[2026] JMSC Civ 93

IN THE SUPREME COURT OF JUDICATURE OF JAMAICA

IN CIVIL DIVISION

CLAIM NO. SU 2021 CV 01036

BETWEEN	**NAVEINEY GAYLE** **(Personally, and as Administrator Ad Litem, In the Estate of Vijae Gayle, Deceased)**	**1ST CLAIMANT**
AND	**BURNS GAYLE** **(Personally, and as Administrator Ad Litem, In the Estate of Vijae Gayle, Deceased)**	**2ND CLAIMANT**
AND	**BOARD OF MANAGEMENT, UNIVERSITY HOSPITAL OF THE WEST INDIES**	**DEFENDANT**

IN OPEN COURT

Ms Jacqueline Cummings and Mr Matthew Palmer instructed by Mesdames Archer, Cummings & Company for the Claimants

Mr Matthew Royal, Ms Kandi Chin and Mr Jamaiq Charles instructed by Messrs. Myers, Fletcher & Gordon for the Defendant

Heard: 16, 19, 23 September 2024, 10 February and 11 February 2025, 10 July and 24 July 2026

Negligence – Medical negligence – The duty of care owed by a medical practitioner to a patient – Patient admitted at hospital over a period of six days – Patient died while admitted in hospital – Whether the medical practitioners

attached to the hospital owed a duty of care to the patient – Whether the medical practitioners attached to the hospital breached that duty of care – Whether the medical practitioners attached to the hospital used all proper professional skill, care, competence and diligence during their investigation, diagnosis, management and treatment of the patient – Causation – Foreseeability of damage – Remoteness of damage

Damages – Damages for Psychiatric Injuries, Psychiatric Shock and Mental Distress for Secondary Victims – Quantum of Damages – The Fatal Accidents Act, sections 2, 3, 4 and 5, The Law Reform (Miscellaneous Provisions) Act, sections 2 and 3

A. NEMBHARD J

[1] The Court expresses its sincere gratitude to Learned Counsel Ms Jacqueline Cummings and Learned Counsel Mr Matthew Palmer, instructed by Mesdames Archer Cummings & Company, who appear for the 1st and 2nd Claimants and Learned Counsel Mr Matthew Royal, Learned Counsel Ms Kandi Chin and Learned Counsel Mr Jamaiq Charles, instructed by Messrs. Myers, Fletcher & Gordon, who appear for the Defendant, for their respective Written Submissions and Authorities, which were filed and served in relation to this matter. Those submissions, together with the authorities to which the Court was referred, were of tremendous assistance to the Court in its consideration of the issues raised by the instant Claim.

[2] The Court is equally grateful to Ms Tandi Nunes, Attorney-at-Law and Judicial Counsel, for her invaluable assistance, by way of her legal research, in the preparation of this Judgment.

[3] The Court sincerely apologizes for the delay in the delivery of this Judgment.

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INTRODUCTION

[4] The instant Claim raises the important consideration of the duty of care that is owed by a medical practitioner to his patients, in his diagnosis and treatment of them, and the circumstances in which a medical practitioner might be held liable for a breach of that duty of care. Significantly, the Claim also raises the imperative consideration of whether, as a matter of law, the 1st and 2nd Claimants, neither of whom suffered physical injuries, are entitled to recover Damages for psychiatric injuries, resulting from the death of their daughter.

[5] The Claim is brought against the background that, on or about 30 March 2018, Miss Vijae Thalia Gayle, in the presence of her parents, the 1st and 2nd Claimants, was admitted by the University Hospital of the West Indies ("the UHWI"), for treatment at its medical facility. Regrettably, six (6) days post-admission to the UHWI, Miss Gayle died at the age of sixteen (16) years. Her parents, Mrs Naveiney Gayle and Mr Burns Gayle, assert that the UHWI failed to use all proper professional skill, care, competence and diligence during their investigation, diagnosis, management and treatment of their only child. Specifically, Mr and Mrs Gayle assert that this failure caused their daughter's rapid deterioration and subsequent death.

[6] By way of a Claim Form, which was filed on 15 March 2021, Mr and Mrs Gayle, in their representative capacities as Administrators Ad Litem for their daughter's Estate,[1] seek to recover Damages and Damages for Lost Years under the Law Reform (Miscellaneous Provisions) Act and the Fatal Accidents Act. In their personal capacities, Mr and Mrs Gayle seek Damages for negligence, mental distress and psychiatric injuries which they allege that they suffered as a result. Additionally, Mr and Mrs Gayle seek an award of Special Damages, Aggravated Damages and Costs.

[1] See – Formal Order, which was filed on 20 October 2020

THE ISSUES

[7] The seminal issues which are raised for the determination of the Court may be distilled in the following way: -

(i) Whether the UHWI by its servants and/or agents owed a duty of care to Miss Gayle;

(ii) Whether the UHWI by its servants and/or agents breached the duty of care owed to Miss Gayle;

(iii) Whether the breach of the duty of care by the servants and/or agents of the UHWI caused or materially contributed to the injuries sustained by and the subsequent death of Miss Gayle; and

(iv) Whether, as secondary victims, Mr and Mrs Gayle are entitled to recover psychiatric Damages, resulting from the UHWI's breach of the duty of care.

BACKGROUND

The Claimants' Case

[8] In or around 2018, Miss Vijae Gayle was an accomplished and promising fifth-form student at Campion College, in the parish of St. Andrew. Miss Gayle was preparing to sit the May/June sitting of the Caribbean Secondary Examination Council (CSEC) examinations.[2] It is said that she had entrepreneurial dreams and aspirations to become a scientist or a medical researcher.[3]

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[2] See – **Exhibits 13-40**, which contain various school report cards, certificates and educational records for Vijae Gayle from the primary and secondary schools she attended.

[3] See – Paragraphs 2 and 124-126 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023

[9] On or about 27 March 2018, Mrs Gayle asserts that her daughter complained of what had become a persistent headache. Mrs Gayle observed that her daughter was warmer to touch than usual. Concerned, Mr and Mrs Gayle consulted their family doctor, Dr Francia Prosper-Chen, to whom Vijae later complained that she was feeling pain to the right frontal part of her head. Mr and Mrs Gayle assert that Dr Francia Prosper-Chen examined their daughter and prescribed her medication.[4]

[10] On or about 28 March 2018, it is alleged that Miss Gayle indicated to her parents that, despite taking the medication, she was still experiencing a headache, although it was not as painful as it was the day before.[5]

[11] On or about 30 March 2018, at approximately nine in the morning, Miss Gayle complained to her parents that her headache persisted and that she was feeling weak. Mrs Gayle asserts that she noticed that, in attempting to rise from her bed, her daughter moved her left foot slowly. During that day, Mr and Mrs Gayle observed that their daughter was unable to perform simple tasks.[6] Increasingly concerned, Mr and Mrs Gayle began to suspect that their daughter was suffering from another bout of meningitis, an illness with which she had been diagnosed at the age of eight (8) years.[7] Mr and Mrs Gayle decided to take their daughter to the UHWI.[8]

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[4] See – Paragraphs 3 and 4 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, Paragraphs 3 and 4 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023. See – **Exhibit 88**, which contains a copy of the Apex Pharmacy Portmore Profile for Vijae Gayle, detailing a variety of prescriptions and drugs dispensed for Vijae Gayle, from on or around September 2001 to March 2018. On or around 27 March 2018, the drugs of Panadeine, Baralgin and Histal DC Syrup were dispensed for Vijae Gayle. *This history is noted throughout Vijae Gayle's Medical Docket but is first noted on the page numbered 57 of the Medical Docket (totaling 154 pages).*

[5] See – Paragraph 8 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, Paragraph 7 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023

[6] See – Paragraphs 16 and 17 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023

[7] See – Paragraph 129-131 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023

[8] See – Paragraphs 10-14 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraph 9-11 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023

Miss Gayle's admission to the UHWI

Friday, 30 March 2018

[12] After registration at the UHWI, Mrs Gayle gave a nurse her daughter's medical history and indicated her suspicions that her daughter had meningitis.[9] It is alleged that Mrs Gayle also told the same nurse that her daughter was experiencing weakness in her left hand and left leg, among other symptoms.[10] Miss Gayle was taken to the emergency room in a wheelchair, placed on an available bed and was seen by the attending physician, Dr Brown. Mr and Mrs Gayle shared with Dr Brown the information concerning Miss Gayle's history of meningitis and their suspicions that she was currently experiencing a meningitis.

[13] Dr Brown informed Mr and Mrs Gayle that she would speak with her Consultant about Miss Gayle's condition and that she would inform them of the next steps.[11] Dr Brown also advised Mr and Mrs Gayle that tests would be performed on Miss Gayle to determine what was wrong with her. To that end, Dr Brown took blood samples from Miss Gayle.[12]

[14] At approximately 8:30 pm, one Dr Rose attended to Miss Gayle and examined her reflexes. Shortly thereafter, she was administered ibuprofen and Mr and Mrs Gayle were informed that a CT scan would be done in short order. This was done at approximately 10:30 pm. Subsequently, Mr and Mrs Gayle were advised by one Dr Bernard that the CT Scan result was normal.[13] [14]

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[9] See – **Exhibits 95 and 96**, which contain copies of the Medical Dockets for Vijae Gayle, bearing registration number 10016377, from the University Hospital of the West Indies.

[10] See – Paragraphs 18-21 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023.

[11] See – Paragraphs 22-26 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraph 15 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

[12] See – Paragraphs 27-28 and 30 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023.

[13] See – Paragraphs 31-35 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023.

[14] See – **Exhibits 1** and **2,** which contain copies of the Radiology Reports, both dated 30 March 2018, prepared by the Department of Radiology of the UHWI, bearing the signatures of Drs Gardner and W. West respectively.

Saturday, 31 March 2018

[15] On or about 31 March 2018, Mrs Gayle avers that she was informed by Dr Rose that they would be attempting to perform a lumbar puncture on her daughter. This attempt, performed by Dr Rose, was unsuccessful and Mr and Mrs Gayle assert that they were informed that their daughter would be transferred to an available ward and that the ward consultant would re-attempt the lumbar puncture.[15] Significantly, Mr and Mrs Gayle contend that the lumbar puncture was never revisited. Mr and Mrs Gayle were informed later that day by Dr Rose that their daughter was suffering from hemiplegic migraine. Dr Rose provided Mr and Mrs Gayle with a prescription of Ibuprofen, Epilim Chrono 200 mg and Lansoz 30 mg and assured them that the UHWI would begin to administer these drugs to Miss Gayle until they [Mr and Mrs Gayle] were able to procure the same.[16]

[16] At approximately 6:00 pm, Mrs Gayle was asked to acquire diapers for Miss Gayle as she [Miss Gayle] had become incontinent. At approximately 7:30 p.m., Mrs Gayle returned to her daughter's bedside and observed that the hospital bed, bedding and floor were soaked in urine. During her attempts to clean and change Miss Gayle, Mrs Gayle alleges that her daughter was unable to move without assistance and that her verbal communication skills were non-existent.[17]

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[15] See – Paragraphs 36 and 40 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraph 24 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

[16] See – Paragraphs 41, 47 and 48 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraph 27 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023. See **Exhibit 89**, which contains a copy of receipt dated 31 March 2018 from the Med-Life Pharmacy for the drug, Epilim Chrono 200mg tablets.

[17] See – Paragraphs 54-56 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraphs 31 and 32 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

Sunday, 1 April 2018

[17] In the wee hours of Sunday, 1 April 2018, Mrs Gayle asserts that she observed that her daughter began to present with a fixed stare.[18] Miss Gayle was examined by Dr Kelly, a Neurologist Resident and Dr Rhomes-Moving, who advised that the Consultant Neurologist, Dr Gilbert, had been consulted.[19] Mrs Gayle further alleges that after Dr Rhomes-Moving left, her daughter started having a fever and then vomited. Shortly after this, Miss Gayle started having seizures, having approximately eighteen (18) seizures in succession.[20] [21] Mr and Mrs Gayle contend that one Dr Choi enquired whether their daughter was allergic to any antibiotics and/or intravenous drips. Mr and Mrs Gayle maintain that they advised Dr Choi that their daughter is allergic to Augmentin.[22] Mrs Gayle was informed that her daughter would be administered three (3) different antibiotics, two (2) intravenous fluids, one (1) by way of drip and the other to be administered orally.[23]

[18] Sometime after 6:00 p.m., Mrs Gayle observed that her daughter was experiencing difficulties breathing. After being instructed to leave the ward, Mr and Mrs Gayle allege that they were approached by one Dr Soutar, who introduced himself as being from the ICU B ward. It is further alleged that Dr

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[18] See – Paragraph 57 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraph 34 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

[19] See – Paragraphs 53, 58-61 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023.

[20] See – Paragraphs 62-64 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023.

[21] See – Paragraph 36 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

[22] See – Pages 1 (numbered 57), 6 (numbered 61), 23 (numbered 77), 43 (numbered 97), 45 (numbered 99), 47 (numbered 101), 49 (numbered 103), 51 (numbered 105), 52 (numbered 106), 61 (numbered 114) of **Exhibit 96**, which contains a copy of the Medical Docket of Vijae Gayle from the UHWI, total pages 154). See also, pages numbered 199, 201 and 204, which is titled, University Hospital of the West Indies Patient Medication Record of the documents which comprise **Exhibit 96**.

[23] See – Paragraph 65 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023.

Soutar advised them that Miss Gayle would be moved to the ICU B ward for further care.[24]

[19] At approximately 8:30 p.m. that day, whilst on the ICU B ward, Mr and Mrs Gayle allege that they were advised by one Nurse Hill that there were doctors attached to the UHWI who wanted to meet with them. A meeting was had with Dr Soutar, Dr Myers and Nurse Hill, in a room, where Mr and Mrs Gayle were advised that the doctors were unable to obtain a reading from their daughter's brain.[25] Mr and Mrs Gayle were further advised that the attending physicians were still able to detect their daughter's pulse and her heartbeat and further that she was placed on oxygen. Miss Gayle was placed on life support.[26] Again, Mr and Mrs Gayle voiced their suspicion that their daughter had a meningitis despite the UHWI's diagnosis of hemiplegic migraine.

Monday, 2 April 2018

[20] On Monday, 2 April 2018, upon their arrival at the UHWI, Mr and Mrs Gayle met with Dr Soutar, Dr Myers and another physician and were informed by Dr Myers that their daughter had two (2) heart attacks that morning and further that should she suffer a third, the medical team would not be able to revive her. This because the doctors had already administered the highest dosage of adrenaline to Miss Gayle.[27]

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[24] See – Paragraphs 66 and 67 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraph 38 and 39 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

[25] See – Pages 37-38 (numbered pages 91-92) of **Exhibit 96**, which contains a copy of the Medical Docket of Vijae Gayle from the UHWI, total pages 154).

[26] See – Paragraphs 69-71 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraph 41 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

[27] See – Pages 49-50 (numbered pages 103-104) of **Exhibit 96**, which contains a copy of the Medical Docket of Vijae Gayle from the UHWI, total pages 154).

Tuesday, 3 April 2018

[21] Mr and Mrs Gayle were advised by one Dr Barnett that he ceased to administer the drug Epilim Chrono to their daughter and that she was now receiving Ludoprin and Adrenalin. Miss Gayle was examined by an Ear Nose and Throat (ENT) Specialist who allegedly observed that Miss Gayle's neck was swollen. Mr and Mrs Gayle also observed a tube attached to their daughter's right side, which was taking bloody fluid from her body to a bottle which was attached to a machine.[28]

Wednesday, 4 April 2018

[22] On Wednesday, 4 April 2018, Mr and Mrs Gayle were advised by one Dr Hannah that the results from the blood tests which were conducted on their daughter came back negative and that the attending physicians were not getting the response which they needed. Dr Hannah advised Mr and Mrs Gayle that the attending physicians wished to repeat the performance of a lumbar puncture on their daughter to determine whether she had a meningitis. Dr Hannah further advised that the doctors would first have to ascertain whether Miss Gayle had any swellings on her brain. To that end, an Ophthalmologist was asked to examine Miss Gayle's brain.[29] [30] [31]

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[28] See – Paragraphs 77-78, 80 and 83 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also – Paragraphs 45, 47 and 48 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

[29] See – Paragraphs 85 and 86 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also – Paragraphs 51 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

[30] See – Page 60 (numbered 113) of **Exhibit 96**, which contains a copy of the Medical Docket of Vijae Gayle from the UHWI, total pages 154)

[31] See – Paragraphs 87 and 88 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also – Paragraph 49, 52 and 53 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

Thursday, 5 April 2018

[23] On the afternoon of 5 April 2018, Mr and Mrs Gayle met with the secretary of the ICU, a nurse and a doctor, who informed them that, given the severity of their daughter's case, specifically the two (2) heart attacks which she suffered and the high dosage of Adrenalin, which was being administered to her, the attending physicians were unable to save her life. Regrettably, Miss Gayle was pronounced dead at 3:20 p.m. on 5 April 2018, by one Dr Halsal.[32]

After Miss Gayle's Death

[24] On or about 6 April 2018, the Claimants visited the UHWI and attended the Birth and Death Department, to have their daughter's body released to them.[33] At a meeting with one Dr Dean-Minott, a nurse and the secretary of the ICU, Mr and Mrs Gayle were advised that the UHWI would not be able to release their daughter's body to them because the hospital was unable to determine the cause of her death. Mr and Mrs Gayle were provided with the contact information for the Attorney-at-Law for the UHWI, Dr Peter Glegg. Mr and Mrs Gayle consented to an autopsy being performed on the body of their daughter to determine the cause of her death.[34]

[25] On or about 11 April 2018, Mr and Mrs Gayle were escorted by members of the Jamaica Constabulary Force to the UHWI, Pathology Department, where they were met by one Dr Elaine Williams, a Senior Pathologist and one Dr A.

