COMMONWEALTH OF THE BAHAMAS

IN THE SUPREME COURT

Common Law and Equity Division

2015/CLE/gen/00116

BETWEEN

MARY ELLEN KNOTT

Plaintiff

AND

THE PUBLIC HOSPITALS AUTHORITY

Defendant

Before Hon. Mr. Justice Ian R. Winder

Appearances: Janet Fountain for the Plaintiff

Kirkland Mackey with Kenny Thompson for the Defendant

30 August 2017, 18 May 2018

JUDGMENT

WINDER, J

This is a claim in negligence.

1. The plaintiff's (Knott's) claim is set out in her Statement of Claim which is settled, in part, as follows:

> 4. The Plaintiff was admitted to the Princess Margaret Hospital on the 8th February 2014 and the procedure was carried out at about 5:00pm by Dr. Locksley Munroe on the same day without incident.
> 5. In the early morning hours following the surgery, at about 3:00am, the Plaintiff buzzed the nurses' station to request a bed pan. Three nurses answered the call, a senior nurse, Nurse Hunt, and two junior nurses. Nurse Hunt told the Plaintiff to walk to the bathroom rather than use a bed pan. The Plaintiff advised Nurse Hunt that she felt woozy and did not think that she could walk to the bathroom. The nurses insisted that the Plaintiff get up out of the bed and as she so did, she fell to the floor and lost consciousness. When the Plaintiff gained consciousness she realized that she was bleeding from under her left arm. The nurses instructed her to try and get up off the floor but she could not get up by herself. She asked the nurses to push the bed closer so she could leverage herself up off the floor. The Plaintiff was later seen by the surgeon on call. On Monday evening at around 9:00 p.m. the Plaintiff was attended by Dr. Locksley Munroe at which time she advised of him of the incident.
> 6. By reason of the aforesaid, the Plaintiff sustained severe injuries and has suffered loss and damage.
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> **Particulars of Injuries**
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> The Plaintiff suffered the following injuries:
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> (i) Partial wound dehiscence;
> (ii) Flap necrosis;
> (iii) Prolonged hospitalization;
> (iv) Delay in chemotherapy treatment;
> (v) The Plaintiff also suffered anguish and worry due to the delay in chemotherapy treatment such delay increasing the possibility of the recurrence of the cancer, and
> (vi) Scarring at the wound site has caused the Plaintiff mental anguish
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> **Particulars of Special Damages**
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> (i) Medical expenses
> (Dr. Munroe – debriding) $600.00
> (ii) Nursing care (help at home and driving) $1000.00
> (iii) Cost of obtaining hospital and doctor's reports/notes $130.00

7. The said injuries loss and damage were occasioned to the Plaintiff by reason of the negligence and/or breach of duty on the part of the defendant authority to ensure the application of efficient and appropriate techniques, systems and standards for the delivery of health care in the Princess Margaret Hospital.

PARTICULARS

(i) Failure of the nursing staff to assist the Plaintiff in getting off the bed and walking her to the bathroom when the nurses knew or ought to have known that she would have required care and assistance;

(ii) Failure of the nursing staff to heed the Plaintiff's advice that she was feeling woozy and could not walk to the bathroom;

(iii) Failure of the nursing staff to assist the Plaintiff in getting up off the floor and back into bed;

(iv) Failure of the nursing staff to advise the surgeon on call in a timely manner or at all that the Plaintiff had fallen and might have sustained injuries as a result; and

(v) Failure of the nursing staff to advise Dr. Munroe in a timely manner or at all that the Plaintiff had fallen and might have sustained injuries as a result.

