COMMONWEALTH OF THE BAHAMAS

IN THE SUPREME COURT

COMMON LAW AND EQUITY DIVISION

2010/CLE/GEN/FP/00098

BETWEEN

SHEREL MOSS

First Plaintiff

AND

JEFFERY MOSS

Second Plaintiff

AND

DR. HAVARD T. COOPER

Defendant

BEFORE	The Hon. Mrs. Justice Estelle Gray-Evans
APPEARANCES:	Mr Elliott Lockhart and Mrs Gia Moxey for plaintiffs Mrs G. Ingrid Tynes and Ms NtShonda Tynes for defendant
Hearing dates:	6, 7 and 8 May 2013
Written closing submissions	Defendant: 5 July 2013 Plaintiffs: 11 September 2013

JUDGMENT

Evans, J.

1. The plaintiffs, Sherel Moss and Jeffrey Moss, are husband and wife and the parents of three children. They reside and work in Freeport, Grand Bahama.

2. The defendant, HC, is an obstetrician/gynecologist, practicing in the Island of Grand Bahama aforesaid.

3. The plaintiffs commenced this action on 23 March 2010 claiming against the defendant damages for loss and damage suffered by the plaintiffs as a result of the defendant's professional and medical negligence before, during, and after the said tubal ligation surgery performed on the first plaintiff and which subsequently failed.

4. In their statement of claim filed 21 June 2010, and amended on 10 May 2013, the plaintiffs allege that in October 2008, the defendant agreed with the first plaintiff to perform a tubal ligation using the "cut and burn" method; that a consent form for that surgery and method authorising the defendant to perform the same was executed by the plaintiffs; that contrary to their agreement, the defendant on 22 October 2008 performed a tubal ligation surgery on the first plaintiff using Filshie clips, which procedure was not discussed with, nor agreed to by, the plaintiffs. The plaintiffs allege further that notwithstanding the tubal ligation performed by the defendant, the first plaintiff discovered on 1 April 2009 that she was pregnant with, and gave birth to, the plaintiffs' third child on 6 December 2009.

5. The plaintiffs say further that following the delivery of the said child, Dr Paul Ward, on 7 December 2009, performed another tubal ligation on the first plaintiff, at which time he removed the two Filshie clips inserted by the defendant. The plaintiffs say that they were informed that the clips were not in their proper place; that one clip was partially hanging on the first plaintiff's left fallopian tube and the other clip was not affixed to the right fallopian tube but instead clipped to the mesosalpinx. Hence the occurrence of the plaintiffs' third pregnancy.

6. The plaintiffs also allege, that in the premises the operation performed by the defendant failed to render the first plaintiff sterile; that the first plaintiff remained at all material times fertile and as a result, the plaintiffs have the added financial responsibility of a third child. The plaintiffs say that as a result of the foregoing, the defendant was negligent, and they provide the following particulars of negligence:

a) Failure to exercise reasonable care and skill of a prudent medical practitioner.

b) Failure to act in the best interest of the plaintiffs.

c) Failure to properly advise the plaintiffs or give any warnings of the possibility that the said operation might be unsuccessful.

d) Failure to adhere to the fiduciary relationship existing between the plaintiffs and the Physician.

e) Failure to obtain the informed consent from the plaintiffs for the surgery performed.

f) Failure to inform the plaintiffs of the intended surgery.

g) Causing or permitting only partial application of two clips to the fallopian tubes resulting in only partial occlusion thereof, whereby the plaintiff remained fertile.

h) Discharging the first plaintiff without any further advice as to possible failure of the said operation.

i) In the premises the defendant failed to take any or any adequate care in performing the said operation or in counseling the plaintiffs before or after the same, failed to ensure that the said operation was performed by sufficiently expert and experienced staff, and unnecessarily exposed the plaintiff to distress and a further pregnancy.

j) Failing to conduct a proper examination of the plaintiff upon discharging the first plaintiff and upon knowledge of the third pregnancy.

7. In his defence filed 4 October 2010, the defendant admits that the operation performed by him failed to render the first plaintiff sterile but denies that he (or any of his servants or agents) was guilty of the alleged, or any, negligence. The defendant also denies that the matters complained of by the plaintiffs in their statement of claim were caused as alleged in the statement of claim or at all and he makes no admission as to the alleged or any injuries, loss or damage.

8. Evidence at the trial was given by each of the plaintiffs and the defendant along with their respective expert witnesses: Dr Paul H. Ward and by Dr Frumentus Leon.

9. Dr Ward has been practicing since 1984. He is a Consultant Obstetrician and Gynecologist and Medical Chief of Staff at the Rand Memorial Hospital in Freeport, Grand Bahama and a Fellow of the Royal College of Obstetrician and Gynecology in the United Kingdom. He performed a second tubal ligation on the first plaintiff and his testimony was based on his operative report with respect thereto as well as his general knowledge of tubal ligation, as an obstetrician gynecologist.

10. Dr Leon has been practicing for approximately 25 years. He is a member of the Royal College of Obstetrician and Gynecology in the United Kingdom, the Federation of the Royal

College of Physicians, and the Faculty of Reproductive and Sexual Health Care of the Royal College of Physicians. He is also a Fellow of the American College of Obstetrician and Gynecology. Dr Leon's evidence was also based on his general knowledge of tubal ligation, as an obstetrician gynecologist. He did not examine the first plaintiff.

11. The first issue which arises on the pleadings is whether there was an agreement between the parties for the defendant to perform a tubal ligation surgery on the first plaintiff using the "cut and burn" method?

12. In her witness statement filed 2 February 2012, the first plaintiff states, inter alia, as follows:

> 1) After giving birth to my second child on the 21st April, 2007, my husband and I discussed getting tied off. I approached the defendant with this view in September 2007 and he said "No and to wait another few years." I responded that I was not prepared to do that and that as a result I would go to another doctor.
>
> 2) After waiting a year, I attended the defendant sometime in September or October, 2008 for annual checkup. At the conclusion of that checkup, the defendant said to me "see you next year with twins." I responded "Hell no! The Devil is a liar."
>
> 3) Sometime in early October 2008, my husband and I spoke and agreed to go into Doctor Cooper to get a Consultation on a tubal ligation.
>
> 4) We spoke to the defendant about the process of a tubal ligation using the cut and burn method, because we were adamant that we did not want nor could we afford having anymore children...
>
> 5) The defendant indicated that he did not have a problem doing the operation. However, he also said that he believed God sent us here to be fruitful and multiply.
>
> 6) Sometime before the operation, we signed a blank consent form authorizing a tubal ligation.

