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LEGAL TOPIC: MEDICAL NEGLIGENCE PART II - LANDMARK DECIDED CASES AND AWARDS MADE

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We start out this particular article by stating that in our respectful view, the scale of awards and damages for many of these areas of medical Neglicgence are way too low in Trinidad and Tobago but we invite the public to be the Judge and to form their own opinions hereupon, as we present a few of the decided cases and the awards therein.

ANTHONY JORDAN v NORTH CENTRAL REGIONAL HEALTH AUTHORITY CV2012-03889

The Claimant in this matter was involved in a motor vehicular accident and sustained injury including, inter alia, a severe fracture of his right hip. As a result of the failure of the staff of the Eric Williams Medical Sciences Complex (EWMSC) to diagnose severe fracture of his right hip, his injury was not treated appropriately and he was not operated upon or placed in traction, and the fracture was not given an opportunity to unite. The result was that there was a maluniting at the hip joint which required a total hip replacement with use of special prosthesis as the only option for treatment of the injury. Furthermore he developed Cauda Equina syndrome, the effect of this condition appeared from his medical report to be loss of sensation and erectile dysfunction as a result of

the impact of the accident. This remained undiagnosed and untreated. The medical/surgical staff at the EWMSC failed to diagnose, manage and/or treat the Claimant's injuries in a timely fashion. A dislocated hip loses its viability after twelve (12) hours. In the case of this Claimant, the twelve (12) hour window for a hip to remain viable had long passed, with the severity of the injury not having been recognized at the EWMSC. As a result of this extreme negligence in the delay in diagnosis and treatment of the Claimant's injury to his right hip, the femoral head's blood supply would have been significantly compromised, the end result being that a situation which was reversible was allowed to become irreversible.

The Court was of the view that the normal procedure should have been manipulation and reduction under general anesthesia after the patient was stable with the reduction then held in place by skeletal traction. The Claimant thereafter would have been fully resuscitated and reconstructive hip surgery ought to have been performed and this would have obviated the need for a total hip replacement as was subsequently dictated by his condition at the time of this matter being heard. The Court awarded the Claimant the sum of $375,000.00 in respect of General Damages for Pain and Suffering and Loss of Amenities and the sum of $75,000.00 in respect of loss of future pecuniary prospects.

Samdaye Harrilal v South West Regional Health Authority; The Attorney General of Trinidad and Tobago H.C.A.555/2003.CV APP. #60 of 2008

In this matter the Claimant had given birth to a stillborn male child at the San Fernando General Hospital on 23rd April, 2002 due to the negligence of the Hospital, its servants or agents and claimed damages for the loss of her child, as well as damages for distress, anxiety and inconvenience. The senior doctors at the hospital had taken an industrial action by withholding their services to the extent that at the time of the Claimant's admission, there was no Obstetrician on duty. At no time during her stay at the hospital, from admission to delivery of her child, was the Claimant seen or treated by a doctor. The Trial Judge ordered judgment in the

Claimant's favour and awarded damages in the sum $140,000.00 for medical negligence.

This matter was appeal and the appellate Judges dismissed the appeal on the issue of liability. However the appeal was allowed in part on the issue of quantum of damages and the damages awarded by the Trial Judge were reduced to $120,000.00 on the basis that that Ms. Harrilal had not proved damages for physical illness brought on her by the grave misfortune and thus the Court made no award in respect of same.

In this matter the Court of Appeal expressed that: "The issues raised in this Appeal are of great public interest, moreso because, ultimately, the cause of action may have resulted from unprecedented industrial action taken by medical doctors at a public hospital. Additionally, our reasons are being published at a time of great public anxiety about the quality of medical care being given to members of the public, (most of whom cannot afford private care) at our public medical institutions and particularly so in respect of maternity cases." The Court of Appeal further stated that: "In the case of a public hospital, such as the San Fernando General Hospital, such a duty of care is beyond question. Indeed, it has been expressed as a fundamental proposition that the operation of a public or general hospital is "affected with a public interest". The same is to be said of the operation of the San Fernando General Hospital and indeed all public health facilities in Trinidad and Tobago."

