AMINA SHAH v NALINI NARAYAN and Anor

GATES J

26 July 2001, 18–22 February 2002, 19 September 2003

[2003] FJHC 340

Negligence — professional negligence — damages — abandoned needle in Plaintiff's perineum while undergoing surgery — doctor's negligence towards Plaintiff — hospital also liable.

Plaintiff sought damages due to an abandoned broken surgical needle in her perineum while undergoing obstetric procedure at a hospital. She alleged medical negligence and the damage that resulted by its presence.

Held — The hospital authorities owed a duty of care towards their patient, the Plaintiff. By leaving inside her body the broken surgical needle whose breaking would have been obvious to the person using the needle at the time of its breaking, that duty of care was breached. The 2nd Defendant failed to rebut the inference of negligence concerning the needle, and the hospital authorities, having control and management of their medical staff, was liable for the resultant damage caused.

Damages awarded.

Cases referred to

Attorney-General v Jainendra Prasad Singh Civ App No ABU 1U of 1998S; *Attorney-General v Charles Valentine* Civ App No ABU 19 of 1998S; *Bennett v Chemical Construction (GB) Ltd* [1971] 1 WLR 1571; *Bolitho v City & Hackney Health Authority* [1998] AC 232; *Easton v Ford Motor Co Ltd* [1993] 4 All ER 257; *F v R* (1983) 33 SASR 189; *Jefford v Gee* [1970] 2 QB 130; *Lloyde v West Midlands Gas Board* [1971] 1 WLR 749; *Moore v R Fox & Sons* [1956] 1 QB 596; *Renee Wurzel v Minika Tappen Management Ltd* Civil Act No HBC 180 of 1995L; *Rogers v Whitaker* (1992) 175 CLR 479; 109 ALR 624; [1992] HCA 58; *Swan v Salisbury Construction Co Ltd* [1966] 1 WLR 204; *Sisters of St Joseph v Fleming* [1938] 2 DLR 417; *Surya Deo Sharma v Jovesa Sabolalevu* [1999] 45 FLR 204, cited.

Barkway v South Wales Transport Co Ltd [1950] 1 All ER 392; *British Gas Plc v Green Elms Ltd* [1988] CA Transcript 89; *Byrne v Boadle* (1863) 2 H & C 722; *Cassell & Co Ltd v Broome* [1972] AC 1027; *Cropper v Smith* (1884) 26 Ch D 700; *Halford v Brookes* [1991] 1 WLR 428; *Himmat Soni v Attorney-General* Civ Act No HBC 279 of 1984S; *Hucks v Cole* [1993] 4 Med LR 393; *Kralj v McGrath* [1986] 1 All ER 54; *Mahon v Osborne* [1939] 2 KB 14; *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634; *Navnesh Neil Singh v Attorney-General* Civ Act No HBC 26 of 1995S; *Nesbitt v Holt* [1953] 1 DLR 671; *Paul Praveen Sharma v Attorney-General* Civ Act No HBC 728 of 1984S; *Scott v London & St Katherine Docks Co* (1865) 3 H & C 596; *Brisbane South Regional Health Authority v Taylor* (1996) 186 CLR 541; 139 ALR 1; 70 ALJR 866; *Tildesley v Harper* (1878) 10 Ch D 393; *Tara Wati Naidu v Dr Isikeli Tami* Civ Case No HBC 145J of 1994L; *Tevita Tabua Waqabaca* Civ Action No HBC 60 of 1993S, considered.

S. Maharaj for the Plaintiff.

S. Kumar for the 1st and 2nd Defendants.

[1] Gates J. On 13 August 1993 the Plaintiff was informed by a surgeon at the Lautoka Hospital that there was a foreign body lodged in her perineal region. During an operation performed subsequently at a hospital in Auckland, this object was removed. It was found to be a broken surgical needle, measuring 2 cm in length.

[2] The issues for determination in this case concern when was the needle left in, who was responsible for leaving the needle in the Plaintiff's body, and what damage resulted from its presence. There were other issues as well, chief of which were whether the Defendants had managed and treated the Plaintiff's various gynaecological symptoms negligently, whether they should have removed her uterus, and whether the Plaintiff had given her informed consent to such removal.

[3] The 1st Defendant is sued as the executrix of the estate of Dr Raghwa Narayan, the doctor who was the consultant obstetrician and gynaecologist employed by the Government of Fiji at the Lautoka Hospital and who had attended to the plaintiff at the material time. The 2nd Defendant is sued as the legal representative of the Government of Fiji responsible for the provision of medical services at the Lautoka Hospital, and vicariously as the employer of the 1st Defendant.

Background facts

[4] The Plaintiff now lives in Sydney. In 1975 she married Shariyad Shah. Until 1996 they lived in Lautoka. They had two children, a son Faimeen Faiyaz Shah born on 5 June 1976 and a daughter Razmeena Mainaz Begum born on 4 June 1978.

[5] At both births, there had been some stitching. The first delivery had involved an episiotomy. The second delivery had required stitching to repair vaginal lacerations. The Plaintiff said she had suffered some swelling, but experienced no pains before the first child. She experienced a pricking pain during sexual intercourse, near the vaginal area on the left side. It was not a pain she felt all of the time, nor was it severe. It depended, she said, on the position in which she had sex.

[6] First she consulted her family doctor. Various tests were undertaken, and she was prescribed tablets for the pain. On a repeat visit she was advised to lose weight.

[7] On 12 July 1988 the Plaintiff consulted Dr Raghwa Narayan at the Lautoka Hospital. She complained of severe pelvic pain, post coital bleeding as well as pain during intercourse. She was then aged 34. A brief history was taken which showed she had been taking the contraceptive pill Nordette 21, and suffered painful and heavy periods. She was asked to come in again to the clinic on 28 July 1988.

[8] A further history was then taken. Dr Narayan had previously told her he needed to clean the uterus, and to do other procedures. Because of vaginal infection, these procedures were put off till 12 August 88.

[9] On that day, Dr Narayan performed an examination under anaesthetic, a D & C (dilatation and curettage), a cone biopsy and an excision of a perineal sinus. This sinus (an abnormal canal or passage leading to an abscess) was recorded by Dr Narayan as being sited on the right side of the anal opening. In his report of 7 September 1993 however, Dr Narayan said it was sited in the left ischio-rectal space. He confirmed again that the first sinus was on the left in a report to his solicitors dated 12 July 1995 at a time when he was clearly aware that litigation had commenced.

[10] Over the next three visits to clinic for review the Plaintiff was found to be well, free of bleeding, the sinus excision site was well healed up, the uterus normal, and its adnexal or adjacent parts normal also.

[11] During 1989 the Plaintiff made seven visits to the clinic. From the complaints of vaginal discharge and itch Dr Narayan diagnosed vaginal thrush — candida. She was treated with anti-fungal pessaries and cream. There was no further sign of the sinus.

