IN THE COURT OF APPEAL, FIJI

[On Appeal from the High Court]

CIVIL APPEAL NO. ABU 003 of 2021

[High Court Civil Case No. HBC 237 of 2016L]

BETWEEN : **THE PERMANENT SECRETARY FOR HEALTH**

1st APPELLANT

THE ATTORNEY GENERAL

2nd APPELLANT

AND : **KITIONE WAQA WILKINSON**

RESPONDENT

Coram : **Basnayake, JA**
Lecamwasam, JA
Jameel, JA

Counsel : **Mr J. Mainavolau for the Appellants**
Mr K. Maisamoa for the Respondent

Date of Hearing: **07 February 2023**

Date of Judgment: **24 February 2023**

JUDGMENT

Basnayake, JA

[1] I agree with the reasoning and conclusions arrived at by Lecamwasam, JA.

Lecamwasam, JA

[2] This appeal is preferred against the judgment of the learned High Court Judge at Lautoka dated 07th December 2020. A brief exposition of the factual background is as follows:

Viliame Tiko (the Respondent before this court) is the father of the deceased child who was born on 24th March 2013. At the time of death, the deceased was approximately 2 years of age. On 12th April 2015, the deceased had been injured as a result of a wooden splint piercing the underside of his tongue. The father of the deceased had taken the child to the Ba Health Centre on 13th April 2015 where Biudole Sokia, the staff nurse who was on duty had initially attended to the deceased but had not referred the matter to the doctor. The staff nurse had given him 2 bottles of 'pink coloured fluid' and had advised the father to make the child gargle with warm salt water. She had also asked the father to bring the child back for further medical treatment if the condition worsens. Having taken the child back home, the father had administered the prescribed medication with the aid of a syringe.

[3] However, as the condition of the child deteriorated he was taken back for further medical care to the Ba Health Centre on 15th April 2015, by which time the wound had infected, swollen, and had been causing pain. On this second visit, Sokia, the same nurse had referred the deceased child to Dr. Renita. Dr Renita in-turn had referred the child to the X-ray room and had advised the Respondent father to rush the child to the Lautoka Hospital. Dr Renita, and one of the nurses had also accompanied the Respondent to Lautoka Hospital. Even though the child had been treated at the Lautoka hospital, he had unfortunately succumbed to the infection on the following day, i.e.16th April 2015. Thereupon, the Respondent sued the Defendant-Appellant (hereinafter referred to as the Appellant) for medical negligence

of his servants, agents, and employees and claimed special damages, general damages, punitive damages, costs and interest etc.

[4] The Appellants, by way of affidavits filed by the Consultant Paediatrician and the acting Medical Superintendent, *inter alia* denied any negligence on their part, subsequent to which, the trial commenced. At the trial before the High Court, the Respondent had called 2 witnesses while the Appellants had called 4 witnesses. The parties had also filed written submissions, upon which the learned judge entered judgment and made the following orders;

1. *The defendants shall pay a sum of $168,260.00 to the plaintiff as compensation.*
2. *The defendants shall also pay summarily assessed costs of $3,000.00 to the Plaintiff.*

[5] Being aggrieved by the above decision, the Appellants filed the instant appeal on the following grounds of appeal:

1. *The Learned Judge erred in law and in fact in finding the Appellants liable for medical negligence in the death of the Appellant Kitione Waqa Wilkinson.*
2. *The Learned Judge erred in law and in fact in awarding the sum of $25,000.00 (twenty five thousand dollars) to the Respondent for general suffering.*
3. *The Learned Judge erred in law and in fact in awarding excessive and disproportionate damages in the sum of $132,000.00 (one hundred thirty two thousand dollars) to the Respondent for loss of earnings and not taking into account the Respondent's very young age.*
4. *The Learned Judge erred in law and in fact in awarding the sum of $10,000 (ten thousand dollars) to the Respondent as exemplary damages plus a further $3000.00 (three thousand dollars) being for costs.*
5. *The Learned Judge erred in fact as follows:*
    - *The Learned Judge wrongly disregarded staff nurse Biudole Sokia's (DW1) evidence on the Respondents father (PW1) not informing her about the Respondent's fall when the Respondent first visited Ba Health Centre on 13 April 2015.*