The Court of Appeal considered that the Trial Judge found that the SWRHA was in breach of its duty of care to Ms. Harrilal and summarized its reasons as follows: (i) no option was given to Ms. Harrilal to attend another medical facility staffed with doctors, in the event that one would be required; (ii) there were no doctors available in the hospital to attend to Ms. Harrilal at the earliest possible time, should there have been an indication that something may have gone wrong with the baby's heart rate; (iii) there was a delay in the administering of the antibiotic to Ms. Harrilal because the nurse had to obtain authorization of a doctor via the telephone; (iv) Ms. Harrilal had been in excruciating pain and had requested a doctor to attend to her but none was available; (v) there was no monitoring to decide whether to do delivery via caesarean section; (vi) the lack of availability of doctors on the labour ward,

eliminated all possibility of delivery by forceps or caesarean section, since this was a decision to be made at the ward by doctors on duty; (vii) the very fact that Ms. Harrilal suffered from Ventricular Septal Defect (VSD) and that something could have gone wrong should have put the nurses on guard, they should not have taken the responsibility of accepting a VSD patient and the fact that she suffered from VSD made her a high risk patient; and (viii) the baby was three days overdue. This meant that the pregnancy had entered a danger zone. An obstetrician should have seen Ms. Harrilal so as to make a considered judgment long before any kind of serious labour started.

The Court of Appeal was of the view that the negligence was compounded by the fact that Ms. Harrilal (as Dr. Trotman testified) was a high risk patient with a congenital heart condition who required antibiotic treatment under supervision by a doctor. This also did not occur. The absence of a medical doctor to address such an emergency amounted to negligence on the Hospital's part, if there were no doctors available to deal with medical emergencies, then patients such as Ms. Harrilal who were high risk (in the respondent's case, due to her medical condition and to the fact that she was overdue), should have been re-directed to private hospitals or, once admitted, transferred to a private institution, when it became obvious that no doctor was available.

The Court of Appeal expressed that the fact of a stillbirth does not necessarily mean that a hospital is negligent and as to whether there is negligence this will turn on the evidence. In their judgment in this matter the Court of Appeal found that there was sufficient evidence on which to conclude, on a balance of probability, that there was the negligence of the hospital, in not having a doctor available to deal with the emergency which led to the stillbirth.

The Court of Appeal found it unreasonable (if not scandalous), that it should have taken thirty minutes, forty-five minutes or even an hour to prepare a patient in labour for C-section surgery in circumstances of emergency in which the life of the child is at immediate risk and stated that if such were the case, then the system at the San Fernando General hospital which was set up to deal with emergency C-

section surgeries was an inefficient and inadequate system which in all probability would have resulted in the death of the child. The Court stated that "in circumstances of emergency where the life of the child is at risk, a fifteen minute window is sufficient time within which to perform an emergency C-section to save the child and good conscience should always inform any decision in which innocent members of our citizenry are likely to be adversely affected."

Paula Mapp Joseph and Hugh Joseph v Minister of Health NWRHA H.C.2405/2002

In this matter the Claimant had a history of chronic pelvic pain and was misdiagnosed by a doctor at a public hospital as having an infected left fallopian tube and her fallopian tubes were wrongly removed rendering her permanently infertile.

Due to this negligence, the Claimant, who had two children from a previous relationship, was deprived of the opportunity to have children with her current husband who had no children of his own. The Judge found the NWRHA to be liable for the medical negligence and ordered general damages in the sum of $300,000.00.