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[32] See – Paragraphs 91 and 94 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraph 56 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023. See also, page 63 (numbered 116) of **Exhibit 96**, which contains a copy of the Medical Docket of Vijae Gayle from the UHWI, total pages 154).

[33] See – Paragraph 97 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraph 60 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

[34] See – Paragraphs 98 and 99 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraphs 61 and 62 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

Howell.[35] An autopsy was performed on the body of Miss Gayle. The Autopsy Report prepared by the Department of Pathology of UHWI, which contains the Final Anatomical Diagnosis states that the main finding was hypoxic ischaemic encephalopathy associated with necrosis of the cerebellum. Further, the histological evaluation of the brain showed Lymphocytic Meningo-Encephalitis, as detailed in the microscopic description of the sections taken from Miss Gayle's brain.[36]

[26] On or around 20 April 2018, Mrs Gayle asserts that she received instructions to collect her daughter's body. Mr and Mrs Gayle, escorted by a police officer, went to the Pathology Department of the UHWI where they were given some documents to sign. Mr Gayle, accompanied by the said police officer, visited the Papine Police Station where he obtained the Order for Burial (Before Registry), which was prepared for the release of his daughter's body to him.[37] Mrs Gayle attended the Medical Records Department of the UHWI to obtain a copy of the Autopsy Report and was given a preliminary report.[38] That preliminary report is alleged to have contained discrepancies and inaccuracies.

[27] In the days following their daughter's death, Mr and Mrs Gayle sought the assistance of a private pathologist, who advised that he was unable to perform an autopsy on the body of their daughter.[39] Notwithstanding, Mr and Mrs Gayle

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[35] See – Paragraph 100 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraphs 63-65 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

[36] See – **Exhibit 5** and **Exhibit 6,** which contain the Postmortem Examination Report prepared by Dr A. Howell, Resident of the Department of Pathology of the UHWI, The Autopsy Report containing the Provisional Anatomical Diagnosis, completed by Dr A. Howell and the Cause of Death Confirmation Form bearing the signatures of Dr A. Howell and Dr E. Williams, respectively. See also, **Exhibit 8**, which contain The Autopsy Report containing the Final Anatomical Diagnosis, completed by Dr A. Howell and Dr E. Williams, dated 1 May 2018.

[37] See – **Exhibits 10-12**, which contain the Order for Burial (Before Registry) for Vijae Gayle, the Notification of Burial and the Notification to Registrar.

[38] See – **Exhibit 7**, which contains the Receipt from the UHWI in the sum of One Thousand Two Hundred Dollars ($1,200.00) paid for copies of the Medical Record of Vijae Gayle.

[39] See – Paragraphs 109-110, 112 and 115 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraphs 68 and 72 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

sought and obtained the assistance of Forensic Consultant Pathologist, Professor Hubert Daisley, CMT, BSC, BSc, MBBS, DM, FRCPE, MFFLM, and obtained a medical report from him, which is dated 22 August 2018.[40]

[28] On or about 19 May 2018, Mr and Mrs Gayle laid their daughter to rest.[41] [42]

The Claim for Damages for Psychiatric Distress

[29] Unmoored and set adrift from the loss of their only child, Mr and Mrs Gayle assert that they suffered emotional and psychiatric distress. Mr Gayle alleges that he became unable to focus and that he became depressed and angry. This made it difficult for him to retain employment.[43] Mrs Gayle alleges that, as a Sales Manager, the mental distress caused by and the toll of her daughter's death affected her so drastically that she could not discharge her functions as well as she did before.[44] Mr and Mrs Gayle attended and participated in numerous counselling sessions with Associate Clinical Psychologists and Senior Associate Counsellors attached to the Family Life Ministries, in an effort to cope with the anguish of losing their only child.[45]

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[40] See – **Exhibits 97A and 97B**, which contain the Expert Report of Professor Hubert Daisley, which is dated 22 August 2018.

[41] See – Paragraphs 121 and 122 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraphs 78 and 79 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023. See – **Exhibits 41-53**, which contain copies of various funeral related expenses incurred by the Claimants from 20 April 2018 – 19 May 2018. See also, **Exhibits 90 and 91**, which contain copies of the Vijae Gayle's Funeral Bookmarker and Funeral Programme respectively.

[42] The Claimants assert that to date, they still have not received their daughter's Death Certificate.

[43] See – Paragraphs 74 and 80 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023.

[44] See – Paragraph 123 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023.

[45] See – Paragraph 117-120 of the Witness Statement of Naveiney Gayle, which was filed on 30 June 2023. See also, paragraphs 74-77 of the Witness Statement of Burns Gayle, which was filed on 30 June 2023. See also, **Exhibits 54-85**, which contain copies of receipts generated by Family Life Ministries for counselling sessions for both Claimants during the period commencing on 6 June 2018 through to 13 December 2018. See also, **Exhibits 93 and 94**, which contain the Expert Reports prepared by Ms Kathleen Roberts, Associate Counseling Psychologist and Senior Associate Counselor with Family Life Ministries on Mrs Naveiney Gayle and Mr Burns Gayle, both dated 24 June 2019, respectively.

The Defendant's Case

[30] In seeking to refute the allegations of medical negligence levied against it, the UHWI relies on the evidence of Dr David Gilbert and on the expert evidence of Dr Tameka March-Downer. Dr Gilbert is a Consultant in Internal Medicine and Neurology at the UHWI and has worked in that capacity since 1 August 1998. Dr March-Downer is a Consultant Neurologist at the UHWI. Dr March-Downer avers that that she was never involved in the treatment and/or management of Vijae Gayle.[46] Both doctors staunchly maintain that the UHWI and its medical teams acted in accordance with standard practices and specifically that there were no actions of negligence in the diagnosis, treatment and/or management of Miss Gayle.

[31] The UHWI assert that, at presentation, Miss Gayle was not febrile, nor did she have any viral prodrome or symptoms of meningeal irritation. The UHWI maintain that she was given a diagnosis of a Left Hemiplegic Migraine,[47] likely migrainous infarct, by the Neurology Service.[48] It is the Defendant's case that Miss Gayle's admission was complicated by continuous seizures, a presumed pulmonary embolism, severe hypoxia unresponsive to oxygen therapy and severe hypotension refractory to treatment.

[32] The UHWI further asserts that, despite antiplatelet therapy, heparin anticoagulation, anti-seizure and antibiotic therapy, Miss Gayle died five (5) days after being admitted. The UHWI maintain that the autopsy revealed non-specific lymphocytic meningeal infiltrates, thin clear meninges with no evidence of

[46] See – Paragraph 3 of **Exhibit 98**, which contains a copy of the Expert Report of Report of Dr Tameka March, dated 20 October 2023.

[47] See – Paragraphs 11-13 of **Exhibit 98**, which contains a copy of the Expert Report of Dr Tameka March, dated 20 October 2023.

[48] See – Paragraph 14 of **Exhibit 98**, which contains a copy of the Expert Report of Dr Tameka March, dated 20 October 2023.

meningitis or bacterial or viral organisms and widespread severe hypoxic brain injury.[49]

[33] Dr Gilbert avers that the brain autopsy findings of inflammation are non-specific and are not in keeping with viral meningoencephalitis (inflammation of the brain and the meninges), nor are they significant or extensive enough to account for Miss Gayle's severe hypoxia and refractory hypotension.[50] Dr Gilbert asserts that ante-mortem and post-mortem culture of Miss Gayle's blood and brain revealed no bacterial or viral organisms.[51]

[34] The UHWI contends that the main autopsy finding was that of hypoxic ischaemic encephalopathy, low blood oxygen levels (hypoxia) in a low or absent blood flow state (ischaemia) causing disease (pathy) of the brain (encephalo) associated with necrosis (hypoxic death of cells) of the cerebellum. Consequently, Dr Gilbert maintains that Miss Gayle suffered a rare and catastrophic stroke consequent on long-standing partially treated migraine.[52]

The Diagnosis, Treatment and Management of Miss Gayle while admitted to the UHWI

30 and 31 March 2018

[35] It is alleged that when Miss Gayle presented at the UHWI, on or about 30 March 2018, her medical history was significant for inflammatory conditions, with three (3) different sources of inflammation near to or involving her brain.[53] Both Dr Gilbert and Dr March-Downer maintain that the UHWI is a teaching hospital and

[49] See – Paragraph 23 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023.

[50] See – Paragraph 21 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023.

[51] See – Paragraph 22 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023.

[52] See – Paragraph 22 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023.

[53] See – Paragraph 8 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023. See also, pages 1-11 (numbered pages 57-66 of **Exhibit 96**, which contains a copy of the Medical Docket of Vijae Gayle from the UHWI, total pages 154).

consequently, on presentation at the Emergency Room, patients are first seen by the most junior physician. The junior physician is trained to consider several possible diagnoses which could explain the patient's symptoms. In doing so, the most likely diagnosis is given first and then the alternative diagnosis (ses) with less or incomplete evidence is given after and written as a 'query diagnosis' to be ruled out or to be evaluated. Dr Gilbert and Dr March-Downer maintain that the Junior Doctor, operating in the internal chain of command, will then present the patient's medical history and examination findings to a Senior Doctor, who will give the diagnosis which best explains the patient's presenting clinical features.[54]

[36] It is alleged that Miss Gayle presented at the UHWI with a three (3) day history of worsening headaches and a background of recurrent headaches over the years. Further, the Emergency Room Junior Physicians who first attended to her, found that she had a normal body temperature, was alert (no drowsiness) with mild weakness of her left upper and lower limbs. Considering these observations, they gave a query diagnosis of hemiplegic migraine and referred Miss Gayle to the Internal Medicine Physicians, the specialist doctors who deal with the diagnosis and management of medical conditions such as migraine and meningitis.[55] [56]

[37] It is further alleged that the Junior Internal Medicine Physician who reviewed Miss Gayle found her to be mildly drowsy with moderate left limb weakness and gave diagnoses of:

i. Migraine with Aura; and
ii. Complex Partial Seizures (seizures involving limited areas of the brain and accompanied by reduced awareness of one's surroundings).[57]

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[54] See – Paragraph 9 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023.

[55] See – Paragraph 10 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023.

[56] See – Paragraphs 6 and 10 of **Exhibit 98**, which contains a copy of the Expert Report of Dr Tameka March, which was filed on 20 October 2023.

[57] See – Paragraph 10 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023.

[38] It is the Defendant's case that the Junior Internal Medicine Physician also suggested "evaluation for meningitis" (a R/O diagnosis). The Junior Internal Medicine Physician then discussed Miss Gayle's clinical findings with the Senior Internal Medicine Resident and the Internal Medicine Consultant who referred her to the Neurology Service, having made diagnoses of:

i. Hemiplegic Migraine; and
ii. Complex Partial Seizures.[58]

[39] Both Dr March-Downer and Dr Gilbert assert that recurrent headaches of months to years in duration are not consistent with an acute infectious meningitis. They contend that a diagnosis of meningitis was never made by any UHWI physician who reviewed Miss Gayle, as there were no supporting features specific to that diagnosis.

[40] Dr Gilbert asserts that, as the supervising Neurology Consultant on call on the day following Miss Gayle's presentation to the Emergency Room, there were no features of a bacterial infection, nor any features specific to a bacterial meningitis (no fever, no stiffness of the neck and no elevation of Miss Gayle's white blood cell count). Dr Gilbert further alleges that he observed no evidence of a preceding viral infection, viral prodrome (headache, loss of appetite, fever) or viral meningitis in at least four (4) months prior to Miss Gayle's presentation to the Emergency Room. Consequently, Dr Gilbert states that the diagnosis made by the Neurology Service was that of hemiplegic migraine progressing to a migrainous infarct (death of brain cells). Dr March-Downer and Dr Gilbert maintain that migraine headaches are accompanied by recurrent narrowing of vessels in the brain and subsequent lack of blood flow and oxygen to parts of the brain. A migrainous infarct is a type of stroke due to persistent vessel narrowing and lack of blood flow and oxygen, leading to limb weakness (hemiplegia) or

[58] See – Paragraph 11 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023.

death of brain tissue (an infarct). A large stroke (infarct) causes swelling of the affected brain, leading to limb weakness, fever, drowsiness and seizures.[59]

1 April 2018

[41] By noon on 1 April 2018, Miss Gayle demonstrated worsening left limb weakness and drowsiness but remained without a fever or stiffness of the neck.[60] Dr Gilbert asserts that as a standard of medical care, a lumbar puncture procedure is contraindicated in patients with an associated limb weakness, as it is suggestive of high pressure within the skull, like what occurs in a large stroke. The UHWI maintains that there were no symptoms, clinical examination or laboratory findings of an acute infection or a meningitis and further, that, in the face of likely increased intracranial pressure and one-sided limb weakness, a lumbar puncture was strongly not recommended nor performed by the Neurology Service of the UHWI.[61]

[42] With respect to the ICU Resident's note, which was recorded on 1 April 2018 at 11:00 pm, and which is contained in Miss Gayle's Medical Docket, Dr Gilbert asserts that Miss Gayle's blood pressure was very low, recorded at 74/35 mmHg, her pulse was 126 beats per minute and her oxygen saturation was thirty-two (32%) percent (when it should be 100% in room air, with 6 mm fixed and dilated pupils (unresponsive pupils not responding normally with reduction in size to light). It is asserted that fixed and dilated pupils can be caused by severe hypotension (low blood pressure), severe hypoxia (low blood oxygen levels) and drugs such as epinephrine (used in resuscitation attempts) and not only by brain

[59] See – Paragraphs 12 and 13 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023. See also, pages 13-21 (numbered pages 67-75 of **Exhibit 96**, which contains a copy of the Medical Docket of Vijae Gayle from the UHWI, total pages 154).

[60] See – Pages 22-44 (numbered pages 77-98 of **Exhibit 96**, which contains a copy of the Medical Docket of Vijae Gayle from the UHWI, total pages 154).

[61] See – Paragraphs 14 and 15 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023.

death.[62] Dr Gilbert asserts that the standard criteria for the determination of brain death include, as pre-requisites: -

i. Normal systolic blood pressures;
ii. Absence of hypoxia and
iii. Absence of drugs which could confound the evaluation of the pupillary response to light.

[43] In this regard, Dr Gilbert maintains that it would be medically inappropriate to make a brain death determination in the immediate post-arrest context (within thirty-six (36) hours of presentation to the Emergency Room), without allowing for possible resolution of confounders such as hypoxia and shock. He contends that Miss Gayle had an acute onset of severe hypoxia, shock and bloody endotracheal tube aspirate, which warranted treatment for a presumed pulmonary embolism. Considering this, Dr Gilbert asserts that the heparin infusion used to treat Miss Gayle for her presumed pulmonary embolism would be expected to result in abnormal laboratory tests.[63]

[44] It is asserted that Miss Gayle's hypoxia remained severe and unresponsive to intubation and ventilation on one hundred percent (100%) oxygen, circumstances which Dr Gilbert alleges would not be explained by raised intracranial pressure or any intracranial event. Dr Gilbert maintains that disease involving the brain cannot cause hypoxia if the patient is on a ventilator and intubated with direct access to one hundred percent oxygen. Dr Gilbert further maintains that pulmonary edema (excess fluid in the lungs) would also be an unlikely cause of the severe hypoxia noted at Miss Gayle's respiratory arrest.

[45] The UHWI alleges that on 1 April 2018, a twenty-four (24) hour, negative fluid balance of 2.4 litres (total input 2.3 litres, output 4.7 litres) was recorded. This

[62] See – Paragraphs 16 and 17 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023. See also, paragraphs 15-17 of **Exhibit 98**, which contains a copy of the Expert Report of Dr Tameka March, which was filed on 20 October 2023.

[63] See – Paragraph 17 and 18 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023.

reading, Dr Gilbert asserts, indicates that the body fluid output was greater than the body fluid input and that consequently, less body fluid, not more, would be present in the lungs. Dr Gilbert avers that pulmonary embolism is a better explanation for prolonged hypoxia unresponsive to one hundred percent (100%) therapy. He avers that severe, prolonged hypoxia would worsen the brain injury which was caused by Miss Gayle's migrainous infarct. This would cause more swelling on the brain and even more brain injury. Severe hypoxia, and not an infection, would lead to severe injury to the centers in the brain which control the heart rate and respiration and resulted in cardiac and respiratory failure and the subsequent death of Miss Gayle.[64]

THE LAW

The claim in negligence

[46] It is well established by the authorities that, in a claim grounded in the tort of negligence, there must be evidence to show that a duty of care is owed to a claimant by a defendant, that the defendant acted in breach of that duty and that the damage sustained by the claimant was caused by the breach of that duty.

