IN THE SUPREME COURT OF JAMAICA
IN COMMON LAW
SUIT NO. CL 1995/B-407

BETWEEN	COLEEN BURRELL	PLAINTIFF
AND	CORNWALL REGIONAL HOSPITAL (Board of Management Montego Bay Region)	1ST DEFENDANT
AND	DOCTOR WRIGHT	2ND DEFENDANT
AND	THE ATTORNEY GENERAL OF JAMAICA	3RD DEFENDANT

Mr. Clyde Williams instructed by Haughton & Associates for the plaintiff
Mrs. Susan Reid-Jones instructed by the Director of State Proceedings for 1st, 2nd and 3rd defendants

Heard May 27,28,29, 30, 31 June 7, 14, 21, 2002 and July 26, 2002

MEDICAL NEGLIGENCE

Sykes J (Ag)

THE ILLNESS

Stephen Johnson's Syndrome (SJS) is an extraordinarily rare disease. So rare that the two doctors who testified in this case, with combined medical experience of forty eight

years, have seen at most nine cases. Dr. Valens Jordan, an ophthalmologist, who testified on behalf of the plaintiff has seen only two cases, one in the Commonwealth of Dominica, which was in its end stage and the instant case. Dr. Manolina Malenova, Senior Medical Resident at the Cornwall Regional Hospital (CRH), has seen six or seven other cases and the instant case is either her seventh or eighth.

SJS is also called erythema multiforme. Dr. Jordan describes the illness as a mucocutaneous vesicular bollous eruption. It is so described because it tends to attack first and foremost the mucous membranes. Dr. Malenova's describes the illness as mucocutaneous disorder. Both agree that it is a systemic disorder. That is the normal operation of the victims body is disrupted. She says that in its early stages it is called erythema multiforme. The second stage is called erythema multiforme major. The third stage is called toxic epidermal necrolysis. These descriptions do not even begin to give any indication of the illness's potentially destructive nature.

No one knows the precise cause of the disease but it is commonly associated with allergies. I say "associated" and not "caused" deliberately. Although SJS may follow an allergic reaction it would not be true to say, according to both doctors, that allergies cause SJS. The allergy seems to act as a trigger. The trigger can also be viral, bacterial or fungal infections. There is no particular type of viral infection, bacterial infection or fungal infection that triggers the illness. Drugs (referring only to prescription drugs) have been known to precipitate SJS; the most common drugs being dilantin and penicillin.

SJS is said to be an extreme form of antigen/antibody reaction. An antigen is an organism or material external to the human body when introduced to the body causes the production of antibodies. The antibodies are produced to counteract the antigen that is introduced to the body. The antibody is trying to rid the body of the antigen. In many instances the antigen/antibody reaction passes without any permanent damage to the host. Thus if the antigen takes the form of a drug, a viral, bacterial or fungal infection the body produces antibodies to counteract the antigen. In many persons this interaction between antibody and antigen does not produce any serious illness however in some cases the interaction leads to SJS.

The following detailed description of the disease comes from Dr. Malenova and Dr. Jordan. There was virtually no difference between the witnesses on what might precipitate the illness and its effects. As Dr. Malenova as already stated it is mucocutaneous disorder. This means that the disease affects the areas of the body that have mucous membranes (e.g. eyes, mouth, anogenital region) and the skin. These include the oral mucosa, conjunctiva and the anogenital region.

There is what is called a prodromal phase of the illness. Prodromal here means the symptoms that tend to precede systemic disorders. In the case of SJS prodromal refers to the symptoms that precede the beginning of SJS.

During this stage the symptoms are similar to other illnesses. There is nothing distinctive about the prodromal phase of SJS.

I will now describe the prodromal phase of the illness. In the prodromal phase it is impossible to detect SJS. The reason why it is impossible to detect SJS in its

prodromal phase is that it has no specific symptom. According to both doctors it is because these symptoms are consistent with many other ailments that makes the diagnosis of SJS in the prodromal phase impossible. During the prodromal phase the body displays flu-like symptoms. The prodomal symptoms are fever, pharyngitis, general feeling of malaise, headache, a cough, coryza (runny nose), vomiting, diarrhea, chest pain, conjunctivitis, myalgia (muscle pain) and arthralgia (joint pain). These symptoms do not have to be all present at the same time. Some may even be absent.

After this prodromal period the first rashes, lesions or bullae (the expressions are used interchangeably) appear on the skin. The rash, lesions or bullae are fluid-filled blisters. This fluid becomes purulent (i.e. filled with pus) as time passes. The presence of the bullae without more does not mean that the person has SJS. This is why both doctors say that skin lesions or bullae are not in and of themselves an indication of SJS. It is the morphology of the rash over time that tends to confirm the presence of SJS. This means that even after the prodromal phase has ended and the patient has the flu-like symptoms and the bullae are present but are in their early stage the doctor may not diagnose SJS.

From the evidence the morphology of the bullae plays a critical role in diagnosing SJS. It is the morphology of the bullae along with the flu-like symptoms and the secretions from the mucous membranes that confirm the existence of SJS. It is when these things happen that the medical practitioner begins to think of SJS. And even then the doctor may even suspect septicemea. These signs can

only be observed. This is why the illness is diagnosed clinically.

I now explain the significance of the descriptions given by Dr. Malenova earlier in this judgment. In its early stages it is simply called erythema mutiforme. This is so because the early appearance of lesions or bullae (i.e. skin rash) on the skin does not readily lead to the conclusion that the patient has SJS. So at this stage the bullae may indicate just a skin disease and not a severe systemic disorder. In the second stage it is called ertythema multiforme major. At this stage the skin lesions or bullae have changed to become purulent. There is now marked involvement of the mucous membranes. The secretions from these parts of the body are constant. The third stage is characterized by toxic epidermal necrolysis. At this state the patient begins to shed his or her skin. The difference between the stages is the presence of and morphology lesions or bullae that appears on the skin. It is not just the extent of the lesions or bullae but their morphology (i.e. how they change over time). The common feature in all stages is the presence of lesions or bullae but as the disease progresses they become more extensive and purulent.

Until you get the disease no one can say that you have it. Dr. Malenova said that it is diagnosed clinically (i.e. by taking a detailed history and by observation) rather than by medical tests.

The prodromal phase can last anywhere between one to fourteen days.