13. The evidence is that prior to the surgery, the first plaintiff, on 20 October 2008, signed a consent form acknowledging her consent to the surgery and both plaintiffs signed a "Sterilization Permit" dated 21 October 2008. The contents of both forms are set out hereunder:

"Consent for Operations & Procedures

> INSTRUCTIONS: This form is to be completed by the physician following an informed consent process which involves a discussion between the physician or team member performing or assisting with the procedure/operation, the patient, next of kin or legal representative.

I ....Sheryl Moss...........................of..

Consent to the procedure ....T&L...
(Write procedure(s) in full)

being performed on ....myself..
(Name of Patient)

1. I understand the procedure/operation and accept the advantages, benefits, alternatives and possible side effects that have been explained to me by the physician.
2. I understand the procedure/operation will be performed by Dr Cooper and or Designee.........................
3. I consent to any further or other operative measures which may be found necessary during the procedure/operation.
4. I consent to the administration of general, local or other anesthetics for the procedure/operation.
5. I understand blood and/or blood products (may/will/will not) be used during the procedure.

(Circle & Initial the applicable number/s)

14. That document was signed by the first plaintiff, Dr Cooper and Nurse JA as witness.

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"Sterilization Permit

Date 21.10.08 Hour:____M

I hereby authorize and direct Doctor Havard Cooper and assistants of his choice to perform the following operation upon me at Rand Memorial Hospital Freeport, Bahamas.

And to do any other procedure in (h)is (their) judgment may dictate during the above operation. It has been explained to me that I may (or will probably) be sterile as a result of this operation, but no such result has been warranted. I understand that the word "sterility" means that I may be unable to conceive or bear children, and in giving my consent to the operation have in mind the possibility (probability) of such a result. I absolve said doctor, his assistants and the hospital from all responsibility for my present condition or any condition that may result from said operation.
Signed (Sheril Moss)
Signature Witnessed
By Dr C

I join in authorizing the performance upon my wife (husband) of the surgery consented to above. It has been explained to me that as a result of the operation my wife (husband) I may be sterile.

Signed: Jeffrey J Moss
Signature Witnesses (sic):
Dr Cooper"

15. The second plaintiff, in his witness statement, also filed 2 February 2012, states, inter alia, as follows:

> 1) After the birth of our second child on the 21st April, 2007, my wife and I discussed getting tied off.
>
> 2) Sometime in early October 2008, my wife and I spoke and agreed to go into Doctor Cooper to get a Consultation on a tubal ligation.
>
> 3) We spoke to the defendant about the process of a tubal ligation using the cut and burn method, because we were adamant that we did not want nor could we afford having any more children.

16. Under cross examination, the plaintiffs admitted that it was only the first plaintiff who "consulted" with the defendant in October 2008. In that regard, the first plaintiff's evidence, as I understand it, is that there was no discussion between her and the defendant as to the method of tubal ligation at the 2008 meeting. She said that she was not curious to find out anything about a tubal ligation at that time because she had already obtained relevant information from persons at her place of employment, so that in 2008, her only intention was to have the procedure done.

17. The first plaintiff's evidence is that the only reason for the October 2008 consultation with the defendant was to confirm that he would, in fact, perform the surgery and to find out how soon it could be done, as she and the second plaintiff had already made up their minds and she wanted to be able to take advantage of her un-used sick days before the end of that year.

18. In response to counsel for the defendant's question as to whether she was interested in anything else, other than the time period for the procedure, the first plaintiff responded: "To be honest, this conversation took place prior to 2008, and I told him if he didn't do it we would go to another physician. We went back and he said that since we were so serious about it he would do the procedure."

19. Under cross examination, both plaintiffs said that it was in 2007 when both of them met with the defendant, and that it was at that time that they discussed and agreed the "cut and burn" method of sterilization. The husband's evidence is that the 2007 meeting occurred during one of the first plaintiff's regular check-up visits to the defendant, while she was pregnant with their second child, who was born in April 2007. The first plaintiff's evidence is that that meeting occurred in September 2007, sometime after the birth of their second child.

20. In any event, I understood both plaintiffs' evidence to be that, notwithstanding what is pleaded in their statement of claim and what they appear to be saying in their witness

statements, the discussion and "agreement" regarding the "cut and burn" method of sterilization occurred in 2007 and not in 2008.

21. The defendant admits having had discussions with the plaintiffs about him performing a tubal ligation on the first plaintiff, but denies that there was any agreement for him to use the "cut and burn" method specifically. His evidence, under cross examination, is that the first time he heard that expression was after the first plaintiff became pregnant with the plaintiffs' third child.

22. Curiously, the first plaintiff's evidence is that when she spoke to Dr Ward about sterilization, she told him that she wanted to be 100% sterilized; that he "went down the path of the tie method" but she told him that she did not want the tie method but the "cut and burn" method specifically. However, in response to a question by counsel for the plaintiffs as to whether the first plaintiff had told him her preference for the surgery, Dr Ward said that she had not. His evidence is that the first plaintiff simply told him that she had a failed tubal ligation and she wanted him to "tie her tubes this time". I note here that Dr Ward did use the modified Pomeroy or "cut and burn" method of tubal ligation when he performed the second surgery, although I understood him to say that the usual practice was to use a different method when the first surgery failed.

23. Nevertheless, assuming, without deciding, that the plaintiffs did tell the defendant at the meeting in 2007 what method of sterilization they preferred, by their own evidence, the actual surgery was not performed until more than a year later and it seems to me that the onus would have been on the plaintiffs to ensure that the defendant either remembered or had made a note of their preferred method of sterilization. Yet, by the first plaintiff's own evidence, at the 2008 meeting, at which she said she did most of the talking, she did not mention the "cut and burn" method.

24. Furthermore, the first plaintiff admits having read and signed the form giving her consent to the surgery, which form was dated 20 October 2008, two days before the surgery. The first plaintiff also admits that although the form, the contents of which she had read and understood, expressly provided that it was "to be completed by the physician following an informed consent process...", it was she, and not the defendant, who completed the same and it was she who wrote "T & L" as the procedure to be performed, notwithstanding provision is made on the form for the procedure to be written in full.

25. On the other hand, the defendant's evidence is that he recommended, and the plaintiffs agreed to, the laparoscopic method of tubal ligation, which he says, he explained to the plaintiffs using a photographic model. He says that he did not use the term "Filshie clip" when explaining

the procedure because it was not his practice to use such medical terms when speaking to patients.