5 **[12]** The Plaintiff was monitored in two documented visits in 1990 and was asymptomatic. In 1991 she returned with pelvic pain and menstrual abnormality. Initially she was treated with antibiotics. The symptoms persisted. Histologically it was confirmed she had endometritis (inflammation of the mucous membrane of the uterus) and chronic cervicitis. In August 1991 the notes suggest pelvic 10 clearance or hysterectomy was being considered for January 1992.

[13] In fact a total abdominal hysterectomy was carried out by Dr Narayan on the Plaintiff on 17 December 1991. The uterus was found to be normal and regular as were both fallopian tubes and the ovaries. No pelvic adhesions were present nor endometriosis.

15 **[14]** In 1992 she complained of dysuria (painful urination) but investigation for dysmenorrhoea (painful menstruation) and cancer, proved negative. In June 1992 Dr Narayan noted a sinus on the left side, and that it was a raw area. Nothing more was noted of it. On 13 October 1992 he noted an ischio-rectal abscess on the right side of the rectum.

20 **[15]** On 23 February 1993 an ischio-rectal abscess was recorded this time on the left side. Dr Narayan noted there was no discharge and saw the Plaintiff the following week when he noted again there was no discharge.

[16] On 6 April 1993 he referred the Plaintiff to the surgeons with a description 25 of symptoms that she had chronic sinus on the left ischio-rectal space with intermittent collection of pus and discharge.

[17] The surgeon noted on the file that she had had this sinus since January 1992, and that it had discharged pus from time to time. Initially the surgeon treated the sinus with amoxil [amoxicillin]. This course of drugs was 30 then repeated.

[18] On 13 August 1993 the surgeon diagnosed chronic fistula in ano post episiotomy. Following an X-ray and a sinogram [a radiograph of a sinus tract with a radiopaque contra medium] the surgeon was able to confirm the presence of a foreign body. He thought it was probably a needle, and that it had caused the 35 longstanding fistula or sinus discharge.

[19] He discussed with the Plaintiff and her husband what should then happen to remove the foreign body. On 4 August 1993 one of the surgeons said the operation should be done overseas by a colo-rectal surgeon. Subsequently, on 20 August 1993 another surgeon, Dr Tami, told them it was a minor procedure 40 and could be done at the Lautoka Hospital. The Plaintiff said she did not have faith in the doctors at Lautoka anymore and insisted on having her operation overseas.

[20] The Plaintiff flew to New Zealand in September 1993 and contacted a relative who was also a doctor. Through him an appointment was made with a 45 Dr Boon Lim MBBS, MRCOG, FRNZCOG, an obstetrician and gynaecologist, who eventually carried out the operation at 8 October 1993. The next day Dr Lim showed the Plaintiff the foreign body. It was a broken off piece of surgical needle. In his report of 30 November 1993 Dr Lim noted

> 50 That the original sinus opening had communicated to another opening at around the 3 o'clock position of the anus. The sinus tract was opened up and excised and a small surgical needle was removed deep to the sinus tract.

[21] This last operation was a success. There was no recurrence of sinus. The Plaintiff said she had no pain upon having sexual intercourse subsequently. She no longer suffered periods or blood stains.

5 **The evidence and the witnesses**

[22] In this case it must be remembered that no witness has been called to give evidence who actually attended the Plaintiff between 1976–1993, the relevant period for focus. Dr Narayan is now deceased. Other doctors or registrars in his Obstetric and Gynaecology team who may have seen the Plaintiff were not
10 called, nor were any of the surgeons in the surgery department at the Lautoka Hospital. Dr Tami died after the trial was over. No explanation was given in evidence as to why certain of the participants in the Plaintiff's treatment were not made available or called.

15 **[23]** There is of course no burden on a litigant to call any particular witness. A civil trial is not a public inquiry. Any evidence presented to the court is a matter for the legal advisors of a party to decide upon in consultation with their clients, and rarely does a penalty or handicap attract to a litigant for failing to call a witness.

20 **[24]** This being a civil trial the burden rests upon the Plaintiff throughout to prove her various claims as set out in the statement of claim. She must prove her case on the balance of probabilities. I shall refer to a relevant exception to this rule further on.

25 **[25]** The only eyewitness as it were, was the Plaintiff herself. Her husband supported her briefly on symptoms. The remaining three witnesses were all doctors who had studied the hospital file, some more closely than others. Their evidence consisted of opinions on the diagnosis and treatment carried out or prescribed and on appropriateness. None of these three had examined the Plaintiff
30 at the relevant time.

[26] The exhibits for the most part consisted of extracts of medical textbooks, articles from professional journals, diagrams, the hospital file, medical reports, and the broken needle. So with the exception of the Plaintiff herself and to a lesser extent her husband, consideration of the factual events in the case had to
35 rest on the notes of what the doctors said they had done, and expert evidence to assist in the interpretation of the significance of those notes in deducting what had occurred and whether it accorded with professionally acceptable standards.

[27] This situation is far from ideal. It is important therefore to avoid rushing to judgment on those not able to defend themselves in court or to explain their
40 conduct.

The hospital file

[28] The hospital file on the patient dating from 1988 was exhibited. Anyone who was not already thoroughly familiar with the details of this difficult case
45 would not have been readily assisted by it. It was often out of chronological order, and prior to a clinic the file may have required a full re-reading in order to ensure all of the significant factors and incidents were brought clearly back to mind. In an overcrowded clinic this would not always have been possible. The somewhat muddled state of the file could have led to the failure to move on, and
50 along, the diagnostic path rather than to the repeating of tests at the clinic that had already been tried on many previous occasions.

When was the needle left inside?

[29] The Plaintiff said she had a tear near her vagina at the delivery of her first child in 1976. The tear was stitched. She does not remember who the doctor was who attended her at that birth. The stitching occurred at the Lautoka Hospital. According to the medical witnesses a similar surgical needle to the one recovered by Dr Lim would have been in use at Lautoka in 1976.

[30] The only other procedure the Plaintiff said she had had was when she underwent a stitching in the perineal region for the hysterectomy carried out by Dr Raghwa Narayanon 17 December 1991.The Plaintiff omitted to say in evidence that there had been some stitching with the second delivery also. But she had told Dr Lim of it when he took a full history.

[31] The Plaintiff said she first experienced pain in that region after the first child. It was not all the time. But it was on the left side of the vaginal area. At first it was not very severe.

[32] Upon consulting Dr Narayan a sinus was discovered in 1988 which was excised. At that time the site of the sinus was neither probed nor X-rayed. There was no recurrence of sinus for 3 years. Dr Narayan carried out the hysterectomy in late 1991. By January 1992 the Plaintiff had a recurrence of the sinus, and suffered ischio-rectal abscesses in October 1992 and February 1993.