So non-specific are the symptoms that Dr. Jordan agreed that if a patient arrives at a hospital complaining of a sore throat and on examination the tissues of the

pharynx are inflamed, the throat is swollen and tender to the touch and tonsils are inflamed it is reasonable for the doctor to diagnose that the person is suffering from tonsillitis. All these symptoms may well be the prodomal symptoms of SJS but they may the symptoms of another illness. At this point there are no lesions or bullae on the skin. These incidentally were the symptoms that the plaintiff presented with at CRH on December 4, 1994.

Dr. Malenova said that she would not expect a doctor exercising ordinary skill and competence to diagnose SJS if person presents with sore throat, temperature, malaise, inflammation of the eyes and a rash. These symptoms and signs could be the beginning of any bacterial or viral infection.

In children the most common trigger of SJS is infection. In adults and children over the age of sixteen years prescription drugs are the most common trigger.

From that has been said by the doctors there is no known cure for SJS. Once you have it, it has to run its course. The best that one can do is to management the disease properly and hope that the effects are not very serious.

SJS can lead to death. It has a mortality rate of between 5%-15%. The most long lasting and debilitating effect of SJS is that it can leave the victim totally blind. Fifty percent of cases of SJS involve the eyes.

How does it affect the eyes? Dr. Jordan answers this question. The doctor says that because the disease attacks the moist areas of the body including the eyes, these areas develop swellings (called vesicles). Some of these vesicles have blood in them. They rupture and this rupture leads to the formation of adhesions. In the eyes the vesicles

rupture and the adhesions are formed between eyeball and eyelid. The eyelid is "pasted" to the eyeball. This leads to scarring and damage of the eyeball with the consequential loss of vision.

From what has been said it is clear that the most competent medical practitioner may not diagnose SJS if he sees the patient during the prodromal period. He may think it is something else. Indeed if he sees the patient in the earliest stages of the bullae or lesion he may not diagnose SJS.

Dr. Malenova went as far as to say that a Resident in a hospital (i.e. a doctor who has completed his internship and has begun a residency programme leading to some post graduate qualification) would not be expected to diagnose SJS. So rare is the disease he may not recognise it all. Dr. Jordan said that the plaintiff is the second case he has seen in over twenty seven years of practice. He has practised in England, the Commonwealth of Dominica and Jamaica.

It is common ground that the plaintiff suffered an attack of SJS. The hospital came to this conclusion in December 1994. The issue in this case is whether Dr. Wright and the nurse, who administered the penicillin, were negligent in how they treated the patient and if they were did their negligence precipitate the plaintiff's SJS?

THE EVIDENCE FOR THE PLAINTIFF

The evidence for the plaintiff is much more digestible if it is divided in parts. The first part is the evidence of the plaintiff herself which will be sub-divided into two

visits to CRH. I will then deal with the medical evidence called by the plaintiff.

The First visit to CRH

The plaintiff alleges that it is the negligence of Dr. Wright who first saw her in the casualty department of the CRH on December 4, 1994 as well as the negligence of the nurse who administered the penicillin that led to the attack of SJS. According to the plaintiff she was administered penicillin after which she developed an allergic reaction that precipitated the attack of SJS that has now left her with very poor vision.

It is common ground that on her visit to the casualty department of CRH on December 4, 1994 she was given an injection from the penicillin group of medicines. That injection might have been ampicillin. The evidence of the plaintiff is that a nurse administered the injection. She says that when she arrived at the hospital she was suffering from a sore throat only. She says that she told Dr. Wright, who was the casualty officer at the material time, that she was suffering from a sore throat. She said that she told him that her throat pained her whenever she swallowed. He palpated her throat and she said that it was tender to the touch. He asked her to open her mouth so that he could see her throat. The plaintiff said that Dr. Wright told her that he was trying to see her tonsils.

He then told her to go to get two injections. She went there and she received two injections, in the buttocks, from a nurse. Shortly after she received the injection she felt numb in the lower limbs but she was assured by the nurse that that was the normal side effect of penicillin

and that the feeling would soon disappear. This was how the plaintiff knew that she received penicillin. The nurse's reassurance was correct; the numb feeling did pass. She went back to Dr. Wright who gave her a prescription for a number of medicines. Neither she nor Miss Stewart (her foster mother) who went with her to the hospital can recall either the names of the drugs or the number of drugs that was on the prescription.

I should say at this point that the only evidence from the defence countering this sequence of events comes in the form of exhibit 7 which was described by Dr. Malenova as a detailed in patient record of the plaintiff's stay at CRH. The record is silent on what took place between Dr. Wright and the plaintiff and between the nurse and the plaintiff on December 4, 1994. I accept the plaintiff's evidence of the interaction between herself, Dr. Wright and the nurse.

After they received the prescription they went to the CRH pharmacy. They say that they received only one drug on the prescription and they got back another prescription with the drug that was not purchased which they were to take to a commercial pharmacy in order to purchase that drug (see exhibit 6 which had the drug primalan).

Exhibit 6 was said to be the prescription they received from the CRH pharmacist along with the only drug they received. Miss Stewart of the plaintiff who took her to CRH on December 4, 1994 insists that exhibit 6 is the document she got back from the CRH pharmacy. Though she says that the original prescription that was received from Dr. Wright had more than one drug written on it.

The plaintiff and Miss Stewart say that on December 4, 1994 neither Dr. Wright nor the nurse asked her if she was

allergic to penicillin. More will be said of this aspect of the case.

The plaintiff then went home on December 4, 1994.

The second visit to CRH

The plaintiff says that when she woke up on the morning of December 5, 1994 she noticed that her eyes were not opening and they were feeling sticky. She struggled to the bathroom and washed her face. When she washed her face the stickiness left but quickly returned. The more she washed the "more it kept coming". She looked in the mirror and she noticed that her eyes were not just oozing the sticky substance but there were also dark bumps on her forehead, ears and around the eyes. From the medical evidence this was clearly the early stage of SJS.

Her tongue felt heavy. She noticed that her tongue was swollen. She was taken back to CRH. By the time she got to CRH the lesions or bullae were over her back, stomach and hand. This time she was admitted. She said the lesions "just keep coming up". As the day of December 5, 1994 progressed her vagina, buttocks, thighs, legs, soles of her feet were covered with the lesions.

