MEDI-CIRCLE SDN BHD

v.

NUR ZULAIKHA DZULZAILI & OTHER APPEALS

Court of Appeal, Putrajaya
Vazeer Alam Mydin Meera, S Nantha Balan, Nordin Hassan JJCA
[Civil Appeal Nos: W-02(NCVC)(W)-1393-10-2020, W-02(NCVC)(W)-1460-10-2020 & W-02(NCVC)(W)-1489-10-2020]
2 February 2022

Tort: *Negligence — Medical negligence — Claim by plaintiff against private hospital and its specialist consultants — Liability of hospital and obstetrics and gynaecological doctors — Vicarious liability — Whether only hospital liable for negligence — Costs, whether "Sanderson" order ought to be made — Quantum of special and general damages – Multiplier used to calculate award of compensation*

The present three appeals, Appeal 1393, Appeal 1460 and Appeal 1489, were against the decision of the High Court Judge ("Judge") in a civil suit ("Suit 144"). They arose from a claim in medical negligence against a private hospital and its specialist consultants. The plaintiff in Suit 144 was Nur Zulaikha Binti Dzulzaili. She suffered from spastic quadriplegic cerebral palsy and would continue to be dependent on others for all activities of daily living for the rest of her life. The appellant in Appeal 1393 (the 1st Defendant in Suit 144) were the owners of Pusat Rawatan Islam Az-Zahrah ("Hospital"). The appellant in Appeal 1460 (the 3rd defendant in Suit 144) was Dr Ariza Bte Mohamed ("Dr. Ariza"), while the appellant in Appeal 1489 (the 2nd defendant in Suit 144) was Dr Fatimah bte Mustafah ("Dr. Fatimah"). The plaintiff was the respondent in all three appeals. The Hospital offered a variety of specialist services including outpatient and in-patient obstetrics and gynaecological ("O&G") services. Dr. Fatimah and Dr Ariza ("O&G doctors") were practising as O&G consultants in the Hospital at the material time; they were the only O&G doctors at the Hospital at that time. The main dispute in these appeals related to the question of liability of the Hospital and the O&G doctors for medical negligence and also to the issue of quantum of damages.

The plaintiff's claim in Suit 144 was specifically for negligence in regards to the ante-natal treatment, diagnosis and management of her mother ("PW3") who had sought maternity care, treatment and management at the Hospital. Essentially, it all boiled down to the failure to properly evaluate and properly diagnose PW3 as presenting symptoms of early preterm labour. The other aspect of the negligence was the failure of an unidentified doctor to alert either of the O&G doctors that PW3 was presenting symptoms of early preterm labour. The plaintiff was born prematurely on 26 February 2003. She suffered and continued to suffer permanent mental and physical disabilities, namely spastic quadriplegic cerebral palsy, allegedly as a consequence of the negligence in the obstetric services which were given to PW3 at the Hospital. Suit 144 was

filed on 21 March 2018, which was almost 15 years after the plaintiff was born. However, the defendants in Suit 144 did not take up the issue of limitation. The Judge found in favour of the plaintiff and held that negligence was proven against all the defendants and allowed general, special damages and costs. During the trial, the court's attention vis-à-vis liability was primarily focussed on PW3's last ante-natal visit on 24 February 2003. It was also important to note that despite a pre-action order for discovery, the Hospital did not produce PW3's medical records relating to her pregnancy which was the subject matter of Suit 144. The Hospital's failure to produce the medical records was a major issue at the trial. The Judge made several adverse findings in regards to, inter alia, the Hospital's failure to preserve and produce PW3's medical records pertaining to her pregnancy. In this regard, it was common ground that if the unidentified attending doctor who had seen PW3 on that day had properly assessed PW3 and diagnosed that she was exhibiting signs of early premature labour, then appropriate steps should have been taken including alerting the O&G doctors and administering drugs to delay labour and to give the baby's lungs an opportunity to mature.

Held (dismissing the Hospital's appeal (Appeal 1393) on liability; the Hospitals' appeal on quantum was allowed to the extent that the multiplier of 49 years was substituted with a multiplier of 33 years; allowing Appeal 1460 and Appeal 1489):

(1) It was not in dispute that the O&G doctors did not see or treat PW3 on 24 February 2003. Hence, they could not be liable for anything that took place on that day. The systems failure or organisational failure could not be placed on the shoulders of the O&G doctors as they were not the alter ego of the Hospital. They were not employees of the Hospital nor were they partners in the Hospital. Dr Ariza and Dr Fatimah were independent contractors who carried on as O&G consultants at the Hospital and they paid rental to the Hospital for utilising the clinic space at the Hospital. Although they might have agreed during cross-examination that there should have been guidelines and protocols for dealing with patients who presented premature birth symptoms and that as consultants in the Hospital they had a role in the formulation of these guidelines or protocols, the absence of any written guidelines or protocols did not mean that the midwifes and medical officers at the Hospital were clueless as to what had to be done in such situations. In fact, Dr. Ariza had said that there were unwritten protocols in regards to what had to be done when a patient presented symptoms of preterm labour. (para 114)

(2) Clearly, the unidentified doctor who saw PW3 on 24 February 2003 did not see it fit or necessary to call Dr Fatimah or Dr Ariza to escalate the patient's symptoms to the O&G doctors. The mistake was that of the doctor who examined PW3 on 24 February 2003. She should have consulted either Dr Fatimah or Dr Ariza and they would have then admitted the patient and initiated the appropriate treatment with Tocolytics and Dexamethasone and monitored the foetal heartbeat via cardiotocograph. The systems failure

or organisational failure was a failure for which only the Hospital was answerable. Dr Ariza and Dr Fatimah were not responsible or liable for the acts or omissions of the medical officer or other staff at the hospital unless such acts or omissions were as per their instructions. There was no evidence that the O&G doctors had anything to do with the event which occurred at the Hospital on 24 February 2003. Hence, it was clear that the date 24 February 2003 was a "missed opportunity" for intervention. It was a missed opportunity to (a) admit PW3, (b) use Tocolytics to prolong the gestation by between 24 hrs and 7 days and (c) administer Dexamethasone to allow the baby's lungs to mature, (d) conduct foetal heart monitoring to detect foetal distress. It was suggested that the use of Tocolytics could not prevent pre-term delivery. That was true. But the experts were agreed, and counsel for the Hospital accepted that the timely use of Tocolytics with Dexamethasone and foetal distress monitoring (on 24 February 2003) might have prevented this unfortunate child-birth event. Thus, if Tocolytics and Dexamethasone had been administered on 24 February 2003, the plaintiff might have had a better prospect and outlook. The missed opportunity occurred because of the unidentified doctor's failure to detect that PW3 was presenting symptoms of pre-term delivery and should have been admitted, and Dr. Fatimah or Dr. Ariza should have been alerted. The missed opportunity was a manifestation of negligence on the part of the unidentified attending doctor, and the Hospital was thereby vicariously liable for the negligence of that doctor. (paras 115-117)

(3) In so far as the medical records were concerned, regardless of the relevant regulatory regime requiring retention of medical records for a fixed period of time or, as in this case, until the patient recovered from her disability (therefore to be kept forever), there was no evidence to link the absence of medical records to the disastrous event that took place on 24 February 2003. The Judge's conclusion that the failure to produce the medical records or their absence resulted in the poor treatment of PW3, had no basis whatsoever. The absence of the medical records only made it difficult for the Court to ascertain what exactly took place. The failure to preserve and produce the medical records prevented the Court from ascertaining the identity of the attending doctor and her qualifications, training and experience (or the lack thereof). All in all, the Hospital could not take advantage of its own failure to put forward the best evidence possible to exonerate themselves of the allegation of negligence made against them vis-à-vis the event on 24 February 2003. (paras 118-119)

(4) In the circumstances, the negligence by the Hospital could not be visited upon Dr. Fatimah and Dr. Ariza who were not even aware of the events that took place on 24 February 2003 as the attending doctor who ought to have recognised PW3 as exhibiting symptoms of early preterm delivery, failed to alert either of the O&G doctors. In the circumstances, it was only the Hospital which was liable for negligence. (para 123)

(5) In regards to costs, a "Sanderson" order was made whereby an unsuccessful defendant was ordered to pay the costs which were payable by the plaintiff

to the successful defendant. The rationale for the discretion to make a "Sanderson" order was to avoid injustice to a plaintiff who sued multiple parties not knowing which party should be sued for the wrong done. The discretion to make a Sanderson order must be exercised with care, given that its exercise had the effect of making the Hospital liable for the costs that were payable by the plaintiff to the successful defendants, ie the O&G doctors. In this instance, given the circumstances including but not limited to the fact that the medical records were missing and information was not forthcoming despite a pre-action order for discovery, it was reasonable for the plaintiff to have sued all the defendants. But once that the dust of conflict had settled, it had become clear that Dr. Ariza and Dr. Fatimah ought not to have been cited as parties. Given the situation that presented itself at the time when Suit 144 was filed, it was fair and just that the Hospital should carry the costs payable to Dr. Ariza and Dr. Fatimah. (paras 125-127)

(6) There was no merit in the appeals in regards to the quantum of special and general damages. The defendants did not produce any witness or adduce any evidence to rebut the claims that were made by the plaintiff. In particular, there was no contrary opinion to rebut the evidence that was given by the Rehabilitation Physician ("PW2") as to the plaintiff's needs to sustain her life until the end of her expected life span. It was trite that an appellate court would interfere with a trial judge's assessment or determination of damages in very limited circumstances, namely, when it was adequately demonstrated that the trial judge had acted on a wrong principle of law or had misapprehended the facts, or had, for those or other reasons, made a wholly erroneous estimate of the damage suffered. Thus, in regards to the defendants' complaint that the plaintiff had not produced receipts and other documents to prove special damages, the question of whether items of special damages ought to be allowed was par excellence a question for the Judge to decide after having seen and heard the witnesses and having due regard to the circumstances attendant upon the case including the fact that the suit was filed about 15 years after the plaintiff was born. It was a matter of opinion or impression and to an extent, an exercise of discretion for the trial judge to decide after comprehensively examining the evidence that was presented. In this instance, there was no compelling reason to interfere with the Judge's assessment and award of special and general damages. (paras 128, 129, 137 & 139)

(7) There was, however, a misdirection (warranting appellate intervention) in regards to the "multiplier" that was used. In this case, the Judge used the multiplier of 73 years based on the evidence of PW2 who opined that the plaintiff had a life expectancy of 63 years plus 10 years (given during re-examination). However, in her report dated 28 October 2018, PW2 stated that on average the plaintiff had an additional 48 years of life expectancy. The Judge then applied a 15% reduction and arrived at 49 years. The multiplier should actually be based on 63 years minus 16 years (age of the plaintiff at the time of trial) less 30% for contingencies and accelerated payment, which gave a

multiplier of 33 years. Therefore, it was ordered that the award of compensation be calculated based on a multiplier of 33. (paras 140-142)

Case(s) referred to:

Amar Singh v Chin Kiew [1960] 1 MLRA 284 (folld)

Dr Hari Krishnan & Anor v. Megat Noor Ishak Megat Ibrahim & Anor and Another Appeal [2018] 1 MLRA 535 (folld)

Inas Faiqah Mohd Helmi (A Child Suing Through Her Father And Next Friend; Mohd Helmi Abdul Aziz) v. Kerajaan Malaysia & Ors [2016] 1 MLRA 647 (folld)