Medical negligence

[47] A medical practitioner owes a duty in tort to his patient irrespective of any contract between them. Once a person has been accepted as a patient, the medical practitioner owes a duty to exercise reasonable care and skill in diagnosing, advising and treating the patient. Any negligent error in carrying out treatment, or omission to provide adequate treatment, will be actionable, if it causes injury to the patient. To amount to medical negligence, any alleged error

[64] See – Paragraph 19 of the Witness Statement of Dr David Gilbert, which was filed on 30 June 2023. See also, paragraphs 18 – 21 of **Exhibit 98**, which contains a copy of the Expert Report of Dr Tameka March, which was filed on 20 October 2023.

in diagnosing and/or treatment must be shown to be derived from a failure to attain the required degree of skill and competence of a reasonable medical practitioner. This question falls to be answered in the light of the medical practitioner's specialty and the post that he holds.[65]

The burden and standard of proof

[48] It is equally well settled that, where a claimant alleges that he has suffered damage resulting from a defendant's negligence, a burden of proof is cast on him to prove his case on a balance of probabilities.[66] This principle was enunciated by Lord Griffiths in **Ng Chun Pi and Ng Wang King v Lee Chuen Tat and Another**.[67] He stated at pages 3 and 4: -

> *"The burden of proving negligence rests throughout the case on the plaintiff. Where the plaintiff has suffered injuries as a result of an accident which ought not to have happened if the defendant had taken due care, it will often be possible for the plaintiff to discharge the burden of proof by inviting the court to draw the inference that on the balance of probabilities the defendant might have failed to exercise due care, even though the plaintiff does not know in what particular respects the failure occurred…*
>
> *…it is the duty of the judge to examine all the evidence at the end of the case and decide whether on the facts he finds to have been proved and on the inferences he is prepared to draw he is satisfied that negligence has been established."*

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[65] See – **Clerk & Lindsell on Torts**, 20th Edition, Sweet & Maxwell, 2010, page 639, at paragraphs 10-44 and page 651, at paragraph 10-63 and Halsbury's Laws of England/Medical Professions (Volume 74 (2019), at paragraph 23

[66] **Kimola Merritt (suing by her mother and Next Friend Charm Jackson) and the said Charm Jackson v Dr. Ian Rodriquez and The Attorney General of Jamaica**, unreported, Suit No. CL1991/M036, judgment delivered on 21 July 2005

[67] Privy Council Appeal No. 1/1988, judgment delivered on 24 May 1988

[49] In **Miller v Minister of Pensions**,[68] Denning J, speaking of the degree of cogency which evidence must reach in order that it may discharge the legal burden in a civil case, had the following to say: -

> *"That degree is well settled. It must carry a reasonable degree of probability but not so high as is required in a criminal case. If the evidence is such that the tribunal can say 'we think it more probable than not', the burden is discharged but if the probabilities are equal it is not."*

The duty of care

[50] To establish a duty of care, there must be foreseeable damage, consequent upon the defendant's negligent act.[69] There must also exist sufficient proximate relationship between the parties, making it fair and reasonable to assign liability to the defendant.

[51] Lord Bridge, in **Caparo Industries plc v Dickham**,[70] spoke to the test in the duty of care, sufficient to ascribe negligence, in this way: -

> *"In determining the existence and scope of the duty of care which one person may owe to another in the infinitely varied circumstances of human relationships, there has for long been a tension between two different approaches. Traditionally the law finds the existence of the duty in different specific situations each exhibiting its own particular characteristics. In this way the law has identified a wide variety of duty situations, also falling within the ambit of the test of negligence."*

[52] At pages 573 and 574, Lord Bridge went on to say: -

> *"What emerges, is that, in addition to the foreseeability of damage, [the] necessary ingredients in any situation giving rise to a duty of care are that there*

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[68] [1947] 2 All ER 372, at pages 373-374

[69] **Roe v Ministry of Health and Others. Woolley v Same** [1954] 2 All ER 138 B-C

[70] [1990] 1 All ER 568, at page 572

should exist between the party owing the duty and the party to whom it is owed a relationship characterized by the law as one of 'proximity' or 'neighbourhood' and that the situation should be one in which the Court considers it fair, just and reasonable that the law should impose a duty of a given scope on the one party for the benefit of the other."

Breach of the duty of care

[53] A medical practitioner is in breach of the duty of care owed to a patient if his conduct falls below the standard of care required of an ordinary skilled man exercising and professing to have that special skill. The standard of care demanded of medical practitioners is that required of any professional person.[71]

[54] The vital decision of **Bolam v Friern Hospital Management Committee**[72] [73] makes it clear that, in determining whether a defendant has fallen below the required standard of care, great regard must be shown to responsible medical opinion and to the fact that reasonable doctors may differ. There, McNair J outlined the test for determining whether the conduct of a skilled professional falls below the required standard of care. He stated, in part, as follows: -

"…where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the

[71] See – Paragraph 92 of **The Attorney General for Jamaica & Anor v Tahjay Rowe (A Minor, suing by Tasha Howell His Mother and Next Friend)** [2020] JMCA Civ 56, per Edwards JA: "*It is undisputed that a doctor has a duty of care to his or her patients to treat them with reasonable care (see **Bolam v Friern Hospital Management Committee** [1957] 2 All ER 118, which was considered and applied by the House of Lords in **Sidaway v Bethelem Royal Hospital Governors and others** [1985] 1 All ER 643 and the Privy Council in **Chin Keow v Government of Malaysia** (1967) 1 WLR 813). So too does a hospital and all the medical staff under whose care a patient is admitted (see also **Cassidy v Ministry of Health and Annissia Marshall v North East Regional Health Authority Saint Ann's Bay Hospital and the Attorney General** [2015] JMCA Civ 56]). In this regard, in **Cassidy v Ministry of Health**, Lord Denning gave the following opinion, at page 360: 'In my opinion authorities who run a hospital, be they local authorities, government boards, or any other corporation, are in law under the selfsame [sic] duty as the humblest doctor; whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment… and if their staff are negligent in giving the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him.' "*

[72] [1957] 2 All ER 118, at page 121, paragraphs C-F

[73] See also – **Genas v The Attorney General of Jamaica** C.L. G 105 of 1996, decision handed down October 6, 2006

test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

…

> *In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.*

I myself would prefer to put it this way: 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. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view." [74]

[55] In **Hunter v Hanley**,[75] Lord President Clyde opined that, where the conduct of a medical practitioner is concerned, establishing a breach of duty is not as clear cut as in a normal action based in negligence. The true test, for establishing negligence in diagnosis or treatment on the part of the doctor, is, whether he has

[74] This test was approved by the Court of Appeal in **The Attorney General of Jamaica and The South East Regional Health Authority v Tahjay Rowe (A Minor, suing by Tasha Howell his Mother and Next Friend** [2020] JMCA Civ 56, at paragraph [95], per Edwards JA

[75] 1955 SC 200, at page 205

been proved to be guilty of such failure of which no doctor of ordinary skill would be guilty, if acting with ordinary care.

[56] In **Maynard v West Midlands Regional Health Authority**,[76] the House of Lords considered circumstances where a physician and a surgeon who worked together in the treatment of a patient were guilty of an error of professional judgment of such a character as to constitute a breach of their duty of care towards the patient. The physician and surgeon recognised that the most likely diagnosis of the patient's illness was tuberculosis, but took the view that Hodgkin's disease, carcinoma and sarcoidosis were also potential diagnoses. The medical team decided to perform a mediastinoscopy to obtain a biopsy instead of awaiting the result of a sputum test, that would involve a delay of weeks as Hodgkin's disease is fatal unless remedial steps were taken in its early stages. The procedure was carried out and regrettably, there was damage to the patient's left laryngeal recurrent nerve, even though mediastinoscopies innately involve that risk. It was later revealed that the patient was in fact suffering from tuberculosis and not Hodgkin's disease. The patient brought a claim against the health authority seeking damages for negligence.

[57] The trial judge preferred the evidence of the expert witness called for the patient, who presented evidence that the case had almost certainly been one of tuberculosis from the outset and should have been so diagnosed. The trial judge deemed the two doctors negligent, but the Court of Appeal reversed the trial judge's decision, finding that they were not. Lord Scarman, in delivering the decision of the House of Lords made the following salient pronouncements: -

> *"The present case may be classified as one of clinical judgment. Two distinguished consultants, a physician and a surgeon experienced in the treatment of chest diseases, formed a judgment as to what was, in their opinion, in the best interests of their patient. They recognised that tuberculosis was the most likely diagnosis. But, in their opinion, there was an unusual factor, viz,*

[76] [1984] 1 W.L.R 634

swollen glands in the mediastinum unaccompanied by any evidence of lesion in the lungs… It is said that the evidence of tuberculosis was so strong that it was unreasonable and wrong to defer diagnosis and to put their patient to the risks of the operation. The case against them is not mistake or carelessness in performing the operation, which it is admitted was properly carried out, but an error of judgment in requiring the operation to be undertaken.

A case which is based on an allegation that a fully considered decision of two consultants in the field of their special skill was negligent clearly presents certain difficulties of proof. It is not enough to show that there is a body of competent professional opinion which considers that their [sic] was a wrong decision, if there also exists a body of professional opinion, equally competent which supports the decision as reasonable in the circumstances. It is not enough to show that subsequent events show that the operation need never have been performed, if at the time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper. I do not think that the words of Lord President Clyde in ***Hunter v Hanley****, 1955 S.L.T 213, 217 can be bettered:*

> *'In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men… The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care…'*

I would only add that a doctor who professes to exercise a special skill must exercise the ordinary skill of his speciality. Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other: but that is no basis for a conclusion of negligence.

…

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

Causation

[58] In an action for medical negligence the ordinary rules of causation apply. A claimant is required to prove that the defendant's breach of duty of care caused, or, at the very least, materially contributed to the damage or loss sustained by him. A claimant must establish, on a balance of probabilities, a causal link between his injury and the defendant's negligent act.[77] Where a breach of a duty of care is proved or admitted, the burden still lies on the claimant to prove that the defendant's breach caused the injury suffered. Even if a claimant has successfully established medical negligence, the issue of causation must still be determined.[78]

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[77] See – **Kimola Merritt (suing by her mother and Next Friend Charm Jackson) and the said Charm Jackson v Dr Ian Rodriquez and the Attorney General of Jamaica**, supra, at page 9, per M. McIntosh J

[78] **Bolitho (Administratrix of the estate of Bolitho (deceased) v City and Hackney Health Authority [**1997] 4 All ER 771, at page 776 e-f

The 'but for' test

[59] The test often employed by the court to determine whether there is a causal connection between the damage sustained by a claimant and a defendant's conduct is the 'but for' test. That is to say that the damage would not have occurred but for the defendant's negligent conduct.

[60] In **Clements v Clements**,[79] McLachlin CJ provided a comprehensive analysis of the nature and application of the 'but for' test. He is quoted, in part, as follows: -

> *"The test for showing causation is the "but for" test. The plaintiff must show on a balance of probabilities that "but for" the defendant's negligent act, the injury would not have occurred. Inherent in the phrase "but for" is the requirement that the defendant's negligence was necessary to bring about the injury — in other words that the injury would not have occurred without the defendant's negligence. This is a factual inquiry. If the plaintiff does not establish this on a balance of probabilities, having regard to all the evidence, her action against the defendant fails.*
>
> *The "but for" causation test must be applied in a robust common-sense fashion. There is no need for scientific evidence of the precise contribution the defendant's negligence made to the injury. See Wilsher v. Essex Area Health Authority, [1988] A.C. 1074 (H.L.), at p. 1090, per Lord Bridge; Snell v. Farrell, [1990] 2 S.C.R. 311.*
>
> *A common-sense inference of "but for" causation from proof of negligence usually flows without difficulty. Evidence connecting the breach of duty to the injury suffered may permit the judge, depending on the circumstances, to infer that the defendant's negligence probably caused the loss."*

[61] In actions for medical negligence, causation may be difficult to prove. This is so especially in cases where there are several possible causes of a claimant's

[79] [2012] 2 S.C.R., at paragraphs 8-10

injury. In this context, what can be gleaned from the authorities is that, if there are several possible causes of a claimant's injury, only one of which involves the defendant's negligence, the claimant's action will fail if he cannot positively prove that the defendant's negligence caused or materially contributed to his injury.

[62] In **McGhee v National Coal Board**,[80] the court had to grapple with the dilemma of there being two (2) possible causes of the claimant's injury. There, the claimant, who was employed to clean out brick kilns, contracted dermatitis from the accumulation of coal dust on his skin. There were no shower facilities provided by the defendant at work and, as a result, the claimant would cycle home each day covered with dust. It was determined that the defendant was negligent in failing to provide proper shower facilities. It was, however, unclear whether the dermatitis was caused by the absence of the shower facilities or by the unavoidable levels of ambient brick dust during the work day.

[63] The House of Lords held that the defendant's breach of duty to provide shower facilities had materially increased the risk of injury to the claimant and came to a finding that the defendant's breach of duty had materially contributed to the claimant's injury. Lord Reid stated as follows: -

> *"It has always been the law that a pursuer succeeds if he can shew that fault of the defender caused or materially contributed to his injury. There may have been two separate causes, but it is enough if one of the causes arose from the fault of the defender. The pursuer does not have to prove that this cause would of itself have been enough to cause him injury."* [81]

[80] [1972] 3 All ER 1008

14 The damage which is reasonably foreseeable must be of the same kind and type as that which actually occurred and, in this regard, each case turns on its own particular set of facts. See – **Overseas Tankship (U.K.) Ltd. v Morts Dock & Engineering Co., Ltd.** [1961] 1 All ER 404

Remoteness of damage

[64] A defendant is only liable for the consequences of his negligent conduct which are foreseeable. He will not be liable for consequences which are too remote.

[65] In this regard, in **Roe v Ministry of Health and Others. Woolley v Same**,[82] Lord Denning posited as follows:-

> *"The first question in every case is whether there was a duty of care owed to the plaintiff; and the test of duty depends, without doubt, on what you should foresee. There is no duty of care owed to a person when you could not reasonably foresee that he might be injured by your conduct: see* Hay (or Bourhill) v Young *and* Woods v Duncan *([1946] AC 426, per Lord Russell of Killowen, and ibid, 437 per Lord Perter). The second question is whether the neglect of duty was a "cause" of the injury in the proper sense of that term; and causation, as well as duty, often depends on what you should foresee."*

ANALYSIS AND FINDINGS

i. Whether the UHWI by its servants and/or agents owed a duty of care to Miss Gayle

[66] In the present instance, the Court must first determine whether the UHWI by its servants and/or agents owed a duty of care to Miss Gayle. To prove their case, Mr and Mrs Gayle must prove that: -

(i) the UHWI by its servants and/or agents owed their daughter a duty of care;

(ii) the UHWI by its servants and/or agents breached that duty of care; and

(iii) Miss Gayle suffered harm that was reasonably foreseeable because of that breach.

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[82] (supra), at page 138 A-C

[67] The authorities establish that a medical practitioner owes a duty of care to his patients to diagnose, advise and treat them with reasonable care and skill. This duty of care is owed by a medical practitioner to his patients, irrespective of the existence of any contract between them. It is equally well established that a medical practitioner who professes to exercise a special skill or competence must exercise the ordinary skill required of his speciality.

Findings

[68] In light of the principles established by the authorities and in the circumstances of this case, the issue of whether the UHWI, by virtue of the medical practitioners employed or attached to it, owed Miss Gayle a duty of care is not a complex one. On this issue, the Court finds that: -

i. Miss Vijae Gayle was duly admitted to the UHWI as a patient by medical practitioners who were acting as its servants and/agents by virtue of their employment or otherwise;

ii. In the circumstances of her admission, the UHWI, by its servants and/agents, owed a duty of care to Miss Gayle to diagnose, advise and treat her with the ordinary skill which is required of an ordinary skilled man exercising and professing to have the special skill or competence involved.

ii. Whether the UHWI by its servants and/or agents breached the duty of care owed to Miss Gayle

[69] The law is equally well settled that a medical practitioner is in breach of the duty of care owed to a patient if his conduct falls below the standard of care required of an ordinary skilled man exercising and professing to have his special skill.

[70] The UHWI professes to be a fully accredited and recognized academic institution and teaching hospital. It maintains that, because of its model as a teaching hospital, a patient who is admitted is likely to be seen by several medical

practitioners in any twenty-four-hour period. Dr Tameka March-Downer, the expert witness called for and on behalf of the UHWI, averred as follows: -

> *"The patient would have been seen by the first responders, who are the emergency room doctors, junior and senior. Depending on what the case is, whether in patient or outpatient, they then would refer to internal medicine."*

[71] That notwithstanding, in the context of a public hospital, the duty of care arises in circumstances where a patient is examined, assessed and treated by medical practitioners who are themselves acting as servants and/or agents of the hospital, by virtue of their employment or otherwise. In the present instance, all medical practitioners who are employed or attached to the UHWI are required to provide the standard of care required of an ordinary skilled man exercising and professing to have their special skill. They are not required to possess the highest expert skill.

