IN THE HIGH COURT OF FIJI
WESTERN DIVISION AT LAUTOKA
CIVIL JURISDICTION

CIVIL ACTION NO. HBC 237 OF 2016

BETWEEN : **KITIONE WAQA WILKINSON TIKO** a minor suing by next friend Viliame Tiko of Vatusekiyasawa Village, Rakiraki, Ra.

PLAINTIFF

AND : **THE PERMANENT SECRETARY FOR HEALTH**, Ministry of Health, Dinem House, Amy Street, Suva.

FIRST DEFENDANT

AND : **THE ATTORNEY GENERAL OF FIJI** is being sued pursuant to the State Proceedings Act Cap 24.

SECOND DEFENDANT (NOMINAL)

Appearances : Mr K. Maisamoa for the plaintiff
Mr J. Mainavolau for the defendants
Date of Trial : 1-5 & 8 June 2020
Date of Submissions : 6 July 2020 (both parties)
Date of Judgment : 7 December 2020

JUDGMENT

Introduction

[01] The plaintiff brought this claim against the defendants seeking damages for the death of an infant while getting treatment. The claim arises out of a medical or clinical negligence at the hands of the defendants.

Factual background

[02] In order to explain the factual background, I have taken facts from the statement of claim.

[03] Viliame Tiko, the plaintiff is the father and brings this action as a beneficiary interested in the estate of Kitione Waqa Wilkinson Tiko who was born on 24 March 2013.

[04] The first defendant owned, managed and administered Ba Health Centre and Lautoka Hospital respectively and provided medical, specialist and other health services, has the general responsibilities of supervising as an employer of its servant and/or its employees and/or its agents both in Ba Health Centre and Lautoka Hospital respectively.

[05] In the morning of 13 April 2015, the plaintiff took the infant to the Ba Health Centre for medical attention and examination due to the injury caused by a small piece of stick that pierced under the infant's tongue on the eve of 12 April 2015.

[06] At the Ba Health Centre the staff nurse, Biudole Sokia advised the plaintiff to take the infant home and put salt in the warm water and wash the infant's injury with it.

[07] The plaintiff, according to the statement of claim, insisted to the staff nurse Biudole Sokia that the infant must see a doctor and wanted the doctor's advice, but she (nurse) insisted that the plaintiff and the infant to go home and wash the infant's injury under the tongue with salted warm water.

[08] The nurse, without referring the infant to the doctor, gave the infant two small bottles contained pink colour fluid for the infant's consumption without the prescription and endorsement of the doctor.

[09] The nurse then advised the plaintiff to bring the infant back immediately for medical attention and examination if the infant's injured tongue is worsened.

[10] On the morning of 15 April 2015, the plaintiff had to rush the infant back to Ba Health Centre because the infant was not eating and noticed that the infant's right side of his face down to the chin was swelling and paining when touched.

[11] The nurse after checking the infant's injured tongue immediately referred the infant to Dr. Ranita.

[12] Dr Ranita immediately referred the infant to the x-ray department in Ba Health Centre and straight after the x-ray without advising the plaintiff with the result of the x-ray said that the infant has to be rushed to Lautoka Hospital.

[13] According to the plaintiff, the nurse at Ba Health Centre did not follow the proper outpatient procedure, she failed to refer the infant to the doctor at the first instance which led to the infection of the injury and the deterioration of the infant's injury.

[14] The statement of claim particularises negligence of the staff nurse Sokia as follows:

Particulars of Negligence of Staff Nurse Sokia

a) *The first defendant through its servant and/or its employee and/or its agents in failing to observe the outpatient procedures by recording the injury sustained by the infant in order for the employed Doctor's perusal and failing to refer the infant to be medically examined by the employed Doctor in Ba Health Centre led to the infection of the injury of the infant.*
b) *The first defendant through its servant and/or its employee and/or its agents in failing to give adequate health advice in terms of precautionary measures for the injury sustained of the infant led to the infection of the injury.*
c) *The first defendant through its servant and/or its employee and/or its agent in failing to refer the infant to the employed Doctor led to no medical attention and examination of the injury sustained thus allowed the infection to occur.*
d) *The first defendant through its servant and/or its employee and/or its agent in failing to refer the infant to the employed Doctor led to no proper medication transcription and possible recommended tetanus injection.*
e) *The first defendant through its servant and/or its employee and/or its agent in failing to work within the employed Doctor's advice as a result the first defendant*

through its servant and/or its employee and/or its agent on her own volition she gave two small bottles contained pink colour fluid for the infant consumption.

f) *The first defendant through its servant and/or its employee and/or its agent in failing to exercise such degree of care that led to the infant injury deterioration and infection.*
g) *The first defendant through its servant and/or its employee and/or its agent in failing to foresee that medical carelessness will further endanger the health of the infant.*
h) *The first defendant through its servant and/or its employee and/or its agent in failing to properly treat the infant injury via the doctor's recommendation or advice led to the infection of the injury.*
i) *The first defendant through its servant and/or its employee and/or its agent through its failure to allow proper treatment of the infant's injury under the floor of his tongue to be infected.*
j) *The first defendant through its servant and/or its employee and/or its agent through its failure to allow infection to occur.*

[15] When the infant was referred to Lautoka Hospital and without further medical examination the plaintiff and the infant were directed to the surgery room where the plaintiff was advised that the infant would undergo a surgery.

