on several occasions and subsequential debridement carried out..." for his submission that there was "poor management of the claimant".

[37] Mr. Page said that the defendant also fell below the standard of care in that they failed to perform the first debridement within the traditionally recommended 6 hour period after first being brought to the hospital, and pointing to the expert report of Dr. Konrad Lawson, noted that he states that the first debridement (surgery) ought to be done as soon as possible and at the first opportunity. He submitted further that "the time and duration of the administration of antibiotics and the excision of dead and devitalized tissues were inadequate in the circumstances".

[38] It was also submitted by Mr. Page on behalf of the Claimant, that the defendant also failed to administer the appropriate antibiotics as the defendant had to discontinue the use of the antibiotic "oral one flagyl", because the claimant had begun vomiting and experiencing discomfort. He added that the defendant breached their duty of care in failing to address the wound more frequently after the first surgical procedure and that the defendant did not do frequent checks in the initial days after the first surgical procedure and had they done so "the detection of the bacteria could have been done at a much earlier stage thereby preventing the claimant from suffering severe injuries and complications.

[39] Counsel stated that the approach in the case of **Bolitho,** (supra) has been followed in this jurisdiction as seen in the case of **Howard Genas v The Attorney General of Jamaica & Others,** Suit No. CL1996/G105, where the court stated that in appropriate cases the failure or omission to act may amount to medical negligence.

[40] Citing the case of **Tahjay Rowe (a minor, suing by Tasha Howell, his mother and next friend) v The Attorney General of Jamaica and SERHA,** Claim No 2009HCV02850, delivered September 10, 2015, a case from this court, Counsel

submitted that “it would have been reasonable to expect the defendant to carry out certain investigations which would determine the care and steps to be taken in the management of the claimant.” He therefore concluded that the omissions by the servants and or agents of the Defendant are sufficient to ground the claim in medical negligence and that the injuries, complications and disability sustained by the claimant “are a direct result of the actions of the servants and/or agents of the Defendant and the injuries are a directly foreseeable result and therefore the Defendant should be held liable...”

Defendant’s Submissions

[41] Counsel for the defendant in their closing submissions, set out the undisputed facts, carried out an assessment of the evidence presented to the court, and invited the court to make some particular findings of fact.

[42] Reference was made to the case of **Kimola Merritt v Dr. Ian Rodriquez & Anor**. Suit No CL1991/M036, unreported, delivered July 21, 2005, as showing that doctors owe a duty of care to persons they accept as patients and in order to prove that a doctor was negligent, a claimant must show that the acts of the doctor fell below the required standard of care applicable to the medical profession as expressed in the leading case of **Bolam v Friern Hospital Management Committee,** [1957] 2 All ER 118.

[43] It was pointed out by Counsel that the test in **Bolam** was subsequently modified by the House of Lords in the case of **Bolitho v City and Hackney HA,** *supra,* and the effect is that a court can still find a defendant hospital negligent even where that hospital provides expert evidence on its behalf. Counsel stated that it is a power to be sparingly used and its only proper application is where a court is satisfied that the defendant’s expert’s evidence is so flawed that even though a body of medical opinion supports it, that body is neither logical, reasonable nor responsible.

[44] Counsel indicated that both **Bolam** and **Bolitho** have been applied and approved in a number of cases in the Jamaica Supreme court and with reference to a judgment of this court, **Shawn Davy v The Attorney General & Anor.,** [2015] JMSC Civ 126, unreported, delivered June 26, 2015, suggested that an identical finding of law is justified. In **Shawn Davy**, the court found that the Claimant failed to establish a causal link between the surgeries performed by the doctors and the subsequent loss of function of the lower limb of the claimant. Additionally, this court had found that the claimant had failed to prove that the servants of the Crown were negligent.

[45] Counsel indicated that the experts' evidence presented by the claimant were incapable of establishing the defendant's negligence while the defendant called two consultant orthopaedic surgeons and the expert evidence of Dr. Lawson, "was from a body of opinion that was manifestly logical, reasonable and responsible and even bolstered by an academic publication. It is more than capable of withstanding logical analysis as contemplated in the Bolitho test".