[33] Dr Lim in a careful report noted that on first examination there was a "sinus opening on the left side of the perineum approximately 3 cm to the left of the fourchette. There was no obvious episiotomy scar on the left side although the scar was noted to be more towards the midline and to the right". He concluded:

> I am unable to determine if the foreign body was left behind after the first or second childbirth. However it would appear that she also had trouble with her menses and dysmenorrhoea at the same time when she was complaining of her perineal pain. It is therefore unlikely that the foreign body was left behind after the hysterectomy.

[34] Dr Narayan himself said in his report of 12 February 1995 "The needle in the perineum probably has been there since her previous child birth either in 1976 or 1978". The old hospital notes were not available. More was not provided, though Dr Taoi said hospital records are destroyed after 10 years. I found the evidence on this point unsatisfactory. Were they destroyed or had they been sent to National Archives? The Defendant's counsel is probably correct in submitting that the old delivery notes are not relevant to many of the issues in this case. But the notes would have indicated the site where stitching had been carried out, which was of importance. Dr Narayan thought the 1978 delivery had probably been carried out by a midwife, which might explain his next comment. He said:

> Another important thing is to realise the fact that normally (the) cut in the perineum (episiotomy) at child birth is done at the right side but this needle was found on the left side.

He did not open the door for a suggestion that the needle was left in during the hysterectomy of 1991.

[35] Dr Mary Schramm FRCOG, FRACOG (Hon) stated in her report of 17 April1 997 that she considered the presence of a needle fragment in the perineum for 12 years was very uncommon. This must be so. An article was however exhibited which referred to a case where 20 years after a delivery involving the stitching of a vaginal scar, a pelvic X-ray had by chance visualised

a fragment of a broken needle. The woman was not aware of it, but after the delivery, had complained of lower abdominal chronic pain and insisted on a hysterectomy.

[36] Dr Tui Taoi MBBS, MRCOG, now the Consultant Gynaecologist at the Lautoka Hospital, considered it unlikely that a foreign body at the episiotomy site would remain "silent". She noted that the sinus resulting from the foreign body had been quiescent for years. It was of course an unusual phenomenon but such quiescence was not unknown for foreign bodies.

[37] I conclude that the needle was not left in the Plaintiff's body at the time of the hysterectomy. I found the Plaintiff to be a careful and truthful witness. On the balance of probabilities I find that the needle was left in her perinuem at the time of the stitching of the lacerations at the second delivery in 1978.

[38] Those lacerations may have been on the left side, and hence the discovery of the broken needle on the left side. I accept Dr Narayan's opinion in his report that for episiotomy procedures, incisions to the perineum are normally made to the right. This fact would tend to rule out the abandonment of the needle at the time of the episiotomy at the first birth in 1976.

Res ipsa loquitur

[39] The maxim res ipsa loquitur [the thing speaks for itself] is "used in actions for negligence where no proof of negligence is required beyond the accident itself, which is such as to involve a prima facie inference of negligence on the part of the Defendant": Jowett, The Dictionary of English Law. In certain cases one fact raises a presumption of another fact, unless and until the contrary is proved. The fact or the accident here is the abandonment of the broken surgical needle in the perineum of the Plaintiff while she underwent an obstetric procedure at the Lautoka Hospital. The maxim applies only to the claim against the authorities charged with providing hospital services at Lautoka [2nd Defendant] not to Dr Narayan, for he was not shown, or claimed, to have been responsible for leaving the needle behind.

[40] The maxim applies whenever the happening of an accident is so improbable without the negligence of the Defendant being the cause. In *Scott v London and St Katherine Docks Co* (1865) 3 H & C 596 at 667 Erle CJ delivering the majority decision of the court said:

> There must be reasonable evidence of negligence. But where the thing is shewn to be under the management of the defendant or his servants, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of explanation by the defendants, that the accident arose from want of care.

[41] That was the case where six bags of sugar fell from a warehouse during loading onto a customs officer as he walked along a street. In *Byrne v Boadle* (1863) 2 H & C 722 it was a barrel of flour rolling out from an upper doorway above a shop which similarly fell on an innocent passerby. Pollock CB (at 301) said:

> and in my opinion the fact of its falling is primâ facie evidence of negligence, and the Plaintiff who was injured by it is not bound to shew that it could not fall without negligence, but if there are any facts inconsistent with negligence it is for the Defendant to prove them.

[42] Once such basic facts are proved, which constitute reasonable evidence of negligence and which cannot be described as a mere scintilla of evidence, a burden is cast upon the Defendant, here the 2nd Defendant, to disprove negligence. This is a burden that can be discharged; *Swan v Salisbury Construction Co Ltd* [1966] 1 WLR 204 at 212. If the doctrine is relevantly engaged, as it is here, then the burden or inference is not discharged by defence evidence showing that the occurrence of the accident was inexplicable: *Moore v R Fox & Sons* [1956] 1 QB 596.

[43] In *Barkway v South Wales Transport Co Ltd* [1950] 1 All ER 392 at 394 per Lord Porter said:

> The doctrine is dependent on the absence of explanation, and, although it is the duty of the defendants, if they desire to protect themselves, to give an adequate explanation of the cause of the accident, yet, if the facts are sufficiently known, the question ceases to be one where the facts speak for themselves, and the solution is to be found by determining whether, on the facts as established, negligence is to be inferred or not.

At at 399 per Lord Porter concluded:

> but it is accepted doctrine that each case must depend and depend only on the evidence prjesented.

[44] Lord Radcliffe concurring with Lord Porter observed (at 403):

> I do not think that the appellant was entitled to judgment in the action because of any special virtue in the maxim res ipsa loquitur. I find nothing more in that maxim than a rule of evidence, of which the essence is that an event which in the ordinary course of things is more likely than not to have been caused by negligence is by itself evidence of negligence.

[45] *Mahon v Osborne* [1939] 2 KB 14, concerned an instance where a surgeon and theatre nurse were sued for the consequences of a swab being left inside a patient after an operation. At 38 per MacKinnon LJ said:

> The plaintiff, having no means of knowing what happened in the theatre, was in the position of being able to rely on the maxim res ipsa loquitur so as to say that some one or more of these five must have been negligent, since the swab was beyond question left in the abdomen of the deceased.

[46] It was suggested that res ipsa loquitur was a late amendment to the plaintiff's pleadings, and therefore statute barred. Under Fiji's High Court Rules as well as under the English Rules there is no requirement that reliance on the doctrine be specifically pleaded [O 18 r 7]. It is not a material fact in the case but a rule of evidence concerned with the effect of evidence in certain circumstances. Fleming called it "only an aid in the evaluation of evidence": Law of Torts, 3rd ed, 1965. It need not be expressly pleaded: *Bennett v Chemical Construction (GB) Ltd* [1971] 1 WLR 1571; *Lloyde v West Midlands Gas Board* [1971] 1 WLR 749.

