G.I.C.

IN THE PRIVY COUNCIL (12) 1961 No. 40 of 1959

ON APPEAL

FROM THE COURT OF APPEAL FOR EASTERN AFRICA

AT NAIROBI

B E T W E E N :

ROSETTA COOPER (Plaintiff) Appellant

- and -

1. GERALD NEVILL
2. KENYA EUROPEAN HOSPITAL ASSOCIATION (Defendants) Respondents

---

RECORD OF PROCEEDINGS

MERRIMAN, WHITE & CO.,
3, King's Bench Walk,
Inner Temple, London, E.C.4.
Solicitors for the Appellant.

LOVELL, WHITE & KING,
1, Sergeants' Inn,
Fleet Street, London, E.C.4.
Solicitors for the Respondents.

IN THE PRIVY COUNCIL No. 40 of 1959

ON APPEAL

FROM THE COURT OF APPEAL FOR EASTERN AFRICA

AT NAIROBI

B E T W E E N :

ROSETTA COOPER (Plaintiff) Appellant

- and -

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RECORD OF PROCEEDINGS

INDEX OF REFERENCE

PART I

PART II

E X H I B I T S

LIST OF EXHIBITS NOT TRANSMITTED TO THE PRIVY COUNCIL

Exhibit Mark	Description of Document
X	Bundle of Swabs
Y	Turkish towelling
I	Swab

DOCUMENTS TRANSMITTED TO THE PRIVY COUNCIL BUT NOT REPRODUCED

Judges Notes of Court of Appeal for Eastern Africa

Order granting conditional leave to appeal to Privy Council - 21st May 1959

IN THE PRIVY COUNCIL No. 40 of 1959

ON APPEAL
FROM THE COURT OF APPEAL FOR EASTERN AFRICA
AT NAIROBI

B E T W E E N :

ROSETTA COOPER (Plaintiff) Appellant

- and -

1. GERALD NEVILL
2. KENYA EUROPEAN HOSPITAL ASSOCIATION (Defendants) Respondents

---

RECORD OF PROCEEDINGS

No. 1

PARTICULARS OF CLAIM

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.1

Particulars of Claim,

29th June 1957

IN HER MAJESTY'S SUPREME COURT OF KENYA AT NAIROBI

CIVIL CASE NO. 808 OF 1957.

L.Q.T. COOPER	.. .. ..	FIRST PLAINTIFF
MRS. R. COOPER	.. .. ..	SECOND PLAINTIFF
	versus	
G. NEVILLE	.. ..	FIRST DEFENDANT
KENYA EUROPEAN HOSPITAL ASSOCIATION	.. .. ..	SECOND DEFENDANT

P L A I N T.

1. The First Plaintiff resides at Limuru and his address for service for the purposes of this suit is care of Sirley & Kean, Advocates, Princes' House, Government Road, Nairobi.

2. The Second Plaintiff is the wife of the First

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.1

Particulars of Claim,

29th June 1957 - continued.

Plaintiff and her address for service for the purposes of this suit is care of Sirley & Kean, Advocates, Princes' House, Government Road, Nairobi.

3. The First Defendant is a Surgeon having his office at Sirona House, Nairobi, and his address for service for the purposes of this suit is care of Daly & Figgis, Advocates, Northey Street, Nairobi.

4. The Second Defendants inter alia manage and maintain the Nairobi European Hospital and their address for service for the purposes of this suit is care of Messrs. Archer & Wilcock, Advocates, Mutual Building, Hardinge Street, Nairobi.

5. On or about the 1st February 1956 the First and Second Plaintiffs retained and employed the First Defendant as surgeon for reward to operate on the Second Plaintiff for a rupture of an ectopic tubal pregnancy.

6. The said operation was performed at the said Nairobi European Hospital. The First Defendant was assisted by a Nurse or Nurses the servant or servants or agent or agents of the Second Defendant.

7. By reason of the negligence of the First Defendant and by reason of the negligence of the said servant or servants or agent or agents of the Second Defendant or alternatively by the negligence of one or other or others of them a abdominal swab was left in the body of the Second Plaintiff.

PARTICULARS OF NEGLIGENCE OF FIRST DEFENDANT

Failing to count the number of swabs used in the operation and to check that the correct number of swabs was removed from the body of the Second Plaintiff; failing to instruct the said Nurse or Nurses to keep a check on the number of swabs used and/or failure to personally counter-check the number of swabs, failure to observe that one swab remained in the body of the Second Plaintiff.

PARTICULARS OF THE NEGLIGENCE OF THE AGENT OR AGENTS OR SERVANT OR SERVANTS OF SECONDD DEFENDANT

Failure to count the number of swabs used in the said operation; failing to detect that one swab had not been removed in accordance with instructions

given by the First Defendant or in accordance with usual practice.

8. By reason of the negligence aforesaid the Second Plaintiff has suffered great pain and permanent injury and the First and Second Plaintiffs have incurred great loss and expense for medical and surgical attendance and otherwise.

PARTICULARS OF PAIN AND SUFFERING OF SECOND PLAINTIFF

Pain and suffering for nine months after the date of the said operation; and pain and suffering in the course of and as a result of an operation on 29th October 1956 to remove the said swab, including forty six days spent in hospital in connection with removal of the said swab; further pain and suffering up to the date of filing this action and possibility of future pain and suffering.

PARTICULARS OF INJURIES OF SECOND PLAINTIFF

Removal of six feet of intestine; abscess as a result of the said swab; sinus from the wound; generally undesirable effect from the point of view of the future life of the Second Plaintiff of having had one third of the small intestine removed.

By reason of the premises the First Plaintiff lost the society and service of the Second Plaintiff for the period hereinbefore mentioned and was put to the expense hereinafter mentioned.

PARTICULARS OF EXPENSE AND LOSS OF BOTH PLAINTIFFS

Contained in the statement marked "A" annexed hereto.

10. The cause of action is within the jurisdiction of this Honourable Court.

WHEREFORE the FIRST PLAINTIFF claims against the Defendants or one or other of them:

Damages for loss of consortium.

WHEREFORE the SECOND PLAINTIFF claims against the Defendants or one or other of them:

Damages for pain and suffering and injuries.

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.1

Particulars of Claim,

29th June 1957 - continued.

WHEREFORE BOTH PLAINTIFFS claim against the Defendants or one or other of them:

1. Shs.10,858/05 special damages.

2. Interest at Court rates.

3. Costs of this suit and in the event of one Defendant being found not liable costs of the Defendant so found not liable to be paid by the Defendant found liable.

DATED at NAIROBI this 29th day of June 1957,

(Sgd) L. Kean
SIRLEY & KEAN
Advocates for the Plaintiffs.

PARTICULARS OF EXPENSE

1st February 1956	Paid to Joseph	Shs.	80.00
" " "	" " Gillespie		100.00
21st February 1956	" " European Hospital		873.75
26th February 1956	" " Lowes		200.00
31st March 1956	" " Spiers		105.00
24th April 1956	" " Hopkirk		80.00
27th April 1956	" " Preston		210.00
8th May 1956	" " Maia Carberry Nursing Home		80.05
10th May 1956	" " Dr. Nevill		510.00
26th June 1956	" " Dr. Nevill		600.00
July 1956	" " Laylord		694.50
9th October 1956	" " Dr. Nevill		900.00
15th August 1956	" " Lewison		105.00
13th September 1956	" " Thompson		195.00
3rd December 1956	" " European Hospital		1226.75
13th December 1956	" " European Hospital		405.00
3rd December 1956	" " Thompson		550.00
6th November 1956	" " European Hospital		15.00
22nd January 1957	" " Dr. Carman		300.00
29th January 1957	" " Dr. Hopkirk		180.00
31st January 1957	" " Dr. Thompson		30.00
15th February 1957	" " Dr. Barber		1663.00
25th February 1957	" " Dr. Thompson		45.00
11th March 1957	" " Laboratory of Clinical Medicine		310.00
		Shs.	9458.05

PARTICULARS OF LOSS

Loss of profit from poultry farm	Shs.	1400.00

No. 2

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.2

Particulars of Defence of the First Defendant, 27th July 1957

PARTICULARS OF DEFENCE OF THE FIRST DEFENDANT

IN HER MAJESTY'S SUPREME COURT OF KENYA

AT NAIROBI

CIVIL CASE NO. 808 OF 1957

L.Q.T. COOPER	.. ..	FIRST PLAINTIFF
MRS. R. COOPER	.. ..	SECOND PLAINTIFF
	versus	
G. NEVILL	.. .. ..	FIRST DEFENDANT
KENYA EUROPEAN HOSPITAL ASSOCIATION	.. ..	SECOND DEFENDANT

DEFENCE OF THE FIRST DEFENDANT

1. Paragraphs 1, 2, 3, 5 and 6 of the Plaint are admitted.

2. The First Defendant denies that he was negligent as alleged or at all.

3. The First Defendant does not admit that any swab was left in the body of the Second Plaintiff as alleged or at all.

4. The alleged injuries, loss and damage are not admitted.

5. Save as is expressly admitted herein, the First Defendant denies each and every allegation contained in the Plaint as though the same were set out herein and traversed seriatim.

WHEREFORE the First Defendant prays that this suit be dismissed with costs.

DATED at NAIROBI this 27th day of July 1957.

(Sgd) A.E. HUNTER
for DALY & FIGGIS
Advocates for the First Defendant.

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.3

Particulars of Defence of the Second Defendant,

29th July 1957

No. 3

PARTICULARS OF DEFENCE OF THE SECOND DEFENDANT

IN HER MAJESTY'S SUPREME COURT OF KENYA

AT NAIROBI

CIVIL CASE NO. 808 OF 1957

L.Q.T. COOPER		FIRST PLAINTIFF
MRS. R. COOPER		SECOND PLAINTIFF
	versus	
G. NEVILL		FIRST DEFENDANT
KENYA EUROPEAN HOSPITAL ASSOCIATION		SECOND DEFENDANT

DEFENCE OF THE SECOND DEFENDANT

1. Paragraphs 1, 2, 4, 5 and 6 of the Plaint are admitted.

2. The Second Defendant denies that the Association was negligent as alleged in the Plaint or at all.

3. The Second Defendant denies that any mopping-Swab was left in the body of the Second Plaintiff as alleged in paragraph 7 of the Plaint, or at all.

4. The alleged injuries, loss and damages are not admitted.

5. Save as is expressly admitted herein the Second Defendant denies each and every allegation contained in the Plaint as though the same were set out herein and traversed seriatim.

WHEREFORE the Second Defendant prays that this suit be dismissed with costs.

DATED AT NAIROBI THIS 29TH DAY OF JULY, 1957.

ARCHER & WILCOCK
Advocates for the Second Defendant.

Copy to:
MESSRS. SIRLEY & KEAN,
Advocates for the Plaintiffs,
Princes House,
Government Road, Nairobi.

MESSRS. DALY & FIGGIS,
Advocates for the First Defendant,
Northey Street, Nairobi.

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.4

Notice of Amendment to Particulars of Claim,

16th January 1958

No. 4

NOTICE OF AMENDMENT TO PARTICULARS OF CLAIM

SIRLEY & KEAN.
ADVOCATES

Princes House,
Government Road,
NAIROBI.

Ref: BS/2424.

16th January 1958.

Messrs. Archer & Wilcock,
Advocates,
NAIROBI.

Messrs. Daly & Figgis,
Advocates,
NAIROBI.

Dear Sirs,

Re S.C.C.C. No. 808 of 1957
L.Q.T. Cooper & Mrs. R. Cooper
vs. G. Neville & Kenya European
Hospital Association.

We write to advise you that at the hearing of this case, we shall apply to delete the word "mopping" before the word "swab" in Paragraph 7 of the Plaint.

In order to clarify the matter, we would add that from our instructions, it appears that a swab used either for packing or mopping was left in the body of the second Plaintiff.

Yours faithfully,
for SIRLEY & KEAN

(Sgd) L. Kean.

No.5

Notes of Proceedings,

15th July 1957 to 27th January 1958

No. 5

NOTES OF PROCEEDINGS

15th July 1957

2nd Defendant, Kenya European Hospital Association, appears by Messrs. Archer & Wilcock, Advocates, Nairobi.

J. Chambers
Dy. Registrar.

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.5

Notes of Proceedings, 15th July 1957 to 27th January 1958 - continued.

16th July 1957

Defendant No. 1 G. Neville, appears by Messrs.Daly & Figgis, Advocates, Nairobi.

J. Chambers
Dy. Registrar.

29th July 1957

Defence of 2nd Defendants filed by Messrs. Archer & Wilcock, Advocates, Nairobi.

J. Chambers
Dy. Registrar.

30th July 1957

Defence of 1st Defendant filed by Messrs. Daly & Figgis, Advocates, Nairobi.

J. Chambers
Dy. Registrar.

16th August 1957

Bhan Singh for Messrs. Sirley & Kean - Plaintiffs.
H.P. Dave for Archer & Wilcock - 2nd Defendant.

Bhan Singh: Daly & Figgis represent 1st Defendant - duly warned but not present. Order 9 rule 9(1).

By Consent of Sirley & Kean and Archer and Wilcock hearing fixed for 27, 28 and 29 January, 1958, 10.30. Notice to be served on Daly & Figgis on payment of fees.

J. Chambers
Dy. Registrar.

13th December 1957

Call over.

Kean. Kalsi. Three days. Case to stay in the list.

J. Chambers
Dy. Registrar.

20th January 1958

Call over.
Mrs. Kean.

Hunter also representing Archer & Wilcock. Case fixed for 17.1.58 - but will be heard if a Judge is available to hear it.

B.R. Miles, Judge.

27th January 1958

Coram Miles J.
Mrs. Kean for Plaintiffs.
C.W. Salter Q.C. and Hunter for 1st defendant.
R.D. Wilcock for 2nd defendant.

Mrs. Kean opens:

At an operation a swab left inside body of 2nd plaintiff. Plaintiffs alleged this due to negligence of 1st defendant or similarly of 2nd defendants or partly of both.

Law. No law. Each case on own facts. Urry v. Bierer and others. Times 16.3.55.

Duty of nurse. Maitland p.86. Surgeon should have detected that one swab not accounted for. Small number. He should have counted in this case. I ask leave to amend plaint by deletion of "mopping" in para. 7.

Salter. Defendants should know number of swabs left. Two kinds of swab, (1) gauze, (2) packing swab. It would be of assistance if plaintiff told us what kind of swab left in body.

Kean. Each hospital has own system. Two kinds of swab, (1) abdominal, normally used for packing. Types vary. May be used for mopping if unusual amount of mopping; (2) mopping swab - much smaller. Particular swab was an abdominal swab. I ask for "abdominal" to be obliterated.

Salter. If it is clear that this is a type of swab which might be used for mopping or swabbing, I have no objection to amendment.

Order. Plaint amended by substitution of "abdominal" for mopping in paragraph 7.

Kean. 2nd plaintiff discharged from hospital. Unwell for considerable period. Defence is - Surgeon - acute attack - sent to Maia Carberry Nursing Home from 5th to 7th May 1956. Cause not diagnosed. On

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.5

Notes of Proceedings, 15th July 1957 to 27th January 1958 - continued.

28.10.56 plaintiff became seriously ill. Admitted to New European Hospital. Great pain 3 or 4 days. Cause not diagnosed. Operation by Mr. Barber. 6 - 8 feet of small intestine removed. Found obstruction was a swab. Major operation. Mortal danger to plaintiff - 46 days in hospital. Propose to call medical evidence first. Mr. Barber has to operate to-morrow. Also other doctors are busy. This will assist development of plaintiff's case.

No objection by Salter or Wilcock.

Issues. I frame issues as follows:

(1) Whether a swab was left in the body of the 2nd plaintiff in the course of the operation performed by the 1st defendant.

(2) If so, was that fact due to negligence on the part of the 1st defendant.

(3) If a swab was left in the body of the 2nd plaintiff, was this due to negligence on the part of the 2nd defendant.

(4) Was there negligence on the part of both defendants.

(5) To what damages (if any) are the plaintiffs or either of them entitled.

Plaintiffs' Evidence.

No.6

W.C. Barber - Examination.

No. 6

EVIDENCE OF WILFRED CARLISLE BARBER

P.W.1 - WILFRED CARLISLE BARBER, Christian sworn:

Examined Mrs. Kean. I practise as a consulting surgeon. I am a Bachelor of Medicine and Surgery of Cambridge University and a Fellow of the Royal College of Surgeons of England. I have had my fellowship for 23 years. I performed an operation on Mrs. Cooper, the 2nd plaintiff, on the 1st November 1956. Mrs. Cooper was suffering from intestinal obstruction. On opening the abdomen I found an abscess cavity centrally situated surrounded by ahderent coils of small intestines. There was a localised peritonitis. This means inflammation of

the lining of the abdominal cavity. I tried to determine which portion of the adherent intestine might be causing the obstruction, and I endeavoured to separate one or more of the adherent coils, but I found in doing this that it resulted in leakage of the bowel content and as there were so many adherent areas, I decided that the safest plan would be to remove the whole of the affected portion of the bowel. Afterwards I measured it; it was approximately 7 feet. I felt something in the piece of bowel I removed. I handed it to others who took it outside the theatre and who subsequently informed me what they found. I handed the piece of bowel to Dr. Thompson and the theatre sister, Sister Banks. It was an abdominal pack or swab. I looked at it, saw it was stained with bowel contents. I couldn't say if it had a tape or not. I didn't measure it, but think it would be about 9 inches by 7 inches. They are not standard sizes. They vary 2 or 3 inches each way. That is roughly the average size used generally. The general size is used in the European hospital here, for abdominal packing or mopping. The pack was made of something that looked like Turkish towelling. That is the usual material used for packs of that type at the European hospital. I saw it in Dr. Thompson's hand as a soft lump of material, not spread out. I think it was the definite final cause of the obstruction and of the abscess. Localised peritonitis is the same as an abscess in the peritoneal cavity. The adhesions were caused by inflammation of the loops of the intestines. That inflammation, it would be reasonable to suppose, was set up by the presence of a foreign body. Mrs. Cooper was suffering from an intestinal obstruction which had become acute and which, unless relieved, would inevitably cause death. It would be a question of days. The operation I performed was definitely a major operation. There were risks to Mrs. Cooper's life and health attaching to the operation. There was the risk of general peritonitis. It made the outlook much more serious, though not necessarily fatal. There was the risk of leakage from the intestine where it had been joined together. It might lead in itself either to peritonitis or the formation of a track discharging somewhere on the surface of the body, a fistula or sinus. The fistula would prolong the convalescence. There is a mortality rate in all major operations. Various complications can follow a major abdominal operation, e.g. chest

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs' Evidence.

No.6

W.C. Barber - Examination - continued.

complications and formation of clots in blood vessels. This was not a "clean" operation because there was peritonitis. I can't remember the exact number of days Mrs. Cooper spent in hospital as a result of this operation. It was 5 or 6 weeks. I was attending her continuously until she left hospital. She certainly had a great deal of pain in the few days immediately following the operation. She developed a fistula which required additional treatment. She developed an abscess in the pelvis which resolved without surgical intervention. The fistula was treated by a "sucker" and creams to protect the surrounding skin. It eventually closed itself before she left hospital but she had a discharging sinus from where a drainage tube had been left in. It closed and broke down again I believe but did not see it except just after Mrs. Cooper left hospital. I don't know that she has any adhesions now at all. Adhesions are a common cause of intestinal obstruction. I can't rule out adhesions developing. The vast majority of abdominal operations do not result in the development of adhesions but there is always the possibility in any abdominal operation. There are approximately 22 feet of small intestine. I would say that she has probably got sufficient for normal digestive purposes but the amount lost is about the borderline amount which might lead to ill-effects. If further trouble developed I think that if she lost more than a third it would have some effect on her digestive ability. I think a patient might manage with half the length of small intestine with little or no digestive disturbances but they would probably have more frequent bowel action than normally. I know the patient's previous history of operations and I thought it very likely that the husband would ask me what the cause of the condition had been. I rang up Mr. Nevill and explained what I had found to him, and said that if I were asked what the cause of the trouble had been I would have to inform the relative, the husband. Mr. Nevill agreed that this was the correct method of procedure. I knew she had had an operation performed on her by Mr. Nevill for the rupture of an ectopic tubal pregnancy. I was aware that a previous operation had been performed on Mrs. Cooper by Mr. Preston. I was informed of its nature. I understood it to be the re-implantation of the ends of the Fallopian tubes and uterus and the insertion of polythene tubing. I contacted Mr. Nevill because the last operation

the plaintiff had had was about 10 months previously and during that time I had received some information. I thought it likely that this swab was left in at the previous operation. If a swab of this type was left in a patient, in the few cases I have seen in 20 years, symptoms have usually developed in a few months or even weeks.

Q. Assuming Mr. Preston's operation was carried out in February 1955 and further that from the period February 1955 until Mr. Nevill's operation on 1st February 1956 Mrs. Cooper had no symptoms of any foreign body having been left inside her, does that or does it not for all practicable purposes, rule out the possibility of the swab having been left in in the operation of February 1955?

A. I cannot say with absolute certainty that that would indicate that the swab was left in at the second operation, but I think it very likely that it was.

In the European Hospital provided the theatre is not in use, I have operated there on many occasions on half an hour's notice. The instruments have to be sterilized, the trolleys set out, the materials for sewing and tying, the swabs and packs set out. In my experience half an hour is sufficient for that. The instruments are kept partly on a wheeled trolley and partly in an oven - tapes on the patient's legs in an abdominal case or on the patient's lower abdomen or other surface in the course of the operation. The bed is a great deal wider than the operating table. There is a greater area to be covered with towels and it would make it a good deal more difficult for everybody concerned because (1) one is stooping, which is tiring, (2) the patient is further away from you. Those are the main disadvantages. The instruments and swabs would be on the tables and trolleys as usual. Abdominal packs are inserted into the abdominal cavity for the purpose of exposing the particular place upon which the surgeon wishes to operate by keeping other obstructions out of the operating field. They are also used when there is a great deal of blood or other fluid which has to be removed from the abdominal cavity. Those are the two main uses. If used for the second purpose they would be used for the function of mopping or swabbing. One would retain it in one's hand. In packing proper for the first purpose depending on the size, I myself if

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs' Evidence.

No. 6

W.C. Barber - Examination - continued.

wanting to expose the uterus, would use anything between one and three. These packing swabs would be placed by the surgeon himself in the body of the patient. In the European Hospital by my own observation and knowledge, when the theatre is being prepared for an operation case a qualified member of the theatre staff, but not as a rule one who is going to take the case, prepares the trolleys and places on them bundles of swabs and packs from sterile drums. Before the operation commences the sister who is taking the case breaks the stitches in the bundles of swabs and counts them. The large abdominal packs are usually put in bundles of three. The small gauze swabs in bundles of 10 or 12. It varies with different theatre sisters. I can't say from memory what size they use in the European Hospital. If further packs or swabs are required during the course of the operation the contents of the bundle are again checked by the sister before she starts giving them to the surgeon. All swabs and packs as they are discarded are laid out individually in rows on the floor of the theatre where the sister can see them and count them. At the end of the operation and before the closure of the wound is commenced, the sister will either inform the surgeon that the count is correct, or the surgeon, if she has not done so, will ask her if the numbers are correct. This check applies to every swab taken into the original count whether it has been used or not. It is known to surgeons that in the case of an abdominal operation there is a risk of a swab being overlooked by being unaccounted for by being left in the body. If I leave a pack in the abdominal cavity I fasten an artery forceps to the tape which is at the corner of the pack or if there is no tape I fasten an artery forcep to the corner of the pack itself. At the European Hospital the packs are used with tapes. It is my routine when I use abdominal packs. It maybe that the sister hands it to me with a forcep attached but usually I clip it to the forcep myself. Alternatively I may hold up the tape and the sister clips it on for me. This is the same as a "Spencer Wells Artery forcep". The smaller ones are about 5" long; they look like scissors with ring handles and jaws. The locking catch is a ratchet with two or three teeth. The tapes with the artery forcep on the end hangs outside the wound on the patient's body surface. If there were no tape one would leave a corner of the pack sticking out of the wound. If I were using

a swab for mopping I would not attach a forceps. I would keep it in my hand and hand it to the sister or throw it on the floor after use. I have never come across the practice that the sister herself is responsible for fastening a forceps on the swab. If I were using the swab for mopping the forceps would get in the way. A mopping swab would not leave my hand until I decided to use it as a packing swab, in which case I would attach an artery forcep. You get hold of the nearest piece that presents itself to extract the swab and gently ease the whole thing out. I usually grasp the pack itself and not the tape. If I have put in packs in an abdomen I do a mental count of the packs when I insert them. I keep the mental count in my mind and I expect to find the same number when I remove them at the end of the operation. I think if one knows in a big operation that one has used a number of packs I do sub-consciously feel round the area in which I have been working but I can't say that this is a conscious search. I do this because I might be afraid I might leave one behind. This feeling takes a second or two. I do not make a general search of the whole abdomen for packs. It might take half a minute to do that. Packs always move in the course of an operation further from the original manipulations and partly as the result of movements of the intestine brought about by the patient's breathing. This happens in every case. The count carried out by the sister is fallible. This is well known to surgeons. A Spencer Wells has disappeared inside the abdominal cavity too. I think that every surgeon knows that there have been cases on record of an instrument being left in the abdominal cavity. I can't recall a clip being detached from the tape. The packs are made I think, by the members of the theatre staff or supervised by them. The checking of the instruments is done by the qualified nursing staff in the theatre. When the swab was discovered Sister Banks was most upset. My operation was done at the Nairobi European Hospital. I don't know how much blood there was in Mr. Nevill's operation so I could not estimate how many swabs would be needed for mopping. Some hospitals use racks with little hooks and put swabs on that. A surgeon always takes out the swabs which he has placed in the wound except that if he is working with an assistant, other than a sister, the assistant might pull one out. The assistant might be qualified or a theatre sister or a medical student. Sometimes

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs' Evidence.

No.6

W.C. Barber - Examination - continued.

one has to finish an operation as rapidly as possible because of the patient's condition. If the patient's condition was not critical and one to three swabs were being used, I would withdraw the number of swabs I thought I had put in the abdominal cavity.

To Court. If there is a lot of fluid or blood flowing in the abdominal cavity the large swabs or packs are used for mopping. I could not say whether the pack which was found was used for mopping or packing.

Adjourned to 2.15 p.m.

2.15 p.m.

P.W.1 further examined.

BY COURT.

By Court.

To Court. In a very small operation the smaller swabs might be used for packing but not in the abdominal cavity. The swab I found was as thick as an ordinary bath towel.

CROSS-EXAMINED.

Cross-Examination.