Mohamed Ibrahim & Anor v. Christopher Piff & Anor [1980] 1 MLRA 131 (folld)

Sanderson v. Blyth Theatre Company Limited [1903] 2 KB 533 (refd)

Scott v. Musial [1959] 3 WLR 437 (folld)

Sivalingam Periasamy v. Periasamy & Anor [1995] 2 MLRA 432 (refd)

Rasidin Partorjo v. Frederick Kiai [1976] 1 MLRA 93 (folld)

Stucken v. East Kent Hospitals University NHS Foundation Trust [2016] Med LR 380 (refd)

Skelton v. Lewisham and North Southwark Health Authority [1998] QBDJ 324 (refd)

Tan Kuan Yau v. Suhindrimani [1985] 1 MLRA 183 (folld)

Legislation referred to:

Limitation Act 1953, s 24

Private Healthcare Facilities And Services (Private Hospitals And Other Private Healthcare Facilities) Regulations 2006, reg 43

Private Hospital Regulations 1973, reg 17

Counsel:

Civil Appeal No: W-02(NCVC)(W)-1393-10-2020

For the appellant: Fozi Addhwa Mohd Fozi (Nor Mohd Syazwan Che Hasim, Azeel Eskandar Azmi & Azzan Aznan Abdul Rahim with him); M/s Syazwan Hasim & Azeel Eskanda

For the respondent: Manmohan Singh Dhillon (K B Karthi & Jeremy Balang with him); M/s PS Ranjan & Co

Civil Appeal No: W-02(NCVC)(W)-1460-10-2020

For the appellant: Raja Eileen Soraya (Michelle Khor Chiew Hong & Melanie Lim Sheng Ning with her); M/s Raja Darryl & Loh

For the respondent: Manmohan Singh Dhillon (K B Karthi & Jeremy Balang with him); M/s PS Ranjan & Co

Civil Appeal No: W-02(NCVC)(W)-1489-10-2020

For the appellant: Harikannan Ragavan (Phoong Li Shan, Auzan Hasanuddin Sazali, Marwan Abdullah & Nur Atiqah Zainol Alam with him); M/s Mu'az Aiman Halem Auzan & Associates

For the respondent: Manmohan Singh Dhillon (K B Karthi & Jeremy Balang with him); M/s PS Ranjan & Co

JUDGMENT

S Nantha Balan JCA:

Introduction

[1] This is our judgment in respect of three appeals which were heard together. The appeals are: Civil Appeal No W-02(NCVC)(W)-1393-10/2020("Appeal 1393"), Civil Appeal No W-02(NCVC)(W)-1460-10-2020 ("Appeal 1460") and Civil Appeal No W-02 (NCVC)(W)-1489-10-2020 ("Appeal 1489"). The appeals are directed at the decision of the learned Judge ("Judge") of the High Court dated 10 September 2020 in Suit No WA-22NCVC-144-03-2018 ("Suit 144"). They arise from a claim in medical negligence against a private hospital and its specialist consultants.

[2] The plaintiff in Suit 144 is Nur Zulaikha Binti Dzulzaili. She suffers from spastic quadriplegic cerebral palsy and will continue to be dependent on others for all activities of daily living for the rest of her life. By reason of her permanent disability, she had to file Suit 144 through her father and litigation representative, Dzulzaili Bin Muhammad Nor ("PW4").

[3] The appellant in Appeal 1393 is Medi-Circle Sdn Bhd (No.Syarikat 424904-V), (the 1st Defendant in Suit 144). They are the owners of Pusat Rawatan Islam Az-Zahrah ("the Hospital").

[4] The appellant in Appeal 1460 is Dr Ariza Bte Mohamed ("Dr Ariza"). Dr Ariza was the 3rd defendant in Suit 144.

[5] The appellant in Appeal 1489 is Dr Fatimah bte Mustafah ("Dr Fatimah"). Dr Fatimah was the 2nd defendant in Suit 144.

[6] The plaintiff is the respondent in all three appeals.

[7] The Hospital offered a variety of specialist services including outpatient and in-patient obstetrics and gynaecological ("O&G") services. Dr Fatimah and Dr Ariza were practising as O&G consultants in the Hospital at the material time. Dr Fatimah and Dr Ariza shall be referred to collectively as "the O&G doctors". They were the only O&G doctors at the Hospital at that time. We shall refer to the Hospital, Dr Fatimah and Dr Ariza collectively as "the defendants" and the respondent in all the appeals to as "the plaintiff".

[8] The main dispute relates to the question of liability of the Hospital and the liability of the O&G doctors for medical negligence. The appeals also relate to the issue of quantum of damages. The plaintiff's claim in Suit 144 is specifically for negligence in regards to the ante-natal treatment, diagnosis

and management of her mother, Puan Hilwana binti Mohd Shafie ("PW3") who had sought maternity care, treatment and management at the Hospital. Essentially, it all boiled down to the failure to properly evaluate and properly diagnose PW3 as presenting symptoms of early preterm labour. The other aspect of the negligence was the failure of an unidentified doctor to alert either of the O&G doctors that PW3 was presenting symptoms of early preterm labour.

[9] The plaintiff was born prematurely on 26 February 2003. She suffered and continues to suffer permanent mental and physical disabilities, namely spastic quadriplegic cerebral palsy, allegedly as a consequence of the negligence in the obstetric services which were given to PW3 at the Hospital. Suit 144 was filed on 21 March 2018 which is almost 15 years after the plaintiff was born. However, the defendants in Suit 144 did not take up the issue of imitation.

[10] The High Court's decision was delivered on 10 September 2020,wherein after a full trial lasting several non-consecutive days, the Judge found in favour of the plaintiff and held that negligence was proven against all the defendants and allowed general and special damages and costs.

[11] During the trial, the court's attention *vis-a-vis* liability was focussed on PW3's last ante-natal visit on 24 February 2003 and also the date when the plaintiff was delivered - 26 February 2003. On 26 February 2003, PW3 was initially taken to the Hospital as an emergency case, and subsequently transferred on the same day to Hospital Putrajaya. Thus, whilst some procedures were conducted at the Hospital on 26 February 2003, ultimately the plaintiff was not delivered at the Hospital, but was delivered instead at Hospital Putrajaya.

[12] It is important to mention at the outset that despite a pre-action order for discovery, the Hospital did not produce PW3's medical records relating to her pregnancy which is the subject matter of Suit 144. The Hospital's failure to produce the medical records was a major issue at the trial. The Judge made several adverse findings in regards to *inter alia*, the Hospital's failure to preserve and produce PW3's medical records pertaining to her pregnancy.

[13] The Judge also proceeded to hold the O&G doctors responsible for the missing medical records and ruled that this had led to poor treatment and management of PW3. The O&G doctors took the position that they are not responsible nor liable for the preservation and/or production of medical records as that was the responsibility of the Hospital.

[14] The Judge also found liability against the defendants in regards to the failure to take appropriate steps on 24 February 2003, *inter alia*, to prevent a pre-mature delivery by administering the necessary drugs and to conduct foetal monitoring. The Judge also found negligence against the defendants in regards to the events that occurred at the Hospital on 26 February 2003.

[15] However, it is quite apparent to us that the missing medical records did not have any link or causal connection to the events which took place at the Hospital on 24 February 2003 and the subsequent event which occurred on 26 February 2003. Thus, the missing records had no relevance to the issue of liability.

[16] Essentially, it is our view that whilst the failure to preserve and produce the medical records might have demonstrated the Hospital's poor record keeping and/or failure to comply with their statutory or common law duty to preserve the records, there is just no evidence to suggest that the missing medical records had in any way caused or contributed to the plaintiffs disabilities. This is elaborated in the later part of this judgment.

[17] Although we mentioned the date of delivery, 26 February 2003 as being part of the narrative on liability, ultimately the only date that is germane *vis-a-vis* the issue of negligence is 24 February 2003. In this regard ,it is common ground that if the unidentified attending doctor who had seen PW3 on that day had properly assessed PW3 and diagnosed that she was exhibiting signs of early premature labour, then appropriate steps should have been taken including alerting the O&G doctors and administering drugs to delay labour and to give the baby's lungs an opportunity to mature.

[18] From the evidence that was adduced at trial, it is apparent that a diagnosis of premature labour was not made on 24 February 2003 and PW3 was instead reassured that everything was "fine" and asked to go home. In the result, the plaintiff was delivered on 26 February 2003 as a premature baby with severe permanent disabilities.

Status Of The O&G Doctors

[19] The plaintiff pleaded a case of negligence against the Hospital by way of "direct" liability for systems failure, as well as "vicarious liability" for the negligence of the O&G doctors. Thus, on the footing that the O&G doctors were negligent, it was necessary to determine whether the O&G doctors were employees of the Hospital, or were independent contractors. The O&G doctors' pleaded case and testimony at the trial was that they practiced in the Hospital as independent contractors. The O&G doctors said that they paid rentals for the use of space in the Hospital to carry out their clinical practices. They testified that they are not employees of the Hospital. On the other hand, counsel for the plaintiff described the O&G doctors as "partners" with the Hospital.

[20] Counsel for the plaintiff sought to bolster his argument that the O&G doctors were partners with the Hospital on the basis of the evidence by the O&G doctors that they worked as a "team" in the Hospital and that they had a "role" in the formulation of guidelines and protocols for the medical staff including midwifes and medical officers. But counsel for the O&G doctors contended that the phrase "partners" is loosely used and that they are

not "partners" in any legal sense. The O&G doctors asserted that they are independent contractors and are not employees or agents of the Hospital and were not in a partnership with the Hospital.

[21] We think that the issue in regards to the status of the O&G doctors should be dealt with and resolved at the outset. In our view, the evidence suggests quite clearly that the O&G doctors were at all times independent contractors. Clearly, they practiced as O&G Consultants in the Hospital. They were not employees of the Hospital. They were not "partners" with the Hospital. Indeed, it is legally untenable for the O&G doctors, as individuals to be "partners" with the Hospital which is owned by the 1st Defendant, which is a separate and independent legal entity. No doubt, the O&G doctors did work with the other personnel of the O&G department namely, the medical officers, the midwives and clinic/ward nurses. But we do not think that working as a "team" altered their status as independent contractors.

[22] Another aspect of the plaintiff's complaints was that there was alack of guidelines and protocols for the medical officers and midwives which contributed or caused the system failure on the critical date - 24 February 2003. The systems failure here was manifested by the failure of the (unidentified) medical officer to properly assess PW3 as a high-risk patient and to alert the O&G doctors as to PW3's condition.

[23] According to the plaintiff, the O&G doctors have an important/critical role and indeed a responsibility in ensuring patient safety and to formulate the necessary best practice guidelines and protocols for medical officers and midwives. Counsel for the O&G doctors took the stand that it was not their duty to put in place guidelines and protocols for medical officers and mid-wives and that this was the Hospital's duty. In any case, the O&G doctors' position was that there were "unwritten protocols" in place and the attending doctors should know what to do, ie to alert them if any patient exhibited signs of pre-term delivery.

[24] In this case, the relevant medical records in regards to PW3'smaternity treatment and management at the Hospital *vis-a-vis* the plaintiff were not produced. According to the plaintiff, the Hospital and the O&G doctors were under a duty to ensure that the medical records were preserved and produced at trial. Despite an order for discovery the relevant medical records were not produced. According to the Hospital the records are only kept for 8 years and thereafter destroyed. We shall come back to these aspects of the plaintiff's case in the later part of this judgment.