[16] The plaintiff alleges the following negligent acts occurred at the Surgery Department, Lautoka Hospital:

a) *Failing to properly inform the detail information of the seriousness of the infection to the injury.*
b) *Failing 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) *Failed to carry out the surgery with care since it led the infant to have brain death.*
d) *Allowing the infant to go for a surgical operation when it was not necessary when there are available medical procedures.*

[17] The plaintiff, the nurse and the doctors would take care of the infant after the surgery.

[18] The plaintiff alleges that the infant's health became worsen because some of the nurses were not consulting the doctors when giving injection, when the plaintiff complained about this to the doctor who told the plaintiff that what the nurse was doing was wrong.

[19] The particulars of negligence at the children's ward at Lautoka Hospital, as alleged by the plaintiff, include:

a) Failing to take care of the infant knowing very well that the infant was in intubation.
b) Nurse giving injection to the infant without consulting the ward doctor.
c) Failed to carry out its duty of care properly when the infant was in pain they were yarning, eating ice blocks and engaged in face book.

[20] The plaintiff alleges that the infant died as a result of the defendant's negligence and/or careless acts and liable to pay damages to the plaintiff.

Defendant's position

[21] The defendant in the statement of defence states:

21.1 Staff nurse Biudole Sokia was on duty on the morning of Monday 13 April 2015, when the deceased was brought into the IMCI clinic by the plaintiff with complains of an injury below his tongue. The deceased was not seen in General Outpatient because of his age as all children below the age of five years are seen in the IMCI clinic by the qualified IMCI nurse.

21.2 Upon initial assessment on 13 April 2015, it was discovered that the deceased was slightly inflamed and pain was obvious in him. Two bottles of Elixir Flucloxacillin (pink coloured fluid) 10mls was issued with instructions that they be given four times daily for 7 days for the treatment of the abscess; and Elixir Paracetamol 7.5ml to be given 6 hourly/prn for pain as per IMCI guidelines. The plaintiff was also advised by staff nurse Sokia on saline gurgle and the deceased was to return. Tetanus injection was not given as child was still covered from DTP Helo

Hib vaccination given in the first three months of birth (i.e. given at 6 weeks, 10 weeks and 14 weeks consecutively and the next dose of tetanus toxoid will be at school entry. (Year 1 or 6 years of age). After treatment, the plaintiff and the deceased were told to go back home.

21.3 On 15 April 2015, the deceased was brought back into the clinic at Ba Hospital and was seen again by staff nurse Biudole. The plaintiff advised staff nurse Biudole that the deceased had a history of fall on 12 April 2015. He did not mention this in the initial visit. The plaintiff also advised staff nurse Biudole that he did not administer the antibiotics given to him by the hospital on the deceased because according to him the deceased was not improving.

21.4 When Dr. Renita Maharaj examined the deceased, she found that he was irritable and had a high fever. She assessed the deceased as having Ludwig's Angina clinically. A cervical x-ray was conducted on the deceased thereafter. Upon consultations with the Surgical Registrar at Lautoka Hospital, Dr Maharaj as per the advice of the Surgical Registrar at Lautoka Hospital, transported the deceased to Lautoka Hospital.

21.5 The deceased was admitted to Lautoka Hospital at 1200hrs on 15 April 2015. History and examination showed that the deceased as a 2 year old child. He had a history of injury to his mouth from a stick three days prior. Examination notes in the medical notes stated that he was having a fever. There was a swelling at the right submandibular area (jaw area where it joins the neck). He was drooling saliva and unable to open his mouth. The floor of the mouth was also noted to be swollen. His assessment then was right submandibular abscess and impending airway obstruction, medical emergency. A difficult intubation was anticipated. Consent was obtained from the plaintiff for surgery.

21.6 The deceased's condition at the time of admission was that of a medical emergency. Signs and symptoms in the aforementioned paragraph were consistent with impending airway obstruction.

21.7 Withholding food or drinks (known as NIL BY MOUTH) from the child is normal procedure before the surgery due to risk of aspiration of stomach contents during anaesthesia.

21.8 No documentation is in the patient's folder showing that discussion with the plaintiff took place. However, the plaintiff signed consent for surgery.

21.9 No better treatment option was available for the deceased other than emergency surgery to drain the pus from submandibular abscess. He was already started on antibiotics. Non-surgical treatment through antibiotics only was not adequate. If surgery had been delayed any further, the child's mouth swelling would most likely have worsened, leading to complete obstruction to his upper airway and breathing and subsequently death.

21.10 Wood is usually radiolucent not raido opaque and will not likely show on x-ray. Operative findings confirm presence of fragments of wood splinters in the mouth which were removed during surgery.

21.11 There was no better option than surgery to drain the pus and remove any remaining foreign bodies, in this case splinters of wood.

21.12 Due care was provided during surgery. The anaesthesia team encountered difficulty inserting endotracheal (ET) tube due to the swelling in the mouth and around his upper airway. An ET tube size 3.5, which was two sizes below appropriate ET tube size of his age, was the only tube that can be passed through his airway indicating the difficulty in visualizing his upper airway. Surgery lasted 10 minutes and was successful in draining pus and removing the remaining pieces of wood in his mouth.

21.13 There is no documentation in the folder showing that the plaintiff was told by the defendants' agents that the deceased would be "fine". The surgery was considered minor as it involved making an incision to drain pus and cleaning the wound sustained by the trauma from the stick.

21.14 The first defendant's plan surgery was to continue to support the deceased in his breathing through mechanical ventilation for 24 hours to

allow swelling in his mouth and around his upper airway to subside and ensure patency of his airway.