Cross-examined Salter. There is a check by the person who makes the packs up, secondly by the person who puts them in the drum and thirdly by the sister who takes the case. They may be placed on the trolley by somebody else for her but she checks them. In the European hospital so far as I know, the packs have always been put up in bundles of three. All those packs that I have used in the European Hospital have a tape attached to them. They are laid out on a mackintosh on the floor of the theatre when they have been used. They are laid out by somebody who has not scrubbed up so that the theatre sister can check them. The large ones if made up in bundles of three would be laid out in threes. The theatre sister sees a bundle come in and counts them. I would agree that the system in use at the European Hospital is a good one so far as these packs are concerned. I have operated when that system was in use on many occasions. I place reliance on that system. I know Sister Banks. She has been theatre sister at the European Hospital for about 3½ years I think. She has carried out those duties when I have been

operating myself. I think I can say I haven't seen a more conscientious theatre sister in the time I have been doing surgery. I agree entirely that Mr. Nevill is a very highly qualified surgeon and of considerable ability. I don't think that if the surgeon and staff followed the system I have described that they could do any more. It is an accepted accounting system in surgical circles. With a surgeon and sister of that experience it is second nature to follow that system. I was informed that Mrs. Cooper had an operation in February 1955. I have been told it was carried out in the Princess Elizabeth Hospital. I had done an occasional case there in 1955. I cannot recall whether packs there always had tabs on. I only operated there perhaps once or twice a year. I can't remember whether packs are laid out on the floor or on racks there. The system of counting in every operation is the same. If I were told that on 1st February 1956 Mrs. Cooper was pulseless and had to be given 6½ pints of blood in an hour, I should say she was as near death as anyone could be. One would only operate on a patient in a bed if her condition was very serious. One would think that the movement would be a factor in making her more collapsed than she already was. If Mr. Nevill said that there was no bleeding or pressure when he made his incision I would conclude that the patient was in a very severe state of shock or collapse. Four pints of blood sucked out from the body into bottles would indicate a severe degree of haemorrhage. Two pints of blood drawn out by packs is a very large amount indeed. I would describe an operation on a patient in this condition and in bed as an extremely difficult and hazardous operation. It would reflect a great deal of credit on the surgeon and nursing staff if it were successful. I think Mrs. Cooper might consider herself fortunate to be alive to-day. It would be necessary to use a large number of large packs to scoop out this amount of blood. It could be as many as 20. The surgeon would be anxious to find the source of the bleeding as rapidly as possible. It is possible that he would have to hold the source of the haemorrhage with his left hand while using his right to scoop. There would be no need to let go the pack with which he was scooping. Packs would be used to give the surgeon a clear field in which to tackle the source of the haemorrhage. It would be normal for sewing up the uterus to use up the three packs. It would be my procedure to have a tape and a Spencer Wells on these

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs' Evidence.

No.6

W.C. Barber - Cross-Examination - continued.

packs. I would expect Mr. Nevill would probably memorise the three packs he had placed in, not the ones he used for mopping. It does happen that the theatre sister informs the surgeon that the count is correct before the surgeon asks. Sister Banks has done that when I have been operating. Invariably the surgeon would ask if the sister did not tell him first. There were a series of loops of intestine all stuck to each other forming the walls of a cavity. I came to the conclusion that it would be better to remove that part and join up the healthy part. The bowel was distended but as I felt it after deciding excision would be safer, I felt a thicker mass inside one of the loops of the bowel. I handed the specimen out and continued with the operation. The part I excised was not actually out of the abdomen. Later I felt the object. It was after I decided to excise the affected portion. I handed it to somebody standing at the side. I can't remember whether it was Dr. Thompson or Sister Banks. I think it was one of those two but I am not 100% certain. Dr. Thompson was not taking part in the operation but was in the theatre. There were the anaesthetist, the theatre sister and another sister. I can only remember two sisters by number. I don't remember the name of the sister taking the case. It might have been Sister King. Dr. Thompson came back into the theatre and showed me what he had found in the specimen. As far as I recollect he brought the swab into the door of the theatre. I examined it afterwards. I have no doubt that it was in the bowel. I had no doubt as I passed it out that there was a foreign body in the intestine. It was heavily stained with bowel content. It was causing intestinal obstruction. It would not have been possible for it to have passed along the intestine from the bowel in which it was lying. I saw it as a floppy piece of material in Dr. Thompson's hands. I saw it flattened out in a dish afterwards. Sister Banks was in the sluice where the specimen had been placed. I looked at the material. I did not pay particular attention to it. I came to a conclusion about it and gave it no further thought. Eventually it was thrown away, not on the day of the operation. Sister Banks asked me if I wanted it kept. I said "No". I have had experience of metallic foreign bodies remaining in the body for an indefinite period of time without causing any harm. One often uses material such as silk and leaves it inside the abdominal cavity for the rest of the patient's life.

It depends on the material how long it would take to ulcerate. I have never met a case when material such as Turkish towelling had remained quiescent for a long period. I have no experience of such a thing happening. I think it might be possible. I think it might be possible for it to remain quiescent in the abdominal cavity. It might start causing irritation if disturbed when it had not caused irritation previously. I balanced the situation and thought it was the best thing to excise 7 feet of intestine. I do attach importance to the loss of 1/3 of an organ but I think she can compensate with the remaining 2/3 satisfactorily. As far as her nutrition is concerned, I think it has been satisfactory. That is a reason why she should not become pregnant. There is a possibility that her remaining tube is thickened. It may be blocked as the result of any operation that has occurred within the peritoneal cavity or any catastrophe. It is not utter nonsense that as a result of the effects of the swab being left she cannot become pregnant. If a s a result of the peritonitis caused by the swab the tube is blocked she cannot become pregnant. I do not know whether the tube was blocked before. As to whether she should or should not attempt to become pregnant, it depends on the psychological effect on Mrs. Cooper. There was an abscess cavity with loops of bowel. Any one of those loops could cause obstruction or could be the site of obstruction. The portion of the bowel I removed was very firmly filled by a mass which I think was the pack. When closing up the wound I don't do a general search. It would be harmful in certain cases to do this. It is not considered necessary in view of the routine practice. It is not desirable to handle the organs more than necessary. It is correct that in Mrs. Cooper's condition at the operation by Mr. Nevill, the sooner the wound was closed the better.

To Court. I don't think Mr. Nevill would have seen the pack if it had been left there at the time of the operation by Mr. Preston because the abdominal cavity contained six pints of blood. It is almost certain that it would have been hidden somewhat by coils of intestine. I did not see it because it was inside the intestine.

Wilcock states that generally he will adopt the cross-examination of Salter.

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs Evidence.

No.6

W.C. Barber - Cross-Examination - continued.

Cross-examined Wilcock. As far as I recollect there was a sister helping me. Sister Banks was in the theatre but not taking part in the operation. She was not scrubbed up. There was a theatre sister taking the case. She would be scrubbed. I can't remember the reactions of the sister in charge when this swab was found. Everybody was upset.

RE-EXAMINED.

Re-Examination.

Re-examined. This pack could not have been evacuated through the rectum. The patient may have been better but only relatively better. No patient who has lost six pints of blood will be "better" for two or three days. The sooner an operation on a patient in that condition is finished the better. The "subconscious feel" would not harm the patient. If you felt a pack there you would certainly take it out. If you were certain that you had put three packs in and only two had come out, you would go on looking till you found the other in any circumstances. The loss of seven feet in some people might affect their nutrition. In other cases they might notice no ill-effects whatsoever. I formed the opinion that there was an abscess cavity localised centrally in the abdomen caused by the pack which was removed from the bowel, that loops of bowel had become adherent round the abscess cavity and that the pack had ultimately ulcerated through into the lumen of the intestine. The "conclusion" was that this was a pack left in at an operation and that it had been the cause of the obstruction for which I operated on Mrs. Cooper.

No.7

G.C. Dockeray - Examination.

No. 7

EVIDENCE OF GERALD CECIL DOCKERAY

P.W.2 GERALD CECIL DOCKERAY, Christian, sworn:

Examined Mrs. Kean. I am M.D. (Dublin), M.S.Sc. Fellow of Royal College of Physicians, Ireland. I am now engaged in pathology. I was Kenya Government

Pathologist for five years. I was requested by Mrs. Cooper's legal adviser to have a consultation with Dr. Thompson and Mr. Barber relating to Mrs. Cooper's condition. I had a consultation on 28th March 1957. As a result I was acquainted with Mr. Preston's, Nevill's and Barber's operations as told to me by Dr. Thompson. If a piece of Turkish towelling of the size described was left in the abdomen of a patient, I have had no personal experience of this, but from my knowledge of the literature on the subject, I would expect a piece of towelling of that nature to give trouble within a few weeks or a few months. In one case I read of it was something like nine months. I think it is a theoretical possibility that the material could have been left in at the time of Mr. Preston's operation and not shown any symptoms until the time of the operation by Mr. Nevill, but I think it is very improbable. It would make the patient feel depressed possibly or hypochondriacal. People with abdominal symptoms tend to be gloomy. As a result of the swab operation we don't know what adhesions were present or if there were we don't know whether they were the result of the ectopic or the operation of Mr. Barber. My personal opinion is that her chance of pregnancy even after Mr. Preston's operation were very poor indeed. Her tubes must have been defective by chronic inflammation. I have known the threading of such tubes where the person got an "ectopic" in one of the tubes and that is the sort of thing one would expect. She has only one tube now but with any chronic inflammation even without an operation there is a chance of an ectopic pregnancy. It is harder for the egg to get down the tube. As soon as an operation of the type performed on Mrs. Cooper has taken place there is a chance of an ectopic pregnancy.

No. 8

NOTES OF PROCEEDINGS

Salter. I object. This is not pleaded.

Kean. This goes to general damages.

Court. I cannot take this into account in assessing damages.

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.8

Notes of Proceedings,

27th January 1958 - continued.

A. I have listened to Mr. Barber's evidence on the effect of removal of seven feet of intestine and am in agreement with what he said. I heard Mr. Barber's evidence on Mrs. Cooper's pain and suffering and I agree with what Mr. Barber said.

Plaintiffs Evidence.

No.9

No. 9

EVIDENCE OF GERALD CECIL DOCKERAY
(Continued)

G.C. Dockeray (continued) - Cross-Examination.

Cross-examined Salter. I have been in Court; I heard most of Mr. Barber's evidence. I am familiar with Van Wyk's case. I reviewed Gordon, Turner & Price's Medical Jurisprudence, 3rd Edn. (p.139/140). That was a case where no discomfort was felt for twelve months. I think there is a theoretical possibility that a swab could remain in such a position as to cause no symptoms for 12 months. It was a large packing swab in Van Wyk's case. If it were disturbed in a second operation it could cause trouble. A maximum time could be fixed for ulceration, i.e. up to two or three months. I don't think you could fix a minimum time. It would be quite reasonable to expect a symptom within two or three months of the disturbance. It might go on for six months, or longer. It is not within my experience that a swab remained without causing any symptoms.

Cross-examined Wilcock. No questions.

RE-EXAMINED

Re-Examination.

Re-examined. I agree with the medical evidence that Van Wyk's case was exceptional. I do not know of any other case where a swab was left for so long a period without causing disturbance.

Adjourned to 28.1.58 at 10 a.m.

B.R. Miles, J.

No.10

28th day of January 1958

EVIDENCE OF FRANK ACKROYD THOMPSON

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs Evidence.

No.10

F.A.Thompson - Examination.

P.W.3 - FRANK ACKROYD THOMPSON , Christian sworn:

Examined Mrs. Kean. I am M.R.C.S., L.R.C.P. I have been practising as a doctor for 18 years. Mrs. Cooper is a patient of mine. She has been under my care for about 7 years. In February 1955 Mrs. Cooper underwent an operation performed by Mr. Preston. I was acting as her general medical adviser and attendant at this time. It is within my knowledge that the two Fallopian tubes were blocked. The blocked parts were removed and the patent parts of the tubes were reimplanted in the uterus. That operation was successful. I continued to see her from time to time after this operation. Her general health after this was alright. An operation was performed on Mrs.Cooper by Mr. Nevill on 1st February 1956. Subsequently to Mr. Nevill's operation Mrs. Cooper came into me two to three months later, with an attack of vomiting and abdominal pain. She had been vomiting throughout the night and had had a lot of pain. I admitted her to the Maia Carberry Nursing Home for observation. Within two hours she was completely free from symptoms and felt quite well again. On clinical examination at that time I could find no cause for her pain. She had visited me on the 24th April complaining of abdominal pain which I thought was due to adhesions at that time. That was before the admission to the Nursing Home and not the cause of the admission. After her discharge I saw her on several occasions with regard to other matters, but she was complaining of occasional abdominal pain. I thought it was probably due to adhesions. I did not pay much attention to it. I can't recall what Mrs. Cooper said she might be suffering from. Apart from continued attacks of pain nothing further happened, until her admission to the European Hospital. She had a very severe attack of pain and vomiting. I admitted her to the European Hospital for observation. I cannot recall the date; it was October. An X-ray on admission showed no evidence of obstruction, but 24 hours later an X-ray did in fact show that there was an intestinal obstruction. As an operation was necessary I asked Mr. Barber to come and

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs Evidence,

No.10

F.A. Thompson - Examination - continued.

see Mrs. Cooper. She was operated upon that day. I acted as assistant surgeon at the operation. The cause of the obstruction was not discovered immediately. After the coils of intestine had been removed I took them into the sluice with Sister Banks and cleaned out the coils by running tap water through them and the swab was washed out in the process. We looked at the swab, Sister Banks and I. It was Turkish towelling. I did not see a tape but I didn't specifically examine it for a tape; I should think it was 10" x 8", something of that nature. We took it into Mr. Barber in the theatre. Sister Banks and I were both exceedingly surprised. Happily I have never seen a case of a swab left in a patient. I am acquainted with the literature on the subject. From my medical knowledge and from having been Mrs. Cooper's medical attendant it is very difficult to be dogmatic about it, but Mrs. Cooper was symptom-free after Mr. Preston's operation and only showed symptoms between two and three months after Mr. Nevill's operation and as I was taught that swabs normally produce symptoms within six months, I feel it is unlikely that it was left in at the time of Mr. Preston's operation, otherwise she would have had symptoms earlier. It was obviously Mr. Barber's decision to make as to what action was to be taken. Subsequent to Mr. Barber's operation she had a small sinus which was a small stitch abscess. She did at the beginning complain of a fair amount of diarrhoea and she has complained of abdominal pain. A subsequent X-ray of stomach and intestine was quite satisfactory and one presumes that her pains must again be due to adhesions. These pains can go on indefinitely. They could do so for the whole of her life. I think it was about two months before the stitches came out. She had been emotionally very upset. I think the attacks of pain were due to adhesions that had formed round the swab and that the obstruction and the abscess were due to the swab having eroded through the intestines. She has had an internal examination but you can't really form an opinion from that as to whether she is capable of having a child. To find out whether she has a chance of becoming pregnant would mean her going to hospital and having a special investigation under an anaesthetic to see whether the remaining tube was in fact still patent. I have advised Mrs. Cooper not to have it done because I think if she did in fact become pregnant, with a history of a ruptured uterus, the termination of that pregnancy

would certainly have to be considered. I think she has had quite enough trouble with her recent experiences. That would have been my advice before the swab episode. I don't think she asked my advice before the swab episode. I think she first brought that up afterwards. It means yet another anaesthetic and yet more hospitals. That is why I gave that advice. I should not think that the adhesions would have an effect on the pregnancy. The tube may have been thickened by blood at the time.

CROSS-EXAMINED.

Cross-examined Salter. I would say that Mrs. Cooper's inability to have a child has nothing to do with any swab having been left in her body at any time. It certainly affects my decision to advise against further examination. It is not true that I have ever advised her that she cannot and must not become pregnant as the result of the swab having been left in her. That did not affect the issue to my mind. After Mr. Preston's operation I saw her when she first became pregnant which was about nine to ten months after the operation. She said that up to that time she had been well and remained well. She was consulting me then with regard to her pregnancy. I have discussed this case with Mr. Barber. My views are the same as his. I did not see her for about two months after Mr. Nevill's operation. I would not say that it was possible for material, metal yes, but not Turkish towelling to remain in the abdominal cavity quiescent for a long period. You are bound to get tissue reactions to it. I would say she would produce symptoms within six months; as this is my first case I can only quote that I was taught. I was taught that six months was the maximum. I find it difficult to believe that a swab was left in for 12 months without producing symptoms. It is bound to be a freak otherwise it would not be written up like that in a text book. It would be a most unusual case. Although it had been accepted legally that a swab had remained quiescent for 12 months, it does not alter my impression that it is almost impossible for such a thing to have happened. I don't know whether it would be possible. I would not altogether agree with Mr. Barber's opinion. You would be bound to get adhesions forming. I was "scrubbed-up" for Mr. Barber's operation. I am certain I observed the condition of the intestine before he excised this particular

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs Evidence.

No.10

F.A.Thompson - Cross-Examination - continued.

section. I saw a mass of coils of intestine with adhesions and an abscess cavity. Mr. Barber took the decision. Mr. Barber handed the piece of intestine to one of the sisters who took it into the sluice. I went out about 5 minutes later when the operation was being completed. At that time the towel was still coiled up. I had not felt it before that. Mr. Barber made no comment about finding anything inside the intestine till afterwards. As the intestines were distended so the material came through. It was inside the lumen of the intestine and popped out of the end of it. It came out something like a sausage. We opened the thing up to see what it was. I don't recall Sister Banks saying "it looks rather like a pack". She opened it up with forceps holding it up unravelled. I think Sister Banks took it into the theatre to show Mr. Barber. It was there the following day. I don't know what happened to it subsequently. I imagine it was thrown away. Certainly it is the custom in the European Hospital for packs to have tapes. I don't know whether they all have tapes. I don't think packs should be used without tapes but whether packs are ever used without tapes at the European Hospital I don't know. I am primarily concerned with the medical rather than the surgical side. The tape is sewn on to the swab. This is the sort of thing which is used. (Three packs marked X for identification). The pack I found was like this (X 1.) Most surgeons attach a clip if they are used for packing. It is a Spencer Wells forceps. This is about six inches long. You would have the end of the tape plus the forceps outside the body.

BY COURT.

By Court.

To Court. I suppose it would be possible for the stitching to become rotted in the tabs but I would not like to give an opinion. The one shown to me is well and truly sewn on.

A. We found no tape in the towel. None was looked for. We were not examining the inside of the intestine. Whether there was a tape on that swab I do not know. I don't know Sister Molloy by name. There were two other sisters in the theatre at the time. Surgeons commonly use ordinary cotton and silk for stitches and they stay in the body for ever.

(Witness rolls up material as it was found).

You don't roll up the pack. You push it in. This was inside the intestine therefore it had got to be rolled up. I should think it would be very difficult to swallow. I have been attending Mrs.Cooper very frequently since Mr. Barber's operation. She has recovered from the operation certainly. She has residual symptoms, abdominal pains and occassional loose stools, not diarrhoea now. I don't know if records were kept in the theatre of the persons taking part in operations.

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs Evidence.

No.10

F.A.Thompson- Cross-Examination - continued.

Cross-examined Wilcock. The swab was faecal coloured. It was Sister Banks who opened it with forceps and disclosed that it was a bit of flannel. I don't think all the sisters went into the sluice room. Mr. Barber and I examined it together. Whether the sisters looked at it subsequently I don't know. At the time I did not hear a remark about there being no tape. In the past I operated quite a lot myself. Now I do very little of it. I know Sister Banks. I think she is absolutely first-class.

RE-EXAMINATION

Re-examined. Nil.

Re-Examination.

No.11

No.11

R. Cooper - Examination.

EVIDENCE OF ROSETTA COOPER

P.W.4 - ROSETTA COOPER, Christian sworn:

Examined Mrs. Kean. I am the wife of Mr.L.T.Cooper, the first plaintiff. I had an operation performed on me by Mr. Preston in February 1955. Subsequent to Mr. Preston's operation my state of health was normal. My normal health is very good. I had no attacks of vomiting before or after Mr. Preston's operation in my life. I suddenly became very ill on 1st February 1956. I was taken to hospital by neighbours. I was escorted by Dr. Spiers and Dr. Gillespie. While I was in hospital after Mr. Nevill's operation I had an attack of vomiting exactly a week later. I presume it was rather a bad one because Mr. Nevill came to see me. I said

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs Evidence.

No.11

R. Cooper - Examination - continued.

"I feel extremely ill, like dying". He said "I don't think you should think terrible things like that because if you did not die a week ago you will not die this time". When I came out of hospital I stayed for a period in town because I had to see Mr. Nevill, also I did not feel fit to go home. I live at Limuru. I had a bruise on my left leg. I could not imagine for a few days the cause. Nobody told me the cause. I took no action over it, I went back to Limuru. For a few weeks I suppose I was a bit upset but physically I could say I was recovering but then I believe the night before the 24th April I went out with some people to dinner and suddenly I started feeling very queer. I had a pressure in my right side in the back. Then I felt I wanted to be sick so I decided to go home. For about two hours I kept on feeling the same way. Finally the pain sort of cleared out; I felt extremely exhausted; I went to sleep. Soon after, the day after or a day or two, I went to see Mr. Thompson and he asked me what my complaint was. I told him I felt something like air or pressure in my back. He gave me more tablets which did not help much. I did not get really alarmed until the 5th May. At the beginning of May very severe pains started soon after dinner - general pains. I was not vomiting when they first started. Then from 8 to 10 o'clock the pains went on. About 10 o'clock my condition seemed improved. I went to bed, I believe I slept for about one hour. Then suddenly again I was wakened by very acute pains and I started vomiting once every half hour. My husband phoned Dr. Thompson, he asked his advice. Dr. Thompson suggested going to see Dr. Spiers about 12 or 1 a.m. He was a bit puzzled. He gave me some tablets to be taken at home. I vomited them almost immediately. I went to sleep about 6 a.m. I went to see Dr. Thompson. I was admitted to the Maia Carberry Nursing Home. It was a long nightmare after I left the Maia Carberry until my last operation. I kept on having attacks like that. I had lost confidence in myself and doctors. Attacks especially came at night. I would get up and drink something. I thought it might be cancer. I was not vomiting a lot but I was trying to. I was getting general pains and wanting to be sick. Before Mr. Nevill's operation I ran a small poultry farm. I could not really do much after the attacks started. I was very upset. The last attack started the night before I was admitted to the European Hospital again when I was at the cinema. We went home. I went on vomiting practically the whole

night. The following day I went to hospital again. The pains were extremely severe. The vomiting itself was very painful. After admission and before the operation many times I think I was unconscious because of the pains. I only recall pains very severe. After the operation while in hospital I was there 46 days. I think I was in very severe pain within 3 and 4 weeks. After that I felt more comfortable. There was "an instrument of torture", I hear the doctors call it a "sucker". It is a sort of electric pump with a tube. It was attached inside my stomach. It made a noise like an electrical machine - I could not sleep. I kept on telling Mr. Barber why did I have to keep this on. Before the operation I was so much in pain, one night in the medical ward I thought it might be cancer. I got out of bed, I put on my coat and shoes. I thought I would run out and throw myself under a car. Nurse O'Regan stopped me. I was told the cause about two or three weks before I came out. Before I was told I still was thinking the operation was for removal of a cancer. None of the answers satisfied me. The doctors were a bit evasive, I could feel it. Physically the sinus was not painful but it was depressing because I had to attend to it twice a day changing the gauze. Since my discharge I kept on having kinds of pain especially on my right side, all over the abdomen. The left side could not be better. I saw Dr. Thompson. I think my digestion has been affected. I used to be very fond of raw fruit and vegetables. Now I have ruled out of my diet things like that because it seems that they give me tummy trouble and loose stools.

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs Evidence.

No.11
R. Cooper - Examination - continued.

CROSS-EXAMINED.

Cross-examined Salter. I was present in Court when Mr. Barber gave his evidence. I heard him say that on 1st February 1956 I was as near death as anyone could be. I heard him say I could consider myself fortunate to be alive to-day. Naturally I do consider myself to be lucky to be alive after all. I agree that it reflected great credit on Mr. Nevill and the nursing staff that I am alive. I was very grateful at the time.

Cross-Examination.

(Witness complains that Mrs. Nevill is staring at her).

I owe my life to Mr. Nevill and a few other people who did help me. It is my wish to claim damages

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs Evidence.

No.11

R. Cooper - Cross-Examination - continued.

against him. Perhaps I would not be here if I didn't. (List of special damages shown to witness). Shs.873.75 paid to the European Hospital was in respect of the time that I was in the European Hospital when I was operated on by Mr. Nevill. I think the hospital is entitled to all what they charge for the time I spent. All this list in the first stage, we were under the impression that all the trouble caused by the swab had jeopardised for good my chance of becoming pregant again. So without prejudice we made out a list claiming for more or less all the treatments I had received even before because my first operation at this stage proved itself as being wasted. I do not now wish to recover the Shs.873/75 I don't know who is responsible. I believe Mr. Lawes was the anaesthetist at Mr. Nevill's operation. All the rest are subsequent to Mr. Nevill's operation. When I became pregnant in 1955 I don't think I got morning sickness. There were no pains before the operation by Mr. Nevill. The pregnancy was not very normal but I had no pain. I suppose I had the normal discomfort. I got the feeling I was pregnant. As a pregnant woman I was feeling well; I had no pains. I had a good many blood transfusions in my leg. There is a cut where the transfusion had been done. On two occasions I had very acute pains when I was admitted to the Maia Carberry and the European Hospital. I don't remember any injections between May and October 1956. I went in a car to the hospital. I arrived at the hospital between 1 and 2 o'clock. I remember a stretcher outside waiting for me. I remember being put in bed. I remember the arrival. I was feeling very ill.

RE-EXAMINATION

Re-Examination.

No Re-examination.

Adjourned to 2.15 p.m.

2.15 p.m.

No.12

P.G. Preston - Examination.

No.12

EVIDENCE OF PHILIP GEOFFREY PRESTON

P.W.5 - PHILIP GEOFFREY PRESTON, Christian sworn:

Examined Mrs. Kean. I am Bachelor of Medicine, Bachelor of Surgery and F.R.C.O.G. I am practising

as an obstetrician and gynaecologist. I performed an operation on Mrs. Cooper on 24th January 1955 at the Princess Elizabeth Hospital, Nairobi. I think one or two abdominal swabs were used at that operation. No abdominal swabs were used for mopping in that operation. The one or two swabs were used for packing. At that time the type of abdominal swab used at the Princess Elizabeth Hospital was this type, (put in as Exhibit 1). I counted the swabs myself. I am perfectly certain. These Turkish towelling swabs I always count myself when I put them in the abdomen. The gauze swabs I leave to the sister to count. As a rule I use one or two - very rarely I use three. It has always been my custom to do so. I check on the swabs myself. It is impossible for one of the swabs I used on Mrs. Cooper to have been left in.

CROSS-EXAMINATION

Cross-Examination.

Cross-examined Salter. I would be as confident as any other surgeon that I had not left a swab in after an operation. I got this swab (Exhibit 1) from the Hospital recently, this morning. The Princess Elizabeth Hospital was always under the Kenya European Hospital Association. Mr.Braimbridge has now assumed responsibility for the administration of that hospital in Spring 1957. In 1955 I think Mr. Bramish was secretary. Mr. Rudolf Anderson was chairman of the Board. Neither of these held medical qualifications. In 1955 I think the sister in charge of the theatre would be responsible for the preparation of instruments and swabs. I don't know if these packs are now made in the hospital. I don't know how they were made in 1955. I don't know whether there was any rule in 1955 in the Princess Elizabeth Hospital that all packs of this type should have tapes. It is the custom. I have been offered packs without tapes and refused them at the Princess Elizabeth Hospital in 1955 on more than one occasion.