At days end she could not speak. Her tongue was heavy; her eyes were paining and were closed. For the two weeks that she spent at CRH before being transferred to the Kingston Public Hospital (KPH) her eyes were closed. This was quite likely the eyelid adhering to the eyeball. She stayed at KPH from December 19, 1994 to April 1995. Her eyes remained closed from December 5, 1994 until at least April 1995.

The evidence of Dr. Malenova who was part of the medical team treating the plaintiff is that she (the plaintiff) would have been in great pain and discomfort. Her body was covered with the bullae that were painful to the touch. Whenever the plaintiff was handled for treatment purposes such as erecting an IV line or inserting a nasogastric tube she would be in even more pain.

This must have been quite traumatic and frightening for a sixteen-year-old girl.

She had difficulty swallowing hence the necessity for the nasogastric tube. She was crying constantly because of the pain. At times she was difficult to treat and had to be held down for the IV to be inserted in her hand and the nasogastric tube to placed in her stomach. She was fed through the nasogastric tube.

CURRENT STATE OF PLAINTIFF

Dr. Jordan described in quite graphic terms the great misfortune that has befallen the plaintiff. When he first saw her on August 24, 1995 she was suffering from keratitis and dry eyes. Keratitis is an inflammation of the cornea. The cornea was swollen and very scarred. Blood vessels were growing into the substance of the cornea. This was unusual because the cornea does not have blood vessels. The conjunctiva had begun to take on the appearance of skin. What Dr. Jordan saw was consistent with SJS.

The eyes were dry because the tear glands were damaged. She is now using tear replacement. She will have to use it for the rest of her life.

She suffers from loss of vision between 70%-90%. He said although some surgical intervention can take place the

prognosis is not good. He remarked at one point that if he could maintain her current level of vision he would regard that as a success and any improvement in her vision would be miraculous. Spectacles would not help because he cornea of the eye is too scarred and contact lenses could not be worn because the eyes lack moisture. Cornea grafting is a possible solution but the problem would be the same: lack of moisture in the eye.

Other than the adhesions produced by the disease that there was yet another way in which the eyeball or cornea was scarred. He said that the cornea became scarred because each of the eyelids developed two rows of eyelashes. Each eye normally has two rows of eyelashes - one row the upper and lower eyelid. One of the ~~rows on~~ each of the four lids curls down unto the eyeball and the friction there scars the eye. One way of dealing with this problem is by killing the root of the eyelash but in ~~negr~~oes the eyelids would be discoloured and aesthetically unpleasant. The method of dealing with the eye lashes scarring the cornea is by removing the eyelashes manually. At first Dr. Jordan did this every two/three weeks but over time the frequency was reduced to every six weeks.

She was given chloraphencal ointment, an antibiotic, to prevent infection. The ointment moistens the eyes as well. This is used twice per day. She is also given a gel called viscotears to moisten the eyes. This is used three to five times per day or more often depending on how dry the eye becomes. The ointment will have to be used for the rest of her life. The risk of infection in the eye arises because the additional row of eyelashes that grows on all four lids constantly scratch the cornea if they are not removed. The scratching creates a raw area that is exposed

to infection. The antibiotic is to prevent this from happening. Both the ointment and the gel last one month. She will have to be on them for the rest of her life.

The cost of removing the eyelashes is between $2,000.00 to $3,000.00. At present she would need approximately ten visits per year to do this. The worst case is that the cornea becomes so scarred that it develops the texture of skin and so there would no longer be any necessity to remove the eyelashes. The removal of eyelashes should continue for the next thirty or so years unless the cornea develops the skin-like texture.

Dr. Jordan said that the current vision that she now has is an improvement on what she had when he first saw her on August 24, 1995. At that time she could only see movements of person or hands close to her face but now she can count fingers. It may be that her vision has improved beyond that. She works in a cloth store where she has to sell material by colour to the purchasers. She also measures the cloth using a measuring device. No evidence of her earnings was given.

She has 20/200 vision. That means that she has to come within 20 feet of an object to see it while a person with normal vision can see the same object from 200 feet. The cornea is irritated by sunlight and so she needs dark glasses to protect her eyes.

She is able to read the bold headlines in newspapers. She can cook and launder her clothes but if any has a stain she is not able to see it. She was learning Braille but because she has some vision she was tempted to look at the dots rather than rely on her tactile sense. She has not learnt Braille.

Despite her disability she sings on the church choir. Before her illness she liked to read. She enjoyed watching the athletic endeavours of cricketers and footballers on television. One of her joys was traveling to new places and meeting new people.

She says that her quality of life has deteriorated. She is no longer free to go about as she could before the illness. She had plans of reading a course at the Heart Academy in food and beverage management. She had successfully completed the written part of the selection test and was waiting to be interviewed when this tragedy befell her.

The negligence alleged

The plaintiff has identified penicillin as the trigger for her condition. Penicillin has been identified ~~by~~ the evidence as one of the drugs that can trigger SJS. What ought a doctor to do when he is about to prescribe or administer any drug to a patient? Again both medical witnesses agree on the appropriate way of doing this.

Dr. Jordan said that any doctor administering or prescribing any medication ought to enquire from the patient whether she is allergic to the particular drug and if yes then another drug is prescribed after asking the appropriate questions. If the patient is allergic to the drug it is given if and only if it is the only drug to treat the particular condition of the patient. If the patient is unsure or if the doctor is not satisfied with the patient's answer then he should administer a test dose and not the treatment dose. In other words no drug is prescribed or administered until the doctor has satisfied

himself that the patient is not allergic to it. Dr. Malenova agrees with this. Her words were, "This is a must."

Dr. Jordan also said that penicillin in particular has been known to produce allergic reactions and if the patient is allergic to it then it is not given unless of course it is the only drug to treat the particular malady. If the patient is not sure whether she is allergic then a test dose is given. If the test is negative then the penicillin can be given. Naturally if it is positive then it is not given unless it is the only drug that can treat the specific illness. Dr. Malenova concurs.

It is being said in this case that the failure to take the plaintiff's history relating to drugs in general and penicillin in particular led to it being given to her. This administration of penicillin (an antigen) caused antibodies to be produced in the body of the plaintiff to "fight" the antigen and it is this antigen/antibody reaction that led ultimately to the plaintiff developing SJS.

