The Court of Appeal for Bermuda

CIVIL APPEAL No 2 of 2013

Between:

KAMAL WILLIAMS

Appellant

-v-

THE BERMUDA HOSPITALS BOARD

Respondent

Before: **Evans, J.A.**
Ward, J.A.
Bell, A.J.A

Appearances: Mr. Jai Pachai, Wakefield Quin, for the Appellant
Mr. Allan Doughty, Trott & Duncan, for the Respondent

Date of Hearing: **19 November 2013**
Date of Judgment: **17 March 2014**

JUDGMENT

Ward, J.A.

1. On 30 May 2011 at 7:30 a.m. the Plaintiff/Appellant was at his home and feeling unwell. Nevertheless he went to work where at 9:30 a.m. he experienced lower abdominal pain.

2. At 10:15 a.m. he was taken to the King Edward VII Memorial Hospital (KEMH) operated by the Bermuda Hospitals Board (BHB) with severe abdominal pain.

3. An hour later at 11:16 a.m. he was admitted to the Emergency Department of the hospital. Dr. Okereke was the doctor who admitted him. He was examined and at 11:31 a.m. he was found to have excessive pain (10 out of 10), abnormally low blood pressure, 86/57, abnormal pulse rate, 105, and an abnormal respiratory rate of 24. He was a very sick man.

4. At 11:44 a.m. he was again examined by Dr. Okereke. The patient was screaming in considerable pain. He would not allow the doctor to touch his belly. He was diagnosed as showing symptoms consistent with appendicitis. He also informed the medical personnel that other members of his family had suffered with a similar ailment. He was given Pethidine to alleviate the pain which he was suffering.

5. At 12:15 p.m. Dr. Okereke again examined the patient. By this time the Pethidine had begun to take effect and the patient was more comfortable. But it did not mean that the internal situation in the patient was any less dangerous.

6. At 1:10 p.m. Dr. Okereke made a further examination and ordered a CT scan which was described as the appropriate test before surgical consultation. This test was ordered almost three hours after the patient went to the hospital at 10:15 a.m. and almost two hours after his admission at 11:16 a.m.

7. There followed delay in the taking of the CT scan and in obtaining the results of the CT scan.

8. At 3:00 p.m. Dr. Okereke called the Diagnostic Imaging Department to stress the urgency of carrying out the CT scan. He spoke to a technician

who said that the department was still very busy and the scan would be taken as soon as possible.

9. The patient continued to grow worse. At 3:18 p.m. he had an abnormally rapid pulse rate of 118 and he was again showing signs of pain. He was given more Pethidine which had last been administered at 11:44 a.m. Its purpose was to mask the pain but it did not address the underlying problem.

10. At 4:00 p.m. there was a changing of the guard. It was the end of the work day of Dr. Okereke and his final day at work at KEMH. He handed over the care of the patient to Dr. DiLullo.

11. Dr. DiLullo examined him at 4:17 p.m. and again at 4:45 p.m. His vital signs were stable but he was still in considerable pain with severe abdominal tenderness.

12. At 5:12 p.m. the patient was taken for the CT scan which was completed by 5:30 p.m.

13. At 5:38 p.m. Dr. DiLullo again examined the patient who had a slightly elevated heart rate but his blood pressure was lower.

14. At 5:50 p.m. she paged the on-call radiologist but received no answer. It later transpired that the radiologist had been feeling unwell and left his office early. There was no person remaining in the office in Bermuda whose job was to read the CT scan and it was therefore sent to the Overseas Reporting Agency in Australia for interpretation at 6:27 p.m.

15. For the fourth time Dr. DiLullo examined the patient at 7:00 p.m. when she received a report from the nurse that the patient had vomited and also had diarrhoea. His vital signs were stable.

16. At 7:19 p.m. the report was received from Australia of the reading of the CT scan which stated that the findings were consistent with acute appendicitis and would require surgery. Had the Plaintiff/Appellant been physically able, he would no doubt have responded that he told them that from the beginning.

17. At 8:54 p.m. Dr. Miller, the surgeon, discussed the case with Dr. DiLullo. At that time the patient's pain was recorded at a measurement of nine out of ten.