RE-EXAMINATION

Re-Examination.

Re-examined. In 1955 in the Princess Elizabeth Hospital I would not have used a pack of this type without a tape. I am positive, definitely.

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.13

Submission by Counsel for first defendant.

No. 13

SUBMISSION BY COUNSEL FOR FIRST DEFENDANT

Salter. We agree the particulars of expenses apart from Sh.873/75; Sh.510/- and Sh.600/- to Mr. Nevill. The gross total to Dr. Thompson we agreed at Sh.1010/-.

Plaintiffs Evidence.

No.14

L.Q.T.Cooper - Examination.

No. 14

EVIDENCE OF LEONARD QUENTIN TYRRELL COOPER

P.W.6 - LEONARD QUENTIN TYRRELL COOPER. Christian sworn:

Examined Mrs. Kean. I live at Limuru. I am the husband of Mrs. Cooper, the second plaintiff. I have been married to her since the end of 1948. Up to Mr. Preston's operation she was always a very healthy person indeed. After Mr. Preston's operation up to Mr. Nevill's operation her health was quite normal and apart from convalescing after Mr. Preston's operation it was more or less the same as it was before. After Mr. Preston's operation my wife did not suffer from attacks of abdominal pain that I am aware of up to the time of Mr. Nevill's operation. We have for several years tried and taken medical advice on the matter of children. Finally we consulted Dr. Thompson as to the possibility of my wife undergoing an operation. He agreed and we thought that we should not let any opportunity be missed whereby we could have children. Mrs. Cooper had an operation to enable her to have children which was performed by Mr. Preston. After Mr. Nevill's operation I can corroborate everything my wife has said. I can also add that she was in a lesser degree of discomfort a lot of the time. In fact at one stage at that time it did occur to me that she might have been exaggerating. She was depressed a lot of the time. She did not normally suffer from this to the same extent prior to this operation. Prior to this operation she did assist in the poultry farm. Between Mr. Nevill's and Mr. Barber's operation she could hardly assist at all. I think if you do not get

proper supervision of labour then the profits will decrease. In this instance my wife could not give her usual supervision. That particular year production dropped by 5.15% from the average of 1955 and 1957. I have worked a figure which was approximately £180 but I believe the figure I handed in to you was much less. I would be agreeable to the latter figure as it would be difficult to prove my latest figure. During the 46 days Mrs. Cooper was in hospital I had a boy in the house. I used to come and see my wife quite a lot which meant that I had to stay in Nairobi and I could not attend properly to my business. It was inconvenient. I am a farmer; I own business as a contractor, in wattle cutting, building. Since the operation by Mr.Barber my wife has no acute pain but has paid a number of visits to Dr. Thompson. She does speak to me about certain pains she feels in her abdomen.

CROSS-EXAMINATION

Cross-Examination.

Cross-examined Salter. The amount of Shs.1400/- for loss of profit from the poultry farm was an estimate over about 9 or 10 months. I don't know when it began or ended. I cannot remember the dates. I considered that it was a less figure than the actual figure. It was over 9 to 10 months in 1956. I haven't got my accounts with me. I have no idea of my profits in 1955. I haven't even handed my accounts for 1957 in for audit. I keep a running total of production every day. I mean production of eggs. Production has dropped 5.15% over the whole of 1956. My production in 1955 was 190,000 eggs. In 1957 it was 187,521. In 1956 it was 179,504. There are 3 permanent labourers in the poultry farm and two women permanent and depending on the season up to as much as 10 - 20 casual labourers. They are all on the farm. There are other things besides poultry. I don't think my wife did manual labour. She went to supervise. She would see that your employed labour do what you tell them to do. You are present to see that it is done correctly. The head boy has been there four years. He is reliable as labour are. There is one year considerably better than the two average years I have taken. I keep about 700 - 800 laying hens on average. It varies. I can't say what profit I make. It is much more than £50. I have no idea. I saw an accountant who said unless I could give comparative figures for a period of 10 years he could not produce anything which would go

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs Evidence

No.14

L.Q.T.Cooper - Cross-Examination - continued.

down in a court of law. I am fully alive to the great service which Mr. Nevill afforded to my wife on 1st February 1956. Damages to myself are limited to those out of pocket expenses. I probably had something to do with instituting this suit. It is probably the idea of my wife and myself, in some things she is guided by me. I think we both guided each other in this matter. I can't remember how the train of events built-up. I had in my mind at one time the idea that because of the swab my wife would not be able to have a child. Initially it was something that played a part in my decision to claim damages but afterwards it was not. It would be true that Dr. Thompson said words to the effect that because of the swab my wife would not be able to have a child. I was not present when he said that. It was reported to me by my wife. I heard Dr. Thompson say in the witness box that he never said anything of the kind. I believed what my wife told me. I would not say it had a considerable bearing on my decision to bring this case. It did influence the matter. I took the decision at the end of 1956.

Re-Examination.

RE-EXAMINATION

Re-examined. I was told by Mr. Barber.

Salter. The witness cannot give evidence as to the details of the conversation.

Mrs. Kean. The cross-examination has made this admissible.

Court. I do not think the details of the conversation are admissible.

A. As a result of what Mr. Barber told me I formed the impression that everything was finished so far as Mrs. Cooper's chance of having a pregnancy was concerned because of the last operation by Mr. Barber. After Mr. Nevill's operation my impression was that there was still a chance. I talked to Mr. Nevill about it. He told me that whilst he had not examined the other tube he did think that after six months we could try again. My wife consulted Dr. Thompson about this after Mr. Barber's operation. It is not within my knowledge that she consulted him after Mr. Nevill's operation. The effect on me of what Dr. Thompson advised was very depressing. I believe I had Mr. Barber's opinion. I am pretty certain I first wrote to Mr. Nevill before my wife saw Dr. Thompson. Before I brought the

suit I had been told it would necessitate another operation to my wife in order to prove whether she could have a child. We had been advised that in view of my wife's experiences it was inadvisable for her to undergo any more surgery. Dr. Thompson advised this.

Close of Case for Plaintiffs.

In the Supreme Court of Kenya at Nairobi Eastern Africa

Plaintiffs Evidence

No.14

L.Q.T.Cooper - Re-Examination - continued.

No.15

ADDRESS BY COUNSEL FOR FIRST DEFENDANT

No.15

Address by Counsel for first defendant,

28th January 1958.

Salter. Opens defence.

No negligence on part of 1st defendant. Mahon v Osborne, 1939, 1 A.E.R. 535. 1939 2 K.B. 14, p.31. These tests applicable here. Dunlop v. James 1931 B.M.J. In that case no emergency an exceptional circumstance. The theatre sister was not called. Evidence as to count was unsatisfactory. They found search not necessary. In Urry case - no emergency or exceptional circumstances only 2 or 3 packs used. Surgeon did not need tapes. He said he was entitled to rely on sister's count. No effort to remember himself. Van Wyk v. Lewis. Difficult operation - emergency. Mahon - Osborne - emergency. Swab count asked for - large number of packs. v. Miles 1930 1 B.M.J. Morris v. Winsbury-White, 1937. All England Reports 494. Evidence will show operation carried out under exceptional circumstances, 20 swabs used in mopping. No packs used in this hospital without tapes. Plaintiff must prove tapes left in at this operation. There must be real doubt whether swab found in this case was used in this operation.

No. 16

Defendants Evidence.

No.16

G.E. Nevill - Examination.

EVIDENCE OF GERALD EDWARD NEVILL

D.W.1 - GERALD EDWARD NEVILL - Christian, sworn:

Examined Salter. I am a Bachelor of Medicine (Dublin), F.R.C.S. Master of Surgery (University of Dublin). There is no degree of surgery that I

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Defendants Evidence.

No.16

G.E. Nevill - Examination - continued.

would value higher than Master of Surgery. I qualified in 1938 in medicine and surgery. I have been in continual practice ever since. In the war I was with the East African Forces. I was involved in the surgical side of the unit to which I was attached throughout my service. Since 1944 I have been practising surgery in Nairobi. I am Hon. Consulting Surgeon to King George VI Hospital and Church of Scotland Mission Hospital at Kikuyu. During my 20 years practice I have performed something between 2000 and 4000 operations. On 1st February 1956 I was called out of a general meeting of the Association of Surgeons of East Africa at about 3 o'clock p.m. I went to the European Hospital. I went to a ward in which there was a patient, Mrs. Cooper. Dr. Lawes, the senior Government anaesthetist was there and Dr. Wilson, Dr. Robertson-Glasgow; Mr. Braimbridge was somewhere. There were several assistants. Mrs.Cooper was almost dead. She had no pulse that could be felt. I was informed that her blood pressure could not be measured. She was ashy grey in colour and she breathed very infrequently. Dr. Lawes told me that she had been in a similar condition when he had been summoned to attend Mrs. Cooper immediately on her arrival and that he had already established an intravenous drip system, a saline drip, as a preliminary to blood-transfusion. I diagnosed that she had had a very severe internal haemorrhage in her abdomen and the diagnosis had been made by the doctors who brought her down from Limuru that this was in fact a ruptured ectopic pregnancy. I had no reason to doubt that diagnosis. I agreed with Dr. Lawes and the other doctors present that we would have to operate on her in order to stop the bleeding which was killing her but that she was not in any sense of the word a "reasonable operative risk". Very shortly afterwards the blood we had sent for arrived and everybody present assisted in getting this into her. My notes read that she was given 6½ pints of blood, 1 pint of glucose saline, 1 pint of Dextrin. It was a continuous process of perhaps one hour. The blood content of the body is generally accepted to be 10 pints. We thought at first we would have to operate on her in her bed in the ward because we were not "catching up" with her haemorrhage, but after a little while she seemed to improve just a little bit and we agreed that we could afford the risk of bringing her bed into the operating theatre. We did that. We knew we would have to operate in order to

save her and we know that the available blood in the bank was limited. There came a time when we had to get on with it because otherwise she would have continued to lose all the blood we were giving her. I had never operated on a patient in bed before. The disadvantages are that the bed is too low, too wide and the ends get in the way. We felt certain that to move her on to the operating table would kill her.

Adjourned to 29th January 1958 at 10 a.m.

B.R. Miles, J.

29th January 1958.

D.W.1 - GERALD EDWARD NEVILL

Examined Salter (continued). In this particular case we were ready to operate for say 10 minutes before the anaesthetist would let me start at all. The question was in continual discussion and we had to make up our minds when the correct time was. There were scrubbed-up with me my assistant, Dr. Wilson, he is in the U.K., and Sister Banks, who was taking the case, Dr. Lawes who was giving the anaesthetic and in general charge of keeping the patient alive. Dr. Robertson-Glasgow who is also anaesthetist was given the special job of looking after the blood transfusion and helping Dr. Lawes. Sister Pearce was present; she was the ward sister and was asked to remain. There was at least one additional "dirty" nurse. At that moment I cannot recollect seeing Mr. Braimbridge. I made a mid-line incision. There was no bleeding from the woman's body. That is unusual. I concluded she was even closer to death than we had thought. When we got into the abdomen cavity it was full of blood, confirming our diagnosis. I put my left hand deep into the pelvis and could feel that the left corner of the uterus had burst. I grabbed this, which was the bleeding point, between my finger and thumb and held firm. This, I thought would control any further bleeding. We then started to suck blood out of her abdominal cavity and into specially prepared bottles. This blood was to be used later as required for auto-transfusion. There were some four pints removed in this manner. There was still a great deal of blood in the abdomen in the form of clots and having flowed into various corners. This was removed using our hands to scoop out the clots and

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G.E. Nevill - Examination - continued.

using mopping packs to assist. Dr. Wilson and I were both doing this. Speed in that matter was absolutely essential. For mopping we were using packs of this sort (Exhibit "X"). At that stage I cannot say whether the packs had tapes or not. At that stage for mopping we attached no clips or forceps; at the mopping stage you would not leave them in the body, you don't let go, I hand the pack to sister if it is not too dirty. If it obviously cannot be used again you put it in a basin beside you. That is what I did. I observed Dr. Wilson very closely. He did the same as I was doing. Everything that he did was done at my instruction. I was standing on the left side of the patient, Dr. Wilson was on the opposite side to me. In clots and on mops we estimated that we removed some 2 or 3 pints of blood. There was still more inside. As an estimate the sucking and mopping took 5 to 8 minutes. It has to be done slowly and gently. I was then able to see that the uterus was in fact ruptured. I had to sew the ruptured part over and in order to keep my field of work clear I packed back all the intestines using packs of this material, (Exhibit "X"). I used two or three. They had tapes on and they had a clip at the end of each tape. You use the pack flat to push the intestines back. You don't even pull it over once. Ordinarily speaking the whole of the pack would be inside the body. The tape is left to come out through the wound with the clip attached. If the pack was far from the wound only the corner of the tape would be outside. If close to the wound most of the tape would be outside. I sewed up the uterus. I found the foetus which had caused the trouble lying free in the pelvis cavity, and beside it the plastic tube which had been used in order to achieve the pregnancy. I knew she had had a previous operation. I felt the other tube and it still had its plastic tube in situ. I checked at the pelvis cavity that it was free of blood clots and there was no further bleeding from the ruptured uterus which I had stitched. We were then getting ready to terminate the operation. Having checked that the pelvis cavity was clear I then removed the packing swabs which I had placed, checked carefully the area involved removing at the same time considerable quantities of blood which were oozing down from the upper parts of the abdomen. When I was sure that I had done all that I should do in the way of routine checking for packs I was ready to sew up. Whilst

I was checking inside the theatre staff under the direction of Sister Banks were checking up outside in our routine procedure to ensure against leaving any swabs behind. I was assured that the swab count was correct. Sister Banks assured me. You do not sew up until you are informed and until you have completed your own check. Prior to that operation Sister Banks had been taking the majority of my cases since the opening of the hospital. She is a first class theatre sister in whom I place absolute reliance. My absolute routine is that I personally always remove the packs which I know that I have placed in the abdomen or my assistant has placed. It is my responsibility. I then always check the operation area to make sure that some others or any foreign body could have crept in by mistake. We take standard precautions that all packs we use as restraining packs have got tapes on them and if they are to be left in the abdomen a clip forceps is attached to the tapes. The small gauze swabs which are notoriously easy to lose inside the body we always have held directly in forceps, specially made for the purpose. These little swabs are of course also subject to the sister's count. If I am personally satisfied having had a good look round and a good feel with one's hands into reasonable corners for a foreign body that no foreign body is there, either I ask sister or she tells me in a loud voice so that other people in the theatre can also hear it, that the swab count is correct. I have followed that routine for as long as I have been doing surgery when such routine is possible. I have had to do a great deal of surgery under war conditions and often in ill-equipped and in below standard conditions. There may be no theatre sister - in such cases you have to rely on your own checking entirely. This gets one into the habit of having a good look. I took every precaution in this operation to ensure that I did not leave a swab in this particular case but I am very well aware that almost every surgeon in his career has in fact left such a swab behind. This was an incredibly difficult and I think delicate operation. I have never been faced with conditions such as this in my whole career. If the pack had been in the pelvis before my operation I would have found it. If it had been in the middle or upper part of the abdomen I would not have found it as I made no search of those areas. The small intestine starts in the upper abdomen. There are 22 feet of it. It can be found in coils in every

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Defendants Evidence.

No.16

G.E. Nevill - Examination - continued.

corner of the abdomen not already occupied by some firm fixed organ such as the liver or uterus. The small intestine would be in close contact with my operational area. I have heard the swab described as "towelling". All the packs that we used to the best of my knowledge and belief have tapes attached to them at all times. I could not give an assessment about each individual pack which I used for mopping. It would have been far too dangerous to check on that point. All packs at the European Hospital have tapes - we don't have to consider that point. It was inserted to get the blood out of the cavity as quickly as possible. I don't think there was anything to prevent me seeing a pack used for mopping if it had remained there. There was still blood seeping about. I used my hand to go into corners I could not see within reason. We were moving very swiftly all the time because our patient had been critically ill to start with and all operative manipulations, however gentle, cause an increase in surgical shock, and we knew that the slightest increase in this shock would kill our patient. A swab can remain in the abdominal cavity without causing trouble almost indefinitely unless because of its size or some extraneous facts inflammation might start causing complications. I personally have never left a swab in to my knowledge. I have knowledge of a swab being removed at a second operation eleven years after the first operation in which presumably it was used. There was never any departure from my careful and usual routine on this occasion.

BY COURT

By Court.

To Court. The operation took something in the nature of ¾ hour - but Dr. Lawes recorded that sort of thing.

CROSS-EXAMINATION

Cross-Examination.

Cross-examined Wilcock. Sister Banks was extremely good during this operation. The hospital staff as a whole displayed a skill and attention to duty which I have never seen surpassed.

Cross-examined Mrs. Kean. The following morning after his operation Mr. Barber communicated with me. I agreed that Mr. and Mrs. Cooper should be told. I would say that it is right as a matter of professional etiquette that the patient should

be told. I agree that Mr. Barber did the correct thing in communicating with me before passing on the information. I received a letter of which this is a copy (put in as Exhibit 2) from Mr.Cooper. I was very distressed on hearing this. It is a very upsetting thing to happen to a surgeon. The danger of leaving behind a swab is a perpetual nightmare to a surgeon. I would agree absolutely that I cannot take all the credit for having saved Mrs. Cooper's life. I agree that had it not been for the speed of action of Dr. Spiers and Dr.Gillespie Mrs. Cooper would not have been alive to tell the tale. She would not have been alive when I arrived if Dr. Lawes had not started resuscitation. I would not say it is a justification for making a mistake that the operation saved the patient's life. I felt depressed when I got the news from Mr.Barber because I felt personally concerned. I obey the commands of the Medical Protection Society. It would be my instinct to convey my distress to Mrs.Cooper. I made several approaches at a later date to Mrs. Cooper. I made no personal contact. She would not come. During the war we always had had a sort of theatre table. Frequently I had to perform an operation under fire. I was in a field ambulance for 18 months. Frequently I was called on to attend a person who could not be moved to a makeshift operating theatre. You would always take a patient back to hospital for anything requiring "cutting". You have surgical instruments for life saving action. It is theoretically possible that that might involve cutting. There are places where a theatre sister attaches clips to tapes whether the swabs are used for mopping or swabbing but have never used that practice myself. My own opinion is that it is unnecessary. Other safeguards are sufficient without this. We use the system of racks and a black board at King George VI Hospital. They work in units of ten. There are 10 hooks. You have several lots of hooks. Swabs are never removed from the theatre. It is my duty to see that there is a clip attached to every pack used for restraining purposes whether such clip is attached by myself, my assistant or the theatre sister. It might be applied by either of the three. I have heard of a system whereby the theatre sister always applied the clips but I have not worked under such a system. It would entirely be within my control as to whether such a system was used in my operation. I don't agree that this would be an additional safeguard. I should say 45 minutes elapsed

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G.E. Nevill - Cross-Examination - continued.

between the time of my arrival and the commencement of the operation. It is a wide estimate. The 45 minutes was before I was ready to operate. I would agree that it takes ½ hour to prepare a theatre at the European Hospital adequately for an emergency operation. I have come across packing swabs made of muslin. We prefer these (Exhibit "X") because they are better for every purpose. You can't mistake muslin for anything else. This (Exhibit "X") is more absorbent, cheaper, more durable. No mopping swab left my hand at this operation. I cannot say that a mopping swab never left my assistant's hand. It would be an improper thing to happen as a general rule. In this operation it would not have been necessary. I never observed Dr. Wilson letting go of a mopping swab. I knew where I had put the two or three packs. I only keep count of packing swabs. It would be quite impossible in an operation of this sort to keep a count of mopping swabs. The packing swabs were put in in this case either by me or my asistant. We usually work together. Either he holds the intestine and I put the pack in or vice versa. In either case I would know where they had been put and it would be my responsibility to see that they were taken out. Almost certainly I think I must have placed the packs in this case. I personally removed them. I removed them by catching the actual swab. I wouldn't have needed any guidance to the swab, they were quite obvious. I cannot recollect whether there were two or three packing swabs. All swabs move to some degree. These swabs did not move appreciably. In this case they moved perhaps an inch. I place absolute reliance on Sister Banks. I never do rely completely on the theatre sister's count. I rely on my own count in addition. I do not recollect in this particular operation whether I asked Sister Banks whether the count was correct. I am absolutely certain that either I asked her or she told me. In this case I did carry out my routine check. We did the best we could. I carried out my routine check. I remove the swabs that I know I have placed in position. I look to see within reasonable limitations that there are no other swabs visible. These swabs would be visible. I feel with my hand into all reasonable places where a swab might hide itself and when I am absolutely certain that there are no foreign bodies inside the abdomen I question sister about her swab count unless it may be that she has already told me her swabs are correct, in which case the question would be superfluous. That is what I

did in this case. I carried out my routine check within reasonable limits before sewing up. That is my routine check. I carried out my usual routine check in this operation. This is not a case which made the routine check impossible. By the time for sewing up Mrs. Cooper was very relatively better. I can't recollect if she was coming round. They wake up very quickly. I would not agree that she was "very much better", but she had improved. This is a letter I wrote to Dr. Thompson (put in as Exhibit 3). These words are used here. This was an accurate description of the patient's condition written in a colloquial manner to a colleague. If I had been informed in this case that the swab count was not correct, I would have made another search. I have heard the evidence of Mr. Barber, Dr. Dockeray and Dr. Thompson. I heard them say that according to all text books symptoms would start from 3 - 6 months if a swab were left in the body. You have the Van Wyk - Lewis Case. I am talking about an opinion I have formed. What I have read in a medical book has helped to form that opinion. We use a lot of cotton in surgery for sewing up wounds and tying blood vessels. We have numerous references in surgical literature to its relatively inocuous properties in the body. It is therefore possible that cotton can remain in the body for an indefinite time without causing trouble. I would however expect trouble to ensue if there was a large mass of such material interfering with an otherwise normally functioning organ. That is one of the cases on which I formed my opinion. We have knowledge of a cotton swab staying in the body innocuously for 11 years so I am told. Dr. Gregory told me about this. I have no experience of this. There are many opinions that symptoms will occur in 3 to 6 months in medical jurisprudence books. It is not correct that I base my opinion solely on the cotton. It is none of my business to go into this before I came to Court. The main factor in my opinion is that cotton is an innocuous material. This material is cotton. The Van Wyk case had a bearing on my opinion. It had an important bearing. It bore out my ideas. In that case I understood it was an abdominal pack presumably made of cotton. I don't know if it was Turkish towelling or muslin. I don't know what muslin is made of. I presume it is cotton. It may be so far as I know in a different way from cotton or towelling. I don't recollect that the patient in the Van Wyk case had very many symptoms. She passed it through the rectum.

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Defendants Evidence.

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G.E. Nevill - Cross-Examination - continued.

It would show some effects before this. I would expect a thing of this kind on general grounds to cause trouble sooner or later. I am not a pathologist. My knowledge is very limited on this point but we have evidence that it can stay there for a very long time. I am not absolutely convinced that a surgical pack was ever left in the body of Mrs. Cooper. I have not seen it. Mr. Barber said a piece of Turkish towelling was found. I was talking of swabs. I would expect a pack of this size to cause trouble in an abdomen within a few weeks of its being placed there or even days. That is the general behaviour of packs, there would be exceptions. I recollect that a few days after I performed this operation on Mrs. Cooper she had a very bad attack of vomiting. I have a note of it. She had jaundice as the result of the blood transfusion. I don't recollect a bruise on her leg. I have a vague recollection of a conversation with Mr.Cooper on the lines he talked about. This operation was even more delicate than most. It is impressed on theatre sisters in training that they must keep their heads in emergencies, also that the counting of swabs was one of their most important duties. It is well-known that the risk of a pack being left in the body of a patient is very serious. Sister Banks in this case performed her duties admirably. I did not tell her she must do her counting particularly quickly, nor did anybody else in my hearing. I would agree with Mr. Barber's evidence as to Mrs. Cooper's pain and suffering. The piece of Turkish towelling found by Mr. Barber is much more likely to be a surgical swab. I could not make clear whether it would be a swab used for mopping or a swab used for packing. They are both the same. We have discussed other possibilities than it being an abdominal swab but in my mind I have dismissed them.

Adjourned 2.15 p.m.

2.15 p.m.

D.W.1 further cross-examined Mrs. Kean:

Since Mrs. Cooper's operation I have performed about 100 abdominal operations. I have used my notes to refresh my memory. Without these notes there are many matters I cannot specifically recollect. I think it would be correct that my memory of the uncommon features of the operation would be better than that of the routine features. I have

remembered this case extremely clearly. I knew six weeks afterwards that Mrs. Cooper was coming round when she was sewn up. I could not remember it to-day. Should such be required the anaesthetist from time to time during the operation gives me a report as to the condition of the patient. The state of the patient before I start to sew up is something which concerns me. Whether Mrs. Cooper was better at the start of the sewing up would be something that concerned me at the time. My note reads "patient much better at this time". No mention of "coming round". I specifically remember carrying out the steps that I have detailed in this particular operation. You have an incision of about 5 inches in the lower part of the abdomen. We had packed away the intestines as described upwards. I checked the pelvic cavity very carefully. There one is coming out of the abdomen and checking up as it were "behind you". The pelvis is clear. You then remove the restraining packs and as you do that you observe that there is nothing behind in the same area and as you do it the intestines tend to fall downwards. We had by this time removed all the packs that we were aware of but there was a certain amount of blood coming down from the corners and very gently one collects that blood under vision. When we thought all was safe I felt around in that same area, i.e. the area immediately adjacent to the wound in which I had been working and slightly out into either flank. The "feeling around" would not take more than 30 seconds. "We" means "I". I have heard of the case of Mahon v. Osborne. I have not seen the law report. I skimmed through "Medical Jurisprudence" by Gordon, Turner and Price, the passage dealing with swab cases, I have looked at Maitland. I got a little lost in Nathan. It is very legal. Dr. Wilson's bill would be part of my account. He assisted at my request. He would be acting under my direction. I was telling him exactly what I wanted him to do. It would be his duty to obey my directions. I did not come across an abdominal swab without a tape in the European Hospital in 1956. It would be the theatre staff's duty to see that the tapes were securely attached and that the Spencer-Wells clips were in good order. The theatre staff would be aware that the surgeon would be relying on their count of the swabs used for mopping. Abdominal packs are always laid out in groups of three. In an ordinary operation one group of three would be enough and would be all that is set

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G.E. Nevill - Cross-Examination - continued.

out. In other operations others would be available immediately as required. I don't recollect in this particular operation how many groups of three were set out. We had sent a message to the theatre that we would be coping with an abdomen full of blood. They have a standard pack of gauze swabs, 12 in each pack. They are placed separately after use on a mackintosh. The main part of the mopping would be done before the sewing. There was mopping done with abdominal swabs after the sewing, not during. During the sewing we had it under control in this case. I haven't the remotest idea how many Turkish towelling swabs were used for mopping.