Rana Ramlal v SWRHA , Deonarine Patricia Dr.; Attorney General of Trinidad and Tobago H.C.1291/1998

In this matter a young woman who was eighteen (18) weeks pregnant, had complaints of abdominal pains and bleeding and she attended the San Fernando General Hospital where she was negligently treated when a cervical polyp was mistaken for products of conception by an intern, the most junior in a team of doctors who had recently qualified as a doctor and she was treated for an incomplete abortion.

The Court heard substantial evidence to suggest that the occurrence of a polyp in pregnant women is extremely rare. It could easily be mistaken for products of conception by even senior doctors and that the only test which could distinguish the polyp from products of conception was the histo-pathological test. The Court was inclined to the view that the greater experience of the examining doctors would have

made the difference. The Judge expressed its view that where the Second Defendant (intern) must be held responsible is in her failure to heed the complaints of the patient. She dismissed the patient's complaints of fetal movements, as impossible, a view which, by the evidence of her own expert witnesses was clearly wrong. Had the Second Defendant paid even remote attention to the patient's observations, she may have sought the help of her senior and it would have been prudent to ascertain whether the fetus was alive. Dr. Rajkumar, expert witness, stated that an intern in that situation should seek the guidance of a post registration doctor. The second Defendant failed to do this, she sought, what in the Court's view, was the rubber stamping of the senior doctor and not his guidance. The senior was not in a position to check the correctness of the intern's conclusions by simply looking at her notes, which though neatly recorded may have been, and in fact, were wrong. It was not enough simply to take her notes to her senior, but to apprise him of the patient's complaint of fetal movements and to enable him, by his own examination to test the accuracy of the intern's findings. The Honourable Madame Justice Dean-Armorer awarded damages in the sum of $7,500.00 for medical negligence.

Dr. Patricia Deonarine appealed this decision and the Appeal was dismissed with costs. According to the Court of Appeal judgment delivered by Justice of Appeal Mendonca in 2003, the Court found that the doctor had mistaken the products of conception for an endo-cervical polyp which is extremely rare in pregnant women. The Court of Appeal expressed that although the polyp could have been removed by twisting it off, that is not what the Doctor attempted to do and what she succeeded in doing was causing pain to Ms. Ramlal. Dr. Deonarine was found to be competent to treat Ms. Ramlal and fell short of the standard expected of a person of ordinary skill.

GRACE PRIMA -V- AG H.C.A NO. 6501 OF 1985

In this case the Honourable Justice Persad Maharaj, awarded the sum of $130,000.00 as general damages plus interest, special damages in the sum of

$1,690.00 and legal costs where due to the negligence of medical staff, the Plaintiff lost not only the baby, but her ability to have more children and her uterus.

The plaintiff who was a high risk case because of her bad past obstetric history and past pregnancy records was made/ allowed to push during her second stage of labour for a prolonged period without progress under the care and attendance of a midwife without specialist doctors even though red writings on the plaintiff's medical records were present to alert all medical staff of the high risk nature of her case. Vaginal examinations or the results of same, during the second stage of labour the most crucial part of the plaintiff's pregnancy were not recorded. After pushing for over an hour without success, her uterus ruptured. She began screaming in pain which lasted for over an hour before she was anesthetized and underwent surgery. The child was delivered by caesarian section and was dead. The umbilical cord was found to be wrapped three times around the baby's neck. Her uterus was so badly ruptured that it was excised, thereby rendering her sterile.

The Court held that the nurses on duty were negligent in failing to pay due or any due regard to the plaintiff's case notes and previous medical history in particular the red writings on the medical records and the plaintiff was treated as a normal patient and had they done so they would have put themselves on guard. The nurse or nurses on duty were bound to inform the medical team doctors that the plaintiff a high-risk patient was admitted to the labour ward. These nurses conduct is deserving of censure and was most inexcusable. They fell below the standard of reasonable competent nurses in the particular midwifery field. The plaintiff had a previous still birth and almost died. The admission nurses were duty bound to inform the medical team of her admission to ensure that there was no re-occurrence of the previous incident and a high risk patient as the plaintiff needed special supervision and care and ought to have been monitored by the labour ward doctors.