18. The surgery began at 10:15 p.m. almost 12 hours after the Appellant first arrived at the hospital and approximately 11 hours after his admission. He was found to have a perforated appendix. His counsel made the point which has not been disputed, that the rupture of the appendix occurs progressively. Because of that rupture the patient suffered from sepsis in the blood stream which is a generalised infection of the body that is carried through the blood stream.

19. During the surgery the patient suffered from impaired heart function, otherwise described as a cardiac event, his heart and lungs were malfunctioning and he was admitted to the Intensive Care Unit at 15 minutes after midnight in a critically ill condition with acute respiratory distress syndrome and he was placed on a ventilator where he remained for the next seven days.

20. On 7 June 2011 he was transferred to a general ward where he was cared for until his discharge from the KEMH on 13 June 2011.

21. On 1 August 2011 he was diagnosed by his private physician as having developed adhesions as a complication of the perforation.

22. Having considered the factual matrix, I ask myself whether the BHB omitted to do anything which it ought to have done and as a result of which omission the patient suffered damage.

23. The answer comes back with resounding clarity that it did.

24. The numerous delays individually and collectively were contributing factors to the damage ultimately suffered. There were delays between arrival, admission, examination, the ordering, taking and reading of the CT scan and the surgery. And when viewed against the background of the physical signs exhibited by the Appellant on his arrival at the KEMH, his tossing and screaming, I find the delay to be inordinate.

25. The Appellant complained of the failure of the BHB to have in place an adequate system for the diagnosis and treatment within a reasonable time of patients arriving in the Emergency Department of the hospital with appendicitis.

26. The learned judge wrote in paragraphs 102 and 103 of his Judgment: -

> "...as Dr. Conn stated, in matters of suspected appendicitis it is important to proceed with expedition.
>
> In order to facilitate this, an Adequate System would provide that a CT scan in a case of suspected appendicitis should in the normal course of events be obtained on a STAT basis. An Adequate System would

> further provide that, where the CT scan was sent to an overseas reporting agency, the need for an interpretation on a STAT basis was communicated to the agency. It appears from the Root Cause Analysis (RCA) that in May 2011 there were no such provisions in place at the hospital. It is obvious to me that there should have been. I consider that this shortcoming was essentially administrative rather than medical. Had Mr. Williams' CT scan been obtained on a STAT basis then it is probable he would have been diagnosed and treated more rapidly."

27. The learned judge then reasoned somewhat surprisingly that even if there had been a system in place for quick diagnosis, it did not follow that the patient would have been operated on before the rupture of his appendix because there may have been other delaying factors such as a longer wait for an operating theatre. With respect, this was unwarranted speculation. There was no evidence of other delaying factors.

28. In paragraph 108 the learned judge concluded that the BHB did negligently breach its duty of care to the Appellant but went on in paragraph 114 to find that the Appellant had failed to prove that the complications he developed during and after surgery were probably caused by the BHB's failure to diagnose and treat him expeditiously. Had the CT scan been obtained and interpreted promptly these complications might have been avoided, but he was not satisfied that they probably would have been avoided.

29. The learned judge then proceeded to award the Appellant limited damages for pain and suffering caused by the delay in treating him, but not damages for pain and suffering and loss of amenity resulting from the complications of having a ruptured appendix.

30. The BHB conducted its own Root Cause Analysis dated 7 June 2011 to find out what went wrong, to detect defects in their system and to receive recommendations of corrective measures for the future leading to development of Risk Reduction Strategies.

31. It revealed that some things went wrong in the treatment of the patient. To begin with the CT scan should have been carried out immediately and not delayed until the Diagnostic Imaging Department technician could fit it into his heavy schedule. The power to determine the timing of the examination should have rested with the physician and not with the technician. As it was an emergency, the test should have been performed immediately and its result should have been obtained and given to the physician in charge of the patient immediately.

32. The BHB should be commended for preparing the Root Cause Analysis which revealed a readiness to admit that something went wrong which should be corrected and where possible, avoided in future.