The plaintiff said that the medical staff at the hospital (i.e. Dr. Wright and the nurse who administered the injection) did not take a full and comprehensive history from her in that they failed to ask her if she was allergic to any drug and penicillin in particular. This then is the alleged negligence that led to the plaintiff developing SJS.

The evidence on penicillin allergy.

The plaintiff in her evidence said, on at least two occasions, that she had never ever received any penicillin injection before December 4, 1994. Miss Gwendolyn Lawrence,

the natural mother of the plaintiff, gave evidence that when her daughter was ten years old she was taken to the CRH where it was discovered that she was allergic to penicillin. This was no doubt to suggest that the hospital ought to have known that the plaintiff was allergic to penicillin.

Counsel for the plaintiff sought to elicit evidence from Miss Lawrence about the result of a test allegedly done by a Dr. Dixon on the plaintiff on December 5, 1994 at CRH. Miss Lawrence was not present when the alleged test was done. On enquiry by me from counsel he said that the evidence he was seeking to elicit was the result of the test allegedly done by Dr. Dixon who told Miss Lawrence the result of the test. This evidence was not allowed on the basis that it was hearsay. No attempt was made to rely on section 31E that extends even to statements made orally or otherwise. On this point the defendants agree that a penicillin test was done but they say that it was done on December 6, 1994.

In this particular case Dr. Malenova has said why the testing for penicillin allergy is reliable. This aspect of her evidence was not challenged by the plaintiff during cross examination and no contrary evidence came from Dr. Jordan who testified for the plaintiff. Dr. Jordan said he was unable to say what caused the plaintiff's SJS .

Dr. Malenova said that before penicillin is administered a test dose ought to be given to determine if the patient is allergic to the drug. The test dose is given if the patient is not sure whether she is allergic to penicillin or if the doctor is not satisfied with the answer from the patient on the issue of penicillin allergy. The test dose depends upon for its reliability on the

presence in the human body of a substance known as immunoglobulin e.

This substance is always in the body and the quantity of it remains the same. It is this characteristic (i.e. presence and consistency in amount in the body) that makes the testing described by Dr. Malenova reliable.

When the test dose of penicillin (antigen) is introduced into the body it causes the body to produce immunoglobulin e (antibody). The immunoglobulin e is attached to the epitheral cells of the skin. The penicillin comes in contact with the immunoglobulin e and if the person is **not** allergic to penicillin then there is redness of the elevated area of the skin that is no bigger than 5mm. If the person is allergic then the elevated area of the skin is larger than 5mm. As understood by me the test is an example of an antigen (penicillin)/antibody (immunoglobulin e) reaction referred to earlier in this judgment. The danger with this test is that the person may produce an allergic reaction that precipitates SJS. However this apparently is the accepted method of testing for penicillin allergy.

This reaction between immunoglobulin e and penicillin is consistent says Dr. Malenova. She said that if there were variable levels of immunoglobulin e within the same person then the test would be useless because it would be very unreliable. I understood her to be saying that the response to penicillin by any person is consistent because the immunoglobulin e level in that person does not vary and so the reaction to penicillin of that person will be the same most if not all the time. This is what makes the test reliable.

Now we come to what may be the most telling bit of evidence. She says:

> **It is not possible to have no allergic reaction to test dose but allergic reaction to injection.**

I understand this evidence to mean that if the patient is in fact allergic to penicillin and she was exposed to penicillin **before** the test dose was administered then there ought to be an allergic reaction to the test dose. In other words one cannot be allergic on one day but not allergic on a subsequent day. There was qualification of this in cross examination.

In cross-examination she said that a person might not have an allergic reaction to a drug to which he may be allergic. She said that for an allergic reaction to be triggered then that person would need to have been exposed to the allergen at some previous point in time. I understood this to mean, in the context of this case, that the plaintiff may not have an allergic reaction to the test dose. However for one to be allergic any at all there must have been previous exposure to the allergen.

Dr. Jordan in answer to a question posed by the court said that:

> **If penicillin is given on the 4th of December 1994 and the test dose is given on the 5th of December 1994 is negative it would be reasonable for doctor to conclude that person is not allergic to penicillin.**

Dr. Jordan said also that:

If the test dose is given on December 6, 1994 after exposure on December 4, 1994 and it is negative it is reasonable to conclude that the person is not allergic to penicillin.

This evidence is really no different from Dr. Malenova's.

At the end of the day I have looked at Dr. Jordan's evidence and Dr. Malenova's evidence and I conclude that what they were saying is that is that it was unlikely for the plaintiff not to produce an allergic reaction to penicillin when the test dose was done if she was in fact allergic to it.

THE LAW

There is no doubt that the hospital through its servants or agents owe a duty of care to the plaintiff. That is not in issue in this case. Equally there is no doubt that the plaintiff cannot recover unless and until she proves that it was the breach of the duty of care owed to her that led to her illness. That the plaintiff has suffered injury is not in doubt. The only issue is whether (i) there was a breach of duty by the hospital acting through Dr. Wright and the nurse and (ii) if there was a breach of duty did that breach cause the illness suffered by the plaintiff.

There is no doubt on whom the burden of proof lies. Lord Browne-Wilkinson said in ***Bolitho v City Hackney Health Authority*** [1997] 3 W.L.R. 1151, 1157:

> *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 a breach caused the injury suffered: Bonnington Castings Ltd. v Wardlaw* [1956] A.C. 613; *Wilsher v Essex Area Health Authority* [1988] A.C. 1074. *In all cases the primary question is one of fact: did the wrongful act cause the injury?*

Similarly in respect of medical professionals the test for establishing negligence is not in doubt. The now famous Bolam test propounded by McNair J in the case of ***Bolam v Friern Hospital Management Committee*** [1957] 2 All ER 118, 121E, 122B-C; [1957] 1 W.L.R. 582, 586, 587 has been approved by the Court of Appeal in ***Millen v University Hospital of the West Indies Board of Management*** (1986) 44 W.I.R. 274, 283b-284g. This is the test that I have applied in this case.

SECTION 31F OF THE EVIDENCE ACT

The defendants have relied exclusively on certain statements in the docket of the plaintiff to rebuff the allegation that their negligence caused the illness of the plaintiff. The statements were admitted into evidence under section 31F of the Evidence Act. This aspect of the case is so crucial that I have allotted to it a very portion of this judgment.