26. The defendant also says that he discussed with the plaintiffs the possibility of the second plaintiff having a vasectomy as an alternative method of sterilization, but the plaintiffs did not agree to that suggestion. The plaintiffs deny that the defendant recommended the laparoscopic method or that he explained the procedure to them and they also deny that he recommended that the second plaintiff have a vasectomy instead. Unfortunately, it does not appear that the defendant documented any of his consultations with the plaintiffs or either of them. Certainly no evidence of any such documentation was provided during the trial and there was no note on the sterilization permit, as was the case in the form used by Dr Ward, to indicate that the defendant had specifically explained the procedure and failure rate to the plaintiffs.

27. Counsel for the plaintiffs submits that, the defendant having failed in his duty to write out the procedure in full on the consent form and having admitted that he at no time mentioned the use of the Filshie clips to the plaintiffs, this Court should accept the plaintiffs' evidence as to the agreed procedure to be performed on the first plaintiff as more reliable than the defendant's and find that the defendant did not have the consent of the plaintiffs to sterilize the first plaintiff using the laparoscopic method with the application of the Filshie clips.

28. On the other hand, counsel for the defendant argues that the plaintiffs' evidence that they specifically requested the "cut and burn" method is inherently unreliable through being self-contradictory.

29. In that regard, counsel for the defendant points out that notwithstanding the first plaintiff having at paragraphs 7, 8 and 9 of her witness statement, and the second plaintiff at paragraphs 8 and 9 of his witness statement, described details of a consultation with the defendant in 2008, in cross examination both admitted that the details given in their witness statements relate to a consultation which took place in 2007 and not 2008.

30. Counsel for the defendant points out further that the plaintiffs in their statement of claim allege that a consent form authorizing the defendant to use the "cut and burn" method was executed by both plaintiffs, however, no such consent form was produced at trial. Instead, she points out, the plaintiffs produced a consent form in which the first plaintiff consented to a procedure which she referred to as "T & L" and which is understood to mean "tubal ligation".

31. In that regard, counsel for the defendant submits, and I agree, that since the plaintiffs were so concerned and "adamant" about their preferred method of sterilization, and insisted that they had agreed with the defendant to perform a "cut and burn" procedure, it would seem that

they, or at least the first plaintiff, would have ensured that the form expressly stated the "cut and burn" method of tubal ligation.

32. I say that in light of the fact that the form required the procedure to be written in full and the first plaintiff admits that she is the one who completed the form in October 2008, more than a year after, by her evidence, their discussion with the defendant in 2007 where they say the "cut and burn" method of tubal ligation was agreed.

33. In my judgment, therefore, the plaintiffs have failed to prove that they had an agreement with the defendant for him to perform a tubal ligation on the first plaintiff, specifically using the "cut and burn" method or that a consent form for that method specifically was executed by the plaintiffs.

34. It is common ground that the Pomeroy (or modified Pomeroy) method, also referred to as the "cut and burn" procedure, as well as the laparoscopic method, using clips, referred to as the "occlusion" method, are two commonly used and acceptable methods of effecting permanent sterilization in women.

35. According to the defendant, he chose the laparoscopic method for its several advantages, which he identified as follows:

(a) Operation time is relatively short;

(b) The incisions are small, one being 10 millimeters and the other 7 millimeters which, because the incisions are small, reduces the time needed for them to heal and the recovery time post-surgery;

(c) There is a reduced change of infection;

(d) It is not as painful as other procedures;

(e) Cosmetic advantage – smaller scar;

(f) Easier to reverse should the patient change her mind because only 4 millimeters of tube is destroyed.

36. The experts agree that both procedures have the same objective: to prevent a woman from becoming pregnant and, if performed correctly, have the same effect, that is, each one renders the patient sterile. They say that the major difference between the two procedures is that with the Pomeroy method, a portion of the fallopian tube is excised and sent to the laboratory for confirmation that what has been removed is in fact the fallopian tube. There is no similar procedure when the laparoscopic method is employed.

37. The experts also agree that regardless of the method used, there is an inherent failure rate for each procedure, so, Dr Leon says, no "right-thinking gynecologist would or should do a

sterilization procedure without having the patient sign, seal and deliver, in the presence of a witness, that they were accepting that there will be and there can be a failure rate."

38. According to Dr Ward, the failure rate in the literature for the Pomeroy method is 1 in 200 and between 1 in 300 and 1 in 500 for other methods, including the laparoscopic method. According to Dr Leon, the failure rates are comparable.

39. As I understand the doctors' evidence, failure with all methods may result from error by the surgeon or by re-canalization. However, when using Filshie or other clips, failure may also result from some mechanical defect either in the clip or the applicator. If failure occurs because of a mechanical defect or because of re-canalization, in my view, in light of the consent form which the patient signs, no liability attaches to the surgeon. If, however, failure results from the surgeon's error, then the surgeon may be liable in negligence.

40. Therefore, in my judgment, whether or not the parties had agreed a specific method of tubal ligation is not critical to a determination of what I consider to be the real issue in this case, that is, whether or not the defendant in performing the tubal ligation on the first plaintiff, by whatever method, was negligent and that such negligence resulted in the first plaintiff becoming pregnant and subsequently giving birth to an "unwanted" child.

41. It is accepted that in cases alleging medical negligence, the test for establishing negligence, referred to as the *Bolam* test, is as stated by McNair J. in the case of Bolam and Friern Hospital Management Company [1957] 2 All ER 118. In that case, McNair J, adopting the views expressed by Lord President Clyde in the Scottish case of Hunter v Hanley ([1955] SLT 213 at p 217), that the "true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care", said that the test can also be expressed as follows:

> "[A doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art. ...Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice merely because there is a body of opinion that takes a contrary view."

42. The *Bolam* principle has been accepted by the House of Lords as applicable to diagnosis and treatment: Whitehouse v Jordan [1981] 1 WLR 246; and was later applied by their Lordships in Sidaway v Bethlehem Royal Hospital Governors [1985] 1 All ER 643, where Scarman, LJ, at page 659, opined:

> "the *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a

> responsible body of medical opinion, even though other doctors adopt a different practice. In short, the law imposes the duty of care; but the standard of care is a matter of medical judgment."