2. The defendant (the PHA) defended the claim in a defence which is settled, in part, as follows:

4. Paragraph 4 of the Statement of Claim is admitted.

5. Paragraphs 5 of the statement of claim are vociferously denied, rather the Defendants aver:

a. On 9th February, 2014 on or around 2:00am the plaintiff was observed standing and not moving at the end of her bed.

b. A nurse inquired of the Plaintiff why she was standing and the Plaintiff informed the nurse that she felt woozy.

c. There appeared to be visible oozing substance from the surgical area banded area of the Plaintiff's body.

d. The nurse instructed the Plaintiff not to attempt to move and the nurse immediately called for the assistance of other nurses on duty.

e. With the assistance of two other nurses the Plaintiff was informed that she would be gently eased to a sitting position on the floor until more assistance arrive to assist with getting the Plaintiff back onto the bed.

f. Easing the Plaintiff onto sitting position of the floor was necessary due the Plaintiff extreme weight, size and condition; the three nurses would require additional aid from a male assistant. During the time of the incident the Plaintiff weighed 344 pounds.

g. The nurses with the aid of a male assistant were able to properly get the Plaintiff back into her bed.

h. It was observed that the Plaintiff's surgical wound was bleeding therefore the intern on duty was called. The

Intern Doctor changed the Plaintiff's dressing and reapplied new dressing to the wound.

i. At no time during the incident did the Plaintiff request a bed pan nor did the Plaintiff fall onto the floor or lose consciousness.

j. At no time did any nurse ever refused to attend to the Plaintiff's need or request for assistance, or insisted that the Plaintiff walk to the restroom.

6. Paragraph 6 of the Statement of Claim is denied, the Defendants states that there was not any negligence and/or breach of duty on the part of the Defendants and/or its agents. The Defendants state further that alleged injury suffered by the Plaintiff if at all, was a result of the Plaintiff's own actions.

7. Paragraph 7 of the Statement of Claim is denied. The Defendants avers that any injuries as alleged by the Plaintiff which is denied, were a result of the Plaintiff's own negligence and not as a result of any action on the part of the Defendant and or its agents. The Defendant further repeat paragraph 5 of the Defendant's Defence contained herein.

3. At trial Knott gave evidence and called Drs Loxley Munroe and DuVaughn Curling as witnesses in her case. The PHA called nurses Lauralee Kemp, Mary Ramsey and Patrice Knowles-Hunt as witnesses in their case.

4. Knotts evidence at trial was that she entered the Princess Margaret Hospital on 6 February 2014 for her procedure. During the procedure Dr. Munroe had placed a portocath above her right breast, right below the collar bone, for future chemotherapy. There was no tube connected to it. On her left side, he placed an apparatus for the drainage and collection of fluid. A wound was on the left side and was covered with a padded white bandage. The bandage covered the sutures and part of a tube and was wrapped under the arm and came up the back up to her right shoulder.

5. Knott says that at around 2:53am, she buzzed the Nurses' Station as she needed to relieve herself. Three nurses came to her room, Nurse Patricia Hunt, Nurse Simmons and Nurse Campbell. She was familiar with Nurse Hunt from being hospitalized before. When the nurses arrived she asked them if she could have a bed pan. According to Knott, Nurse Hunt approached her and said, "Ms. Knott I think you need to get up and try to go to the bathroom." Hunt lowered the bed railing, placed her right hand on her left shoulder and helped her to get

into a sitting position while still on the bed and then she helped her to stand. Knott says that she felt wobbly and disoriented and fell on the floor. She remembered someone tapping her on her cheeks and telling her not to go to sleep and she wondered at the time if I had hit my head.

6. Knott says that the bandage was out of place and she could see that part of the surgical incision which ran from her breast to under my arm. The bandage was now displaced so the fluid was not getting onto the bandage but rather, it was flowing onto her and onto the floor. Knott says that she asked them to call her doctor but nobody moved. They were saying to her to get up off the floor. She remembered rolling toward her right hand as that was where the bed was. She says that she held onto the railing on the left hand side of the bed and using her hands and knees was able to grab hold of the bed. They were able to help her get off the floor from that position and positioned her buttocks onto the bed. They cleaned her up and as they finished up Dr. McQuay came into the room.

7. When Dr. McQuay came into the room, he introduced himself and said that Dr. Munroe had called him and told him to check on her. He pulled the gown down from the shoulder. He added more gauze under the bandage. She does not recall him checking the drainage tube.