[72] To determine whether the UHWI breached the duty of care that was owed to Miss Gayle, there are three (3) sub-issues which must be resolved: -

i. Whether negligence ought properly to be ascribed to the UHWI in relation to its diagnosis, treatment and management of Miss Gayle and of her presenting symptoms or condition while she was admitted to the UHWI;

ii. Whether the UHWI, by its servants and/or agents, negligently failed to accurately diagnose, treat and/or manage Miss Gayle; and

iii. Whether that failure resulted in Miss Gayle's rapid deterioration and subsequent death.

[73] In this regard, Learned Counsel Ms Jacqueline Cummings and Learned Counsel Mr Matthew Palmer submit that the UHWI, by its servants and/or agents, were negligent for the following reasons: -

i. That the UHWI failed to heed or to act on Miss Gayle's symptoms of persistent severe headaches, persistent fever, and generalized weakness, each or all of which were suggestive of a meningitis;

ii. That the UHWI failed to make a diagnosis of meningitis in time or at all, by carrying out a lumbar puncture, in circumstances where a diagnosis of meningitis was made on three (3) separate occasions (30 March 2018 at 4:20 pm; 30 March 2018 at 9:30 pm; and 1 April 2018 at 12:10pm);

iii. That the UHWI failed, in time or at all to appreciate, heed, or to act on the fact that migraine with left hemiplegia was a misdiagnosis because a diagnosis of meningitis was made on three (3) separate occasions;

iv. That the UHWI failed in time or at all to diagnose and/or to treat Miss Gayle for meningitis;

v. That the UHWI failed to institute or operate or to ensure the institution or operation of any or an adequate system to ensure that diagnoses are followed upon, to ensure that tests are carried out to confirm or disprove a diagnosis;

vi. That the UHWI wrongly concluded and treated Miss Gayle for migraine with left hemiplegia without reference to the three (3) prior diagnoses of meningitis and without prejudice to the generality of this allegation, considering the following facts and matters: -

    a. That Miss Gayle had no history of left hemiplegia migraine;
    b. That Miss Gayle had a history of meningitis at age eight (8) years old;
    c. That Miss Gayle had the symptoms of meningitis;

d. That diagnoses were made of meningitis on three (3) separate occasions by UHWI doctors before the misdiagnosis of migraine with left hemiplegia was made;
e. That there were three (3) requests for a lumbar puncture to assess the nature of Miss Gayle's cerebrospinal fluid before the misdiagnosis of migraine with left hemiplegia was made.

vii. That the doctors failed, refused and/or neglected to carry out a lumbar puncture to assess the nature of Miss Gayle's cerebrospinal fluid (CSF) when:
a. A lumbar puncture would have assessed the intracranial pressure of Miss Gayle and would have guided the doctors with methods to reduce the intracranial pressure to prevent coning and ultimately brain death;
b. The lumbar puncture would have provided valuable information of its cell type and count and the aetiology of the meningitis and the treatment to be administered to Miss Gayle, that is, antiviral if it were a virus causing the meningitis, immunosuppressive therapy, if there were an immune cause of the meningitis or antibiotics if there were a bacteria responsible for the meningitis.

viii. That the UHWI failed or refused to recognize that Miss Gayle was brain stem dead on the 1 April 2018;

ix. That the UHWI permitted or suffered Miss Gayle's condition to be or to remain undiagnosed or untreated or inadequately treated and thereby to deteriorate to the point that she suffered brain death and died;

x. That the UHWI failed correctly to investigate or to manage or to treat the deceased's condition;

xi. That, in the premises, the UHWI caused, permitted or suffered Miss Gayle's condition to deteriorate and caused her to suffer from meningitis and to die;

xii. That, in the premises, the UHWI failed to institute or operate a safe or sufficient system for the investigation, management or treatment of Miss Gayle;

xiii. That the UHWI failed to take any or appropriate or timely steps for the care, safety and treatment of Miss Gayle;

xiv. That the UHWI exposed Miss Gayle to a foreseeable risk of injury, loss and death.

The Medical Evidence

[74] Mr and Mrs Gayle maintain that the UHWI was negligent in its diagnosis, treatment and management of Miss Gayle and of her presenting symptoms or condition while she was admitted to its medical facility. Mr and Mrs Gayle contend that the medical team at the UHWI and, in particular, the Neurology team, ought properly to have diagnosed Miss Gayle with meningitis, having regard to her symptoms at presentation. To substantiate their Claim, Mr and Mrs Gayle rely on the evidence of the expert witness, Forensic Consultant Pathologist, Professor Hubert Daisley, CMT BSC. BSc. MB BS. DM. FRCPE. MFFLM.

[75] For its part, the UHWI relies on the evidence of the expert witness Dr Tameka March-Downer. The UHWI also relies on the evidence of Dr David Gilbert, who was called as an ordinary witness in his capacity as the Consultant in Internal Medicine and Neurology who attended to Miss Gayle. Dr Tameka March-Downer is a Consultant Neurologist in the Faculty of Medical Sciences at the UHWI. She

obtained a Bachelor of Medicine and Surgery and a Doctorate of Medicine from the University of the West Indies, Mona, in 2006 and 2012, respectively. Dr Tameka March-Downer completed her Neurology training at the Royal College of Physicians of London, at the Leeds Teaching Hospital, in 2021. At the time of the reception of her evidence, during the trial of this matter, Dr Tameka March-Downer was a Consultant Neurologist for three and a half (3½) years. Both Dr Tameka March-Downer and Dr David Gilbert are attached to the UHWI, by virtue of their employment.

[76] The evidence of Dr David Gilbert, as is contained in his witness statement, which was filed on 30 June 2023, provides the context of Miss Gayle's admission to the UHWI, in so far as the hospital alleges. The evidence reads, in part, as follows: -

> *"9. When a patient comes to the emergency room (ER) of a university teaching hospital, the patient is first seen by the most junior physician. The junior physician is trained to consider several possible diagnoses which could explain the patient's symptoms. The most likely diagnosis is given first and an alternative diagnosis with less or incomplete evidence given after and written as a query (a query diagnosis) or a diagnosis to be ruled out or to be evaluated (an R/O diagnosis). The Junior doctor, in what is referred to internally as the "chain of command", will then present the patient's medical history and examination findings to a senior doctor, who will give the diagnosis which best explains the patient's presenting clinical features.*
>
> *10. Miss Gayle presented at the UHWI with a 3-day history of worsening headaches, worsening over the previous 4 months on a background of 9 years of recurrent headaches. The two (2) UHWI Emergency room (ER) junior physicians who first attended to Miss Gayle found, as did her family doctor who saw her three (3) days before presentation, a normal body temperature, 36.4 degrees centigrade. The ER Junior physicians also found Miss Gayle to be alert (no drowsiness) with mild weakness of her left upper and*

lower limbs and gave a diagnosis of "Hemiplegic migraine" (migraine presenting with headache and weakness ("plegia") involving half ("hemi") of the body). They reviewed Miss Gayle and gave a "query meningitis" diagnosis and referred Miss Gayle to the Internal Medicine (IM) physicians (specialists in the diagnosis and management of medical conditions including e.g., migraine and meningitis). The junior IM physician who reviewed Miss Gayle, found her to be mildly drowsy with moderate left limb weakness and gave diagnoses of:

A. Migraine with aura; and

B. Complex partial seizures (seizures involving limited areas of the brain and accompanied by reduced awareness of one's surroundings).

11. *The Junior IM physician also suggested "evaluation for meningitis" (an R/O diagnosis). The junior IM physician then discussed Miss Gayle's clinical findings with the senior IM Resident and IM Consultant who gave diagnoses of 1) Hemiplegic migraine and 2) Complex partial seizures. Recurrent headaches of months to years duration are not consistent with an acute infectious meningitis. A diagnosis of meningitis was never made by any UHWI physician who reviewed Miss Gayle as there were no supporting features specific for that diagnosis. Miss Gayle was referred by the consultant IM physician, on the day following her admission to the ER, to the Neurology service (the subspecialty service with expertise in the management of neurological conditions including infections of the brain, stroke, migraine and its complications). The referring diagnoses were 1) Hemiplegic migraine 2) Complex partial seizures.*

12. *As the supervising Neurology Consultant on call, I personally reviewed Miss Gayle on the day following her presentation to the ER. There were no features of a bacterial infection and in*

particular no features specific to a bacterial meningitis i.e. no fever, no stiffness of the neck and no elevation or [sic] her white blood cell count (WBC). An initial WBC of "11.20" (normal range of 3.75-11.00) in any acutely ill patient in the ER is insignificant and would be found as a non-specific feature of numerous non-infectious conditions presenting to the ER. Similarly, there was no evidence of a preceding viral infection, viral prodrome (headache, loss of appetite, fever) or viral meningitis in at least the 4 months prior to presentation to the ER. The diagnosis made by the Neurology service was a hemiplegic migraine progressing to a migrainous infarct (death of brain cells).

13. *Migraine headaches are accompanied by recurrent narrowing of vessels in the brain and subsequent lack of blood flow and oxygen to parts of the brain. A migrainous infarct is a type of stroke due to persistent vessel narrowing and lack of blood flow and oxygen leading to limb weakness (hemiplegia) or death of brain tissue (an infarct). A large stroke (infarct) causes swelling of the affected brain leading to limb weakness, fever, drowsiness and seizures.*

14. *Miss Gayle, by 12:10 pm, April 1, 2018, within 24 hours of admission demonstrated worsening left limb weakness and drowsiness but remained without fever or stiffness of the neck. As a standard of medical care, a lumbar puncture is contraindicated in patients with an associated limb weakness and features suggestive of high pressure within the skull (as occurs in a large stroke). Spinal fluid circulates from the lower back into the skull as cerebral fluid which surrounds the brain separating it from the overlying meninges, hence called cerebrospinal fluid (CS). A lumbar puncture performed in the lower back removes CSF and created an area of low pressure at the site of the needle puncture.*

15. *The CT brain on admission showed no acute intracranial event and not "no acute intracranial pathology". A normal CT brain does not equate to a normal brain. Miss Gayle's autopsy revealed*

necrosis of the cerebellum, a part of the brain which lies next to vital centres controlling respiration and heart rate. Necrosis (death of brain cells due to prolonged lack of blood flow and oxygen as in a stroke) would be accompanied by marked brain swelling. Miss Gayle's clinical picture was best explained by an expanding stroke.

….

17. Fixed and dilated pupils can be caused by severe hypotension (low blood pressure), severe hypoxia (low blood oxygen levels) and drugs such as epinephrine (used in resuscitation attempts) and not only by brain death. Standard criteria for the determination of brain death include as pre-requisites (a) normal systolic blood pressures (b) absence of hypoxia and (c) absence of drugs which could confound the evaluation of e.g. the pupillary responses to light. It would be medically inappropriate to make a brain death determination in the immediate post-arrest context (within thirty-six hours of presentation to the ER), without allowing for possible resolution of confounders such as hypoxia and shock.

18. Miss Gayle's hypoxia remained severe and unresponsive to intubation and ventilation on 100% oxygen, and this would not be explained by raised intracranial pressure or any intracranial event. Disease involving the brain cannot cause hypoxia if the patient is on a ventilator and intubated with direct access to 100% oxygen….

…

20. In meningitis the normally thin and clear meninges would become "thickened and opaque". Lymphocytic infiltrates and microglial nodules are inflammatory cells seen in brain injury from any cause whether infection, hypoxia, trauma, medication side effect and are not specific to infection. They are expected findings in a patient

with a previous history of inflammatory disorders including asthma, tonsillitis, and meningitis at age 8 years.

21. The brain autopsy findings of inflammation are non-specific and are not in keeping with viral meningoencephalitis (inflammation of the brain and the meninges), nor are they significant or extensive enough to account for Miss Gayle's severe hypoxia and refractory hypotension.

22. Ante-mortem and post-mortem culture of the blood and brain revealed no bacterial or viral organisms. The main autopsy finding was of hypoxic ischaemic encephalopathy – low blood oxygen levels (hypoxia) in a low or absent blood flow state (ischaemia) causing disease (Greek word origin, "pathy") of the brain (Greek word origin, "encephalo") – associated with necrosis (hypoxic death of cells) of the cerebellum. Miss Gayle suffered a rare and catastrophic stroke consequent on long-standing partially treated migraine."

The Expert Evidence

The Expert Evidence of Professor Hubert Daisley

[77] The following extract of the viva voce evidence of Professor Daisley bears repeating: -

"Q: What is meant by 'hemi'?

A: 'Hemi' means 'half of', so it's a migraine, which is a sort of headache that brings about bulging or widening of the blood vessels in the brain. It causes these persistent headaches, or pain in the head. Associated with it is this hemiplegia, which means that there is weakness on one side of the body associated with this migraine headache. In this case, she had the right sided headache but her left hand and the left lower limb, were weak. She had left sided hemiplegia.

'Meningitis' is the inflammation of one of the coverings of the brain. The covering of the brain that is directly in contact with the brain substance is called the meninges. Inflammation of that layer or that covering is called meningitis.

That can occur for a variety of reasons and one of the most common things that can cause meningitis is infection, viral bacteria, protozel, fungal.

I have seen hemiplegic migraines.

I have seen those conditions in a clinical setting, with patients on the ward. Over the years I have seen those. My practice…deals more with Pathology and its interface with clinical medicine.

Q: What about the meningitis? Have you treated patients or interfaced with patients with meningitis?

A: I have and…I have seen those who have succumbed to meningitis.

Q: Is it required for a Neurologist to treat meningitis?

A: Yes. Most physicians too. It is not exclusive to a neurologist.

Q: What is a lumbar puncture? What is it for? What does it do?

A: The brain is in a skull encasement, and it is continuity. It is attached in parts, in continuity, with the spinal cord, which is housed in vertebral bones or column situated at the back. The cerebral spinal fluid (CSF) is a natural fluid that is manufactured in the brain, and it flows over the surface of the brain and down into the spinal column. If you want to have an evaluation to see if there is inflammation of the brain and you want to find out if there is inflammation of the brain, you will try and get some of that CSF.

How we do it is, we would insert a needle after you do a little local anaesthetic in the lumbar area of the back. That needle is inserted into the spinal canal and some of the fluid would be cautiously withdrawn. That fluid is csf and a series of tests would be done on it. One of it is to evaluate the cells that are within the csf. Whether the cells are neutrophils or whether the cells are lymphocytes, if they are neutrophils, then we probably would suspect a bacterial infection. If they are lymphocytes then we would suspect that there is a viral infection. Just those two

simple things would tell us what sort of infection is there, and the physician could then plan the medication accordingly, if it is neutrophils, then they could give antibiotics. If on the other hand it is lymphocytes, one would suspect a virus that is causing the meningitis, and anti-viral agents are given.

The other things that are done with that fluid is that we would measure the protein content. If the protein content is elevated, then we would say again there is infection there. We would also do the glucose content. If the glucose is low, we could conclude that possibly there is bacterial infection.

The other things that are done something like a gram stain on it and that could tell us if there are bacteria or no bacteria because the stain would, for instance, if it were meningococcus, we would see it.

That fluid is then cultured in a bacteriology laboratory to see again what sort of organism is there and subject that organism to appropriate antibiotic testing so that the appropriate antibiotic would be used in treating the patient.

There are many other tests that could be done and if you have the facilities for doing immunology or immunochemistry, we can further use that to identify whether it is a virus, what sort of virus, that is causing the meningitis.

But as I said very early, if you find that the predominant cells are neutrophils, you want to set out using antibiotics because meningitis is a very, very serious infection and within a short period of time there can be disaster to the patient. Within a matter of hours, a few hours, disaster could occur.

Q: *How does this disaster occur?*

A: *As I mentioned before, the brain is housed in the skull. At the base of the skull, there is an opening that we call the foremen magnum. In that region, where there is the opening, just above that you have a part of the brain that is called the brain stem. The brain stem is very, very important because it houses the respiratory centre, that is the centre that controls respiration. It houses the cardiac centre and that is the centre that houses the control of the heart and the other appendages of the heart. It also houses the vomiting centre.*

When the brain becomes inflamed it begins to swell. It begins to swell because fluid leaks out from the blood vessels in the brain into the brain substance and it

is called cerebral oedema. With the continued swelling of the brain, the continued inflammation, the brain has no room to expand, and it literally plunges itself through the foremen magnum. If that happens, you will have compression of the brain stem and that is a disaster. In medicine we call that coning of the brain stem.

What happens is you will have cardiopulmonary arrest and the patient, in a short space of time, will die.

Q: How does the lumbar puncture assist the process?
A: It would tell you whether there is inflammation, meningitis.

Q: Do you have any comment on the triage assessment notes that you have there?