[47] In explaining the purpose of the rule in *Mahon*, Goddard LJ in a minority judgment said (at 50):

> It is no disparagement of the devoted and frequently gratuitous service which the profession of surgery renders to mankind to say that its members may on occasion fall short of the standard of care which they themselves, no less than the law, require, and, if a patient on whom had befallen such a misfortune as we are now considering were not entitled to call on the surgeon for an explanation, I cannot but feel that an unwarranted protection would be given to carelessness, such as I do not believe the profession itself would either expect or desire.

[48] In *Nesbitt v Holt* [1953] 1 DLR 671 SCC it was said at 673:

> Res ipsa loquitur is not a doctrine but "The rule is a special case within the broader doctrine that Courts act and are entitled to act upon the weight of the balance of probabilities": *Sisters of St. Joseph v Fleming,* [1938] 2 DLR 417 at 420, SCR 172 at p 177. It may apply in malpractice cases depending upon the circumstances and for the reasons already given. It applies here.

That was a case where a dentist failed to count the number of sponges during an operation under full anaesthetic. A sponge had become lodged in the trachea of the patient who died of asphyxia as a result:

> What is complained of is that anyone, even without the appellant's training, knowledge and experience, would have checked the sponges, and that when he noticed the patient turning pale, he would have looked to see if all the sponges were accounted for.

[49] In the instant case, the hospital authorities clearly owed a duty of care towards their patient, the Plaintiff. By leaving inside her body the broken surgical needle whose breaking would have been obvious to the person using the needle at the time of its breaking, that duty of care was breached. It has not been suggested that such a thing could happen without negligence: *Cassidy v Ministry of Health* [1951] 2 KB 343 at 366 per Denning LJ. The 2nd Defendant has failed to rebut the inference of negligence concerning the needle, and I find the hospital authorities, having control and management of their medical staff, liable for the resultant damage caused. I shall consider further on what that damage amounted to.

Is this part of the claim statute barred?

[50] Dr Taoi informed the Plaintiff on 13 August 1993 that it was likely there was a foreign body in her perinuem. The Plaintiff was shown the foreign body namely a needle by Dr Lim on 9 October 1993, the day after the operation for its removal. The Plaintiff was only therefore in possession of material facts on 9 October 1993 which might have given rise to a claim in negligence, about matters that could have occurred unbeknownst to the Plaintiff as early as 1976. She would have needed to have consulted a lawyer to discover whether she did in fact have such a claim.

[51] A writ was issued against Dr Narayan and the 2nd Defendant on 11 April 1994. This was a claim for medical malpractice for negligence. It was a claim in tort. In the first statement of claim the presence of a foreign body was pleaded, and details provided that it was a needle which had been in situ since either 1976 or 1978 at the time of the births of the Plaintiff's children. The particulars of negligence however focussed on the 1st Defendant's failure to detect the presence of the needle in the perinuem. The particulars at that time, did not specify the abandonment of the needle inside the Plaintiff's perineum by unknown medical personnel at the births in 1976 or 1978 and allege vicarious liability against the hospital authorities.

[52] By motion of 6 March 1995 however the plaintiff applied to the court for leave to amend the statement of claim. It was heard inter partes on 21 April 1995 when Sadal J granted leave. At para 12 (d) negligence was particularised as:

> Leaving the needle in the perineum of the plaintiff.

The amended writ was filed on 25 April 1995

[53] A statement of defence had been filed on 6 August 1994, para 5 of which pleaded a blanket denial of para 12 of the then statement of claim. No defence was filed to the amended writ. The plaintiff's counsel admits that the Defendant failed to plead to para 12(d), and so are to be taken to have admitted that allegation. There were further amendments by consent to the statement of claim, whereby the leaving in of the needle allegation became para 22(i) [16 July 2001].

[54] The amended defence of 20 June 2001 pleaded that the Defendants had no knowledge of the presence of the needle and could therefore neither admit nor deny being responsible for the leaving in of the needle.

[55] In relation to the defence claim that the amendment to the claim involved a new cause of action, the parties must now be bound by the order of Sadal J permitting the amendment in 1995. Further amendments by consent were clarifications of the particulars not new causes of action. The Defendants go on to submit that the presence of the needle claim is barred by virtue of the Limitation Act. In the Minutes of Pre-Trial Conference of 17 July 2001 the two issues were clearly set out, that is whether the Defendants were negligent in leaving the needle in the perineum in 1976 or 1978, and whether (that part of) the Plaintiff's claim is statute barred.

[56] Actions or omissions in 1976 or 1978 for which the 2nd Defendant was to be held responsible by a writ filed in 1994 were clearly well outside the 3 year limit for the bringing of such litigation, a claim in tort for medical negligence causing personal injuries [s 4(1)(a) proviso (i) Limitation Act Cap 35]. Leave to be allowed to proceed with this part of the claim was not sought as it should have been [ss 16 and 17].

[57] Having reviewed the authorities, I have decided that I should grant the necessary extension to the limitation period and allow this part of the claim to proceed and for it to be considered along with the other claims in the writ and statement of claim. I do so for several reasons. First, I would exercise a residual discretion since I believe it would achieve justice in this case. The majority of the High Court in *Brisbane South Regional Health Authority v Taylor* (1996) 186 CLR 541; 139 ALR 1; 70 ALJR 866 agreed that a discretion was only to be exercised in an applicant's favour if in all the circumstances justice was to be best served by so doing. But prior to a consideration of such exercise, it is necessary to consider whether the Plaintiff qualifies under the Limitation Act. I will return to this a little later on.

[58] In *British Gas Plc v Green Elms Ltd* [1988] CA Transcript 89, 5 February 1988 Staughton LJ had said:

> I start with what was said by Bowen LJ in *Cropper v Smith* (1884) 26 Ch D 700 at 710–711: "It is a well-established principle that the object of the Court is to decide the rights of the parties, and not to punish them for mistakes they make in the conduct of their cases by deciding otherwise than in accordance with their rights … I know of no kind of error or mistake which, if not fraudulent or intended to overreach, the Court ought not to correct, if it can be done without injustice to the other party. Courts do not exist for the sake of discipline, but for the sake of deciding matters in controversy, and I do not regard such amendment as a matter of favour or grace." That passage is or ought to be engraved on the heart or lodged firmly in the brain of every practitioner.

He went on:

> But, even if there was reprehensible delay, I remind myself that courts do not exist for the sake of discipline or to punish mistakes but to decide the rights of the parties.

5 **[59]** In *Tildesley v Harper* (1878) 10 Ch D 393, Thesiger LJ at 397 said:

> The object of those rules is to obtain a correct issue between the parties, and when an error has been made it is not intended that the party making the mistake should be mulcted in the loss of the trial.

[60] It was found to be important "that the court shall so exercise its 10 jurisdiction in any cause or matter before it so as to secure that as far as possible all matters in dispute between the parties are completely and finally determined and all multiplicity of legal proceedings with respect to any of those matters is avoided": *Easton v Ford Motor Co Ltd* [1993] 4 All ER 257 at 261. I had referred to these decisions in a ruling allowing a late amendment of pleadings thus 15 permitting a defendant to plead the defence of limitation in *Renee Wurzel v Minika Tappen Management Ltd* (unreported, Lautoka High Court, Civil Action HBC180.95L, 14 August 2001).

