IN THE COURT OF APPEAL FIJI ISLANDS
ON APPEAL FROM THE HIGH COURT OF FIJI

CIVIL APPEAL NO. ABU0015 OF 2006S
(High Court Civil Action No. HBC 266 of 2003L)

BETWEEN: **INDIRA WATI**

Appellant

AND:

1. **ATTORNEY GENERAL**
2. **SHIREEN AIYUB**
3. **LOSANA BURUA**

Respondents

Coram: Ward, President
Barker, JA
Scott, JA

Hearing: Tuesday, 27th February 2007, Suva

Counsel: S. Maharaj for the Appellant
A. Tuilevuka]
P. Prasad] for the Respondents

Date of Judgment: Friday, 9th March 2007, Suva

JUDGMENT OF THE COURT

Introduction

[1] The appellant is the widow of the late Raj Kumar Singh (father's name, Nabu Singh) ('the deceased'). On her own behalf and as administratrix of the estate of the deceased, she brought action in the High Court at Lautoka under both the Compensation to Relatives Act (Cap.29) and the Law Reform (Miscellaneous

Provisions) (Death and Interest) Act (Cap.27), seeking damages in respect of the death of the deceased at the Nadi Public Hospital on 23 March 2002.

[2] She sued the Attorney-General, as representing the State which operated the hospital, and two medical practitioners employed at the hospital. She claimed that the death of the deceased had been caused by his mistreatment whilst in the care of the hospital.

[3] In an interim judgment delivered on 16 September 2005 after a 3 day hearing, Finnigan J reviewed the evidence. He found that no negligence had been proved against the second respondent (Dr Aiyub) but that the third respondent (Dr Burua) had been blatantly negligent by any standard of hospital care. In the Judge's words ***"... they abandoned the deceased after his admission with suspected coronary disease and simply did not take care of him."***

[4] The Judge however found, on the balance of probabilities, that the death of the deceased from acute inferior myocardial infarction, two days after his admission to hospital, had not been caused by the respondents' breach of duty properly to have treated him. The cause of death, according to the Judge, was a condition in the deceased's body. The appellant had not proved that any breach of duty had supplanted his heart condition as the cause of death nor had the appellant proved ***"failure to do some act that would have prevented it."***

[5] The appellant submitted that the second respondent should have been found negligent by the Judge. However, counsel did not pursue this ground of appeal, in view of the very clear finding of negligence against the third respondent. A finding of negligence against the second respondent would not have made any difference to the outcome. The Judge had seen and heard the witnesses and was entitled to find that the second respondent had not been negligent.

[6] Finnigan J issued a final judgment on 3 February 2006 after considering further submissions based on his earlier finding that the respondents' negligence did not cause the death. He declined to make an award under Cap.29 and awarded damages as follows:

(a) to the appellant personally, $5,000 plus interest for mental anguish.

(b) to the appellant as administratrix $15,000 plus interest for the suffering of the deceased.

(c) costs of $3,000 a figure reached summarily, after holding that the appellant was entitled to indemnity costs because, he said, she should never have been put in the position of bringing the proceedings.

[7] Although the quantum of the award of pain and suffering for a period of only two days seems high, there was no cross-appeal over any of the damages findings. Essentially, the appellant challenges Finnigan J's finding that the negligence of the respondents did not cause the death. If that finding were overturned, damages under Cap.29 would have to be assessed. She also challenges the quantum of the costs award.

The Facts

[8] There is no dispute over the facts as recorded in the judgment. The challenge is to the proper inferences to be drawn from the proven facts, a task which this Court is as qualified to undertake as the trial judge. Curiously, it was the respondents who called the only significant medical evidence. This came from a Doctor Baravilala, a specialist in internal medicine at Lautoka Hospital. The appellant's case would not have been be so strong had Dr Baravilala had not been called by the respondents. Dr Baravilala stated in cross-examination that he had first been approached to give evidence by lawyers for the respondents on the evening before he testified. His

evidence did not assist the respondents on the question of negligence and it is therefore hard to see why they called him.

[9] The appellants called a Doctor Goundar, a general practitioner from Lautoka with qualifications in pathology. He really added little to the store of knowledge that had been provided by other witnesses. He opined that the deceased should have been better managed and produced extracts from a textbook about the initial management of patients presenting with cardiological problems.