A: They said presenting complaint was generalized weakness and severe headache. They also continue to say that she had asthma and a history of meningitis, seven years ago. They also said that she was alert, generalized weakness. Her gait was very unsteady. She had leg pain and left wrist

It is the first time I am seeing this neck pain being recorded and the neck pain with the symptoms and so forth could suggest that she might be having a meningitis. This is one of the things that we try to elicit in a patient who has meningitis, reflects the neck and if they get neck pain, in bending the neck it would inflame the meninges. That is one of the signs that we would use for meningitis. This is the first time that I am seeing this. I never saw that. That was all on the triage on that page.

Cross Examination conducted by Learned Counsel Mr Matthew Royal

Sugg: That failing to opine on the diagnostic significance of headaches since age seven is a serious deficiency in your report.

A: I don't agree with you. Each presentation must be assessed as a different presentation. This presentation that is being discussed is completely different from the rest of the presentation.

Q: What makes this presentation different?

A: *This patient died during this presentation, and it was not similar. That presentation was not a migraine presentation, although there were headaches, the headaches were not migrainous headaches.*

Yesterday, Counsel asked me questions concerning pathologists and physicians on the ward. I told Counsel that the definitive diagnosis of a patient disease often is made by the pathologist. Many things could cause headaches. This patient had headaches on this presentation and throughout her stay she was managed as having migraine with hemiplegia.

This patient died after being treated adequately for migrainous headache. After death, the physicians who treated her requested an autopsy to find out what was the cause of the headache and what was the cause of death. The autopsy was performed, and their findings were the patient had lymphocytic meningoencephalitis, which would give you headaches also. As I said before, the pathologist in medicine is the person at times that makes the final diagnosis. This diagnosis was made by three pathologists working together, Dr Williams, the Consultant, Dr Howell, and Dr Jaggon. Nowhere in their diagnosis did they mention migraine. In fact, in their histological or microscopic examination of the brain, they gave a detailed microscopy. ***(Page 4 of the Pathology Report, which is PM2018/31C) Bundle 4, page 17)****.*

The description there is quite clear that the covering of the brain (meninges) was diffusely (all over) infiltrated with lymphocytes. This patient would have a viral meningitis. This infiltrate here gives the connotation that it might be a viral meningitis that the patient succumbed to. That diffuse infiltrate is never seen in migraine. In addition to that, with the sentence beginning "also", there are numerous microglial nodules within the brain matter. The microglial cells are normal immune cells that are in the brain. They are to protect the other cells in the brain, like the nerve cells and the glial cells. They are called the watchmen. When they form nodules like this in the brain, it means then that there is some destructive pathological process going on or some invading organism, like a virus.

These nodules are often seen in viral encephalitis.

There was pathology in the brain and the pathology in the brain was brought about by what is described here, meningoencephalitis.

Lymphocytic meningoencephalitis

Lymphocytes are types of white blood cells. These white blood cells are responsive to injury. Injury anywhere in the body.

Sugg: Those are types of white blood cells as well?
In your report Professor, you mention on page 9 of your report that the microglial nodules are small foci or neurotic brain tissue. Some of these show evidence of what is interpreted as neuronophagia. In your evidence just now, you said that the presence of these means that there is some destructive pathology or some invading organism. You would agree with me that in the autopsy report ***(Page 17 of the Bundle),*** *there is the phrase lymphocytic meningoencephalitis?*

A: In the meninges as well as in the substance of the brain. Yes.

Sugg: This invasion of lymphocytes in the meninges as well as in the substance of the brain can occur in cases of infection.

A: Yes.

Sugg: It can also occur in non-infectious pathology.

A: Correct.

Sugg: In severe head trauma?
A: Yes.

Sugg: It can also occur in cases of a stroke.

A: I disagree. You wouldn't see a lymphocytic infiltrate.

Sugg: Would you see it in inflammatory conditions?
A: Like infections, yes.

Sugg: Would you see it result from hypoxia.

A: Not to this extent. You would see some but not to that extent.

Sugg: Can you indicate where in the autopsy report informs of the extent of the lymphocytic infiltrate?

A: At page 4, Dr Jaggon reviewed the sections of the meningeal role. Microglial cells literally eating dead cells.

Witness directed to Page 017 – Binder No. 4

Sugg: The overall features are indicative of a lymphocytic Meningoencephalitis: the exact aetiology of which cannot be determined. This pathologist and this pathology report make no conclusion that the meningitis was caused by meningitis.

A: You are playing with words. A meningoencephalitis is two things: It is a combination of a meningitis and as you see on page 4, the section of the meningeal role showed marked. Meningoencephalitis means inflammation of the meninges, as Dr Jaggon describes, and it also means inflammation of the brain substance. So, the deceased had a meningitis and an encephalitis because it continues in sections of the cerebrum (two large hemispheres) show a somewhat patchy perivascular infiltrate similar to that described in the meninges. This patient died of a lymphocytic meningoencephalitis.

Sugg: Inflammation of the meninges and inflammation of the brain substance can be caused by factors that are not infectious in nature.

A: You would make those diagnoses based on the clinical evidence. Someone like the patient in discussion presented in a particular manner. Another patient would present with let's say multiple sclerosis. The clinical presentation would give you an idea as to what might have caused the meningoencephalitis. In a loose, general sense, we could say that a meningoencephalitis can be caused by a variety of things.

Sugg: The autopsy report mentions the microglial modules. Microglial modules can be found as a result of a variety of degenerative diseases.

A: That's a general statement. Yes. It is a general statement, but each case varies. In this case there was a certain presentation and that has to be taken into consideration.

Sugg: Your conclusion of meningitis is based on the presence of the inflammation of the meninges and the substance of the brain substance combined with her clinical presentation.

A: They make that diagnosis based on their findings.

Sugg: Your assessment is based on her on ward presentation.

A: Based on the pathology report of Ms Gayle. It suits the clinical presentation. The symptoms she presented to the doctors on ward.

Sugg: I don't recall seeing in your report the clinical symptoms of meningitis.

A: It is at page 2 of my report.

Sugg: The clinical symptoms of meningitis are fever, headaches, and neck stiffness.

A: Yesterday you brought to my attention the triage bit. You can have just headache and fever. You could also headache, fever and neck stiffness. As far as I see in the notes, Ms Gayle had all three.

Witness directed to page 2 of Binder No. 6, exhibit 95

Mr Royal reads: "No chest pain, no cough, no diarrhoea. Neck stiffness zero."

Sugg: On presentation, Vijae Gayle did not have a symptom of neck stiffness.

A: It is noted there.

Witness directed to page 6 of Binder No. 6, exhibit 95

Mr Royal reads: "This is the note on the day of admission at 9:30 p.m."

Sugg: Body temperature of 36.4 is not indicative of a fever.

A: It is not elevated. She had Panadol before. The Panadol would bring down the fever.

Sugg: Ms Gayle did not present to the UHWI with the hallmark clinical symptoms of meningitis.

A: I don't agree with you. The classical presentation is what Learned Counsel said. The child was having headache. The child was having fever. On the triage page her gait was unsteady. Right after that she had neck pain. To say that she didn't present with it, the triage nurses had it ticked off.

Sugg: *A presentation with headache alone is not sufficient for a diagnosis of meningitis.*

A: *I don't agree with you. This child did not present with headache alone. The child presented with headache, a fever, which was treated just before coming to the hospital. They did a blood cell count and that was elevated, with an increase in the neutrophils. The casualty doctor wrote in the notes the question mark meningitis. If that is written in any medical note, that is a diagnosis which has to be ruled out. Once you put that in the note, it incriminates you. You have to rule out that. That is universal.*

Sugg: *A patient who presents with a current headache and a history of similar type of headache from age seven is more consistent with migraine and not meningitis.*

A: *I don't agree with you. The clinical presentation of this child was one that was different from the rest of them. You have to pay attention to the current one because you are going to miss things. When something new presents you are going to miss it.*

Sugg: *You make the conclusion that a lumbar puncture should have been done and you go on to say that it was negligent for a lumbar puncture to not have been done.*

A: *Of course it was negligent.*

Sugg: *Ms Gayle presented to the hospital with symptoms of limb weakness and drowsiness.*

A: *Among other things.*

Sugg: *Ms Gayle's presenting condition was suggestive of a situation of high pressure within her skull.*

A: *Oh, yes. With the meningitis that she had the brain began to swell. The intracranial pressure was rising all the time.*

Sugg: *A lumbar puncture performed in the lower back to remove CSF would have created a situation of low pressure in the brain and that situation would have caused coning.*

A: *No. It may not. In the hands of a consultant, especially a neurologist, the way the aspiration needle is made up, you could aspirate, close off and insert the same volume of sterile normal saline back into the canal. I have experienced that several times on the medical ward. However, this has to be done cautiously, in the hands of an expert. Certainly, a neurologist is an expert in this matter.*

Sugg: *In your report you concluded that Ms Gayle was brain dead on 1 April.*

A: *Yes. On the pathology report she coned at that particular time."*

The Expert Evidence of Dr Tameka March-Downer

[78] Conversely, Dr March-Downer's evidence is that: -

"*Q:* *Why was a lumbar puncture not done on this child?*

Witness directed to page 15 of the Medical Docket, page 13 of the Judge's Bundle

A: *She was found to have left sided weakness; right side was found to be of normal strength. Once there is focal weakness, then the lumbar puncture is contraindicated. When we insert the needle in the back of the spine there is pressure that is created around the brain. What we would do is insert a needle in the spinal column of the patient that creates a vacuum, once that vacuum is created that brain will herniate or cone.*

Q: *Despite those three independent diagnoses, you are saying that a lumbar puncture should not have been done to rule it out?*

A: *Yes. I am. For this patient.*

Witness directed to Page 138 of Volume F

Ms Cummings reads "At 1:10 am on 30 March, lumbar puncture was unsuccessful."

Sugg: *Do you agree with me that an attempt was made?*

A: *Yes. It was. According to this note. I don't know what category of doctor, Dr Rose was.*

Sugg: *From as early as her admission, it was noted that this patient was to be admitted for a possible lumbar puncture. Would it not be incumbent on the Consultant to come and do the lumbar puncture himself?*

A: *No.*

Q: *Was this patient treated for any viral illness?*

A: *There is no medication for a viral illness. It is rest and fluids.*

Q: *How do you treat a viral meningitis?*

A: *There is no medication for it. We have to make sure that they don't progress. We support them with fluid. We give them antipruritic, antifever medication to make sure that the temperature stays within the normal realm. There are antiviral drugs. …Viruses don't grow on cultures. For the routine cultures, they don't grow on those cultures. We will test for the bacteria because that can grow and multiply. When that comes up negative, we will make a decision to treat as aseptic, which is another term for viral meningitis.*

Q: *That test is done by first doing a lumbar puncture?*

A: *Yes.*

Q: *Would you say that meningitis is a rapidly progressing disease?*

A: *I wouldn't say that it is a rapidly progressing disease. It is a disease that if you don't treat it, then it can actually escalate. I wouldn't say that it is a rapidly progressing disease.*

Sugg: *The symptoms of meningitis are fever, headache, neck stiffness, vomiting.*

A: *I have never treated patients with one or two of those symptoms only. Neck pain and neck stiffness, it could be synonymous. We have to ask the patient to clarify exactly what they are experiencing.*

Sugg: *The patient must display all four symptoms before you can make a diagnosis of meningitis.*

A: *Symptoms along with examination findings.*

Sugg: *This patient had sufficient symptoms and examination findings for her to be tested for meningitis.*

A: *I disagree."*

The approach of the Court to expert evidence

[79] The United Kingdom Supreme Court in the authority of **Griffiths v TUI (UK) Ltd**[83] opined: -

> *"It is trite law that as a generality in civil proceedings, the claimant bears the burden of proof in establishing his or her case. It is trite law that the role of an expert is to* assist *the court in relation to matters of scientific, technical or other specialized knowledge which are outside the judge's expertise by giving evidence of fact or opinion; but the expert must not usurp the functions of the judge as the ultimate decision-maker on matters that are central to the outcome of the case. Thus, as a general rule, the judge has the task of assessing the evidence of an expert for its adequacy and persuasiveness."*

[80] The Jamaican Court of Appeal in the authority of **Clarke v Beckford et al**[84] [85] made the following pronouncements: -

> *"The peril facing expert evidence is that, like any other evidence tendered, it may for good reason, be rejected. The trail [sic] judge had the benefit of listening to and observing this witness testify…Further, he had the benefit of addresses from counsel for both parties who examined his evidence in great detail and then he demonstrated in his judgment his assessment of the evidence before concluding that he preferred the real evidence to the comparison evidence."*

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[83] [2023] 3 WLR 1204

[84] 1993 JMCA 33

[85] See – **Paul Griffith v Claude Griffith** [2017] JMSC Civ 136

The approach to be adopted by the Court in circumstances where there are conflicting expert opinions

[81] The dicta of Henry LJ, in the authority of **Flannery and Anor v Halifax Estate Agencies Ltd (trading as Colleys Professional Services)**,[86] is demonstrative of the approach to be adopted by a tribunal when treating with conflicting expert evidence. At page 381, Henry LJ made the following pronouncements: -

> *"It is not a useful task to attempt to make absolute rules as to the requirement for the judge to give reasons. This is because issues are so infinitely various. For instance, when the court, in a case without documents depending on eye-witness accounts is faced with two irreconcilable accounts, there may be little to say other than that the witnesses for one side were more credible: see de Smith, Wolf and Jowell, Judicial Review of Administrative Action, 5th ed. (1995), pp. 465-466, para. 9-049. But with expert evidence, it should usually be possible to be more explicit in giving reasons: see Bingham L.J. in Eckersley v Binnie (1988) 18 Con. L.R. 1, 77-78:*
>
> > *'In resolving conflicts of expert evidence, the judge remains the judge; he is not obliged to accept evidence simply because it comes from an illustrious source; he can take account of demonstrated partisanship and lack of objectivity. But save where an expert is guilty of a deliberate attempt to mislead (as happens only very rarely), a coherent reasoned opinion expressed by a suitably qualified expert should be the subject of a coherent reasoned rebuttal, unless it can be discounted for other good reasons. The advantages enjoyed by the trial judge are great indeed, but they do not absolve the Court of Appeal from weighing, considering and comparing the evidence in the light of his findings, a task made longer but easier by possession of a verbatim transcript usually (as here) denied to the trial judge.'*

[86] [2000] 1 WLR 377

[82] In the authority of **English (appellant) v Emery Reimbold & Strick (respondents) & Ors**,[87] Lord Phillips MR stated: -

> *"It is legitimate, where there is a direct conflict of expert evidence, for the judge to prefer the evidence of one expert to the other simply on the ground that he was better qualified to give it, or was a more authoritative witness, if the judge is unable to identify any more substantial reason for choosing between them. This should not often be the case. If this is the basis for the judge's conclusion, he should make it plain."*

[83] These authorities have long established that, as a generality in civil proceedings, the role of an expert witness is to assist the court in relation to matters of scientific, technical or other specialized knowledge, which are outside the judge's expertise. The expert witness does this by giving evidence of fact or opinion. It is equally well established that a coherent, reasoned opinion, expressed by a suitably qualified expert, should be the subject of a coherent reasoned rebuttal, unless it can be discounted for some other good reason. Where there is a direct conflict of expert evidence, it is open to the trial judge to prefer the evidence of one expert to that of the other on the ground that he was better qualified to give it or that he was a more authoritative witness.

[84] There can be no doubt that Professor Hubert Daisley and Dr Tameka March-Downer are suitably qualified professionals in their respective areas of speciality. Nor is there any basis for a finding that either expert witness demonstrated partisanship and/or a lack of objectivity. The task for the Court then is to assess the evidence of each expert witness for its adequacy and persuasiveness.

Findings

[85] In this regard, the Court accepts the evidence of the expert witness, Professor Hubert Daisley. The Court finds that Professor Hubert Daisley is better qualified and more experienced to give the evidence which he purports to give and that he

[87] [2002] EWCA Civ 605

was a more authoritative witness. The Court finds Professor Hubert Daisley's evidence to be a coherent, reasoned opinion expressed by a suitably qualified expert in Clinical and Forensic Pathology. Additionally, the Court accepts the evidence of Professor Hubert Daisley of his personal knowledge of and experience with cases of Hemiplegic Migraine with aura and Meningitis, including from a clinical perspective.

[86] In determining the issue of whether the UHWI breached the duty of care which it owed to Miss Gayle, the Court finds that, regrettably, there are aspects of negligence on the part of the UHWI, which are of great concern.

i. The failure to rule out a diagnosis of Meningitis

[87] The following portion of the viva voce evidence of the expert witness Dr Tameka March-Downer is instructive: -

> *"…there may be a diagnosis or differential that is put forward by the junior team that will be dispelled, once that case is discussed with the consultant. The consultant is the only person who makes diagnoses."*

[88] The documentary evidence discloses that, during the course of Miss Gayle's admission to the UHWI, it was noted on three (3) separate occasions that a diagnosis of Meningitis was to be ruled out. A request was made for a lumbar puncture to be performed to assess the nature of her CSF. The lumbar puncture was attempted and was unsuccessful and no attempt was made to repeat the same. In fact, it is readily apparent from the Medical Docket in relation to Miss Gayle, that, no further attempt was made to rule out or to exclude the differential diagnosis of Meningitis.