[61] When the writ was first filed in 1994 it would have been obvious to the 20 Defendants that they needed to find out as much as they could about the foreign body. After all it was this matter which gave rise to the diagnostic problem which had in turn faced Dr Narayan and his employers. Meanwhile they could have got on with the business of discovering relevant files, ascertained who were the attending doctors or midwives, and made necessary inquiries in order to prepare 25 their defence. The eventual amendment of the particulars of negligence in 1995 would hardly have come as a surprise.

[62] Since the presence of the embedded needle was a fact of a decisive character, material to the institution of a claim concerning it, and a fact unknown to the Plaintiff within the relevant 3–year period following the leaving behind of 30 the needle, the Plaintiff meets the crucial issue for leave [s 16(3)]: *Surya Deo Sharma v Jovesa Sabolalevu & Attorney-General of Fiji* [1999] 45 FLR 204 at 206E. The plaintiff would not have had any reason to know of the needle until Dr Lim produced the needle to her. Nor would she have known that the needle was medically responsible for a proportion of her symptoms and sufferings 35 [s 19]. Her evidence in the case together with the exhibits, the hospital file, and various doctors opinions combined to establish her cause of action [s 17(3)].

[63] Though the needle was discovered in 1993, the exact date when the needle was left behind would not have been known to her, till later. The Plaintiff could be held to have constructive knowledge of the time of abandonment once 40 discovery in the course of proceedings had taken place. But even this is open to some doubt. It would have required, as has been the case in this trial, a thorough scrutiny of all of the evidence, and of the doctor's reports in order to settle on a date of abandonment. Was it at the first delivery in 1976, or the second in 1978 or at the time of the hysterectomy in 1991? It may have been thought initially that 45 the hysterectomy was the most likely occasion for the abandonment, in which case leave would not have been required.

[64] This was not an easy case in which to issue an immediate writ with a detailed statement of claim. Much legwork would have been needed forensically to discover a correct causation. "Knowledge" of facts means more than mere 50 reasonable belief or suspicion: *Davis v Ministry of Health* (unreported, 26 July 1985, Court of Appeal (Eng), Transcript No 413 of 1985). In *Halford v Brookes*

[1991] 1 WLR 428 per Lord Donaldson MR said "Suspicion, particularly if it is vague and unsupported, will indeed not be enough, but reasonable belief will normally suffice". Some delay in dealing with the abandonment claim and its medical consequences was to be expected.

5 **[65]** I find that little additional prejudice is attracted to the 2nd Defendant by the grant of leave. These issues were, as I have said earlier, well known to the 2nd Defendant at the outset, though since clarified in the amended pleadings and set out as trial issues by both counsel in the PTC Minutes. I have not been satisfied that the delivery notes were indeed looked for or that they had been
10 destroyed by virtue of archival practice.

[66] As for the residual discretion to allow this part of the Plaintiff's claim to proceed, she having succeeded in meeting the three requirements for leave under the Limitation Act, I find that there would be great injustice in not granting leave. Justice must be done if at all possible within the Rules. Kirby J in Brisbane
15 Authority (above at 884) said:

> Secondly, the Act, in providing for extensions of time, has incorporated provisions which are protective and beneficial. In the specified circumstances, they afford a privilege to a person to bring a claim, notwithstanding the expiry of the normal limitation period. Such provisions should not be narrowly construed or applied.
> 20 Although the burden remains on the applicant throughout, once the preconditions are established, that burden is not a heavy one. Most potential plaintiffs will face their real difficulties in establishing the preconditions.

[67] Had the application been made at the correct time, it would surely have
25 been granted. Possibly in that event, the 2nd Defendant would not have persisted with its statute barred claim in the trial, bearing in mind a palpable wrong, a negligent act in error, had been done to the Plaintiff in the public hospital. For all of the above reasons, I consider it right that leave at this late stage, unusually, should be granted.

30 **Should the Defendants have diagnosed the foreign body?**

[68] The plaintiff called Dr Sachida Mudaliar DSM (Fiji), Dip Obst (Auck), a Fiji registered specialist in gynaecology and obstetrics. I found him a careful and thoughtful witness, who had studied and analysed the hospital file meticulously.

35 **[69]** Dr Narayan excised the perineal sinus on 12 August 1988. The patient had been suffering from dyspareunia (pain in the — labia, vagina or pelvis during or after sexual intercourse). The sinus was discovered when Dr Narayan came to do the D & C and the cone biopsy under anaesthetic. "You need to know the cause of a sinus" claimed Dr Mudaliar. Both defence doctors, Dr Schramm and Dr Taoi
40 agreed with this obvious statement. There was nothing in the hospital notes however to suggest Dr Narayan attempted to establish the cause of this or any other sinus. As it turned out, the sinus tract healed up after excision and did not recur for another 4 years [in 1992].

[70] Dr Mudaliar referred to *"A Short Practice of Surgery"*, 18th ed by Bailey
45 and Luff, pp 67, 68. The editors there listed eight causes of a sinus, the first cause proposed for consideration being "a foreign body or necrotic tissue … eg: a suture, sequestrum, a faecolith or even a worm". In advising treatment it said that "the remedy depends upon the removal or specific treatment of the cause".

[71] Dr Mudaliar referred to another standard text, Professor K Das' *"Clinical*
50 *Methods in Surgery"*, 8th ed: Professor Das similarly placed foreign body at the top of his list of likely causes of sinus, or of their persistence. Professor Sir

Norman Jeffcoate's *"Principles of Gynaecology"*, 4th ed was also referred to, in which was stressed the importance of removal of the foreign body to avoid infection and its potentially dangerous sequelae.

[72] Both Dr Taoi and Dr Mudaliar agreed that it would be necessary to keep in mind that the sinus might be caused by a foreign body. But first Dr Mudaliar said the cause of the sinus must be established before going ahead with its excision. He considered it incorrect procedure to carry out the excision, a dirty operation, simultaneously as carrying out the examination under anaesthetic, the D & C and the cone biopsy, essentially clean operations. There was a danger of cross-infection at the site of the raw areas.

[73] Dr Schramm considered the combined operation performed by Dr Narayan saved the plaintiff a further operation. But she did state that she would have removed the foreign body first, if she had known of it. She accepted also that the cause was to be ascertained first.

[74] Dr Mudaliar said: "You need to know by investigation, physical examination, X-ray, dye. Once you have a picture, then you treat that sinus". He said all sinuses should be X-rayed. When eventually 5 years on in this case, a sinogram was undertaken, the question posed by this diagnostic problem was immediately answered.