(a) the interpretation

I admitted into evidence the docket of the plaintiff compiled by CRH between December 5, 1994 and December 19, 1994. Mr. Williams objected to the admissibility of three statements in the docket. Those statements related to the administering of a penicillin test to the plaintiff while she was at CRH. The objection arose in this way.

On May 31, 2002 Mr. Williams had indicated that he had not received the docket that the defendant proposed to rely on in the trial and neither had he received any notice as required by section 31F(4). The court adjourned until June 7, 2002. Mrs. Reid Jones informed the court on that date that Mr. Williams had received a copy of the docket. Mr. Williams confirmed this. He said that he was not taking the point about notice. This was a shorthand reference to section 31F(4) of the Evidence Act.

This is how I understood the objection. He was concerned with those parts of the docket that dealt with the administration of the penicillin test. He was not taking issue with the rest of the relevant parts of the docket. He had no difficulty with the other parts being admitted into evidence. Specifically Mr. Williams submitted that 31F required that the entry in the nurses notes should have been initialed or signed so that one could be sure that the test dose of penicillin was in fact administered.

In other words the entries stating that the test was done cannot be admitted for the truth unless the person who made the entry is known or identifiable. Since this was not done then the statement in the docket indicating that the

test dose of penicillin was administered is not admissible to prove that fact.

I did not understand him to be saying that he wanted the nurse who administered the test to be called as witness which is a right conferred on him by section 31F(5) of the Act. This becomes of importance when section 31F(4) is examined.

I formed the view that this was an appropriate case for me to exercise my discretion under section 31F(7) to admit the statements in the docket into evidence.

Miss Reid-Jones said that she was relying on section 31F to admit those portions of the docket to which objection was taken.

The relevant parts of section 31F needs are:

(1) Subject to section 31G, a statement in a document shall be admissible as evidence of any fact stated therein of which direct oral evidence would be admissible if in relation to
(a)…
(b) civil proceeding, the conditions specified in -
(i) subsection (2); and
(ii) subsection (4),
are satisfied.

(2) The conditions referred to in subsection …(b)(i) are that -
(a) the document was created or received by a person in the course of a trade business, profession or other occupation or as the holder of an office, whether paid or unpaid;
(b) the information contained in the document was supplied (whether directly or indirectly) by a person, whether or not ***the maker of the statement****, who had or may reasonably be supposed to have had, personal knowledge or the matters dealt with in the statement;*
(c) each person through whom the information was supplied received it in the course of a trade, business profession or other occupation or as

the holder of an office, whether paid or unpaid.

(3) The condition referred in subsection (1)(a)(ii) is that it be proved to the satisfaction of the court that the person who supplied the information contained in the statement in the document-

(a) is dead;

(b) is unfit, by reason of his bodily or mental condition, to attend as a witness;

(c) is outside of Jamaica and it is not reasonably practicable to secure his attendance;

(d) cannot be found or identified after all reasonable steps have been taken to find or to identify him;

(e) is kept away from the proceedings by threats of bodily harm and no reasonable steps can be taken to protect the person; or

(f) cannot be reasonably be expected, having regard to the time which has elapsed since he supplied the information and to all the circumstances, to have any recollection of the matters dealt with in the statement.

(3A)…

(4) Subject to subsection (5) to (8), the condition referred to in subsection (1)(b)(ii) is that the party intending to tender the statement in evidence shall, at least twenty-one days before the hearing at which the statement is to be so tendered, ***notify every other party to the proceedings as to the statement and as to the person who made the statement.***

(5) Subject to subsection (6), every party so notified shall have the right to require that ***person who made the statement*** *be called as a witness.*

(6) The party intending to tender the statement in evidence shall not be obliged to call, as a witness, the person who made it if is proved to the satisfaction of the court that such person-

a) is dead;

b) is unfit, by reason of his bodily or mental condition, to attend as a witness;

c) is outside of Jamaica and it is not reasonably practicable to secure his attendance;

d) cannot be found or identified after all reasonable steps have been taken to find or identify him;

e) is kept away from the proceedings by threats of bodily harm.

(7) The court may, where it thinks appropriate having regard to the circumstances of any particular case dispense with the requirements for notification as specified in subsection (4).

(8) *Where the person who made the statement is called as a witness, the statement shall be admissible only with the leave of the court.* (My emphasis)

I disagreed with Mr. Williams. I now set out why I disagreed with Mr. Williams then and now.

Section 31F was introduced into the ***Evidence Act*** by way of an amendment in 1995. This section was one of a number of provisions that was introduced to modify the rule against hearsay which reached it high water mark in Jamaica in ***R v Homer Williams*** 11 J.L.R. 185; (1969) 13 W.I.R. 520; ***R v Paulette Williams*** (1970) 30 W.I.R. 237. In ***Homer Williams*** (supra) the Court of Appeal adopted the reasoning in ***Myers v DPP*** [1964]2 All ER 877, [1965] AC 1001 and held in effect that no more exceptions to the hearsay rule would be created by judges. Parliament had to intervene. The legislature finally headed the numerous calls for reform by enacting the amendments in 1995. The 1995 amendment now appears as Part 1A of the ***Evidence Act*** under the heading **"Hearsay and Computer-generated Evidence"**. Section 31F is a part of Part 1A.

The intention was to reverse the rule against hearsay in certain circumstances provided certain conditions were met. If the section 31F is going to be properly understood then it must be examined in the light of the whole Act and especially Part 1A.

The legislative scheme made a clear distinction between criminal and civil cases. In criminal cases all the statements that may now be admitted under the Act must be

in tangible form. The same does not apply to all statements that may be admitted in civil trials. Section 31E makes oral hearsay statements admissible.

Part 1A introduces a definition of document. It is defined in this way:

> *"document" includes, in addition to a document in writing-*
>
> a. *any map, plan, graph or drawing;*
> b. *any photograph;*
> c. *any disc, tape, sound track or other device in which sounds or other data (not being visual images) are embodied so as to be capable (with or without the aid of some other equipment) of being reproduced therefrom;*
> d. *any film (including microfilm), negative, tape or other device in which one or more visual images are embodied so as to be capable (with or without the aid of some other equipment) of being reproduced therefrom.*

This definition of document clearly contemplates that the document is preserved in some permanent form. The definition takes account of modern ways of storing and retrieving information.