[89] This Court is of the view that there is an absolute need for a physician to ensure that sufficient tests and detailed investigations are conducted before ruling out one disease over another. Negligence must be ascribed to the UHWI, by its servants and/or agents, for its failure to properly employ all usual diagnostic aids in ruling out the possibility of Meningitis, including a lumbar puncture test. An

erroneous diagnosis does not alone determine a medical practitioner's liability but if the medical practitioner, as an aid to diagnosis, does not accurately obtain the patient's history, does not perform a lumbar puncture test, the net result is not an error in judgment but constitutes negligence.

[90] The Court is strengthened in this position by the dicta of Madam Justice Toscano Roccamo of the Superior Court of Justice in Ontario, Canada, in the authority of **Vicki Williams, by her Litigation Guardian and Ors v Adrian P. Bowler, The Belleville General Hospital, and The Trenton Memorial Hospital**,[88] to which the Court was referred. For present purposes, the following pronouncements of Madam Justice Toscano Roccamo are instructive: -

> *"[237] In exercising sufficient care and skill in making a diagnosis, the physician should avail himself of available resources, including up-to-date texts, articles and works in that particular field. This is especially important where a doctor makes a differential diagnosis. As noted by Quijano J. in* ***Hughes v. Cooper Estate****, there is an absolute need for the physician to ensure that sufficient tests and detailed investigations have been conducted before ruling out one disease over another.*
>
> > *To rely on a differential diagnosis, as Dr Cooper did, in the presence of rectal bleeding, and to take no further steps to confirm that diagnosis or to determine the source of the rectal bleeding, is below the acceptable standard of care for a general physician.*
> >
> > ***Hughes v. Cooper Estate****, [1997] B.C.J. No 1303 at para. 18 (S.C.) (Q.L.).* ***Bergen Estate v Sturgeon General Hospital District No. 100****, [1984] A.J. No. 2575 at para. 18 (Q.B.) (Q.L.) [Bergen Estate].*
>
> *[238] In the case of* ***Wade v Nayernouri****, a patient suffering from severe headache, nausea, dizziness, numbness and photophobia was diagnosed as having migrainous headaches plus nervous overtone in 15 minutes by a doctor employed in an emergency ward. In fact, the patient was in the early stages of a*

[88] 2005 CanLII 27526 (ON SC)

subarachnoid hemorrhage and died some days later. In finding liability for a misdiagnosis, the court concluded that:

> *Negligence must be attributed to the doctor for his failure to properly employ all usual diagnostic aids in reaching his conclusion, for his failure to take adequate neurological tests including tests as to neck stiffness, including a lumbar puncture test so as to rule out the possibility of a subarachnoid hemorrhage and his failure to refer the case to a neurologist, or at least obtain a second opinion before discharging the patient from the hospital.*
>
> *…*
>
> *In my opinion the cases have established that an erroneous diagnosis does not alone determine the physician's liability. But if the physician, as an aid to diagnosis, does not avail himself of the scientific means and facilities open to him for the collection of the best factual data upon which to arrive at his diagnosis, does not accurately obtain the patient's history, does not avail himself in this particular case of the need for referral to a neurologist, does not perform the stiff neck tests and the lumbar puncture test, the net result is not an error in judgement but constitutes negligence.* ***Wade v Nayernouri*** *(1978), 2 L. Med. Q. 67 (Ont. H.C.) at 70-71."*

[91] The Court is mindful of the evidence of Dr Tameka March-Downer that: -

> *"She [Miss Gayle] was found to have left sided weakness; right side was found to be of normal strength. Once there is focal weakness, then the lumbar puncture is contraindicated. When we insert the needle in the back of the spine there is pressure that is created around the brain. What we would do is insert a needle in the spinal column of the patient that creates a vacuum, once that vacuum is created that brain will herniate or cone."*

[92] The Court is equally mindful of the reason provided by Dr David Gilbert for the decision to refrain from repeating the lumbar puncture. Dr Gilbert avers that: -

> *"If the risk of doing the lumbar puncture outweighs the benefits, the doctor would administer the antibiotics and withhold the lumbar puncture. Decide first whether you need the lumbar puncture. It is safer to do it, but it is going to take at least*

half an hour to do it. That patient could have died in that half hour. You give the antibiotics and then do the lumbar puncture. It will neutralize the bacteria and then when you do the spinal fluid testing it will come back negative.

Dr Aung would have decided that this patient does not have a meningitis. You need neither to do a lumbar puncture or to administer antibiotics."

[93] It is instructive that no member of the Neurology team at the UHWI elected to repeat the lumbar puncture nor did the Consultant in Internal Medicine and Neurology, who is a highly trained specialist, elect to repeat it. It is equally instructive that the medical practitioners at the UHWI did not presume a diagnosis of Meningitis nor did they treat Miss Gayle for it, even in the face of her rapid deterioration, despite being treated adequately for Hemiplegic Migraine with aura. Instead, focus was placed on the diagnoses of Migraine with aura and Complex partial seizures (seizures involving limited areas of the brain and accompanied by reduced awareness of one's surroundings). The Court finds that the omission to repeat the lumbar puncture falls below the expected standard of care which is expected of the UHWI when investigating patients with a meningitis or who may be suspected of having a meningitis.

[94] The Court accepts the evidence of the expert witness Professor Hubert Daisley that the failure to repeat the lumbar puncture led to the untimely death of Miss Gayle; that the raised intracranial pressure and coning of her brain caused by the meningitis was that acute event which occurred on 1 April 2018, at 7:30 p.m.; and that led to the deoxygenation to forty percent (40%), despite her being on oxygen.

ii. The failure to recognize that Miss Gayle was brain dead

[95] The Court finds that the UHWI was negligent in the failure on the part of its servants and/or agents to recognize that Miss Gayle was brain dead on 1 April 2018 at 11:00 p.m.

iii. The plan of treatment for Miss Gayle

[96] The evidence of the rapid deterioration in Miss Gayle's condition in the five (5) days following her admission to the UHWI is concerning. The Court finds that there was no clear plan of treatment, on the part of the servants and/or agents of the UHWI, to treat Miss Gayle, in the face of her rapid deterioration, whilst being admitted as a patient to the UHWI. Nor does there seem to have been a corresponding, commensurate escalation in the UHWI's plan of treatment or course of treatment of Miss Gayle, in the face of her rapid deterioration.

[97] The Court finds that the circumstances of Miss Gayle's presentation at the UHWI and that of her assessment and treatment whilst admitted there, beg the following questions: -

i. Why did Miss Gayle develop recurrent generalized seizures despite being treated adequately for seizures?

ii. What was done for Miss Gayle, by the UHWI, in the face of an obvious infection, evidenced by her increased white blood cells?

iii. Why were Miss Gayle's white blood cells increasing?

iv. Is it the increase in Miss Gayle's white blood cells which led to her seizures?

v. What was done, on the part of the UHWI, to prevent Miss Gayle's recurrent, generalized seizures, which may cause hypoxic brain injury?

vi. Why was Miss Gayle administered Augmentin by the UHWI, where it is expressly noted on the Medical Docket in respect of her that she is allergic to Augmentin?

vii. What caused the rapid deterioration and subsequent death of Miss Gayle, despite being treated adequately for Hemiplegic Migraine with aura?

viii. What accounts for the presence of lymphocytic infiltration in circumstances where Hemiplegic Migraine with aura does not cause the presence of lymphocytic infiltrates?

[98] The Court finds that these questions highlight additional aspects of negligence on the part of the servants and/or agents of the UHWI.

[99] Based on the evidence of the expert witness Professor Hubert Daisley, the Court makes the following additional findings: -

i. The microscopic examination of Miss Gayle's brain confirmed that she suffered a Lymphocytic Meningo-Encephalitis. This was the cause of her headaches, left hemiparesis and fever. This meningoencephalitis could have been diagnosed had a lumbar puncture been performed.

ii. The examination of the lungs did not confirm aspiration pneumonia but instead pulmonary oedema and pleural effusions, most likely due to fluid overload.

iii. Miss Gayle, having been treated adequately for Hemiplegic Migraine with aura, continued to deteriorate and did so rapidly. She developed recurrent, generalized seizures, having a total of eighteen (18) seizures in one (1) night.

iv. The covering of the brain (meninges) was diffusely (all over) infiltrated with lymphocytes, which suggests that Miss Gayle had a viral meningitis, to which she succumbed. That diffuse infiltrate is never seen in migraine. Additionally, there were numerous microglial nodules within the brain matter, which are normal immune cells that are in the brain. They protect the other cells in the brain, such as the nerve cells and the glial cells. When they form nodules such as this in the brain, it suggests that there is some destructive pathological process which is ongoing or some invading organism, such as a virus. These nodules are often seen in viral encephalitis.

v. There was pathology in the brain which was brought about by meningoencephalitis.

vi. Lymphocytes are types of white blood cells. These white blood cells are responsive to injury anywhere in the body.

[100] Having regard to the foregoing, the Court finds that the conduct on the part of the servants and/or agents of the UHWI fell below the standard of care which is expected of the UHWI. Regrettably, the Court finds that the UHWI breached the duty of care which it owed to Miss Gayle in its diagnosis, treatment and management of her and of her presenting symptoms.

iii. Whether the breach of the duty of care by the servants and/or agents of the UHWI caused or materially contributed to the rapid deterioration and the subsequent death of Miss Gayle

[101] Having regard to the foregoing, the Court also finds that the breach of the duty of care by the servants and/or agents of the UHWI caused or materially contributed to the rapid deterioration and subsequent death of Miss Gayle.

ASSESSMENT OF DAMAGES

The approach

[102] Generally speaking,[89] no special principles govern awards of Damages in claims for medical negligence. The general principles relating to the measure of Damages in claims for personal injuries apply.[90] The important consideration in making an award of General Damages is the need to arrive at a figure which will compensate the claimant for the injuries he sustained.

[89] There are, of course, exceptions, such as cases involving failed sterilization.

[90] See – Clerk & Lindsell on Torts, 20th Edition, Chapter 28

[103] There are established principles and a process to be employed in arriving at awards in personal injury matters. In determining quantum, judges are not entitled to simply "pluck a figure from the air". Consistent awards are necessary to inspire and maintain confidence in the system of justice and litigants as well as the public are entitled to know the reasons for the decisions of the court. Regard must be had to comparable cases in which complainants have suffered similar injuries.

[104] In **Beverley Dryden v Winston Layne**,[91] Campbell JA said:

> *"…personal injury awards should be reasonable and assessed with moderation and that so far as possible comparable injuries should be compensated by comparable awards."*

[105] In the case of **Singh (an infant) v Toong Fong Omnibus Co Ltd**,[92] Lord Morris of Borth-y-Gest said: -

> *"…As far as possible it is desirable that two litigants whose claims correspond should both receive similar treatment, just as it is desirable that they should both receive fair treatment. Those whom they sue are no less entitled."*

The Award

General Damages

The Claim made under The Fatal Accidents Act

[106] Mr and Mrs Gayle seek to recover Damages under The Law Reform (Miscellaneous Provisions) Act as well as The Fatal Accidents Act. In the authority of **Margarita Davis (near relation – mother of Andre Davis,**

[91] SCCA No 44/87, judgment delivered on 12 June 1989

[92] [1964] 3 All ER 925, at page 927

deceased) v The Attorney General of Jamaica,[93] Lindo J highlighted the important difference between these two (2) pieces of legislation in the following way: -

> *"[19] The Fatal Accidents Act (FAA) provides a right of action to* ***'near relations'*** *of a deceased person against the person liable in law for his death, while the Law Reform (Miscellaneous Provisions) Act (LRMPA) provides a right of action to the* ***personal representatives of a deceased person for the benefit of the estate of the deceased****, in circumstances where the deceased died due to the unlawful actions of another."*

[107] Sections 2 to 5, inclusive, of The Fatal Accidents Act are relevant for present purposes. The sections provide as follows: -

> *"2(1) In this Act –*
>
> *…*
>
> *'near relations' in relation to a deceased person, means the wife, husband, parent, child, brother, sister, nephew or niece of the deceased person;*
>
> *'parent' includes father and mother and grandfather and grand-mother, and stepfather and stepmother;*
>
> *…*
>
> *'personal representative', in relation to a deceased person means the executor or administrator of the deceased person;*
>
> *3.* ***Whensoever the death of a person shall be caused by wrongful act, neglect or default, and the act, neglect or default is such as would (if death had not ensued) have entitled the party injured to maintain an action, and recover damages in respect thereof, then and in every such case the person who would have been liable, if death had not ensued, shall be liable to an action for damages notwithstanding the death of the person injured***

[93] [2017] JMSC Civ 7

and although the death shall have been caused under such circumstances as amount in law to felony*.*

4.(1) Any action brought in pursuance of the provisions of this Act shall be brought –

(a) by and in the name of the personal representative of the deceased person; or

(b) …

And in either case any such action shall be for the benefit of the near relations of the deceased person.

(2) Any such action shall be commenced within three years after the death of the decease person or within such longer period as a court may, if satisfied that the interests of justice so require, allow.

(3) Only one such action shall be brought in respect of the same subject matter of complaint.

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

(5) In the assessment of damage under subsection (4) the court –

(a) ***may take into account the funeral expenses in respect of the deceased person, if such expenses have been incurred by the near relations of the deceased person****;*

(b) shall not take into account any insurance money, benefit, pension, or gratuity which has been or will or may be paid as a result of the death;

(c) ….".

(emphasis supplied)

[108] It is common ground among the parties that Mr and Mrs Gayle are the parents of Miss Gayle. This fact is noted on the Birth Certificate of Vijae Thalia Gayle, which was received in evidence as an exhibit during the trial of this matter. Mr and Mrs Gayle therefore satisfy the statutory definition of 'near relations' and are classified as near relations of Miss Gayle. There can be no doubt then that Mr and Mrs Gayle possess the requisite locus standi to bring this Claim for any recoverable sums under The Fatal Accidents Act.

[109] Lord Wright,[94] in the authority of **Davies v Powell Duffryn Associated Colliers Ltd**.,[95] pronounced as follows: -

> *"The starting point is the amount of wages which the deceased was earning, the ascertainment of which to some extent may depend on the regularity of employment. Then there is the estimate of how much was required or expended for his personal and living expenses. The balance will give a datum of basic figure which will generally be turned into a lump sum by taking a certain number of years purchase."*

[110] Sinclair-Haynes J (Ag.) (as she then was) in the authority of **Elizabeth Morgan v Enid Foreman & Anor**,[96] referenced the law as outlined in the head note of **Taff Vale Railway Co. v Jenkins**,[97] which reads: -

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[94] Lord Wright also stated: "*There is no question here of what may be called sentimental damage, bereavement or pain and suffering. It is hard matter of pounds shillings and pence, subject to the element of reasonable future probabilities."*

[95] [1942] AC 601

[96] Claim No. HCV 0427/2003

[97] 1913 AC 1

"It is not a condition precedent to the maintenance of an action under the FAA 1846 that the Deceased should have been actually earning money or money's worth or contributing to the support of the Plaintiff at or before the date of the death, provided that the plaintiff had a reasonable expectation of a pecuniary benefit from the continuance of his life."

[111] Lindo J in the authority of **Margarita Davis (near relation – mother of Andre Davis, deceased) v The Attorney General of Jamaica**,[98] opined as follows: -

"[30] … Additionally, it is well known that the calculation of damages arising from fatal accidents or other wrongful causes is by nature a very speculative exercise.