The Relevant Facts

[25] During the trial the plaintiff relied on the events that took place on 24 February 2003 and 26 February 2003. The Judge found negligence against all the defendants in respect of the events that took place at the Hospital on both these dates.

[26] However, when the appeals come on for hearing before us, Counsel for the plaintiff abandoned the allegations against the defendants *vis-a-vis* the events that took place on 26 February 2003. Obviously the plaintiff's stance in this regard had a direct effect on the Judge's finding *vis-a-vis* the events which unfolded on 26 February 2003. Hence, based on the stance which was taken by Counsel for the plaintiff, the event at the Hospital on 26 February 2003 was jettisoned from the factual matrix for purposes of establishing negligence against all the defendants. The plaintiff therefore confined her case for negligence purely on the events that took place at the Hospital on 24 February 2003, ie PW3's last antenatal visit before the plaintiff was born two days later on 26 February 2003.

Antenatal Visit - 24 February 2003

[27] PW3's ante-natal visit on 24 February 2003 was a highly disputed topic. The defendants argued that there was no ante-natal visit on that date. The defendants also made much of the fact that the ante-natal visit on 24February 2003 was not specifically pleaded in the Amended Statement of Claim ("ASOC"). The defendants took the position that the plaintiff had failed top lead and prove that PW3 visited the Hospital on 24 February 2003.

[28] According to PW3, she was previously a patient at the Hospital. She had delivered her 2nd child (Muhammad Dzulhafiz bin Dzulzaili) on 14 June 2002. The delivery of her 2nd child appears to have been uneventful. When she became pregnant with her 3rd child (the plaintiff), she sought maternity treatment at the Hospital. She had been to last ante-natal clinic on a number of occasions in respect of her 3rd pregnancy.

[29] On 24 February 2003 when she was in her 6th month of pregnancy, she visited the Hospital as it was an ante-natal visit. She presented various complaints to an unidentified medical officer who attended to her. It is not in dispute that she was not seen by the O&G doctors on 24 February 2003.

[30] On 24 February 2003, PW3 complained to the medical officer that she had severe abdominal pain, the urge to deliver, had pain whilst urinating, had pain when walking and that there was less foetal movement. PW3 said that she was seen by an unidentified Malay lady doctor (with headscarf) who she was notable to identify. She said that the doctor performed a scan, which was most likely an ultra-sound scan of the baby.

[31] The said unidentified doctor did not do a urine test and did not call, or refer PW3 to the O&G doctors or to inform either of them, about PW3'scondition. The doctor reassured PW3 that everything was fine and told her to go home.

[32] The consensus amongst the medical experts who testified at the trial was that PW3's symptoms on 24 February 2003 (when she in her 6th month of pregnancy) were consistent with premature labour and that PW3 should have been admitted as an in-patient and tests should have been conducted.

According to the experts, PW3 ought to have been administered with Tocolytics (to delay labour) and given Dexamethasone injection to help the lungs of the foetus to mature. The foetal heartbeat should have also been monitored via cardiotocograph monitoring("CTG").

[33] PW3's evidence as to what happened on 24 February 2003 is reproduced herein:

21. Q: Sebelum 26 Februari 2003 bilakah kali terakhir anda pergi ke Pusat Rawatan Islam Az-Zaharah?

A: Kali terakhir adalah pada 24 Februari 2003, Tarikh ini adalah Tarikh appointment yang telah ditetapkan iaitu pemeriksaan mengandung 6 bulan.

22. Q: Siapakah doktor yang melihat anda pada hari itu?

A: Pada 24 Febuari 2003, doktor yang merawat saya adalah doktor perempuan bertudung dan saya tidak pasti nama doktor berkenaan. Itu adalah kali pertama saya berjumpa doktor itu.

23. Q: Adakah suami anda bersama anda pada hari itu?

A: Ya, suami saya juga datang bersama saya pada hari itu

24. Q: Apakah aduan anda pada hari itu?

A: Saya mengadu pada doktor 2 hari yang lepas sehingga sekarang (24 Februari 2003) saya merasa tidak selesa dan sakit dibahagian perut dan sukar untuk berjalan, berdiri, duduk, naik tangga, kencing sakit dan baby dalam kandungan kurang bergerak. Bila dibuat pemeriksaan tetapi doktor tidak ambil apa-apa tindakan, doktor hanya memaklumkan itu hanya perkara biasa dan keadaan itu adalah normal katanya kepada saya.

25. Q: Apakah yang dibuat oleh doktor pada hari itu?

A: Doktor mengambil bacaan tekanan darah dan membuat ct-scan. Semasa membuat ct-scan doktor hanya memaklumkan baby dalam keadaan baik dan kandungan tiada masalah, Pemeriksaan air kencing juga tidak dilakukan.

26. Q: Adakah doktor memberi sebarang nasihat pada hari itu?

A: Tiada sebarang nasihat hanya memaklumkan baby dalam keadaan baik dan kandungan tiada masalah.

27. Q: Adakah lawatan pada hari itu lawatan temujanji yang dirancang?

A: Ya, Tarikh itu adalah tarikh temujanji saya untuk pemeriksaan antenatal yang ke 6 bulan.

26 February 2003 - The Emergency

[34] Although the complaint of negligence *vis-a-vis* 26 February 2003 has been abandoned, for completeness, it is nevertheless necessary to refer to the event that took place on that day. On 26 February 2003, PW3 was brought to the Hospital at around 7.00am, as an emergency case. Dr Ariza was on call that morning. She attended to PW3. She immediately examined PW3 and found that she was in premature labour. Dr Ariza's findings were that:

(a) PW3 was at 26 weeks gestation and the foetus was in extreme severe prematurity.

(b) By the time Dr Ariza saw PW3, there were strong contractions andthe foetal head was engaged. The cervix was fully effaced.

(c) The membrane was intact and had funnelled into the vagina.?

[35] Dr Ariza's diagnosis was that PW3 was in an extremely severe premature labour which was at an advanced stage. Dr Ariza informed PW3 of her condition. Dr Ariza informed PW3 of the need for an injection of intramuscular Dexamethasone to mature the plaintiff's lung, which she then injected. Dr Ariza then informed PW3 that she would refer her to Putrajaya Hospital because the baby would require a tertiary medical centre with facilities and expertise to manage an extremely premature infant. Whilst PW3 was being prepared for transfer to Hospital Putrajaya, PW3 had the urge to push and started pushing. Dr Ariza noted that PW3's cervix had dilated to 10cm. Given that PW3 appeared to be in imminent delivery, Dr Ariza informed PW3 that she would carry out the delivery at the Hospital and would carry out an Artificial Rupture of Membrane ("ARM").

[36] Following the ARM procedure, PW3 ' s contractions lessened, she did not push, and the cervix regressed to 6cm. Dr Ariza therefore decided to proceed with the initial plan to transfer PW3 to Hospital Putrajaya. PW3 was duly transported to Hospital Putrajaya, where the plaintiff was delivered per vaginal delivery at 10.20am. The plaintiff was placed in the Neonatal Intensive Care Unit of Hospital Putrajaya and later transferred to Hospital Kuala Lumpur for further management.

[37] The plaintiff's pleaded case is that the O&G doctors and the Hospital were negligent in regards to the treatment that was carried out on 26 February 2003. During the trial, evidence was led in regards to the events that took place on 24 February 2003 and 26 February 2003. The plaintiff's medical expert ("PW1") described Dr Ariza's handling of the emergency situation on 26 February 2003 as grossly negligent.

[38] It should be emphasised that Dr Fatimah and Dr Ariza did not seePW3 on 24 February 2003. And on 26 February 2003, PW3 was seen by Dr Ariza only. Dr Fatimah did not see the patient on that day. Nevertheless, the Judge

cast the net widely and determined liability against the Hospital and the O&G doctors in respect of the events that took place on 24 February 2003 and on 26 February 2003.

[39] As mentioned earlier, at the outset of the hearing of the appeals before us, Counsel for the plaintiff said that he was abandoning the allegations of negligence against all the defendants in respect of the emergency event that took place at the Hospital on 26 February 2003.

[40] In the circumstances, the Judge's finding of negligence against the defendants in respect of the events that took place at the Hospital on 26 February 2003 including in particular, the treatment that was administered by Dr Ariza, namely Dexamethasone injection and the Artificial Rupture of the Membrane ("ARM"), are no longer sustainable.

[41] Put simply, the event on 26 February 2003 had fallen out of the equation for purpose of liability for medical negligence against all the defendants. For the avoidance of doubt, we think that it is necessary to mention that, by abandoning this part of the allegations of negligence, the plaintiff has expressly or implicitly conceded that there was no negligence by Dr Ariza on 26 February 2003.

[42] By extension of logic or by parity of reasoning, this would also mean that the criticism that was levelled by the plaintiff's expert ("PW1")against Dr Ariza's handling of the situation on 26 February 2003, was totally unwarranted. Hence, by reason of the stance that was taken by Counsel for the plaintiff in abandoning the allegations of negligence *vis-a-vis* the events at the Hospital on 26 February 2003, Dr Ariza was totally exonerated from the stigma of professional negligence that was made against her.

[43] As mentioned earlier, the plaintiff was born on 26 February 2003. The plaintiff's mother, had previously given birth to her 2nd child at the Hospital on 14 June 2002. The delivery of PW3's 2nd child was uneventful and there were no complications. But the time period or "spacing" between the delivery of PW3's 2nd child and the 3rd pregnancy was short and this had contributed to the risk of premature delivery. PW3 said that before 26 February 2003, she had attended six antenatal clinic sessions at the Hospital. The Judge found as a fact that PW3 was at all times a patient of the Hospital, and that she did attend the ante-natal clinic on 24 February 2003.

Before The Delivery Of The Plaintiff

[44] It is fair to say that based on the opinion of the experts and of the evidence of the O&G doctors themselves, PW3's complaints on 24 February 2003 coupled with the short time period between the birth of the 2nd child and PW3'spregnancy with the 3rd child (the plaintiff) should have prompted the attending doctor to diagnose PW3 as presenting symptoms of premature

labour and to notify either of the O&G doctors who would then have attended to the patient.

[45] At any rate the plaintiff was delivered prematurely via vaginal delivery at Hospital Putrajaya at 10.20 am on 26 February 2003. In light of the dramatic child-birth events that transpired on 26 February 2003, it is clear as a matter of logic and probability that PW3's complaints on 24 February 2003 were consistent with premature labour. It is not in dispute that the plaintiff was born when PW3 was in her 26th week of pregnancy.

[46] Medically, any delivery prior to 28th week of pregnancy is regarded as premature birth. It is important perhaps to state at the outset that it is not part of the plaintiffs case that the defendants or any of them a reliable or responsible for PW3 going into premature labour.

[47] And it is common ground that premature birth carries a high risk of cerebral palsy secondary to foetal respiratory distress syndrome. The delivery at Hospital Putrajaya was uneventful. But the plaintiff was born with severe permanent disabilities as was eventually diagnosed as spastic quadriplegic cerebral palsy. Hence, the liability question rested entirely on PW3's ante-natal visit on 24 February 2003.

24 February 2003 (The Missed Opportunity)

[48] It is obvious enough that the date of PW3's last ante-natal visit, ie 24 February 2003 is the critical date in these proceedings. The date was correctly described by the experts as a "missed opportunity" for the Tocolytics and steroid Dexamethasone to be administered. Tocolytics are administered to slow down contractions and delay the delivery by between 48 hours and 7 days depending on the type of Tocolytic which is used, whilst Dexamethasone is administered intra-muscularly to assist in the maturing process of the lungs of the foetus.