The Court further held that the nurses were negligent in not calling in the medical team of doctors to monitor and supervise the progress of the plaintiff in her second

stage of labour and had this been done the unfortunate demise of the plaintiff's baby could have been avoided as well as the damage to her uterus.

CASES WHERE MEDICAL NEGLIGENCE RESULTED IN DEATH:

KAREN TESHEIRA v GULF VIEW MEDICAL CENTRE, CRISEN JENDRA ROOPCHAND CV 2009-02051

Russel Tesheira died as a result of medical negligence at Gulf View Medical Centre in the pre-operative and post-operative care of Mr. Tesheira as well as their management of the risk of excessive continuous post-operative bleeding after a Transurethral Resection of the Prostate (TURP) was performed on him to treat an enlarged prostate. Upon admission to the private medical institution there was no record of intake of the patient nor interview by the anesthetist to determine his fitness for surgery, medical history or whether there was any drug use that may impede the clotting ability of the blood. The Court found that the Defendants failed to:

- properly monitor and manage his blood transfusions
- determine if the deceased was taking aspirin before performing the TURP
- monitor pre-operative and post-operative recovery
- have on site and to make suitable arrangements for sufficient blood products appropriate for transfusions for dealing with excessive bleeding and problems attendant with excessive bleeding

Upon consideration of all the medical evidence and expert testimony Justice Kokaram stated that: "The problem with this patient was that there was uncontrolled clotting in the blood circulation where clotting factors and platelets in the blood were being consumed, this condition could have been managed by transfusions of fresh whole blood and platelets, fresh frozen plasma and cryoprecipitate. However, failing to properly manage the subsequent transfusion with proper products can lead to TURP syndrome or fluid overload."

The Court further stated that "It was a risk that has been admitted by the Defendants as a standard risk of TURP procedures. TURP is a surgical procedure which carries with it a known risk of significant post-operative bleeding. For this reason a responsible team of medical professionals should anticipate post-operative bleeding and plan for it."

The Court assessed the damages for the wrongful death of Mr. Tesheira which was caused as a result of the negligence of the Defendants in the sum of EIGHTEEN MILLION AND THIRTY FOUR THOUSAND SEVEN HUNDRED AND SEVENTY TWO DOLLARS AND THIRTY THREE CENTS ($18,034,772.33). The matter was subsequently appealed but the Court of Appeal upheld the Trial Judge's ruling.

Lisa Ann Mc Kenzie, Ornella Mc Kenzie and Daniella Mc Kenzie v Medcorp Ltd and Cancer Centre of The Caribbean Ltd TT 2019 HC 14

In this matter, the widow and orphans of the late Ricardo "Smokey" McKenzie, of SMOKEY & BUNTY fame, sought compensation for his untimely death. They alleged that his demise was precipitated by the negligence of the Defendants in their failure to ensure the proper functioning of the Varian Clinac IX Linear Accelerator, the radiation machine, by which he was treated.

The Court was of the view that the Claimants have succeeded in establishing on a balance of probabilities that the presence of radiation necrosis materially contributed to Mr. McKenzie's death on the 21st December, 2010. The Court stated that there was a systemic fault, and this falls within the category identified in **SWRHA v Harrilal** where Mendonça JA said: "[23] The decided cases are also clear that hospital authorities will be held liable not just for the negligence of their staff….but also for inadequate systems and procedures which result in injury to their patients….".

