In the High Court of Fiji

At Labasa

Civil Jurisdiction

Civil Action No. HBC 55 of 2017

Robert Leonard Koroi

Plaintiff

v

The Permanent Secretary for Health

First defendant

The Attorney General of Fiji

Second defendant

Counsel: Mr K. Maisamoa for the plaintiff
Mr J. Pickering for the defendants

Dates of hearing: 17th and 18th June, 2019

Date of Judgment: 7th February, 2020

Judgment

1. The plaintiff, in his statement of claim states that on 19th April, 2014, he was admitted to Waiyevo Hospital,(WH) in Taveuni, with an injury on his left leg. On the same day, he was conveyed to Tukavesi Health Centre,(THC).The following morning he was transported and admitted to Labasa hospital,(LH).The plaintiff states that trainee Doctors attended to him most of the time. Doctors and surgeons came on visitation. He was informed that he had a serious injury and would be transported to CWM hospital, but the evacuation was cancelled. He was not consulted nor advised that his left leg would be amputated. The first defendant owed him a duty of care to ensure that reasonable care was at all times taken in relation to his medical, nursing and other care and to ensure a safe system of health care, including proper and effective means of communication of risks and/or information. The plaintiff claims that in LH, he was not treated as expected of medical professional. He now experiences pain and suffering, as he was not treated properly. He claims damages.

2. The defendants, in their statement of defence state that the plaintiff's leg could not be saved, as he had a very serious injury with an open fracture, due to his own contributory negligence of climbing a coconut tree, while having epilepsy. On admission to LH, the Accident and Emergency and surgical staff attended to him, though it was a public holiday. He was visited by Doctors, Registrars and Surgeon. No plans on initial evacuation to CWM hospital were made, as priority of wound wash and external fixation superseded. He was well advised on the seriousness of his injury.

3. The statement of defence continues to state that the initial plans were to continue as far as possible to salvage the limb from a bone healing perspective. All reasonable care and alternative measures were accorded, prior to the recommendation for amputation. The plaintiff was advised and consulted with regard to the amputation and confirmed consent verbally. The amputation was discussed from 23 April,2014, and documented. On 7 May, 2014, his written consent was taken before the operation. He was given pre-operation counselling sessions. The documentation confirmed his consent. The persistent pain for life is highly likely regardless of surgical treatment accorded considering the extent of his injury.

4. The plaintiff in his reply to statement of defence reiterates the averments in his statement of claim. The plaintiff states that he was in transit at THC and admitted to LH at 2.50 am on 20th April, 2014.

The determination

5. The main issue for determination is whether the defendants breached their duty of care to the plaintiff, in failing to treat him "*with the standard medical and surgical methods*" at LH.

6. The particulars of negligence pleaded read:

   i) Failing to advised and consulted the plaintiff for the amputation.
   ii) Failing to accord the plaintiff alternative treatment instead of amputation.
   iii) Operating on the plaintiff when it was unnecessary to do so.
   iv) Failing to attend to the Plaintiff during the Public Holiday in order to give him proper medical assessment and medication

7. In the first instance, I find it necessary to ascertain how the plaintiff befell the injury.

8. PW1,(*the plaintiff*) in evidence in chief said that on the morning of 19th April,2014, he climbed a coconut tree. When he was on top of the tree, he felt his sickness: epilepsy coming on. He locked himself on the branches and lay on top of the tree. He said that "*all I know when I knew myself again I was on the emergency in the hospital....the branches of the coconut tree fractured my tibia*". He saw the x-ray film taken in LH. It showed that his leg was fractured inside. He did not fall from the tree. He said that he came sliding down the tree and crawled to the road. In cross examination, Mr Pickering, counsel for the defendants asked him how the branches of the coconut tree fractured his tibia.

9. DW1, (*Dr Katarina Tinfulagi, Medical Officer*) in evidence in chief said that in April, 2014, PW1 came to TH with a traumatic serious injury of his left leg caused by a fall from a distance. It was an open fracture. He was seen at 12pm. An x-ray confirmed that it was a "*comminuted fracture of his left tibia and fibula*". The injuries were not caused by the branches of a tree. The plaintiff, as an epileptic patient should not have engaged in such physical activity as climbing a coconut tree.

10. The contemporaneous clinical notes recorded by TH on 19th April,2014, and their referral to LH provide that the plaintiff fell from a coconut tree after fainting. The folder maintained at LH provides that on admission, he had informed a surgical intern that he had climbed a 20 meter tall coconut tree and fell down from the tree after an attack of epilepsy.