[49] Although the Judge cast the net of liability far and wide and imposed liability for the missed opportunity on the Hospital as well as on the O&G doctors, it is will be seen quite clearly that the missed opportunity stems from a systems failure. On the present facts, that systems failure is attributable only to the Hospital.

[50] Indeed, Counsel for the plaintiff readily conceded that the Judge made no finding against the O&G doctors in respect of the systems failure *vis-a-vis* the missed opportunity. In fact, the Judge made a finding that it was the Hospital that was negligent in regards to the system failure. Thus, it can be said quite decisively that the O&G doctors are not liable for any aspect of the systems or organisational failure. The Judge also concluded that the defendants (including the O&G doctors) were under a duty to preserve and produce the relevant medical records in relation to PW3's 3rd pregnancy and that the missing medical records had contributed to the poor treatment and management ofPW3. In

our view, the Judge made an unwarranted and unjustified quantum leap in concluding that the missing medical records resulted in the poor treatment and management of PW3 on 24 February 2003. Indeed, there is nothing to suggest that at all times when PW3 was a patient of the Hospital, the relevant medical records were missing. On the contrary it would appear that at all times the Hospital did have the requisite documents and as per their practice, the documents were still with them until about 8 years after the plaintiff was born.

Witnesses

[51] The witnesses who testified at the trial were:

(i) Dr Milton Lum Siew Wah, a Consultant Obstetrician & Gynaecologist, expert witness for the plaintiff ("PW1");

(ii) Dr Kavitha Uma Ratnalingam, a Consultant Physician, expert witness for the plaintiff ("PW2");

(iii) Puan Hilwana binti Mohd Shafie, the plaintiff's mother ("PW3");

(iv) Encik Dzulzaili bin Muhammad Noor, the plaintiff's father and litigation representative ("PW4");

(v) Dr Fatimah binti Mustafah, (2nd defendant) ("DW1");

(vi) Mohd Norazmi binti Ismail, the Head of Medical Records at the Hospital ("DW2");

(vii) Dr Rohana binti Jaafar, a Consultant Paediatrician, expert witness for the O&G doctors ("DW3");

(viii) Dr Imelda Nasreen binti Nasarudin, a Consultant Obstetrician and Gynaecologist, expert witness for O&G doctors ("DW4");

(ix) Dato' Dr Mukundan a/l Krishnan, a Consultant Obstetrician & Gynaecologist, expert witness for O&G doctors ("DW5"); and

(x) Dr Ariza Binti Mohamed (3rd defendant) ("DW6").

The Medical Records

[52] As mentioned earlier, the Hospital did not produce any medical records especially to explain what took place on 24 February 2003. But the O&G doctors some how produced PW3's medical records for her 2nd pregnancy in 2002. These records were produced through DW2. The Judge made adverse findings against all the defendants in regards to the failure to produce the medical records for 24 February 2003.

[53] The Judge made a finding that the failure to produce the medical records had caused the plaintiff to suffer the birth injury. Counsel for all the defendants

took issue with this part of the Judge's findings. The Judge said that the failure to keep any of the medical records "had resulted in the poor treatment and management given". Counsel for the O&G doctors said that there was absolutely no causal link between the failure to produce medical records and the plaintiff's disabilities.

[54] On the issue of failure to keep and produce the requisite medical records, particularly the records for 24 February 2003, the Judge said:

> "The plaintiff took umbrage at the 1st Defendant for its failure to keep a proper medical record of PW3 for the year 2003. PW3's medical records for an earlier pregnancy in 2002 were available. The plaintiff realising that the medical records of PW3 in 2003 is crucial, had filed a pre-action discovery of the medical records in 2016 against the 1st Defendant. The 1st Defendant said that it is their policy that all medical records were to be destroyed after having kept them for 8 years. Not only did the 1st Defendant fail to produce PW3's medical record but have also failed to produce the patients' register, the2nd and 3rd defendants respective patients' appointment diaries and other documents that could have assisted the parties and the Court as to who had attended to PW3 on 24 February 2003. In the midst of the trial the 1st Defendant had made discovery of documents in staggered manner. The documents which the 1st Defendant disclosed in Court were the patients' appointment diaries (Bundle B9)of medical officers Dr Rahaya and Dr Aziani."

[55] The Judge made the following findings against the Hospital in regards to the failure to keep proper records.

> "From the evidence adduced by the plaintiff and the admission of DW2 it is the finding of the Court that the 1st Defendant had simply failed to keep any of the medical records as regards the plaintiff's ante-natal care and birth. **Such failure had resulted in the poor treatment and management given**. The witness for the 2nd and 3rd defendants DW2 - Mohd Nor Azmi bin Ismail - head of Medical Records of 1st Defendant stated that the records would be destroyed after keeping it for 8 years. However the 1st Defendant case summary stated that the medical records which expired more than twelve (12) years shall be disposed of by the 1st Defendant."
>
> [Emphasis Added]

[56] This was reiterated in the later part of the Judge's grounds of judgment where he said:

> "The Court was of the considered view that the 1st Defendant as a provider of healthcare to the plaintiff was negligent in that it had breach its duty of care to the plaintiff in not keeping any of the medical records as regards the plaintiffs ante-natal care and birth in particular medical records of 24 February 2003. The 1st Defendant cannot delegate its non-delegable duty of care to the 2nd and 3rd defendants respectively. **Such failure had resulted in the poor treatment and management given**. The Court was also of the view that since the plaintiff was born premature and has suffered brain damage the medical records should be kept until the plaintiff reaches the age of majority

> or recovers from brain damage. The evidence of DW2 who was in charge of keeping the record informed the Court that the medical records were only kept for 8 year sand thereafter be destroyed is unacceptable with regards to the plaintiff's case."
>
> [Emphasis Added]

[57] Judge then held the O&G doctors to be liable for negligence *vis-a-vis* the failure to keep proper medical records.

> "As for the 2nd and 3rd defendants being specialists attached to the 1st Defendant's Hospital, **they too were under a duty to see that the medical records were kept by the 1st Defendant for the duration of the limitation**. If the medical records of the plaintiff were kept properly by the 1st Defendant, then perhaps the 2nd and 3rd defendants would know how to treat the plaintiff prior to labour. They could not shift the fault for not keeping the medical records on to the1st Defendant. The 2nd defendant was aware that the limitation period will not run if the child patient has suffered brain damage. PW1 Dr, Milton Lum in his testimony stated that in cases of brain-damaged patients the medical report are kept forever."
>
> [Emphasis Added]

[58] Thus the High Court was of the view that the medical records with regards to the plaintiff should have been kept by the Hospital until the plaintiff reached the age of majority ie 18 years or when she recovers from her brain damage. The High Court Judge was perplexed as to how the medical records of PW3 for the year 2003 could not be traced when the other medical records for the year 2002 in regards to the delivery of her 2nd child were available. The Hospital's response was that they only kept medical records for a period of 8 years.

[59] According to the Hospital, since the plaintiff was not delivered at the Hospital, they had no knowledge of her condition and as such they were not obliged to keep records of PW3's maternity treatment which was on an outpatient basis.

Pleadings (Ante-Natal Visit On 24 February 2003)

[60] One of the main issues that was taken up in the appeals before us was that the plaintiff had not pleaded or given particulars of the Hospital's breach of its non-delegable duty or the Hospital's direct liability for negligence. In this case, the plaintiff had pleaded direct liability for negligence against the Hospital as well as vicarious liability for the alleged negligence of the O&G doctors. Further, the defendants argued that the alleged ante-natal visit on 24 February 2003 was not even pleaded, and not proven.

[61] The main evidential question for the Judge was whether PW3 did visit the Hospital for an ante-natal appointment on 24 February 2003. The defendants submitted that the plaintiff's effort was mainly focusing to establish the events that happened on 24 February 2003 which was not pleaded in the ASOC.

However, PW3 and PW4 respectively testified that 24 February 2003 was the date of appointment for 6th month pregnancy. The defendants submitted that the plaintiff failed to prove the event on 24 February 2003 existed. The defendants emphasized that there was no documentary evidence to support PW3's assertion that the 6th Antenatal Check-up was scheduled on the 24 February 2003.

[62] In this regard, it was pointed out that during cross-examination, PW4 was referred to the medical officers' "Dairi Temujanji" and was asked whether he agreed that the ante-natal was scheduled on the 21 February 2003. PW4agreed that the appointment date in the Notis Temujanji was on 21 February 2003. PW4 had also agreed that the 24 February 2003 was not fixed by the Hospital.

[63] DW2 in examination in chief stated that based on the Hospital's record there was no clinic Anc-MO which was opened on that day and if there was any appointment on 24 February 2003 then it was brought forward to the 21 February 2003. It was highlighted that in the ASOC, the plaintiff did not plead that there was an ante-natal appointment/visit on 24 February 2003.

[64] Counsel for the plaintiff conceded that ante-natal appointment and visit to the Hospital by PW3 on date 24 February 2003 was not pleaded in the ASOC. However, it was contended for the plaintiff that the defendants were not taken by surprise and that they were independently put on notice that the plaintiff would be relying on the ante-natal visit on 24 February 2003.

[65] First, the plaintiff referred to paragraph [12] of the ASOC which read as:

> The plaintiff's mother was seen ante-natally in the Hospital on "various occasions".

[66] Counsel for the plaintiff argued that "various occasions" would include the last ante-natal visit on 24 February 2003.

[67] Next, counsel for the plaintiff referred to the plaintiffs Summary of Case which was filed on 29 January 2019 which was before the commencement of trial. No objection was taken by any of the defendants. The plaintiff's Summary of Case read as:

> 1. The plaintiff's claim against the defendants and each of them is for negligence and breach of duties.
>
> 2. The plaintiff's mother was seen antenatally in the 1st Defendant's hospital at various occasions.
>
> **3. On 24 February 2003, during a scheduled antenatal visit the plaintiffs mother was seen by a locum doctor to whom she complained of abdominal pain, difficulty in walking, standing, painful urination and**

that the baby was not moving much but was sent home without further treatment.

[Emphasis Added]

[68] In so far as the plaintiff's mother (PW3) was concerned, she testified (per her witness statement as follows):

21. Q: Sebelum 26 Februari 2003 bilakah kali terakhir anda pergi ke Pusat Rawatan Islam Az-Zaharah?

A: Kali terakhir adalah pada 24 Februari 2003, Tarikh ini adalah Tarikh appointment yang telah ditetapkan iaitu pemeriksaan mengandung 6 bulan.

22. Q: Siapakah doktor yang melihat anda pada hari itu?

A: Pada 24 Februari 2003, doktor yang merawat saya adalah doktor perempuan bertudung dan saya tidak pasti nama doktor berkenaan. Itu adalah kali pertama saya berjumpa doktor itu.

23. Q: Adakah suami anda bersama anda pada hari itu?

A: Ya, suami saya juga datang bersama saya pada hari itu

24. Q: Apakah aduan anda pada hari itu? Saya mengadu pada doktor 2 hari yang lepas sehingga sekarang (24 Februari 2003)

A: Saya merasa tidak selesa dan sakit dibahagian perut dan sukar untuk berjalan, berdiri, duduk, naik tangga, kencing sakit dan baby dalam kandungan kurang bergerak. Bila dibuat pemeriksaan tetapi doktor tidak ambil apa-apa tindakan, doktor hanya memaklumkan itu hanya perkara biasa dan keadaan itu adalah normal katanya kepada saya.