- *The Learned Judge wrongly elected to accept PW1's evidence over DW1's evidence by holding that on 13 April 2015, PW1 had told DW1 of the Respondent's fall. The correct position is that PW1 did not tell DW1 of the Respondent's fall on the above date.*
- *The Learned Judge wrongly assessed Senior Medical Officer Doctor Renita Maharaj (**DW2)** as saying that it is not the practice in Fiji to give a two year old child salt water to gargle with despite DW2 evidencing in trial that same was indeed the practice.*
- *The Learned Judge disregarded DW1's evidence on the treatment of the Respondent and wrongly elected the evidence of Josefa Koroivueta (**PW2**) over DW1's in regard the Intergrated Management of Childhood illness (**IMCI**) guidelines and their applicability to the Respondent's case despite DW1 being an IMCI nurse and PW2 having no expertise knowledge in IMCI.*
- *The Learned Judge reached the wrong conclusion that the Respondent's blood count was done at Ba Health Centre despite DW2's evidence that the Respondent's Blood Count were done at Lautoka Hospital. The Learned Judge disregarded DW2's evidence that when a patient is transferred from a sub divisional hospital to a divisional hospital, the blood count is collected at the sub divisional hospital (Ba Hospital) and processed at the divisional hospital (Lautoka Hospital)*
- *The Learned Judge wrongly held that DW2 had taken the Respondent's file with her to Lautoka Hospital, therefore suggesting that the First Appellant had hidden the Respondent's file. The correct position is that DW2 had only taken the Respondent's referral from Ba Health Centre to Lautoka Hospital and that there was no file.*
- *The Learned Judge wrongly held that the Respondent's IMCI folder and the referral prepared by DW2 were one and the same document despite said documents being distinct of each other.*
- *The Learned Judge wrongly assessed DW1 to be an untruthful witness based on her evidence that the IMCI folder at Ba Health Centre had gone missing; and wrongly disregarded her evidence on oath pertaining to the treatment she provided the Respondent at his first presentation on 13 April 2015 and the failure of PW1 to inform her of the 'tongue injury' on same date.*
- *The Learned Judge made a wrong assessment that DW2 had behaved negligently at Lautoka Hospital in taking the Respondent straight to the surgery theatre without prior scanning at the scan room; ignoring DW2's evidence that the Scan Room was full and that the Respondent was in distress coupled with a deteriorating condition which had compelled her to exercise a clinician's discretion.*
- *The Learned Judge reached the wrong conclusion in holding that the Respondent was in a healthy and stable condition before surgery and totally ignored DW2's evidence that the Respondent's health was deteriorating due to Ludwig Angina.*
- *The Learned Judge wrongly assessed that PW1 had not given his informed consent in terms of the Respondent's surgery despite Doctor Mara Seru's*

*(**DW3**) testimony and evidence of the consent form indicating that informed consent by PW1 had been given prior to surgery.*