BY COURT

By Court

To Court. A looped tape is considered to be a better and stronger way of sewing it on I understand.

RE-EXAMINATION

Re-Examination.

Re-examined. I make notes of an operation as soon as I have convenient time in my office in every case. These are the complete notes of this case. Nothing routine would be put down. My note "after saline drip" means blood drip. That would not be normal after a cold operation. The next entry is "following day still alive and settling slowly". That is not a usual comment. By "settling slowly", she had had a very bumpy period having been desperately ill and she was by this time living on borrowed blood entirely, but her pulse and other records that we keep were gradually reaching a more normal level. She was very considerably better than at the closing of the operation. She had been exceptionally ill. As we were closing her up she was better. She was still critically ill and the following day she was still critically ill although better than she had been. The longer you leave an abdomen open and the longer anaesthetic and other procedures are carried on the greater will be the shock imposed. Therefore you must close up a shocked patient at the earliest moment. Forceps would get in the way of mopping thereby slowing your movements down and in addition they would be a hard metal object which should not be moved around the abdomen. I think the system in force at the European Hospital is a sound, safe and well recognised system. It is almost a universal surgical practice throughout the world to use Turkish towelling. Dr. Wilson had been qualified about

4 or 5 years. He had a D.R.C.O.G. and he had served for some two years as a graded surgeon in the Army following on the customary house surgeon jobs. There would be no reason at all to let a swab go out of your hand for mopping. I have no doubt in my mind as to the removal of the restraining packs from where I had put them. The mopping swabs would normally be counted by the sister and then one always checks up the operating field oneself. We used a very much larger number in this operation and in many cases after they had been handed to sister it may be that she rinsed them and handed you back the same pack again. If the sister tells you the count is not correct you will proceed to re-examine the abdomen while sister would review her count and a further search would be made in possible hiding places. In a cold case with no rush you might spend up to 15 or 20 minutes searching. In a case where the patient is in a critical condition you then have to make up your mind whether it is better to prolong the search indefinitely with possible very serious complications to the patient or to accept the evidence of your own eyes and hands that there is no swab inside and close up the wound. I have never had to close up a wound where the count was not eventually correct. With a very efficient theatre staff it never happens because the sisters are aware of where a pack is at any given time. Almost always the swab turns up somewhere else. The patient's life is the only thing that matters. I have been told of the case where a swab was left in for 11 years. It was Mr. Tom Latham. He was living in Nairobi until his decease not so very long ago. He managed the New Stanley Hotel. The object shown to me is a piece of Turkish towelling. I would not call it a surgical pack but a face flannel (marked "Y" for identification). If an object like this ("Y") got there in a surgical operation it would have the same chances as a surgical swab. Ordinarily there is no need for a report from an anaesthetist. One is aware of the condition of the patient from one's own observation. In a case such as this there would be an almost continuous report going on. I don't remember any particular report from Dr. Lawes. We were just keeping contact as to whether she was still alive. I have had no personal experience of a case of similar severity. That is why I remember the details clearly.

Further cross-examined by leave. I mean that this ("Y") would have the same chances as a Turkish towelling pack. I mean by "chances" that it would show symptoms in the same period.

No. 17

In the Supreme Court of Kenya at Nairobi Eastern Africa

Defendants Evidence.

No.17

W.E. Lawes - Examination.

EVIDENCE OF WILLIAM ERIC LAWES

D.W.2 - WILLIAM ERIC LAWES, Christian sworn:

Examined Salter. I am F.F.A., R.C.S., D.A., D.T.M. and H. I am senior Government anaesthetist in the Colony. I have practised for 18 years. On 1st February 1956 I received an urgent call to go to the European Hospital. I saw a case of Mrs.Cooper at 2.40 p.m. She was comatose, pulseless, no blood pressure, grey faced, cold and sweating with sighing respirations and the heart could be just heard with a stethoscope. In short she was dying. I took a sample of blood from a vein in the neck as this was the only vein available to a needle. This was sent to the laboratory for grouping and cross-matching against blood in the blood bank. We gave her altogether 9½ pints of fluid to resuscitate her. We gave her three pints of saline and artificial plasma under pressure in 10 minutes while blood was being made available. I can't remember doing that any faster. Mr. Nevill's assistant arrived at 3 o'clock. I then phoned Mr. Nevill. He arrived shortly after 3. The patient was beginning to show signs of life. The blood pressure could not be recorded. At the time of his arrival she was just becoming an operable risk. You have to decide what is the right time to operate. She was operated on in her bed in the theatre. At the time of the operation if bleeding had not been stopped within a matter of minutes without too much handling she would have died during the operation. The anaesthetist's main job is to maintain the patient's state of health during the operation. Dr. Robertson-Glasgow supervised the collection, the filtering and giving of blood which was obtained from the patient's abdomen. There were 6½ pints of blood given in toto up to 4 o'clock. The operation went on quite reasonably considering the risk that was present when we started. Mr. Nevill stopped the bleeding within one or two minutes. I can't remember any specific report by me. We have worked together before. He just raises his eyebrows. You nod and off you go. Her blood pressure at the end of the operation was 95. Normal is 120. I should describe the operation as a brilliant piece of surgery.

CROSS-EXAMINATION

Cross-Examination.

Cross-examined Wilcock. The hospital staff were extremely good throughout the operation. Onedoesn't

take specific notice but one has come to expect it from Sister Banks that her work is of an extremely high standard.

In the Supreme Court of Kenya at Nairobi Eastern Africa

Defendants Evidence.

No.17

W.E. Lawes - Cross-Examination - continued.

Cross-examined Mrs. Kean. Mr. Braimbridge phoned me. I came straight up. I assume she had been in about 10 minutes. I have no note of the time the operation commenced. I should say it was between 3.20 and 3.30. It took perhaps ½ hour. Dr. Robertson-Glasgow was asisting me. His account is not included in mine. He was probably asked to assist by Mr. Nevill. People just help in an emergency. He was not specifically asked to help by me. The time for operation was agreed by mutual arrangement. I can't honestly say whether Mr. Nevill asked Sister Banks whether the swabs were correct. It is not in my sphere at all. I have no recollection of Sister Banks making any announcement or of Mr.Nevill putting the question.

RE-EXAMINATION

Re-examined. So far as I know in that respect there was no departure from the usual procedure. It was a perfectly routine operation.

Re-Examination.

No.18

No.18

M.Robertson-Glasgow - Examination.

EVIDENCE OF MARY ROBERTSON-GLASGOW

D.W.3 - MARY ROBERTSON-GLASGOW, Christian sworn:

Examined Salter. I am Bachelor of Medicine; Bachelor of Surgery. I was in the European Hospital on 1st February, 1956; I assisted in the blood transfusion on Mrs. Cooper. I received a telephone call at the surgery from Dr. Wilson. He asked me to come up immediately. I was in Court while Dr. Lawes gave evidence. I agree with what he said about the operation. I arrived at 3.20 and met them carrying Mrs. Cooper to the theatre. I should think the operation started about 3.30. The operation lasted I should think half an hour from the time the anaesthetic was given to the sewing up. I was asked by Dr. Lawes to supervise the auto-transfusion. I did so. I was doing this from the beginning . I started by supervising the drip. I had six bottles which were filled. Some of the solution would be citrate to prevent clotting. The

In the Supreme Court of Kenya at Nairobi Eastern Africa

Defendants Evidence.

No.18

M.Robertson-Glasgow - Examination - continued.

natural amount of blood taken out in bottles was five. All the blood was being put in through a cannula which Dr. Lawes had already put in the leg. The mackintosh sheet on which the mopping up swabs were placed was in front of the table where I was working. I did glance at it, frequently to see the amount of blood which was coming out. I made no accurate count. I don't remember hearing anything said by Mr. Nevill or Sister Banks with regard to the count. I have taken part in many operations. There was no departure from the usual routine. I act as Mr. Nevill's anaesthetist, I am not concerned with the surgical side.

CROSS-EXAMINATION.

Cross-Examination.

Cross-examined Wilcock. I have taken part in many operations in which Sister Banks was theatre sister. I think her abilities are exceptional as theatre sister in charge. The theatre staff all carried out their duties at this operation extremely well.

Cross-examined Kean. Blood was sucked into six pint bottles. One pint was used only for auto-transfusion. It was no part of my duty at this operation to count the swabs nor to put any swabs into Mrs. Cooper's body. I was very busy attending to my own work. I had a particular opportunity to see the nurse who was collecting the dirty swabs as she was putting them on the mackintosh sheet in front of me. Also she was assisting me. Very often I used to turn towards the site of the operation. I would not say it is part of the routine for an announcement to be made in a loud voice with regard to the swab count at the hospital. I don't agree it is usual. It is not always done in a voice that everyone can hear. I don't know of any instructions as to giving the announcement in a loud voice. Sometimes the surgeon asks are swabs correct. Sometimes the sister says - "swabs correct sir". The sister announces it in a voice the surgeon can hear.

RE-EXAMINATION

Re-Examination.

Re-examined. I have heard the sister say or the surgeon ask. One hears it at every operation. In a routine operation with very little bleeding one does not look at the swabs. But if there is a great deal of bleeding one looks at the swabs to assess the amount of blood needed. I thought there

were about 20 used at this operation.

To Court. I do not recollect seeing any swabs being rinsed out.

Adjourned to 30.1.58 at 10 a.m.

B.R. Miles, J.

30th January 1958.

In the Supreme Court of Kenya at Nairobi Eastern Africa

Defendants Evidence.

No.18

M.Robertson-Glasgow - Re-Examination - continued.

No.19

E.R. Ormerod - Examination.

No.19

EVIDENCE OF EDWARD RONALD ORMEROD

D.W.4 - EDWARD RONALD ORMEROD, Christian sworn:

Examined Salter. I am Bachelor of Medicine and Surgery, Member and Licentiate of Royal College of Surgeons, F.R.C.S. (Edinburgh). I am M.R.C.O.G. I qualified in 1921. I was House Surgeon and Physician in Royal Infirmary of Manchester for 3 years. I was House Surgeon and Physician in the Royal Children's Hospital, Manchester. I was House Surgeon and Gynaecologist, Obstetrical Department at Nottingham General Hospital. During the war I was in charge of the Surgical Department in E.A.Command. Since the war I have been consultant in Gynaecology and Obstetrics of Middlesex County Council. I came out here in 1950 to practise as a consultant. I am one of the consulting Obstetrical and gynaecologic surgeons to King George VI Hospital. I have had a description of the operation by Mr. Nevill given to me. I am familiar with Mrs. Cooper's condition at the time. I don't think it exists except as an emergency operation. As a surgeon I would describe it as an operation of extreme difficulty. I would say it is one of the most difficult emergencies of surgery. The patient is quite often in a moribund condition and literally loses a very high fraction of her total blood volume. If the operation is successful, then the surgeon and staff are entitled to congratulate themselves highly on an excellent result.

Q. As a surgeon, if in these circumstances a swab were left in the body of the patient what would you say?

In the Supreme Court of Kenya at Nairobi Eastern Africa

Defendants Evidence.

No.19

E.R. Ormerod - Examination - continued.

Objection by Mrs. Kean, but now withdrawn as she misunderstood the question he originally put.

A. I would say that under those conditions of extreme stress no element of carelessness existed on the part of the surgeon performing that operation. The nursing staff if they carried out their part of the routine check of the swabs and reported to the surgeon that the check was correct and the surgeon had made a rapid examination of the site in which he had been working and in which he knew he had deliberately placed a swab, I would say that under those conditions the surgeon could not be held responsible for any degree of carelessness. I would say that the nursing staff also shared in the conditions of speed and stress present on that occasion and that if they did carry out under those conditions their part of the procedure they should also be absolved of carelessness. This operation is one which requires a high degree of combination of dexterity and speed. With a moribund patient the life of the patient depends on those qualities in the surgeon. If the patient was "much better" before the abdomen was closed, I would say that that indicated that the surgeon had in fact achieved the object he set out to achieve. He had succeeded in stopping the source of bleeding but that would not give the surgeon any right to take any liberties which might extend the time of the operation because such appearances of improvement are often only temporary appearances, i.e. having known the condition of the patient a few minutes before the improvement, no surgeon of experience would trade on that improvement. Definitely he would not be justified in slowing the improvement up. Speed is of paramount importance. I think in the hands of an inexperienced and slow surgeon such a patient might die on the table. In a "cold" operation circumstances are of course entirely different. The surgeon would first remember exactly where he would put a swab or swabs or packs and when he had finished the operation under "cold" conditions he would remove those packs or swabs himself. He would then ask the theatre sister in charge of the case if her swab and pack count were correct. If she said "yes", he would then make a final examination and finding nothing present he would finally close the abdomen. He would make an inspection by eye and he would feel with one hand the area in which he had been working. Under ordinary cold conditions it would be possible

to make a search which would be thorough. I would say that it would take the best part of a minute if the area of operation is easily visible. In emergency conditions there would be a very considerable difference. I would expect an ordinary careful surgeon in those particular conditions and under the conditions of this operation where the abdomen has recently been full of blood and doubtless is still obscured by blood clots which have a habit of reappearing right up to the last minute, I would expect him to feel in the position where he thought or remembered he had put a pack. I would then expect him to turn to the sister in charge and ask her if she was satisfied. I think he would always ask. If she volunteered the information that would render the question unnecessary. I would then expect him to close the abdomen as rapidly as possible. I think Mr. Nevill went as far as he possibly could. I know Mr. Nevill personally very well. I regard his skill and capabilities as a surgeon as of a very high order. I have had experience of packs and swabs being left in an abdomen. In the event of a pack of Turkish towelling, the usual size is that of the one on the table. If a foreign body of that nature were left in among the coils of the intestine, I would expect trouble very shortly. I think it is impossible to be certain on a question of this sort. The circumstances surrounding its position relative to vital structures would determine the time factor in the onset of symptoms. In the case I have in mind, some 15 years ago a swab was left in the peritoneum and I think within a fortnight its presence was suspected. Within three weeks it was removed. There is an exception I think. First that the foreign body be outside a vital area, second that the conditions would be completely free of infection and it is possible under those conditions that the foreign body might become what pathologists call "encysted", i.e. shut off entirely from vital process. If that condition came about I think it is impossible to fix a time limit to that process. It might remain shut off for all time. There might be no limits. If the adhesions shutting it off were broken down at a subsequent date it could then become a "new" foreign body. A subsequent operation could be a cause of such disturbance.

CROSS-EXAMINATION

Cross-examined Kean. A foreign body made of metal would behave in an entirely different manner from a

Cross-Examination.

In the Supreme Court of Kenya at Nairobi Eastern Africa

Defendants Evidence.

No.19

E.R. Ormerod - Cross-Examination - continued.

Turkish towelling pack. I think all things are possible in the human body. I think even a Turkish towelling pack could remain encysted for all time. I agree that it is possible but not probable that Turkish towelling would remain encysted for all time. I would agree with text books that symptoms would normally be expected to manifest themselves within days or weeks. I have not come across a case in medical literature where Turkish towelling has been left in a body and symptoms have not manifested themselves within months. I am familiar as one can be with literature on the subject. That is the only case of a swab being left in an abdomen that I know and the swab had to be removed in about three weekstime. You can't rule out possibilities of a pathological nature. They can be accidental. The reimplantation of Fallopian tubes is not an operation that can be called routine in the sense that it is practised very often. It is a cold operation. The uterus may be abdominal or pelvic. The operation is carried out in the abdomen rather than in the pelvis. The uterus is drawn up in the abdomen. I have performed the type of operation that Mr. Nevill performed on Mrs. Cooper I should think in my time 20 at the outside. It might be a little more. They were mostly successful. One died on the table and one of a complication that developed further on. The constitution of the patient would be a definite factor in the prospects of survival. The patient died on the table from haemorrhagic shock. The determining factor would be the amount of blood which was lost and the speed with which it was stopped. One patient might be able to lose more blood than another. Transfusions would be a most important factor. That is the function of one of several people. The anaesthetist quite frequently undertakes it. A great deal of skill would be required on the part of the anaesthetist. Resuscitation comes first and surgery second. I think the decision as to the time the operation takes place is most important. One performs 10 cold operations to one emergency. That is my own figure. In hospital he would have a larger proportion. Surgeons vary in their functions. A surgeon who is a consultant, the number of emergencies he would perform 1 in 10 I think would be a fair estimate. I think you have to take into account the whole context. You are working under conditions of stress. You are very much in the position of a captain at sea in a storm. Your routine tends to be a bit displaced. I did not say it

would not be negligence on the part of the surgeon if a swab were overlooked in the body of Mrs.Cooper. I said it might not. It is possible that in attempting to get a clear view of the area he would pack a swab down and forget where he put it under those conditions of stress. He might even fail to remember that he had put it there. That would be a packing swab. I think he would only be excused under conditions of extreme stress in failing to remember that he had in fact put it there. I can conceive another set of circumstances. I can imagine that a swab might be placed in a certain position and during the manipulations which are necessary in this particular operation that swab could be displaced and it could become surrounded by coils of the gut. That would be any form of swab or pack. While he is mopping a mop would not and should not leave the surgeon's hand. I can conceive that suddenly he might decide to use it in another form, for packing. In a woman who is so dangerously ill it would be very meddlesome surgery to rummage among those coils because that would be attended by further shock. There is nothing else. In Mrs. Cooper's operation it would be difficult to know. For packing you might need 3 or 4; sometimes if the area is difficult you might need more. I think the final appeal would be to the swab count. If you used more swabs the chances of one being left behind are possibly a little greater. I don't think I have heard of the way Mrs. Cooper's intestines moved during the operation. I think a factor in determining negligence in failing to remove swabs is the condition of the patient immediately before the sewing up. If the anaesthetist were to warn the surgeon to get the patient off the table that would be a relevant factor. If that factor was not present that would also be relevant. An assistant if one could be obtained would be a great help. I don't know if this operation was performed by Mr. Nevill without an assistant. I have heard who the anaesthetist was. I have been informed that someone was helping with the transfusion. If a surgeon has a reasonably qualified assistant the cares on his head are somewhat alleviated. I think it would have helped Mr. Nevill greatly to have had an assistant. If he could have got an assistant his task would have been lessened. I know Dr. Wilson only very slightly. I would say he was a competent general practitioner. I have heard and seen that he did assist Mr. Nevill on many occasions. I would say it could so happen that a pack

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Defendants Evidence.

No.19

E.R. Ormerod - Cross-Examination - continued.

would move much more than one inch. I would not query it if Mr. Nevill said that they did not move more than one inch. I don't know the number of packs used for mopping in this operation. I don't know how long the operation took. I can imagine that it might be that the swabs were clearly visible. I think Mr. Nevill would be guided by the anaesthetist. He would satisfy himself in any event as to when to close the abdomen. The check in a hot operation would be completed in so far as it did not prejudice the patient's chances. I think the whole thing depends upon a proper conception of the whole circumstances. You cannot conceive the difficulties in an operation of this kind in which the surgeon has one objective and to insist on the routine "cold" checks being carried out and to insist that no accident shall take place under those conditions is a tremendous lot to ask. If a pack was left in in the circumstances described by Mr. Nevill it was an accident. It may have been placed in a certain position and in view of the exigencies of the operation it could have been displaced. I can imagine that Mr. Nevill may honestly have thought that he put that number in. It is a vital duty of the theatre sister to count the swabs correctly. That means to account for all used and unused swabs that had been taken out for the particular operation. The number of used swabs checked with the unused swabs should add up correctly at the end. If a swab has been overlooked and the sister confirms that the count is correct that means she has made a mistake. I would expect the sister to count correctly in a "perfectly routine operation". When I am operating I know how many swabs I have in action at the time. I definitely know that. I generally know how many mopping swabs I have in hand. I don't think in an ordinary operation there would be more than two of this kind used for mopping. In this operation there might be several. I don't count the ones outside. The sister counts those. I relate my mental number to her count. That is my invariable practice. I think one knows the number which I have used for mopping. It would ultimately be the theatre sister's responsibility to give the answer however much help she had. If she had help she might have more time to give to the count. I think the presence or absence of care would depend on whether the anaesthetist had said that it was necessary to get the patient off. I think it could have influenced the position. A mistake would be more excusable in

those circumstances. I have never operated at the European Hospital. It is a conversation which takes place between herself and the surgeon. It is audible to those around the body. It is no secret. It is a vitally important part of the routine. Indeed the consequences of leaving a swab in the body are so serious that a great deal of care must be used by all concerned to avoid it. In no case in which I have been concerned has a swab been left in the body.

RE-EXAMINATION

Re-Examination.

Re-examined. I would say the loss of over six pints of blood was a very severe loss. If bleeding was stopped within half a minute of the incision I would say that was highly expert. One would certainly need 3 or 4 mopping swabs for six pints. They would be wrung out and used again. To mop up two pints of blood if you use one swab after another without re-using you might use 10 - 15. It is quite possible 20 - 25 would have to be used. If those were being handled by the assistant surgeon I would not expect the surgeon to keep count of them. If used for mopping they would not have forceps attached. I think if the circumstances permitted forceps ought always to be applied to tapes. If packs used for restraining I think it is easy to miss anything under circumstances of stress such as those in which this operation took place.

Mrs. Kean. I object. This does not arise out of cross-examination.

Salter. Cross-examination was as to possibility of packs being lost.

Court. This does arise out of cross-examination.

A. It is possible for forceps to become detached. I would expect to find them as a rule outside the wound. The forceps would be lying on a towel often among other Spencer Wells. It might not be noticed that a forceps had come off. Having an assistant surgeon might in some respects lower the time factor of such an operation. It might enable the surgeon to proceed more quickly although the responsibility for carrying out all procedures is still the responsibility of the surgeon doing the operation; with the aid of a good assistant he might be able

In the Supreme Court of Kenya at Nairobi Eastern Africa

Defendants Evidence.

No.19

E.R. Ormerod - Re-Examination - continued.

to go a little bit faster. It would never be a question of his going a little bit "easier". His responsibility remains the same. When I refer to a swab being "displaced" it would be I think one placed as a pack. The time of doing a check will depend on the efficient way the swabs have been laid out on the floor. I think the check might be more difficult in an emergency particularly of this nature than in a cold operation. I think there is more chance of accidental error on the part of the theatre sister rather than the surgeon or a combination of both. Under the conditions of this operation the atmosphere for the theatre sister and her difficulties are parallel with the surgeon's difficulties. She is in a harrassed position. She is very often harrassed by the surgeon himself. There would be a temptation for the surgeon to perform his check more quickly for the sake of the patient in an emergency. Under these circumstances if a surgeon has a mental note of the number and is assured by the theatre sister that the count is correct, I would say he is not required to do more than that. His mind would be at rest. I would say in this particular instance it compared very favourably with the ordinary practice of a careful surgeon. If in addition he makes a visual check and does something with his hand he has done all he could do. I do not think a reasonably careful surgeon could have done anything else. In the difficult circumstances he achieved considerable success.

To Court. I think the fact that the surgeon was operating under considerable stress would place a greater responsibility on the theatre sister to see that the swab count was correct. Under those circumstances I can't imagine her the victim of an accidental error.

FURTHER EXAMINATION

Further Examination.

To Court Examined at request of Wilcock: I think such an accidental error would imply carelessness.

FURTHER CROSS-EXAMINATION

Further Cross-Examination.

Further cross-examined Kean. I would hold the theatre sister ultimately responsible. I don't know what assistance she had. I don't know how much time she had.

No.20

EVIDENCE OF CHARLES FREDERICK DERMOT McCALDIN

In the Supreme Court of Kenya at Nairobi Eastern Africa

Defendants Evidence.

No.20

C.F.D. McCaldin - Examination.

D.W.5 - CHARLES FREDERICK DERMOT McCALDIN, Christian sworn:

I am Bachelor of Medicine, Trinity College, Dublin. I have been in practice in Kenya over 30 years. I know of a case in which a swab has been left in a patient for a number of years. I assisted at an abdominal operation in 1929 when an appendix was removed. Sometime in 1940 or afterwards, the patient came to see me and he brought with him a glass jar in which was a specimen. The patient is deceased.

Mrs. Kean objects - Hearsay. I sustain Mrs.Kean's objection.

A. It was a globular mass about the size of a duck's egg. I couldn't swear as to its consistency. It is 20 years ago. I can't say whether it contained any strands of fibre. I can't remember; I could not say what it was made of.

Mrs. Kean. Section 32 Indian Evidence Act. None of these exceptions apply.

I rule that evidence as to what was said by the deceased does not come within any of the exceptions mentioned in Section 32 of the Indian Evidence Act.

A. That is the only case I have come across of a foreign body remaining for a number of years.

CROSS-EXAMINATION

Cross-Examination.

Cross-examined Kean. I don't know the literature on the subject.

Adjourned to 2.20 p.m.

2.20 p.m.

No.21

No.21

C.V.Braimbridge - Examination.

EVIDENCE OF CLIFFORD VINEY BRAIMBRIDGE

D.W.6 - CLIFFORD VINEY BRAIMBRIDGE, Christian sworn:

Examined Salter. I am M.R.C.S. (England), L.R.C.P. (London), B.A., B.M., B.Surgery, Cambridge University, F.R.C.S. (Edinburgh). I hold a diploma of

In the Supreme Court of Kenya at Nairobi Eastern Africa

Defendants Evidence.

No.21

C.V.Braimbridge - Examination - continued.

