BARBADOS

IN THE SUPREME COURT OF JUDICATURE

HIGH COURT

CIVIL JURISDICTION

SUIT NO. 1694 of 2006

BETWEEN

MELLISSA BISSETTE **CLAIMANT**

AND

QUEEN ELIZABETH HOSPITAL **1ST DEFENDANT**

DR. BEST **2ND DEFENDANT**

DR. GREENIDGE **3RD DEFENDANT**

DR. FERDINAND **4TH DEFENDANT**

DR. LASCELLES **5TH DEFENDANT**

Before Dr. The Hon. Madam Justice Sonia L. Richards, Judge of the High Court.

2020: December 11

Appearances:

Mr. Arthur Holder, Attorney-at-Law for the Claimant.

Mr. Ivan Walters, Attorney-at-Law for the Defendants.

DECISION

Introduction

[1] On 27 October 2017, judgment was entered for the Claimant, pursuant to a claim for damages for personal injuries. The Court has before it the assessment of damages, and on 26 July 2019 counsel for the parties consented to a determination based on the written submissions.

Background

[2] On 07 November, 2002, the Claimant presented herself to the Accident and Emergency Department of the Queen Elizabeth Hospital ("QEH"). Her complaint was abdominal pain, vomiting and diarrhea. Similar symptoms with intermittent fever had manifested about three weeks earlier.

[3] The Claimant was 18 years of age with no untoward previous medical history. On 06 November 2002, her general practitioner diagnosed appendicitis and referred her to the QEH. She was admitted to the hospital, and between 11 November 2002 and 17 July 2003, the Claimant underwent four abdominal surgeries connected to her appendicitis.

[4] Between these operations, there were lengthy periods of hospitalisation. The Claimant was again admitted to the QEH in February 2005 with partial small bowel obstruction. This emergency was managed without surgical intervention.

The Pleadings

[5] The Writ of Summons was filed on 21 September 2006. The Claimant alleged therein that she:

> "12…sustained permanent scarring of her stomach and physical body, loss of her right ovary, a punctured lung, irreparable damage to her intestine, deep permanent psychological pain and suffering, loss of her sexual appetite and sexual appeal, reduction and possible permanent loss of her procreative capacity, shame, hurt and embarrassment, low self esteem, ridicule, and permanent psychological complications relative to her intestine".

[6] It is alleged that the Claimant's losses and damages, detailed at paragraph [5], were caused by the 2nd, 3rd, 4th and 5th Defendants as servants and/or agents of the 1st Defendant. The particulars of negligence are that the Defendants:

1. failed and/or neglected to use correct procedure, care, expertise, knowledge, and skill in performing the surgery to remove the Claimant's appendix in the first surgery.

2. failed and/or neglected to remove pus from the Claimant's appendix in the first surgery;

3. failed and/or neglected to remove pus from the Claimant's abdomen in the first surgery;

4. left the appendix entangled in the intestine after the first surgery;

5. failed and/or neglected to remove the appendix in the first surgery causing the infected intestine to infect the ovary, resulting in the loss of the right ovary;

6. punctured her intestine creating five holes or fistulas in the intestine;

7. failed and/or neglected to use correct procedure, care, expertise, knowledge and skill in performing the first surgery, resulting in a permanent kink in the Claimant's intestine;

8. failed and/or neglected to use correct procedure, care, expertise, skill and knowledge in performing the first surgery resulting in the Claimant developing a hernia;

9. failed and/or neglected to give proper and/or adequate aftercare service to the Claimant after the first surgery;

10. failed and/or neglected to observe or to act or to investigate properly or at all the steady and obvious serious deterioration in the condition of the Claimant while at the Surgical Intensive Outpatient Unit;

11. failed and/or neglected to act in a timely manner to investigate properly or at all the steady and serious and obvious deterioration in the condition of the Claimant while under the care of the respective Defendants;

12. failed and/or neglected to use the correct procedure to correct and/or repair the damage caused by the first surgery; and

13. failed and/or neglected to observe and or to act properly in inserting a CVP line, thereby puncturing the Claimant's right lung.

[7] The claim against the Defendants, jointly and severally, is for general damages for pain and suffering, interest and costs.

[8] All five Defendants filed their defences on 02 March 2007. Essentially they each denied negligence, or that the Claimant suffered any loss or damage, or that the Claimant was entitled to any of the relief she claimed.

The Heads of Damage

[9] The heads of damage submitted by counsel for the Claimant are:

1. general damages for pain, suffering and loss of amenities, loss of

family life and loss of educational opportunities, future medical expenses, future travel expenses, gratuitous assistance and domestic home care and services; and

2. special damages for medical expenses.

[10] It is to be noted that the claim as filed was limited to damages for pain and suffering. No amended claim to incorporate other heads of damage was seen on the Registry file. However, counsel for the Defendants did not make this an issue. He addressed the heads of damage raised in the Claimant's quantification of damages, and conceded some of the heads.

[11] The Claimant asks for the sum of $2,394,322.00 as damages as follows:

General Damages

(1)	pain, suffering and loss of amenities	$1,614,277.50
(2)	past loss of educational opportunities	$ 5,000.00
(3)	future medical expenses	$ 700,000.00
(4)	future travel expenses	$ 2,000.00
(5)	domestic services, home care and services	$ 15,000.00

Special Damages

(1)	medical expenses	$ 7,375.00
(2)	transportation and travel expenses	$ 420.00
(3)	home care and services	$ 50,000.00

Miscellaneous Expenses

(1) disbursements	$	260.00

[12] The Defendants are of the view that the Claimant is entitled to no more than $75, 837.50. This figure was calculated as follows:

General Damages

(1) pain, suffering and loss of amenities	$	58,962.50

Special Damages

(1) medical expenses	$	7,375.00
(2) past domestic assistance	$	8,820.00
(3) past transportation/travel expenses	$	420.00
(4) disbursements	$	260.00

[13] From the outset then, there is no dispute about the following:

(1) medical expenses	$	7,375.00
(2) past transportation/travel expenses	$	420.00
(3) disbursements	$	260.00
TOTAL	$	8,055.00

The Disparity

[14] More than two million dollars separates the parties. The Defendants rely heavily on the argument that "It was the Claimant's General practitioner who had misdiagnosed her and prescribed antibiotics for her symptoms and which had masked the Claimant's appendicitis and it was the Claimant's parents

and/or the Claimant who had delayed seeking medical help for "three weeks" and thus triggered the body's defence mechanism of surrounding the appendicitis in [a] mass of tissue which resulted "from longstanding untreated appendicitis" and which made the surgery formidable". (See para. 25 of the Defendants' Assessment of Damages: Counter-Quantification, filed on 15 January 2019).

[15] It is the view of the Defendants that the Claimant's delay in seeking surgical intervention was the cause of her subsequent misfortune. Despite this assertion, none of the Defendants so pleaded in their defences. Neither did they plead contributory negligence on the part of the Claimant. In addition, the Defendants have never appealed this Court's order of 27 October 2017, whereby an unconditional judgment was entered in favour of the Claimant. Therefore, it is too late in the proceedings for the Defendants to be attempting to escape or significantly reduce their liability, for any acts of negligence occurring during or after the first surgery, on the basis that the Claimant waited too long to come to the QEH for medical intervention.

Pain, Suffering and Loss of Amenities

[16] The Claimant relies on her medical notes from the QEH, and their interpretation in a report by a medical expert Dr. T.R. Shepherd, FRCS (Ed.). Additional medical reports were provided by Dr. J.E. Bennett, an obstetrician

gynaecologist. There are also witness statements from the Claimant and her husband Kenroy Hope.