- *The Learned Judge made a wrong inference in holding that the Appellants had deliberately withheld calling the surgeon, Dr. Rounak as their witness because of their alleged fear that his evidence would not have assisted their case. On the contrary, Dr. Rounak's verbal evidence would not have made any difference in the Appellants' case at all. The Respondent's medical folder showed that Dr. Rounak had endorsed the consent for surgery by signing at the relevant places. The Respondent had agreed in the Pre-Trial Minutes that his father had consented to the surgery.*
- *The Learned Judge wrongly ignored DW3's evidence that Dr Rounak would not have operated on the Respondent if he had not endorsed the consent of PW1 as is the accepted procedure in medical practice.*
- *The Learned Judge reached the wrong conclusion in holding that the Respondent was overdosed while recovering from surgery at the Paediatric Intensive Care Unit (PICU) of Lautoka Hospital and totally ignored the expertise evidence of DW3, a consultant anaesthetist who had articulately explained in detail the various dosage of drugs that were legally administered on the Respondent at PICU.*
- *The Learned Judge wrongly inferred that the Respondent's condition was stable and healthy before the surgery and disregarded the evidence of DW2 and Chief Medical Officer Doctor James Auto (DW4) that although the Respondent's vital signs were stable, there was an impending airway which would have caused the Respondent to collapse if urgent intervention had not been afforded.*
- *The Learned Judge wrongly favoured the evidence of PW2 over the evidence of DW3 and DW4 to conclude that the Respondent had been overdosed; and he did not take into account that unlike DW3 and DW4, had not practised medicine for ten years, plus PW2's own admission on oath that his medical knowledge had regressed over the years of non-practice.*
- *The Learned Judge made a wrong inference that DW4 had blamed the surgery team for not doing the surgery properly and disregarded DW4's evidence that given the Respondent's age and the need not to overinflate the lungs, a smaller tube could not be inserted down his throat.*
- *The Learned Judge wrongly disregarded DW4's evidence that the Respondent had developed lung infection as a result of Ludwig Angina, which was the root cause of his death.*
- *The Learned Judge wrongly adjudged DW4 as stating that the staff and Lautoka Hospital's PICU were negligent despite DW4's evidence to the contrary.*
- *The Learned Judge wrongly concluded that there was no clinical evidence, such as scan, x-ray and blood test to substantiate that the child had Ludwig Angina. The Learned Judge disregarded DW2's evidence that Ludwig Angina is a clinical diagnosis made by the clinician at his discretion and that it is a serious condition of an impending airway which if deemed to be*

life threatening as in the Respondent's case, then adjuncts such as x-ray and scan do not play a role.

- *The Learned Judge wrongly misquoted DW4's evidence in that it was not procedure to bag (pumping oxygen) a patient after surgery from the operation theatre to PICU. DW4's actual evidence was that it was accepted procedure to bag a patient who requires mechanical ventilation while transferring from surgery theatre to PICU, akin to the case of the Respondent.*
- *The Learned Judge erred in holding that only trained personnel is to be present when a drug is administered on a child.*
- *The Learned Judge wrongly disregarded DW4's evidence that the Respondent not breathing for 10 minutes did not imply that no one in PICU attended to the child. DW4 stated in his evidence that the nurses in PICU and all the intern doctors had fully exerted their efforts in resuscitating the child when he encountered breathing problems.*
- *The Learned Judge erred in disregarding DW4's evidence that when the Respondent was not breathing, the nurses commenced resuscitation; that when Dr. Joseph arrived, he continued the resuscitation process. The Learned Judge failed to consider DW4's evidence that the PICU staff did not neglect their duty in trying to revive the Respondent for the 10 minute time period in which he was not breathing.*
- *The Learned Judge made a serious omission of fact in failing to take into account DW4's evidence that all drugs to be administered in standing orders are chartered in the drug treatment sheet.*
- *The Learned Judge made a serious omission of fact in failing to take into account DW4's evidence that the nurses in PICU are specialist nurses who are authorised and qualified to administer on their own the drugs that are instructed by the doctors.*
- *The Learned Judge made a serious omission of fact in failing to take into account DW4's evidence that a doctor does not have to be present at such time a drug is administered if he has already ordered the drug on the treatment sheet which the nurses follow.*
- *The Learned Judge made a serious omission of fact in disregarding the pathology report, the primary document that confirms a patient's true cause of death.*

6. *The Learned Judge erred in law in allowing PW2 to give expert evidence without a medical report prepared by him and disclosed to the other party in advance, contrary to the High Court Rules.*

7. *The Learned Judge erred in law and in fact in granting an order that the Appellants pay the costs in the sum of $3,000.00*

[6] Considering the evidence and the written submissions of both parties in the High Court it is evident that the Respondent considers the Appellant culpable for the death of his child.