[10] The essential findings of fact are summarised by the Judge as follows:

> *"(1) The deceased was a hard-working and successful man, popular among those who knew him, both in the family context and the work environment. His qualities as husband, father, friend and tradesman were valued highly by the witnesses.*
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> *(2) The cause of his death was acute inferior myocardial infarction.*
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> *(3) This was a physiological condition which may be caused or accelerated by pre-conditioning risk factors. The deceased displayed several of those risk factors. It was a physiological condition of the deceased alone, not a condition caused or contributed to by any of the Defendants. Their function throughout was to treat and alleviate this condition, i.e. to reduce his pain, keep him sedated and prevent his death, if his death was preventable, using the resources that they had available. In this, they were bound to observe a certain standard of care which is imposed by law.*
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> *(4) There is a standard treatment once this condition occurs. Its purpose is to stabilise the condition, which is monitored by reading the "vital signs." Thus the patient must be sedated immediately, given muscle relaxant medication, kept still, deprived of stimulation and constantly monitored. This must be maintained for the first twenty-four hours at least. By the evidence, this is the treatment. Little or nothing more can be done.*
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> *(5) The deceased was exhibiting some signs of cardiac failure for more than twenty-four hours before cardiac failure was diagnosed by the Third Defendant, and the first diagnosis, in the evening of Thursday 21 March 2002, in hindsight was wrong. It favoured gastric upset but on balance from the evidence, this was not in breach of a duty*

of care. The Second Defendant prescribed angina medicine as well as gastric medicine and the deceased appeared to improve. The "non-Q" indication given by the ECG on the morning of Saturday 23 March indicated that the tissue damage from the right inferior blockage had commenced only a matter of hours before, so that there was by that time no muscle death.

(6) *From that point on, the treatment of the deceased as patient was badly mismanaged. The Nadi Hospital has no cardiac unit, and on Saturday 23 March 2002, it seems to have had a shortage of medical staff. What was done or not done was the responsibility of the Third Defendant. There was a serious breakdown of communication between the Third Defendant and the patient's family. The result of this was that any treatment and monitoring of the patient was provided by the family, who had no idea at all in their heads about administration of sedative painkillers or about the necessity for quiet, for muscle relaxation and rest. They did not, and could not be expected to, provide those essential ingredients of the treatment.*

(7) *Thus, the last twelve hours of the life of the deceased was a time of almost unbearable pain for him and deep stress and frustration for his wife and other family members. This pain and stress was caused primarily by the Third Defendant. It could have been avoided had the treatment of the patient been kept by the Third Defendant under her control.*

(8) *The defendants did not by negligence cause this death I cannot hold that they failed to prevent it.*

(9) *Although the patient suffered pain for much of the twenty-four hours preceding his admission there is startling conflict in the evidence about whether the Defendants should have detected and diagnosed heart failure in that period. I make no finding. The evidence of even the Defendants however suggests that in another place and at another time he would have been admitted for observation and care on suspicion of heart failure at least twenty-four hours before he was. This care would at that stage have been palliative, to allow the patent's own body to stabilise itself and, if it was able, to recover. It may or may not have improved the chances of recovery, I do not know; but properly handled it should have reduced the pain."*

[11] The Judge summarised Dr Baravilala's evidence as follows:

"I accept the evidence that was given for the Defendants by Dr Tevita Baravilala. He is a specialist in internal medicine, currently at Lautoka

Hospital. At the time of the hearing he was acting Consultant Physician. His responsibilities included cardiac cases. He said there are no practicing cardiologists in Fiji. His evidence was that the Third Defendant's admitting notes, diagnosis and prescribed medication all indicated that the patient had suffered an acute inferior myocardial infarction. The "non-Q" reading indicated that the blockage had occured recently, perhaps only hours before. He had suffered a very acute injury which at the stage of admission had not resulted in any heart muscle death. Death of heart muscle was the next great risk to the patient's life and needed to be avoided at all costs. He gave the statistics for acute inferior myocardial infarction patients, saying fifty percent to sixty percent of them die en route to hospital before anything can be done for them. The survival rate increases dramatically once the patient is admitted to a coronary care unit, the mortality rate falling to about three percent. The single most important ingredient of hospital care is complete rest. He told the Court that the drugs prescribed by the Third Defendant were the normal drugs prescribed to achieve that result. The patient was intended to be immobile, sleeping and relaxed. He must be sedated. There must be no visitors in the first twenty-four hours. At Lautoka Hospital they provide one nurse dedicated to one cardiac patient to monitor vital signs in that first twenty-four hours and to call the doctor if there is any change. This is so even if it reduces staff elsewhere in the hospital.

He told the Court that the most frequent cause of death in these cases is arrhythmia in cases of acute inferior heart attack. The right coronary artery is blocked, the pace maker mode is affected and there is thus greater risk than in other cases of abnormal rhythm. The prescription for bed-rest is absolute in the first twenty-four hours.

Any disturbance may set off the arrhythmia. Disturbance includes visitors, sitting up for meals, going to the toilet. etc. Toilet functions if any are performed in bed. Once admitted these patients do not travel within the first twenty-four hours. Even lifting them from a bed on to a trolley is to be avoided as that may set off arrhythmia and bring on death. The care given in the first 24 hours is critical to survival. The patient's surroundings must be orderly, peaceful, quiet, restful and silent.