The Court was of the view that without the onset of radiation necrosis the Deceased could have survived up to five (5) years from the first occurrence of the tumour. It was the Court's view that as a result of the breach of the Defendants, he lived only eighteen (18) months from the first occurrence of the tumour. The Defendants were

ordered to pay to the Claimants the sum of TWO MILLION TWO HUNDRED AND SIXTY SEVEN THOUSAND NINE HUNDRED AND EIGHTY FOUR DOLLARS AND TWENTY SEVEN CENTS (TT$2,267,984.27) and an additional sum of ONE HUNDRED AND NINETY SEVEN THOUSAND THREE HUNDRED AND NINETY SEVEN USD (US$197,397.00USD) being Costs for the funeral in Miami and medical treatment at Jackson Memorial Hospital in Florida.

Mary London (The Administratrix of the Estate of the Deceased Kennis London) v North Central Regional Health Authority CV2013-05017

Kennis London, a known sickle cell patient, was admitted to the Eric Williams Medical Sciences Complex and provided with improper care which led to his death. The Deceased was experiencing unbearable stomach pains on the morning of the 8th of August 2010 and his mother Mary London took him to the Eric William Medical Sciences Complex around 6:00am that said morning. He was placed on a stretcher in the corridor of the Emergency Department and given intravenous fluids and an injection. Twenty Four hours later, about 8:00am on the 9th of August 2010, the next time the Claimant saw her son, he was on the same stretcher in the corridor of the Emergency Department and he was still experiencing severe stomach pains. He informed her that around 3:00am on the 9th of August 2010 he was visited by a team of Doctors including a Dr. Aleong and was taken for an x-ray and a blood test was conducted. Later that day, the Deceased called his mother and reported that he had overheard that his file was lost. The Claimant returned to the hospital in the afternoon of the 9th August, 2010 and was informed by a Dr. Zani that London's files which contained his registration and test results could not be located. The Claimant, upon instructions to do so, physically took London to re-register. He also had to be re x-rayed and another blood test had to be done, a process called a 're-check'.

Thereafter, Dr. Zani informed the Claimant that her son had developed pneumonia and had fluid in his lungs. The Claimant personally attempted to get a ventilator and even suggested that London should be transferred to another health institution. The Claimant's request about the transfer went unheeded. During this time, the afternoon and evening of the 9th of August 2010, the Deceased was complaining of

severe pains and he was administered morphine although his records had not been found. Thereafter, London's breathing became abnormal – very fast and he had frothing at the mouth. The Claimant immediately contacted the Doctor on duty, Dr. Ahmed, who indicated that the Doctors who treated him earlier should arrive in about twenty (20) minutes. Another Doctor, a Dr. Seuratsingh also indicated that he could not attend to the Deceased as he had not seen him initially and did not have London's file as it could not be found. Around 10:00 pm on the said 9th of August 2010, the team of doctors including Dr. Zani and Dr. Aleong arrived and examined London and he was rushed to a critical area.

The Claimant was informed by one of the doctors that London was in a critical condition and had to be taken to the Intensive Care Unit (ICU) department or the High Dependency Unit (HDU). The Claimant was also informed that London needed a ventilator to help his breathing but that none was available. The Claimant was informed that her son needed an electrocardiograph to determine the cause of the fluid leaking into his lungs, but that the electrocardiograph machine was not working, there was no one present to administer the test and that the door to the electrocardiograph machine was locked. After some time, room was made for the Deceased in the ICU. Eventually, the Claimant was later informed that while they were transferring London to the ICU, he died.

The Court found that Defendant was negligent and stated that London's patient notes evidenced that the standard of care required was not given and that there was negligence by the Defendant.

The Court stated as follows:

"65. Firstly, the patient needed to be properly admitted to the hospital. On the evidence it took two attempts before London was admitted. London was first registered at 5:30 a.m. on the 8th of August 2010. Then again, at 4:00pm on the 9th of August 2010 when the Claimant had to physically take London to be registered again. This delayed the care that was required as what had already been done had to be redone.

66. Secondly, proper patient notes needed to be made and kept for the proper care of London. In this case the London's medical notes were lost.

67. Thirdly the patient needed to have an electrocardiogram test performed on him. In this case, London did not have such a test performed because the room was locked, there was no technician available and there was no portable machine available.