[17] There are no witness statements or affidavits filed on behalf of the Defendants. Two expert medical reports were provided by Dr. Carlos Chase, Head of the Department of Obstetrics and Gynaecology at the QEH, and another report by Mr. Selwyn Ferdinand, a Consultant Surgeon at the QEH. As a matter of interest Mr. Ferdinand is the 4th Defendant to the claim.

[18] As unpleasant as it may be, it is necessary for the Court to detail what transpired in relation to the Claimant and her several surgeries at the QEH.

1. The First Surgery

[19] This surgery occurred on 11 November 2002, after a pre-operation diagnosis of appendicitis. The hospital notes indicate the surgical findings as "Retroileal inflammatory mass with turbid peritoneal fluid and walled off by the omentum and small bowel. No appendix to be found".

[20] Dr. Shepherd explains the notes in this way:

> "In operating theatre, the surgeons encountered a classical appendix mass situated behind the last portion of the small bowel.
>
> [An appendix mass results from longstanding untreated appendicitis. Initially when the appendix is inflamed it lies more or less freely in the abdomen. If the patient comes to surgery quickly there is not time for a mass to form. If however there is a delay

> the body attempts to wall off and protect itself from the infected appendix by forming a "mass" around it. This usually consists of a fatty structure called the omentum, along with nearby bits of intestine which all wrap themselves around the inflamed appendix forming a mass, in the centre of which is often a varying amount of pus]".(Page 33 of Report).

[21] The Claimant was discharged from the QEH five days after her first surgery. She was seen on two occasions as an out patient on 19 and 26 November 2002. There is no evidence that either the Claimant or her immediate family members were told that the appendix had not been removed. There is no evidence of any cause for concern on the part of her medical team.

[22] Dr. Shepherd was critical of this aspect of the Claimant's management by the QEH and its agents. He noted that:

> "An appendix mass often makes surgery quite difficult and a really complex mass can result in surgery lasting hours instead of the usual 30 minutes or so for an uncomplicated appendix. In this case, things were so difficult that the surgeons **DID NOT FIND THE APPENDIX,** even though it was reasonably clear by now that they were dealing with appendicitis. A drain to assist removal of pus was placed and the abdomen washed out to dilute the infectious process". (Page 33 of Report).

[23] Dr. Shepherd continued:

> "The surgical team eventually made the correct diagnosis and operated. They met the difficult situation of an appendix mass but critically were not able to locate the infected appendix. **This was the signal event that more than any other, was**

> **responsible for [the Claimant's] series of misfortunes.** It is not possible for me to say whether this was due to lack of skill, lack of application, pure surgical difficulty or other technical issues. Knowing that one is finally dealing with appendicitis, the very aim of surgery is to remove the appendix even if this requires hours of exploration. If, as can happen when a patient is extremely ill and is in danger of death on the operating table, or after a diligent but fruitless search, surgery has to be aborted before a suspected inflamed appendix is found, one may abandon the search IN THE FULL KNOWLEDGE that the patient has not been treated optimally. In such a case the aim would be to return the patient to the OR later after the acute phase has passed and remove the appendix". (Pages 40 - 41 of Report).

[24] On this issue there is a deafening silence from the Defendants. They offered nothing to rule out negligence on the part of the surgical team. Nothing in the medical notes explains the failure to formulate an urgent plan to return the Claimant to surgery, in order to locate and remove her appendix. There is no defence, witness statements, affidavits or expert reports that explain this omission.

[25] Dr. Shepherd discussed several scenarios in which an appendix may not be found. (Page 41 of Report). There is no evidence that any of these scenarios were relevant to the Claimant.

[26] Dr. Shepherd concluded that:

> "The fact then is that [the Claimant] was eventually discharged after this first operation, still having an untreated appendicitis. The reason she appeared to

> improve has to do with the power of antibiotics to suppress the normal virulence of many infections. However, they will not cure an appendicitis. Just over a month later [the Claimant's] appendix blew up again, much worse than at first". (Page 41 of Report).

[27] The Claimant was readmitted to the QEH on Christmas Day 2002. She was vomiting and complaining of pain in her lower abdomen, and frequent burning urination. The hospital notes for that day record that the Claimant looked ill, and that she was pale with a high temperature and a rapid pulse rate. The diagnosis considered was intestinal blockage from adhesions.

[28] A surgical team, that included the 4th Defendant, operated on the Claimant on 27 December 2002. She remained at the QEH for over three months. Prior to her discharge on 04th April 2003, she underwent a third operation on 17 January 2003. Dr. Shepherd best describes the Claimant's treatment and status during this period.

2. The Second Surgery

[29] According to Dr. Shepherd:

> "The findings were dramatically different from the first operation. There were 1700 mls of free pus in the abdominal cavity. In addition, there were several smaller collections of pus between bowel loops (interloop abscesses), as well as an abscess in the pelvis. A mass of inflamed material was found in the right lower abdomen and when this was explored, the appendix was found stuck on the posterior abdominal

> wall. Significantly, the tip of the appendix was missing – the surgeons only found the part of the appendix that was attached to the bowel. [The presence of so much pus indicate a highly toxic environment].
>
> The surgeons sucked away the pus and did the same with the other abscesses. During this process, 2 lacerations (holes) about 1cm in diameter were made in the cecum [the first part of the large bowel.] These lacerations were repaired with catgut. A mass in the pelvis was also removed. The abdomen was then washed out, drains inserted to aid in the removal of pus postoperatively and a gastrostomy [tube into the stomach for later feeding] was constructed. The patient was then taken to [the SCIU] for recovery". (Page 34 of Report).

[30] Having failed to remove the Claimant's appendix on 11 November 2002, or soon thereafter, the Claimant continued to degrade internally. It was approximately six weeks between the first and second surgeries. The early post operative phase was described as critical, because of the Claimant's massive internal toxicity discovered during surgery. She was placed on a ventilator to reduce the stress of breathing while fighting the infection. Her pulse rate was a cause for concern during the weeks of recovery. Her temperature was markedly elevated; she was anemic and jaundiced with decreased protein levels. Dr. Shepherd considered that the lowering of her protein levels was a sure sign of malnutrition. (Pages 34-35 of Report).

[31] Dr. Shepherd's graphic narrative continues:

"After about a week the recent operative wound started to leak fluid and a swelling appeared in the right lower abdomen near the site of the first operation. In addition, xrays of the chest also showed fluid in both lung cavities, and her limbs were edematous (swollen). [If protein levels in the blood become too low because of prolonged starvation, fluid leaks out into various organs and body cavities]. An attempt was made to correct this by transfusing protein solutions, but eventually the collections in the lung cavities had to be drained so as not to further compromise her breathing. Initially the fluid was merely aspirated but eventually a larger bore tube was inserted into the left chest cavity for more permanent drainage.

Around this same time, an attempt was made to wean her off the ventilator and allow normal breathing. However, within a short time she became too weak to breathe effectively and had to be put back on the ventilator. [This inability to breathe effectively was likely due to a combination of events - sepsis, lack of nutrition, the physical shock of surgery, the fluid in the lung cavities, abdominal pain from the surgical incision and abdominal distension].

This was now the first week of 2003, some 10 days after surgery. She was noted to be very ill with high fever and pulse. Then another event occurred - the main abdominal wound started to drain pus and bowel contents. This was the start of a fistula - an abnormal connection between the intestine and the skin which allows gut contents to exit prematurely, through the skin. [This has several ill effects. The most obvious is the very unpleasant fact of liquid material smelling like stool coming out of the wound. Less obvious but more significant is the loss of fluid and nutrients to the body resulting eventually in weight loss, dehydration, failure to thrive, and poor general health].