11. DW2, (*Dr Jaoji Vulibeci, General Surgeon, Medical Superintendent of LH*) said that the injury was caused by a high energy impact. DW3, (*Dr Maloni Bulanauca, Head of Dept of Surgery, Labasa Hospital*) testified that the plaintiff had suffered an open fracture to his tibia and fibula, the two bones of the lower leg.

12. In my judgment, the evidence conclusively establishes that the plaintiff suffered the serious injury to his leg, as a result of a fall from a coconut tree after he admittedly, had an epileptic fit.

13. PW1, in evidence in chief said that he was only given an injection at TH. No tablets were given nor was an x-ray taken of his leg. In cross-examination, he said that he did not know if he was given medicine, as he was having epilepsy. In re-examination, he said that he was getting sick, his mind was not connected and he didn't know if an x-ray was taken or not.

14. Mr Maisamoa, counsel for the plaintiff contended that the wound was not cleaned at TH. He referred to an entry made by Dr Muggi on 20th April,2014 at 8.45 pm, that the wound was "*Dirty & swollen*". It was also contended that the plaintiff was not treated with antibiotics from 12 to 6 pm when he was transported to Natuvu.

15. DW1 said that the plaintiff was given diazepam intravenously, a tetanus injection, oxygen therapy, cloxacillin and gentamicin, as stated in the referral to LH An x-ray was done at 1 pm, as documented. Blood tests were done. A pressure bandage and plaster was applied. The "*wound was cleaned*", although it was not recorded. PW1 was advised that the x-ray depicted a fragmented fracture of the fibula and tibia. The practice is to destroy x-ray films after 5 years. In cross examination, DW1 said that the plaintiff was not transferred to LH immediately, as he had to be stabilized first and then referred to LH for specialist orthopedic care. DW 2 confirmed he saw that x ray.

16. I find that an x ray was taken. I am not satisfied the wound was cleaned.

17. In my judgment, the plaintiff has not established that the wound was dirty and swollen on the day after he befell the injury, for the reason that it was not cleaned at TH and antibiotics were not given, as contended. DW3 said that some antibiotics are given once or twice a day. Antibiotics are not a hundred per cent guarantee. It will help 33%.

18. In cross-examination, DW2 was asked the reason the "*wound was better and swelling done* (but) *still some discharge from wound and tendons probably dead* (with) *some grass*", as stated in the entry of 27th April, 2014. He said that the grass still appeared, as it was a "*high energy*" wound. The upper end of the bone had gone into the grass and mud.

19. DW3 said that the wound was "*infected from the beginning*", as it was a seriously graded open fracture. The wound was dirty due to the injury sustained, All efforts were made to debride and wash the wound. It was very difficult to get rid of bacteria on soft tissue, as revealed by the laboratory wound swab tests. The bacteria was consistent with the injury. It was swollen as a result of natural inflammation. DW3 disputed the suggestion made in cross-examination that bacteria had grown, as the wound was not taken care of properly.

20. In my view, the plaintiff has not shown that the procedures adopted by the medical personnel "*fell below the appropriate standard...of reasonable care*", as stated by Calanchini JA(as he then was) in ***AG of Fiji v Narayan,***(Civil Appeal No. ABU 0057 of 2008,(1st April,2011)

21. In ***Kumari v Taoi,***[2005] FJHC 347 Finnigan J stated:

> *I am bound to hold that every person who enters into the medical profession undertakes to bring to the exercise of it a reasonable degree of care and skill, that is a fair reasonable and competent degree of skill. I take reasonable skill to be skill that reasonable according to the standards of what the profession does in a given situation. The course I believe I must adopt, so long as there is evidence, is to consider what the profession does in a given situation and then determine for myself what the reasonable doctor would have done.*(emphasis added)

22. In my judgment, the medical evidence reveals that reasonable care and precautions were taken. The plaintiff was in the first instance stabilized at TH with diazepam intravenously, a tetanus injection, oxygen therapy and antibiotics. The wound was cleaned. He was transported to LH the next day with a nurse. He was operated on the same day. There were change of dressings and wound washes thereafter.