25. Q: Apakah yang dibuat oleh doktor pada hari itu?

A: Doktor mengambil bacaan tekanan darah dan membuat ct-scan. Semasa membuat ct-scan doktor hanya memaklumkan baby dalam keadaan baik dan kandungan tiada masalah, Pemeriksaan air kencing juga tidak dilakukan.

26. Q: Adakah doktor memberi sebarang nasihat pada hari itu?

A: Tiada sebarang nasihat hanya memaklumkan baby dalam keadaan baik dan kandungan tiada masalah.

27. Q: Adakah lawatan pada hari itu lawatan temujanji yang dirancang?

A: Ya, Tarikh itu adalah tarikh temujanji saya untuk pemeriksaan antenatal yang ke 6 bulan.

[69] Counsel for the plaintiff also argued that counsel for the Hospital did not cross-examine PW3 on the ante-natal visit on 24 February 2003 and further counsel for the O&G doctors had specifically referred to 24 February 2003 and posed questions on the premise or implicitly suggesting that PW3 did in fact visit the Hospital on that date.

[70] Counsel for the O&G doctors referred to the ante-natal visit on 24 February 2003 and were concerned only to ensure that the O&G doctors were "extricated" from the event that occurred on that date. This is how the questions were posed:

Q: **Puan, saya pergi kepada insiden untuk 2 hari sebelum 26 Februari 2003, which is check-up pada 24 Februari 2003** iaitu soalan no: 21, 22, 23, 24, 25, 26 dan 27 untuk merujuk kepada insides pada 24 Februari 2003, Puan setuju dengan saya, apabila Puan merujuk kepada jawapan soalan no 22 (Soalan no, 22 dibaca). So Puan setuju dengan saya, jawapan ini tidak merujuk kepada Dr Ariza mahupun Dr Fatimah, Defendan Ketiga dan Defendan Kedua?

A: Betul.

[Emphasis Added]

[71] Further counsel for the O&G doctors asked the following questions which expressly or implicitly accept that PW3 did go to the Hospital on 24 February 2003 for the ante-natal appointment as follows:

Q: **Dan saya cadangkan kepada Puan, pada hari itu, 24 Februari 2003 ujian air kencing dibuat kepada Puan, setuju tak?**

A: Kalau pada 24 Februari 2003 itu, dia ambil ujian air kencing saya setuju, tapi dia tak ambil ujian itu selalunya.

Q: Puan, pada tarikh 24 Februari 2003 itu, masa Puan check-up itu, hari itu Puan kerja ke bercuti Puan.?

A: Saya tak ingat dah.

Q: Kemudian Puan maklumkan pada 24 Februari 2003, Puan rasa tak selesa sakit dibahagian perut.

A: Saya rujuk jawapan no 24 (AHS reads out the answer to Q&A 24 of PW3(A).

Q: Bila selesai Puan jumpa doctor pada 24 Februari 2003 pulang ke rumah, rasa sakit itu masih berterusan tak Puan?

A: Sakit keadaan yang saya terangkan disini, masih. (at page 168)

Q: Pada 25 Februari 2003, Puan ingat lagi tak Puan masih lagi berterusan sakit macam 24 Februari 2003 atau pun tak sakit dah Puan?

A: Masih sakit masih dalam keadaan macam 24 Februari 2003 tu.

[Emphasis Added]

[72] It is clear from the line of questions that were posed by counsel for the O&G doctors that they accepted either expressly or implicitly that PW3 did go to the Hospital on 24 February 2003. If it was their position that the ante-natal visit on 24 February 2003 did not take place, then it is quite odd that their counsel could pose questions which suggested that the event of 24 February did in fact occur.

[73] As far as the Hospital was concerned, their position was that the plaintiff failed to plead and prove the event on 24 February 2003 ever happened and there is no documentary evidence to support that there was a 6th antenatal check-up scheduled on 24 February 2003. Counsel for the Hospital said that the material fact of 24 February 2003 that PW3 had gone for an antenatal check-up was not pleaded in the ASOC and that the parties are bound by their pleadings. Counsel said that by relying on the alleged event on 24 February 2003, the plaintiff had done a complete manoeuvre and/or departed from their pleadings.

[74] However, the Judge came to the conclusion that not with standing that PW3's ante-natal visit on 24 February 2003 was not specifically pleaded, the parties were not taken by surprise. The Judge said that the ante-natal visit of 24 February 2003 was subsumed in para 12 of the ASOC. Further, the date,24 February 2003, was expressly stated in the plaintiffs Summary of Case (which was tendered before the trial) and no objection was taken.

[75] The Judge noted that learned counsel for the defendants did not even suggest to PW3 in cross-examination that on 24 February 2003 she did not go to the Hospital for an ante-natal check-up. However DW2 had stated that according to the patients' register, there was no antenatal check-up because the ANc Clinic was not opened on 24 February 2003. The Judge noted that even when the plaintiff's counsel started referring to the 24 February 2003 as the date that PW3 had gone to the Hospital, no objection was raised by the defendants.

[76] Counsel for the Hospital submitted that the plaintiff failed top lead specifically the Hospital's negligence. It was contended that the plaintiff's claim against the Hospital was for direct negligence and vicarious liability for the conduct of the O&G doctors. The claim against the Hospital in so far as it pertained to a breach of a non-delegable duty of care, had to be specifically pleaded.

[77] In so far as the Hospital's liability is concerned, the Judge found that the plaintiff had pleaded in para 23 of the ASOC that the Hospital was vicariously liable for the negligence of its servants and agents. The plaintiff further avers that is not in dispute that the Hospital was a provider of healthcare. Hence it owed a duty of care to its patients regardless of the status of the O&G doctors as independent contractors.

[78] In the present case, the Judge ruled that the Hospital had assumed a non-delegable duty to ensure that PW3 was seen ante-natally at the Hospital at various occasions and were carefully conducted and supervised, by whomever they had entrusted to perform those functions. The Judge relied on a passage from Principles of Medical Law 3rd Edition in regards to the non-delegable duty where it was stated that where reasonable care or skill is not taken of a patient by an employee or independent contractor, the institution will be liable for breach of a primary, non-delegable duty owed to the patient. Expanding on the non-delegable duty the Judge ruled that the Hospital's responsibility for organisational errors emanates from its 'a duty to use reasonable care to ensure that the hospital staff, facilities and organisation provided are those appropriate to provide a safe and satisfactory medical service for the patient'.

[79] Dr Ariza testified that the O&G doctors will undertake risk profiling of pregnant women and that high risk pregnant women will be seen only by the O&G specialist. Dr Ariza also said that all deliveries will be undertaken by the specialists. The medical officer and midwives were therefore under a duty to refer all high risk pregnant women to the O&G specialist (ie the O&G doctors).

[80] Dr Ariza agreed that PW3 had a higher risk profile because of the poor spacing of her pregnancies and should have at some point in time of her pregnancy been seen by an O&G specialist. The plaintiff's case was that PW3should have been referred to either of the O&G doctors. The plaintiff's case was that the Hospital should have had a proper and effective system of keeping the medical records, coupled with protocols and guidelines for premature deliveries.

[81] The key issue in regards to the event that occurred on 24 February 2003 was the (unidentified) attending doctor's failure to refer PW3 to the O&G doctors and/or to admit PW3 for observation for further tests and to do foetal monitoring. Indeed, if the attending doctor had notified the O&G doctors, it is without doubt that they would have admitted PW3, conducted further tests and done foetal monitoring and most importantly, they should have ensured that she was given Tocolytics and Dexamethasone. According to the O&G doctors there was an unwritten protocol that "high risk" patients and those presenting symptoms of preterm labour must be referred to either of the O&G doctors. Hence, that protocol was not followed.

[82] Indeed, it is quite certain that if the attending doctor had notified the O&G doctors as to PW3's condition, they or one of them at least would have come

and personally attended to PW3. But none of that was done. The question that arose for consideration was whether the attending doctor failed to make a proper diagnosis because there were no written protocols or guidelines.

[83] In this regard, Dr Ariza testified that they as O&G doctors had a role in formulating guidelines and protocols and that whilst there were no written protocols, there were "unwritten" protocols. Essentially, it was Dr Ariza's testimony that the attending doctor should have known what to do. It is obvious from Dr Ariza's testimony that as far as the O&G doctors were concerned, the attending doctor being duty trained and having the requisite medical knowledge and experience, should have made a diagnosis of premature labour and alerted the O&G doctors to obtain urgent instructions on the next steps. But that was not done.

[84] The question is whether the O&G doctors are responsible for the attending doctor's failure to take the necessary steps on 24 February 2003 or whether the Hospital, as the employer of the attending doctor was solely liable for the attending doctor's gross negligence in failing to diagnosis PW3 as presenting signs of premature labour.

[85] Of course, if the medical records had been preserved and disclosed at trial, then that would have shed much needed light on what the attending doctor did and did not do. In the absence of the contemporaneous documents, the trial Judge had no choice but to rely entirely on PW3's oral testimony as to what took place on 24 February 2003.

[86] But it is important to emphasise that the missing medical records were not causally connected or linked to the plaintiff's disabilities. As we said earlier, there is no evidence to prove that the missing medical records caused or contributed to PW3's poor treatment or management on 24 February 2003.

[87] Indeed, there is nothing to suggest that the medical records were not available on 24 February 2003. The non-availability of medical records at the trial cannot be conveniently conflated with any alleged non availability during PW3's maternity treatment and management at the Hospital.

Tocolysis And Dexamethasone

[88] There is no dispute that if there were signs and symptoms of premature labour, the pregnant mother (PW3) should be given Tocolytic drugs with a view to suppressing the labour and prolonging the pregnancy and should also be given Dexamethasone so as to improve the lung function of the foetus.

[89] The experts have also agreed that the best opportunity to give Tocolytic drugs and Dexamethasone would have been on 24 February 2003 when PW3 had signs and symptoms of early premature labour. It was submitted for the plaintiff that the premature delivery of the plaintiff on 26 February 2003

could have been avoided only if PW3 had been advised on 24 February 2003 regarding the use of Tocolytic drugs and Dexamethasone.

[90] The evidence of the medical experts in relation to the missed opportunity on 24 February 2003 may be summarised as follows:

(i) The attending doctor ought to have paid attention to PW3'scomplaints and duly recognised them as symptoms of early premature labour.

(ii) The patient (PW3) should have been treated in accordance with the standard of care applicable in a case of early premature labour.

(iii) The opportunity on 24 February 2003 to use Tocolytic drugs and Dexamethasone so as to prolong the pregnancy and to improve the lungs function of the foetus was "missed".

(iv) The O&G specialists, the medical officers, and the midwives had a joint responsibility to provide advice and information on 24 February 2003.

(v) A safe system that should have been available in the Hospital which offered specialist maternity services.

Our Decision

[91] We shall start with the pleading point. The question is whether a failure to specifically plead the 6th ante-natal visit on 24 February 2003 in the ASOC was fatal to the plaintiff's case. In the ASOC, the plaintiff had stated that PW3 was ante-natally seen at the Hospital on "various occasions". In the plaintiff's Summary of Case, there was an express reference to the said date and as to what took place.