Vital signs he said should be checked half hourly and recorded on the nursing notes. Morphine at the dose prescribed by the Third Defendant could be administered every fifteen or twenty minutes.

This witness gave evidence also of risk factors. The major risks for heart disease he said were smoking, high blood pressure, heredity, diabetes and stress. Males in their mid-50s were statistically at risk from that factor also. Looking at the patient notes he commented on the history given by or for the deceased. His age was 55 years and five months. His brother had had

a heart attack, his younger brother had high blood pressure. He smoked cigarettes. His blood sugar reading had been higher than normal heart attack stress would cause, this was to have been monitored but death had intervened. The patient may have been a little overweight."

[12] There was no medical evidence before the Judge giving any view on whether the deceased was more likely than not to have died had he been given the proper care after his admission to hospital. There is no problem about whether these were appropriate facilities at a small Fijian hospital. The evidence was clear that 24 hour complete bed-rest was called for, but it was not provided. The Judge had some evidence from Doctor Baravilala about statistics for acute myocardial infarction patients. These came from the United States and were quoted by the doctor without providing any reference to any learned publication and without any better breakdown of the statistics as to age, sex, ethnicity, prior history and the like.

Submissions

[13] There were detailed submissions filed by the appellant on the liability of the respondents but none on causation of death. The respondent submitted *res ipsa loquitur*. Put another way: the deceased did not receive the proper treatment even though his heart was already seriously damaged: the deceased died after he failed to receive proper treatment from the appellants: therefore, the appellants' negligence cause his death. This was far too simplistic an approach. There was no submission in this Court or the High Court on what chance of living the deceased would have had, if he had been given the appropriate treatment.

[14] The respondent's submissions in both Courts also failed to address this important question. At the conclusion of his submissions, counsel for the respondents referred to the House of Lords decision in ***Gregg v Scott*** [2005] 4 All ER 812. He made few submissions on the case but later supplied a copy of the decision to the members of the Court. The decision was not referred to Finnigan J. This is not

surprising given that it would not have been available at the time of the hearing before him. The case is very important with basic similarities to the instant case.

Discussion

[15] In ***Gregg v Scott***, the essential facts were set out by Lord Hoffman at 827-8 as follows:

> "*The Facts*
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> *(61) My Lords, this is an action against a doctor for negligence in failing to recognize that his patient might have cancer. When Mr Gregg showed Dr Scott a lump under his arm, the doctor told him it was a collection of fatty tissues. That was the most likely explanation but unfortunately it was wrong. Mr Gregg had cancer of a lymph gland. This was discovered a year later, when another GP referred him to a hospital for examination. By that time, the tumour had spread into his chest. He suffered a good deal of pain and had to undergo a particularly debilitating course of high dose chemotherapy. The treatment temporarily destroyed the tumour but was followed by a relapse which left Mr Gregg with a poor prospect of survival.*
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> *The Claim*
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> *(62) Mr Gregg alleged in his particulars of claim that Dr Scott ought to have referred him to a hospital for examination. His 'particulars of pain and injury' alleged that if he had been diagnosed earlier 'there would have been a very high likelihood of cure: I shall come back in a moment to what, in this context, was meant by a cure. In the event, he said, the prospects of obtaining a cure had been reduced to below 50%.*
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> *The Judge's Findings*
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> *(63) The judge found that Dr Scott had been negligent in excluding the possibility that the growth might not be benign. A routine reference to a hospital would have settled the matter. There has been no challenge to this finding.*
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> *(64) The question which has given rise to this appeal is whether Dr Scott's negligence caused injury to Mr Gregg. As I have said, the injury of which he complained was that the delay had reduced his prospect of a*

> ***cure to less than 50%. The expert witnesses treated a cure as meaning survival for more than ten years. They produced statistical evidence about the progress of the disease in other patients. The judge summarized the effect of this evidence by finding that if Mr Gregg had been treated earlier, the cancer would probably not have spread as quickly as it did. The treatment would probably have produced a remission. But a remission might have been followed by a relapse and the probability was that someone with Mr Gregg's condition would either not have responded to treatment or, if he did respond, would afterwards have relapsed. In statistical terms, the evidence showed that, out of 100 patients suffering from a similar condition, only 42 would, even if treated immediately, survive more than ten years. The rest would have died earlier, either because they were part of the minority which did not respond to treatment or because, having responded, they then relapsed. What the delay had done, according to the experts, was to reduce the chances of survival for more than ten years even further, from 42% to 25%.***
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> ***(65) On this evidence the judge held that the delay had not deprived Mr Gregg of the prospect of a cure because he would probably not have been cured anyway. He therefore dismissed the action.***

[16] The House of Lords was divided 3-2 on the issue whether the prospect of a favourable outcome ('loss of a chance') can be a recoverable head of damages. The majority held that that principle cannot apply to cases of clinical negligence. The facts of ***Gregg's*** case differ from the present in that the patient here did not survive, whereas Mr Gregg was alive at the date of hearing. Moreover, Mr Gregg suffered from cancer, whereas the deceased had a heart condition. However, the principle is applicable to all cases of medical negligence where there has been a negligent failure either to diagnose or to treat properly.