43. As a general rule, the burden of proving negligence is on the plaintiffs and in order for them to discharge that burden, they must establish: (i) that the defendant owed them a duty of care; (ii) that the defendant breached that duty; (iii) that such breach of duty was the cause of the damage they suffered; and (iv) that such damage was reasonably foreseeable.

44. In Halsbury's Laws of England 4th edition re-issue, volume 30, para 35, the learned authors say:

> "A person who holds himself out as ready to give medical advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Whether or not he is a registered medical practitioner, such a person who is consulted by a patient owes him certain duties, namely a duty of care in deciding what treatment to give, and a duty of care in his administration of that treatment.

45. In that regard, I accept the submission of counsel for the defendant that the defendant owed no such duty to the second plaintiff, as he was not a patient of the defendant.

46. There can, however, be no dispute that the defendant as a medical practitioner owed the first plaintiff as his patient a duty to perform the tubal ligation with reasonable care in accordance with a practice accepted at the time as proper by a responsible body of medical opinion.

47. The first plaintiff's evidence is that following the surgery by the defendant on 22 October 2008, as a precaution, she continued taking oral contraceptives until the end of January 2009, although the defendant had not advised her to do so. She says that she missed her period for the months of February and March 2009 and on 1 April 2009, because of the pregnancy-like symptoms she was experiencing, she took a pregnancy test and discovered that she was "about 4 and 5 weeks pregnant" with her third child, the subject of these proceedings.

48. The plaintiff said that after that discovery she and the second plaintiff visited the defendant's office on 1 April 2013. She gave the following account of that visit:

> 1) I arrived at the defendant's Office at 3:15 pm. We waited. I saw the defendant between 4:30 pm to 5:00 pm.
>
> 2) The Nurse took a urine sample and did the whole routine check.
>
> 3) When the defendant entered the room I said nothing to him. He said "congratulations Mrs. Moss you are pregnant with twins". I asked him "how is it possible and I had tubal ligation done in October 2008. His response was "Well who did that?" I wanted to curse him out. I said "You did!"

4) The defendant then went to his computer and started to look at dates. I asked him how is it possible?

5) My husband came into the room and the defendant moved us into the procedure room. The defendant asked me if I was in any pain. He said an egg could have moved through the fallopian tube. I was stressed.

6) The defendant did search. But he could not find the baby. He said to me that my baby may be in the fallopian tube. He offered me a pill to flush my uterus.

7) I refused the pill because I was baffled that he did not know where the baby was and I do not believe in abortion. I told him he would be killing my baby if it was in the right place.

8) The defendant gave me his cell phone. He indicated to me that he wanted me to do some lab work the next day, but he never gave me the forms. He jokingly said to me to get a discount at the Rand.

9) I left the defendant's office and that was the last time I saw him as a patient.

10) I went to the Rand Doctor for consultation and he filled out all of the forms to verify a healthy pregnancy.

49. The first plaintiff said that thereafter she saw Dr Paul H. Ward for her antenatal care; that he delivered the plaintiffs' third child on 6 December 2009 and performed a second tubal ligation on 7 December 2009.

50. Following that surgery, Dr Ward, on 8 December 2009, prepared an operative report, in which he wrote as follows:

"OPERATIVE REPORT

NAME:	Sherel Moss
DOB:	16th November 1974
ADDRESS:	#27 Prospero Drive, Freeport, GB
SURGERY:	Post Partum Tubal Ligation
SURGEON:	Paul H. Ward, M.D. FRCOG
ANAESTHESIA:	General: Dr. V. Burton
DATE OF SURGERY:	7th December 2009
PLACE OF SURGERY:	Rand Memorial Hospital
INDICATION FOR SURGERY:	Failed previous sterilization.

PROCEDURE
Following I.V. Anaesthesia and endotracheal intubation, patient abdomen cleansed and draped. A transverse subumibical [sic] incision was made. The left fallopian tube was held and tubal ligation done by a modified Pomeroy method. The tubal segment was sent for histological evaluation. The Filshie clip on the left tube was noted to occlude only part of the tubal lumen. This clip was removed.

The right fallopian tube was identified and a similar original procedure done. The tilshie [sic] clip was not on the right tube but on the mesosalpingx [sic]. The flshied [sic] clip was removed. The abdominal incision was closed in layers.

Dr. Paul H. Ward, M.D. FRCOG
Consultant Obstetrician & Gynecologist"

51. The plaintiffs contend that the respective locations of the Filshie clips, as discovered by Dr Ward in December 2009, is where the defendant placed them when he performed the tubal ligation in October 2008 and that the clips were improperly placed, as a result of which the first plaintiff became pregnant.

52. The defendant denies that he placed the Filshie clips where they were said to have been found by Dr Ward. His evidence is that when he performed the tubal ligation surgery on the first plaintiff in October 2008, he examined the entire length of both tubes to identify the appropriate location for the clips; that he then placed one clip on each tube in the narrowest area of the tube, closest to the uterus, as, he said, that location produced the best desired result. The defendant said that he then examined both tubes to ensure that the entire circumference thereof was included in the clips. He said that there were no complications during or after the surgery and that he exercised all reasonable care and skill in conducting the same; that he followed proper procedures and that there was no negligence on his part.

53. Included amongst the plaintiff's bundle of documents is a copy of the in-patient chart showing the first plaintiff's progress notes with respect to the tubal ligation performed by the defendant in which the defendant noted, inter alia:

> "Procedure: The patient was cleaned and draped; catheterized.
>
> Subumbilical transverse incision was made. The needle was inserted and pneumoperitoneum crated – lapraoscopic trocar was inserted and the findings above were noted.
>
> Both tubes identified and Filshie clip applied to each tube after proper identification. Laparoscopic exam was reversed and the abdomen deflated."

54. As for how the Filshie clips came to be found as Dr Ward described, the defendant, in his witness statement filed 6 May 2013, proffered the following explanation:

> 1) The position of the Filshie clips 14 months after the date of their original placement is irrelevant to whether or not they were correctly placed originally. Movement of the Filshie clips over time is normal in the absence of a pregnancy and more likely during a pregnancy.
>
> 2) The movement of the Filshie clips is a normal occurrence since the tissues to which the clips are attached will die and as the tissue dies the clips will either slip to the left or to the right of their original location or they will fall off completely. This movement does not affect the likelihood of the patient becoming pregnant.

55. The experts, Dr Ward, for the plaintiff, and Dr Leon for the defendant, agreed with the defendant that where the clips were found fourteen months after surgery was not necessarily where they were placed during surgery.