Tropical Medicine and Hygiene in London. I was qualified in 1916, joined R.A.M.C. in which I served 4 years. I returned to St. Bartholomew's Hospital where I was House Surgeon. I joined Colonial Medical Service of which I was a member for 35 years, the last 20 as senior surgical specialist. Since retiring I have been and am a Director of the Kenya European Hospital Association. As Director my duties are to supervise the work being carried on in all three institutions. On 1st February 1956 when Mrs. Cooper was admitted I was in the European Hospital. I saw her. I looked at her, saw she was nearly dead; although it was not my business I called Dr. Lawes to come at once and start a transfusion. I did this because I knew the surgeon to whom she had been referred, Mr. Nevill, could not possibly arrive in time before she was dead. I saw her in the ward before the operation. Her condition was very slightly improved in spite of the amount of blood which was being given to her. I was present at the operation, not all the time but in and out. It was a matter of interest because I had seen her when she came in and because it is my hospital. I was satisfied with the arrangements for the operation. There was no difference between the arrangements for this and a cold operation. The system for checking swabs in the European Hospital is the system which has been in use in my hospitals and theatres for 37 years. The instructions are that tapes should be attached to packing swabs. I call this (Exhibit 1) a pack. They are different from ordinary swabs. The regulations regarding tapes apply to this type (Exhibit 1). These packs are made in the workroom in the hospital. I insist to the best of my ability on the regulations being carried out by inspection and personal observation when operating. In my hospital I have never known a pack of this kind being used without a tape. In other hospitals, yes. If a pack came into the theatre without a tape the theatre sister would discard it automatically. Mrs. Cooper's operation was of extreme emergency. I have only knownone similar emergency which I did myself. That was exactly the same operation. I regarded speed as paramount. I should think that the amount of blood Mrs. Cooper lost would be about the same amount as in the one I did. I could not see when Mr. Nevill arrested the haemorrhage the exact moment. I should think it was about a minute. I would say half a minute was well inside the record. I would have been in and out when the mopping was done but I was

not standing close to the table. I am not able to say how many packs were used in the mopping process. In my operation I had someone assisting me in the surgical part of the operation. I would ask sister for a mop, wipe it round, hand it to sister or drop it on the floor. When actually mopping there wouldn't be need to let it out of my hand but I might let it out of my hand when it was in the body in order to see where the blood was coming from so as to see where to put the next mop in. I might leave it to the end of the operation, but it would be against my normal rule. In an operation of this kind anything might happen. I hope that would imprint itself on my mind. If sister has not already put a forceps on the restraining swab I would put one on. According to the particular size needed I fold it. I can't remember how many restraining swabs I used. Three would be the normal number. I remove the packs which to the best of my knowledge and belief I put in. By this time sister has told me if the count is correct or not. If the count is correct I start to sew up the abdomen. If she has not told me anything I ask her but she always has told me in my theatre. Where a lot of mopping swabs are used I think it might be very difficult for a surgeon to remember how many were used. I would not try myself. In an emergency as compared with a "cold" operation, I do not vary my routine with regard to asking the sister before I sew up. I would definitely vary the speed with which I check. When I had remembered all the ones I was conscious of having put in I should do no more. I would not feel around or have a look if the sister told me the count was correct. I have a normal routine of how and where I put in packs for an abdominal operation of this nature. Normally I put in three. There are exceptions. I cannot remember if I was present at that stage of Mr. Nevill's operation. I think Mr. Nevill did more than was necessary in making a visual check and feeling around. It is a bad thing to do a manual search even in a cold case. Nothing causes more shock than handling bowels. I regard Mr. Nevill as an extremely efficient, competent and experienced surgeon. If in the circumstances of this operation a swab has been left in, I would as a surgeon, to put it bluntly, say that it was a bit of bad luck, nothing else. In the circumstances of this operation I think there is no reason why it should cast any reflection on anyone concerned in the operation in the absence of other evidence, e.g. that the surgeon was drunk.

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C.V.Braimbridge - Examination - continued.

In the circumstances that I saw there was nothing to suggest a reflection on the surgeon or staff. The removal of 7 feet of small intestine would have no effect. 12 feet to 15 feet would have to be removed to affect the digestion. I know of a case of a patient left with 1 foot who is leading a reasonably happy and healthy life. I have had experience of abdominal packs being left in the body. I had two cases at least. The first case was a woman from whom I removed an ovarian cyst in 1931. Nineteen years later I operated on her for the removal of another ovarian cyst and I found a small pack inside her abdomen. In those days we used smaller packs than these. It was perhaps a little smaller than X.1., (the smaller). It is a long time ago (demonstrates 2/3rd). This is the sort of material I used since I started surgery in Kenya in 1921. The second case was more recent - 1947. It was a straightforward abdominal operation done cold in my own theatre with my own trained staff at every possible advantage. The operation was apparently successful. I went on leave 3 months later and when I returned I saw the patient who showed me an abdominal scar. This was three or four months after the first operation. In the first case the swab was found alongside the uterus. It is not uncommon for foreign bodies in the abdomen to be surrounded and walled off by the omentum. It was surrounded. Any foreign body left in the abdomen is surrounded automatically by "omentum". This is a curtain of fat lying on the top of the bowels like an eiderdown. It keeps the bowels comfortable and warm. If Mrs. Cooper had pain in April, May and October 1956 material could have been in the body for years. As a surgeon I would not be satisfied that it had come from Mr. Nevill's operation.

Examined Wilcock. I know of no more infallible method of checking packs than that in use at the European Hospital. I know Nurse Smith. She is a very competent nurse. The duties of a "dirty" nurse are to empty and change lotion bowls, to pick out used swabs from bowls in which they have been put or from the floor on which they have been dropped. An operation of the nature performed by Mr. Nevill would throw an additional burden on the "dirty" nurse only by reason of the enormous number of swabs that would be used. I know Sister Banks very well. I think she is the most competent and conscientious theatre sister who has ever worked for

me. I have frequently operated when Sister Banks and Nurse Smith worked together as a team and there would always be more than those two. In carrying out an abdominal operation I would have complete confidence in them as likely to do their job properly. During an abdominal operation the theatre sister in charge's duty is to put the instruments on the table. If there is an assistant surgeon her duty is to hand the surgeon what instruments he requires, to hand him mops and swabs as and when he asks for them, to keep a check on the number of swabs and packs used, to thread needles and do anything else she is asked to do. In an operation of Mr. Nevill's type there would be a greater burden on her than in a cold operation because everything would have to be done in double quick time. In my theatre and in most theatres the swabs and packs are lined up on the floor or table or on hooks. Before she reports to the surgeon she asks the dirty nurse if the count is correct. If she says yes, she recounts herself. Then she reports to the surgeon. She also checks with the clean packs. That is all that is required of a normal skilled nurse. We have a series of operations in one afternoon. The soiled packs are removed from the theatre after the patient is wheeled out. If a patient were returned to the theatre the theatre would be cleaned up and the soiled packs removed in the interim. Soiled packs are taken outside to the sluice room after the operation is completed. I shouldn't think the theatre sister in charge would count the soiled packs. It would not be the usual duty of a theatre sister to count such soiled packs. If she did she would be extremely conscientious.

CROSS-EXAMINATION

Cross-Examination.

Cross-examined Kean. The first operation, on the 1947 case, was one I performed. It was "cold". I don't recollect how many packs I used. It was probably three. If it was a pack I left inside I would say it was a piece of bad luck. It was not a pack that I left inside. There were no emergency features at that operation. I don't feel my trained staff would be in any way to blame. It is my opinion that anyone might have a cold operation and have a pack left behind and that it would be bad luck. I am not aware of it being standard procedure in some hospitals after the patient is sewn

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C.V.Braimbridge - Cross-Examination - continued.

up for a second check to be made. I would agree it would be an extra safeguard. I consider it unnecessary to introduce this safeguard in the hospitals which I control. I am aware that the risk of a swab being left in the body of a patient is very great and the effects may be very serious or even fatal. I do consider it the duty of all concerned to take elaborate and stringent precautions. It would be not too much trouble to count six times but I don't think it is necessary. It is just my opinion that the count by the dirty nurse and the count by the theatre sister is enough. I recollect Mr. Cooper coming to discuss this matter with me. I don't recollect saying to him that there had been another case of a swab being left in a patient and that I had advised the young husband to hush it up. I never said such a thing. I would never advise such a thing to be hushed up. The only direct evidence I have is of the cases with which I myself was concerned. In this type of operation the less the intestine is played about with the better for the patient. It is impossible to express an opinion whether I would be content having counted to myself and had an assurance from the sister in an emergency operation whether I would be content without further exploration. I could not possibly say exactly what I would do. It depends on the circumstances of each operation. I suppose I have done 40 or 50 operations for ruptures of ectopic gestations. The amount of blood in operations of that kind is unbelievable. About 25 were complete ruptures. I don't think any died on the table. I remember one now but could not give an answer without my notes. The great majority were successful. It is not part of my routine to make a search after I have counted myself and had an assurance. I do not consider that a search is necessary as a matter of routine in all cases. I consider it unnecessary and inadvisable. If it is done in every case it is unnecessary in my opinion. If a surgeon as a matter of routine makes a search by eye and hand I think he is a more careful surgeon than I am. If the bowels are pushed about a lot it is inadvisable. If they are moved gently for a peep it is not inadvisable. I don't attempt even a gentle search as a matter of routine. I agree it would be more inadvisable to make a search as a matter of routine in a "hot" than in a "cold" operation. I read my books. I see other surgeons operating. We all make a search at the site of the operation. I would of course make a search in the place where I thought

I had put packs. In my previous answers I thought I was asked if I would search all around the abdomen. If I was not satisfied with a look I would put a hand in as well. I should as a matter of routine make a manual search of the area where I had put in packs. One has to push things out of the way. A general search of the whole abdomen might take a quarter of an hour. I cannot remember at what stage in this operation I was in and out. I was in when the abdomen was opened. I can't remember being in at any particular phase. I can't remember any particular thing being done by the nurses. I should have noticed if they had not been carrying out their duties according to plan. That is my job. I would not have noticed if they had not carried out their duties by miscounting swabs. I should have noticed if they were handing things to the surgeon as they should and carrying out the general routine. I should not have stood over their shoulders and counted the swabs with them. Half an hour would be a reasonable time to prepare the theatre for the operation. I would not be prepared to express a definite opinion.

Adjourned to 10.30 a.m. on 31st January 1958.

B.R. Miles, J.

31st January 1958.

D.W.6 - further cross-examined Mrs. Kean.

If I were operating I would not hesitate at all before I cut out 8 feet of the small intestine. One naturally would not remove it unnecessarily. If it were not absolutely necessary it would not be desirable because it would be an unnecessary operation. By inadvisable I mean that it would be undesirable as an unnecessary operation not from the point of view of the patient's future. It would not be undesirable because she was left with that amount less spare. On the contrary it might be advantageous. There would be less intestine to suffer from diarrhoea. I disagree that the removal of that amount of bowel or that part of the bowel would necessarily have the effect of causing loose stools. It is not very likely to have that effect. There is nothing impossible in the human frame. Even if there were loose stools as a result of the excision of that amount of intestine, I cannot see that it would do any harm. It might be advantageous because there is less bowel to go wrong. It

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C.V.Braimbridge - Cross-Examination - continued.

might be an excellent thing for all of us to have 7 feet less of intestine to go wrong. Up to 12 feet could be removed without any harm. It is undesirable to remove anything which is unnecessary because of the risk of the operation itself. It would be undesirable because it would lengthen the operation. There is no other reason except the time and risk for saying it is undesirable. I form the opinion that it is undesirable without any reason. I was not aware of the opinions of Mr. Barber, Dr. Thompson and Dr. Dockeray. I would say that they are reasonably competent and knowledgeable in their respective functions. I can only state from my own personal experience and opinion. I do not know who makes the packs in the European Hospital. It is very important that they should be properly made. It is under the control of my matron in whom I have the greatest confidence. This does not enter into my direct office. I leave it to the matron. I do this in the other hospitals. I do not supervise in any way the making of packs. I frequently go into the workrooms where I presume the packs are made. I do not go into the workrooms for the purpose of inspecting the packs. I look at a cupboard in the theatre periodically which contains packs and swabs. I test them to see if they are properly made. I do not examine packs when they are on the table before I use them. When they are put in my hand I look at them before I put them in the body to make sure the tape is all right. That is always my practice. I would not use a pack without a tape unless there was an emergency and I could not wait. A pack without a tape would and should be discarded by the sister automatically. I do not think any sister would hand me a pack without a tape. If a sister should do such a thing she would be failing in her duty. It might be necessary for reasons which I have given for a swab used for mopping to leave my hand. If there is a lot of blood in the cavity you might be using a mop and you might leave that particular mop over a bleeding point to slow up the flow of blood while you mopped in the adjacent area. It would not be a most unusual thing to do. It would not be against my normal rule. It would be held by my assistant while I continued mopping. It might be left in the cavity without someone holding it. It would not be against my normal rule. It might not have a forceps attached to it if it had been inserted primarily for mopping and it were found advantageous to leave it there for an

appreciable measure of time. There is no difference between a mopping swab or a packing swab. It might be used for one thing or the other according to the exigencies of the situation. One might pick up a pack for one purpose but when one finds what is going on in the abdomen one might use it for the other purpose. It might be anything. I don't agree that the only way in which it would be properly left in would be if I decided to use it as a restraining swab. It might be left in to the end of the operation otherwise than for restraining, for staunching the blood from a bleeding point. I can't think of any other purpose but I am not prepared to say definitely. It would not be against my normal rule if it were left in for staunching the blood in this sort of operation. A pack like that might be overlooked but not easily. It would not be less likely to be left in without anybody holding it if I had an assistant. It would make no difference. Personally I think it is improbable that one would forget a swab left in for mopping. I think it would imprint itself on my mind just as any other pack which I used had I forgot any pack. It might be normal routine to leave a swab used for mopping inside the body until the end of the operation. I would not describe this as a routine use of a mopping swab. If I seize a swab and use it for mopping it would not leave my hand. But if I see a bleeding point I might leave the mop inside to stop bleeding. One or two packs would be left in the abdomen for stopping bleeding. I would try to keep count of those. It is vital to pay special attention to every act one makes during an operation, not one more than another. I would not pay special attention to the packs which I had left in without tapes and clips hanging out. Leaving a pack to staunch would only be necessary if blood was flowing, not necessarily a considerable amount but quite a lot. It is a question of degree. There might be another flow of blood in this case although the flow had been held. I do not know whether there was in this case. I would make a search in the area in which the operation was carried out but not in the whole abdominal cavity. There are a number of places in which packs might have to be placed. I would have routine places in which to place packs in a cold operation, but not in an operation of this sort. The process of removing the so-called restraining packs would be accompanied by a search for any other packs or swabs or forceps or any other instruments or articles which may have been used during the

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operation. I should and do search within the area of the operation. I do not explore the whole abdominal cavity which would be dangerous and unwarranted. I mean the whole area with which I had interfered during the course of my activities. I would call mopping an interference in the course of my activities. The search would be in the whole area where mopping had taken place. Mrs. Cooper was lying on a bed. The blood would be mostly confined to the pelvis because it is in the pelvis that the female organs lie. When it comes to the count I think it is understandable that if the anaesthetist told me the patient must be got off the table I would have to do my count as quickly as possible. If he did not I would have more time. Getting off the table is different from sewing up. It would not require an effort to remember the mopping swabs left in. I would do it automatically. I would take out automatically the number of swabs left in. In an operation like Mrs. Cooper's it is the same area where restraining packs and mopping packs are put in. The organs are moving all the time. I have performed many similar operations. I think the number I gave was 25. I have only known one patient who came into my hospital moribund. I don't know Mrs. Cooper's condition just before the incision was made. The bleeding point was at the cornu of the uterus. I did not see it. That is hearsay. I don't know where the foetus was found. I don't know the technical details of this operation. I know them by hearsay. As far as I understand, the abdomen was opened, a rupture was found in the uterus and the foetus was floating loose in a sea of blood in the abdominal cavity, the large artery in the uterus which was bleeding was seized, blood mopped out, foetus removed, the uterus sewn up and the abdominal wall closed. That is the routine of operations of this nature. I don't know exactly where the foetus was found. I did not inform myself. The blood might only be in the lower part of the abdomen. The restraining packs would be placed in the lower part of the abdomen. That would push the guts out of the pelvis and lower abdomen in order that the operation area would be visible. They must be above the operation area. The mopping would be done where the restraining packs are. You would not put in restraining packs until you had done the mopping. When mopping is done one starts at the bottom of the pelvis holding the bowels behind the restraining mops and lifting the bowels upwards with the restraining mops. The

restraining mops start at the bottom and ascend. The mopping might be done outside the boundaries of where the restraining packs ended their migration. I might or might not make a search outside that area. It would depend on what I had done previously. I could not say whether it would be necessary in that particular operation. It is part of my education to know the medical literature on the subject of the time a swab left in a patient would show symptoms. I would say that that is the most likely state of affairs that symptoms would appear within days, weeks or months. I have no limit to set. It is not likely to be days or weeks than months. The most likely period according to medical literature I agree is not more than 12 months. I know of a case in medical literature where symptoms manifested themselves after 12 months. It would take me a month to find out. I have read of such a case. I can't remember the type of swab or where it was left. I have been on the editorial board of the British Journal of Surgery. It might well have been in an article submitted for publication. I would not regard it as unusual. Foreign bodies of different substances can react in different ways. Some bodies are electrically composed and would cause different reactions. I would agree that metal bodies can remain slightly more innocuous than other bodies. It is common knowledge that metals remain in people for a long time without causing disturbances. I would say it was possible not likely. It would not be improbable. It would not be answered in a loud voice but a moderate voice that the swab count was correct. It would be answered so that people round the patient can hear. This is routine in the theatres of which I have had control. It is the routine in the theatre of the European Hospital. Sister Banks knows. I regard the standard of my theatres as particularly high. I only employ very competent people. I have no reason to think otherwise than that the theatre was properly prepared before the operation. There would always be a sufficient supply of Turkish towelling packs available. If there were no medical man acting as an assistant one of the theatre staff would do the job, not necessarily the sister in charge of the operation. It would depend on the wishes of the surgeon who was operating. Some surgeons would like the theatre sister to undertake those tasks, some would not. The theatre sister would be able to perform those tasks competently. If she were

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C.V.Braimbridge - Cross-Examination - continued.

performing those tasks she would still have the final responsibility in the counting of the swabs. I cannot remember whether I saw Mrs. Cooper after the operation on the same day. I don't know whether she was able to talk. I call only socially on patients who are not my patients. The packs are packed in drums in specific numbers. I don't know how many packs we had in the drums at the European Hospital. The theatre staff put them in the drums. Not Africans. The packs are put in cupboards first. From the cupboards they are put in drums when required. They are counted when they go into the cupboards and they are counted when they go into the drums. I have not laid down any routine as to how many people count them before they go into the drums. I can well believe that it is routine in some hospitals for two people to count them. The drums are put in a sterilizer and the contents sterilized. The next count is when they are taken from the drums when required for an operation and placed on the instrument table. This may be some days later. In each drum there are packs tied in bundles. I am not certain if the number is the same in each bundle. I haven't laid down any routine as to that. They are counted individually not in bundles on the table. I would suspect that they are always the same number. I have not laid it down in writing but I may have verbally when I took over. I might not mention minor details if I thought theatre sister was competent, which I did. The number of bundles in a drum would not be counted because drums are of different sizes. I have not given instructions as to whether Turkish towelling packs are to be laid out in bundles before an operation. I do operate in the European Hospital. When I operate I have observed that they are laid out in piles. I think there is only one pile of packs on the table for one operation. They are always laid out in bundles. I can't say what the number of packs is laid out before I begin to operate. I do not count the packs used and unused at the end of the operation. In a cold operation it is quite normal to use large packs for mopping. Some surgeons won't use small swabs at all because they think it is safer to use large packs. I have performed thousands of operations where I have not used large packs for mopping. Where I have used packs only for restraining purposes, I do not check the number of packs afterwards by reference to the number of used or unused packs. I rely on my memory of the ones I have used and secondly on the theatre sister's count.

Adjourned to 2.15 p.m.

2.15 p.m.

D.W.6 - further cross-examined Mrs. Kean.

I have no reason to think otherwise than that adequate staff was present in the theatre at Mrs. Cooper's operation. I cannot remember who was present. I would say that Sister Banks, Nurse Smith, Sister Pearce, an assistant surgeon, an anaesthetist and Dr. Robertson-Glasgow would be an ample staff. Each person would be able properly to perform his or her duties in his or her own particular sphere. In a hot operation everything must be done in double quick time. I don't think there would be any need to count swabs in double quick time by the nursing staff; I was referred to the operation. I can quite understand that the normal procedure of rinsing out packs would not be possible when so many packs would be required at a rapid rate. Some surgeons prefer packs rinsed in saline. I prefer them dry. It is a matter of individual taste. I don't lay down any routine for coutning packs or swabs during the operation. To the best of my knowledge and belief at the European Hospital the swabs and packs are laid out in rows on a mackintosh on the floor in a corner of the theatre. In fact they are so laid out; the dirty nurse lays them out. She gets them (a) from buckets on the floor, (b) on the floor itself when the surgeon has missed the bucket, (c) from the hands of the sister in charge, (d) from outside the sterilised area where they may have been pushed during the manipulations of the operation or dropped from the surgeon's hands. As far as I am aware they are placed in rows. I don't know the exact number in a row. I think it is usually ten - I am not sure. I issue no instructions. I think finger swabs are in bundles of ten but I don't know. I don't know if the number of dirty swabs in groups bear any relation to the number of clean swabs. I think it might be easier if each were laid out in the same number, clean or dirty. The dirty ones on the floor are counted by the dirty nurse and recounted by the sister in charge. The clean swabs are counted by the sister in charge on her table. I don't know if anyone else counts them. I have heard of the system of a blackboard being used. I don't like it because I consider it adds an extra element of error. There is the possibility of an incorrect marking on the board. Somebody might write down 11 and count 10. We used the system where there is a rack which is filled then it is crossed

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C.V.Braimbridge - Cross-Examination - continued.

off on the blackboard. We discarded this as unsatisfactory. That was in the original native hospital of Nairobi before the time of King George. The system now in force dispenses with the mechanical aids. There is too much danger in mechanical aids. It is essential to have sufficient theatre staff available to count without mechnical aid properly. At the European Hospital I would not like to express an opinion as to the proportion of emergency to non-emergency operations. I can give no idea of the relative proportions of the operations I have performed. An emergency operation is not an unusual occurrence in the European General Hospital. I don't know how many emergency operations are performed in a week at the European General Hospital. There is no difference between the treatment of an emergency from a non-emergency operation as regards the theatre staff. It would be their duty to perform their functions in the same way. All routine has to be carried out the same. The counting of swabs would be carried out in the same way.

RE-EXAMINATION

Re-Examination.

Re-examined. I know there is a routine for the making of packs and bringing them out. The minor details of the routine would be laid down by the theatre sister and for the matron. It is the matron who would be responsible with a competent theatre sister, it would be left to her. The matron would be responsible for seeing that that routine was kept to. The matron would get any complaint first that the routine had broken down. She would discuss it with me. I have had no discussions on this with this particular matron of this particular hospital. In an adbominal operation non-emergency she is standing at the side of the surgeon handing him swabs, packs, instruments as and when asked for, threading needles. In a not very severe operation in which there is not a second sister scrubbed up, she might even be asked to retract, apart from the job at all times of keeping the numbers of the swabs. I would not expect her to relax. If I thought I had left a swab in the patient on whom I had operated this morning I should be worried stiff and would not sleep. I would still think it was bad luck. I would think that everything humanly possible to avoid such a catastrophe had been done. I must have performed thousand of abdominal operations. I can only speak

of my experience which is two cases of packs left behind in my lifetime. I cannot remember performing an operation of this type on a patient in bed. I cannot remember performing an abdominal operation on a patient in bed. It would make a considerable difference as to where the blood would go because an operation table has certain gadgets which enable the table to be moved into certain positions which make it more easy to perform any specified operation. In this type of operation sometimes the patient is tilted, but only after the abdomen is open, with the head downwards. The reason is that the female organs are enclosed in the pelvis, which is the base formed by the hip bones. Normally this is also occupied by bowels. If the body is tilted the bowels tend to fall up towards the chest so enabling the female organs to be seen. If there is no tilt the operation is more difficult because the bowels come down and obscure the site of the operation despite the restraining packs. The appendix does not perform any useful purpose so far as is known. It is a frequent custom to remove the appendix at the same time as another operation, but I would not advise its removal as a precautionary measure. If Mr. Nevill held the bleeding part in his left hand and that was the only bleeding point, it would not be necessary for him to let go the mop. If there were a bleeding point which I could not catch with my hand or forceps I would apply a swab and press on it, but I would not know until I got inside what I was going to use the swab for. I should remove clots with my gloved hand without using a pack. I should use a pack in the same way (demonstrates). A pack would catch small clots which one could not catch with ones fingers. It is normal practice to use packs to remove clots in the scooping way I have described.

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NOTES OF PROCEEDINGS

Salter. My friend, Mr. Wilcock, is calling Sister Molloy. If I can adopt her evidence as part of my case that is the case for the first defendant.

It is agreed that the issues so far as the first defendant is concerned are wide enough to cover the negligence, if any, of Dr. Wilson.

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Wilcock. I rely on cases cited by Mr. Salter. Scott L.J. in Mahon v. Osborne p.540 - "Positive evidence of neglect of duty is surely needed". Van Wyk v. Lewis - "Plaintiff must show an absence of such care as under the circumstances it was the duty of the defendant to have observed during the performance of the operation".

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EVIDENCE OF MARY MACKENZIE MOLLOY

M.M.Molloy - Examination.

D.W.7 - MARY MACKENZIE MOLLOY, Christian sworn:

Examined Wilcock. I am a State Registered nurse. I have been nursing 4½ years. I am now employed as a sister at the New European Hospital. I have been there 19 months. I was present in the operating theatre when Mr. Barber performed an operation on Mrs. Cooper. I assisted Mr. Barber. I took the part a house surgeon would take at an operation. I remember a portion of intestine being removed from the patient. It was taken into the sluice. I did not see it again until the operation was over. I don't remember seeing the dissected part of intestine in the sluice. I saw another specimen in a bowl in the sluice. The sluice is immediately off the operating theatre. It looked like a piece of Turkish towelling. I lifted it up. I can't remember how. It was roughly 7" x 9". I can't remember whether it had hemmed edges. I did not notice a tape. I lifted it up in my fingers and I think had there been a tape I would have seen it. I don't recall any conversation about a tape. I don't remember whether Sister Banks was present at the time, I don't think she was. It was thrown away. I cannot say by whom or when. Since I have been at the hospital I have attended many operations at the theatre. I know the procedure concerning the provision of packs for an operation. Packs are made up in bundles of three. It doesn't vary. The packs are laid one on top of the other and then rolled up. There are always three - (Exhibit X), (demonstrates). They would be checked to see that all had tapes. All the tapes would be at the same corner. That is the quite invariable practice. A bundle has never contained 4 to 5 packs to my knowledge. One of the sisters rolls

up the packs. It has never happened that 4 packs have been rolled up. They are first rolled up in a bundle of three either when they are brought to the theatre new or when they are washed and dried. They would come new from the sewing room in the hospital. A European is in charge of the sewing room. The Africans bring them in when they have been dried. They are placed in a drum in the theatre until sister who is to make them up into bundles is free. When made up in bundles of three they are placed in a cupboard in the theatre where the reserve stock is kept. They are placed by sister into a drum which is kept for abdominal packs or else they are made up into a laparotomy set. The laparotomy set is also in a drum. The drum contains all the dressings while they are being sterilised and keeps them sterile. They are again checked before they are placed in the drum. They remain in the drum until needed for an operation. They are removed from a drum with a pair of sterile forceps by one of the theatre staff, one of the sisters. They are placed on a trolley which is being made up for an operation or if required during an operation, they are taken straight into the theatre and placed on a trolley. It is not possible to check them when they are taken out of the drum. When the sister begins to prepare for her case, she checks the bundles of packs or if they are taken straight into the theatre she immediately checks them. Before they are used the sister taking the case checks them. They would be dropped separately one after the other on to the trolley. They are always checked like that, never by looking at the corners. It is the duty of the "dirty" nurse to collect the used packs. She lays out both swabs and packs on a mackintosh. Swabs are laid out singly in a row until 12 are laid out. There are 12 swabs in a bundle. After 12 dirty swabs are laid out the dirty nurse picks them up and places them in a pail on the mackintosh. The sister usually asks her to check them. If she doesn't she usually reports to the sister in charge of the case that there are 12 there. In all cases the dirty nurse reports to the sister before putting them in the bucket. Packs are laid out on the mackintosh singly until there are three. The dirty nurse counts them and reports to sister that there are three. All three are brought together in a little pile on the mackintosh. They are not put in a pail. The dirty nurse collects them with forceps. She lays them not spread out. If there

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M.M.Molloy - Examination - continued.

are more than three again they are laid out singly until three are accumulated. When there are three, they are placed in a separate pile. It is the invariable practice. I have never seen anything else done. At the close of an abdominal operation sister will check the swabs on the floor and the swabs on her trolley by counting herself first and then the dirty nurse also counts the swabs on the floor. The dirty nurse usually repeats the number on the floor to the sister. If the sister is satisfied that the number is correct she reports to the surgeon that the swabs are correct. That does not include swabs and packs. If packs are used she will say, "the swabs and packs are correct". Once the patient has left the theatre the swabs are removed from the theatre. They are not in normal circumstances counted again. Packs are washed, dried and used again. They are not normally counted again before they are washed.