> However, by now [the Claimant] is off the ventilator and breathing on her own, albeit with difficulty – she was recorded as being in respiratory distress. She continued to be quite ill - with a high pulse and fever. Over the following week she gradually improved with some settling of her fever and improved breathing, though regularly needing some ventilator support. The drainage from the wound continued and indeed within a few days a second fistula appeared". (Page 35 of Report).

[32] Between the second and third surgeries, the Claimant's condition was life threatening. Despite the increased difficulty of the second surgery, the remainder of her appendix was found and removed. The Defendants offered no explanation as to why the tip of the appendix was missing. During this surgery the large intestine was torn accidentally in two places. It is the professional opinion of Dr. Shepherd that the two lacerations to the cecum are understandable, given the complications of the surgery, and "would not be considered a failure of good surgery". The Court accepts this assessment.

[33] While he was willing to excuse the additional damage to the Claimant's cecum, Dr. Shepherd questioned the suturing of the two incisions with catgut. He opined that:

> "Catgut is a "dissolvable" suture that quite rapidly loses its tensile strength and would not normally be relied upon SOLELY to close a large gut laceration". (Page 43 of Report).

Dr. Shepherd commented that the likelihood of breakdown or fistula

formation was high. He reasoned that:

> "Large gut contents have a high bacterial content. A breach of the large gut means contamination and possible severe infection even in a previously healthy clean abdomen. In a very sick patient with an abdomen that is already full of pus, the wisdom of simple closure of not one but two cecal lacerations is highly questionable. The likelihood of breakdown or fistula formation is high. One can often "get away" with it, but when one doesn't the price paid can be very high, as in this case.
>
> It is true that classical ("old style') treatment of such lacerations is quite unpleasant to most modern surgeons, as well as to the patient. It is also true that the advent of very powerful antibiotics has made these procedures almost obsolete. But the logic is simple. One tries to minimize or prevent fecal passage through the lacerated part while healing is in progress. This invariably means some sort of operation to divert the fecal stream. In the case of the cecum, this would mean a cecostomy or ileostomy – both of which are not pleasant.
>
> [… The advantages of these managed approaches is that the ostomy is constructed deliberately so that the effluent can be collected in a managed fashion – usually by placement of a bag over the stoma. This minimizes the cosmetic insult which the fistulas generally cause, and help reduce soreness in the adjacent skin. On the other hand, they always require a second operation to restore normal intestinal anatomy].
>
> Because of this, one tries to avoid them as much as possible. However, with the degree of sepsis that was present in this case, it might have been the better course". (Page 42, para. a of Report).

[34] Dr. Ferdinand's report dated 23 October 2006, confirms an appendectomy of the proximal appendix stump. He revealed that the proximal half of the appendix was bound down to the posterior abdominal wall in the right iliac fossa. The distal half of the appendix was not seen. The Claimant's left tube was normal, however her right ovary was not seen. He admits that two by one cm tears occurred to the wall of the cecum while it was being mobilized. These tears were "repaired with sutures in standard fashion". (See second page of report). The hospital notes for 27 December 2002 are unequivocal that catgut was used to repair the tears.

[35] Dr. Ferdinand's report details his medical encounters with the Claimant. The report offers no explanation as to why part of her appendix remained after the first surgery. The Court accepts that Dr. Ferdinand was not a member of the surgical team that performed the first surgery. It is telling that no member of the first surgical team has produced a report for the Court. The Court then is left with the Dr. Shepherd's expert opinion that the failure to remove the Claimant's appendix during the first surgery engendered a number of negative outcomes for the Claimant.

[36] There is no expert response to Dr. Shepherd's assertions that catgut was the wrong choice, or that the use of this material, to suture the tears to the cecum, inevitably led to the development of two fistulas. Counsel for the Defendants

is adamant that:

> "Dr. Shepherd must be here expressing a personal preference because there is apparently no medical consensus on the matter of choice of suture materials. It would seem that the choice of suture material depends on the taste of the surgeon, but catgut was in standard use in the [QEH] in 2002 at the time when the procedure was done on the Claimant and furthermore, from the medical literature it was used [in] many hospitals throughout the world". (Para. 13 of Assessment of Damages: Counter – Quantification filed on 20 March 2019).

[37] With respect, counsel used his submissions to impart evidence to the Court. There is nothing in the Defence, and no witness statement or expert evidence to support the statement that the choice of suture material "depends on the taste of the surgeon". It is true that Dr. Ferdinand's report states that the tears in the cecum were repaired "in standard fashion". While this statement may imply that the use of catgut was standard at the QEH when the second surgery was performed, it does not address the important issue as to whether catgut was appropriate for sealing a tear to the intestine in a toxic environment.

[38] Counsel relies on various writings that assess the use of catgut. The quotations from these writings do not discuss the use of catgut in the context of a repair to the intestine. No alternative argument is advanced by the Defendants either to counter Dr. Shepherd's analysis, or to suggest that fistulas were not the direct result of choosing catgut to close the tears to the Claimant's large

intestine. Put bluntly, there is a lack of evidence to support the contention that the use of catgut to seal the tears to the intestine was an acceptable medical choice in the circumstances.

[39] In **Boyce v. Lorde et al [2012] 3 LRC 167,** the Barbados Court of Appeal opined that:

> "Legal authorities indicate that the assessment of medical risks and benefits is a matter of clinical judgement which a judge would not be able to make without expert evidence (Lord Browne – Wilkinson in **Bolitho v. City and Hackney Health Authority [1997] 4 AllER 771)** but the judge must refrain from using a preference for the practice of one body of respectable medical opinion over another as a basis for making a determination of medical negligence: "It is not enough to show that there is a body of competent professional opinion which considers that there was a wrong decision if there also exists a body of professional opinion equally competent which supports the decision as reasonable in the circumstances". Per Lord Scarman in **Maynard v. West Midlands Regional Health Authority (1984) 1 WLR 634.** He also observed at page 639: "…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 specialty if he be a specialist) is necessary". However, it is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed: per Lord Browne – Wilkinson in **Bolitho** (supra)". (Per Mason JA at paras. 38-39 of judgment).

[40] The dearth of expert evidence confirming that the use of catgut to seal intestinal tears in a toxic environment was reasonable, in the circumstances of this case, compels this Court to a finding of negligence in the use of that material. The direct consequence of this negligence was the formation of fistulas and the leaking of the Claimant's bowel contents.

[41] The discovery of a partially removed appendix, during the second surgery, also confirms the negligence perpetrated during the first surgery. (See paras. [24] – [27] supra). It is *prima facie* evidence of a lack of skill that was not rebutted. The issues surrounding her missing right ovary will be addressed later in this judgment. (Infra at paras. [73] – [84]).

3. The Third Surgery

[42] Dr. Ferdinand's report indicates that eight days after the second surgery, ie on 04 January 2003, "a wound discharge with bubbling became evident suggesting a bowel fistula". The reconstructed QEH notes for 05 January 2003, record, "Wound exam – purulent drainage with bubbling suggesting a bowel fistula". The notes for 07 January refer to severe peritonitis, a bowel fistula, pleural effusion and respiratory impairment. The Claimant's bowel contents were seen on the surface.