8. She said that that she did not tell Dr. McQuay that she had fallen as at the time that he came to see her she was overwhelmed, disoriented, discombobulated and weary and did not have the presence of mind to relay to him what had just happened. She said that the next morning she told Nurse Andrea Nottage what had happened the night before, *"that I had asked the night nurses for a bed pan but they told me to get up and to go to the bathroom and in the process I fell."* Later that day, she told a member of Dr Munroe's as by that time she had collected herself and wanted to make sure that they knew what had happened to her. When she saw Dr Munroe he was angry that he had not been told what had happened.

9. Her hospitalization period was supposed to be 3 to 5 days but it ended up lasting for 9 days. Upon discharge the wound was not healing and in fact some

of the tissue had died as it had been agitated to the extent that the sutures separated and did not fall back into place.

10. Dr Locksley Munroe's evidence was as he was Knott's attending physician. Following the procedure he received a call from Nurse Hunt to advise that Ms. Knott was bleeding. He instructed Dr. McQuay, who was the Senior House Officer on duty, to attend Ms. Knott and to examine her for bleeding. McQuay followed the instructions and his findings, as recorded in Ms. Knott's medical record, are that the wound dressing was soaked but there was no oozing from the wound.

11. On Monday night he attended Ms. Knott himself and learned what had happened. That was the first time that he heard anything in relation to something having happened to Ms. Knott or that there was any kind of incident which followed her surgery. Until then, the only information he had received was that the patient was bleeding. If he had received information that his patient had fallen, or experienced any other untoward event, then his instructions to Dr. McQuay would have would have been (sic) specific to that event. When he examined Ms. Knott he found that there was an excessive accumulation of discharge coming through the JP Drain, which he would not have expected at 48 hours post-op.

12. According to Dr Munroe, if a patient experiences bleeding following a surgery then one would expect blood to accumulate under the sutures so that the wound itself, when palpated, would feel spongy or bogged down with fluid. That is not what he or Dr McQuay observed with Ms. Knott when they examined her. Dr. McQuay's notes do not indicate that he found any evidence of bleeding, although he notes that the bandages were soiled.

13. In light of what he observed when he saw Ms. Knott, her explanation of what happened was compatible with what he observed later at the wound site. It was clear that there was had been a pressure exerted on the chest wall and there had been an aggressive rubbing against the chest wall and the excessive drainage was compatible with that.

14. In his view the excess drainage constituted an unexpected event and it was very likely due to a pressure exerted on the chest wall or some aggressive rubbing on the chest wall, which would have occurred upon Ms. Knott's fall and/or the efforts to get her back into bed following the fall.

15. There was no indication from the nurses either by telephone, or otherwise that Ms. Knott had fallen or that anything untoward had occurred in the early hours of Sunday morning. It is to be noted that in their notes for that time period, there is no indication that they had to get Ms. Knott back into bed. There is absolutely no indication from reading those notes that Ms. Knott had fallen, or that she was found at the foot of the bed, or that they had had to get her off the floor and back into her bed.

16. According to Dr Munroe, following Ms. Knott's discharge from PMH she experienced wound dehiscence. During surgery, the incision into the flesh creates two sides of a wound that are sutured together. The separation of the two sides or flaps is wound dehiscence. Partial wound dehiscence is when a part of the wound separates. If the dehiscence is such that one side of the wound dies, that is the wound tissue dies, then that condition is described as flap necrosis. Because of the necrosis, he had to debride the wound and cut away the dead tissue and then allow the live tissue to heal before she was able to undergo the second phase of her treatment, which was about 4 months later in mid-July.

17. Upon Ms. Knott conveying to the nurse that she felt woozy he would have expected the nurses to tell her to sit down and then to assist her with getting back into bed, or at the very least to pull a chair close to her and have her sit down until they were able to put her back into the bed. There were three of them and so it is reasonable, in his view, that they could have achieved this without incident.

18. According to Dr Munroe, he had not assigned any bathroom privileges to Knott, in which case she ought not to have been out of her bed. Further says Dr Munroe:

(1) Ms. Knott's surgery proceeded without incident. She was expected to commence chemotherapy 2 weeks following surgery and hence the placement of the Portacath during surgery. Her chemotherapy was delayed until the middle of July. There is an optimum window of opportunity in which chemotherapy ought to commence following surgery.
(2) Ms. Knott's experience and required treatment post-op due to excessive drainage and flap necroses put her well outside that window. Consequently, her chances of a recurrence of breast cancer are increased. In his view, the excessive drainage was a result of the events which occurred on the early hours of Sunday 9 February 2014. He accepts Ms. Knott's version of events and they correlate with his findings following his examination of her and the required subsequent treatment.
(3) In his view, the nurses in whose care Ms. Knott was placed neglected to treat her with the standard of care required by nurses of their training and experience.