[92] In the witness statement, PW3 and her husband (PW4) had said that on 24 February 2003, PW3 had gone to the Hospital and presented various complaints. The experts are in agreement that PW3's complaints are consistent with premature labour. It was not put to PW3 that on 24 February 2003 she was not seen ante-natally at the Hospital by an unidentified doctor. The Hospital failed to produce the medical records for PW3's 3rd pregnancy. The questions that were posed to PW3 during cross-examination were clearly and unequivocally suggestive of an express if not, tacit acceptance that on 24 February 2003, PW3was seen ante-natally at the Hospital.

[93] In so far as the evidence was concerned, PW3 was clear in her testimony in regards to her ante-natal visit on 24 February 2003. She said, "Pada 24 Februari 2003, doktor yang merawat saya adalah doktor perempuan bertudung dan saya tidak pasti nama doktor berkenaan". She said that she informed the

unidentified doctor that she, "… merasa tidak selesa, dan sakit dibahagian perut dan sukar untuk berjalan, berdiri, duduk, naik tangga, kencing sakit dan baby dalam kandungan kurang bergerak?".

[94] Her husband, PW4 was asked, "Sebelum 26 Februari 2003, bilakah isteri anda pergi ke Pusat Rawatan Islam Az-Zahrah?" and he answered, "Dua hari sebelum kelahiran Nur Zulaikha iaitu pada 24 Februari saya membawa isteri dan pada hari tersebut adalah hari checkup yang ke 6 bulan" No doubt it was put to him that the appointment was 21 February 2003 rather than 24 February 2004.

[95] It was the Hospital's position that the diaries for the medical officers on duty on 24 February 2003 showed that there were no appointments on that day. This is where counsel for the plaintiff found it rather odd that the Hospital and the O&G doctors were able to produce the diaries for the medical officers on 24 February 2003 but not the plaintiff's ante - natal records for her 3rd pregnancy. The diaries for the O&G doctors for 24 February 2003 were also not produced?

[96] PW3 agreed she was not seen by the O&G doctors on 24 February2003. But, that is precisely the plaintiff's complaint. Essentially, it was contended on behalf of the plaintiff that having been apprised of PW3's complaints, the unidentified medical officer should have taken down the patient's history and that would have revealed that she had previously delivered her 2nd child at the Hospital on 14 June 2002, which would mean that there was "poor spacing" between her last pregnancy and the current (3rd pregnancy) and therefore that she was a high-risk patient for premature delivery. As such, the O&G doctors should have been alerted of PW3's high-risk status. But that was not done. There is no explanation by the Hospital as to why the O&G doctors were not alerted as to PW3's high-risk situation. It was submitted for the plaintiff that the Hospital has skirted and fudged around the issue by claiming that PW3 did not come to the Hospital on 24 February 2003.

[97] Indeed, according to the plaintiff, the problem would have been solved or the mystery unraveled had the Hospital produced the medical records ,in particular PW3's ante-natal records. Somehow the Hospital was able to producePW3's ante-natal records for her earlier pregnancy and delivery on 14 June 2002. But where it concerned the plaintiff, the Hospital's position is that the records in regards to her 3rd pregnancy had been destroyed. It was submitted for the Hospital that the 2002 records were kept because PW3 was an in-patient and that as far PW3's subsequent pregnancy when she was carrying the plaintiff, she was an "outpatient". We think that this hardly qualifies an explanation by the Hospital. Indeed, after the plaintiff was born, the doctors at the Hospital did discuss the plaintiff's condition with PW4. So they would have known about her condition and ought to have preserved the medical records.?

[98] The defendants also did not produce their patients' register or any other document that could have assisted the parties and the Court to identify the

doctor who had attended to the plaintiffs mother on 24 February 2003 and also would have disclosed what the clinical facts on that date were. The register is required pursuant to reg 17 of the Private Hospital Regulations 1973 which was in force in 2003 but has since been repealed and replaced with reg 43 of the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006. The relevant passages from reg 17 are reproduced below:

> "(1) A person conducting a private hospital shall keep and maintain a Register of Patients and shall cause to be recorded therein, in respect of each patient-
>
> (a) his full name;
>
> (b) his age;
>
> (c) his sex;
>
> (d) his identity card number;
>
> (e) his home address and office address and telephone numbers;
>
> (f) his marital status;
>
> (g) the name and address of the registered medical practitioner or nurse or midwife under whose professional care the patient had been, immediately prior to admission;
>
> (h) a short history of the patient's stay in the private hospital stating particularly-
>
> (i) the name of the admitting doctor and of the doctor or doctors treating the patient during his stay;
>
> (ii) the date of admission;
>
> (iii) the nature of any disease manifest at the time of admission;
>
> (iv) diagnosis on discharge;
>
> (v) the description of any operation performed on the patient together with the name of the person or persons who performed the operation and the result of the operation; and
>
> (vi) the date of discharge from the private hospital or in the event of death, the date of death.
>
> (2) Where the private hospital is a maternity hospital, there shall also be recorded in the register maintained under sub-regulation (1) in respect of each patient admitted for confinement, the date of and a short history of the confinement, stating particularly-
>
> (a) the date and time of the confinement and whether live-birth, still-birth or abortion;

(b) the sex, weight and height of the new born, circumference of head and condition of the newborn at birth;

(c) the name or names of persons attending on the patient during the confinement;

(d) the condition of the mother and new born during their stay there; and

(e) the name and address of the person who removed the new born from the private hospital on discharge.

(3) A person conducting a private hospital shall maintain in respect of each patient-

(a) doctor's case notes; and

(b) daily nursing progress notes.

(4) A person conducting a private hospital shall also maintain a register for dangerous drugs as specified under the Dangerous Drugs Regulations, 1952.

(5) A record shall be kept of all persons employed in the private hospital containing the following particulars of each employee-

(a) name

(b) age;

(c) sex;

(d) address;

(e) identity card number;

(f) qualifications; and

(g) duties.

(6) The Register of Patients kept pursuant to these Regulations shall be made available, on demand, for inspection by a medical officer of health."

[99] Counsel for the plaintiff also referred to the publication "*Good Medical Practice 2001*" where the following was stated in regards to medical records:

"2.4 Medical Records and Reports

In general, well-kept Medical Records are the hallmark of a good medical practice. Patient cards should record all relevant information, physical findings and diagnosis in the course of patient management. Such records should be accurate, legible, comprehensive and up-to-date, and contribute to easy recall of patient information for continuity and follow-up of patients, as well as for future reference such as preparing reports.

> Investigations and treatment should be recorded in detail, and in the case of invasive procedures, the indications for, and the nature of, the procedures, must be clearly documented. Properly justified procedures can be defended by peers in the event of conflict or litigation, but when the clinical notes are sketchy, poorly made out, illegible, vague, ambiguous and superimposed with deletions and corrections, this may be difficult."
>
> "It is well to remember that while the clinical notes and records physically reside with the doctor and to the hospital, the information therein contained belongs, morally and ethically to the patient and to regulatory authorities. These documents may be demanded by the patient or his appointed officers for various purposes, ranging from need to seek second opinion, to seek further treatment elsewhere, or for litigation."

[100] Reference was also made to *Skelton v. Lewisham and North Southwark Health Authority* [1998] QBDJ 324 ("*Skelton*") at p 329, where the Court had said that poorly written medical records can give rise to an inference of negligence.

> "In my judgment the evidence is clear: these notes were well below the standard which was acceptable in 1983 and, Mr Irwin submits, either Dr Casson was habitually poor noter (which I doubt) or, as seems likely, for some reason he fell below his own normal standards."

[101] Counsel for the plaintiff also referred to *Stucken v. East Kent Hospitals University NHS Foundation Trust* [2016] Med LR 380 ("*Stucken*") at p 392, where the Court had made the following comments in regards to poor medical records:

> "First, in my judgment Mr Poon's operation note falls short of the standard required after a procedure which has gone disastrously wrong. It is partly illegible, unclear, confusing and, in places, perfunctory. I appreciate that a poor note does not necessarily translate into poor clinical practice, but it is capable of bearing on the issue and so I cannot and do not ignore it."
>
> [Emphasis Supplied]

[102] Counsel emphasised that in the present case the situation is far worse than that in *Skelton* and *Stucken* because the relevant medical records were never produced in evidence. Counsel said that in the present case, the plaintiff, a minor, is under a double disability because of the brain damage injury. Counsel said that pursuant to s 24 of the Limitation Act 1953 the limitation period will be 6 years after "such person ceased to be under a disability...". As such the medical records ought to have been kept forever or as long as it takes. It was submitted for the plaintiff that the failure to keep the medical records is also a reflection of the poor treatment and management given in this case. The Judge agreed with Counsel's submission and concluded that the failure to keep the medical records contributed to or resulted in thePW3's poor treatment and management at the Hospital. But as we said earlier, there is no evidence that the missing medical records resulted in PW3's poor treatment and management *vis-a-vis* 24 February 2003.

[103] As stated earlier, one of the major points in issue was the fact that the plaintiff had not pleaded the event on 24 February 2003 in the ASOC. In so far as evidence is concerned, it is quite clear that the O&G doctors did not see PW3 and did not attend to her on 24 February 2003. However, the Judge examined the evidence in its entirety and concluded that PW3 did go to the Hospital on 24 February 2003. We are mindful that the event on 24 February 2003 was not specifically pleaded in the ASOC. But the ASOC did mention that PW3 was seen in the ante-natal clinic on various occasions prior to 26 February 2003. The event on 24 February 2003 was also specifically mentioned in the plaintiff's Summary of Case, which was filed in advance of the trial.

[104] Thus, all sides were fully aware that the plaintiff would be introducing evidence in respect of the event which took place on 24 February 2003. To put it bluntly - there was no element of surprise. The defendants knew the case that they had to meet.

[105] In her testimony PW3 said that she went to the Hospital on 24 February 2003. It is necessary to mention that counsel for the Hospital did not put to PW3, that she "did not" go to the Hospital on 24 February 2003. (See: the decision of the Court of Appeal in *Sivalingam Periasamy v. Periasamy & Anor* [1995] 2 MLRA 432 (CA). And it is also to be noted that counsel who acted for the O&G doctors specifically suggested to PW3 during cross-examination, that on 24 February 2003 a urine sample was taken for analysis. PW3 denied that a urine sample was taken.

[106] As rightly submitted by counsel for the plaintiff, the trial notes of evidence show that the defendants had tacitly admitted during the trial, including by cross-examination of PW3, that the visit on 24 February 2003 had taken place.

[107] Counsel for the plaintiff said that it was only after the close of the plaintiff's case, realising very late that they were in trouble, essentially for not doing anything or enough for a mother and a foetus who were in a vulnerable condition on 24 February 2003, they suggested to the contrary through learned counsel for the O&G doctors, when another witness, a medical records officer (DW2) who was called by the O&G doctors, gave evidence.

[108] Thus, counsel for the plaintiff said that the evidence, when taken together, makes it quite clear that during the plaintiff's case at least, the position that was taken by the defendants was that on 24 February 2003 PW3 did go to the Hospital. The Judge accepted PW3's evidence that on 24 February 2003 she did go to the Hospital.

[109] In our view, the Judge's finding in this regard is unimpeachable. On the evidence that was presented at the trial, and having seen and heard PW3'sevidence, the Judge was entitled to make the conclusion that on 24 February2003, PW3 did go to the Hospital for the ante-natal appointment where she was attended to by an unidentified female Malay doctor who was

wearing a head scarf. For our part, we found no compelling reason to disturb the Judge's finding in this regard.