Section 31F(1) says that a statement in a document is admissible of any fact if direct oral evidence would be admissible. This makes it clear that it is the statement and not the whole document itself that is admissible. Also the wording of section 31F(1) and the definition of document makes it clear that documents referred to in section 31F must, like the statement and documents, referred to in sections 31C and D must also be in a

permanent form. I do not see how section 31F can apply to oral statements.

Section 31F(2)(a) says that the document must have been **"created or received"** in the course of a trade, business, profession or other occupation (my emphasis). This means that the person who received the document need not be the creator of the document. The person who has the document may also be the creator but this is not necessary since he may be in possession of it because he received it. What is important is that the document was either created or received in the course of a trade, business, profession or other occupation. The entries in the docket were undoubtedly created in the course of profession or other occupation.

Section 31F(2)(b) contemplates that the information in the document may have been supplied by some one other than the person who made the statement. The emphasis here is on the supplying of the information. Section 31F(2)(b) also contemplates that the information may pass through several persons. The information may be supplied "directly or indirectly". The subsection say divides the knowledge persons through whom the information passes into two categories. One category is those who had "personal knowledge of the matters dealt with in the statement". The second category are those **"may reasonably be supposed to have** personal knowledge of the matters dealt with in the statement. The evidence that will establish the first category is obvious. For the second category the proof is really by inference. This inference will no doubt be drawn from the evidence given of the route through which the information traveled and from this evidence the court will see the persons who dealt with the information (whether

identifiable or not) thereby being placed in a position to draw the appropriate inference. This really goes to the question of reliability. It seeks to answer such questions as how did the information get in the document that is now before the court?

Section 31F(2)(c) seeks to further safe guard the reliability of the information by requiring that each person through whom the information passed received it in the course of a trade, business, profession or occupation or an office holder paid or unpaid.

When one examines section 31F(2)(a),(b) and (c) the clear intention is that there has to be some evidence showing how the statement in document came into existence. The evidence may be direct or inferential. If it was transmitted through a number of persons then the evidence should show how this happened so that the court can form an opinion on the reliability and accuracy of the statement. In civil cases the standard would be on a balance of probability.

The questions that arise are

1. what does the expression "**maker of the statement**" mean in section 31F(2)(b)?
2. does "**person who made the statement**" in section 31F(4) and (5) refer to the "**maker of the statement**" as used in section 31F(2)(b)?
3. must the "**maker of the statement**" be the person who created or received the document?

I will deal with the first question. There are two possible meanings. The first is that it means the person who actually made the physical entry of the statement in

the document. The second is that it means the person who can speak testimonially to the facts expressed in the statement whether or not he received or created the document or made the actual entry/writing. That is the person who did the fact or witnessed the fact spoken of in the statement. If it is the latter meaning then the actual writer of the statement would simply be a recorder of the event. I conclude that it means the person who can speak testimonially to the facts expressed in the statement who may or may not be the person who made the actual writing/entry in the document.

I have come to this conclusion because of the purpose of the amendment as stated earlier. The purpose of the amendment was to make admissible ~~what would have~~ been hearsay. An example will make the point clearer, I hope. If A witnesses B preparing an invoice and tells C who was not present who then includes what A told ~~him~~ in a report (the document), under the hearsay rule C could not repeat what A told him in order to prove that B prepared the invoice. Only A's testimony would be admissible to prove that B prepared the invoice. In this example I assume that there is no other evidence of B preparing the invoice. What the statute is seeking to do is to make A's statement to C that is now in the report (the document) admissible without necessarily calling A. The statue wants the document to speak for itself. The intention is to make A's statement in the document speak for itself in the absence of A. C has not seen B do anything. He has merely written what A said he saw. If C is called to testify his evidence would be limited to saying what he wrote. He could not say that he saw B prepare the receipt. He could only say that what he wrote is what was reported to him by A. It is not the fact

of C writing that the statute seeks to make admissible but what A said he saw. Thus the statement that A saw B prepare the invoice is now made admissible to prove the fact that B prepared an invoice.

Thus a document received in the course of a trade that has information supplied by persons who may have or may reasonably be supposed to have personal knowledge of the matters in the statement is admissible even if those persons are not the makers of the statement provided that each conduit of the information received it in the course of a trade, business, profession or other occupation.

The words "trade, business, profession or other occupation" are wide enough to cover hospital records.

I now answer the second question (i.e. does "**person who made the statement**" in section 31F(4) and (5) refer to the "**maker of the statement**" used in section 31F(2)(b)?) I conclude that it does. The purpose of the notice under section 31F(4) is to indicate to the other parties that the tendering party intends to adduce evidence by relying on a statement that is found in a document for the truth of whatever facts the statement expresses.

Section 31F(4) requires the tendering party to give twenty-one days notice of both the statement **and** as to person who made the statement. The notice party is supposed to be told, not who made the written record, but who did the fact(s) that are being relied on. Both things must be done by any notice served under this subsection. The purpose of the notice period is to give the notice party time to decide whether he will accept the hearsay evidence or he wants viva voce evidence of the facts in question.

Again I will repeat that the amendments do not change the classification of the evidence. It does not move

evidence from hearsay to non-hearsay. What has happened is that the evidence that would have been hearsay and therefore inadmissible is now admissible.

Unless the notice is served and the notice complies with the section the hearsay evidence cannot be given unless section 31F(6) or (7) is activated.

Even though section 31F(4) uses the word "shall" section 31F(7) permits the court to dispense with the "**requirements** for notification as specified in subsection (4)" (my emphasis). The notification requirements can only refer to the statement **and** who made the statement. This power can only be exercised where the court thinks that this is appropriate having regard to the circumstances of any particular case.

The notice party may choose not to exercise the right under subsection (5) or he may not take any point on the question of notice.

If the notice party wishes to exclude the statement in the document then any exclusion must either be based upon a failure to satisfy the other requirements of section 31F or the residual discretion vested in the trial judge or the statutory discretion given to the judge by section 31L.

I now turn to the third question (i.e. must the "**maker of the statement**" be the person who created or received the document?) I believe that the wording of section 31F(2) makes this answer "no". In some instance this may in fact be the case but this is not a necessary precondition for the evidence to be admitted.