[75] Professor Das advised careful examination of the mouth of the sinus to look for sprouting granulation tissue. He said "this is significant of a foreign body in the depth". Dr Taoi said if there was granulation at the mouth then there could be a foreign body. There were several symptoms to look for but all the doctors agreed with Professor Das' recommended approach that a probe be done. He had said (p 33):

> C. *Examination with a probe* should be made cautiously without using any force. The following points are noted: (a) the direction and depth of the sinus; (b) the presence of any foreign body or a movable sequestrum; (c) whether the end of the probe enters a bony cavity or a hollow viscus; (d) whether fresh discharge comes out on withdrawal of the probe.

[76] Dr Mudaliar considered the removal of the foreign body should only be undertaken by the surgeons not by the consultant Gynaecologist. Dr Schramm and Dr Taoi said they would have dealt with it themselves by operation. It was within a gynaecologist's expertise. I accept that. However I do not accept that the procedure could be carried out blind without prior preparatory works, namely X-ray, probe, swabs to ascertain histology, and examination for and of granulations.

[77] There was some criticism of the standard texts referred to by Dr Mudaliar on the basis that they were not the latest editions of those works. This was correct, but no criticisms were directed to any of the tests or procedures urged by Dr Mudaliar suggesting they had now been discarded or replaced with others. The careful methodology of approach recommended by Dr Mudaliar could not be faulted.

[78] "Find cause first" said Dr Mudaliar "if you are going to find right treatment". None of the cautious and recommended steps to diagnosis of the cause of the sinus were commenced by Dr Narayan with the first sinus in 1988. The sinus came back of course and the Plaintiff suffered further pain, discomfort and discharge in 1992. Apart from pap smears, none of the appropriate diagnostic procedures were undertaken with the persisting sinus. Both defence doctors had to admit that the referral by Dr Narayan to the surgeons in April 1993 was late,

and that the surgeons themselves were tardy in not carrying out an X-ray by sinogram for another 4 months after referral.

[79] I find that Dr Narayan failed in his duty of care to the Plaintiff in that his treatment of the Plaintiff fell below the necessary professional standard expected by his peers. Had he approached the diagnosis of the sinus methodically and professionally rejecting the short-cut "blind" approach, he would have ascertained the cause of the sinus and treated it correctly so that it would not have recurred. His treatment in this regard was negligent.

Was it negligent to remove the uterus?

[80] The parties doctors disagreed on this issue. Dr Schramm and Dr Taoi concluded that since conservative management of the Plaintiff's gynaecological problems, the chronic cervicitis, the perennial warts, the endometritis and the pelvic pain, had failed, it was reasonable to offer the Plaintiff the hysterectomy.

[81] Dr Mudaliar referred to Professor Jeffcoate's text. But even Jeffcoate considered hysterectomy necessary for endometritis "if there is widespread infection in the pelvic organs" (pp 317–8) or "if the condition of cervicitis is so severe that it cannot be satisfactorily treated" (p 316–7). Jeffcoate did specify however that "The indication for hysterectomy in any case must therefore be clearly defined and should be one for which more conservative treatment is not likely to be efficacious": p 731.

[82] In evidence Dr Mudaliar gave his opinion as follows:

> From the notes and presenting symptoms and findings it appears that the chronic discharge from the sinus was introduced into the vagina at intercourse, or its presence in the vaginal orifice ascending into the cervix causing cervicitis, contact bleeding, pain with intercourse, and further ascent of the infection into the endometrium and treating a pelvic cellulitis situation giving rise to menorrhagic and pelvic pain.

[83] In short, it was the sinus discharge that gave rise to all the other complaints and infections. Dr Mudaliar considered the removal of the uterus was not justified. After the total hysterectomy which Dr Narayan carried out, it was found that the uterus, ovaries, tubes, adnexae, all were normal.

[84] No doubt attitudes have changed concerning hysterectomies. In opening remarks to his Ch 47 "Hysterectomy and its Aftermath" Professor Jeffcoate said:

> Hysterectomy is a relatively easy operation to perform and is often easiest when least necessary. Many thousands of women die annually as a result of having this operation unnecessarily. It has even been said by some gynaecologists that, once a woman's family is complete, the uterus is a foreign body which should be removed. Many perform the operation merely at the request or demand of their patients who are led to believe that all their troubles originate in their pelvic organs and that they will be cured by "having everything removed". The surgeon lacking in conscience or care to make an accurate diagnosis can take a similar view, and so resorts to hysterectomy on the slightest pretext and for indications such as "chronic pelvic pain" of unknown aetiology. It is not exaggerating the situation to say that an ever-ailing woman is sometimes deprived of her uterus and appendages so that the gynaecologist can thereafter shun responsibility for her care, on the grounds that there is nothing left in "his department" which can possibly cause her symptoms.

Even for the woman who does not wish to have more children the uterus is not an organ to be discarded lightly. The very knowledge that she is "normal" and the recurrent evidence of this by way of menstruation, are psychologically if not physically important, both to her and to her husband.

[85] Perhaps some of this was intended to be provocative material for medical students. But it also represented a respectable body of contemporary opinion on the matter. Dr Schramm was less enthusiastic. I accept that there are two responsible schools of thought on the issue, and that fact alone would tend to negate negligence.

[86] Lord Scarman in *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634 at 639 said:

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

[87] Lord Browne-Wilkinson cited Lord Scarman's passage in his lordship's speech in *Bolitho v City and Hackney Health Authority* [1998] AC 232 at 241 Lord Browne-Wilkinson continued:

> My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a Defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the Defendant's treatment or diagnosis accorded with sound medical practice. In the Bolam case itself, McNair J. [1957] 1 WLR 583 at 587 stated that the Defendant had to have acted in accordance with the practice accepted as proper by a "responsible body of medical men". Later, at 588, he referred to "a standard of practice recognised as proper by a competent reasonable body of opinion". Again, in the passage which I have cited from Maynard's case [1984] 1 WLR 634 at 639, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives—responsible, reasonable and respectable---all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.

Ultimately it will be for the court to decide if the doctor had reached a defensible conclusion.

[88] In *Hucks v Cole* [1993] 4 Med LR 393 Sachs LJ said:

> On such occasions the fact that other practitioners would have done the same thing as the defendant practitioner is a very weighty matter to be put on the scales on his behalf; but it is not, as Mr. Webster readily conceded, conclusive.

[89] Dr Mudaliar considered that if the sinus was not treated and continued to discharge it would have been re-infecting the cervix and the endometrium and caused pelvic cellulitis and persistent pelvic pain. Both Dr Schramm and Dr Taoi thought it unlikely that infection from the sinus could have found its way into the area of the uterus.

[90] Medical opinion was divided as to the cause of the Plaintiff's pain and suffering in the pelvic region. Dr Mudaliar said there was nothing to indicate that the pain could have emanated from the normal organs seen.

[91] Before there could be a sound basis for advising the Plaintiff to undergo the removal of her uterus, a logical approach had to be applied to the diagnosis and treatment of the sinus. Without such an approach how would it be possible with evidential foundation to link the pain, or any of the other symptoms, to the uterus or to any other organ of the pelvic region? How, without this knowledge, could the gynaecologist be sure that a hysterectomy would eliminate the symptoms, or absent the sinus, that the hysterectomy was necessary?