[43] On 09 January an open wound in the Claimant's lower abdomen draining

fluid is noted. Then on 10 January there is a reference to abdominal sepsis and an intestinal fistula. Also on that date a sump drain was "fashioned for fistula drainage". The possibility of a "fistula from cecum" was also mentioned. The wound was explored on 15 January and a 1cm fistula opening observed at the edge of the wound margin. A second fistula was also discovered.

[44] The Claimant returned to surgery on 17 January 2003 for her third operation. The 4th Defendant was assisted by the 5th Defendant. The purpose of the surgery was the exploration and suturing of the fistulas. The reconstructed QEH notes outline the findings and the extent of the surgical procedures.

[45] No notes appear to have been produced to the Claimant for the period from 18 January 2003 to 02 February 2003, approximately two weeks. As a result, Dr. Shepherd was unable to comment on this intervening period. It is Dr. Ferdinand's report that explains the operation of 17 January as follows:

> "A new traverse incision was made on the right abdomen for better access and to minimise risk of injury to adherent bowel. A small pelvic abscess was found and evacuated. The bowel loops were severely matted and inflamed. The leaking bowel was mobilized extremely carefully and sutured closed. A wound drain was sited in the region of the abscess exiting the lateral end of the wound". (Second page of Report).

[46] From Dr. Ferdinand we learn that on February 01, after 36 days in the Surgical Intensive Care Unit, the Claimant's major problems were persisting

tachycardia, fever, yeast infection from the wound and a small bowel fistula. An infection of her left eye, that appeared at the end of January, was resolved by February 04. Also on January 20 the Claimant was reviewed by a dietitian and her increased oral nutritional supplementation continued.

[47] The Claimant's fistula reopened and was evidenced by wound drainage. Dr. Ferdinand attributes this development to "her sepsis and poor nutritional state". (At third page of Report). By 05 February, the QEH notes assessed the Claimant as critical but stable. She appeared to have lost weight, but her wound was healing well. She was being fed both externally and by a central line for increased nutritional support. She complained of pain in the area of the wound when the dressings were changed. At this time a plan was articulated to involve a counselor or psychiatrist in the Claimant's management because she appeared "to be emotionally labile …. possibly due to prolonged SICU care".

[48] During the final week of February 2003, the fistula was still leaking stool. (QEH notes for 24 Feb.). In March it was noted that the abdominal wound was full of stool, and the Claimant reported that she would feel soft stool coming out of the fistula. (QEH notes for March 7and 8).

[49] After remaining in hospital for over three months, the Claimant was discharged to her father's care on 04 April 2003. The fistula was contracting but not completely closed. And she continued to complain about pain and burning in

the area of the fistula whenever the dressings were changed. She was advised to take sea baths, and she received medical supplies to assist with cleaning the wound.

[50] Dr. Shepherd is disapproving in his analysis of the third surgery. He wrote that:

> "Desperate to close the fistula the team took [the Claimant] to surgery again. Again on opening the abdomen an abscess was found much smaller this time. Again simple suture was done. Again the result is the same, failure to close. The lessons of the second operation should have more powerfully informed the decision making this time. The presence of yet another abscess would not augur well for success. It might have been better to treat the abscess and postpone fistula surgery until all infection was corrected". (Page 43 of Report).

[51] And once again there is no response from the Defendants that the methodology of the medical team during surgery was an acceptable medical choice in the circumstances. In her statement of claim the Claimant relied upon the doctrine of *res ipsa loquitur*. (See para. 14). If this doctrine is applicable to the facts of this case, the Defendants have to establish that any damage caused to the Claimant, was caused in a manner inconsistent with negligence on their part. The Defendants have not done so. Alternatively, if the pleading of *res ipsa loquitur* cannot be relied upon by the Claimant, the Defendants have not responded effectively to the serious allegations or negligence made against them. (See **West Indian Hoisery Manufacturing Co. Ltd v. Pitt (1978) 32**

WIR 82). The Court has had to rely on Dr. Shepherd's report to absolve the Defendants in some respects.

4. The Fourth Surgery

[52] After her discharge from the QEH on 04 April 2003, the Claimant was seen as an outpatient on 20 May and 03 June 2003. Although the fistula opening was decreasing in size, she had lost weight and was dehydrated. She was readmitted to the QEH on 03 June for weight gain through central line and oral feeding. The Claimant was experiencing dizziness, burning at the fistula on her skin, constipation, variable appetite and general ill health. It is recorded that she lost 4.6 pounds in one month. (See QEH notes for 03 June; she is also described as "wasted and feeble" with muscle wasting).

[53] Dr. Shepherd was not surprised by these developments. His assessment was that:

> "…it is the development of the fistula that decided [the Claimant's] future".

He explained the nature and effect of a fistula as follows:

> "[A fistula is an abnormal communication with the skin. In this case it was an abnormal communication between either small bowel or cecum and the surgical wound, permitting intestinal contents that would normally remain in the gut to divert to the outside.]
>
> Several litres of essential nutrients course through the intestines on a daily basis, eventually becoming

> absorbed in the large bowel, leaving a few millilitres of stool for discharge normally. A small bowel or cecal fistula radically alters this status, as it diverts this fluid out of the body. Apart from the unpleasant smell and distress to the patient, the loss of vital material is a steady drain on the body's resources. It may be difficult for the patient to eat or drink enough to keep up with the loss, especially since the more one eats and drinks, the more the fistula leaks – as [the Claimant] soon discovered. An additional discomfort results from the intestinal enzymes that are present in the fluid which attack the surrounding skin and make it sore". (Page 43 of Report).

[54] At the beginning of July 2003, the Claimant had developed a black and blue discoloured region over her right hip. A fungal infection to the skin of her groin was also seen. (QEH notes for 01 and 06 July). Dr. Ferdinand performed the surgery to close the fistula on 17 July 2003. By the third day after surgery the Claimant was recorded as feeling great, walking around and doing well. (Page 5 of Report). She was discharged on 27 July after approximately six weeks in hospital.

[55] When the Claimant was seen as an outpatient on 16 September 2003, she had no complaints and her weight had increased from 42 kgs in May to 58.2 kgs. (Page 5 of Dr. Ferdinand's Report). And the records for 16 March 2004 indicate that the fistula had healed. (QEH notes).

[56] Dr. Shepherd was not surprised by the outcome. It is his view that:

> "This time there was no more infection. The fistula was closed. Even though the cecum got torn again, it

> healed properly and the fistula remained closed. It is hard not to conclude that the absence of infection was a major contributor to the excellent outcome this time around". (Page 43 of Report).

5. Other Unfortunate Events

[57] Sometime after the second surgery, and while the Claimant was still hospitalised, a central line was established in one of her large veins, near her heart, to accommodate additional nutritional support by special intravenous solutions. Her right lung was punctured in this process. This caused breathlessness, distress and chest pains. The collapse lung was re-expanded over the next week.

[58] Dr. Shepherd is of the opinion that, although unfortunate, the medical team should not be faulted because such procedures, "are technically very difficult". It is his view that:

> "The good thing is that the rupture was recognized speedily and dealt with appropriately. In such cases no permanent harm usually follows". (Report at p. 44).

[59] Dr. Shepherd is of the same mind in relation to the two occasions on which the central line became infected. He described these occurrences as "a common hazard of intravenous feeding". (Report at p.44).

[60] The Claimant was readmitted to the QEH on 09 February 2005 because of a partial small bowel obstruction. This issue was resolved without the necessity

for surgery. After a slow recovery, she was discharged on 15 February. Dr. Shepherd explained that the obstruction was due to adhesions. He opined that:

> "Adhesions can form in the abdomen even after one uncomplicated operation. ...Again, this is not a failure of surgical technique or management". (Report at p. 44).