21.15 The deceased was admitted at the Paediatrics Intensive Care Unit (PICU) and not the children's ward.

21.16 As per the medical notes the plaintiff was present in PICU most times after the deceased's surgery.

21.17 The deceased required extra sedative medications on numerous occasions to allow ease of mechanical ventilating.

21.18 The PICU nurses consulted the paediatric doctors after the operation each time the deceased required extra dose of sedative medicines.

21.19 The care provided after operation was appropriate until the early hours of 16 April 2015, at about 0635 hours when the deceased went into cardiac arrest. The complication arouse as a side effect of anaesthesia.

21.20 The correct treatment was provided to the deceased. This included surgery, antibiotics and ventilation after surgery to support his breathing.

21.21 The deceased died of anaesthesia complications which has a high occurrence in infants.

Agreed facts

[22] At the pre-trial conference (PTC), the following facts were agreed between the parties:

1. *The plaintiff was born on 24 March 2013, and he was 2 years old and I month on or before 13 April 2015, and he was a healthy baby.*

Ba Health Centre

2. *The plaintiff was injured by a small piece of stick that pierced under his tongue on the eve of the 12 April.2015.*
3. *The plaintiff's father took the plaintiff to the Ba Health Centre on 13 April 2015, because of the tongue injury.*

4. *The plaintiff was received by staff nurse Biudole Sokia on 13 April 2015.*
5. *The plaintiff asked staff nurse Sokia that the infant baby needed to see the doctor for advice.*
6. *The staff nurse gave two small bottles of pink coloured fluid for the plaintiff's consumption.*
7. *The staff nurse advised the plaintiff to come back for medical attention if the infant plaintiff's tongue injury worsened.*
8. *The infant plaintiff was taken back to Ba Health Centre on 15 April 2015, because the injury was infected, swollen and paining.*
9. *That upon his second visit, staff nurse Sokia immediately referred the infant plaintiff to Doctor Ranita whom the plaintiff knew.*
10. *That Doctor Ranita referred the infant plaintiff to the x-ray department at Ba Hospital and said that the plaintiff be rushed to Lautoka Hospital.*
11. *The first defendant employs medical surgeons, nurses and other staff at Ba Health Centre and Lautoka Hospital.*

Lautoka Hospital

12. *That the plaintiff died.*

The issue

[23] The issue at the trial was whether the defendants were clically negligent and breached their duty of care in diagnosing treating the two-year-old Kitione Waqa Wilkinson Tiko at Ba Health Centre that led to the infection or deterioration of the injury under the floor of the tongue, and at Lautoka Hospital both before and post operation.

The evidence

[24] At the trial, the plaintiff called two (02) witnesses namely Viliame Tiko Vailoa, the plaintiff (PW1) and Josefa Koroivueta, a medical officer (PW2) while the defendant called four (04) witnesses. The defendant's witnesses include: Biudole Uluitoga Sokia, staff nurse (DW1), Renita Vikashni Maharaj, Senior Medical Officer (DW2), Mara Vukivuki Seru., Specialist Anaesthetists (DW3) and James

Auto, Chief Medical Officer (DW4). In addition, the plaintiff tendered 57 documents marked *"PEX1" – PEX57"*) and on behalf of the defendants 26 documents marked *"DEX1"- "DEX26"*).

Ba Health Centre

[25] On 13 April 2015, PW1 took his child to Ba Health Centre where staff nurse (DW1) was on duty. PW1 complained to her that the child had got an injury under the tongue. DW1 did not refer the child to a doctor. Instead, she told PW1 that: *"You have to go home and mix the salt with warm water then give to the son to gargle."* even though PW1 told the nurse that his son was injured under the tongue.

[26] DW1 maintained in her evidence that PW1 did not tell her that his son got injury under the tongue due to a fall.

[27] PW1 was firm and consistent in his evidence that he told DW1 that his son got injury under the tongue. Counsel for the defendant was unsuccessful in his attempt to dent this piece of evidence of PW1 during cross-examination.

[28] I had the opportunity of observing PW1's behaviour while giving evidence. I found him to be sober coherent and consistent in his evidence. He answered the cross-examination questions without any hesitation.

[29] It is noteworthy that the defendant's own witness, Dr Renita (DW2) who was on duty on 13 April at Ba Health Centre, told the court that it is not the practice in Fiji to give to a two-year old child salt water to gargle with it.

[30] DW1 also said in her evidence that PW1 told her, on his second visit that he did not administer the medication to his son.

[31] PW1 was adamant in his evidence that he administered the medication to his son with a syringe.

[32] DW1 could not produce the child's medical folder in Ba Health Centre. When asked about the child medical file, DW1 said it was missing. DW1 was the staff nurse who attended to the child. She should have noted the history of the injury and the medication prescribed for the child injury under the tongue. To every one's surprise, DW1 said the medical folder relevant to the child maintained in

Ba Health Centre was missing. Under these circumstances a couple of inferences possibly may arise. She might have hidden it or destroyed it because it would not have supported her position, if produced in court.

[33] DW1 attempted to justify her action at Ba Hospital by saying that she was entitled to see a child under 5 years under Integrated Management of Childhood Illness (IMCI) as she was an IMCI nurse.

[34] It is true an IMCI nurse can see a child under 5 years in treating illness and to give antibiotic for the illness shown in the IMCI guideline.

[35] PW2 in his evidence said that is not an illness and is not falling under the IMCI guidelines. Therefore, I accept his evidence that any injury of child must be referred to the doctor by the IMCI nurse immediately.