68. Fourthly, the patient needed to have assistance with breathing. There was trouble with the machines. At 5:43pm on the 9th of August 2010 London was supposed to have been assisted with his breathing by oxygen via face mask. Orr's evidence which, the court accepts, was that he heard the nurses speaking about no oxygen in one tank and another malfunctioning. He was not cross-examined about this evidence.

69. Fifthly, the patient needed to be closely monitored. In this case London remained on a stretcher in the corridor of the hospital for many many hours.

70. Sixthly, the patient needed to have the specialist care available on the ICU or HDC wards. In this case it took many many hours for such arrangements to be made, London did not get to the ICU alive. The nurses commenced arrangement to transfer London to the ICU at 12:50am on the 10th of August 2010 and he died at…….before arriving at ICU.

71. Seventhly, the patient needed the care of specialist such as hematologist. None was either available or called.

72. Eighthly, the patient needed to be specially monitored with special machines. In this case no cardiac monitor was available."

In her judgment dated 7th March 2018 the Honourable Madame Justice Quinlan-Williams ordered the Defendant to pay to the Claimant $25,000.00 for the loss of expectation of life, $25,000.00 for the Deceased's pain and suffering and special damages in the sum of $19,400.00.

Brian Lezama (Administrator of the Estate of Karen Lezama, Deceased) v Dr. Kong Sheik Achong Low CV2008-00912

This matter involved the death of Karen Lezama, a gestational diabetic, who died as a result of post-partum haemorrhaging after delivering a still born baby boy at a private nursing home. The Court found that the Defendant was negligent by failing to

take urgent and immediate or any reasonable steps to stop the haemorrhage once it had started, failing to administer sufficient medication to stop the bleeding and failing to exercise all due care and diligence in the treatment of the deceased in all the circumstances of the case.

On the issue of haemorrhaging post-delivery, the Honourable Mr. Justice Ricky Rahim stated that "Nothing less than prudence was required in light of the information provided whether or not it was correct….more than sufficient time had elapsed between the time of birth and the time in which assistance in the care of the deceased was enlisted and sourced. During which time steps should have been taken to source and administer more blood and blood products. It means that tests should have been performed on the deceased immediately in an effort to begin the process of sourcing blood. This means the Defendant ought to have requested the blood at an earlier stage than that which it did….In Trinidad and Tobago there is a significant shortage of blood and blood products…it was not sufficient to simply sit by and say that the process of obtaining blood was a difficult or lengthy one.

In this matter the Court accepted the testimony of the medical practitioners that the administering of more blood and blood products at an early stage as an accepted method of treatment and interpreted this to mean that the earlier the patient was given an adequate supply of blood and blood products the more likely the patient would be to survive. Justice Rahim further stated "medical practitioners bear the unenviable task of often times managing the fragility of human life under tremendous pressure and dynamic circumstances. The management often involves literal life and death situations with no time for leisurely reflection……it is a responsibility entrusted to them by the public at large in whose collective and singular interest they must at all times act by adhering to the accepted practice in their area of specialty even under the most dire circumstances."

In his judgment dated 26th July 2012, the Honourable Justice Ricky Rahim, having only dealt with issue of liability, ordered that there be judgment for the Claimant with damages to be assessed by a master. This judgment was subsequently appealed, and the Court of Appeal upheld the Trial Judge's decision on 27th March 2018.

In the case of BRIAN NURSE -V- ERHA where the Claimant complained of a botched delivery of his child at the Sangre grande Hospital resulting in the said child being born with cerebral palsy the Claimant was eventually awarded a sum of SIX MILLION FOUR HUNDRED THOUSAND DOLLARS ($6,400,000.00) in Damages.