[110] We proceed now to discuss the implications of the "missed opportunity". In this context, there appeared to be consensus amongst the specialists on both sides that 24 February 2003 was a critical date. There was no disagreement between the experts that on that date, the medical officer who examined PW3:

(a) should have spotted the symptoms of premature delivery.

(b) should have advised PW3 of the possibility of premature delivery.

(c) should have alerted the O&G doctors of the situation.

(d) should have admitted PW3.

(e) should have given PW3 Tocolytics to slow down the contractions and prolonged gestation.

(f) should have administered Dexamethasone which would have helped the foetus's lungs to mature.

(g) should have taken a urine sample to check for any infection.

(h) should have monitored the foetal heartbeat via antenatal cardiotocography.

[111] The Tocolytics would have slowed down the contractions and prolonged gestation by at least 48 hours. Dexamethasone would have helped the plaintiff's lungs to mature. The steroid Dexamethasone (given in 2 doses 12 hours apart) would have required at least 48 hours in order for it to have full effect. Whilst the O&G doctors are not to be blamed for PW3 going into premature delivery, the question is whether they are liable for the actions which were taken or not taken by those at the Hospital, who attended to PW3 on 24 February 2003.

[112] Counsel for the plaintiff said that as the O&G consultants at the Hospital, they had a responsibility to assist the Hospital to come up with protocols and guidelines to enable midwives and medical officers to deal with situations where pregnant mothers present symptoms of premature birth. If that had been done, then it is perhaps reasonable to presume that the plaintiff might have had a better outcome instead of the bleak circumstances into which she was born. In our view, there is no doubt that at least in so far as the ante-natal visit on 24 February 2003 is concerned, PW3 was clearly not treated in accordance with well- established and well defined medical standard of managing a patient who presents symptoms of premature delivery.

[113] As PW1 said, the following should have been done:

- The Hospital should have consulted Dr Ariza or Dr Fatimah and the patient (PW3) should have been admitted.

- They should have taken a urine sample to check for an infection.

- The foetal heartbeat should have been monitored via ante-natal cardiotocography.

- Next, Tocolytics should have been given to delay the labour by slowing down the contraction.

- Lastly, PW3 should have been administered with Dexamethasone so that the plaintiff's lungs would mature and be able to function as soon as delivery is complete. All of these were not done.

- Instead the unidentified doctor who attended to PW3 told her that her symptoms were "normal" and she was told to go home.

[114] It is not in dispute that the O&G doctors did not see nor treat PW3 on 24 February 2003. In our view, they cannot be liable for anything that took place on 24 February 2003. The systems failure or organisational failure cannot be placed on the shoulders of the O&G doctors as they are not the *alter go* of the Hospital. They are not an employees of the Hospital nor were they, as contended, partners in the Hospital. Dr Ariza and Dr Fatimah were independent contractors who carried on as O&G consultants at the Hospital and they paid rental to the Hospital for utilising the clinic space at the Hospital. Although they might have agreed during cross-examination that there should be guidelines and protocols for dealing with patients who present premature birth symptoms and that as consultants in the Hospital they had a role in the formulation of these guidelines or protocols, the absence of any written guidelines or protocols does not mean that the midwifes and medical officers at the Hospital were clueless as to what had to be done in such situations. In fact Dr Ariza said that there were unwritten protocols in regards to what has to be done when a patient presents symptoms of preterm labour.

[115] Clearly, the unidentified doctor who saw PW3 on 24 February 2003 did not see it fit or necessary to call Dr Fatimah or Dr Ariza to escalate the patient's symptoms to the O&G doctors. The mistake was that of the doctor who examined PW3 on 24 February 2003. She should have consulted either Dr Fatimah or Dr Ariza and they would have then admitted the patient and initiated the appropriate treatment with Tocolytics and Dexamethasone and monitored the foetal heartbeat via cardiotocograph. The systems failure or organisational failure is a failure for which only the Hospital is answerable. Dr Ariza and Dr Fatimah are not responsible or liable for the acts or omissions of the medical officer or other staff at the hospital unless such acts or omissions were as per the instructions of Dr Ariza or Dr Fatimah. There is no evidence that the O&G doctors had anything to do with the event which occurred at the Hospital on 24 February 2003.

[116] Hence, it is clear that the date 24 February 2003 was a "missed opportunity" for intervention. It was a missed opportunity to (a) admit PW3, (b) use Tocolytics to prolong the gestation by between 24 hrs and 7 days and (c) administer Dexamethasone to allow the baby's lungs to mature, (d) conduct foetal heart monitoring to detect foetal distress. It was suggested that the use of Tocolytics cannot prevent pre-term delivery. That is true. But the experts are agreed, and counsel for the Hospital accepts that the timely use of Tocolytics with Dexamethasone and foetal distress monitoring (on 24 February 2003) may have prevented this unfortunate child-birth event. Thus, if Tocolytics and Dexamethasone had been administered on 24 February 2003, the plaintiff might have had a better prospect and outlook.

[117] The missed opportunity occurred because of a failure on the part of an unidentified doctor who examined PW3 on 24 February 2003 to detect thatPW3 was presenting symptoms of pre-term delivery and she should have been admitted, and Dr Fatimah or Dr Ariza should have been alerted. The missed opportunity is a manifestation of negligence on the part of the unidentified attending doctor, and the Hospital is thereby vicariously liable for the negligence of that doctor.

[118] For completeness, in so far as the medical records are concerned, we are of the view that regardless of the relevant regulatory regime requiring retention of medical records for a fixed period of time or as in this case, until the patient recovers from her disability (therefore to be kept forever), there is no evidence to link the absence of medical records to the disastrous event that took place on 24 February 2003.

[119] The Judge concluded that the failure to produce the medical records or their absence resulted in the poor treatment of PW3. In our view, the Judge's conclusion in this regard has no basis whatsoever. The absence of the medical records only made it difficult for the Court to ascertain what exactly took place. The failure to preserve and produce the medical records prevented the Court from ascertaining the identity of the attending doctor and her qualification, training and experience (or the lack of it). All in all, the Hospital cannot take advantage of its own failure to put forward the best evidence possible to exonerate themselves of the allegation of negligence that were made against them *vis-a-vis* the event on 24 February 2003.

[120] As far as the Hospital's complaint that the plaintiff had not pleaded the breach of a non-delegable duty, we think that this is a non-issue and a non-starter. It is plain that the plaintiff had pleaded the Hospital's own negligence and in particular, that it was negligence due to a failure of its systems In this regard, we reproduce herein the relevant paragraph of the ASOC which brings out the allegation of negligence *vis-a-vis* the Hospital. They areas follows:

> 18. The plaintiffs' claim against the defendants and each of them is for negligence and breach of their other aforesaid duties, additional in the case of the plaintiff, for breach of a contractual duty to act with reasonable care

and skill, thereby causing injury, including the spastic quadriplegic cerebral palsy and their sequelae suffered by the plaintiff, and loss and damage to the plaintiff.

Particulars Of Negligence And Breach Of Contractual And Other Duties Of The defendants And Each Of Them And Their Servants And Agents

18.1 failed to have a safe and reliable system on advising pregnant patients, including the plaintiff's mother, of the delivery options and the risks and benefits associated with each of these options;

18.2 failed to have a safe and reliable system to manage premature labour;

18.3. failed sufficiently or at all to take steps to prevent premature labour;

18.4. failed to have a safe and reliable system for advising patients including the plaintiff's mother on the use of tocolytics to suppress uterine contractions;

18.5 failed to have a safe and reliable system for advising patients with premature labour, including the plaintiff's mother, on the need for NICU facilities for the newborn;

18.6 failed to have a safe and reliable system for an obstetrician and gynaecologist to attend to patients in premature labour;

...

10. The plaintiff avers that the 1st Defendant is liable directly in respect of the loss and damage suffered by reason of the negligence and breach of other duties and is also vicariously liable in respect of such loss and damage by reason of the negligence and breach of other duties of the 2nd and 3rd defendants and the respective servants and agents of the defendants and each of them.

...

23. The plaintiffs avers that the 1st Defendant is liable directly in respect of the loss and damage suffered by reason of the negligence and breach of contractual and/or other duties...

[121] In so far as the complaint that breach of a non-delegable duty was not expressly pleaded in the ASOC, it is useful in our view to refer to the case of *Dr Hari Krishnan & Anor v. Megat Noor Ishak Megat Ibrahim & Anor and Another Appeal* [2018] 1 MLRA 535 where the Federal Court had stated as follows:

"[109] It was contended before us that the issue of non-delegable duties should not be allowed to be raised, since the plaintiff had not pleaded direct liability on the hospital's part for negligence. From a careful reading of the pleadings, this is not the case. We note that the plaintiff had pleaded particulars of the hospital's own negligence in the statement of claim; in his reply to the hospital's defence, the plaintiff had also alluded to the hospital's duty of care to the plaintiff to ensure that a competent standard of practice is exercised during the operation. Since 'the nature of a non-delegable duty

is, in essence, a positive duty to ensure that reasonable care is taken' (Dr Kok Choong Seng), we find that the essence of a non-delegable duty have been sufficiently pleaded."

[122] In our view, the plaintiff had per para 18 of the ASOC, pleaded the necessary particulars of negligence against the Hospital. The plaintiff had also pleaded at para 23 of the ASOC that the Hospital is "liable directly in respect of the loss and damage suffered by reason of the negligence and breach of contractual and/or other duties and is also vicariously liable in respect of such loss and damage by reason of the negligence and breach of other duties of the 2nd and 3rd defendants and the respective servants and agents of the defendants and each of them." Thus, we are satisfied that the plaintiff had pleaded sufficient details to show that the Hospital owed anon-delegable duty of care, that is, direct liability as distinguished from vicarious liability.

[123] In the circumstances, the negligence by the Hospital in the manner and for the reasons as described above cannot be visited upon Dr Fatimah and Dr Ariza who were not even aware of the events that took place on 24 February 2003 as the attending doctor who ought to have recognised PW3 as exhibiting symptoms of early preterm delivery, failed to alert either of the O&G doctors. In the result, by reason of all the circumstances alluded to above, including the withdrawal of the claim in negligence for the event on 26 February 2003, we find that the O&G doctors are not liable for negligence and it is only the Hospital which was liable for negligence.

[124] As such, on liability, we found in favour of O&G doctors and allowed Appeal No 1460 and Appeal No 1489 with costs of RM100,000.00 each to Dr Ariza and Dr Fatimah as costs here and below.

[125] In regards to costs, after hearing the parties, we decided to make a "Sanderson" order whereby an unsuccessful defendant is ordered to pay the costs which are payable by the plaintiff to the successful defendant. (See: *Sanderson v. Blyth Theatre Company Limited* [1903] 2 KB 533). In this regard, there is no doubt that the Court has the discretion to order the unsuccessful defendant to directly pay the successful defendant's costs. The rationale for the discretion to make a "Sanderson" order is to avoid injustice to a plaintiff who sued multiple parties not knowing which party should be sued for the wrong done.

[126] We are conscious of the fact that the discretion to make a Sanderson order must be exercised with care, given that its exercise has the effect of making the Hospital liable for the costs that are payable by the plaintiff to the successful defendants (ie the O&G doctors).