6. Psychiatric Damage/Post-Traumatic Stress Disorder

[61] Counsel for the Claimant submitted in 2017 that her "…continuing psychiatric and psychological injuries manifested themselves in a variety of ways as outlined in the medical reports and notes…". (Page 9 of the Quantified Claim filed on 25 July 2017). A claim was made here for $ 250.000.00.

[62] The Claimant filed a witness statement on 20 January 2015 in which she averred that after the second operation:

> "…. I could not walk and my family would rub and massage my legs and feet. Me! Mellissa! Not walking really pulled me into a sad depressive state of mind. I lost hope in myself and God. When I thought about everything that I had to do in order to get well, hopelessness and despair stepped in …". (Para. 29).

[63] After the third operation, the Claimant says that:

> "When I awoke the upper part of my stomach had been stitched up, unfortunately the lower area under my navel was still open but without any tubes. That was when the trauma intensified: literally seeing my skin being burnt off right before my eyes it was

> excruciatingly agonizing physically and mentally". (Para. 31).

[64] Finally, the Claimant alleged in her witness statement that:

> "…these events were traumatic both to myself and my family and were emotionally and physically draining to my body. As a result, I became depressed and still psychologically [?] whenever this period of my life is discussed or thought about". (Para. 64)

[65] The Claimant's husband also filed a witness statement on 20 January 2015. He referred to her stress and depression only in relation to the preparation of documents and statements for this case. He deposed that:

> "… the preparation of these documents and statements has caused the Claimant tremendous stress, depression and frustration as she relived the entire ordeal of recounting these horrid memories. That as a husband and best friend, I offered her all of the support and comfort that I could to help her in the best possible manner. However, it appeared as though there was no escaping of her emotions". (Para. 13).

[66] Counsel for the Defendants objects to the Court making any award for psychiatric damage or post–traumatic stress disorder because there is no medical evidence to support an award. It will be recalled that Dr. Ferdinand raised concerns about the Claimant's emotional state after the third surgery. There was a recommendation for a counselor or psychiatrist to become involved in her management as she appeared to be "emotionally labile". (See para. [47] supra).

[67] Unfortunately, no psychiatric or psychological reports were produced to the Court to substantiate any psychiatric damage or post-traumatic stress disorder arising from the Defendants' negligence. The Claimant does not confirm receiving any counseling or psychiatric intervention while at the QEH, or from private practitioners.

[68] When asked to report on the effect that the Claimant's injury has had on her life and physical well being, Dr. Shepherd responded that:

> "There is no doubt that the several weeks [the Claimant] spent in SICU were emotionally traumatic, as revealed in one hospital note that suggested she be referred for counseling. All patients who have chronic fistulae would be expected to suffer from varying degrees of depression, anxiety and a fear that they may not survive. This is in addition to the physical effects that lead to poor appetite, wasting and other nutritional defects. Depending on the mental makeup of the individual, some people will make a full emotional recovery. Others may suffer residual trauma for years. I cannot state for certainty which category [the Claimant] falls into. During my brief interview with her she did not display major signs of emotional disease". (Page 46 of Report).

[69] Dr. Shepherd made no claim to psychiatric or psychological expertise. However, it is his expert opinion that having experienced a chronic fistula, the Claimant would be expected to suffer depression, anxiety and fear of not surviving. But he was unable to say whether the Claimant would make a full emotional recovery, or whether she would suffer years of emotional trauma.

There is no appropriate expert evidence to inform this Court as to which end of the emotional spectrum the Claimant occupies. Therefore, any award is likely to be at the lower end of the scale.

7. Scarring

[70] The four surgeries have left the Claimant with unsightly and severe scarring to her abdomen, due to the different surgical incisions from each operation. The closed fistulas are easily identifiable, and the disfigurement is permanent. Counsel for the Defendants submitted that an award of $30,000.00 is reasonable in the circumstances.

[71] The Claimant deposed in her witness statement of 20 January 2015 that "… as a result of these surgeries, I now have permanent and disfiguring scars all over my abdomen". (Para. 63). Her counsel informed the Court that she no longer attends the beach and constantly wears a dress size that is larger than her regular size so as to avoid any embarrassment of the disturbance of her body image". (Qualified Claim at p. 12). There is nothing in the Claimant's witness statement or affidavits that support these allegations by Counsel.

[72] Dr. Shepherd confirmed that the Claimant "has and will always have, rather uncosmetic abdominal scars". He described her scarring as "a cosmetic insult, but [they] do not impose a disability on any physical function". (Pages 44 and 45 of Report). The scarring is to be compensated by the Defendants.

8. Infertility

[73] The Claimant and her husband wish to start a family. However, she has not conceived, and she believes that her inability to conceive is due to the removal of her right ovary and fallopian tube, and/ or pelvic adhesions, and/ or blocked tubes. There is a claim of $ 300,000.00 for damage to her reproductive system.

[74] Dr. Ferdinand's report confirmed that during the second surgery he observed that the Claimant's left fallopian tube was normal, but he did not locate her right ovary. (See para. [34] supra). An examination report by Imaging and Ultrasound, Inc., dated 10 February 2015, indicates that the Claimant's uterus and left fallopian tube were normal in appearance. An abdominal and pelvic ultrasound was conducted on 28 January 2015 by Diagnostic Radiology Services. Their report states that the right ovary had been removed, but the left ovary was normal with a dominant follicle.

[75] Dr. Bennett examined the Claimant in January 2015 when she was 32 years old. Initially, Dr. Bennett assessed her as being subfertile "probably as a result of adhesions". (Page 2 of undated Report). Subsequent findings indicated that the Claimant failed to ovulate in the tested cycle. She was diagnosed as subfertile, and this could not "be attributed wholly to mechanical factors (i.e.) tubal damage". (Ibid).

[76] In an undated second addendum to her report, Dr. Bennett concluded that:

"However given:-

(i) the structural damage to [the Claimant's] gynecological tract (i.e. loss of the right fallopian tube and ovary as well as damage to the left fallopian tube), which would cause not only difficulty in achieving fertilization and therefore pregnancy but would also increase her chances to having an ectopic (tubal) pregnancy.

(ii) A low progesterone level which confirms that her ovarian function is impaired.

It is highly unlikely that this couple can achieve pregnancy naturally….Even with assisted reproduction methods the chances of them achieving a successful pregnancy would be markedly reduced given the additional compromise to her fertility resulting from loss of one ovary and the malfunctioning of the remaining ovary".

[77] With respect, the reports from Imaging and Ultrasound Inc. and Diagnostic Radiology Services do not support Dr. Bennett's statements that either the Claimant's left ovary or left fallopian were damaged. Therefore, her conclusion, that structural damage to the Claimant's gynecological tract would cause difficulty in achieving fertilisation and pregnancy, is open to challenge.

[78] Another specialist in obstetrics, and gynecology offered another expert view about the Claimant's fertility. Dr. Chase submitted a report dated 24 December 2018. He reviewed Dr. Bennett's report together with the reports from Imaging and Ultrasound and Diagnostic Radiology Services, various lab

results and a semen analysis for the Claimant's husband.