56. Dr Ward, during his evidence-in-chief, in response to counsel for the plaintiffs' question as to whether he would say that where he found the clips is where they were initially placed, said:

> "It is very hard for me to speculate with regards to Filshie clips because there are so many possibilities in terms of Filshie clips. In review of the literature on Filshie clips you can have manufacturing faults or operational faults. I know if you clip a tube it can cause what we call necrosis – the blood vessel is rotting off the area and the clip can drop off. When I worked in England I noticed that if you don't see it in the pelvis that does not mean she is not sterilized. It is well known that clips can fall way from where they were placed".

57. With regard to the left tube, in response to counsel for the plaintiffs' question as to whether the clip on the left tube being partially in place would have been an incorrect procedure, Dr Ward said he could not say because it could have been in the correct place and moved. As for what would cause the clip to move, Dr Ward said:

> "Well, you know living people, their bodies move. There is natural movement of the tissues inside your body. A variety of reasons can cause things to move, I really don't know".

58. Under cross examination, the following exchange occurred between Miss Tynes for the defendant (Q:) and Dr Ward (A:):

> Q: You indicated in your operative report...."the Filshie clip on the left tube was noted to occlude only part of the tubal lumen". Are you saying there that the Filshie clip was improperly placed initially 14 months prior?
>
> A: No, I'm saying the Filshie clip that I saw was on part of the tube. It would be unfair to say what happened 14 months earlier. I only can say what my findings are and I cannot say what happened before. I will be making some assumptions.
>
> Q: So you are not saying that 14 months prior the Filshie clip was improperly placed?
>
> A: I'm not saying that. I'm not implying that. No.
>
> Q: Are you saying that the clip that was on the mesosalpinx was improperly placed 14 months prior?
>
> A: I cannot infer that at all. This is why I cannot spell that out. I can only say what my findings are. That is a medical term over the fallopian tube so the Filshie clip instead of being over the tube it would have been on the tissue that covers the fallopian tube. I cannot infer whether it was placed there.

Q: Is it possible that these clips were properly placed there initially and by that time they had migrated? That is possible?

A: That is possible.

59. In addition to the natural movement of tissues within the body, the doctors also spoke about the effect that necrosis has on the movement of Filshie clips.

60. The defendant explained the process like this:

> "... any time a clip is placed somewhere, the tissue beneath that clip is destroyed almost immediately. The blood supply to that area, if you could see in between the Filshie clip as demonstrated here, any tissue being squeezed that hard, as delicate as the tubes are, is destroyed immediately. There is no blood supply to that area and as a result of that, the area beneath that dies. The two ends on either sides of the clip would begin to heal. You have some inflammatory response that is occurring and as it heals this has nothing to hold onto afterwards. Initially it is holding onto the fallopian tube. The fallopian tube is no longer there because it is destroyed. This clip being heavier than the surrounding area has the ability to just migrate – gravity would move it. It could move it within the tissue, the most adjacent tissue to it, that is, the mesosalpinx,so that it falls within the mesosalpinx. It has the ability to move even further or out of the mesosalpinx, off of the tube".

61. According to Dr Ward:

> "Whenever we introduce a suture or a foreign body it basically removes the blood supply. Once there is no blood supply the tissues go under necrosis, but in layman's terms it is called rotting of the tissues. Now you have a gap where there is no live tissue..."
>
> "If you clip a tube it can cause...necrosis...the blood vessel is rotting off the area and the clip can drop off..."

62. According to Dr Leon:

> "It is a well known fact that when you apply Filshie clips it causes destruction and death of the tissue. By remitting the Filshie clips, even though the clip is locked on the fallopian tube, it moves slowly through the new mechanism and this is the way the body reacts and from resting on any structure, can slowly over time, move through that tissue. It is a very well known fact that, if anybody would want to double check this, it is described in all of the journals, and this happens so much so that if during the process of migration, the Filshie clip or whatever clip is used can actually leave that particular area and be expelled from the body through one of the orifices; can be expelled through the bladder, the rectum, the abdomen."

63. The doctors also say that pregnancy can influence the movement of Filshie clips.

64. The defendant and the experts say further that after a properly performed tubal ligation using Filshie clips, and a separation of the tubes as a result of necrosis, a woman can still

become pregnant through the process of re-canalization, that is, a re-attachment of the two ends of the gapped tube.

65. The experts say that re-canalization is possible regardless of the method of tubal ligation. They agree that re-canalization of the tube or tubes so as to enable a previously sterilized patient to become pregnant is rare. However, they do not appear to agree on the timeline for such re-canalization.

66. According to the defendant, no one can determine over what period there would be complete re-attachment or re-canalization to allow egg to flow through the gapped tube, but, he said, what was known and had been demonstrated is that re-attachment could occur as early as three to four months after necrosis. So far as he was aware, however, there was nothing in the literature to say that the re-attachment or re-canalization occurred in less than 3½ months after necrosis.

67. Dr Ward, during his evidence-in-chief, said that re-canalization is more likely to occur over a period of years after necrosis, rather than as early as within six months thereafter. In the early stages of cross examination, he said that once there was a gap, that is, the tubes separate because of necrosis, "over the years the two ends tend to migrate and join up and for some strange reason a pregnancy can occur".

68. However, later under cross-examination, Dr Ward said that re-canalization could occur earlier. The following exchange between Miss Tynes (Q:) and Dr Ward (A:) is noteworthy:

Q: You spoke about something which is called re-canalization?

A: Yes, the tubes coming back together.

Q: Can it occur sooner?

A: Healing starts immediately and can stretch out a period of months and years. Healing is influenced by the person's immune system because each individual person heals by a generic rate. The rate of healing is different but there is [sic] some general guidelines. You would have rotting within the first couple weeks and one that happens over a period of time - months, years. The re-canalization is a possibility. I have no evidence that this has occurred and I am speculating in the box. Those are all possibilities."

Q: So re-canalization can happen within months?

A: Yes.

Q: And that is the rejoining of tubes?

A: Yes.

69. Then on re-examination, Mr Lockhart (Q:) and Dr Ward (A:):

Q: Ordinarily, do you expect that to occur within six months?

A: I have seen that in the past people coming early, so it is possible. For example, if I do a very small loop and the suture slips off. The tubes are now lined up against each other and it is possible that the person can become pregnant.

Q: With rotting having occurred?

A: Yeah, it is possible.

Q: Rare?

A: It is rare, but possible.