[46] A comparison with the case of **Anthony Jackson v George Donaldson & the Attorney General,** Suit No. CL1995/J 015, unreported, delivered June 27, 2008, was made by Counsel who noted that the court found that, in a claim involving an open fracture to the arm, treatment administered at the Cornwall Regional Hospital in 1994 was held to be negligent. Counsel pointed out that that case can be easily distinguished from the case at bar, as, among other things, there were no medical records available for evidence at trial and the doctor applied plaster of paris cast to the claimant's hand despite no prior irrigation, antibiotics or debridement.

[47] Counsel therefore concluded that the claimant's case "evidentially is woefully and insurmountably deficient to the extent that it ought to fail".

The Law and Application to the facts

[48] In order to be successful on her claim, the claimant has the burden of proving, on a balance of probabilities that the defendant owed her a duty of care which was breached and which resulted in the injury or loss of which she complains. She must show that there is a causal link between the defendant's negligent act or omission of which she complains and the resultant damage, in that the action or inaction of the defendant fell below the required standard of care.

[49] It is established that medical professionals owe a duty of care to anyone they accept as a patient and they are obliged to take all due care which is necessary for the health of the patient. The test as to the standard of care required was established in the well known case of **Bolam v Friern Hospital Management Committee,** supra, where McNair J., in a direction to the jury, formulated the test as follows:

> *"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 round, a man is not negligent, if he is acting in accordance with such practice, merely because there is a body of opinion who would take a contrary view."*

[50] In what is now referred to as the 'Bolam Test', whether or not the doctor has exercised that care, is measured by the standard of the ordinary skilled man, exercising and professing to have that special skill. This 'test' has since been modified in the case of **Bolitho v City and Hackney Health Authority** supra, which shows that a court can still find a defendant hospital negligent even where expert evidence is called on its behalf.

[51] In addressing what is the proper approach of a court in respect of expert evidence, Otton L.J., in **In re B (a minor) (Split Hearing: Jurisdiction**) [2000] 1 WLR 790 said:

> *"The circumstances when judges of the High Court can reject the evidence of a body of medical opinion are rare. This situation was*

> *considered by the House of Lords in Bolitho v. City and Hackney Health Authority [1998] A.C. when revisiting the well known test of Bolam v. Friern Hospital management Committee [1957] 1 WLR 582. Although an action for damages for personal injury arising out of alleged medical negligence, certain observations are of relevance in this case. Lord Browne-Wilkinson, giving the sole speech, with which the other members of the committee agreed, said [1998] A.C. 232, 243:*
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> *"In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion...But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible. I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable...It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed"...*
>
> *But where the dispute involves something in the nature of an intellectual exchange, with reasons and analysis advanced on either side, the judge must enter into the issues canvassed before him and explain why he prefers one case over the other. This is likely to apply particularly in litigation where, as here there is disputed expert evidence; but it is not necessarily linked to such cases..."*

[52] In view of the above authorities, I find that the claimant had the burden of proving on a balance of probabilities that the health care team at the defendant's hospital did not act in accordance with the accepted medical practice in relation to their treatment to her. She had to show that their action fell below the standard of care expected of ordinary skilled persons who profess to have the skill to treat a person with her condition.

[53] The claimant had the report of two experts, consultant orthopaedic surgeons, Drs. Dundas and Mansingh, admitted in evidence without them being called. These surgeons had examined the claimant after she was discharged from the UHWI, on October 18, 2012 and August 29, 2014, respectively. They did not have the benefit of the medical records of the claimant and the history of the injury and subsequent treatment was reported to them by the claimant herself, so

that Dr. Dundas indicated that the claimant was taken to surgery about eighteen hours after being taken to the hospital and that she developed sepsis three days post surgery, which information was later stated to be false by the claimant.

[54] The defendant on the other hand also called two consultant orthopaedic surgeons who gave *viva voce* evidence and were subject to cross examination. Dr. Vaughan had direct interaction with the claimant and Dr. Konrad Lawson, is an independent expert witness who had no interaction with the claimant but provided an opinion based on his examination of the medical records of the claimant kept by the defendant hospital.

[55] In support of his analysis and opinion, Dr. Lawson referred to the notes contained in the docket of the claimant held by the defendant hospital and his opinion evidence was supported by an article from the **Journal of Bone and Joint Surgery...** (Ex 75).