[79] Dr. Chase agreed with Dr. Bennett in certain respects. After assessing the relevant documents, he said:

> "I concur with Dr. Bennett's conclusion that the tests suggest ovulation failure (no egg produced) during the tested cycle.
>
> Additionally, while her partner's sperm was within normal range in numbers and other parameters, the low fructose suggests a potential problem with him as well.
>
> I concur with Dr. Bennett that while there was evidence of tubal damage on the HSG as evidenced by the lack of spill and hydrosalpinx, the left tube and ovary however, appear normal by the testing (HSG and ultrasound) and the left tube was patent. The evidence suggests ovarian anovulation (failure to ovulate) as the main cause of this inability to conceive.
>
> I concur with the diagnosis of subfertility. The evidence suggests that [the Claimant] should be able to conceive with ovulation induction agents. Dr. Bennett stated that her initial clinical diagnosis was one of subfertility secondary to pelvic adhesions. Dr. Bennett however went on and concluded her report by stating that after investigations [the Claimant's] subfertility could not be [attributed] wholly to mechanical factors (tubal damage). I concur.
>
> **Opinion**
>
> My opinion is that [the Claimant] has subfertility and that the main cause of this is ovarian anovulation and not tubal damage from her surgeries".

[80] The Court accepts that the Claimant's right ovary was removed during surgery at the QEH. The Court also accepts that she has a functioning left ovary and left fallopian tube. The Court is guided by the two experts who agree that the Claimant is subfertile. No connection was made between her subfertility and any damage caused by her several surgeries.

[81] Dr. Chase believed that the Claimant could conceive "with ovulation induced agents". Dr. Bennett in her report revealed that:

> "[The Claimant] was prescribed a course of clomiphene citrate in an attempt to induce ovulation and was advised to have the hormone levels repeated at the appropriate time in her cycle.
>
> She has not been seen since and appears to have not followed through with the treatment and tests/investigations requested".

[82] There is no evidence from the Claimant that she followed Dr. Bennett's advice by taking the drug prescribed for the appropriate length of time. There is no evidence that she undertook induced ovulation in her attempts to conceive. Therefore, she has not proved that she failed to conceive using this method. The Court is also reminded of Dr. Chase's expert opinion that the low fructose content of the husband's sperm was a contributing factor to the Claimant's infertility. There is no evidence that the husband did anything to elevate the fructose content of his sperm.

[83] The report and addenda from Dr. Bennett, and the first report from Dr. Chase, did not address the question whether the Claimant's ability to conceive was compromised by removal of one of her ovaries. Dr. Chase gave his opinion on this issue in a second report dated 26 February 2019. He opined as follows:

> "***15. Effects on Fertility with One Ovary***
>
> 16. Can a woman with one ovary get pregnant? Yes, the chances of getting pregnant with one ovary are equal to the chances of getting pregnant with two ovaries. What plays an important role in fertility is the reason for the removal of the ovary. If the ovary had to be removed due to serious conditions, then it lowers the chances of fertility.
>
> 17. The most significant aspect of getting pregnant with one ovary is that it should be next to a healthy fallopian tube. Fallopian tubes hang near the ovaries and are not attached to them. Their primary role is to catch the egg when it is released from the ovaries. If the egg can reach the uterus through the tube, then there is no fertility problem.
>
> 18. Every month the ovaries release the egg alternatively. If only one ovary is present, an egg is still normally released every month. If the ovary is not adjacent to the fallopian tube, as long as it is healthy, the egg can reach the tube. Through this tube, the egg reaches the uterus. However, this increases the chances of an ectopic pregnancy.
>
> ….
>
> ***23. Conclusions***
>
> 24. In summary, women with a single ovary - be it right or left - do not in general have a reduced fertility

> potential to conceive, either naturally or via IVF treatment. However, women have no compensatory mechanism for loss of one ovary and, as the number of primordial follicles in the ovary is finite, these women may have a shorter reproductive life span. The possession of only one ovary may be crucial in women who already have diminished ovarian reserve, and further clinical studies need to be conducted in order to assess the full impact of this situation".

[84] The Claimant has an ovary with an adjacent fallopian tube. There is no evidence of damage to these remaining reproductive structures, including her uterus. The expert evidence, which the Court accepts, is that she should be able to conceive normally. However, her own subfertility, and her husband's low fructose content in his sperm, appear to be the significant reasons for her inability to conceive. The Court cannot say with certainty that the specific removal of one of her ovaries, or the pelvic surgeries in general, contributed in any way to the Claimant's infertility. Consequently, there is no award for infertility.

9. Injuries to Other Internal Organs

[85] The injury to the Claimant's left lung was repaired as soon as it was discovered. But she did experience breathlessness, distress and chest pains. There is no evidence of a continuing disability. The claim is for $125,900.00. Counsel for the Defendants considers that a reasonable award would be $5,862.50.

[86] It is alleged that the Claimant suffered double incontinence, that is, loss of bowel and bladder function. The combine claim here is for almost one million dollars, i.e. $440,250.00 and $550,000.00 respectively. The evidence does not support such large claims. It is true that for some time the Claimant's bowel contents came through the fistula while it remained open. She was on a liquid diet for nutritional support. When visiting the outpatients' clinic on 20 May 2003, she complained of infrequent bowel movements that required suppositories. (Page 4 of Dr. Ferdinand's Report).

[87] The leaking fistula was evidence of bowel impairment. Counsel for the Defendants admits that "The Claimant lost control of her natural bowel movement on account of the fistula which was a severe abdominal injury and was affixed with a colostomy bag for a while". (At para. 131 of Counter-Quantification). He also submits that the sum of $ 23,100.00 is an adequate award, as opposed to the $ 440, 250.00 claimed.

[88] There is no evidence of urinary incontinence during the Claimant's hospitalisation. Dr. Bennett records that during her consultation in January 2015, the Claimant "complained of having difficulty holding her urine at night". Dr. Shepherd does not raise this as an issue in his report.

[89] The Claimant did not mention bladder incontinence in any of her affidavits. It is her husband who stated that:

> "… since the date of our marriage some complications and challenges arose, at times while asleep, I am awakened by the cries of the Claimant in pain because her stomach is cramped so tight that she is unable to move to go to the bathroom. On these occasions, I would have to assist her by placing something under her so that she could urinate. There is never a fixed time that this would happen, other times she would be unable to hold her urine and it would automatically flow". (Para.7 of affidavit filed on 20 January 2015).

[90] The Court does not agree with counsel for the Defendant that a "fib" was made up in relation to bladder incontinence. (See para. 140 of Counter – Quantification). But, unfortunately, there is no medical evidence that makes a causal connection between the negligence of the Defendants, and the Claimant's bladder issues. An award for urinary incontinence cannot be sustained.

[91] The QEH notes refer to a hernia after the Claimant returned there in February 2005, as a result of an intestinal obstruction. The notes speak of tenderness "in area over incision hernia" (11 Feb.); a "hernia orifice" (12 Feb.); and "mild tenderness over hernia orifice" (15 Feb.). Dr. Shepherd reports that "an entry in the records makes mention of a hernia – possible an incisional hernia – for the first time". (Page 39 of Report). Speaking to the Claimant's future prospects, his professional opinion is that:

> "The other development that can occur after abdominal surgery is an incisional hernia – where

> part or all of a scar gives way and allows intestinal contents to bulge. If large and unsightly it may require surgery for closure". (Report at p. 45).

Dr. Shepherd also identified incisional hernia as a possible direct long term sequela. (Report at p. 46).

[92] In the second addendum to her expert report, Dr. Bennett indicates that she reviewed the Claimant in April 2019. Dr. Bennett observed:

> "… a large hypertropic scar which extended vertically from supraumbilical region downwards below her umbilicus. The lower end of the scar was superimposed on an incisional hernia".

The existence of the hernia was recorded by the QEH in 2005, and confirmed by Dr. Bennett in 2019.