Examined Salter. This (Y) is not a pack. It is a face flannel. It is finer material and not hemstitched. It has no tape. The piece of Turkish towelling I saw was of this material (X). The smallest of this (X) is too small. Either this (X.1) or this (Exhibit 1) would be about the size. It was lying in the bottom of a bowl. There was someone with me. I don't remember who it was. I think it was Sister King. I cannot be sure. She is now Mrs. Grant-Smith. As far as I can remember I did not spread it out. When sister checks the unused packs on the trolley she leaves them loose. She does not fold them up. When they are used for mopping they are always used wet in a sterile solution. I wring them out and I remove as much moisture as possible. If they are being used as a restraining pack I make sure that the tape is free. The surgeon may take it from my hands or if he is not quite ready for it I would lay it on top of the sterile towels on the table on top of the patient. I may attach the Spencer Wells clips or the surgeon may attach them but there would be a clip attached. If the surgeon did not hold out his hand for the forceps I would attach the clip myself. I make sure a pack is never used as a restraining pack unless it has a clip. It is my training. I have worked with Mr. Nevill as theatre sister. He is very particular that a pack used as a restraining pack is always fitted with a tape and clip.

Adjourned to 10.30 a.m. on 3rd February 1958.

B.R. Miles, J.

3rd February 1958.

CROSS-EXAMINATION

D.W.7 - cross-examined Mrs. Kean:

There is probably one emergency operation in the European Hospital theatre every night. Some nights we have two. Routine operations are performed from 8.30 to 1 o'clock and 2 o'clock to 5 p.m. The organisation is well equipped to cope with these operations. The duties of the assistant surgeon which a sister might have to perform would be to assist the surgeon to hold artery forceps while the surgeon is tying an artery, occasionally to tie ligatures or to cut ligatures, to hold retractors. A sister would never have a pack in her hands. The duty of the sister taking the case would be to hand instruments required to the surgeon and ligatures and swabs; if there was an assistant surgeon she would thread needles. Lotion bowls are the duties of the dirty nurse. Her duty would be to keep an accurate count of the swabs. She might be asked to assist in holding retractors. It would be her duty to count the swabs whether there was an assistant surgeon or not. If we have warning of an emergency we say we can have the theatre ready in 30 minutes. If a case comes straight from the casualty ward it takes 5 minutes to boil the water. Another sister could be setting the trolley in 5 minutes. If we were warned at 3 the theatre would be ready at 3.30. In my experience I have not come across a surgeon who does not approve of the practice of having tapes on packs. I have never come across any surgeon who might cut off tapes. The routine for counting packs would be the same for an emergency operation as in an ordinary operation. It would not be part of the training or instructions of a sister that she would count the packs more quickly in an emergency operation.

RE-EXAMINATION

Re-examined. I have seen two perhaps three other operations at the European Hospital carried out in a bed. One was an amputation of a limb, the other was multiple injuries, both following accidents. One died, one was in hospital for six months. I have never seen an emergency operation where 9½ pints of liquid have been put in a patient. I have never seen a case where blood was taken out of a patient, cleaned and put in the patient in one of

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M.M.Molloy - Re-Examination - continued.

these operations. A surgeon very seldom asks for instruments. She knows the course of an operation and knows what is going to be needed next. She will have to watch all the time. In a serious abdominal operation it makes no difference to the sister in charge that there is an assistant surgeon present. Her duties are exactly the same. Usually she hands instruments and packs only to one of them. When there is a lot of bleeding the assistant surgeon may clip off swabs as well. His requirements would have to be met as well as the surgeon's.

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P.A. Grant-Smith - Examination.

No.24

EVIDENCE OF PATRICIA ANN GRANT-SMITH

D.W.8 - PATRICIA ANN GRANT-SMITH, Christian sworn:

Examined Wilcock: I was until my marriage known as Sister King. I am a State Registered nurse. I have been nursing 5 years. I have had two years' experience as a theatre sister. I have been at the New European Hospital two years. I took part in the operation in which Mr. Barber operated on Mrs. Cooper. I was in charge of the operation. I remember Mr. Barber cutting out a certain amount of intestine. He put it into a bowl and I gave it to the sister who was "running", Sister Banks - the "dirty" nurse. I saw it in the sluice. I saw the towelling that came out of it afterwards. I think it was lying just beside the intestine but I am not quite sure just where it was. I don't remember touching it. Mr. Barber, I think, held it up. I can't remember distinctly how he was holding it. I think it was a piece of towelling, it was discoloured. I should say it was roughly the same size as this (Exhibit 1). I don't think there was a tape on it. I did not look closely at it. I should think I would have seen a tape had there been one. I was very interested in it. It is very unusual. I can remember somebody saying it did not have a tape but I can't remember who. I think it was thrown away. I don't know when. I don't remember anybody asking about it at all. The system for putting packs in cupboards and drums is followed by everybody. There are always three packs in every bundle. I have never come across a bundle that has contained more than three. As theatre

sister I have never come across a pack in the European Hospital without a tape attached. The system of counting dirty packs is a routine system. It is observed in emergency operations as well as routine operations. It is never varied.

Examined Salter. This system is really second-nature to an experienced theatre sister. If I came across a bundle of packs with more than three the whole bundle would be discarded. It would not be used at all. It is a rule in our theatre. If I came across a pack without a tape the bundle would be discarded as well. It is a rule. The remark about there being no tape was made when I saw it in the sluice. At that time I don't remember apart from Mr. Barber who else was there. I don't remember whether it was a male or female who said this. I remember noticing that it did not have a tape. I don't remember when I noticed it. I might have said myself that it had no tape or it may have been someone else but I don't remember. Nobody to my knowledge went to have a more careful look at it as a result of that remark. At that time the pack was opened out. Thinking back I have no doubt at its having a tape or not. It did not have a tape. Some surgeons have packs handed to them dry, some rinsed. I have been in charge of an operation when Mr. Nevill has been operating many times. He likes the wet packs normally so does Mr. Braimbridge. There are one or two surgeons who like the dry ones. They normally tell me beforehand. Mr. Nevill never ignores the count of packs or swabs. He does not differ in that from Mr. Barber or any of the other surgeons.

CROSS-EXAMINATION

Cross-examined Mrs. Kean. When I operate with Mr. Nevill, usually we volunteer the information that the swab count is correct. I have never volunteered the information that the swab count was incorrect to Mr. Nevill. I have never come across a surgeon at the European Hospital who cuts off tapes. I don't remember who was in the sluice apart from Mr. Barber. It certainly looked like a pack. I thought it was a pack.

Cross-Examination.

RE-EXAMINATION

Re-Examination.

Re-examined. If I was a little slow in reporting to Mr. Nevill he would ask me if the count was correct. It was a question of who was ready first.

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P.D. Banks - Examination.

No.25

EVIDENCE OF PAMELA DASSIE BANKS

D.W.9 - PAMELA DASSIE BANKS, Christian sworn:

Examined Wilcock: I am a State Registered Nurse. I have been nursing nine years. I have been 4 years at the New European Hospital. I am theatre sister. There are no theatre sisters there senior to me. I am senior theatre sister. I have had about 6 years' experience as a theatre sister. During that period I think I have taken probably about 2,000 operations, over 1,000 at the New European Hospital. The senior sister who was in charge when the hospital first opened laid down the system with regard to counting packs. I am in charge of seeing that the system is complied with now. I am responsible. The system is a rigid system. It is never left to the other theatre sister's discretion as to whether it should be varied. The packs are made in the workroom and the tapes sewn on there. Soiled packs are washed on the hospital premises. Packs are washed, boiled and dried in the theatre department and then put into a special drawer to await the sister or whoever is going to check them into the store cupboard. A qualified person puts them in the cupbaord, one of the theatre staff. We are all state registered nurses except one, who is a state enrolled assistant nurse. They are first of all tested to make sure they each have a tape when taken out of the drawer and that the tape is quite secure. Then they are rolled into bundles of three. They are then placed in a storage cupboard. The swabs are not kept in the same cupboard. They are taken out of the cupboard when we want to put them into drums. One of the qualified people in the theatre puts them into the drums to sterilise them. They are again checked to make sure there is a tape on each pack and there are three in the roll. We have different types of drums. We have a standard form of drum, a laparotomy drum for an abdominal operation. I produce this as a laparotomy bundle (put in as Exhibit "A"). It is wrapped in a dressing towel (demonstrates). The sister who is laying out the trolley takes this bundle out of the drum with "cheatle" forceps and lays it on a trolley. These are long forceps which we keep sterile in a pot of carbolic lotion. We use them for taking instruments out of the sterilisers, towels and packs out of drums. The sister who is taking the case takes the cover off the top of the trolley which has two shelves and puts it on to the bottom. She then takes the bundle and lays it on the bottom shelf of

the trolley. She opens it out (demonstrates). This is the Mayo tray cover which is over the tray over the patient's legs. There are four dressing towels for towelling up the patient and a large abdominal sheet which goes on after the towels. The extra towel is for ligatures. We have two bundles of 12 gauze swabs always in bundles of 12 and one roll of three packs and one roll of wool for the very end as a dressing. The person who is taking the case first of all breaks one bundle of 12 swabs and checks to see if there are 12, separating each one. That goes on the top of the trolley. At this stage we do not worry about the packs unless we are definitely going to use them. If we think the packs are going to be used we take the bundle from the bottom and put it on the top of the trolley. We unroll it, and check the packs, one, two, three (demonstrates). If you know when laying a trolley that you are going to need more than three packs we take extra rolls of packs out of another drum labelled "abdominal packs". They would be put at the side of the laparotomy bundle on top of the trolley. This is when you are laying the trolley up. When the person who is taking the case is scrubbed up she then puts the extra packs on the bottom and only leaves on the top the three we are actually using. When the three in actual use are exhausted you take another bundle from the bottom of the trolley and check them in the way I have described. That would be during the course of the operation. At any stage in the operation there would be not more than three packs on the top of the trolley and rolled up bundles at the bottom. While taking an operation I have never come across a bundle containing more than three packs or a pack with no tape. It would be considered a very serious matter if I were to. A pack which is going to be used for restraining has a Spencer Wells artery forceps attached to it; sometimes I do it, sometimes the surgeon does. I have my eye on the tape and I sometimes put the forceps on. When a pack is used for swabbing a Spencer Wells forceps is never put on. I don't think it would be practicable. The artery forceps would get in the way. If the packs have been used as restraining packs the surgeon always hands the pack back to me and I take the artery forceps off the tape and either put it back into the hot saline or discard it. I can warm it and hand it back again if he requires it. If I discard it I put it into a "run around bowl" which is on the floor. When the surgeon has finished

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with a mapping pack he may discard it. He puts it into another "run around bowl" by his feet. I might put it back into the saline or discard it. They are picked up by the dirty nurse with forceps one by one immediately they are discarded. She puts them on to a mackintosh on the floor where I can see it all the time. Packs are put out in threes, (demonstrates) side by side, quite separate. When she has three she reports to me "I have 3 packs sister". I look over and check the three. When I have checked the three she puts them together on the mackintosh. If more than three are used she counts them in threes and leaves the three in the bundle. It is a repetition. The second bundle goes at the side of the first three. Then we start another three. They are left on show throughout the operation. We don't use any packs in any non-abdominal operation or in a normal appendicitis. In a large non-emergency abdominal operation, e.g. removal of the gall bladder, we normally use three packs. These would be all restraining. All the nursing staff wear masks (demonstrates). I sometimes have to say "pardon". At the end I look over to the mackintosh and ask the dirty nurse how many swabs she has. She tells me the number and I check myself. I then check with the clean swabs on my trolley and the total should make 12. The dirty nurse tells me how many complete threes she has. She might say "I have one bundle of three and two odd ones". I then check on my trolley and make sure about the remaining one. I have already checked the threes into three. If the sister tells me there are two bundles of three which I can see I check the odd ones. I was the theatre sister in charge of the operation performed by Mr. Nevill. I was officially due on duty at 3.15. I was having a cup of tea in the mess. I had a telephone call about 3 o'clock from one of the sisters in the theatre. I went to the theatre straight away. I started to lay out two trolleys. The instruments go on the other trolley. I laid out one laparotomy bundle and I had an idea what the case was going to be so I put out about three extra bundles of packs before I had been scrubbed up. I completed laying the trolleys and wheeled them into the theatre and then scrubbed up. I then began to prepare my trolley for the operation. The only packs I had on the top at the start of the operation were three and one bundle of 12 swabs. I had counted the packs when I undid the bundle. There was Nurse Smith who was acting as my dirty nurse. She is now in England. She arrived when I did and did a three-year

contract. She acted as my dirty nurse on other occasions. She was a very good nurse. She used to take a straight-forward appendix operation. A bed being used had the effect on me first of all that I could not use a Mayo tray, and the width of the bed - I was further away from the surgeon than I normally am. The bed was so wide that I think we had to use more towels to make sure it was covered. I have never been sister in charge at an abdominal operation carried out on a bed before. I have never taken part in an operation where blood was taken out of the abdomen, cleaned and returned to the patient. During the operation two or three packs I expect were used as restraining packs. They had Spencer-Wells clips attached. It is automatic. We used about 20 packs all told. I think the mopping packs were all discarded because as they were taken out of the abdomen they were covered in blood and clots. I thought it better to hand the surgeon a fresh pack each time. I can't remember if I washed out any pack at all in the saline. You might leave it in but if the surgeon wants another one immediately, you just put it in, wring it out and give it back to him. More bundles were brought to me. I think it must have been by Nurse Smith. When opened they were counted as normal routine. You don't first check packs when he wants to sew up. You are checking them during the case all the time. I made a final check. I carried out the exact routine I have described. The count was correct. I said, "the swab count is correct". I say "the swab count is correct", that covers the packs. That is always understood as covering the packs by the surgeon. I can't remember whether he asked but I said myself, "the swabs are correct". As I was throwing packs into the bowl I remember saying to Nurse Smith "do be careful", because we were using such a large number. After the patient had been removed from the theatre I saw the packs again. Nurse Smith and I re-checked the packs once more in the theatre. We re-checked each three, the one or two odd ones over which were on the mackintosh and re-checked the clean ones on my trolley. The count was correct. It is not usual to re-check swabs after the abdomen has been sewn up. We re-checked because the packs were still in the theatre and because of the large number we had used. When we did this final check we had no doubt at all as to whether our original check had been correct. When we are doing a routine operating list, when the peritoneum has been sewn up, with the permission of the sister

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who is taking the case, the swabs can be removed from the theatre. That includes packs. This is so that we can go on with the next case immediately. I was present at the operation carried out by Mr. Barber. I was "dirty nurse" or "runner". This operation was again after 3.15 and we normally only have two sisters on duty. The operation must have been after 3.15. Mr. Barber asked me if we could spare anybody to assist him. I told him Sister Molloy could assist, which meant that I had to stay on duty to act as dirty nurse. Sister King was taking the case. Dr. Thompson came into the theatre during the operation. I am aware Mr. Barber removed some intestines. It was handed to me in a bowl by Sister King. I took it into the sluice. Dr. Thompson was in the theatre. He came out into the sluice with me. He took the gut out of the bowl in his hands and put it on the end of the tap. He turned the tap on. The water began to run through the gut. This thing popped out of the other end. It looked like faeces. I had a pair of old forceps. I poked it. I said to Dr. Thompson, "it looks like a swab".

Adjourned to 2.15 p.m.

2.15 p.m.

Further Examination.

D.W.9 - further examined Wilcock.

I did not pick it up. I just poked it with the forceps. Then I think Dr. Thompson went into the theatre. I don't remember if he took the swab with him. The door was still open. I think he said something to the effect, "I think we have found the cause of the trouble". I opened it more or less right out. I might have first dangled it with the forceps. I didn't touch it with my fingers. Nobody picked it up in my presence. It was a piece of Turkish towelling. It was about 9" x 8" (demonstrates $\frac{3}{4}$ size of Exhibit 1). It did have sort of hemmed edges. I don't remember whether it had a tape attached. I did not see a tape. I think I would have seen one had there been one. I didn't hear anyone say anything about a tape at that time. The other two sisters did not come into the sluice room while I was there and look at it. We discussed it amongst ourselves, the theatre staff. We were all upset at finding this. I think I put it in the bin in the sluice. I don't remember anybody actually telling me to do so but someone must have done or I would not have thrown it away. It was never mentioned afterwards. I would only put a pack in the saline if I was likely to be asked for it. I wouldn't leave

it there indefinitely because at the end of the operation when we are about to sew up, if there is a pack still in the saline I take it out and discard it. It goes into the count. That is part of the routine. In this operation I did look into the saline (Mr. Nevill's operation). This is automatic. The saline is in a bowl stand about three feet high. It is right next to my trolley with the towels and packs.

Examined Salter. Mr. Barber must have told me to discard it because it is a ruling that we never discard any specimen without first asking the surgeon's permission. It did not have a frayed edge. It was like that (Exhibit X). It had a turned over edge. When I test the pack to see if the tape is secure you give it a pull (demonstrates). That is done in every case. I did not observe any tearing at the corner of this pack as though the tape had become detached. The surgeon takes out a restraining pack, he holds it by the pack itself. I return the clip to the forceps trolley. You count the clips. You know how many you start with. I have not had experience of a clip becoming detached from a restraining pack. I have other things to do without looking at the operation field all the time, but I would have known when the pack was handed back to me if the clip had become detached. You might have more than one pack in the solution bowl. If I checked a bundle of three packs and knew I was going to use them all, I would put the three packs into the saline, before use at all. You might have more than one dirty pack in the saline. In a large abdominal operation we sometimes have two lotion bowls. We try and keep one clean and one for wringing out packs that have been handed back to you. In this operation I can't remember how many lotion bowls I had. I don't think I used any of the saline bowls for any of the used packs in Mr. Nevill's operation. I remember that there was such a terrific amount of blood in the abdomen that as the mopping packs were taken out they were so thick with blood and clots that I discarded them immediately and handed a fresh pack over. I was handing them over very quickly because Mr. Nevill wanted to see where it was bleeding as quickly as possible. I can't say how long the mopping took. If I had found the count was incorrect in my final count after the patient had been removed I would have told Mr. Nevill straight away. We re-checked each bundle of three which had already been checked

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before, the used ones. I think that is the only difference from my first check. We re-checked the bundles of three and separated each three again. I actually see Mr. Nevill remove any restraining packs because they are handed to me. But while he is carrying out his other search I am not watching him as I am doing my own check. The other surgeons do not do anything different from Mr. Nevill so far as I can observe. In this particular operation nothing different was done. I do make an effort to keep a check on the restraining packs put in. If I had the impression that the surgeon had put in three and handed back only two I would tell him. I remember on opening the abdomen the amount of blood. It was the first time I had seen a case of a ruptured uterus. I remember the foetus being taken out and the bits of polythene tubing. It was the first time I had seen auto-transfusion actually working. It is the first time I have had to take a case where we were operating with the patient in bed and I have never before seen a patient brought into the theatre in such a critical condition. I had to be on the alert and have packs ready. I carried out my usual routine. I would not say the atmosphere in the theatre was really very different from that in other emergency operations.

CROSS-EXAMINATION

Cross-Examination.

Cross-examined Mrs. Kean. I wasn't watching anybody else sucking. Before the operation I had out six bottles with sodium citrate at the bottom in case we had to suck out blood for auto-transfusion. I saw blood being sucked out. I connected up the sucker. I don't know how many bottles were sucked out. It did not concern me. I did not see how many bottles were put back in. I don't know whether any were. I know auto-transfusion did take place. I saw it going on. I don't know how many bottles were put back. I don't know whether any was put back. There were two blood drips going on in the operation. I didn't know whether one was changed over. I don't know whether any of Mrs. Cooper's blood was put back into her. There were two transfusions going on but I don't know whether they put in any blood from Mrs. Cooper. This was the first time I had seen blood taken out of the abdomen for the purpose of auto-transfusion, but I don't know whether it was used or not. I have taken a case at an operation for a perforated duodenal ulcer. There has been an escape of septic matter from the duodenum.

In a perforated duodenal ulcer the hole through which the septic matter is coming is so small that with a sucker you can get rid of the septic contents. It would be impossible for 20 - 30 large packs to be used to clean out the escaped stomach contents. If a patient has been diagnosed properly, in any case I have seen we use a sucker or about one pack. You would have the sucker turned on as soon as the peritoneum was open. You may put in a couple of packs and then repair the whole. Two or three restraining packs would be necessary in my experience. It would surprise me if eight restraining packs were used (Mahon v. Osborne). In Mrs. Cooper's operation I only opened one bundle of 12 gauze swabs was opened so far as I know. I used two for preparing the skin before we made the incision. I didn't use any more. At theend of the operation I used possibly three or four to put on the patient's wound as a dressing. They were only used before the peritoneum was open and after it was sewn. There was no difficulty about counting the finger swabs. They are included in the count. I would say that the system used in this hospital for the counting of packs and swabs is a good system. I automatically put out more packs. I laid the trolley myself. More packs had to be brought from the sterilising room and taken from a drum labelled "abdominal packs". It is really up to the sister who is taking the case if she says "swabs and packs are correct", but if you say swabs are correct the surgeon knows automatically that you mean packs as well. I always say "swabs are correct". I remember saying it in this case. I don't remember whether I said it first because if Mr. Nevill had asked me the swab count I would not have replied "Yes", I would have said "the swabs are correct." From first incision until the peritoneum was sewn up took 40 minutes. Nurse Smith was present, Sister Pearce was present, she is nursing staff, she was helping generally. She was not scrubbed up. She was helping Dr. Lawes. She may have helped Dr. Robertson-Glasgow. She was not helping me at all. She did not help Nurse Smith. Nurse Smith was looking after my swabs. She was perhaps helping Dr. Robertson-Glasgow. I did not actually see her. Nurse Smith's main duty was to look after the swabs and assist me. I don't recollect Mr. Braimbridge being in the theatre. I might not have noticed him. I recognised this discovery immediately as a pack or a piece of Turkish towelling similar to a pack. It imprinted itself

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P.D. Banks - Cross-Examination - continued.

on my mind. All I know is I would not have thrown it away without being told. He discovered the bleeding almost immediately when he put his hand in. We automatically put the sucker on and I started to hand packs. I have no idea what Mr. Nevill is doing while I am doing my count. It was the first case at which I had been present of a ruptured uterus. It is just routine that I know what sort of suture I would be likely to be asked for, By "nothing different" I meant the nature of the operation. You know you have to sew up the uterus. The procedure of sewing up the uterus and putting in packs, nothing different was done and the routine check. I was asked about the swabs or volunteered. The question of transfusion while the patient is on the table is not my business. I am not qualified to say whether a patient is or is not an operational risk. There was no difference in the atmosphere in Mrs. Cooper's operation from any other emergency operation. Nurse Smith started working in the theatre in April 1954 when the hospital was opened. If a pack was definitely left in at Mr. Nevill's operation, there must have been an error somewhere in the count.

RE-EXAMINATION

Re-Examination.

Re-examined. In an operation out of the ordinary, I discuss the operation with the surgeon or doctor afterwards. An auto-transfusion would be the sort of thing. We discussed with the theatre staff, the sisters on the ward. We often discuss cases afterwards. (Description of packs in Mahon v. Osborne read out). I would not consider it abnormal for 25 of the packs described to be used in an operation for a perforated duodenal ulcer.

No.26

M.A. Pearce - Examination.

No.26

EVIDENCE OF MARY AMELIA PEARCE

D.W.10 - MARY AMELIA PEARCE, Christian sworn:

Examined Wilcock. I am State Registered Nurse. I have been nursing since 1946. I have six months' experience as a staff nurse in a theatre, but not as a sister. I am a ward sister in the New European Hospital. I know the routine laid down at the hospital in the checking of packs all the way through.

I was present at the operation on Mrs. Cooper performed by Mr. Nevill. I was helping generally. It was such an unusual case that I went along to see if I could help. Mrs. Cooper was placed under my care when she arrived in my ward. I was not given any specific duties at the theatre. I had quite a lot of opportunity of observing Sister Bank's behaviour during the operation. Before Mr. Nevill sewed up the peritoneum she said "the swabs are correct". Before she reported twice she told the dirty nurse to be careful during the course of the operation. Before the report to the surgeon she looked over to the dirty nurse and counted. I can't remember if I heard any words passing. I heard the dirty nurse say how many she had on the mackintosh. I can't remember seeing Sister Banks do anything else. Sister Banks was quite calm during the operation and very efficient.

Examined Salter. No questions.

CROSS EXAMINATION

Cross-Examination.

Cross-examined Mrs. Kean. I can't remember really any specific thing I did. I was not helping Dr. Robertson-Glasgow at all. I stood near Sister Banks in case she wanted anything. Extra packs were required during the operation. The dirty nurse, Nurse Smith, got them. I went round with the patient because she was so ill. Sister Banks did not need any extra assistance. I was not scrubbed up. I was outside the circle. I was the other side of the trolley. I can't remember definitely how many packs were used. There were a large number, probably 20. I can't remember how many finger swabs were used. Very few were used, just for cleaning the skin. The operation took 30 - 45 minutes. I was looking after Mrs. Cooper afterwards in the ward. Mr. Cooper visited her at about 6. I was not there when he saw his wife. I think I was off-duty that evening. About 24 finger swabs might be used in an ordinary abdominal operation. I don't know how many bundles a laparotomy set contains. I suppose finger swabs would be easy to lose but you take extra care of them.

RE-EXAMINATION

Re-Examination.

No re-examination.

Close of case for 2nd Defendants

Adjourned to 10.45 a.m. 4th February 1958.

B.R. Miles, J.

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.27

Notes of Proceedings, 3rd February 1958.

No.27

NOTES OF PROCEEDINGS

5.0 p.m.

Court proceeds to the New European Hospital with parties and advocates. The operating theatre is viewed and the routine system, with particular regard to the parcelling and counting of packs and swabs is demonstrated by Sister Banks.

B.R. Miles, J.
3rd February, 1958.

No.28

Addresses by Counsel, 4th February 1958.