33. In considering the system which was in place, there are two other observations which I would make. If for some reason the CT scan cannot be performed expeditiously, then the surgeon must be prepared to consider the alternative of performing exploratory surgery based on his clinical examination. The patient cannot be left in agony for ever and his welfare must remain the paramount consideration.

34. I would also observe that even if the radiologist was not feeling well and unfortunately found it necessary to leave, some competent physician should have been left in charge to cover for him until it was time to use the services of the overseas reporting agency. The Diagnostic Imaging Department should not have been left in the hands of the technician.

35. In his report of 7 December 2012 Dr. Leitman expressed the view that the negligent delay was the cause of the complications suffered by the patient. However, in paragraphs 114 and 116 of his Judgment the learned judge did not embrace that firm conclusion but expressed uncertainty as to the cause of the complications and went on to hold therefore that the Appellant had not proved his case.

36. As regards that finding, we hold that the learned judge was in error by raising the bar unattainably high. The proper test of causation was not whether the negligent delay and inadequate system caused the injury to the Appellant but rather whether the breaches of duty by BHB contributed materially to the injury. That those breaches did contribute is beyond argument.

37. Originally where causation was alleged it was for the claimant to establish that the defendant owed him a duty of care, that the defendant was in breach of that duty and that the breach of that duty caused the damage or loss of which the claimant complained. It was for the plaintiff to prove "the real substantial, direct or effective cause." Stapley v Gypsum Mines Ltd. [1953] AC 663 at 687 per Lord Asquith.

38. More recently the boundaries of tortious liability have been expanded and, as explained in Clerk and Lindsell on Torts, Nineteenth Edition para. 2-69, the 'but for' test is sometimes relaxed to enable a claimant to overcome the causation hurdle when it might otherwise seem unjust to require the claimant to prove the impossible. It was described in Barker v Corus UK Ltd. (HL (E)) [2006] 2 AC 572 at 589 quoting from Fairchild v Glenhaven Funeral Services Ltd. [2003] AC 32 (HL (E)) as a different and less stringent

test of causation. In Fairchild a defendant who had created a material risk of mesothelioma (a disease contracted from inhaling dust from asbestos fibres) was deemed to have caused or materially contributed to the contraction of the disease.

39. In Bailey v Ministry of Defence et al [2008] EWCA Civ. 883 the 'but for' rule was modified and the correct question was whether the negligence had caused or materially contributed to the injury and if 'but for' the contribution of the tortious cause the injury would probably not have occurred, the claimant would have discharged the burden of proof.

40. Counsel for the BHB referred to Gregg v Scott [2005] AC 176 which was a claim for damages for loss of expectation of life in which there was a wrong diagnosis of a lump under an arm and as a result of which treatment was delayed for nine months and the chances of a cure were reduced from 42% to 25%. It was held by a majority that there was not a sufficient causal link between the defendant's conduct and the claimant's injury. But there were two dissenting opinions and two statements by Lord Hoffman are instructive namely that for loss to be recoverable it must be shown that the damage in question was attributable to the defendant's wrongful act and there must be a sufficient causal link between the defendant's conduct and the claimant's injury.

41. It is no longer a question of all or nothing but one of sufficiency.

42. In my view in the case at bar causal or causative links between the inordinate delays coupled with the defective system which together contributed to the Appellant's injury were clearly established.

43. The BHB had cross-appealed against the alleged failure of the judge to consider whether the time taken in obtaining a surgical consultation for the Plaintiff was reasonable in the view of a reasonable body of medical opinion and by other hospitals.

44. In paragraph 108 the learned judge found that the BHB has breached its duty of care by the manner in which it treated the patient and, impliedly stated, that no matter what might happen in other hospitals, the standard of care reached on this occasion was not satisfactory. A bad example should never be followed.

45. I would only observe in passing that the "Bolam test" [1957] 1WLR 582 which was applied in that case was acting in accordance with a practice accepted as proper by a responsible body of medical opinion. The Root Cause Analysis prepared by the BHB concluded that what was done was not accepted as proper.

46. There is no merit in the cross-appeal and it is accordingly dismissed with costs.

47. The appeal is allowed. The matter is remitted to the Supreme Court for damages to be assessed with costs to the Appellant.

Ward, JA

Evans, JA

Bell, AJA