[93] The claim here is for $23,000.00 to compensate for a direct inguinal hernia, where there was no pre – existing weakness. (At p. 12 of Quantified Claim). The Defendants reject any notion of compensation for the Claimant's hernia on the basis of the miniscule nature of the claim. They argue that the law does not provide for this kind of compensatory damages. (See para. 147 of Counter - Quantification).

[94] Counsel for the Defendants also relies on Dr. Shepherd's report and quotes him as saying in 2014 that "… after 13 years this [sequela] is vanishingly small". (At para. 146 of Counter- Quantification). With respect, this is a

misrepresentation of Dr. Shepherd's report. Dr. Shepherd was referring to the possibility of recurrent intra-abdominal infection in the Claimant. In this regard Dr. Shepherd stated that "… after some 8 years, this is vanishingly small". Dr. Shepherd was not referring to the possible development of a hernia.

[95] The Court accepts that the Claimant has developed an incisional hernia, and she will be compensated. The question of compensation for future corrective surgery will be addressed when future medical expenses are discussed. (Infra at para. [116]).

[96] Counsel for the Defendant is willing to accept the claim of $ 5,000.00 for loss of educational opportunity. This acceptance is on condition that the Claimant produces the relevant receipt for the payment of fees to the educational institution. Counsel for the Claimant recently indicated that the receipt cannot be found. There is, therefore, no documentary proof of this expenditure.

[97] The Claimant recounted her academic pursuits in her witness statement filed on 20 January 2015. (At paras. 3 -7). There is no reference to the curtailment of her studies as a result of her hospitalization. She made no mention of $ 5,000.00 being paid by her, or on her behalf, to any educational institution. The Claimant's father did not file any affidavit alleging the payment of any such sum for the Claimant's education. There is not a scintilla of supporting evidence on which this Court can rely to substantiate the payment. In the

absence of documentary proof, or other supporting evidence, no award is made for loss of educational opportunity.

Assessment of Damages for Pain, Suffering and Loss of Amenities

[98] Psychiatric Damage/Post Traumatic Stress Disorder: The Court noted earlier that in the absence of any appropriate medical assessment of the Claimant, the damages would be at the lower end of the scale. (See para. [69] supra). There is no medical prognosis or other evidence of the Claimant's inability to cope with life and work; or of negative effects on her relationship with spouse, family, friends or persons with whom she comes into contact; or of any future vulnerability.

[99] Kemp and Kemp refers to less severe cases where a virtual recovery would have been made within one or two years, with minor symptoms persisting over any longer period. The range is £ 3,710 to £ 7,680 or $ 12, 985.00 to $ 26,880.00. (Vol. 3 at para. JCG – 019 (2020)). The Court awards $ 25,000.00.

[100] Scarring: Counsel for the Defendants argues that:

> "It is beyond doubt that the Claimant suffered scars to her abdomen from the five or six surgical procedures and they are uncosmetic. But [the Claimant's] scarring cannot be considered a major or significant cosmetic disability because it is not to her face and the scars can only be seen when the [Claimant] is in an [undressed] state or dresses in a swim suit or during sexual intercourse. However, it is accepted that scarring of any kind is more distressing to a woman than a man (or so it is said)

> and this is taken into consideration. However, scarring to parts of the body other than the face, according to the JSB Guidelines, falls in the range of £1,300 to £7,500 ($4,440.00 to $ 26,250.00). It would seem that the *Guidelines for the Assessment of General Damages in Personal Injury Cases* does not cover surgical scarring, except under Chapter 10: *Scarring to Other Parts of the Body*, at p. 84 in the second column: "In cases where an exploratory laparotomy has been performed but no significant internal injury has been found, the award reflects the operation and inevitable scar": £ 6,575 ($23,012.50 BDS) with 10% uplift to £7,230 ($25,305.00 BDS)". (At para. 150 of Counter-Quantification).

[101] After exploring case law, Counsel for the Defendants submitted that a reasonable compensatory award for the Claimant's scarring would be $ 30,000.00. (At paras. 151 – 153 of Counter – Quantification). The Court is guided by the reference in Kemp and Kemp to a large proportion of awards for a number of noticeable laceration scars, or a single disfiguring scar, of leg (s) or hand (s) or back or chest. The range, after a 10% uplift is £7,350 to £21,330. (Vol. 3 at para. JCG – 082 (2020)). That is $ 25,725.00 to $ 74,655.00.

[102] It is true that the Claimant's scars are not normally visible to other individuals. But, situated as they are on her abdomen, she will have to view them every day for the remainder of her life. The unsightly scarring will remain a constant embarrassing reminder of her harrowing experience. Part of the disfigurement also includes the site of the now closed fistulas, and a distended abdomen. The

Court awards $ 75,000.00 for the Claimant's scarring.

[103] The Collapsed Lung: The Court considers that an award of $ 15,000.00 would be reasonable. (See Kemp and Kemp Vol. 3 at para. JCG – 026 (2020), sub-para. (f)).

[104] Loss of Bowel Function: This is associated with the leaking fistula. The Claimant watched the contents of her bowel leak out with the associated unpleasant smell of stool. She experienced burning in the area of the wound. This continued from early January 2003, to 17 July 2003 when the fistula was closed in surgery. The Claimant endured over six months of pain and discomfort, and nausea from the scent of escaping stool.

[105] Kemp and Kemp cites severe abdominal injury causing impairment of function and often necessitating temporary colostomy (leaving disfiguring scars). The figures stated, with a 10% uplift, are £ 41, 850 to £ 65.440. (See Vol. 3, para. JCG – 038 (2020), sub-para. (d)). These figures translate to $146,475.00 to $229,040.00. Bearing in mind that the Court has awarded $ 75,000.00 for scarring, the sum of $ 120,000.00 is considered to be a reasonable award for the bowel impairment.

[106] Hernia: The Court has accepted that the Claimant now has a hernia resulting from her extensive abdominal surgeries. There is no evidence that the hernia is causing any pain or limitations on physical activity or employment. There

is no evidence that the Claimant requires imminent repair of the hernia, or that it would impact negatively on a pregnancy if she conceives. Any award here will be at the lower end of the scale.

[107] According to Kemp and Kemp, the lower end of the scale accommodates an uncomplicated indirect inguinal hernia, possibly repaired, and with no other associated abdominal injury or damage. The range is from £3,180 to £6,790 with the 10% uplift. (Vol. 3 at para. JCG – 041(2020), sub-para. (c)). The Barbados equivalent is $11,130.00 to $ 23,765.00.

[108] Any associated injury or damage to the Claimant is reflected in the other associated awards. $ 20,000.00 is considered to be a reasonable award for the resulting hernia.

[109] Additional pain and suffering: The QEH notes detailed additional medical challenges that the Claimant experienced while in hospital. These challenges include:

1. vomiting, pain in her lower abdomen, frequent burning urination, high temperature and rapid pulse rate on her return to the QEH after the first surgery failed to remove her appendix completely;
2. massive internal toxicity after the first surgery, which was discovered during the second surgery;
3. fluid in her lung cavities and swollen limbs as a result of protein levels

in her blood being too low;

4. inability to breath without a ventilator;

5. weight loss, dehydration, failure to thrive and generally poor health;

6. tachycardia, fever and yeast infection;

7. an infection of her left eye;

8. a black and blue discoloured region over her right hip, and a fungal infection to the skin of her groin;

9. fear of dying; and

10. multiple surgeries with lengthy periods of hospitalisation.