Deonath Ramkissoon (Legal Personal Representative of the Estate of the late Aaron Ramkissoon) & Denecia Sookram v Eastern Regional Health Authority CV2008-02135

This claim was made by the parents of a Deceased baby. The mother, Denecia Sookram, went into the delivery room at the Sangre Grande Hospital around 10:00 a.m on January 11, 2005. The mother delivered her baby at 11:16 a.m. Shortly after leaving the delivery room she breastfed the baby, burped him and he fell asleep. The following morning the baby was observed to be cyanosed, meaning that not enough oxygen was going into the baby's lungs. The baby at that time was being breast fed by the mother who contends that before she was allowed to burp the baby, he was taken away from her and placed in an incubator. After the baby was taken from his mother and between the hours of 3:30a.m and 11:30a.m, the baby was under the care and management of the hospital staff. The next occasion, on which the mother was allowed to see her baby, he was in the incubator cold and lying still, was no longer breathing and had subsequently died.

A pathologist, Dr. Mohammed, conducted the autopsy of the baby subsequent to its demise. His conclusion of the autopsy revealed the child died of asphyxia, and this in a preterm neonate with associated umbilical sepsis. He also listed immature lungs as a contributing factor. Significantly he noted that this was a baby that deserved special treatment. "There could have been many different causes for the asphyxia leading to the obstruction of the baby's breathing some examples being regurgitation of stomach contents, bedding obstruction, excess mucus in nostrils causing blockage. At the time of the post mortem I did not have details as to position that the baby was placed in on the bed so that I was not able to provide any specific cause for the

asphyxia. It should be noted that this baby was pre term with immature lungs. Such babies are less likely to survive asphyxia because they would already have breathing problems due to immaturity of the lungs. Any obstructions of the breathing would aggravate their condition." Also, he stated that the baby became cyanotic after feeding. The cyanotic state of the baby could have been caused by "a number of reasons severe congenital heart disease or if for some reason the food went down the wrong passage". This baby being a pre term baby needed special attention, since he was considered as being at risk. He commented "they are at risk you need careful monitoring support and care. They need special treatment."

He made mention of the fact that cyanosis is not fatal however it is a sign that there is respiratory distress. As such the appropriate ventilator support which would include oxygen should be administered by incubator or a tube to the baby in distress. Further he highlighted that a proper examination is needed to detect the underlying cause of the respiratory distress. This included physical examination of the oral cavity to determine blockages which are occurring in the baby. Dr. Mohammed was adamant in stating that underdeveloped lungs will not lead to sudden death. He added: "However, no matter what position the baby lies in after being fed, the risk of regurgitation is present if the baby is not burped. With food in the lungs it can cause the baby to die instantly or the food can get down in the lungs and set up a reaction over a period of hours sometimes days." With respect to the treatment meted out by the hospital staff, Dr. Mohammed found that there is a deficiency in the records. "It is an infant. You must record physical condition of the respiration system. This has to be done very often. This baby has to be continuously monitored for pulse rate, respirator rate pulse rate physical appearance."

The Honourable Kokaram J accepted Dr. Mohammed's evidence and found that the hospital was negligent and that the negligence resulted in the baby's death and ordered judgment for the First Claimant against the Defendant and assessed damages for the First Defendant in the sum of $22,000.00 with interest thereon at the rate of 12% per annum from 10th June 2008 to the date of payment.

The Court was of the view that the Second Claimant did not suffer any damage beyond the ordinary grief attendant on learning of the death of her child. As tragic as learning about the death of the child was for the Second Claimant it was not enough to give rise to an award of damages associated with a psychiatric illness as to do so in the absence of any evidence would be to remove the recognizable bounds of liability in tort. The Second Claimant's claim was therefore dismissed but with no orders as to costs.

As stated at the start, the awards of damages in many of these cases in Trinidad and Tobago is way too low and it is necessary to continue the thrust to have these Damages increased and to increase the knowledge and awareness of the general public in T&T so they may be alive to and aware of their rights in scenarios such as these.

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