[36] PW1 took his child to Ba Hospital with a tongue injury. She should have realised that a tongue injury would be more susceptible to infection in the tongue on 15 April 2015 (second referral), when DW2 examined the child and took the child to Lautoka Hospital as an emergency case.

[37] It is significant to note that the referral by DW2 to Lautoka Hospital does not mention of the x-ray done in Ba nor does it mention of the x-ray film attached with the referral.

[38] The defendant was unable to establish their position that the cervical x-ray done in Ba Health Centre. DW2 said in her evidence: *"such x-ray was the x-ray taken from the back of the child and also at the right side of the child's neck."* DW2 had made a written statement regarding the incidence on 10 February 2017, where she says an x-ray was done. It does not tally with the referral written on 15 April 2015. Further, DW2 under cross-examination said that when reaching the scan room, she gave the file with the referral to the surgical room. Whereas DW1 said the file went missing in Ba (see PEX 28, 29 and 30).

[39] PW1 said there was no scanning done to his son and it was confirmed by DW2 during cross-examination. This follows that the surgery for the child had been performed without a scanning of the child.

[40] DW 1 and DW 2 contradicted to each other, especially with regard to medical file of Kitione, the child. DW 1 said the file went missing while DW 2 maintained that she gave the file to the surgical room. If the file was missing, DW2 could not have given it to the surgical room.

[41] DW 1 did not appear to be a credible witness. She conveniently said the medical file of Kitione went missing in Ba Health Centre. She was not truthful in her evidence. I reject her evidence that PW 1 did not tell her that his son was injured under the tongue due to a fall. She could have easily found out the child's injury if she had carefully and properly examined the child. On the evidence, and having been satisfied on the balance of probability, that DW 1 had failed to duly diagnose and treat the child, and that she was negligent in the treatment of the child.

Lautoka Hospital at the Scan Room and Mini Operating Theatre

[42] Both PW 1 and DW 2 said in their evidence that the child was brought as an emergency case from Ba Health Centre to Lautoka Hospital via the ambulance. They took the child to scan room, which was full. So, they were waiting. The emergency case was not attended immediately. After waiting for some time, DW 2 contacted Dr. Losalini who advised to carry out the scanning of the child. However, despite that advice, DW 2 chose to skip the scan and take the child to the mini operating theatre and she left the child with the father in the surgery room and left. DW 2 did not follow Dr. Losalini's advice that the child needed to be scanned, because the scan room was busy. These were evidence of DW 2 during cross-examination.

[43] On the evidence, and having been satisfied on the balance of probability, I find that DW 2 had failed to act diligently in the circumstance of the case in which she failed to approach to the radiographer and inform him or her that her case was an emergency one and needed immediate attention.

[44] The defendant never disclosed the child's Ba medical file. DW 1 in her evidence said the child's Ba medical file was missing. DW 2 however maintained in her evidence that she gave the child's Ba medical file to OT. This leads me to disbelieve DW 2's evidence that she gave the child's Ba medical file to OT. PW 1 also said in his evidence that the child's Ba file was not given to OT.

[45] The child's pre-operative condition was stable. This was conformed not only by the Plaintiff's witnesses (PW 1 and PW 2) but also by the defendant's witnesses

(DW 1, DW 2 and DW 4). DW 4 confirmed that Kitione was a healthy infant according to his weight and age as depicted in PEX 5.

[46] PW 2 was referred to PEX 26, the report that the child was sent from Ba Mission Hospital. He said that according to the report, the child had no obvious respiratory distress or no problem with his breathing. DW 4 also confirmed under cross-examination, referring to PEX 57 (which is also DEX 6), that the child's breathing was good. Interestingly, all witnesses including the defendant's witnesses (PW 1, PW 2, DW 1, DW 2 and DW 4) conformed that the child was healthy according to his age and weight of 10 kg.

[47] On the evidence, having been satisfied on the balance of probability, I find that the child was healthy and stable before his demise, except for the injury under the tongue.

[48] According to PW 1's evidence, DW 3 (Dr. Mara) gave him (PW 1) a blank form, not explaining what it was. Later he (PW 1) saw the form was signed by one Rounak. PW 2 in his evidence said that before signing the consent form (PEX1), the surgeon must properly explain to the patient or parents or guardian the procedures that would be carried out, then allow the patient or parents or guardian to sign. DW 4 also confirmed the same and said the consent form was a critical document. DW 3 said the best person to explain the consent form was Dr. Rounak. The defendant, however, did not call Dr. Rounak as a witness. The Defendant adduced no reason for not calling Dr. Rounak as witness. When there is an unexplained failure by a party to call evidence, to call a witness or to tender documents or other evidence, the court may draw an inference that the uncalled evidence would not have assisted the party *(Jones v Dunkell, (1959) 101 CLR 298).* The defendant in the matter at hand did not explain why they were not calling Dr Rounak as a witness. In the circumstance, the court can, I do so, draw an inference that Dr. Rounak's evidence would not have assisted the defendant.

[49] It is significant to note that the form was not completely filled by the surgeon or one Rounak. The consent form reads: *"I do not consent"* and it was not completely filled in. This incomplete consent form suggests that the consent was not properly obtained from the father (PW 1), and that the surgical procedure was not also properly explained.