[56] An examination of the evidence of Dr. Lawson shows that it corroborated the evidence of Dr. Vaughan in every material respect. This included agreeing with Dr. Vaughan that the recommendations by the experts called by the claimant and that of the UHWI were for further treatment to improve the claimant's condition.

[57] Having considered the evidence of the parties and the submissions of Counsel against the background of the statements of case, I find as a fact that the claimant was taken to the UHWI on February 28, 2012 at about 6pm and was examined and diagnosed with a Grade 3A open fracture. I find also that her wound was irrigated, she was given 'broad spectrum antibiotics' and blood tests and x-ray were done, after which she was placed on a ward and when an operating theatre became available, at about 3 am, that is, approximately nine hours after she arrived at the hospital, she was operated on and returned to the ward and was monitored several times each day, although the wound was first inspected 48 hours after surgery and daily thereafter.

[58] I also find that during the period after the first surgery, and March 5, 2012, when she was discovered to have a greenish discharge coming from the wound, Ms. Blake did not make any complaints in relation to any pains or discomfort etc. from which it could be detected that she might have had an infection and that when she was taken back to surgery on March 6, she was discovered to have developed necrotising fasciitis and Dr. Vaughan removed the infected tissue and she was again taken to the operating room on March 7 where doctors checked to ensure that there was no further infected tissue.

[59] I accept the evidence that necrotising fasciitis (flesh eating disease) is a serious disease which spreads rapidly. I note that the claimant did not accept the advice of the medical experts in relation to having fusion of the ankle joint to correct the deformity and to lengthen the limb so that she would not have 'limb length discrepancy', but she had indicated that she wanted a second opinion.

[60] When I examine the evidence of Dr. Vaughan who was personally involved in the management and care of the claimant, and the expert evidence of Dr. Lawson who is not connected to the defendant, I find that it is shown that there was good and early intervention and management of the claimant from the time she presented at the emergency room of the defendant's hospital, during her stay at the said hospital and even when she was an outpatient.

[61] The defendant's evidence clearly refuted the initial contentions of the claimant that she was not operated on until some 18 hours after she was admitted at the defendant's hospital, that the staff "did not dress the surgical site of the wound more frequently" and that the staff at the hospital "did not do frequent checks on [her]" thereby destroying the very foundation of her claim.

[62] The authorities show that in order to succeed on the contention that the defendant was negligent, the claimant has to show on a balance of probabilities that the delay in treating her was 'at least a material contributing cause' of her resulting condition. However, having shown on her evidence elicited in cross

examination, that there was no such delay, it is clear that her claim would fail on this ground.

[63] Ms. Blake has not shown on her evidence that the health care team at the Defendant's hospital did not act in accordance with accepted medical practice in relation to their treatment to her and has not shown that their actions were below the standard of care expected of ordinary skilled persons who profess to have the skill to treat a person who suffered the injury for which she was admitted to the hospital. She has failed to establish that the care she received fell below acceptable standards and therefore failed to prove on a balance of probabilities that the defendant breached its duty of care and that it resulted in the injuries she complained of. She has also not provided any evidence to refute the testimony of the expert called by the defendant, which testimony served to substantiate the evidence of the defendant, as given by Dr. Vaughan. The evidence of the expert witness, Dr. Lawson speaks volumes in relation to the treatment of the claimant while in the care of the defendant's medical personnel and in my view exonerates the defendant.

[64] When the test laid down in the case of **Bolam** is applied to the facts of the case, it is quite evident that the claimant has fallen woefully short of the burden of proof. It is not enough to attribute blame to the defendant; it is incumbent on the claimant to prove the causal connection between the action, or inaction, of the defendant and the damage she is alleging she suffered. I am not satisfied that Ms. Blake has done so.

[65] Additionally, according to Lord Brown in **Bolitho**,: *"the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has logical basis"* and I must point out that I am so satisfied by the arguments and the observations of Dr. Lawson.

[66] Further, the experts called by the claimant have not supported the claimant's allegations and have not provided any evidence of negligence on the part of the

defendant and in view of all the foregoing it is clear that the defendant was not negligent in the treatment and care of the claimant.

[67] The claim must therefore fail as there was no evidence adduced to show that the defendant was negligent.

Disposition

[68] The claim is therefore dismissed with costs to the Defendant to be agreed or taxed.