No.28

ADDRESSES BY COUNSEL

4th February 1958

Salter for 1st Defendant. Plaintiff abandons further items of special damage, i.e. European Hospital fees and Mr. Nevill's fees. Special damages now claimed - Shs.5,189/80.

1. Damages. Loss of profit - no evidence.
   Loss of consortium.

   Nathan Law of Medical Negligence p.181.

   No reference to any future disability to have a child.

   Damages should only be awarded for 46 days Plaintiff spent in hospital.

2. Scott L.J. in Mahon v. Osborne - 1939 1 All. E.R. 537.

   Defendant has highest surgical qualifications it is possible to obtain.

   Evidence of Dr. Lawes - "Brilliant piece of surgery".

   Ormerod - "end brilliantly achieved".

   Barber - "difficult and hazardous operation".

3. First issue. Question of fact. Argument in favour of swab being left in at second operation comes down to one of time.

Argument against - Condition of pack. Question of tape. Practice in Nairobi European Hospital that no pack prepared without tape.

Evidence of Mr. Preston that he had been handed packs in 1955 - packs with no tapes at Princess Elizabeth Hospital.

Evidence as to discovery. Mr. Barber - "I did not pay particular attention to it".

Sister King - Positive no tape. Whole incident suggests pack had no tape on it. Difficult not to notice tape 3" - 4" long. Final count of Sister Banks after Mr. Nevill's operation. Check again after patient removed. She picked up each individual pack. Never challenged in cross-examination. Must be grave doubt as to whether Plaintiff has satisfied onus on this.

Issues 2 and 3. Negligence. Nevill and assistant are identified. Legal duty of surgeon - Mahon v. Osborne p.537 B. Nathan 79. Duty not absolute. Except for Goddard L.J. - every judge has held res ipsa loquitur does not apply; p.540 C. Mahon v. Osborne - "Positive evidence of neglect of duty is surely needed". Morris v. Winsbury-White, 1937 4 All.E.R. 494 - 499 G Res ipsa Loquitur not applicable. Must be proof of some act of negligence.

Plaintiff : Case here does really depend on res ipsa loquitur.

Plaintiff's case is that a pack here left in therefore negligence. Not a single piece of evidence that defendant Nevill negligent. Whole evidence including that for Plaintiff points to Defendant being not negligent but even skilful, Mahon v. Osborne p.545 F. There every surgeon says that before they close the abdomen they make a mental appreciation of swabs put in. They took out swabs themselves and felt within area of operation, then asked or told what count was. No suggestion that Nevill had not done anything unusual or omitted anything he should have done. In Plaintiff to show defendant did not observe usual practice. Sister Banks says Defendant in this operation did not depart from usual course. Whole of circumstances have to be looked at. Difficulties of operation incredible. Dying patient. Braimbridge had only once in 40 years seen a case like this. Speed dominating factor

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.28

Addresses by Counsel,

4th February 1958 - continued.

to stop bleeding. Shock still maintained throughout operation. Notes "still alive". A mistake can be forgiven if he has done in all circumstances what a reasonable skilful surgeon must do. Van Wyk v. Lewis, 1924. South African Law Reports, Appellate Division p.438 - 470. A surgeon cannot rely only on count. Evidence shows normal routine carried out despite difficulties. Theatre sister wholly reliable. If a swab left in it was an accident; p.471 - Van Wyk v. Lewis. If Court came to the conclusion that there was no negligence I ask Court to say all concerned entitled to great credit.

Court. Is law here different from law in England? Or res ipsa loquitur, Sec.106, Indian Evidence Act.

Salter. Common Law doctrines impeded by article 4 of Order in Council.

Wilcock. I adopt Mr. Salter's observations on law and everything which applies to 2nd Defendants particularly on first issue.

Balance of probabilities might point to pack being left in as 20 packs used. First operation was not emergency. In this operation particular precautions taken.

Nathan - James v. Dunlop - Issue not negligence.

Van Wyk v. Lewis - no negligence on part of nurse.

Mahon v. Osborne - Jury found in her favour.

Urry v. Bierer - only case where nurse negligent - non-emergency.

Nathan p.82 - no tapes used. Same degree of care required of nurse as of surgeon.

Shelton - Law relating to Hospitals, p.124.

Mahon v. Osborne - 553 B.

Van Wyk - p.461, 451.

Defendants could have stood on submission of no case.

Mahon v. Osborne - Goddard L.J. 506.

In Court below Judge and Plaintiff's counsel said no evidence against nurse. System approved by Plaintiff's witnesses.

Evidence of Ormerod and Braimbridge; Nurse Smith thoroughly efficient. Sister Banks quite exceptional theatre sister.

Evidence of Mr. Barber and Dr. Thompson. Lawes and Robertson-Glasgow and Braimbridge are astonishing testimonials. Evidence as to behaviour of staff at operation. Extra strain on theatre sister in this case. Sister Banks did all that was required of her. Not challenged. If packs dirty, possible for two packs to be confused with one. Here one would be confused with two. This impossible. Five checks here. "Excessively conscientious", according to Braimbridge. This not challenged. I cannot believe a pack was left in at operation.

Mrs. Kean. Argument of defence is that leaving of swab in after operation alone is just bad luck. (2) For Plaintiff to show affirmatively how that incident came about, a matter of which Plaintiff, being unconscious, can have no personal knowledge. I submit law does not impose that impossible hardship on the Plaintiff. Majority decision in Mahon v. Osborne was that res ipsa loquitur does apply. Nathan 115, 116. Law Journal Reports agree with K.B. reports 108, L.J. K.B. 567.

Clark v. Turnbull 10th edn. - 384, Salmond 11th edn. 519.

Morris v. Winsbury-White 499, not an authority against res ipsa loquitur.

Winfield p.505 6th edn. 208.

Adjourned to 2.15 p.m.

2.15 p.m.

Mrs. Kean. Mahon v. Osborne. 1939 1 All.E.R. 537 Mackinnon L.J. 553 C 554 C - D. Testing point is whether there was a case to answer. Gordon, Turner and Price 139 ; Van Wyk v. Lewis. Dissenting judgment of Kotze L.J. 451.

Hillier v. St. Bartholomew's Hospital, 1909 2 K.B. 820, 828. Per ipsa loquitur applied. Scott L.J's judgment in Mahon v. Osborne must be read in circumstances of each case, p.537. In that case great amount of movement, 25 - 30 packs for mopping and for packing. Highly dangerous septic matter - no assistant surgeon. 538 H, 540 H. Evidence that packs become discoloured and slimy. 556. Septic matter. 543 D 545.

Van Wyk v. Lewis. Septic matter present, 442, 468. Necessary there to get patient off table, 469, 442,

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4th February 1958 - continued.

470. Swabs unrecognisable, 471. Gordon P.140. Dunlop v. James, 3 packing swabs.

2. If res ipsa loquitur does apply what is legal position?

Charlesworth - Negligence 3rd edn. 41. Suffering of accident more consistent with negligence. Reasonable explanation to show how accident happened without negligence. Extent of explanation. Moore v. R. Fox and Sons, 1956 2 W.L.R. 342. Not sufficient to show accident inexplicable. "Absence of negligence more profitable" but must be shown. Winnipeg Electric Co. v.Geel, 1932 A.C. 699 - "Evidence too evenly balanced". Onus of disproving negligence remains throughout the case.

3. Issue 1. Was swab left in? Onus is on Plaintiff. Balance of probabilities. Barber's evidence. Remote possibility. All professional witnesses agree as to probabilities being against delay in symptoms, i.e. they will appear within days, weeks or months. Nevill retracted in cross-examination. He would only point to cotton. Defendants rely on Mr. Braimbridge's evidence.

Pack - no evidence of exact behaviour. Preston's evidence certain. One or two restraining packs used. None used for mopping. He would not use pack without tape. He accounted himself for packs. Not an emergency operation. No symptoms until 23rd April. It is said no challenge to Sister Banks as to recount after operation. I refer to her last answer in cross-examination. I could not suggest that she was lying without instructions from my client. Both Nevill and Smith and Banks that they honestly believed no swab left in.

Re Tape. Preston swore he never used pack without tape. Nevill unable to say positively about mopping packs that tape attached. 77. No sworn statement that tapes used at this operation. All evidence on probabilities points one way. Dunlop v. James 1931, British Medical Journal, 732.

4. Negligence.

(a) Plaintiff cannot when unconscious produce positive evidence of negligence. Nathan, 106. Circumstantial evidence. Plaintiff can rely on inference properly drawn from facts. P.108. Direct evidence not possible. More consistent with negligence.

(b) No answer for Defendants to say "we are highly competent in our respective spheres".

Plaintiff does not belittle skill, qualifications or conscientiousness of persons involved. Most skilful or careful driver may be guilty of negligence in an accident.

(c) Court decides what constitutes negligence. Opinions of experts inadmissible. Taylor as Evidence. 11th Edition. Vol.II 970, Vol.I 66. All skilled witnesses formed opinion on premises which are inadequate, e.g. Ormerod. All facts to be taken into account, e.g. (1) Presence of assistant surgeon, (2) whether patient had to be got off table, (3) number of packs. Ormerod had no idea of these factors.

Evidence of Braimbridge. He said even if routine operation and only 3 packs used for packing only and experienced staff, that would be "bad luck". Any other opinion he expressed cannot be accepted without great deal of searching.

(d) Duty of care. I agree with Salter. Question is not whether surgeon made reasonable search. Case for Mr. Nevill conducted on generalities. Only people who can descend to particularities are those who know what was going on. Has any explanation been offered here? Burden of defendant to show how this came about. If Nevill's evidence is accepted no explanation has been offered. In all other cases defendants offered possible explanations. None of those circumstances applied to this operation. (1) Presence of assistant to manage to get patient off table. All routine precautions possible. (2) 2 to 7 restraining packs. No little swabs used inside peritoneum. (3) Movement of intestine 1 inch. (4) No septic matter. (5) No evidence packs became slimy or unrecognisable. Clearly visible. Ormerod's two instances of absence of negligence - until cut by Nevill. Nevill remembers he says, routine at this operation. But he could not remember Mrs. Cooper coming round. Nevill says he did more than surgeon would do. I submit no casual connection shown between the difficulties of this operation and the leaving in of the pack.

(a) Bed.
(b) Condition of patient.

(a) Nevill does not explain how bed had effect on placing, or counting or movement of packs. Nevill said intestines did not displace packs. Braimbridge's theory did not apply.

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4th February 1958 - continued.

(b) No suggestion that Nevill flustered or put off usual routine.

Theatre staff. Evidence that atmosphere routine.

Lawes "routine operation". Not exceptional operation. Braimbridge - ample theatre staff available. Nurse Smith's main duty to count packs. Usual number of mops in abdominal operation - 24. Packs of this size and substance easier to account for than gauze swabs. Sister's duties to count correctly 20 packs. Time taken to prepare theatre - 30 minutes. Sister Banks off duty - not tired. If system good it should be all the easier for staff to carry it out.

(5) Law as to nurse's responsibility. Nathan - 86. Goddard L.J. Mahon v. Osborne 566. Court does not have to decide whether mistake was that of Sister Banks or Nurse Smith.

Adjourned to 9.45 5th February 1958.

B.R. Miles, J.

5th February 1958.

5th February 1958

(Hunter for Wilcock).

Mrs. Kean. Mackinnon L.J. at 556 F.G. General duty of nurses not considered in many cases. She need only show degree of care of reasonably careful sister. All judgments show surgeon has multifarious duties to perform. Judges recognise that no absolute duty on surgeon to count swabs because of multifarious duties. These duties do not compare with duties of theatre staff. Counting of swabs most important duty of theatre staff. In this case no evidence that they are absolved from this duty. Ormerod "I would expect theatre staff to count correctly even in a difficult operation". Evidence denies stress and strain. Sister Banks emphasizes that she was in no doubt after her final count after the operation. If mistake arose by having one group of four count at end of operation, relevance of final count would be very small. Nevill did not tell nurse to count quickly. Also Braimbridge "no question of counting in double quick time". Ormerod "determining factor of success in operation is speed with which bleeding stopped". Nevill says bleeding stopped in 30 seconds. Operation took 30 - 45 minutes. Assistant surgeon would lessen speed factor. Condition of

patient would not affect theatre staff. Ormerod says many cases of this sort in which cases moribund. Pack left inside. Not necessary to decide whether restraining or mopping. Only 2 or 3 restraining packs left. If used without tape this would be negligence. Nevill said he had no doubt he removed all restraining packs. If used for mopping, equally negligence. Ormerod "mopping pack would not and should not leave surgeon's hands". Braimbridge "only proper to leave pack in to staunch blood".

Swab count - Nevill says done in loud voice. Lawes and Robertson-Glasgow do not remember Sister Molloy say "swabs and packs correct". Nevill and Banks recollect announcement of count.

In other cases no recollection. Whether either or both negligent. Nathan, 86. Miscellaneous Provisions Ordinance, 1956. Apportionment of damages. Even if res ipsa loquitur does not apply Plaintiff must still succeed. Nathan, p.106-7. Direct evidence not necessary. All facts here available. Rebuttal of inference of negligence. Clarke v. Worboys, Nathan, 109. Van Wyk v. Lewis, 453. Facts must be reviewed as a whole. Moore v. Fox and Son, 1958, 2 W.L.R. Romer L.J. No great difference between a case of res ipsa loquitur and other cases where whole circumstances before Court. Nathan, 105. Evidence of Nevill makes matter fantastic.

Re swab - Conduct of parties ante litem important. Nevill's state of mind.

Damages. Woman in robust health prior to this operation. Now residuary symptoms, loose stools, trouble with digestion and pain as result of adhesions caused by removal of intestine. No one knows if and when these will disappear. She has been frequently going to see doctor. Might be further obstructions caused by adhesions. (Barber). How much spare left?

Evidence that Mrs. Cooper admitted that she should not become pregnant. Not known whether she can. Dr. Thompson advised that no examination desirable in view of this. Short term effects. Mental and physical suffering. She was continually suffering. Cause unknown. She thought she was suffering from cancer. Abdominal symptoms lead to depression. In hospital she intended to take her life. Noise of machine. Urry v. Bierer - £3,000. Duty of Court if a pack is left is to consider all circumstances. Res ipsa loquitur. Nathan, 110. This is a case

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which makes it probable that A and B were both negligent. Mahon v. Osborne. Negligence presumed against surgeon. Presumption against nurse stronger than against surgeon.

Salter. I ask leave to address Court on res ipsa loquitur. Practice over a year that Plaintiff opens law on which she relied. Practice note in January 1957.

Mrs. Kean. Order XVII rule (2) (3). No discretion. No surprise.

Salter. There is a right of reply on fresh points of law. Practice note.

Mrs. Kean. I waived objection.

Salter. Difference of interpretation of Mahon v. Osborne. Halsbury 1936 - Supplement. Judgment ambiguous. Mackinnon L.J. 553 D.E. 554 C. E.F. 553 - Passage ambiguous. Interrogatories had been administered. 540 Answer "I do not know".

Nathan 111, 112, 114.

I submit res ipsa loquitur cannot apply against 1st defendant. Responsibility more on sister. If doctrine does apply position is as laid down in Woods v. Duncan. 1946 A.C. 401, 439. Barkway v. S. Wales Transport Co. Ltd. 1948 2 All.E.R. 460, 463; Fish v. Kapur and other 1948, 2 All.E.R. 176; Moore v. Fox 1956 1 All.E.R. 182; Rose v. Minister of Health 1954, 2 Q.B.66.

80
GA.V

B.R. Miles, J.

17th February 1958.

17th February 1958.

Judgment delivered in the presence of Mrs. Kean for Plaintiffs.

C.W. Salter Q.C. } for 1st Defendant
Hunter }

R.D. Wilcock for 2nd Defendant.

B.R. Miles, J.
17th February 1958.

Mrs. Kean. I ask for certificate for taxation of costs on higher scale under Rule 56 Remuneration of Advocates Order.

Salter. No opposition.

Wilcock. No opposition.

Order. I certify that in view of the importance and difficulty of this case costs should be taxed on the higher scale.

B.R. Miles, J.

Salter. I ask for stay of execution in case of appeal.

Kean. I oppose any such application. Successful appeal would not be abortive. This is a money judgment.

Order. At this stage I consider that no ground has been shown for a stay of execution.

B.R. Miles, J.

No.29

J U D G M E N T

IN HER MAJESTY'S SUPREME COURT OF KENYA AT NAIROBI

CIVIL CASE NO. 808 of 1957

1. L.Q.T. COOPER)
2. MRS. R. COOPER) .. .. PLAINTIFFS

versus

G. NEVILLE)
KENYA EUROPEAN HOSPITAL ASSOCIATION) .. .. DEFENDANTS

In this case the plaintiffs, Mr. L.Q.T.Cooper and Mrs. Rosetta Cooper, claim damages against the first defendant, Mr. G.E. Nevill, and the Kenya European Hospital Association, for negligence. The claim arises out of an operation performed by the first defendant, on the 1st February, 1956, on Mrs. Cooper, the second plaintiff, at the New European Hospital, Nairobi, which is managed and maintained by the second defendants. The operation was for a rupture of an ectopic tubal pregnancy.

The case for the plaintiffs is, that at the operation, an abdominal swab, or pack, was left in

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Judgment, 17th February 1958 - continued.

the body of the second plaintiff. It is alleged that the first defendant was negligent in failing to count the number of swabs used in the operation and to check that the correct number of swabs was removed, that he failed to instruct the nurse, or nurses, to keep a check on the number of swabs used and/or failed personally to counter-check the number of swabs and failed to observe that one swab remained in the body of the second plaintiff. The particulars of negligence against the servants of the second defendant allege failure to count the number of swabs used for the operation and failure to detect that one swab had not been removed, in accordance with instructions given by the first defendant, or in accordance with the usual practice.

The defence, on behalf of both defendants, is first a denial that any pack was left in at the operation performed by Mr. Nevill, and secondly a denial of negligence on the part of any of the defendants.

Before proceeding to consider the various issues in this case, I will commence with a short account of the medical history of Mrs. Cooper, so far as material. On the 24th January, 1955, she was operated on by Mr. P.G. Preston, at the Princess Elizabeth Hospital, Nairobi, for the removal of an obstruction in her fallopian tubes, which were blocked. The blocked parts were removed in that operation and the patent parts of the tubes re-implanted in the uterus. That operation was successful. Mrs. Cooper experienced no ill-effect from the operation and her general health was satisfactory.

On the 1st February, 1956, the operation with which we are concerned in this case, was performed by Mr. Nevill, the first defendant, at the New European Hospital, for a rupture of an ectopic tubal pregnancy. What took place at this operation will have to be considered in detail hereafter.

Mrs. Cooper says that about a week after this operation, while she was still in hospital, she had an attack of vomiting. This may, perhaps, just have been the normal aftermath of a serious abdominal operation. On the night of 23rd April, however, Mrs. Cooper was taken ill at a dinner party. She complained of a pressure on the right side of her back and a feeling of nausea, which continued for some hours, and on the following day she went to

see her doctor - Doctor Thompson - to whom she complained of vomiting and abdominal pain throughout the previous night. This he thought was due to adhesions. She was admitted to the Maia Carberry Nursing Home in May, having had a recurrence. According to Dr. Thompson, she was free of symptoms after some two hours, and a clinical examination failed to reveal the cause. After her discharge from the Nursing Home, she was seen on a number of occasions by Dr. Thompson because she was complaining of occasional abdominal pains, which Dr. Thompson attributed to adhesions. These pains, however, gradually became aggravated and there was frequent vomiting; as a result of which Dr.Thompson admitted her to the New European Hospital for observation, on or about the 28th October, 1956. An X-ray photograph taken on admission revealed no evidence of an obstruction, but on the following day a further X-ray did show that there was an intestinal obstruction. It was accordingly decided that an operation was necessary and this was performed by Mr. W.C. Barber.

Mr. Barber states that on opening the abdomen he found an abscess cavity, centrally situated, surrounded by adherent coils of small intestine. There was a localised peritonitis. Mr. Barber tried to determine which portion of the ahderent intestine might be causing the obstruction. He first endeavoured to separate one or two adherent loops. On doing this, however, it was found that a leakage of bowel content resulted and since there were many adherent areas, Mr. Barber decided to remove the whole of the affected portion of the bowel. He accordingly cut away about seven feet of intestine. The whole length is some twenty-two feet. Mr. Barber says that he felt something in the piece of bowel he removed. The dissected portion was taken into the sluice in a bowl by Sister Banks, who was the "dirty nurse" at the operation. Dr. Thompson, then took the piece of intestine out of the bowl, placed it on the end of the tap and turned on the tap. There then emerged from the piece of bowel, a piece of turkish towelling, measuring some 9" x 7" or 10" x 8", with hemmed edges. This was immediately recognised by all persons present as an abdominal pack. Mr. Barber thereupon decided to ring up Mr. Nevill on the telephone and he informed Mr. Nevill of his discovery. Mr. Barber told Mr. Nevill that if he were asked what was the cause of the trouble he

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would have to inform Mr. Cooper, and Mr. Nevill very properly agreed that this was the correct procedure.

The first issue in this case is whether this abdominal pack was left in the body of Mrs. Cooper at the time of the operation performed by Mr. Nevill, since this has been strenuously denied by both defendants. It had obviously been left in at some operation and the suggestion of the defendants is that it was left in at the operation performed by Mr. Preston on the 24th January, 1955. It is, of course, for the plaintiff to prove affirmatively that it was, in fact, left in during the operation carried out by Mr. Nevill. It is said on behalf of the defendants that the pack could not have been left in at this later operation, because at that time all abdominal packs in use at the New European Hospital had tapes sewn on at one corner and this particular piece of turkish towelling had not such tape. It is necessary to examine the evidence of the various persons present at the time, on this question of tape. Mr. Barber, the surgeon who performed the operation, says he was unable to remember whether it had a tape or not, but that he did not pay particular attention. Dr. Thompson said that he did not see a tape, but that he did not specifically examine it for a tape. Sister Molloy, who was assisting Mr. Barber and taking the part of the House Surgeon at the operation, says that she lifted the piece of towelling up and did not notice a tape. She went on to say that she thought that had there been a tape she would have seen it. Sister King, who was the Theatre Sister in charge at the operation, says that she did not remember touching the towelling, but that she did not think there was a tape on it. She added that she did not look closely at it, but had there been one she thought she would have seen it. She said that she remembered somebody saying it did not have a tape, but she was unable at this stage, to say who the person was. Later on in her evidence she became a good deal more positive and said that she remembered noticing that it did not have a tape and that she might have been the person who made the observation, and finally she stated categorically that it did not have a tape. Sister Banks, who was acting as "dirty nurse", said that she was unable to remember whether it had a tape attached, but she said she did not see one, but that she thought she would have seen it if there had been

one. I am bound to say that it seems to me extremely odd that if anybody had made a remark as to the absence of the tape, so little importance was attached to it, since if what the defendants say is correct as to the practice of using only packs with tapes and there is no reliable evidence to contradict this, it might have gone some way towards clearing Mr. Nevill and the staff of the New European Hospital. The absence of a tape on this pack was never brought to the notice of either Mr. Barber or Dr. Thompson and it is, I think, of considerable significance that although both Mr. Barber and Dr. Thompson were acquainted with Mrs. Cooper's medical history, Mr. Barber decided to get into touch, not with Mr. Preston, but with Mr. Nevill. It is clear, therefore, that there was no doubt in the minds of these two experienced practitioners as to how this pack had got into Mrs. Cooper's body. I am at a loss to understand the decision to throw this pack away. I should have thought it would have been obvious to those concerned that litigation must almost inevitably ensue.

In my opinion, it would be unsafe for me to base my decision in this case upon the presence or absence of a tape on the pack which was found on the 29th October, 1956. The evidence is inconclusive one way or the other.

In my judgment considerably more light is thrown upon this issue by consideration of the time factor. Mr. Barber, who is a very experienced surgeon, says that his experience is that if a pack or swab if left in the body of a patient after an operation, in the few cases he has seen, the symptoms have usually developed within a few months, or even weeks. He agreed, however, that it might be possible for it to remain quiescent for a long period and if disturbed might start to cause trouble when it had not done so previously. It was quite clear, however, that he held the very definite opinion in the present case that the pack had been left in at the time of Mr. Nevill's operation. Dr. Dockeray had no personal experience of such an occurrence, but from his knowledge of the literature on the subject he said he would expect a piece of towelling of this nature to give trouble within a few weeks or months, and he mentioned one case where the interval was something like nine months. He agreed that there was what he described as a "theoretical possibility" that the pack might remain

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quiescent for as much as twelve months. Dr.Thompson said that his teaching was that symptoms would normally be produced after six months and he was rather more positive than any of the other witnesses. Mr. Ormerod, an experienced surgeon, called by the defendants said that it was impossible to be definite on a question of this kind, but that he would expect trouble to develop "very shortly". A material factor would be the site at which the pack was located. It might be in such a position that it was outside a vital area and that the conditions were completely free from infection. In these circumstances a foreign body might become what is known as "encystral", i.e. shut-off entirely from vital processes, in which case it might remain dormant indefinitely, even permanently. He did say, however, that it would be more likely that symptoms would appear within days, weeks or months. Mr. Braimbridge, a surgeon with forty years' experience also called by the defendants, cited one instance of an operation on a woman for an ovarian cist in 1931, in whose case a small pack was found nineteen years later. He said that he was on the editorial board of the British Journal of Surgery and had read of cases where symptoms had developed after twelve months, but he ultimately agreed that a most likely state of affairs would be that symptoms would appear within days, weeks or months, and more probably within days or weeks.

Reference has been made to the case of Van Wyk v. Lewis, reported in the 1924 South African Law Reports - Appellate Division, at p.438, where a piece of muslin of the shape and dimensions of a small size packing swab, with tape attachment, remained twelve months in the body of the patient and was then evacuated. This case was apparently considered of sufficient note to be mentioned in Gordon, Turner and Price's Medical Jurisprudence.

Mr. Preston gave evidence before me and was quite positive that he did not leave a pack inside the body when he performed his operation in 1955. This is only to be expected because no surgeon is usually conscious of having done such a thing. He said that he always insisted upon abdominal packs having tapes and he added that there had been occasions in 1955 at the Princess Elizabeth Hospital when he had been offered packs without tapes and refused them. The operation which he performed was not carried out under conditions of emergency.

No abdominal swabs were used for mopping and Mr. Preston says he thinks that he used one or two abdominal swabs for packing only. In these circumstances, it is unlikely, in my view, that the pack was left in at the time of Mr. Preston's operation. It is, I think, significant that no case has been cited to me in any medical text-book where a pack has remained dormant for over twelve months.

I think that the position can be fairly summed up, as it was, by Mr. Ormerod, namely that while it is possible for a foreign body of this nature to remain quiescent for an indefinite period, it is improbable. The human body is a complex organism, which occasionally behaves in an unpredictable manner and it is difficult to rule out anything as utterly impossible. A Civil Court, is concerned, however, not with possibilities, theoretical or otherwise, but with the balance of probabilities and, applying that test, I see no escape from the conclusion that this pack was left in Mrs. Cooper's body at the time of the operation performed by Mr. Nevill, on the 1st February, 1956, and I so find as a fact.