Lautoka Hospital Post Intensive Care Unit (PICU)

[50] It was PW 1's evidence that he was with his child from the evening of 15 April 2015 to the early morning of 16 April 2015 witnessing both the activities of the nurses. He said that: *"couple of times when the child wake up at night, the nurses came and give injection for him to keep on sleeping (PEX 25). In one of the occasions at night when the child woke up, the nurse was about to give an injection when he (PW 1) stopped the nurses and told them to call the doctor on duty to give permission because he saw that the nurses were frequently injecting his child whenever he woke up, and the doctor on duty stopped the nurses not to give and hold the baby for an hour"*. He further said when the child woke up, one of the nurses on duty was busy with face book while the other staff nurse went out to buy ice block.

[51] The medical record (PEX 27) shows that the child was given frequent injections on the night of 15 and early hours of 16 April 2015. Under cross-examination, DW 4 agreed that the swelling of the brain would have also caused by the administration of the drugs. On the evidence, it appears to me, I find that the nurses at Lautoka Hospital had administered overdose of drugs in the child's body by frequent injections without the doctor's advice.

[52] PW 1 said that: "after the surgery the child was taken to PICU. In the morning of 16 April 2015, the child woke up and was active. The nurse told him to go outside for a few minutes and he said, "No". I have to help them sponge the baby but the nurse told him it was okay. He went out for a few minutes and when he came back he saw the baby lying down with no movement of the stomach and the ventilation machine beeping slowly to indicate that there was no pulse for the baby. He called out! Then staff nurse Francis came running from the other room to see what has happened to the baby. Staff nurse Francis brought the begging compressor and put through the baby's mouth and started squeezing to give oxygen to the baby to revive. The nurse called the doctor on duty. She again told him to go outside since the doctor's had arrived. From outside, he was peeping from one of the windows then he saw nurses and the doctors were trying to revive the baby. After the doctors were trying to revive his son, he came back to the room and he saw the ventilation machine was high causing his son's breathing very fast. He said his son had gone and when he kissed his son's head, his body was cold like plastic taken out of the fridge. He asked Dr Joseph what has happened to the tube and Dr Joseph said that: *"it was not the right size and the right size was out of stock"*.

[53] Whatever PW 1 said in evidence was consistent with the notes recorded by the nurses (PEX 27). In cross-examination DW 4 confirmed that the child has collapsed and he was having no pulse for about 10 minutes. Notably, PW 2 said it was unusual for the doctor to give order ordering the administration of Vecuronium over phone because it was a dangerous drug.

[54] DW 4 said in his evidence that the child was showing sign of recovering, but he was in a coma from 16 April 2015 until the life supporting equipment was removed after the two brain tests to confirm that the child was indeed sustained brain death. DW 4 in cross-examination admitted that after the surgery, the surgery team when hand over the patient to PICU it should accompany their assessment report detailing what has been done to the patient with their recommendation. When referred to the assessment report (PEX15) DW 4 said he cannot comment on the document and the best person to explain was the surgery team.

[55] It is to be noted the surgery team did not completely fill out the bottom part of the form. The surgery team had failed to fill each segment of the form. The total score: at the bottom it was written, "Notify anaesthetist urgently if oxygen saturation score zero…"

[56] DW 3 (Dr Mara) conveyed the child to PICU at the same time he was begging the child to have sufficient oxygen in his lungs. DW 3 was placing the ETI beyond the required mark. It is recorded in PEX 32. DW 4 in cross-examination said it was not normal procedure to beg a patient from the operation theatre to PICU. DW 4 further said the lack of oxygen for Kitione began from the operation theatre, and the ETI was inserted beyond the required mark.

[57] On the evidence, and having been satisfied on the balance of probability, I find that the surgical team at operation theatre breached their duty of care towards Kitione, the child.

[58] According to PW2: it was advisable that only the trained medical personnel to be present when the drug is administered. Dr Joseph came after 2 hours 15 minutes at that time the child was already collapsed for 10 minutes and the child was resuscitated. He said: at 4.20 am on 16 April 2015, Dr Joseph was informed about the child's situation and by the time Dr Joseph arrived at about 6.55 am the child was already collapsed with no pulse for 10 minutes.

[59] Considering the emergency situation, Dr Joseph should have immediately availed himself to the emergency situation in the wards. He came after 2 hours 15 minutes by the time the child was already brain dead from 16 April, 2015, which was confirmed by PW 4.

[60] Under cross-examination, DW 4 said the reason why they found it difficult to insert the endotracheal tube down to the trachea of the baby because the submandibular abscess was not incision properly by the surgeon. It appears to me that DW 4 was blaming the surgery team for not doing the surgery properly. PW 1 said in his evidence that the tube was not right size and the right size was out of stock. Moreover, DW4 under cross- examination confirmed that:

a) the problem with the child lack of oxygen in the lungs began from the operation theatre;

b) DW3 has begged the patient all the way from the operation theatre;

c) if the ETT inserted beyond the required mark of 9cm it would unfairly distribute oxygen to the lungs;

d) the ETT was inserted beyond 9cm by DW3 and DW3 had to put back the ETT to 9cm; and

e) the ETT was leaking (see PEX 32 – PEX40)

[61] PW1 said in his evidence that he saw his son was connected to the ventilator machine as soon as he was in PICU.

[62] There was clear evidence before court that the ETT connected to the ventilator machine was leaking, which would have caused the lack of oxygen supply to the baby's lungs.

[63] DW4 under cross-examination agreed that the correct tube size for the baby of 2 years was 4 – 5cm and not 3.55mm. However, tube that was used for the baby to supply oxygen was 3.55mm, the incorrect size.