[92] Because the persisting sinus could not be discounted as the cause of any of these symptoms, the decision to advise a hysterectomy for removal of the symptoms was flawed and premature. If the sinus had been diagnosed with the correct methodology and eliminated, and the symptoms still persisted, then hysterectomy would have been unquestionably a proper treatment. It might still have been a treatment that lacked favour in some circles. But the decision to carry out the hysterectomy would have been a decision approved by "a body of opinion as being responsible, reasonable and respectable" (*Bolitho* at 242). Such a decision would have had "a logical basis" and "in forming their views, the experts (would) have directed their minds to the question of comparative risks and benefits and reached a defensible conclusion on the matter" (*Bolitho* at 242B).

[93] I find that for these reasons Dr Narayan's approach was not logical. It fell below the required standard of treatment, and in doing so he was negligent.

Was the hysterectomy properly consented to?

[94] The Plaintiff claims that her consent to the hysterectomy was obtained by misrepresentation. She said in evidence she discussed the removal of the uterus with her husband. She was undergoing serious pain at the time. She had made it plain to Dr Narayan that they had hoped to have another child. This was the reason she refused to have the operation when it was first suggested to her by Dr Narayan.

[95] But she said that her husband had agreed in 1991 on the basis that Dr Narayan said it was necessary to remove it in order to relieve pain. They relied on what Dr Narayan had said. She said "we agreed to it".

[96] It seems beyond question that the Plaintiff and her husband realised that the consequences of this operation were that she would not be able to give birth to another child again. The patient was told that all her pain would go if the operation were carried out. It was not, of course. This may have been because of the continued presence of the needle rather than because of the failure of the recommended procedure.

[97] A consent by patient form was signed by the Plaintiff on 16 December 1991, countersigned by Dr Fong. Dr Fong signed below stating "I confirm that I have explained to the patient the nature and effect of this operation". Dr Fong was not called by the Defendants to amplify the bare bones of the form. It is unlikely without a fuller note that Dr Fong would have been able to recall what he had said to the Plaintiff. Dr Fong appears to have taken the history prior to the operation the following day. His note of that examination is detailed and thorough. Accordingly I accept that a proper explanation of the consequences of the operation was made to the Plaintiff.

[98] No doubt a form could have been devised allowing for a more detailed note of the discussions dealing with relevant risks and consequences of the operation showing that the patient had been accorded a fair and proper choice in

the matter. *Rogers v Whitaker* (1992) 175 CLR 479; 109 ALR 625. After all "the paramount consideration (is) that a person is entitled to make his own decisions about his life": *F v F* (1983) 33 SASR 189 at 193. Such a choice is in reality meaningless unless it is made on the basis of relevant information and advice: *Rogers* (at 489). I am satisfied that there was no misrepresentation here. I am also satisfied that the Plaintiff and her husband well understood the consequences of the removal, and that the Plaintiff made her choice with that knowledge.

Special damages

[99] When the needle was eventually discovered, Dr Tami asked the Plaintiff when she wanted it removed. She told him she was not willing to have it done in Fiji. Dr Tami became very angry with her and said "it is just a minor operation". This was Dr Taoi's view of the procedure also. Dr Schramm considered it could have been done in Fiji. I have no doubt of that.

[100] The surgeon noted on the hospital notes for 4 August 1993 that "we suggest that the patient should have overseas operation by colo-rectal surgeon" This was because he considered the Plaintiff could claim on her bank insurance and would be covered. Not surprisingly her claim was rejected by the insurance company. Was it reasonable for her not to have faith in the treatment offered to her in Fiji at that time, and thus to have the corrective surgery performed overseas? Ordinarily a Plaintiff must mitigate his or her loss.

[101] In view of what she had gone through, the negligent abandonment of the needle in her body, the misdiagnosis of her symptoms for a number of years, and the premature and possibly unnecessary hysterectomy, as well as the overbearing rudeness towards her by the doctors who were meant to be attending her and caring for her, once the needle came to light, I conclude it was reasonable for the Plaintiff to seek correction of the error overseas.

[102] The Plaintiff exhibited a schedule for special damages and gave evidence of some of the reasons for items in the schedule. Almost all of these items are reasonable sums. Their extent was not subject to challenge. The defence had the schedule from 26 July 2001 the first day of the trial. I allow the airfare to New Zealand, X-ray charges, anaesthetist, doctors, the surgeons fees and hospital charges, taxis and telephone calls which came to F$2825. Of the expenses while in New Zealand for travel to the hospital, accommodation, sundry expenses, and warm clothing, $1500 is sought, of which I will allow $750.

[103] While the Plaintiff was in pain she employed a housegirl to do the housework that she herself was too sick to do. This was for the period 1988-93. I will allow the claimed amount of $2500 under this head, as also the pharmacy items of $1000. For leave taken from annual leave used as sick leave I will allow a rounded up figure of $2300.

General damages

[104] The line of suffering for the Plaintiff has two stems. The first arose from the negligent abandonment of the surgical needle inside the Plaintiff's perineum. She suffered pain and discomfort between the years 1978 and 1993, a period of 15 years. I am satisfied that most of that pain was caused by the presence of the needle. During that time she was in increasing pain, she had difficulties in sitting down, suffered awkward discharge, all of which interfered with her work at the bank. She was often tired and unable to cope with housework.

[105] Her personal life was disrupted and her marriage nearly ended, since her pain on intercourse and resultant disinclination was attributed by her husband to her interests outside of the marriage. This caused the Plaintiff understandable distress.

[106] No two cases are so similar in cause and effect as to illustrate how a Plaintiff should be compensated. I have been referred to a number of cases to show a range of awards for medical negligence. What is significant here is the long period that the Plaintiff had to endure painful and discomforting symptoms. In *Navnesh Neil Singh v AG* (unreported, Suva High Court, Civil Action HBC0026.95S, 10 June 1999) Byrne J awarded a young boy general damages of $60,000 for delayed treatment resulting in a burst appendix, several correctional operations and lengthy convalescence.

[107] In *Tara Wati Naidu v Dr Isikeli Tami* (unreported, Lautoka High Court, Civil case HBC0145J.94L, 6 October 2000) Madraiwiwi J found a misdiagnosis of cancer resulting in the paintiff nursing "a real sense of anger and resentment at what she had undergone" worthy of an award of $30,000 for pain, suffering and mental anguish.

[108] $85,000 was awarded in *Tevita Tabua Waqabaca* Suva Civil Action 60.93S, 20 March 1998 per Pathik J for pain and suffering following negligence before and after surgery. The infant Plaintiff had developed irreversible brain damage as a result of the non-availability of oxygen in the hospital ward at the crucial time. The results of the negligence were tragic and disastrous. In *Paul Praveen Sharma v AG* (unreported, Suva Civil Action 728.84S, 27 August 1993) the Plaintiff's leg was set too tightly in plaster of paris which eventually led to amputation. An award of $50,000 was made for the pain and suffering endured by the Plaintiff, this part of the award not being altered by the Court of Appeal. I note Byrne J.'s decision was made 10 years ago.