This culpability is a result of the breach of the duty of care on on the part of the Appellant's servants, agents and employees, which amounts to negligence.

[7] Elaborating on instances of negligence, the Respondent first claims that the nurse on duty (DW1) at the Ba Health Centre should have referred the child to the Doctor on duty, as the injury was on the underside of the tongue, which is an area susceptible to bacteria that can cause rapid infection if not treated in a timely manner, with the correct medication. The Respondent further contends that DW1 was also negligent in prescribing gargling for a child so young. It needs no further reasoning as it is common knowledge that a child of such tender age will not be able to gargle effectively by himself and it would be impractical to expect a parent to achieve this feat. The Respondent may have administered medicine with the aid of a syringe also due to the young age of the child. I find that the Respondent attributed negligence to DW1 in other respects as well, which are enumerated under 10 headings from A-J in his Statement of Claim.

[8] The Respondent also alleges negligence on the part of the surgical team on their failure:

a. *to properly inform the detailed information or the seriousness of the infection to the injury*

b. to show the results of the x-ray whether or not film of fragments of pieces of stick present in the injury without that information it led the infant to undergo surgery,

c. to carry out the surgery with care since it led the infant to have brain death.

d. in allowing the infant to go for a surgical operation when it was not necessary when there are available medical procedures.

[9] The Respondent further alleges that the deceased child's health worsened due to some nurses injecting various medication without consulting the Ward doctors, which the doctors had later confirmed, was wrong. The lackadaisical conduct of the nurses, who had idled

during their shifts in the ward, had also drawn the ire of the Respondent. The alleged conduct is reprehensible especially when the deceased child was in critical condition and even intubated.

[10] In order to establish a nexus between negligence and loss, the Respondent must prove on a balance of probabilities that the negligent act caused or contributed to the loss. Evidence reveals that the immediate cause of death was the deprivation of oxygen during surgery. Therefore, it is necessary to advert to the conduct of the surgical team, as the deprivation of oxygen occurred during surgery. As judges, surgical procedures are not within our province of expertise. However, this does not preclude me from determining whether the conduct of the surgical team conformed to the standards of care expected by law. I rely on medical evidence which transpired during the trial to assist me with my inquiry.

[11] As per paragraph 76 of the Judgment it is apparent that DW2 had suspected that the child suffered from Ludwig Angina. If it was due to Ludwig Angina as per medical authorities it is described as a rare form of cellulitis. This bacterial infection affects the skin and underlying tissues. Group A Streptococcal infections and staph infections can cause Cellulitis and such infection spreads quickly in the mouth to the tongue and throat area. Swelling (edema) occurs, which can make it Difficult to Breath. Some people who developed the infection die from the swelling and lack of oxygen (asphyxiation). It is believed that when detected, antibiotics can clear up the infection. When swelling becomes life-threatening and affects the ability to breathe, a Tracheostomy will aid breathing. In this case, that there is evidence of tracheostomy being employed. It may be probably to aid breathing and absence of such may result in death due to lack of oxygen. In this case though they had resorted to a tracheostomy, as I have already said, the tube that was used had been leaking, and thereby child would not have got an adequate supply of oxygen. Use of a defective tube, amounts to negligence on the part of the Appellants.

[12] It is irrefutable that the surgical team owed a duty of care towards the deceased child. Therefore, the conduct of the surgical team requires closer scrutiny. Evidence discloses that the anaesthesia team encountered difficulty in inserting the endotracheal (ET) tube due to the swelling of the mouth and around his upper airway. ET tubes for young children come in two sizes. A size 3.5mm tube had been inserted into the child's airway. DW4 James Auto, Chief Medical Officer under cross examination agreed that the correct tube size for a baby aged 2 was 4-5mm and not 3.55mm. Even though this was not the correct size, it appears that it was the only tube that had been able to pass through his airway indicating difficulty in visualising his upper airway. The surgery had lasted 10 minutes and evidence indicates was successful in draining pus and removing the remaining pieces of wood in his mouth.