[17] Lord Hoffman distinguished cases where proven damage can be attributable to the defendant's wrongful act (829). He approved the following formulation from another case: ***"The rule against recovery of uncertain damages is directed against uncertainty as to cause rather than as to the extent or measure."*** He later said: ***"It is true that the delay caused an early spread of the cancer and that this reduced his percentage chance of survival for more than ten years. But to say that the claimant can therefore obtain damages for the reduction in his chances of survival***

assumes that a reduction in the chance of survival is a recoverable head of damage." He held that there was no such claim tenable in law.

[18] In ***Gregg's*** case, it was said that the negligent doctor may have caused a reduction in the patient's expectation of life and increased the likelihood that his life would be shortened by the disease. Similarly, if the argument of the appellant here is to succeed, it must be her case that the respondents' negligence caused a reduction in the deceased's expectation of life or else deprived him of the chance of living longer. A similar argument failed in ***Gregg's*** case and must fail here if the majority in ***Gregg's*** case is followed.

[19] In **Gregg's** case, both sides employed medical experts who reached a measure of agreement. One of these gave evidence at trial. The statistical evidence was sophisticated but even so, it was found wanting. The trial judge commented: ***"The 100 patients in the worked example include all ages and people with other unrevealed personal characteristics, one of which is the stage of the disease at diagnosis."***

[20] Lord Phillips, also of the majority, was prepared to accept that the expert's model evidenced Mr Gregg's statistical chances at the time when his treatment should have commenced. However, it did not follow that the difference between this and Mr Gregg's actual prognosis at the time of trial was attributable to the delay in starting his treatment. The expert's model gave no indication of the factors that would determine what would befall an individual member of the statisitical cohort.

[21] Lord Phillips at 850 adopted the following words of Mance, LJ in the Court of Appeal:

> ***"the most obvious influencing factors are, one would suppose, internal to the claimant at the time of the negligence, however unknown or unknowable they may be; and they consist of the precise characteristics, development and spread of the cancerous cells at the time of the negligence as well as the claimant's precise physical characteristics and***

resistance. Other influencing factors may very well include subsequent events such as the particular medical treatment received, the patient's subsequent life-style and his or her, or indeed others', reaction to the stress inevitably incurred."

[22] Baroness Hale, another of the majority said at 862: ***"Doctors do not cause the presenting disease. If they negligently fail to diagnose and treat it, it is not enough to show that a claimant's disease has got worse during the period of delay. It has to be shown that treating it earlier would have prevented that happening, at least for the time being."***

[23] The above quotation encapsulates the problem in this case. The appellant here had to show that treating the deceased earlier would have prevented his death when it occurred. The evidence, such as it was, stopped short of proving that.

[24] The opposing arguments in favour of giving damages for 'loss of a chance' of survival or of increased expectation of life if the negligence had not occurred, are attractively expressed in the speeches of the minority in the House of Lords. There is much to be said in favour of extending the law as suggested by Lords Nicholls and Hope who comprised the monority in ***Gregg's*** case. However, for the sake of consistency in the common law, we consider that this Court should follow the majority decision of the highest Court in the United Kingdom.

[25] Accordingly the appeal must be dismissed. The judgment of Finnigan J is upheld but on different grounds. The amount of costs awarded to the appellant in the High Court will stand.

[26] We cannot agree with Finnigan J that the appellant should not have been ***"put in the position of bringing these proceedings."*** We would agree if all he were saying was that the appellants should not have resisted a finding of negligent treatment. Although both counsel failed to focus on causation, the respondents were entitled to oppose an award of damages under Cap 29 on the ground that their negligence

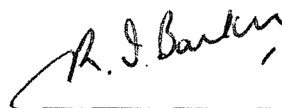
did not cause the death. We therefore decline to vary the costs order which the Judge made of $3,000.

[27] Both sides failed to appreciate the difficult issue in this case. Accordingly, we make no order as to costs in this Court.

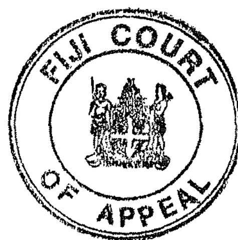
Result

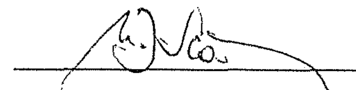
[28] Appeal dismissed.

Ward, President



Barker, JA





Scott, JA

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