70. Then in response to a question by the Court as to whether he was saying that the tubes could come back together and re-attach within six months after necrosis, Dr Ward responded: "Yes ma'am".

71. According to Dr Leon, when one looks at the literature, re-canalization can occur as early as six weeks or as late as 20 years after the tubal ligation procedure was done, although he said he had not personally known of any case where a tube had re-aligned itself within a month, or at all, during his 25 years of practice.

72. Under cross examination, Dr Leon accepted that it was "unlikely" and even "highly unlikely", although "not impossible" that the tubes would realign after a period of six weeks after a properly performed tubal ligation. In response to counsel for the plaintiff's suggestion that the process of realignment was more likely to manifest itself over a period of years rather than over a period of weeks, Dr Leon responded "likely, but not impossible".

73. According to Dr Leon, complete re-attachment of the tubes was not necessary for pregnancy to occur since all that was needed was the "most tiniest" of openings to allow egg and sperm to pass through and meet.

74. None of the experts or the defendant produced any of the literature to which they referred.

75. Counsel for the plaintiffs submits that having regard to the short time that elapsed between the surgery performed by the defendant and the date of first plaintiff's conception with her third child, it is highly unlikely, as described by Dr Leon, that there was necrosis and re-canalization within six weeks of the date of the surgery. Therefore, counsel submits, this Court ought to accept the explanation given by Dr Ward that necrosis is a four to eight weeks process and re-canalization takes many months and years thereafter.

76. In Mr Lockhart's further submission, having regard to the time of the first plaintiff's conception and third pregnancy, the position of the Filshie clips as found by Dr Ward and the fact that both fallopian tubes were not completely severed, the defendant did not perform with ordinary care and skill in carrying out the tubal ligation procedure on the first plaintiff. Therefore, he submits, the defendant failed in his duty to the plaintiffs.

77. Further, counsel for the plaintiff argues that considering the position of the clips in 2009, one clip partially occluding the left fallopian tube and the other clip attached not to the right fallopian tube but to the mesosalpinx and there being no evidence of severance of the tubes and migration of the Filshie clips, as a result of necrosis, it was more likely than not that the clips were originally placed where they were found.

78. Counsel argues further that if one accepts the evidence of the three doctors, as to the process of necrosis, in the absence of which Filshie clips do not migrate, and their evidence relative to re-canalization, the clips would not be where they were found and attached as they were, if this process had taken place. At the very least, counsel points out, a portion of the left tube was not occluded. Therefore, he submits, considering the position of the right clip and there being no evidence of severance to the right tube, the same remained intact. He submits further that the right Filshie clip, which was attached to the mesosalpinx, could only have been originally placed there, as, in his submission, it could not have been attached to the right tube, fall away by the force of gravity, and re-attach to the mesosalpinx. In that regard, Mr Lockhart points out that the defendant admitted that that was impossible as clips do not open and re-attach in the process of migration.

79. On the other hand, counsel for the defendant submits that there was no evidence to support the plaintiffs' allegation of improper application of the Filshie clips on 22 October 2008. Moreover, in her submission, the defendant gave eyewitness testimony as to the surgery performed on that date and both medical experts agree that the location of the Filshie clips on 7 December 2009 had no bearing on their original placement on 22 October 2008,both of them having testified as to the migration of properly placed Filshie clips over time.

80. Furthermore, counsel for the defendant submits, even if the 6 December 2009 birth of the plaintiffs' third child followed a full-term pregnancy, the first plaintiff's conception would have occurred within a time frame when the natural but rare phenomena of re-canalization is known to be able to occur, being more than four and a half months after the tubal ligation surgery of 22 October 2008.

81. Therefore, counsel for the defendant submits, the plaintiffs have failed to establish liability in their claim against the defendant for medical and professional negligence.

82. It is common ground that, since its purpose was to render the first plaintiff sterile, and she nevertheless became pregnant within a few months afterwards, the tubal ligation performed by the defendant failed.

83. The defendant's evidence is that before attaching the clips, he examined the entire length of both of the first plaintiff's fallopian tubes to identify the appropriate location for the clips; that he then placed one Filshie clip on each fallopian tube in the narrowest area of the tube which is closest to the uterus; because that location produces the best desired result. He then examined both tubes on both sides to ensure that the entire circumference of each of them was included in the clip.

84. According to his post operative notes, the defendant noted that both tubes were identified and a Filshie clip applied to each tube after proper identification.

85. However, Dr Ward says that when he performed the second tubal ligation on the first plaintiff, although he found evidence of a previous sterilization procedure in the form of two Filshie clips, they were not located where the defendant said he placed them. Instead Dr Ward reported that one of the Filshie clips was on the first plaintiff's mesosalpinx rather than on the right fallopian tube and the other, although on the left tube, occluded only part of the tubal lumen. Dr Ward's evidence in that regard was not challenged.

86. I, therefore, accept Dr Ward's evidence as to the location of the Filshie clips when he performed the second tubal ligation on the first plaintiff on 7 December 2009, and I find that the said Filshie clips were located as he described in his said operative report.

87. It is not disputed that where the Filshie clips were found by Dr Ward is not where they should have been placed in order to effect the first plaintiff's sterilization. The doctors all agreed that if the defendant had placed the Filshie clips where they were discovered by Dr Ward, he would not have performed the tubal ligation to an acceptable standard and would, therefore, have been negligent (*Bolam* case).

88. However, the defendant and the experts also say that where Filshie clips are found fourteen months after placement and following a full-term pregnancy is not necessarily an indication as to where they were originally placed, as Filshe clips, even those properly placed, migrate.

89. Indeed, Dr Ward, as the plaintiffs' expert witness, said it was "hard" for him to speculate on whether the clips were originally placed where he found them, because "it is well known that clips fall away from where they were placed". On another occasion, when asked by counsel for the defendant whether he was saying that the clips had been improperly placed fourteen months earlier, Dr Ward said: "I'm not saying that, I'm not implying that. No." Then, in response

to two other questions put to him by counsel for the defendant, namely: "Is it possible that these clips were properly placed there initially and by that time they had migrated? That is possible? Dr Ward said: "That is possible."

90. Now, counsel for the plaintiffs' argues that the clip once attached to the right tube could not fall away and re-attach itself to the mesosalpinx, and while I note his submission that the defendant also admitted this, I also note that when counsel for the plaintiffs asked Dr Ward whether the clip was "clamped" when he found it, Dr Ward responded: "it was closed".