[31] Lord Diplock, in ***Cookson v Knowles*** *[1978] 2 All ER 604 at page 608 discussed the degree of speculation on which a court must embark thus:*

> *'This kind of assessment, artificial though it may be, nevertheless calls for consideration of a number of highly speculative factors, since it requires the assessor to make assumptions not only as to the degree of likelihood that something may actually happen in the future, such as the widow's death, but also as to the hypothetical degree of likelihood that all sort of things might happen in an imaginary future in which the deceased lived on and did not die when in actual fact he did. What in that event would have been the likelihood of his continuing to work until the usual retiring age? Would his earnings have been terminated by death or disability before the usual retiring age or interrupted by unemployment or ill-health? Would they have increased and if so, when and by how much? To what extent if any would he have passed on the benefit of any increase to his wife and dependent children?'*

[112] In the authority of **Reginald Brown (father and near relation of Demory Brown, deceased) & Anor v Balford Douglas & Ors**,[99] the learned judge found that: -

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[98] [2017] JMSC Civ 7

[99] [2013] JMSC Civ 205

"[18] … As was stated in the case – ***Jestina Baxter Fisher & Anor v Enid Foreman & Owen Moss*** *claim no. 2003 HCV 0427 heard 11 and 15/10/04, per Clarke J. at page 24 of his judgment – 'the pecuniary loss in question means the actual financial benefit of which they have been deprived and which it is reasonably probable they would have received if the deceased had remained alive.' In* ***Shaun Baker v O'Brien Brown and Angella Scott Smith*** *(op. cit), the facts were that the deceased died at age 6 years old in a motor vehicle accident in which he was hit down by a bus. A claim was brought by the father of the deceased, for damages under the Law Reform (Miscellaneous Provisions) Act and the Fatal Accidents Act. There was though, no evidence that the claimant in that case was dependent on the 6-year-old, or that he had been deprived of any benefit by his death. The court in reaching the conclusion that the claim could not properly be maintained, reasoned at paragraphs 104 and 105 that:*

> *'An action under the Fatal Accidents Act inures to the benefit of the deceased's dependents at the time of his death. A dependent is a near relative who is able to satisfy the court that at the time of the death of the deceased, he was in receipt of a benefit from the deceased, and the death has deprived him of that benefit…*
>
> ***Loss of support to some degree is essential to success under this cause of action. No near relative can succeed unless they can prove actual dependence on the deceased at or before the time of his death or a probability that they would have received some support from him in the future if he had lived. The mere possibility that a child when grown would have maintained his parents, is not enough****:' **Barnett v Cohen** [1921] 2 KB 461.*

[113] Justice Fraser (as he then was) in the authority of **Ainsworth Blackwood, Snr. (Administrator of Estate: Ainsworth Blackwood Jnr. Deceased) v Naudia Crosskill & Anor**,[100] at paragraphs [45] and [46], made the following pronouncements with regard to the awards of Damages under The Fatal Accidents Act: -

[100] [2014] JMSC Civ 28

> *"[45] A claim under the Fatal Accidents Act is for the benefit of the dependents of the deceased. Therefore, assessment of damages under this Act seeks to ascertain the actual or reasonably expected pecuniary loss to each of the near relations of the deceased by reason of the death of the deceased (Section 4(4)). In order to ascertain the loss therefore, the dependents must satisfy the court that they have lost some benefit as a result of the death of the deceased.*
>
> *[46]* ***The deceased was a child and so there is no actual pecuniary loss to his surviving parent arising from his death since he was not working and making a contribution to him. As a result, the claimant has not been deprived of any pecuniary benefit by reason of the deceased's death. In addition, there is no evidence to indicate that the claimant had a reasonable expectation of some pecuniary benefit had the deceased lived. The portion of the claimant's statement referring to the deceased which indicates that, "He had always in my presence and other persons including family members expressed his intention of taking care of his mother and myself", is not sufficient to establish a pecuniary loss under the Act. There is therefore no basis on which an award can be made under this Act****."*
>
> *(emphasis supplied)*

[114] In the present instance, there is no evidence which has been adduced which indicates that Miss Gayle worked in any capacity prior to her passing. Nor is there any evidence before the Court that she contributed financially to her parents, Mr and Mrs Gayle. Consequently, the Court is unable to find that there was any 'actual' pecuniary loss to the 1st and 2nd Claimants. Having so found, the Court must then determine whether there is any evidence to suggest that there is any 'reasonably' expected pecuniary loss which Mr and Mrs Gayle have suffered as a result of Miss Gayle's untimely death.

[115] The uncontroverted evidence is that, prior to her passing, Miss Gayle was a sixteen-year-old high school student, who lived with her parents. She was regarded by her teachers as being "responsible, competent and committed to excellence", "a keen student who has maintained a high standard of work", "a perceptive and enthusiastic worker who shows tremendous potential" and "an

outstanding student"[101] who consistently attained an overall 'B' average.[102] [103] It is accepted that Miss Gayle had the aptitude to perform well in the May/June sitting of the regional CSEC examinations, in 2018. She was expected to sit nine (9) subjects: English Language, English Literature, Mathematics, Additional Mathematics, French, Spanish, Chemistry, Biology and Principles of Accounts.[104] Posthumously, Miss Gayle received her High School Diploma.[105] It is asserted that Miss Gayle had entrepreneurial ambitions and aspirations to become a scientist or medical researcher.

[116] The Court is unable to make a finding that there was a 'reasonable' expectation of any pecuniary benefit from Miss Gayle to the 1st and 2nd Claimants. Consequently, with respect to section 4(5) of The Fatal Accident Act, the Court will make an award of Damages with respect to the funeral expenses of Miss Gayle, which were incurred by the Mr and Mrs Gayle.

The Claim made under The Law Reform (Miscellaneous Provisions) Act

[117] Mr and Mrs Gayle also seek damages under The Law Reform (Miscellaneous Provisions) Act. It is trite law that a party is not entitled to be doubly compensated or overcompensated. This legal principle has been accepted by Ms Cummings.

[118] For his part, Learned Counsel Mr Matthew Royal, in his Written Submissions, submits that if liability is found, the 1st and 2nd Claimants' Damages are limited to Special Damages for funeral expenses and a conventional sum for loss of life, in

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[101] See – **Exhibit 38**, which contain a copy of a letter from Ms Lorna James-Dobson, the then Fifth-Form Supervisor of Campion College, which Vijae attended from September 2013 to April 2018.

[102] See – **Exhibits 28-34**, which contain copies of Campion College Testimonial of Second Honours for the Academic Years of 2013/2014-2017/2018 for Vijae Gayle.

[103] See **Exhibit 39**, which contain copies of Campion College School Reports dated from 2013 through to 2018, for Vijae Gayle.

[104] See – **Exhibits 35** and **36**, which contain copies of the Caribbean Examination Council (CXC) Candidate Timetable for June 2018 CSEC Administration and the Caribbean Examinations Council – Caribbean Secondary Education Certificate (CSEC) Preliminary Results Slip, both dated June 2018 for Vijae Gayle.

[105] See – **Exhibit 37**, which contains a copy of a Campion College High School Diploma awarded to Vijae Thalia Gayle on 28 June 2018.

the region of Two Hundred Thousand Jamaican Dollars (JMD$200,000.00). It was also submitted that, under the Law Reform (Miscellaneous Provisions) Act, Damages for loss of years, pain and suffering and funeral expenses are recoverable.

[119] Sections 2 and 3 of The Law Reform (Miscellaneous Provisions) Act provides: -

> *"2. (1) Subject to the provisions of this section, on the death of any person after the commencement of this Act all causes of action subsisting against or vested in him shall survive against, or, as the case may be, for the benefit of, his estate:*
>
> *Provided that this subsection shall not apply to causes of action for defamation.*
>
> *(2) Where a cause of action survives as aforesaid for the benefit of the estate of a deceased person, the damages recoverable for the benefit of the estate of that person –*
>
> *(a) shall not include any exemplary damages;*
>
> *(b) …*
>
> *(c) where the death of that person has been caused by the act or omission which gives rise to the cause of action, shall be calculated without reference to any loss or gain to his estate consequent on his death, except that a sum in respect of funeral expenses may be included.*
>
> *(3) No proceedings shall be maintainable in respect of a cause of action in tort which by virtue of this section has survived against the estate of a deceased person, unless either –*
>
> *(a) proceedings against him in respect of that cause of action were pending at the date of his death; or*
>
> *(b) the cause of action arose not earlier than six months before his death and proceedings are taken in respect thereof not later than six months after his personal representative took out representation.*

(4) Where damage has been suffered by reason of any act or omission in respect of which a cause of action would have subsisted against any person if that person had not died before or at the same time as the damage was suffered, there shall be deemed, for the purposes of this Act, to have been subsisting against him before his death such cause of action in respect of that act or omission as would have subsisted if he had died after the damage was suffered.

….

3. In any proceedings tried in any Court of Record for the recovery of any debt or damages, the Court may, if it thinks fit, order that there shall be included in the sum for which judgment is given interest at such rate as it thinks fit on the whole or any part of the debt or damage for the whole or any part of the period between the date when the cause of action arose and the date of the judgment:

Provided that nothing in this section –

(a) shall authorize the giving of interest upon interest; or

(b) shall apply in relation to any debt upon which interest is payable as of right whether by virtue of any agreement or otherwise; or

(c) shall affect the damages recoverable for the dishonor of a bill of exchange."

[120] It is equally clear that Mr and Mrs Gayle possess the requisite standing to bring this Claim for Damages under the The Law Reform (Miscellaneous Provisions) Act, as the duly appointed Administrators ad Litem for the Estate of Miss Gayle.

Pain and Suffering and Loss of Amenities

[121] In calculating an award of Damages under this category of Damages, the Court must consider the findings indicated in the Post Mortem Examination Report, dated 11 April 2018, which indicates that Miss Gayle sustained the following injuries: -

1. Lymphocytic Meningo-Encephalitis
2. Cerebral oedema and hypoxia
3. Necrosis of the cerebellum
4. Metabolic acidosis
5. Hypotension
6. Generalised seizures, clinical
7. Pulmonary oedema, bilateral
8. Pleural effusions, bilateral
9. Ovarian follicular cysts, bilateral
10. Hypoxic ischaemic encephalopathy associated with necrosis of the cerebellum.

[122] The following is also noted in the Post Mortem Examination Report: -

> *"The brain was overweight at 1390g and showed signs of hypoxia (decreased oxygen supply) and oedema (swelling). There were no gross signs of meningitis, masses, infarction (stroke) or bleeding.*
>
> *Brain: The meningeal roll shows marked perivascular and, in some areas, diffuse, lymphocytic infiltrate. Scattered plasma cells and macrophages are admixed. Sections of the cerebrum show a somewhat patchy perivascular infiltrate similar to that described in the meninges. Also noted are numerous microglial nodules within the grey matter. Some of these show evidence of what is interpreted as neuronophagia. Occasional perivascular eosinophils are also seen. No organisms are identified, even with the use of special stains. In addition, no intracellular viral inclusions are identified, and no foci of demyelination is present. The overall features are indicative of a Lymphocytic*

Meningo-Encephalitis: the exact aetiology of which cannot be determined. Hypoxic changes are noted in the cerebellum."

[123] Professor Hubert Daisley opined that Miss Gayle was diagnosed with and suffered from various symptoms during her admission to the UHWI: -

1. Migraine with hemiplegia
2. Meningitis in light of elevated white blood cell count
3. Acute viral illness
4. Left hemiplegic migraine with aura-complex partial seizure
5. Migraine infarct
6. Generalized seizures
7. Aspiration pneumonia
8. Glasgow Coma Scale 3/15

[124] It is also noted that Miss Gayle endured continuous seizures (approximately eighteen (18) seizures) and had two (2) heart attacks, while admitted to the UHWI.

[125] In the circumstances, the Court will focus primarily on the nature and extent of the injuries sustained and the pain and suffering endured by Miss Gayle, prior to her death.

[126] It was submitted that an award for pain and suffering in the sum of One Million Five Hundred and Forty-Seven Thousand Six Hundred and Fifty-Six Dollars and Twenty-Five cents (JMD$1,547,656.25), (having updated the award in the authority of **Elizabeth Morgan** to JMD$221,093.7 x 7 as a daily rate), would be appropriate.

[127] The Court will update the award of Fifty Thousand Jamaican Dollars (JMD$50,000.00), which was made in the authority of **Elizabeth Morgan**. Using the CPI for July 2026, that award updates to Two Hundred and Forty-One Thousand Fifty-Four Dollars and Thirty-One cents (JMD$241,054.31). The Court will also take note of the recurrent, generalized seizures (approximately eighteen

(18) seizures) and the two (2) heart attacks endured by Miss Gayle whilst she was admitted to the UHWI. The Court accepts that an award under this category of Damages necessitates a calculation on the basis of a daily rate. Consequently, the Court makes an award in the sum of One Million Six Hundred and Eighty-Seven Thousand, Three Hundred and Eighty Dollars and Nineteen cents (JMD$1,687,380.19), for pain and suffering.

Loss of Life/Loss of Expectation of Life

[128] L. Pusey J, in the authority of **Hugh Collins (near relation and spouse of Dianne Gordon) & Anor v Sergeant Vassell & Anor**,[106] made the following salient pronouncements with regard to Damages under this head: -

> *"(a) Loss of Life*
>
> *[33] The sum to be awarded for the loss of life is to be conventional on the prevailing authorities. The principle for awarding damages under this heading is established in the case of **Yorkshire Electricity Board v Naylor** [1968] AC 529 where is [sic] was stated that –*
>
> > *'It is to be observed and remembered that the prospects to be considered and those which were being referred to by Viscount Simon L.C. in his speech were not the prospects of employment or of social status or of relative pecuniary affluence but the prospects of "a positive measure of happiness" or of "a predominantly happy life."*
>
> *[34] In the case of **Benham v Gambling** [1914] 1 All ER, it was established that the award of damages for loss of life should not be calculated in an actuarial or statistical way and the Court is to "give what is fair and moderate and to use common-sense." The dictum of Lord Scarman in the case of **Lim Poh Choo v Camden and Islington Area Health Authority** [1979] 2 All E.R. 910 (at p 920) states –*

[106] [2023] JMSC Civ 105

> *'An award for pain, suffering and loss of amenities is conventional in the sense that there is no pecuniary guideline which can point the way to a correct assessment. It is, therefore, dependant only in the most general way on the movement in money values. Like awards for loss of expectation of life, there will be a tendency in times of inflation for awards to increase, if only to prevent the conventional becoming the contemptible.'*
>
> *…*
>
> *[37] …Considering the authorities mentioned herein, in particular the case of Devon Bryan, and having regard to inflation, the Court awards the sum of Two Hundred and Fifty Thousand Dollars ($250,000.00) as a reasonable sum for loss of expectation of life."*

[129] Under this category of Damages, Mr and Mrs Gayle rely on the authority of **Angella Diana Brooks-Grant (Administrator of the Estate of Michael Grant, Deceased) v Western Regional Health Authority and The Attorney General of Jamaica**.[107] There, an award of Two Hundred Thousand Dollars (JMD$200,000.00), was made using a CPI of 87.7 for May 2016. It was submitted that this award updates to Three Hundred and Twenty-Two Thousand and Six Hundred and Ninety Dollars and Ninety-Nine cents (JMD$322,690.99), when using the CPI for July 2025. Conversely, the UHWI contends that an award in the sum of One Hundred and Eighty Thousand Dollars (JMD$180,000.00), is reasonable.

[130] Having carefully considered the authorities of **Angella Diana Brooks-Grant**, **Hugh Collins**, **Landis Blake**[108] and **The Attorney General of Jamaica v Devon Bryan (Administrator of Estate of Ian Bryan)**, the Court will update the award of Two Hundred Thousand Dollars ($200,000.00), which was made under this category of Damages in May 2016 (C.P.I. of 87.7). Using the CPI for June

[107] [2016] JMSC Civ 240

[108] [2020] JMSC Civ 116

2026 of 150.9, this award updates to Three Hundred and Forty-Four Thousand, One Hundred and Twenty-Seven Dollars and Seventy cents (JMD$344,127.70). The Court will make an award of Damages in this sum under this category of Damages.

Lost Years

[131] Learned Counsel Ms Cummings submits that it is undisputed that Miss Gayle was about to complete her studies at Campion College and was projected to perform well on her CSEC examinations. Ms Cummings further submitted that there was a high probability that she would have attended university and ultimately would have become a Scientist/Medical Researcher and an Entrepreneur.

[132] Ms Cummings asserts that awards under this category of Damages often form the bulk of the total sum awarded for Damages by the courts. When a child dies, concerns arise in relation to the ability to prove the vocation that that child would have pursued and how much he would have lost in terms of earnings. To support these submissions, Ms Cummings relied on the authorities of **Gammell v Wilson**[109] and **Wensley Johnson v Selvin Graham and Another**.[110]

[133] It was submitted that a multiplier of 16 would be appropriate because Miss Gayle was 16 years old at the time that she died. Ms Cummings contends that while there is no evidence that Miss Gayle was earning at the time that she died, there is evidence that she had committed her mind towards becoming and had a real prospect of going on to become a Scientist/Medical Researcher and Entrepreneur.

[134] It was further submitted that Miss Gayle was a perennial high achiever in contrast to the child in the **Wensley Johnson** case. It was further submitted that Miss Gayle was a polyglot and that the letter dated 14 July 2018, under the hand of

[109] 1 All ER 578

[110] (1983) 20 JLR 124 (SC)

Mrs Lorna James-Dobson, a Fifth Form Supervisor at Campion College, indicated that Miss Gayle was an 'outstanding student' who was expected to obtain grade ones in the majority of her subjects and a grade two in Additional Mathematics and Biology. While it was admitted that there is no evidence as to her earnings as Scientist or Medical Researcher, Miss Gayle would have at least earned a minimum wage, pursuant to the National Minimum Wage Act, the National Minimum Wage (Amendment) Order, 1975, and the amendments to the latter. This, it was submitted, may be used to determine an appropriate multiplicand which would vary with each amendment. In support of these assertions, Ms Cummings relied on the authorities of **Douglas v Kingston & Saint Andrew Corporation; Luletta Flo Douglas v Kingston & Saint Andrew Corporation & Ors (Consolidated)**.[111]

[135] It was submitted that Miss Gayle's pre-trial earnings, from the time that she would have become an adult on 25 September 2019, to the last trial date of 11 February 2025, would have amounted to Two Million Four Hundred and Forty-Eight Thousand Dollars ($2,448,000.00). Her post-trial earnings would have amounted Eight Million One Hundred and Eighty Thousand Dollars ($8,180,000.00). The total loss to Miss Gayle's estate under this category of Damages would therefore total Ten Million Six Hundred and Twenty-Eight Thousand Dollars ($10,628,000.00). This sum, Ms Cummings contends, may be discounted by one third to account for what Miss Gayle would have spent on herself. That leaves a total of Seven Million Eighty-Five Thousand Three Hundred and Thirty-Three Dollars and Thirty-Three Cents ($7,085,333.33).