[110] The Court will add a further $50,000.00 to compensate for the Claimant's additional pain and suffering. The initial computation for pain, suffering and loss of amenity is $305,000.00, which comprises the following:

1.	Psychiatric Damage/Post Traumatic Stress Disorder	$ 25,000.00
2.	Scarring	$ 75,000.00
3.	Collapsed Lung	$ 15,000.00
4.	Loss of Bowel Function	$120,000.00
5.	Hernia	$ 20,000.00
6.	Additional Pain and Suffering	$ 50,000.00
	TOTAL	$305,000.00

[111] The sum of $305,000.00 will be discounted by 10% in order to account for any overlap. This gives a figure of $ 274,500.00 which will be rounded up to $275,000.00 as the award for pain, suffering and loss of amenities.

Future Medical Expenses

[112] Another area of general damages claimed is for future medical expenses. The argument is that the Claimant will incur expenses due to post-surgical adhesions; impairment of her ability to conceive; surgical closure of the hernia; and possible recurrent intra-abdominal infection. Dr. Shepherd's report considered adhesions, and concluded that:

> "[The Claimant] has, and will always have, some number of adhesions. Whether these will result in future intestinal obstruction (at the extreme) or abdominal pain and discomfort is possible but cannot be predicted with any certainty". (At p. 44 of Report).

[113] Dr. Shepherd expressed the view that the Claimant's adhesions were a part of her direct long term sequelae:

> "Adhesions will also always be present. They MAY become a disability if intestinal obstruction develops, especially if surgery becomes necessary to correct such obstruction. However, as long as this does not happen, [the Claimant] will be completely unaware of their presence". (Report at p. 45 and 46).

[114] The Claimant was readmitted to the QEH in 2005 with intestinal obstruction due to adhesions. This was resolved without surgery, and there is no

information before the Court indicating that the Claimant has had to return to the QEH. There are no subsequent complaints of abdominal pain and discomfort attributable to adhesions. There is a complaint of painful sexual intercourse, but the complaint lacks medical evidence to connect this pain to the Claimant's adhesions.

[115] The Court previously stated its findings that the expert evidence did not establish persuasively a connection between the Claimant's inability to conceive and the Defendant's negligence. (Supra at para. [84]). It follows that the argument for future medical expenses, in this regard, cannot be entertained.

[116] With respect to the incisional hernia, the Court made an award of $ 20,000.00. There is no medical evidence that the Claimant will require surgery, in the near future, to close the hernia. However, Dr. Shepherd identified it as a possible direct long term sequela. (See para. [91] supra).

[117] Dr. Shepherd's expert opinion is that the possibility of recurrent intra-abdominal infection "is vanishingly small". (See para. [94] supra). This was in 2014, some 12 years after the initial surgery. It is now 18 years post-surgery, and there is no evidence that the Claimant has experienced recurrent inter-abdominal infection. The Court considers that this aspect of the claim for future medical expenses is now too remote.

[118] This leaves the possibility of future complications in relation to the adhesions

and the hernia. Adhesions were considered as part of the $50,000.00 awarded to compensate the Claimant for additional pain and suffering. (Supra at paras. [109] – [110]. An award of $20,000.00 was considered reasonable for the hernia.

[119] Counsel for the Claimant submitted that $700,000.00 was a reasonable figure for an award for future medical expenses. Of this figure, $400,000.00 was requested for in vitro fertilization. The Court has declined to award any damages connected to the Claimant's inability to conceive. Therefore, what remains for the Court's consideration is the likelihood of complications arising in the future from either the adhesions, or the hernia or both.

[120] Counsel for the Defendant rejected any claim for future medical expenses on the basis that the Claimant was seeking a double indemnity, and that there was no medical evidence to support such a claim. The medical evidence does support the possibility of future medical intervention for the Claimant's adhesions and her hernia.

[121] Bearing in mind that the adhesions and hernia were previously included in the award for pain, suffering and loss of amenities, the Court considers that an additional award of $15,000.00 would adequately address any possible future medical expenses in these areas.

Future Home Care and Travel Expenses

[122] The claim under this head of general damages is for future home care and travel expenses associated with any future medical expenses. The sums claimed are $15,000.00 and $2,000.00 respectively. The Defendants reject this head of damages. The Court's view is that the award for future medical care is enough to accommodate home care and travel expenses, should these costs arise. Therefore, no award is made for these projected expenses.

Past Home Care and Services

[123] The Claimant is entitled to be compensated for the gratuitous care of family members or friends who assisted her. The claim is for $50,000.00 based on a daily rate of $35.00 for a period of approximately 27 months between November 2002 and February 2005. The Defendants considered the amount claimed to be excessive. Their counter offer is $8,820.00 for 36 weeks of home care at $35.00 per day.

[124] The Court accepts the period of home care as 36 weeks, as calculated by counsel for the Defendants. (See para. 166 of Counter – Quantification). In recent times the High Court has applied a daily rate of $40.00 per day. **(See Marshall v. Abacus Builders, No. 1020 of 2011, H.C. B'dos., Civ. Div., decision dated 05 February 2015; Husbands v. Ministry of Public Works and Transport, Civ. Suit No. 0247 of 2009, H.C. B'dos., decision dated 18**

March 2020).

[125] The Court is satisfied that the Claimant was cared for while she was seriously ill and that the care was beyond the ordinary call of duty given the particular needs of the Claimant. The Court pays particular attention to the fact that the Claimant's at home care went beyond cooking, cleaning and washing on her behalf. She had to be taken for sea baths as advised by the medical team. The Claimant required nursing care for her personal hygene, changing wound dressings, and the application of prescribed medicines. There was a period when she was so weak that she fainted regularly and had to be assisted. Her care giver also had to contend with the stench from the leaking fistula.

[126] in these circumstances the Claimant's home care went beyond that provided by the ordinary care giver. It was her father who took on the majority of this responsibility. According to the Claimant her mother brought her food on some occasions, but she was too emotional to deal with the Claimant's needs on a daily basis. Compensation then should not be limited to $35.00 or $40.00 per day. And given the critical state of the Claimant's health, her care could not be limited to 8 hours per day.

[127] An appropriate level of compensation for home care is considered to be $20,000.00

Other Special Damages

[128] The Defendant conceded medical expenses, past transportation/travel expenses and disbursements in the sums of $7,375.00, $420.00 and $260.00 respectively.

Disposal

[129] The Defendants are to pay the Claimant the following sums as general and special damages:

General Damages

Pain, suffering and loss of amenities	$ 275,000.00
Future medical expenses	$ 15,000.00

Special Damages

Past Home Care	$ 20,000.00
Medical Expenses	$ 7,375.00
Past transportation/travel expenses	$ 420.00
Disbursements	$ 260.00
TOTAL	**$ 318,055.00**

[130] On 17 November 2017, this Court made an order for an interim payment in the sum of $ 158,055.00. This sum included pain, suffering and loss of amenities ($50,000.00); future medical care ($50,000.00); past domestic and gratuitous assistance ($50,000.00); past medical expenses ($7,375.00); past travel and

transportation expenses ($420.00); and disbursements ($260.00). Future medical care and gratuitous assistance have been substantially reduced by this judgement, but should not negatively impact the Claimant because additional compensation is still due to her from the Defendants.

[131] The remaining award now due to the Claimant is $160,000.00.

[132] The order of 17 November 2017 did not address the payment of interest, and I will hear the parties with respect to the appropriate order to be made in relation to interest payments, and the date by which payment of outstanding principal and interest should be made.

[133] Costs are awarded to the Claimant to be agreed or determined by the Court.

Sonia L. Richards
Judge of the High Court