[64] DW4 in evidence said that the baby was well and stable, and when asked why the baby's health was deteriorated, he said *"it was the surgeon to explain why the condition of the baby was deteriorated"*.

[65] The child was well and stable before the operation and breathing very well. Dr Rounak (surgeon) in the report recorded (para 3) that "... *but not in obvious respiratory distress*" (see DEX8). DW4 confirmed that the child was breathing very well (see PEX 26) which is also DEX11). All PW1, PW2, DW1, DW2 and DW4 were firm in saying that the child was healthy as per record (see PEX5).

[66] PW2 said in his evidence that some of the drugs administered for the 2 year old child were classified as dangerous drugs **(Ketamine, Fentanyl and Gxamethenium)**. In cross-examination, DW4 was asked to explain the purpose of the drugs and its side effects, he said: the purpose and side effects: **Ketamine** – is for anaesthesia at the start of surgery, provided pain relief, for sedation and memory loss; side effect: drowsiness, Dizziness, dream like feeling blurred vision. **Fentanyl** – similar to Morphine, pain relief, for anaesthesia, sedation; **Gxamethenium** – cause short term paralysis as part of general anaesthesia, used to help tracheal intubation; side effects: drowsiness, confusion, sedation, respiratory arrest, coma, death if over dosed.

[67] DW4 did not appear to be a credible witness. His report was not accurate. The commencement and the completion of surgery time was wrong. The surgery time was 1325hrs and not 1440hrs as stated in his report. The dose of the drug – Ketamine and Fentanyl he put 2mg in his report instead of 7mg and put 10mg in his report instead of 20mg. DW4 has prepared his report irresponsibly. According to PEX30, the surgery was completed at 1335hrs and DW3 was conveying the patient to PICU (see PEX 32) as at 2.30pm the child was injected again with morphine at an interval of 55 minutes from the time surgery was completed and after that at 2.35 on the same day (15/4/2015); again 5 minutes after morphine was administered the child was injected with Ketamine (see PEX 31); yet again on the same day (15/4/2015) at 2.50pm, 3.10pm, 9.05pm and 10.35pm the child was injected with Vecuronium for sedation.

[68] PW2 in his evidence said that some of the drugs administered to the child were classified as dangerous drugs.

[69] On the evidence, and having been satisfied on the balance of probabilities, I find that the child appears to have been over dosed with frequent administration of the dangerous drugs.

[70] The cause of death was Edema, lung infection and clinical details as cerebral edema and necrosis (see PEX19). DW4 in cross examination said that the possible brain edema (swelling) was drugs.

[71] Further, PW4 said the weight of the child was 12kg and the drugs were administered according to the weight. In cross examination, he was taken through PEX29 where he admitted that 10kg was crossed off and replaced by 12kg.

[72] DW4 in his evidence admitted that he did not fill and sign his name on the brain death certificate (PEX56). He further said, under cross – examination that the endorsement by the Pediatric CSN was not required.

[73] It is significant to note DW4's evidence under cross examination. He said that the swelling (edema) of the brain was caused by effect of the drugs. Since there was no injury to the brain, that clinically the cause of death was cerebral edema and necrosis, that cerebral edema was the swelling of the brain caused by some injury or other factor such as a lot of drugs present in the brain whereas necrosis the dead cells in the brain that caused by drugs including injury.

[74] Interestingly, DW4 admits in cross – examination that there was negligence on PICU but he cannot speak on surgical team. He also said it was not procedure to beg (pumping oxygen) patient after surgery from the operation theatre to PICU. This clearly suggests that the surgery team was not doing the work properly which resulted in the child breathless because of lack of oxygen (see PEX 32).

[75] On the evidence, and having been satisfied on the balance of probabilities, I find that the doctors and the nurses were negligence in diagnose and in treatment of the baby starting from Ba Health Centre, to Operation Theatre and PICU.

[76] DW2 maintained that she suspected that the child suffered Ludwig Angina (a skin infection that occurs on the floor of the mouth, underneath the tongue). It appears to be a guessing of DW2. There was no clinical evidence, such as scan, x-ray and blood test, to substantiate that the child got Ludwig Angina.

[77] On the evidence, and having been satisfied on the balance of probability, I answer the liability issues as follows:

(i) Whether the Staff Nurse Biudole was correct in not referring Kitione to the doctor on the first presentation? No.

(ii) Whether Kitione was correctly diagnosed with suspected Ludwig Angina by Dr. Renita? No.

(iii) Whether Kitione's blood count was done at Ba Health Centre? Not proved.

(iv) Whether Kitione needed a scan/x-ray upon his arrival at Lautoka Hospital from Ba Health Centre? Yes.

(v) Whether consent was properly given for the conduct of surgery on Kitione? No.

(vi) Whether Kitione was given proper treatment and care when in PICU? No.

(vii) Whether Kitione was given the correct dose of drugs/medication during his administration at PICU? No.

(viii) Whether it was appropriate to have Kitione's IV drip leaking? No.

Duty of Care

[78] In *Airedale NIIS Trust Board v Bland* (1993 AC 789), *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582, the House of Lords held:

> *"a doctor owes a duty of care towards his patient and in the case of a patient unable to give instructions or consent to treatment, a duty to treat him in the patient's best interest, see in re F (1990) 2 AC 1. The general duty of a doctor is to act in accordance with a responsible and competent body of relevant professional opinion based upon the principles laid down in Bolam v Friern Hospital Management Committee (1975) 1 WR 382."*

[79] In *Bolam'case (above),* McNair J set out the test for determining the standard of care owed by medical professionals to their patients (sometimes referred to as the *'Bolam test'*). The professional will not be in breach of their duty of care if they

acted in a manner which was in accordance with practices accepted as proper by a responsible body of other medical professionals with expertise in that particular area. If this is established, it does not matter that there are others with expertise who would disagree with the practice.