19. Nurse Lauralee Kemp's evidence was that on the 9th of February, 2014 she was working on the 10:30pm to 8:30am shift, along with Nurse Patrice Hunt and Nurse Ramsey. She was assigned to Private Surgical Room 9. Sometime before 2am during her rounds she recall that Knott was standing at the end of her bed.

20. She along with Nurse Patrice Hunt and Nurse Ramsey went to the aid of Knott as she indicated that she felt woozy. Knott was told that for her safety they would ease her to a sitting position on the floor until additional assistance arrived. With the help of a male assistant they were able to return the patient safely to her bed.

21. At the time of this incident Knott weighted approximately 350 pounds. When they first encountered the plaintiff standing at the foot of the bed, there appeared to be visible oozing substance oozing from the surgical area of the plaintiff's body. As a result of the visible oozing substance coming from the surgical wound area of the plaintiff's body, the on-call intern was called and he came and reapplied new dressing on the wound. There was never any conversation with this patient regarding bed pans nor had the patient ever requested a bed pan.

22. The evidence of Nurse Patrice Knowles-Hunt and Nurse Ramsey mirrored that of Nurse Kemp.

Discussion and Disposition

23. The usual starting point in any case of medical negligence is the case of **Bolam v. Frien Hospital Management Committee [1957] 2 All ER 118** and the oft cited dicta of ***Lord McNair***, where he stated:

> How do you test whether this act or failure is negligent? In an ordinary case it is generally said, that you judge that action of the man in the street. He is the ordinary man. In one case it has been said that you judge that by the conduct of the man on top of the Clapham omnibus. He is the ordinary man. But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient that he exercises the ordinary skill of an ordinary competent man exercising that particular art...A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art... Putting it the other was around a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.

24. It is accepted that the test applies equally to Nurses as well as Physicians. There are clearly competing version of the events as to how the incident involving Knott unfolded. Having seen the witnesses and observed them as they gave her evidence, I prefer the version of the event as advanced by Knott and supported by Dr Munroe. I am satisfied that on the night in question Knott was assisted out of her bed to the bathroom by the Nurses and in the course of that assistance she fell. I find that upon falling or in the course of the nurses helping her back to her bed, she disrupted her sutures. I am prepared to accept that this this was a breach of the duty of care as, according to Dr Munroe, she had not been given bathroom privileges. As Ms Fountain, Counsel for Knott

argued, "fundamental to a nurses' duties are to following the doctor's instructions". According to Dr Munroe, when cross examined,

(1) Once the incident was brought to his attention, about 48 hours later, he questioned the head nurse, who told him that Mrs. Knott had fallen.

(2) Walking to the bathroom would have caused more damage to her wound than Mrs. Knott's obesity nor blood thinners

(3) Immediately post-op, while still in the recovery stage of anaesthesia, patients would not be ambulated. The narcotics prescribed post-op would have interfered with Mrs. Knott's balance.

(4) The time of confinement post surgery is dependent upon the length of the procedure. He would not have expected Mrs. Knott to have gotten out of bed and walked to the bathroom.

25. The breach of duty was further compounded as there was a complete failure to notify Dr Munroe as to what transpired or to otherwise properly document what occurred. Instead the physicians were advised that the patient was bleeding which was not the case.

26. Knott sustained wound necrosis and had a prolonged recovery delaying the commencement of her chemotherapy and exposing her to the risk of her breast cancer recurring. In the circumstances therefore I am satisfied that Knott sustained injury and damage as a result of the breach of duty by the defendant and the defendant is therefore negligent. I order that an assessment of damages be carried out by the Registrar.

27. The plaintiff shall have her reasonable costs to be taxed if not agreed.

Dated the 2nd day of April 2019

Ian Winder

Justice