91. In any event, the fact is that neither of the medical experts said, or even intimated, in my view, that it was impossible or even improbable for a clip, properly applied to the right fallopian tube, to have migrated from the tube on to the mesosalpinx. According to the defendant, the clip could move "within the tissue, the most adjacent tissue to it, that is, the mesosalpinx, so that it falls within the mesosalpinx. It has the ability to move even further or out of the mesosalpinx, off of the tube".

92. That evidence was not refuted by the plaintiffs or either of the experts.

93. I, therefore, accept that Filshie clips, even those correctly placed during a properly performed tubal ligation, migrate. In that regard, I also accept that the movement of the clips may be influenced by, inter alia, the natural movement of tissues within the body, as well as by pregnancy, but that the main cause of migration of such clips is necrosis of the tissue enclosed by the clip.

94. As I understand the doctors' evidence, once a tubal ligation using Filshie clips has been properly performed, the effect is to render the patient sterile immediately, although there may be a risk of an ectopic pregnancy. Thereafter, the fallopian tubes at the site of the clip undergo a process of necrosis, or rotting of the tissues as described by Dr Ward, as the blood supply to that area is disrupted.

95. If the defendant performed the surgery as he said he did, then the result should have been two fully occluded tubes, which should have undergone necrosis and eventually separate, leaving two gapped tubes with two healed and occluded stumps on either side. Thereafter, as I understand the evidence, the only way for the first plaintiff to become pregnant would be if the stumps migrated towards each other and re-attach or re-canalize, creating even the "most tiniest of openings" through which sperm and egg can meet.

96. According to the doctors, the possibility of re-canalization is one of the reasons sterility after a tubal ligation is not guaranteed. Hence Dr Leon's testimony that doctors inform their patients that there is an inherent failure rate in all tubal ligations, by whatever method, and then get them to sign a consent form in which it is expressly stated that sterility was not warranted.

97. The defendant says that he explained to the plaintiffs that sterilization could not be guaranteed and that they signed a consent form to that effect.

98. The plaintiffs say that the defendant did not explain the failure rate to them. However, the evidence is that they signed a sterilization permit, the contents of which each said they read and understood, in which it is expressly stated that sterilization, although a probable result, was not warranted. The plaintiffs are, therefore, in my judgment, bound by the terms of that document: L'Estrange v F. Graucob Ltd [1934] 2 KB 394).

99. Moreover, the plaintiffs' evidence is that they spoke to the defendant about success rates and I do not believe that the defendant would have told them about success rates without also telling them about the possibility of the procedure failing, since sterility could not be guaranteed.

100. It is not disputed that in order for the first plaintiff to have become pregnant with an intrauterine pregnancy there would have had to be an opening in at least one of her tubes. It is, however, unclear on the evidence whether a tube was open because it had notbeen occluded when the defendant performed the first tubal ligation or because the tubes, or either of them, although occluded had re-canalized, or, indeed, because of some other reason.

101. If, as contended, by the defendant the clips were properly placed by him and migrated, as he suggested, to the positions described by Dr Ward, then it seems to me that there should have been some evidence of necrosis or scarring on the fallopian tubes in the areas where the defendant says he placed the clips.

102. Conversely, if the clips had been placed where Dr Ward found them, I would have expected there to be some evidence of necrosis in the area of the clips, since the defendant and the experts say that the process of necrosis begins immediately a clip is affixed to the tube. Although there was some difference of opinion on the time frame for necrosis and possible re-attachment or re-canalization, it seems to me that fourteen months after the first tubal ligation, there should, as I said, have been some obvious signs of necrosis.

103. Therefore, in order to be able to make a determination whether the first plaintiff's third pregnancy was caused by the negligence of the defendant in the placement of the Filshie clips or the natural, but rare, phenomenon of re-canalization, the condition of the first plaintiff's tubes on 7 December 2009, that is, whether they were open and or un-occluded because they were not properly clipped or because they had re-canalized, would, in my view, have had to be known.

104. A person alleging negligence against a medical practitioner has to prove that the mishap he suffered was as a result of an error on the part of that medical practitioner and that the error

was one that a reasonably skilled and careful practitioner would not have made. It is, therefore, necessary for the plaintiff to establish how the mishap occurred and that he should provide expert evidence that any error made was a negligent error: Clerk & Lindsell17thEditionat paragraph 8-50.

105. As opined by Diplock, LJ in Sidaway v Governors of Bethlehem Royal Hospital *supra*:

> "In matters of diagnosis and the carrying out of treatment the court is not tempted to put itself into the surgeon's shoes; it has to rely upon and evaluate expert evidence."

106. In that regard, the duties and responsibilities of expert witnesses in civil cases were stated by Cresswell J. in "The Ikarian Reefer" [1993] 2 Lloyd's Rep. 69 at 81 as follows:

1) Expert evidence presented to the Court should be and should be seen to be the independent product of the expert uninfluenced as to form or content by the exigencies of litigation. (Whitehouse v Jordan [1981] 1 W.L.R. 246 at 256 per Lord Wilberforce).

2) An expert witness should provide independent assistance to the Court by way of objective unbiased opinion in relation to matters within his expertise (See Pollivitte Ltd v Commercial Union Assurance Co. Plc [1987] 1 Lloyd's Rep. 379 at 386, per Mr Justice Garland and Re J [1990] F.C.R. 192, per Mr Justice Cazalet). An expert witness in the High Courts should never assume the role of advocate.

3) An expert witness should state the facts or assumptions on which his opinion is based. He should not omit to consider material facts which detract from his concluded opinion (Re J supra).

4). An expert witness should make it clear when a particular question or issue falls outside his expertise.

5) If an expert's opinion is not properly researched because he considers that insufficient data is available then this must be stated with an indication that the opinion is no more than a provisional one (Re J supra).

6) If after exchange of reports, an expert witness changes his view on a material matter, having read the other side's expert's report or for some other reason, such change of view should be communicated...to the other side without delay and, when appropriate, to the Court.

7) Where expert evidence refers to photographs, plans, calculations, analyses, measurements, survey reports or other similar documents these must be provided to the opposite party at the same time as the exchange of reports".

(See also Notes to the 1997 English Supreme Court Practice 38/4/3)

107. As indicated, two experts, Dr Paul Ward and Dr Frumentus Leon, were called by the plaintiffs and the defendant respectively.

108. The experts agree that even with a properly performed tubal ligation, a patient may yet become pregnant without negligence on the part of the surgeon.