23. The next complaint is that he was seen by interns at LH. This complaint is without merit for the following reasons.

24. I find that the plaintiff was seen on 20th April,2014, at 2.55 am by a surgical intern, who had discussed the case with Dr Semiti, Surgical Registrar. Dr Semiti had seen him at 4am. DW2 said that the intern discussed the case with him. He further said that young Doctors see patients first to conduct investigations such as x-ray, blood tests and ECG. A patient is not operated straight away.

25. Mr Maisamoa put it to DW2 that the plaintiff did not give his written consent for the first operation. But the plaintiff, in evidence in chief said he gave his consent, as confirmed by DW2.

26. In my view, there is no requirement that consent must be in writing. Popplewell J in ***Taylor v Shropshire Health Authority***,[1998] Lloyd R Med 395 at pg 398 as cited by Mr Pickering in his closing submissions stated:

> *For my part I regard the consent form immediately before operation as pure window dressing in this case and designed simply to avoid suggestion that a patient has not been told. I do not regard the failure to have specialized consent form at the time to be any indication of negligence.*

27. Finally, the plaintiff contended that he was told that his leg would be cemented and he would be transferred to CWM. His consent for the amputation was obtained by force.

28. PW1 said that on 7th May, 2014, a Doctor from CWM told him that the steel below the knee was smelling, his leg was infected and the best thing that can be done is to amputate the leg and give him a new leg. His LPO to go to CWM was cancelled and his leg was operated in LH. DW2 forced him to sign a document stating that his leg will be amputated, if the operation was not successful.

29. In cross-examination, PW1 said that the seriousness of the operation and the risks of amputation were explained to him. DW2 explained that fixtures were to be inserted in his leg. He gave his consent for change of dressings, wound washes and for the amputation, as nothing more could be done.

30. DW2 said that the plaintiff was operated on 20th April,2014. Sterile screws and fixtures were put to hold the bones so that they do not move and to facilitate easy cleaning of the wound. Sterile screws do not cause bacteria. Bone reduction was done, He explained to the plaintiff that the chances of losing his leg was high, as the tissues were crushed between two ends with no bone in between, as documented. On 27th April, he was taken to the operation theatre for curettage of the bone. The grass was still coming out from the wound. There were three separate wounds. There were fragmented loose bones in the wound. There was a big gap between the lower and upper bones. The bones were infected and he had lost muscle. The muscles and tendons were dead. The leg was not salvageable. The best option was to amputate the leg. Cement could not be used. The seriousness was explained to the plaintiff, before and after the operation.

31. DW2 and DW3 said that they did not tell the plaintiff that his leg would be cemented. Cement could not be used. The Doctors from CWM said that the same operation can be done at LH. There was no reason to send him to CWM.

32. DW3 said the plaintiff was informed that the chances of losing his leg was very high. His tibia continued to be comminuted and unattached. Dr Lofter, Visiting Surgeon from Australia said that there was no attachment of the bone. There was no other surgical treatment to treat the bone deficit. The bones had not healed. Shattered pieces of bone and poor blood supply hampered bone production. If his leg was not amputated, there would be continued infection of the injured leg and the blood stream.

33. Gates J(as he then was) in ***Shah v Narayan,***[2003] FJHC 340 concluded:

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

34. I am satisfied from the medical evidence that there was no alternative treatment .

35. I find that the clinical notes of Dr Alipate, Senior Surgeon of LH of 6th May,2014, provide that the plaintiff was worried about the below the knee amputation and was thinking about surgery. The effect of the amputation was explained to him by Dr Semiti, Dr Alipate and Dr Lofter, as provided in the consent form of 7th May,2014.

36. In ***Chatterton v Gerson,*** [1981]1 All ER 257 at pg 265 Bristow J said:

> *In my judgment what the court has to do in each case is to look at all the circumstances and say, 'Was there a real consent?' I think justice requires that in order to vitiate the reality of consent there must be a greater failure of communication between doctor and patient than that involved in a breach of duty if the claim is based on negligence. When the claim is based on negligence the plaintiff must prove not only the breach of duty to inform but that had the duty not been broken she would not have chosen to have the operation.*

37. In my judgment, the plaintiff has not established his assertion that he was forced to give his consent for the amputation. I am satisfied that the seriousness of the injury, the implications of the operation and amputation were properly explained to him. He understood the consequences and made his choice. There was no duress.

38. The plaintiff's action fails.

39. ***Orders***

i. The plaintiff's claim against the defendants is declined.

ii. I make no order as to costs.

A. B. Brito-Mutunayagam
JUDGE
7th February, 2020
At Suva