[80] A passage from Medical Negligence Law by Andrew Fulton Phillip (pages 16 & 17) was cited with approval in *Moli v Bingwar* (2003) FJHC 279 HBC 0335.1998 (3 April 2003).Pathik J (as he then was), where it states:

> *"The test for medical negligence is essentially objective, and does not therefore take formal account of a doctor's experience, level of qualifications, the resources available within that doctor's practice or hospital, <u>or even how many hours may have been worked prior to the incident</u>. It therefore concentrates upon the relationship between the doctor and patient and generally excludes other considerations. Unsurprisingly, the test is retrospective, but although deterrence of negligent conduct is one aim claimed for the law, there is no formal mechanism for improving the standard of care as a result of any lessons learned in litigation. Nor does it consider a doctor's record or the standards to which she or he may have practised in the past: where negligence is alleged, it is only the incident(s) in question which is (are) examined. Indeed, the most blatant cases of negligence, being indefensible, are likely to be settled out of court". (Emphasis added)*

[81] In the matter at hand, the plaintiff presented his child (two-year-old) to the defendant's employees (doctors and nurses) for treatment with a complaint of an injury under the floor of the tongue. The doctors and nurses at Ba Health Centre and Lautoka Hospital undertook to provide professional medical services to his child.

[82] It was not in dispute that there was a doctor-patient relationship between the plaintiff (child) and the doctors, the first defendant's employees. This translates that the doctors and nurses (first defendant's employees) owed a duty of care towards the plaintiff to diagnose and treat him in his best interest.

Negligence of duty of care

[83] I now turn to the question of negligence of duty of care on the part of the doctors and nurses at Ba Health Centre and at Lautoka Hospital.

[84] On the evidence, and having been satisfied on the balance of probability, I hold that the doctors and nurses at Ba Health Centre and at Lautoka Hospital were negligent in diagnosing and in treatment of the plaintiff (child), resulting in the death of the child, and thereby breached their duty of care owed to the plaintiff. This follows that the first defendant is vicariously liable to the death of the child and is also liable to pay damages to the plaintiff.

Damages

[85] I now turn to assess the damages payable to the plaintiff by the first defendant.

General damages

[86] The plaintiff claims general damages for pain and suffering in the sum of $200,000.00 following *Lusiana Rokodovu v Jovesa Rokobutabutaki & AG* (Civil Action No. 1 of 1997).

[87] In *Rokodovu,* the plaintiff was deprived of enjoyment of amenities of life for rest of his life, as a result of the accident.

[88] In my opinion, *Rokodovu* case is not applicable to the present case the baby had passed on following a surgery.

[89] In this case, the plaintiff presented his son, the baby for medical treatment for the injury under his (son) tongue to Ba Health Centre on 13 April 2015, when DW1, the staff nurse prescribed some home medicine. The child was taken back to Ba Health Centre on 15 April 2015 because the injury was infected, swollen and was painful. This time the child was seen by Dr Renita, DW2. Thereafter, DW1 and DW2 had to rush the baby to Lautoka Hospital as an emergency case in an ambulance, the baby died after the surgery on 16 April 2015.

[90] Indeed, the child would have suffered pain from 13 April 2015 until his death at the hands of the doctors and the nurses on 16 April 2015.

[91] The plaintiff, the father of the baby was with the baby throughout the diagnosis and the treatment of the baby by the doctors and the nurses both at Ba Health Centre and Lautoka Hospital. He did not provide any psychological or Psychiatric report to substantiate his pain and suffering.

[92] In *Yanuca Island v Peter Elsworth* (Civil Appeal ABU No.85/2000), the Fiji Court of Appeal reduced an award of general damages for pain and suffering and loss of amenities from $120,000.00 to $50,000.00.

[93] Counsel for the defendants submits that the plaintiff's post-mortem report reveals that the baby had died of Ludwig Angina arising out of a bacterial infection.

[94] It is to be noted that the post-mortem report simply repeats the diagnostic report. As I have already found that Ludwig Angina was only a guessing of Dr Renita, DW2 without any clinically proven findings.

[95] I take all into my account and allow a sum of **$25,000.00** as general damages for pain and suffering.

Loss of earning or prospective earning

[96] In *Daya Ram v Peni Cara & Ors* (29 FLR 1983), the Fiji Court of Appeal confirmed that the claim on behalf of deceased estate for loss of earnings for lost years is now firmly established as on the same footing as the same claim by a living person, subject to the reservation as to deduction of personal living expenses.

[97] Evidence before court revealed that the plaintiff's son, 2-year-old baby was healthy, no breathing problem and stable pre-operatively.

[98] Counsel for the plaintiff submits that: the baby would have been enjoying his life if the doctors and nurses were doing their job with highest standard of duty of care, but unfortunately the high standards of duty of care was not accorded to the baby resulting in his life to be ended abruptly. If he was alive, he would have earned between $100-$150 per week. He relies on *Kumar v PS for Health* [2006] FJHC 130; Civil Action 45.2004 (20 July 2006).

[99] Under this heading, following *Kumar* case, the plaintiff claims a sum of $156,000.00 ($150 per week x 52 weeks x 20 years = $156,000.00).