109. It was, therefore, in my view, important for this Court to be provided, so far as possible, with evidence as to what occurred at the time the defendant performed the aforesaid tubal ligation on the first plaintiff and whether or not the defendant's treatment of the first plaintiff met the acceptable standard.

110. Of course, the best person to provide that information would have been the defendant who performed the surgery and who, as Miss Tynes pointed out, was in a position to give an "eye witness" account. He, of course, denies that he was negligent or that there was any wrong doing on his part.

111. It seems to me, however, that in the absence of independent "eye witness" testimony, Dr Ward was, as it were, the "next best thing". I say that for a number of reasons. Firstly, Dr Ward was the first person to have the opportunity to inspect the first plaintiff's fallopian tubes and the surrounding areas after the tubal ligation performed by the defendant. Secondly, Dr Ward was aware that the first plaintiff had had a failed tubal ligation. He noted as much in his operative report. Thirdly, during his viva voce testimony Dr Ward said he was concerned as to why the first plaintiff became pregnant after having a previous sterilization. And fourthly, with his knowledge that clips migrate and the reasons for such migration, I expected that he would have examined the first plaintiff's fallopian tubes and document what he found.

112. His operative report is scant: "The left fallopian tube was held and tubal ligation done by a modified Pomeroy method...The Filshie clip on the left tube was noted to occlude only part of the tubal lumen. This clip was removed...The right fallopian tube was identified and a similar original procedure done. The Filshie clip was not on the right tube but on the mesosalpinx. The Filshie clip was removed."

113. Having noted in his said report that the indication for surgery was a failed previous sterilization, I expected Dr Ward to have provided a bit more information. For example, I expected him, as the expert and the doctor with the first opportunity to view the post-surgery condition of the tubes, to say whether there was any necrosis of the tubesor other indication that would suggest where the clips may have been placed originally; whether there was any scarring and/or any indication that the tubes had re-canalized. None of that information was provided.

114. Instead, Dr Ward, when asked by counsel for the plaintiff if he found any evidence of dead tissues relative to the right tube when he "went in there", responded: "I would have to refer to my notes and I'm going from memory. I really can't remember." He did not refer to any notes. And to the follow up question: "If there had been you would have noted?" Dr Ward responded,

"I noted Filshie clips. I was more concerned why this lady got pregnant and she had a previous sterilization".

115. In response to another question by counsel for the plaintiff as to whether he found any necrosis in the area where he found "this particular clip", Dr Ward responded "to be honest with you I did not make a note, but I did a lot of tubal ligations and I really can't honestly answer that question".

116. Counsel for the plaintiffs pointed out that the left clip was only partly occluding the tube and he suggested that that may have been the reason why the first plaintiff became pregnant after the first tubal ligation. He may be correct. However, the plaintiffs' expert witness refused to lay any blame at the defendant's feet for the position of that clip. His evidence in that regard is that the defendant could have performed the procedure correctly and the clip could have moved to where it was found. Indeed, when asked by counsel for the defendant whether he was saying that where he found the clips was where they were placed fourteen months earlier, Dr Ward made it very clear that not only was he not saying that, but that he was also "not implying" that.

117. Further, no evidence was led to show that the defendant did not meet the acceptable standard in his treatment of the first plaintiff or in his performance of the first plaintiff's first tubal ligation and although the experts agree that if the defendant had placed the clips where they were found by Dr Ward he would not have met the applicable standard, none of them could or would say that where the clips were found by Dr Ward is where they were placed, or likely placed, by the defendant.

118. Consequently, in my view, the plaintiffs have failed to establish by expert evidence that the first plaintiff's pregnancy was caused by the negligent error of the defendant.

119. Now counsel for the plaintiffs, in his written closing submissions, appears to have made certain assumptions or to have arrived at certain conclusions as to the condition of the tubes in December 2009, but I remind myself that counsel's conclusions and or arguments, no matter how persuasive or plausible, are not evidence on which this Court may rely.

120. For example, contrary to counsel for the plaintiffs' submissions, there was no evidence that Dr Ward found full length tubes when he did the second tubal ligation on the first plaintiff, although, no doubt, evidence to that effect would have been useful to this Court. Indeed, when counsel for the plaintiffs put that position to him, the defendant pointed out that Dr Ward had made no mention of full length tubes. Further, when counsel for the plaintiffs suggested to the defendant that "in 2009 the tubes had not been severed by rot or otherwise", the defendant

responded that "there is no documentation of that in Dr Ward's notes." Unfortunately, neither of those positions was put to Dr Ward.

121. As for counsel for the plaintiffs submission that the first plaintiff's fallopian tubes "were not completely severed", I note here that no such evidence was given by any of the doctors. Counsel for the plaintiffs may have been referring to the fact that Dr Ward noted in his report that the Filshie clip on the first plaintiff's left fallopian tube only partly occluded the tube. However, as I said, the plaintiff's witness said that it was possible for the clip to have been properly placed by the defendant and then moved to the position in which it was discovered by Dr Ward.

122. In light of the foregoing, I am constrained to accept the submission of counsel for the defendant that there is no evidence to support the plaintiffs' allegation of improper application of the Filshie clips on the 22 October 2008.

123. In my judgment, if the plaintiffs are not able to overcome that hurdle, that is, that the defendant negligently placed the Filshie clips where they were found by Dr Ward, then the plaintiffs' case must fail. Because, even if, which in my view, has not been proven, the position of the clips was the reason for the first plaintiff becoming pregnant after the first tubal ligation, in light of the evidence that even properly affixed Filshie clips migrate, coupled with the absence of any evidence as to the condition of the first plaintiff's fallopian tubes on 7 December 2009, I do not see how this Court can find, as alleged by the plaintiffs, that the first plaintiff's third pregnancy was caused by the defendant's negligence in causing or permitting only partial application of two clips to the fallopian tubes resulting in only partial occlusion thereof, whereby the plaintiff remained sterile.

124. There is no dispute that the tubal ligation performed by the defendant failed. As Dr Ward put it, if the end result was sterilization and the patient becomes pregnant, then the procedure failed. However, the plaintiffs admit signing the sterilization permit in which they accepted that while sterilization was the intended result of the operation, "no such result was warranted".

125. Therefore, in my judgment, in the absence of proof of negligence on the part of the defendant, the plaintiffs' claim against the defendant cannot succeed.

126. The plaintiffs' claim is, therefore, dismissed with costs to the defendants, to be taxed if not agreed.

Delivered this 18th day of December A.D. 2013

Estelle Gray Evans, J.