It is also my view that it is not a requirement that the supplier of the information and the person who wrote or entered the statement in the document needs to be identified.

I draw support for my conclusions from the case of ***R v Gordon Foxley*** [1995] 2 Cr. App. R. 523 C.A. In that case the prosecution had tendered documents procured from overseas companies by means of a request to the law enforcement authorities of the respective countries. On appeal it was argued on behalf of the appellant that section 24 of the Criminal Justice Act, 1988 had not been satisfied and therefore the documents ought not to have been admitted. Section 24 of that Act is very similar to section 31F of the Evidence Act.

Section 24 (1) of the Criminal Justice Act 1998 reads:

> *Subject*
> ...
> ...
> *a statement in a document shall be admissible in criminal proceedings as evidence of any fact of which direct oral evidence would be admissible, if the following conditions are satisfied-*
>
> *(i) the document was created or received by a person in the course of a trade, business or other occupation, or as the holder of a paid or unpaid office; and*
>
> *(ii) the information contained in the document was supplied by a person (whether or not the maker of the statement) who had, or may reasonably be supposed to have had, personal knowledge of the matters dealt with.*

Counsel for the appellant urged that there was no evidence from the creator of the document as to the purpose for which it was created or that the maker had personal knowledge of the matters in the documents or even that it was created in the course of a trade business or profession. It was also argued before the court that there

were no witnesses who spoke to the documents or the transactions reflected by the documents.

Counsel concluded his attack by saying that section 24 was not satisfied because it was not proved that the documents were created or received by a person in the course of a trade or business. It was not proved that the information in the document was supplied by a person with personal knowledge of the contents.

The documents in questions were themselves evidence of the fraud alleged. The only evidence relating to the documents was that of the police officer who said that the documents were seized by foreign law enforcement agencies.

Roche L.J. who delivered the judgment of the court said that the wording of section 24 (ii) showed that Parliament intended the courts to draw inferences as to the personal knowledge of the person supplying the information of the matters dealt with. He indicated that the purpose of section 24 is to "enable the document to speak for itself" (see page 536 F-G).

His Lordship also said that the intention of Parliament would be defeated if "oral evidence was to be required in every case from a person who was either the creator or keeper of the document, or the supplier of the information contained in the document" (see page537 A).

This to my mind is the critical passage of Roche L.J.'s judgment. At page 538 B-C he says :

> *Is direct oral evidence required either from the officer of the appropriate authority in the foreign country that he has seized the documents in accordance with the laws of his country or from an officer of the company that these were indeed documents from his company created in the course of business containing information*

> *supplied by a person who had or may reasonably be supposed to have had personal knowledge of the matters dealt with?* ***In our judgment such direct evidence in not essential, although it will often be desirable to have such evidence****. The court may, as Parliament clearly intended, draw inferences from the documents themselves and from the method or route by which the documents have been produced before the court.* (My emphasis)

This was a criminal case in which the only two witnesses for the prosecution were two police officers one of whom indicated how they came by the documents. No person from the companies testified; no person from the foreign law enforcement agency testified.

It should be noted that the English provision does not have the phrase "whether directly or indirectly" which is present in section 31F(2). The Jamaican statute clearly contemplates that the information in the document does not have to come from the person who did the act that is now being relied on. So if in a case where the statute did not say that the information contained in the document could be supplied indirectly the court held that the evidence was admissible despite the absence of direct evidence of how the documents were compiled a fortiori in a case where the statute expressly permits the supply of information indirectly.

I have not yet set out the reasons why I exercised my discretion under section 31F(7) to dispense with the requirements specified under subsection (4). I now do this. The circumstances that led up to the adjournment on May 31, 2002 and what happened on the resumption of the trial on June 7, 2002 have been set out already. I have already set out the nature of the objection. In these circumstances I am of the view that the statements in the docket ought to

be admitted into evidence. The plaintiff was not seeking to rely on the procedural protection given to him by subsections (4) and (5). The objection was a purely legal one and if that legal objection was resolved against the plaintiff then I do not see good reason why the court should not admit the document.

Section 31F(7) provides permits the court to exercise a statutory discretion if the procedural hurdles have not been met and the case does not fall within subsection (6). I am not saying that subsection (7) is only applicable in instances where there has been a breach of subsection (4) and the case is not within subsection (6). What is being said is that this is one of the circumstances in which the court may admit the document in the exercise of its discretion.

(b) application to case

Qualitatively the instant case is better than Foxley (supra). In this case there was a person who spoke to the creation and compilation of the docket. She herself wrote in the docket and she knew the handwriting of some persons who wrote in the docket. Roche L.J. said that the matters specified in section 24 of the Criminal Justice Act 1988 could be established by inference from the very documents themselves and the route by which they came before the court. Section 31F(2)(c) is not in section 24 of the Criminal Justice Act and to that extent (as well as in the manner already indicated) they are not identical but I see no reason why the requirement of section 31F(2)(c) could not also be established by inference.

Once the notice point was not being taken and the objection was centred on whether the person who wrote the entry in the docket was identified and not a desire to have the person who did the act recorded in the statement attend as a witness then there was no basis on which I could exclude the document if the statute was satisfied and there was no reason, such as unreliability, to exclude the document. To put it succinctly Mr. Williams could not hope to exclude the relevant portions of the docket by simply saying, "We don't know who wrote the particular entry." What the court has to do is to examine the evidence regarding the relevant parts and see if its creation is in compliance with the statute. If it is then it is prima facie admissible subject to the notice requirements. If no point is being made about the notice requirements then the document ought to be admitted. Once it is admitted in evidence the court can examine the statement, take into account all the evidence concerning the statement in order to decide what weight to attach to the statement.

Dr. Malenova gave testimony about how the docket is compiled.

Dr. Malenova gave evidence that the docket is only written up by doctors and nurses employed to the CRH. The nurses who attend to the patient write their notes on the back of the docket. The notes written by nurses are called "nurses' notes". The document on which nurses write is even headed "Nurses' Notes" Thus the record of the care of any patient comprises the notes written in the docket by the doctors and the notes written at the back of the docket by the nurses. In the case of doctors the notes are written by doctors who actually attended to the patient or were present when the patient was being seen. For example, Dr.