[127] In the present case, given the circumstances including but not limited to the fact that the medical records were missing and information was not forthcoming despite a pre-action order for discovery, it was reasonable for the plaintiff to have sued all the defendants. But now that the dust of conflict has

settled, it has become clear that Dr Ariza and Dr Fatimah ought not to have been cited as parties. Given the situation that presented itself at the time when Suit 144 was filed, we were satisfied that it is fair and just that the Hospital should carry the costs payable to Dr Ariza and Dr Fatimah. We accordingly ordered the Hospital to pay the costs that were awarded against the plaintiff in favour of the O&G doctors.

Quantum

[128] We turn next to quantum. In so far as the appeal on quantum was concerned, having considered the issues carefully we did not see any merit in the appeals in regards to the quantum of special damages and general damages. The defendants did not produce any witness or adduce any evidence to rebut the claims that were made by the plaintiff. The Judge was not impressed with the cross-examination by Counsel for the defendants in regards to quantum.

[129] In particular, it may be noted that there was no contrary opinion to rebut the evidence that was given by PW2 (Rehabilitation Physician) as to the plaintiff's needs to sustain her life until the end of her expected life span.

[130] In so far as the plaintiff's permanent disabilities is concerned, it is clear and indisputable from the evidence that:

(a) The plaintiff will never be able to lead an independent life and will require care and assistance from specialist care providers for rehabilitation and treatment of her severe disabilities.

(b) Her parents will need advice, assistance, support and training from specialists in the rehabilitation and treatment of children such as the plaintiff so that they, the parents, will be able to attend to her needs.

(c) The plaintiff will require specialist training so as to enable her to acquire living skills and to reduce her dependence on others.

(d) The plaintiff needs the services of domestic maids. The plaintiff's parents' home will have to be modified to cater to the needs of the plaintiff as she is severely-disabled. Special travel arrangements will have to be made for the plaintiff to travel from one destination to another.

(e) She will need a motor vehicle with modifications and a driver to operate and look after the vehicle. The plaintiff will need medicines, special nutrition, special clothes and shoes, and special appliances.

(f) The plaintiff's parents will also incur further cost and expense to improve the quality of their lives, including for holidays.

[131] The plaintiff also claimed compensation for the living expenses, which are not covered by the other claims for compensation herein, including for accommodation and utilities, that she would incur when she attains adulthood and when therefore her parents would be under no legal duty to pay such expenses.

[132] As pleaded in the ASOC, the plaintiff's parent had, struggled to provide for the special needs of the plaintiff and did not keep the bills and receipts and other documents regarding the expenses that they had incurred for the benefit of the plaintiff. The evidence disclosed that after receiving advice from her medico-legal advisers, the plaintiff's parents tried to construct a retrospective record of the expenses that they had incurred for the benefit of the plaintiff. They were able to produce some documentary evidence in regards to special damages. It is important to keep in mind that Suit 144 was filed about15 years after the plaintiff was born. Hence, it is to be expected that the plaintiff's parents may not have kept all the receipts.

[133] Thus, on damages, it is trite that an appellate court is particularly slow to reverse the trial judge on a question of the amount of damages. We refer to *Mohamed Ibrahim & Anor v. Christopher Piff & Anor* [1980] 1 MLRA 131 where Wan Suleiman FJ said:

> "It would not be amiss to repeat what Lord Wright said in *Davies v Powell Duffryn Associated Collieries Ltd* [1942] AC 601 at p 616:
>
> > "Where the award is that of the judge alone, the appeal is by way of rehearing on damages as on all other issues, but as there is generally so much room for individual choice so that the assessment of damages is more like an exercise of discretion than an ordinary act of decision, the appellate court is particularly slow to reverse the trial judge on a question of the amount of damages.
> >
> > It is difficult to lay down any precise rule which will cover all cases, but a good general guide is given by Greer L J in *Flint v. Lovell* [1935] 1 KB 354. In effect the court, before it interferes with an award of damages, should be satisfied that the judge has acted on a wrong principle of law, or has misapprehended the facts, or has for these or other reasons made a wholly erroneous estimate of the damage suffered. It is not enough that there is a balance of opinion or preference. The scale must go down heavily against the figure attacked if the appellate court is to interfere, whether on the ground of excess or insufficiency."

[134] We also quote the decision of the Federal Court in *Inas Faiqah Mohd Helmi (A Child Suing Through Her Father And Next Friend; Mohd Helmi Abdul Aziz) v. Kerajaan Malaysia & Ors* [2016] 1 MLRA 647 (FC), where the following guiding principles in regards to future loss of damage were enunciated:

> [24] With the above proposition, we are of the view that the standard of proof with regard to the assessment of future loss or damage is on the balance of

> probabilities, but with a lower degree of certainty as to the occurrence of such loss or damage in the future.
>
> From the authorities, one can say that such a lower degree to be attached is best termed by the word "possibility", "chance", "risk", "danger" or "likelihood", but regardless of the words used and their semantics, they must also essentially be a substantial one and not speculative, and that the standard of proving such "possibility", "chance", "risk", "danger" or "likelihood" of the future damage is still, in our opinion, on a balance of probabilities.

[135] In *Tan Kuan Yau v. Suhindrimani* [1985] 1 MLRA 183 (FC) Abdul Hamid Omar CJ (Malaya) (as he then was) stated:

> Now, in an appeal on quantum of damages, it is essential in order to come to a conclusion, to bear in mind certain principles which are well established. The appeal court is slow, indeed, disinclined to interfere with the judge's finding merely because the appeal court thinks that if the case had been before it in the first instance a lesser sum would have been awarded. Azmi CJ (Malaya) (as he then was) giving the judgment of the Federal Court in *Topaiwah v. Salleh* [1968] 1 MLRA 580 said that:
>
> > In order to justify reversing the trial judge on the question of the amount of damages it will generally be necessary that this court should be convinced either that the judge acted on some wrong principle of law, or that the amount awarded was so extremely high or so very small as to make it entirely an erroneous estimate of the damages to which the plaintiff is entitled (see *Flint v. Lovell* [1935] 1 KB 354).
>
> The principle that should guide this court in determining whether it should interfere with the quantum of damages is crystal clear. What is also clear is that much depends on the circumstances of each case in particular the amount of the award. In a particular case therefore it is for the appeal court to consider whether in the light of the circumstances of that case there is an erroneous estimate of the amount of the damage in that, either there was an omission on the part of the judge to consider some relevant materials, or he had admitted for purpose of assessment some irrelevant considerations. If the court is satisfied or convinced that the judge had acted upon a wrong principle of law then it is justified in reversing; indeed, it is the duty to reverse the finding of the trial judge.

[136] And in *Rasidin Partorjo v. Frederick Kiai* [1976] 1 MLRA 93 (FC), Wan Suleiman FCJ stated the principle in the following words:

> The principle upon which an appellate court will interfere with an award of damages made by a judge sitting alone has been stated by Lord Wright in *Davies v. Powell Duffryn Associated Collieries Ltd* (2) at pp 616-617 as follows:
>
> > Where the award is that of the judge alone, the appeal is by way of rehearing on damages as on all other issues, but as there is generally so much room for individual choice so that the assessment of damages is more like an exercise of discretion than an ordinary act of decision, the appellate court is particularly slow to reverse the trial judge on a question of the amount of

> damages. It is difficult to lay down any precise rule which will cover all cases, but a good general guide is given by Greer LJ in *Flint v. Lovell*. In effect the court ,before it interferes with an award of damages, should be satisfied that the judge has acted on a wrong principle of law, or has misapprehended the facts, or has for these or other reasons made a wholly erroneous estimate of the damage suffered. It is not enough that there is a balance of opinion or preference. The scale must go down heavily against the figure attacked if the appellate court is to interfere, whether on the ground of excess or insufficiency. Thus, the appellant here has to convince us that the learned trial judge has acted on a wrong principle of law, or has misapprehended the facts, or has for other reasons made a wholly erroneous estimate of the damage suffered.

[137] It is therefore trite that an appellate court will interfere with a trial judge's assessment or determination of damages in very limited circumstances, namely, when it is adequately demonstrated that the trial judge had acted on a wrong principle of law or had misapprehended the facts, or has, for those or other reasons, made a wholly erroneous estimate of the damage suffered.

[138] The principle was lucidly discussed by Thomson CJ in *Amar Singh v Chin Kiew* [1960] 1 MLRA 284) where the following passage from the judgment of Morris LJ in the case of *Scott v. Musial* [1959] 3 WLR 437 at p 441 was quoted,

> "Where there is an appeal from the decision of a Judge sitting alone, the appeal is by way of rehearing. The rehearing applies to the issue of damages as well as to other issues. But it is recognised that the fixation of damages is so largely a matter of opinion or of impression that differences of Calculation or assessment are to be expected. There is, to some extent, an exercise of judicial discretion. It is for this reason that, if three judges of the Court of Appeal consider that the amount of general damages that they would have awarded would have been a figure different from that decided by the trial Judge, they will not, for that reason alone, give preference to their own figure; they will only do so if satisfied that the Judge has acted on a wrong principle of law or has misapprehended the facts, or has, for those or other reasons, made a wholly erroneous estimate of the damage suffered:"

[139] Thus, in regards to the defendants' complaint that the plaintiff has not produced receipts and other documents to prove special damages, we took the view that question of whether items of special damages ought to be allowed is par excellence a question for the trial Judge to decide after having seen and heard the witnesses and having due regard to the circumstances attendant upon the case including the fact that the suit was filed about 15 years after the plaintiff was born. It was, to quote the case of *Scott v. Musial*, a matter of opinion or impression and to an extent, an exercise of discretion for the trial judge to decide after comprehensively examining the evidence that was presented. For our part, we saw no compelling reason to interfere with the Judge's assessment of and award of special damages and general damages.

Multiplier

[140] Now, although on the topic of quantum we declined to intervene with the Judge's award on damages, we were nevertheless convinced that there was a misdirection (warranting appellate intervention) in regards to the "multiplier" that was used.

[141] In this case, the Judge used the multiplier of 73 years based on the evidence of the plaintiff's rehabilitation expert (Dr Uma Kavitha - PW2) who opined that the plaintiff had a life expectancy of 63 years plus 10 years (given during re-examination). However, in her report dated 28 October 2018, PW2 stated that on average the plaintiff had an additional 48 years of life expectancy. The Judge then applied a 15% reduction and arrived at 49 years.

[142] In our view, the multiplier should be based on 63 years minus 16 years (age of the plaintiff at the time of trial) less 30% for contingencies and accelerated payment, which gives a multiplier of 33 years. We therefore ordered that the award of compensation be calculated based on a multiplier of 33.

Appeal 1393

[143] For the reasons and discussed as above, the Hospital's appeal (Appeal 1393) on liability is dismissed. The Hospitals' appeal on quantum is allowed to the extent that the multiplier of 49 years is set aside, and substituted with a multiplier of 33 years. The judgment sum is to be recalculated and varied accordingly. The Hospital is to pay costs of RM30,000.00 (subject to allocatur) to the plaintiff (respondent).

Appeal 1460 and Appeal 1489

[144] The appeal by Dr Ariza (Appeal 1460) and the appeal by Dr Fatimah (Appeal 1489) on liability is allowed. The decision of the High Court in respect of the plaintiff's claims against Dr Ariza and Dr Fatimah on liability are set aside. We made a *Sanderson* order that the Hospital is to pay costs in the sum of RM100,000.00 each to Dr Ariza (Appeal 1460) and Dr Fatimah (Appeal 1489) as costs here and below. (Both subject to allocatur).