[136] In the seminal authority of **Dyer & Anor v Gloria Stone (Executrix, Estate Edward Joslyn Stone)**,[112] Forte JA (as he then was) made the following pronouncements: -

[111] (1981) 18 JLR 338 (SC)

[112] Supreme Court Civil Appeal No: 7/88

"The principles to be applied in assessing damages recoverable by a deceased's estate under this Act for the deceased's loss of earnings in the lost years are in my view clearly and correctly stated in the headnote of the case of Harris v Empress Motors Ltd Cole v Crown Poultry Packers Ltd (1963) 3 All ER 561 as follows –

> *'The following principles are to be applied in calculating the living expenses to be deducted from his net earnings in the lost years in order to reach the amount of recoverable damages:*
>
> > *(i) the ingredients that go to make up 'living expenses' are the same whether the deceased was young or old, single or married, or with or without dependents;*
> >
> > *(ii) the sum to be deducted as living expenses is the proportion of the deceased's net earnings that he would have spent exclusively on himself to maintain himself at the standard of life appropriate to his situation;*
> >
> > *(iii) accordingly, any sums that he would have expended exclusively to maintain or benefit others will not form part of his living expenses and will not be deductible from his net earnings for the purposes of the 1934 Act. However, where the deceased expended the whole living expenses (such as rent, mortgage interest, rates, heating, electricity, gas, telephone etc and the costs of running a car) for the joint benefit of himself and his dependents, a proportion of that expenditure, (the exact proportion being dependent on the number of dependents) should be treated exclusively attributable to his living expenses and thus deductible from his net earnings in making the assessment under the 1934 Act; …"*

[137] In this regard, the Court finds the approach advanced by Learned Counsel Ms Cummings to be both reasoned and reasonable and will adopt the same. The Court will further reduce the sum of Seven Million Eighty-Five Thousand Three

Hundred and Thirty-Three Dollars and Thirty-Three Cents ($7,085,333.33), to reflect the uncertainties surrounding Miss Gayle's future employment and wages.

[138] The Court makes an award in the sum of Six Million Dollars ($6,000,000.00), representing Lost Years.

[139] The Court makes no award of interest on this sum.

Aggravated Damages

[140] An award of Aggravated Damages is usually awarded in circumstances where the defendant's conduct can be considered as being particularly malicious, oppressive, or callous. This award is compensatory, having regard to the manner in which the tort was committed. Although the circumstances of this case are undeniably tragic, the Court finds that there is no evidence of behavior that can be categorized as either malicious, oppressive or callous, on the part of the UHWI.

[141] Consequently, the Court declines to make an award for Aggravated Damages.

Exemplary Damages

[142] The purpose of an award of Exemplary Damages is to punish and deter conduct which ought to be classified as being 'oppressive, arbitrary or unconstitutional', as espoused by the learned judges in the seminal authority of **Rookes v Barnard**.[113] The Court finds that there is no evidence which indicates that there was conduct on the part of UHWI, which may be classified as being oppressive, arbitrary or unconstitutional. Furthermore, an award of Exemplary Damages is made in circumstances where compensatory Damages are insufficient.

[143] Consequently, the Court declines to make an award for Exemplary Damages.

[113] [1964] 1 All ER 367

The approach of the Court in determining whether to grant Damages for Psychiatric Injury

[144] A defendant owes a duty of care to a claimant if he can reasonably foresee that his conduct will expose the claimant to the risk of personal injury, whether physical or psychiatric, even though physical injury does not in fact occur.[114] The authorities are pellucid that damages are not awarded for emotional reactions, such as grief, sorrow, anxiety or distress.[115]

[145] In a claim relating to psychiatric damage only, the law makes a distinction between two categories of victims, namely, primary and secondary victims. Primary victims are those who were immediately or directly involved in the incident and were well within the range of foreseeable physical injury. The primary victim may recover damages for an unforeseeable psychiatric illness, as long as some sort of physical or psychiatric injury was reasonably foreseeable. Secondary victims are those who witness the death of or injury to another person.[116] As well as having to establish that psychiatric injury was a reasonably foreseeable consequence of the act or omission, the secondary victim must satisfy the 'control mechanism' criteria laid down by the House of Lords in **Alcock v Chief Constable of South Yorkshire**.[117]

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[114] See – **Page v Smith** [1996] A.C. 155 – The House of Lords concluded that there is not a separate test for the duty of care for physical and psychiatric illnesses. A defendant will owe a duty of care whenever it is foreseeable that a person would suffer any personal harm, including both physical and psychiatric harm. On the remoteness of damage, the House applied its previous approach, based on the principle that a defendant must take his victim as he finds him, to psychiatric harm. They confirmed that it did not matter that the exact type of psychiatric harm was not reasonably foreseeable. Instead, the claimant only needs to show that it was reasonably foreseeable that he would suffer some form of personal harm.

[115] See – **Alcock and Ors v Chief Constable of South Yorkshire Police** [1992] 1 A.C. 310.

[116] Per Lord Oliver at page 411A-B: "that description must not be permitted to obscure the absolute essentiality of establishing a duty owed by the defendant directly to him – a duty which depends not only upon the reasonable foreseeability of damage of the type which has in fact occurred to the particular plaintiff but also upon the proximity or directness of the relationship between the plaintiff and the defendant."

[117] Per Lord Oliver at p 411F-H, who stated: "*…first, that in each case there was a marital or parental relationship between the plaintiff and the primary victim; secondly, that the injury for which damages were claimed arose from the sudden and unexpected shock to the plaintiff's nervous system; thirdly, that the plaintiff in each case was either*

[146] Furthermore, a defendant who owes a duty of care will only be liable for damages for psychiatric injury if his conduct resulted in a recognized psychiatric injury.[118]

[147] The authority of **Alcock** concerns an accident. Courts have considered whether the principles demarcated by the court in Alcock are applicable in medical negligence cases. The learned judges of the United Kingdom Supreme Court in the authority of **Paul and Anor v Royal Wolverhampton NHS Trust; Polmear and Anor and Royal Cornwall Hospitals NHS Trust; Purchase and Ahmed**[119] summarised the general law on the recovery of damages for psychiatric illness by secondary victims. In this authority, the United Kingdom Supreme Court considers three cases on appeal where the unsuccessful claimants either witnessed a close family member dying, or witnessed a close family member shortly after their death, in shocking circumstances. In those instances, the deaths were caused by negligent failures to diagnose life threatening medical conditions and concerned the scope of the responsibilities of a medical practitioner as well as the purposes for which care is provided. The judges with the majority view opined that the cope of responsibilities does not normally extend to protecting members of the patient's close family from exposure to the traumatic experience of witnessing the death or manifestation of disease or injury in their relative. The learned judges summarised the state of the law as follows: -

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personally present at the scene of the accident or was in the more or less immediate vicinity and witnessed the aftermath shortly afterwards; and fourthly, that the injury suffered arose from witnessing the death of, extreme danger to, or injury and discomfort suffered by the primary victim. Lastly, in each case there was not only an element of physical proximity to the event but a close temporal connection between the event and the plaintiff's perception of it combined with a close relationship of affection between the plaintiff and the primary victim." See also, paragraph 179 of **Paul and Anor v Royal Wolverhampton NHS Trust; Polmear and Anor and Royal Cornwall Hospitals NHS Trust; Purchase and Ahmed** [2024] UKSC 1, per Lord Leggatt and Lady Rose

[118] See – **White and Ors v Chief Constable of the South Yorkshire Police and Others** [1999] 1 All ER 1 and **Page v Smith** (supra)

[119] [2024] UKSC 1

"179. … There is no need on these appeals to consider the details of those leading cases because the important elements of the general law laid down in those cases are not in dispute. They can be stated, in summary form, as follows:

> *(i) The underlying question is whether the defendant owed a duty of care to the claimant (the secondary victim) not to cause that person a recognised (or recognisable psychiatric illness consequent on the death, injury or imperilment of the primary victim.*
>
> *(ii) The claimant (the secondary victim) must suffer a recognised psychiatric illness as distinct from mental distress (which includes upset, grief and anxiety).*
>
> *(iii) It must have been reasonably foreseeable to the defendant that the claimant, as a person of reasonable fortitude, might suffer a psychiatric illness as a result of the defendant's negligent conduct which has led to the death, injury or imperilment of the primary victim.*
>
> *(iv) There are four additional proximity factors, or controls, that the claimant must establish. Assuming for present purposes that the relevant event (i.e. the event that has resulted in the secondary victim's psychiatric illness is an accident (which is the paradigm situation although whether the relevant event must be an accident is the central question in dispute in these appeals), these proximity factors, or controls, can be expressed as follows. First, that the claimant had a close tie of love and affection with the primary victim. Secondly, that the claimant was close to the accident in time and space or came across its immediate aftermath. Thirdly, that the claimant directly perceived the accident through his or her own unaided senses (rather than, for example, hearing about it from a third party). Fourthly, that the psychiatric illness was caused by a shock to the system: that is, the accident must have been shocking and horrific. As regards that last element, in Alcock, Lord Ackner said, at p 401: "Shock', in the context of this cause of action, involves the sudden appreciation by sight or sound of a horrifying event, which violently agitates the mind. It has yet to include psychiatric illness caused by the accumulation over a*

period of time of more gradual assaults on the nervous system." And, in the words of Lord Oliver in Alcock at p 411, there was a requirement that "the injury for which damages were claimed arose from the sudden and unexpected shock to the plaintiff's nervous system".

[148] In delivering the majority decision of the court, Lord Leggatt and Lady Rose made the following salient pronouncements: -

*"**Duties owed by doctors to non-patients***

134. There are circumstances in which the duty of care owed by a medical practitioner may extend beyond the health of their patient to include other people.

Family members who witness a patient's medical crisis

136. Here the question is whether a doctor who owes a duty of care to a patient also owes a duty to members of the patient's close family to take care to protect them against the risk of illness from the experience of witnessing the medical crisis of their relative arising from the doctor's negligence.

*137. **It cannot be said that a doctor who treats a patient thereby enters into a doctor-patient relationship with any member of the patient's family and thereby assumes responsibility for their health. As regards other factors relevant to whether the necessary relationship of proximity exists, the extent of the control which a doctor may be seen as having over the risk of injury to members of the patient's family and the directness of the causal link between the doctor's negligence and the materialisation of that risk will depend upon the particular facts of the case.***

138. Common to all cases of this kind, however, is a fundamental question about the nature of the doctor's role and the purposes for which medical care is provided to a patient. We are not able to accept that the responsibilities of a medical practitioner, and the purposes for which care is provided, extend to protecting members of the patient's close family from exposure to the traumatic experience of witnessing the death or manifestation of disease or injury in their relative. To impose such a responsibility on hospitals and doctors would go

beyond what, in the current state of our society, is reasonably regarded as the nature and scope of their role.

139. ***There is no doubt that witnessing the death from disease of a close family member can have a powerful psychological impact additional to the grief and deep distress caused by the fact of the death. Whether that impact is damaging or may even help the grieving process must depend on many factors, including the vulnerability and circumstances of the individual who witnesses the event and the place, time and other circumstances in which the death occurs. The experience of seeing a person die or discovering their dead body is rarer today than it once was. Most deaths in the United Kingdom now occur in hospitals or other institutions such as care homes. But although social attitudes and expectations may be changing, we would not accept that our society has yet reached a point where the experience of witnessing the death of a close family member from disease is something from which a person can reasonably expect to be shielded by the medical profession. That is so whether the death is slow or sudden, occurs in a hospital, at home or somewhere else, and whether it be peaceful or painful for the dying person. We do not mean in any way to minimise the psychological effects which such an experience may have on the person's parent, child or partner when we express our view that, in the perception of the ordinary reasonable person, such an experience is not an insult to health from which we expect doctors to take care to protect us but a vicissitude of life which is part of the human condition.***

*…****the persons whom doctors ought reasonably to have in contemplation when directing their minds to the care of a patient do not include members of the patient's close family who might be psychologically affected by witnessing the effects of a disease which the doctor ought to have diagnosed and treated. Hence there does not exist the proximity in the relationship between the parties necessary to give rise to a duty of care.****"*

(emphasis supplied)

[149] Regrettably, this Court is of the view that the Claimants have not established their claim for psychiatric damages as secondary victims. The Court finds that there did not exist a proximate relationship between the 1st and 2nd Claimants (in their personal capacities) and the UHWI, which would enable the former to sustain a claim for psychiatric Damages as secondary victims.

[150] Consequently, the Court makes no award in this regard.

Special Damages

[151] It is trite law that Special Damages must be specifically pleaded and specifically proved for the Court to be able to make such an award.

[152] Mr and Mrs Gayle have produced in evidence a total of thirteen (13) receipts and invoices,[120] with respect to the funeral expenses which they allege that they incurred to bury Miss Gayle.

[153] On that basis, the Court makes an award in the sum of Nine Hundred and Seventy-Five Thousand, Five Hundred and Seventy-Three Dollars and Forty-One cents (JMD$975,573.41). The 1st and 2nd Claimants are entitled to this award pursuant to section 4(5) of The Fatal Accidents Act.

[154] The Court makes an award of Eight Thousand United States Dollars (USD $8,000.00), in respect of the Expert Report prepared by Professor Hubert Daisley.[121]

[155] The Court makes no award for the cost of legal consultation for the reason that the 1st and 2nd Claimants have not provided the Court with an evidential basis on which such an award might be made.

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[120] See – **Exhibits 41 – 53**, which contain copies of receipts and invoices for funeral related expenses incurred by the Claimants for the burial of their daughter, Miss Vijae Gayle.

[121] See – **Exhibit 87**, which contains the Invoice of Professor Hubert Daisley dated 21 August 2018. This Exhibit is contained in Binder No. 4 – Agreed Documents, which was filed on 10 September 2024.

DISPOSITION

[156] It is hereby ordered as follows: -

1. On the issue of liability, the Court enters judgment for the 1st and 2nd Claimants against the Defendant, on the aspect of the Claim which is brought by the 1st and 2nd Claimants in their representative capacities as Administrators Ad Litem for the Estate of Vijae Gayle, Deceased, Intestate.

2. Special Damages are assessed and awarded to the 1st and 2nd Claimants against the Defendant as follows: -
    i. Nine Hundred and Seventy-Five Thousand, Five Hundred and Seventy-Three Jamaican Dollars and Forty-One cents (JMD$975,573.41), representing the funeral expenses of Miss Vijae Thalia Gayle, pursuant to The Fatal Accidents Act, with interest thereon at the rate of three percent (3%) per annum from 5 April 2018 to the date hereof.
    ii. Eight Thousand United States Dollars (USD $8,000.00), representing the cost of the Expert Report prepared by Professor Hubert Daisley, with interest thereon at the rate of three percent (3%) per annum, for 5 April 2018 to the date hereof.

3. General Damages are assessed and awarded to the 1st and 2nd Claimants against the Defendant, pursuant to The Law Reform (Miscellaneous Provisions) Act, as follows: -
    i. One Million Six Hundred and Eighty-Seven Thousand, Three Hundred and Eighty Jamaican Dollars and Nineteen cents (JMD$1,687,380.19), for pain and suffering, with interest thereon at the rate of three percent (3%) per annum from 15 April 2021 to the date hereof.

ii. Three Hundred and Forty-Four Thousand, One Hundred and Twenty-Seven Jamaican Dollars and Seventy cents (JMD$344,127.70), for loss of life/loss of expectation of life, with interest thereon at the rate of three percent (3%) per annum from 15 April 2021 to the date hereof.

iii. Six Million Jamaican Dollars (JMD$6,000,000.00), for lost years. The Court makes no award of interest on this sum.

4. The Court makes no award for Aggravated Damages.

5. The Court makes no award for Exemplary Damages.

6. Costs, in relation to the aspect of the Claim which is brought by the 1st and 2nd Claimants in their representative capacities as Administrators Ad Litem for the Estate of Vijae Gayle, Deceased, Intestate, are awarded to the 1st and 2nd Claimants against the Defendant and are to be taxed if not sooner agreed.

7. On the issue of liability, the Court enters judgment for the Defendant against the 1st and 2nd Claimants, on the aspect of the Claim which is brought by the 1st and 2nd Claimants in their personal capacities.

8. Costs, in relation to the aspect of the Claim which is brought by the 1st and 2nd Claimants in their personal capacities, are awarded to the Defendant against the 1st and 2nd Claimants and are to be taxed if not sooner agreed.

9. The 1st and 2nd Claimants' Attorneys-at-Law are to prepare, file and serve these Orders.