Malenova said that at times she would be leading a medical team and as she made her observations they would be written down by a member of the team. In such circumstances the note would be checked by her. This was the practice at the hospital not only for her but other doctors. The doctor's notes are written during ward rounds. These notes reflect what the doctor observed and/or what was done.

The nurse's notes are written when she (the nurse) does her ward rounds. She writes any new complaint that has arisen since the last round. She also writes when she administers any medication.

It is clear that nurses and doctors notes are kept separate and apart from each other. Where the doctors write no nurse writes and vice versa. Dr. Malenova indicated that the entries written by doctor or nurse should be signed.

The critical entry in this case was not signed. This was the entry indicating that a penicillin test was done as ordered by the doctor who admitted the plaintiff on the hospital ward.

I have examined the entry and I have examined the pages preceding and after the entry. It appears to me that the entry was not a recent invention designed to meet the circumstances of this case. It appears in the logical sequence in which it ought to be, based upon the explanation given by Dr. Malenova of how the docket is compiled. I see no reason to regard the notes as recent inventions or fabrications as suggested by Mr. Williams. It would have been ideal of the entry was signed. I find that entry is true and accurate.

The docket shows that the patient was admitted to CRH on December 5, 1994. The doctor who admitted her and took her history wrote in the docket. This handwriting was

identified to be that of Dr. Maung who had emigrated to the United States of America. Dr. Maung indicated on docket that the plaintiff was to be given penicillin intravenously every six hours after a test dose was done. Mr. Williams had no difficulty with this evidence. This entry was made on December 5, 1994 at 6:00 pm.

The next significant entry made by a doctor is that made by Dr. Malenova herself. She writes the results of her examination of the plaintiff and writes in her own hand "please, give her medication as was ordered". This was written on December 6, 1994 at 8:05 am. This can only mean, inter alia, that the penicillin was to be administered after the test dose was given.

Included in the docket is a drug chart made up by the nurses on which the drugs administered to patients should be recorded. The document is headed "Cornwall Regional Hospital" and "Drug Chart" is written below the heading.

The relevant entry reads:

"6.12.94 11:17 am test dose 3 min given at 11:27 (or 11:28) (-) negat"

The time is not clear. It is either 11:27 or 11:28.

This chart shows that on December 6, 1994 at 11:27 or 11:28 am a test dose was given. The symbol (-) is at the end of the line. The word "negat" was written. Dr. Malenova wrote "negat". She was unable to say who wrote the other parts of the entry. The symbol (-) means that the plaintiff was not allergic to penicillin. This was one of the entries that Mr. Williams said should not be admitted into evidence because the person who made it was unidentified.

The entries in the next three lines immediately below that entry show that penicillin was in fact given to the plaintiff. These entries have a signature beside them. All signatures for these entries appear to have been written by the same person.

The relevant nurses' note in the document headed "Nurses' Notes" that is connected to the penicillin test. That relevant note for December 6, 1994 reads:

"11:10am Pt. seen by Dr. Malenova"

The note in the next line reads:

"11:17 C/Pen test dose given"

There appears to be a signature of some kind beside the second note (i.e. 11:17 C/Pen test dose give). There is no signature beside the first note (i.e. 11:10 am Pt. seen by Dr. Malenova). These are the other entries that Mr. Williams say are inadmissible because the person or persons who made them were not identified.

Having regard to my interpretation of section 31F I conclude that Mr. Williams' objection is not correct. He was objecting to the absence of the signature of the person who made the actual entry in the nurses notes and drug chart but as I have said it is not who made the entry but who actually did the things of which the note speaks that is really important under section 31F(4) and (5). At no time was it said that any of the persons who did the acts recorded in the entries above should attend court to give viva voce evidence.

I conclude that the relevant entries in the docket are reliable and conform to section 31F(2) of the Evidence Act. The entries in question are admitted for the truth of their contents.

CONCLUSION

The plaintiff says that Dr. Wright and the nurse, on December 4, 1994, failed to enquire whether she was allergic to penicillin and compounded that failure by administering penicillin without testing to see if she was allergic to the drug. The argument then is that since it is known that penicillin can trigger SJS and on the facts of this case there is no other candidate as the trigger this means that the hospital is vicariously liable for the negligence of Dr. Wright who prescribed and the nurse who administered the penicillin without taking the necessary precautions.

Only the plaintiff has given evidence about what occurred on December 4, 1994. The hospital records that concerned the treatment of the plaintiff between December 4, 1994 and December 18, 1994 do not show that any history was taken from her on December 4, 1994. There is no evidence in the records that she was asked about penicillin on December 4, 1994 and neither does it show that any test dose was done on December 4, 1994.

Both doctors said that any doctor of ordinary skill and competence should comply with the procedure already described whenever they are going to prescribe or administer drugs. I find that Dr. Wright and the nurse were negligent. Dr. Wright and the nurse breached their duty of

care to the plaintiff. Dr. Wright should have taken the necessary precautions himself or he should have seen to it that it was done by the nurse if he could not have done it himself. The clear evidence is that the nurse herself did not make any of the enquiries as outlined by Dr. Jordan and Dr. Malenova. She should have asked Dr. Wright if he had made the necessary enquiries and even if he did, as an extra precaution she ought to have made the enquiries herself. This obligation is not onerous and it is not costly to implement.

I therefore accept that she was not asked about penicillin in particular and neither was a test dose done on December 4, 1994.

The next question is did this act of negligence precipitate or cause the development of SJS? The relevant entry in the docket indicates that a penicillin test was done on December 6, 1994 and that it was negative. I accept that the test was done on December 6, 1994.

I have already set out Dr. Malenova's and Dr. Jordan's evidence on penicillin allergy and how I interpret their evidence on this point. This means that the plaintiff was not, on a balance of probability, allergic to penicillin on December 4, 1994. If this is so then although there was a breach of duty that breach did not cause the plaintiff's illness.

Finally I should also say that the symptoms that the plaintiff presented with on December 4, 1994 were in fact the early stages of SJS. Whatever the cause of it was it was not, on a balance of probability, caused by the penicillin administered by the nurse.

This means that the plaintiff has failed in her action and judgment must be given for the defendants. Costs to the

defendants in accordance with schedule A of the Rules of the Supreme Court (Attorneys at Laws Costs) Rules 2000.