[100] Earning of $150.00 per week appears to be reasonable in the present context. As regards the multiplier, having considered all the circumstances, I would use the multiplier of 17. Therefore, I award a sum of $ 132,600.00 ($150/week x 52 weeks x 17 = $132,600.00) for loss of prospective earning.

Past and future care

[101] The plaintiff claims a sum of $114,400.00 ($36,400.00 for past cost of care and $78,000.00 for future cost of care).

[102] In this case, in my opinion, past and future care does not arise. Therefore, I would decline to award damages under this heading.

Punitive damages

[103] The plaintiff claim a sum of $10,000.00 under this head.

[104] Counsel for the plaintiff submits that the defendants in the present case in a way had acted tortuously for instant PW1 said that his son was awake and active and then the defendants gave sedative drugs to keep him asleep and knowing that the ETT was leaking and made no effort to correct the leakage which resulted in the patient collapse, which indeed was a torturous act to the plaintiff and, therefore, the defendants should be punished.

[105] Exemplary damages or punitive damages are exceptional and only in rare cases they are awarded. In *Borron v Fiji Broadcasting Commission* [1982] FJCA 7; ABU0040.1981 (2 April 1982), the Court of Appeal said:

> *"Exemplary damages are damages which are awarded to punish a defendant and vindicate the strength of the law. In considering whether exemplary damages should be awarded the court should ask itself whether the sum it proposes to award compensatory damages, which may include an element of aggravated damages is adequate in all the circumstances for compensating a plaintiff and also for punishing or deterring a defendant. Only if it is inadequate for the latter purpose should the Court consider awarding exemplary damages."*

[106] DW1, staff nurse at Ba Health Centre failed to refer the baby to the doctor when the baby was present to her with an injury in the tongue, in violation of the IMCI

guidelines. She failed to investigate the history leading to the injury, which was part of her duty of care. She then unsuccessfully maintained that the plaintiff did not tell her that the injury was due to a fall. The nurses at Lautoka Hospital frequently injected sedative drugs to the baby, which had led over dosing of the sedative drugs to the baby. The surgery had been done on the child on the basis that the child had Ludwig Angina. Ludwig Angina was only a guessing of DW2, the doctor at Ba Health Centre. There was no clinically proven evidence that the child had Ludwig Angina.

[107] I think it is a fit case for granting exemplary damages. The irresponsible behaviours of the doctors and nurses both at Ba Health Centre and at Lautoka Hospital need to be denounced. In the circumstances of the case, I would allow a sum of **$10,000.00** as punitive damages.

Special damages

[108] The plaintiff seeks a sum of $660.00, $500.00 for transportation and $160.00 for care provider.

[109] It is apparent the plaintiff (child's father) was looking after his son in the hospital at PICU and also attending conference with the doctors and nurses. It is also apparent that the plaintiff would have incurred costs for transportation. He would have also incurred other incidental costs. I exercise my discretion and allow the sum of $660.00 as special damages even though the plaintiff did not provide receipts for such expenses. It is rare that people get receipts for this kind of expenses.

Interest

[110] I refrain from granting interest on the judgment sum.

[111] The Law Reform (Miscellaneous Provision) (Death and Interest), as amended, section 4 (3), states: *"… no interest shall be payable on any Judgment Debt entered in any proceedings against the State, or Attorney General."* Based on this section, the Court of Appeal in *Permanent Secretary for Health v Voliti* [2016] FJCA 131; ABU0040.2014 (30 September 2016) set aside award of interest made by the High Court.

Contributory negligence

[112] The defendant's claim that the plaintiff's contributory negligence should necessarily fail. The defence of contributory negligence has no application to the facts of the case. The plaintiff had not done any act to contribution to aggravate the injury.

[113] Hon. Mr Justice W. Calanchini, President, Court of Appeal (his Lordship as then was) in *Permanent Secretary for Health v Voliti,* above said [at para 10]:

> *"[10] … The duty that the Appellants owed to Voliti was to ensure that Voliti's injury as he presented at the Korovou Health Centre was diagnosed and treated to the standard of prudent nurses and doctors exercising reasonable care. So far as the Appellant's were concerned the manner in the injury had either occurred or been treated prior to his presenting at the Korovou Health Centre were matters that needed to be determined as part of the diagnosis. The duty included taking a detailed history of what had occurred prior to presentation and then to diagnose and treat."*

[114] The doctors and nurses at Ba Health Centre and at Lautoka Hospital owed the duty to the plaintiff to ensure that his injury as he presented at the Ba Health Centre was diagnosed and treated to the standard of prudent nurses and doctors exercising reasonable care.

[115] There was no evidence before court that the plaintiff's injury had infected before he was presented to the Ba Health Centre. Therefore, the defence of contributory negligence is irrelevant and accordingly fails.

Costs

[116] As a successful party, the plaintiff is entitled to costs of these proceedings, which I intend to summarily assess. I consider all into my account and assess the costs at $3,000.00.

[117] I summarize the damages and costs to be paid by the defendant as follows:

1) General damages	:	$25,000.00
2) Loss of earnings	:	$132,600.00

3) Exemplary damages	:	$10,000.00
4) Special damages	:	$660.00
		==========
		$168,260.00
5) Costs	:	$3,000.00
		==========
		$171,260.00
		==========

The outcome:

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.

..........................7/12/20

M.H. Mohamed Ajmeer

JUDGE

At Lautoka
07 December 2020

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