[13] However, it is clear as per evidence that, the deceased was oxygen deprived in the lungs while in the operating theatre. The ET tube ideally ought to have assisted with breathing during surgery. Oxygen deprivity may have occurred due to a tube smaller in size being inserted, even though it may have been unavoidable, due to the lack of visualization. While such an inference has not been rebutted by the Appellant, to exacerbate matters, as per PEX 32-PEX40 the inserted ET tube was found to be leaking. The failure to ascertain the integrity and functionality of the ET tube i.e. that it was in working condition and free from any defects, displays patent negligence and breaches reasonable standards of care expected of a surgical team. The surgical team could have replaced the ET tube when the air leak was detected, which may have resolved the issue. However, evidence does not reveal such an attempt. It is unfortunate, and frankly callous that the child was the victim of such negligence. The negligence of the surgical team had resulted in the deprivation of Oxygen which was the immediate cause of death, as evidenced by evidence before court.

[14] Given the complications that the swelling in the upper airway may have caused, the surgical team should have taken all possible precautions to avoid further complications. Hence, even if all other acts of negligence are disregarded, insertion of a leaking ET tube without taking necessary precautions to examine it for defects cannot be disregarded. The *Bolitho*

amendment [**Bolitho v City and Hackney HA [1998] AC 232]** to the *Bolam* test [**Bolam v Friern Hospital Management Committee [1957] 2 All E.R.]**] establishes the legal standard of care required in negligence actions. The Bolitho amendment expands the Bolam test in assessing a professional's acts or omissions for negligence by introducing an additional element. In addition to assessing whether an act is in accordance with a reasonable body of opinion, the Bolitho test requires that the act or omission should withstand the logical analysis of the court. Applying the Bolitho test to the negligent act of using a leaking ET tube, I find that the failure to ascertain the integrity and functionality of the tube pre-surgery and the failure to detect and substitute the leaking tube during surgery do not conform to a reasonable standard of care expected of medical professionals.

[15] Therefore, I conclude that the agents and employees of the Appellant are culpable of negligence towards the deceased child. On the strength of the foregoing reasoning, I answer the grounds of appeal cumulatively against the Appellant and in favour of the Respondent and dismissed the appeal.

[16] In relation to the assessment of damages payable to the Respondent by the Appellant, I do not have any reason to interfere with the orders made by the learned High Court Judge in paragraph 117 of his judgment except as to loss of earnings. As regards to loss of earnings I agree with the submissions made by the Appellant in paragraph 14, 5-xii. This is not a fit case to follow the multiplicand method. Hence, in keeping with the judicial precedents I will approach this issue under the common law. As the child was only 2 years of age and not an economic contributor to the family, I reduce the amount of loss of earnings to $75,000.00 under this head. Accordingly, the total amount payable would be $110,660.00 plus $3000.00 (cost awarded by the High Court).

[17] **Jameel JA**

I agree with the reasons and conclusions of Lecamwasam, J

[18] **Orders of the court**

1. *Appeal is dismissed subject to variation with regard to quantum.*
2. *Appellants shall pay the sum of $110,660.00 to the Respondent as compensation.*
3. *Appellant is ordered to pay cost of $5,000.00 to the Defendant (this is in addition to the cost ordered by learned High Court judge.*

.....
Hon. Justice E. Basnayake
JUSTICE OF APPEAL

.....
Hon. Justice S. Lecamwasam
JUSTICE OF APPEAL

COURT OF APPEAL
FIJI

.....
Hon. Justice F. Jameel
JUSTICE OF APPEAL

Solicitors:

Mr J. Mainavolau for the Appellants

Mr K. Maisamoa for the Respondent