[109] Considering all of the circumstances and consequences flowing from the abandonment of the needle in the Plaintiff's body, I believe an award of $40,000 is appropriate.

[110] For the negligent diagnosis and attention to her medical symptoms, and the premature hysterectomy, all of which occurred over the period 1988–93, I award a further $30,000 under the head of pain and suffering. This period of suffering was a lengthy one, carrying its burden of anxiety and stress. I have concluded that the hysterectomy was premature. It is impossible to say whether or not it might have been indicated by symptoms remaining after removal of the foreign body. I therefore award no damages for its removal as such, and award damages only for its premature removal.

[111] I found the evidence relating to economic loss through loss of promotion and advancement in her employment insufficiently substantiated.

[112] There will be interest on general damages of 6% from date of writ (14 April 1994) to date of judgment: *AG v Jainendra Prasad Singh* (unreported, Court of Appeal, Civil App ABU0001.98S, 21 May 1999). Interest between the same dates is awarded on special damages at 3%: *Jefford v Gee* [1970] 2 QB 130; cited with approval in *AG v Charles Valentine* (unreported, Court of Appeal, Civil App ABU0019.98S, 28 August 1998).

Aggravated damages

[113] The Plaintiff claims aggravated damages. When the foreign body came to light at the time of the sinogram, Dr Tami asked the Plaintiff in the presence of her husband when she wanted it removed. The Plaintiff said she did not want it

to be removed at Lautoka but wanted it removed overseas. Dr Tami then got angry and started shouting, saying it "was just a minor operation, why can't you have it here". That interview ended unpleasantly and he asked them to return on 16 August.

[114] The next interview was no better. Dr Tami thought they might have changed their minds. They had not. The Plaintiff said she had no faith in them anymore. "Why are you here? I am closing the file. This is the end of it" said Dr Tami. He was so angry he could not talk to them said the Plaintiff. He refused them the report and banged the door.

[115] They made a further approach to obtain a report for overseas referral, this time through a friend intermediary. Dr Tami's attitude improved. Dr Narayan was to do the report. She waited patiently outside his clinic. But Dr Narayan treated them brusquely, telling them he had already refused to give them a report. He said "I do not want to see you at all". This was said in front of patients and hospital staff. He shouted that he would not give the report. The Plaintiff eventually got her report, but there was still more of a run-around that she was to be put through first.

[116] In *Himmat Soni v AG* (unreported, Lautoka High Court, Civil Action 279.84S, 7 July 1989) Jayaratne J awarded $5000 for aggravated damages. His lordship had this to say:

> There is evidence in this case to the effect that he was unable to meet any doctor at the hospital when he arrived there on hearing of his wife's condition. It must have been indeed a very anxious moment. He was trying to take her away for overseas treatment. His feelings must have been definitely bent beyond any measurable degree. There is no doubt about it.

The following is an excerpt of his evidence in court:

> Immediately I went to Lautoka Hospital. She (wife) was in the re Unit … She was unconscious. I met Dr. Nair. He said "It is not my fault." I tried to find out her condition. I met Dr. Oldmeadow. I sought permission to take her overseas for treatment. I could not get any information about her condition.

This sort of attitude is most despicable and disgusting to hear of. When the plaintiff is in such agony and anguish and fear for the life of his wife and when he is rebuffed and pushed from pillar to post being still unable to obtain information about the wife, it can only be described as most deplorable. Husband being not in a position to get information about his wife's condition who was more or less was breathing her last is aggravating indeed. The condition that she was in was brought about by the negligence of the 2nd defendant who administered the anaesthetics. It became an overdose. Furthermore there was a restriction on the use of oxygen which was in short supply. I consider it reasonable in the absence of any guidelines for a computation of compensation to award $5,000 under the head.

[117] The whole issue of aggravated damages and exemplary damages has been referred to by Lord Hailsham LC in *Cassel & Co v Broome* [1972] AC 1027 at 1073 as one of "inextricable confusion". He said:

> In awarding "aggravated" damages the natural indignation of the court at the injury inflicted on the plaintiff is a perfectly legitimate motive in making a generous rather than a more moderate award to provide an adequate solatium. But that is because the injury to the plaintiff is actually greater and as the result of the conduct exciting the indignation demands a more generous solatium.

[118] Woolf J in *Kralj v McGrath* [1986] 1 All ER 54 at 61 said:

> "It is my view that it would be wholly inappropriate to introduce into claims of this sort, for breach of contract and negligence, the concept of aggravated damages." His lordship said he considered it inconsistent with the general approach to damages in this area "which is to compensate the plaintiff for the loss she has actually suffered."

[119] However I believe it is right to allow the Plaintiff to be compensated by the public authorities for the matter of her treatment by their public servants. In *Kralj* the "horrific and wholly unacceptable treatment" was that the obstetrician had performed a procedure without anaesthetic. In the instant case the feelings of the Plaintiff had been affected at a particularly vulnerable time, as a result of the injury requiring rectification. She was to be ill-treated for the mistakes of the hospital staff upon her, and was treated disgracefully for their sense of guilt. For this she is deserving of some compensation. I award $4000 under this head.

Costs

[120] A detailed schedule of costs was submitted with Plaintiff's counsel's submissions. Both Plaintiff and defence counsel also are to be thanked for their thorough and detailed written submissions, clearly the product of much thought and industry.

[121] All of the costs listed were reasonable and I see no reason to deny the Plaintiff these, which could not have included all of her legal costs and expenses. Some of those listed are clearly pared down. I allow counsel's fees at 1000 per day for a 7–day trial with three-and-a-half days for instructions, research, preparation and the two written submissions, a figure of $10,500. I allow all of the disbursements for court filing fees, bailiff, and hearing fees, $2100. I allow $160 for miscellaneous photocopying, fax and the like. I allow their expert witness his attendance, travel and accommodation of $4900 and I allow attendance of the plaintiff and her husband, also a witness, from Sydney, air tickets and reasonable pocket expenses, of $5082.

Summary

There will be judgment for the Plaintiff against the two defendants as I have indicated in the course of this judgment.

I tabulate the heads of award which I have rounded up as follows:

		F$
1.	General damages [pain and suffering and loss of amenities]	
	For the needle	40,000
	For the negligence diagnosis etc	30,000
2.	Special damages	9,400
3.	Aggravated damages	4,000
4.	Interest on general damages at 6% (from 14 April 1994 to 19 September 2003)	38,000
5.	Interest on special damages at 3% from 14 April 1994 to 19 September 2003)	2,680
6.	Costs	22,742.00
	The total award is of	$147,622

Damages awarded.