It is now necessary to consider the question of negligence and I will deal with this aspect of the case, so far as the first defendant, Mr.Nevill, is concerned. Before coming to the facts, however, it is necessary to consider the law relating to a case such as this. Mrs. Kean, for the plaintiff, has argued that this is a case where the doctrine of RES IPSA LOQUITUR applies and she has relied on the decision of the Court of Appeal in Mahon v. Osborne, 1939, 1 A.E.R., 535; 1939 2 K.B. 14 - 108 L.J. K.B. 567. There has been considerable argument in the course of the present hearing as to what precisely that case did decide. According to the head-note in the All England Reports, it was held "Goddard L.J. dissenting, that the doctrine of RES IPSA LOQUITUR did not apply in the case of a complicated surgical operation, but the head-note in both the Kings Bench and Law Journal Reports indicates that the majority decision was that it did apply and this view of the effect of the decision is expressed in Clarke and Lindsell - Torts - 10th Edition at p.84 and Salmond on Torts 11th Edition, p.519. It is quite clear that Scott L.J. in Mahon v. Osborne, emphatically decided that the doctrine was not applicable. Goddard L.J. held that it did. The third judgment is that of

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Mackinnon L.J. There are two passages in his judgment which unquestionably indicate that the Learned Lord Justice was of opinion that the doctrine RES IPSA LOQUITUR did apply. I quote from the All England Reports at p.553 para. (c) where the Learned Lord Justice said:

> "The plaintiff, having no means of knowing what happened in the theatre, was in the position of being able to rely on the maxim RES IPSA LOQUITUR so as to say, one or more of these five men have been negligent, since the swab was beyond question left in the abdomen of the deceased".

p.554 - paragraph (c) he says:

> "At the close of the plaintiffs case, no evidence having been called for her on the surgical question, counsel for defendant submitted that there was no case made out. If he had been bold enough to persist in that contention, I think that the Judge would have rightly overruled it".

This is, of course, the test. If the plaintiff in that case had proved no more than the fact that a swab was left in his body and the doctrine of RES IPSA LOQUITUR did not apply, a submission of no case would have been successful.

There does not appear to be anything like complete unanimity of judicial opinion as to the application of the doctrine of RES IPSA LOQUITUR in cases of this kind or, if it does apply, as to the extent of its applicability. In Van Wyk v. Lewis the Appellate Division of the South African Supreme Court unanimously held that it did not apply. In Morris v. Winsbury-White, 1937, 4 A.E.R. 494, Tucker J. held that it did not apply in the circumstances of that case but it is to be noted that at p.499 when dealing with the contention that RES IPSA LOQUITUR applied, he said: "Here you have the plaintiff, it is quite true under the control, you may call it, of the defendant, or in his power during the operations of November 27th and December 18th, and if the whole controversy in question in this case had been what happened at these operations, it may be that there might be something in Mr. Eddy's observations and submissions with regard to that".

The Learned Judge then went on to say that the case for the plaintiff was that the occurrence took place at another time.

I have already referred to Mahon v. Osborne. Mackinnon L.J. was of opinion in that case that the doctrine applied against both the surgeon and the nurse, but a ruling on that point was not necessary for the decision in that case. Goddard L.J., on the other hand, confined it to the case of the surgeon.

It is a general rule that before RES IPSA LOQUITUR can be applied the occurrence must amount to negligence on the part of the person whom the plaintiff wishes to hold responsible, or to negligence on the part of one or more individuals for whose acts that person is vicariously liable. In the present case, of course, the second defendants are not responsible in law for the acts of the first defendant. An illustration of this is the case of Cassidy v. the Ministry of Health, 1951, 2 K.B. p.343. In that case the Court of Appeal held that RES IPSA LOQUITUR did apply, but it is clear from the judgment that the Court based its decision on the fact that the defendant was responsible for all the persons on whose part the negligence was alleged. At p.348 Somervell L.J. said:

> "I have gone straight to the result because, in my opinion, on the basis that the hospital was responsible for all those in whose charge the plaintiff was, the surgeon, doctor and nurses, the result seems to me to raise a case of RES IPSA LOQUITUR".

There is a New Zealand case, MacDonald v. Pottinger, referred to in Nathan, Medical Negligence, p.112, where a patient in whose body a pair of forceps had been left after an operation sued only the surgeon who performed the operation. It was there held that RES IPSA LOQUITUR did not apply, since a number of other persons took part in the operation and might have been responsible for the mishap. In Roe v. Minister of Health, 1954, 1 W.L.R. 128, McNair J. in the Court of the first instance, having held that the defendants were not liable vicariously for the acts of one of the persons whose negligence might have caused the accident, namely the anaesthetist, said:

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> "As to the extent of the application of the doctrine of RES IPSA LOQUITUR where the thing or operation is under the control of two persons not in law responsible for each other, I am unable to understand how it can be said that the maxim can apply to either of such persons since the RES, if it speaks of negligence, does not speak of negligence against either individual".

The Court of Appeal, held, 1954, 2 Q.B. 71, that the defendant was vicariously liable for the acts of the anaesthetist. Somervell L.J. referring to the remarks of Tucker J. in the court below, which I have cited, said at p.80:

> "Our attention was drawn to some observations in Mahon v. Osborne which suggest this is too widely stated".

Later, however, he says:

> "Having come to the conclusion that the hospital were responsible for Dr. Graham, the judge's reason (which is applicable in certain cases) for excluding the maxim has not operated on my mind".

On the other hand, Denning L.J. said:

> "I went into the matter with some care in Cassidy v. the Ministry of Health and I adhere to all I there said. In the second place, I do not think that the hospital authorities and Dr. Graham can both avoid giving an explanation by the simple expedient of each throwing responsibility on to the other. If an injured person shows that one or the other or both of two persons injured him, but cannot say which of them it was, then he is not defeated altogether".

This, of course, having regard to the fact that the court has held that the hospital authority was responsible for the anaesthetist must be regarded as OBITER. The view which, so far as my researches go, appears to have the weight of authority behind it, is that in a case such as the present, where the plaintiff alleges negligence on the part of one or other or both of two persons for whom the defendants are not vicariously liable, the doctrine does

not apply. I respectfully agree with the view expressed in Nathan's Medical Negligence at p.114 on this point. The present case, therefore, must be treated as one in which the plaintiff must establish the negligence which she alleges against the defendants as in the normal case.

As to the standard of care which a surgeon is required by law to show, I cannot do better than quote from the judgment in Mahon v. Osborne of Scott L.J. p.357, in the All England Reports which says:

> This case is one of very great and general importance. It calls for close and anxious attention by reason of the double need on the one hand of enforcing a high standard of care for the surgeon against the grave danger of an overlooked swab, and on the other hand of protecting the surgeon from the risk of condemnation for actionable want of care, where he has in reality been doing his best for his patient, but as, under the urgent need of closing the operation as quickly as possible in the presence of other dangers to the patient, made a slip of memory, perhaps through a failure, unrealised by him, of a mechanical precaution like the swab clip. Whether or not that slip amounts to negligence may be a difficult question. The important principle is that a decision of actionable want of care cannot justly be reached without taking due account of all the circumstances of the particular operation, and the legal standard of care cannot be set higher than that of the ordinarily good and careful practitioner in those circumstances."

At page 548 Scott L.J. says:

> "Before I discuss the Judge's summing up, it is desirable to recall the well established legal measure of a professional man's duty. If he professes an art, he must be reasonably skilled in it ..... he must also be careful, but the standard of care which the law requires is not insurance against accidental slips. It is such a degree of care as a normal skilful member of the profession may reasonably be expected to exercise in the actual circumstances of the case in question.

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> It is not every slip or mistake which imports negligence and, in applying the duty and care to the case of a surgeon it is peculiarly necessary to have regard to the different kinds of circumstances that may present themselves for urgent attention".

The learned Lord Justice then goes on to enumerate a number of circumstances which are applicable to major abdominal operation and which might excuse failure to remove a pack. I shall revert to these later on.

I now come to the evidence with regard to this particular operation. Before describing the operation itself, it will be convenient at this stage to describe the system in force at the New European Hospital for checking and counting of packs and swabs. The expression "swab" appears to be a generic term used to cover two kinds of article, first the small finger swabs which are usually made of gauze and used for mopping blood and various other purposes such as painting the area of the wound, or for dressing the wound after the operation. The second kind consists of pieces of turkish towelling, varying in size, but usually measuring something like 10" x 8" and hemmed at the edges, with a loop at one corner. These may be used either for mopping purposes where the amount of blood is such that finger swabs would be inadequate, or for what has been described as "retaining purposes" i.e. for placing in the body in order to clear the operational field. When used for this purpose it is the usual practice and certainly the practice of all the surgeons who gave evidence in this case, to attach a Spencer-Wells artery forcep to the tape. The forcep is at all times protruding clear of the wound. The amount of tape protruding would, of course, depend upon the proximity of the pack to the outer surface of the wound. The Spencer-Wells forcep resembles a pair of scissors with two finger holes at one end and transversely corrugated arms which, when closed, bite closely on the tape. It is about 5" long. It is not the normal practice for packs used for mopping to be left in the body. The surgeon retains hold of them the whole time until he discards them. It is not usual to have forceps attached since they would get in the way. It appears that some surgeons never use finger swabs for mopping because of the danger of their being overlooked. Mr. Braimbridge

mentioned that he occasionally left mopping packs in the body for the purpose of staunching blood, but that is not a circumstance which is material in the present case.

The system in force at the New European Hospital for checking and counting packs and swabs is as follows:- The packs are made in the workroom at the hospital and tapes sewn on there. Soiled packs are washed in the hospital premises. After washing, boiling and drying, they are put into a special drawer to await the sister, or whoever is going to check them into the store cupboard. This is done by one of the theatre staff. Before being put into the cupboard, packs are tested to make sure that they each have a tape and that this is securely sewn on. The packs are then rolled into bundles of three and placed in a storage cupboard. At a later stage they are taken out of the cupboard and put into drums for the purpose of sterilisation. At this stage they are again checked to make sure that there is a tape on each of them and that they are in bundles of three. Before an operation the sister who is laying out the trolley takes that is known as a laparotomy bundle out of the drum with forceps and lays it on a trolley. The bundle consists of four dressing towels for towelling up the patient and a large abdominal sheet which goes on after the towels, two bundles each of twelve gauze swabs, one roll of three packs and one roll of wool for dressing. The sister who is taking the case, first of all breaks one bundle of twelve swabs and checks to see if the number is correct, separating each one. She places six on the top of the trolley. If it is anticipated that packs are going to be used, the bundle of three is taken from the bottom of the trolley (the trolley consists of two shelves) and placed on the top. The pack is then unrolled and the packs are checked one by one. If it is known at this stage that more than one bundle of packs is likely to be used, extra bundles are taken out of another drum, labelled "abdominal packs". When the trolley is being laid, they would be put at the side of the laparotomy bundle, but when the sister who is taking the case is scrubbed up she puts the extra packs on the bottom of the trolley and only leaves on the top those actually in use. If the three packs in use are exhausted, another bundle is taken from the bottom of the trolley and checked in the same way. At no stage in the operation is more than one

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bundle of three packs on the top of the trolley. If a pack is going to be used for "restraining purposes", the Spencer-Wells clip may be attached, either by the surgeon or the theatre sister in charge. When the surgeon has finished using a "restraining" pack he hands it back to the sister who takes off the forcep and either puts the pack into the bowl of hot saline solution which is by her or discards it. If she discards it, she puts in into what is known as a "run-around bowl" on the floor. When the surgeon has finished with a mopping pack, he may discard it by putting it into another "run-around bowl" by his feet. The sister may then either put it into the saline bowl, or discard it. When packs are discarded they are picked up by the "dirty nurse" with forceps as they are discarded and placed on a mackintosh sheet on the floor, where the sister in charge can keep an eye on them. The packs are invariably laid out in threes, side by side. When there are three packs on the sheet, the "dirty nurse" reports "I have three packs sister" and the sister looks over and checks. When the packs have been checked, the "dirty nurse" puts them together in threes on the mackintosh. If more than three are used the "dirty nurse" counts them in threes, leaving the three in the bundle. The second bundle goes at the side of the first and so on. At the end of the operation the sister in charge looks over to the mackintosh and asks the "dirty nurse" how many swabs she has. On receiving the number, the sister checks herself and checks with the clean swabs on her trolley, to make sure that the total amounts to twelve. Similarly in the case of the packs, the "dirty nurse" tells her how many completed bundles of three she has and gives the number of any odd ones over. This is then checked by the sister with those on the trolley. Prior to sewing up the wound, the surgeon either asks the sister in charge whether the swabs, including of course, the packs, are correct, or it may be that the sister herself volunteers the information. He does not sew up until he has received an assurance that the count is correct None of the experienced surgeons who gave evidence in this case had any fault to find with this system and I see no reason to dissent from this view. It is not in fact the case for the plaintiffs that the system was an improper one. All such systems, however, are in the last resort dependant on the human element and as such liable to human fallibility.

I now come to the circumstances of this particular operation. Mrs. Cooper was brought into hospital somewhere in the neighbourhood of 2.30 p.m. She was first seen by Dr. Lawes who subsequently acted as anaesthetist at 2.40 p.m. She had apparently been removed to hospital as a result of prompt action by Dr. Gillespie and Dr. Spiers. Her condition on arrival was described by Dr. Lawes as follows: "She was comatose, pulseless, no blood pressure, grey-faced, cold and sweating, with sighing respirations and the heart could just be heard with a stethescope. In short, she was dying". Dr. Lawes took a sample of blood from a vein in the neck, which was the only one available to a needle, and this was sent to the laboratory for grouping and cross-matching with blood in the blood bank. He states that while blood was being made available, she was given three pints of saline and artificial plasma under pressure in ten minutes. Altogether six and a half pints of blood were given to her between then and 4 p.m. At 3 p.m. he telephoned Mr. Nevill, who arrived shortly after, and at this time she was, to use Dr. Lawes's words, "just becoming an operable risk". Mr. Nevill described her condition at that time as "not in any sense of the word a reasonable operative risk". Nevertheless, it was decided that an immediate operation was essential, as being the only hope of stopping the haemorrhage which was killing her. At first it was doubtful whether it would even be safe to move the patient into the theatre, but ultimately it was decided to do so. It was, however, considered unsafe to move her on to the operating table and the operation had to be conducted upon the patient in her bed. The disadvantages of this are obvious. The two main ones are, of course, that first a bed is considerably wider than the operating table, with the result that the surgeon cannot get as near to a patient as is desirable and secondly that he has to operate throughout in a stooping position, with consequent additional fatigue. In normal operations, what is known as a "nayo" tray containing instruments, is placed over the patient's legs on the operating table, but this is impracticable if the patient is in bed. This was the first occasion on which Mr. Nevill had ever operated on a patient in bed.

The following persons took part in this operation. First of all there was Mr. Nevill himself. He is a Bachelor of Medicine (Dublin), a Fellow of

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the Royal College of Surgeons and a Master of Surgery (University of Dublin). I am informed that the degree of Master of Surgery is the highest attainable in surgery. He qualified in 1938. During his twenty years in practice he has performed between two thousand and four thousand operations. He was assisted by Dr. Wilson, as assistant surgeon, who had at that stage been qualified for some four or five years. The anaesthetist was Dr. Lawes, the senior Government Anaesthetist. Dr. Robertson-Glasgow supervised the auto-transfusion. The sister in charge was Sister Banks. She is a State Registered nurse who has been nursing for nine years - four of them at the New European Hospital. She had about six years' experience as a theatre sister, in the course of which she has taken some two thousand operations and over a thousand at the New European Hospital. Sister Banks was described by Mr. Braimbridge as "the most competent and conscientious sister who had ever worked for him". She was given the highest testimonials by all the other surgeons and I have not the slightest doubt that these are well deserved. She was assisted by Nurse Smith who has been described by Mr. Braimbridge as "a very competent nurse". Sister Pearce, the ward nurse, was also present, but not scrubbed up and she rendered assistance in various minor ways. Dr. Wilson and Nurse Smith are now out of the country and did not give evidence.

To come to the operation itself. Mr. Nevill states that he made a mid-line incision. There was no bleeding from the body, which is an unusual circumstance and indicates the gravity of the patient's condition. He found the abdominal cavity full of blood. He placed his left hand deep into the pelvis and felt that the left cornu of the uterus had burst. He seized this, which was the bleeding point, between his finger and thumb and held firm to control any further bleeding. The bleeding was in fact stopped within 30 seconds or so. Blood was then sucked out of the abdominal cavity and placed in specially prepared bottles for the purpose of auto-transfusion. There were some four pints removed in this manner. There was still a quantity of blood in the abdomen. This was removed by Mr. Nevill and Dr. Wilson by using mopping packs. Two or three pints were removed in this manner. No clips were attached to these mopping packs. Mr. Nevill is positive that he did

not release hold of any mopping pack that he used, because this would not be the normal practice. He could not say for certain whether Dr. Wilson did or not, but it would be most unlikely. The sucking and mopping took about from five to eight minutes. For the purpose of sewing the ruptured part and in order to keep the field of work clear, Mr. Nevill packedback all the intestines, using two or three packs. These had both tapes and Spencer-Wells forceps. He then sewed up the uterus. The foetus which had caused the trouble was lying free in the pelvic cavity and beside it was the plastic tube which had been used in order to achieve pregnancy. He then checked the pelvic cavity to see that it was free of blood clots, and that there was no other bleeding from the ruptured uterus, which he had stitched. The stage was then reached when he was ready to terminate the operation. Mr. Nevill's account of his actions at this point is as follows:

> "Having checked that the pelvic cavity was clear I then removed the packing swabs which I had placed, checking carefully the area involved; removing at the same time considerable quantities of blood which were oozing down from the upper parts of the abdomen. When I was sure that I had done all that I should do in the way of routine checking for packs, I was ready to sew up. While I was checking inside, the theatre staff, under the direction of Sister Banks, was checking up outside, in our routine procedure to ensure against leaving swabs behind. I was assured that the swab count was correct. Sister Banks assured me. You do not sew up until you are informed and until you have completed your own check".

Later on he says:

> "My absolute routine is that I personally always remove the packs which I know that I have placed in the abdomen or my assistant has placed. It is my responsibility. I then always check the operation area to make sure that none others or any foreign body could have crept in by mistake".

Neither Mr. Nevill or Sister Banks could remember in this particular instance, whether she volunteered the information that the count was correct or

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whether Mr. Nevill first asked the question. Both she and Mr. Nevill are positive that the information was given and I have no hesitation in accepting that. In cross-examination Mr. Nevill said that he knew where he had put the two or three packs. They were in an obvious position and he would not have needed any guidance to them. He went on to say:

> "In this case I did carry out my routine check. We did the best we could".

He then explained his routine check in rather more detail.

> "I remove the swabs that I know I have placed in position. I look to see, within reasonable limitations, that there are no other swabs visible. I feel with my hand into all reasonable places where a swab might hide itself and when I am absolutely certain that there are no foreign bodies inside the abdomen, I question Sister about her swab count, unless it may be that she has already told me her swabs are correct, in which case the question would be superfluous".

Mr. Nevill also said:

> "I never do rely completely on the theatre Sister's count. I rely on my own count in addition".

He emphasised that he carried out this routine in the present case and that this was not a case which made the routine check impossible.

The operation was completely successful, in that it achieved its object, which was the saving of Mrs. Cooper's life. The operation was described by Mr. Barber as "extremely difficult and hazardous", and there is no doubt that it was a brilliant piece of surgery. Mr. Nevill himself described it as an "incredibly difficult and delicate operation", and he said that he had never been faced with conditions such as those in his whole career. Mr. Braimbridge said that he had only known one other case of an operation of this kind being performed on a patient in the condition of Mrs. Cooper. Mr. Nevill readily agreed that the credit was not his alone, but was to be shared by all who had dealt

with Mrs. Cooper, both before and after her admission to hospital on the day in question.

Mr. Barber, dealing with the question of a search at the close of the operation, says:

> "If I have put packs in an abdomen I do a mental count of the packs when I insert them. I keep a mental count in my mind and I expect to find the same number when I remove them at the end of the operation. I think if one knows in a big operation that one had used a number of packs, I do subconsciously feel around the area in which I have been working, but I cannot say that it is a conscious search. I do this because I am afraid that I might leave one behind. This feeling takes a second or two. I do not make a general search of the whole abdomen for packs".

Mr. Braimbridge said that his practice is to remove the packs which, to the best of his knowledge and belief, he has put in. He said that he would make a search in the places where he thought he had put packs, but he would not make a general search of the abdomen. The reason, of course, for this, is that any interference with organs increases the degree of shock. He expressed the opinion, having heard Mr. Nevill's account of what he had done, that Mr. Nevill had done more than was necessary. He also went on to say that in his opinion if a pack was left in at any operation it would just be "bad luck", a proposition which hardly calls for any comment from me. Mr. Ormerod said that in emergency conditions and in the particular circumstances of this operation, he would expect the ordinary, careful surgeon to feel in the position where he thought, or remembered, he had put a pack. He would expect him to ask the sister in charge if she was satisfied. He would then expect him to close the abdomen as rapidly as possible.

There is no direct evidence as to whether the pack in question, which was found in the body, was one of the two or three "restraining" packs, or whether it was one of those used for mopping. The total number of packs used in the whole operation was stated to be in the region of twenty. This is a large number, but was necessitated by the very great amount of blood which had to be removed from the abdominal cavity. To my mind the probabilities

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are that it was one of the restraining packs, because it is not the normal, and in fact would be improper procedure, for a surgeon to release hold of a mopping pack. Mr. Nevill is confident that he did no such thing. In the mopping he was assisted by Dr. Wilson, and although he kept a close observation on Dr. Wilson, he is unable to say with any certainty, whether Dr. Wilson left a mopping pack in the body. If he did so, that would undoubtedly be negligence and it is conceded that Mr. Nevill is responsible for negligence, if there was any, on the part of Dr. Wilson. If it was a restraining pack, it must follow that the forceps somehow or other became detached without anybody noticing it. Stress has rightly been laid by learned counsel for Mr. Nevill on the difficulties of the operation, the circumstances in which it had to be carried out with the patient in bed and, of course, these are all matters which have to be taken into account in deciding whether the surgeon is guilty of negligence. As Lord Justice Scott pointed out in Mahon v. Osborne, p. 545, in the All England Reports, there are a number of factors which are operating on the surgeon's mind, for instance; 1. The patient should not be kept under anaesthetic for a moment longer than is necessary; 2. There should be no pause in the continuity of the operation, even at the time of the count; 3. The patient should be moved and touched as little and possible; 4. That any extension of the field of operation which involves handling should be avoided because of the risk of increasing surgical shock, causing subsequent adhesions and particularly in abdominal cases, of sepsis spreading. Mr. Ormerod said that it is possible, in attempting to get a clear view of the area, the surgeon would pack a swab down and forget where he had put it under these conditions of stress and that he might fail to remember that he had put it there. Furthermore it might be that the pack could be displaced during the manipulations, which are necessary in this operation. It is, of course, not an uncommon occurrence in abdominal operations that the movement of the intestine is so great that this may cause the pack to be displaced, but Mr. Nevill says that the movement in this case was comparatively slight and was not more than an inch or so. Furthermore, he was particularly insistent that he remembered where he had put the packs and that they were in an obvious position, it is not suggested that the final stages of the operation had to be accelerated in this case because the patient was showing

signs of collapse. On the contrary, the evidence indicates that towards the end of the operation, which lasted about half an hour, the condition of the patient had very slightly improved, no doubt owing to the stopping of the bleeding and the transfusion. There was, therefore, no need for special haste at this stage apart from the general overriding necessity for speed in an operation of this kind. It cannot be said either that Mr. Nevill did not have the assistance of an ample staff. It seems to me that all the conditions which might reasonably excuse a surgeon overlooking a pack were excluded by Mr. Nevill in his evidence. Making all allowances for the very great difficulties of this particular operation, and I have endeavoured not to minimise them, I cannot see that there was any casual connection between these difficulties and Mr. Nevill's failure to remove the packs. He said over and over again in his evidence that he carried out his normal routine. In my opinion, the evidence points to the fact that Mr. Nevill did not make such a search as was reasonable and necessary in the circumstances, and that he failed to carry out his routine practice in this case with his usual care. He had only two or three packs to remember, they had not moved appreciably free from the position in which they were originally placed, and they were after all, not inconspicuous objects. It seems to me that Mr. Nevill is in fact convicted of negligence out of his own mouth.

Each case, of course, depends upon its own circumstances, but reference may be made to the case of Dunlop v. James, a report of which appears in Vol.1 of the 1931 British Medical Journal, p.731, where a jury found a surgeon to have been guilty of negligence and the Court of Appeal refused to disturb the verdict. In that case the surgeon made no attempt himself to count the packs, nor to search for them and the evidence as to whether he was informed by the nurse that the count was correct was unsatisfactory. Lord Justice Scrutton made certain observations, which I do not think were intended as laying down any principle of law and, of course, must be considered in the light of the particular case before him, but in my view they are all particularly relevant to the present case. He says at p.731:

> "A well recognised operation was carried out. It was an essential part of the operation to

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Judgment, 17th February 1958 - continued.

wall off the gall bladder by the insertion of certain crumpled up pieces of towelling, or sometimes of gauze. Usually the wall would be made of three bundles of such material. It is quite clear that the only person who puts those things in and selects the places where they shall be put is the doctor. He puts in, not a large number, but generally three. Any jury would be impressed by the substantial character of a crumpled piece of towelling. It is a set part of the operation for the doctor, and the doctor only, to take out the three, or more, big packs of towelling he has put in. He must know where he has put them and it is his business to take them out. The jury answered "no" to the question, "Did the defendant make such search in the wound as was reasonable and necessary?" Is that the answer which the jury might not arrive at reasonably? My impression is that any jury who had felt that towelling and seen the size of it, would come to the conclusion that it was careless not to have taken it out. Dr. Dunlop's case was that the pack might be put in at the commencement of the operation and it might move away. I cannot say that the jury were wrong if they entirely rejected this theory of the perambulating swab, ultimately coming to rest".

As I have said, no such theory has been put forward by Mr. Nevill in this case.

It is not, of course, the duty of a defendant in these circumstances, to prove the absence of negligence, but I think it is significant that Mr. Nevill is not able to suggest any explanation how this pack came to be left in the body. His case is, of course, that he is positive that it was not, but of course, no surgeon who leaves a pack in the body of a patient is ever conscious of having done so. To sum up, if the pack was a mopping pack it was negligence on the part of the person who used it, whether it was Dr. Nevill or Dr. Wilson, to lose control of it and leave it in the body. If it was a restraining pack, having regard to the small number used and their obvious position, the absence of movement and the lack of any particular need for haste at the conclusion of the operation immediately prior to sewing up, it was negligence on the part of Mr. Nevill, not to remove it, the responsibility

being, as he admits, upon him to do so, and there being no justification for departure from the normal routine. In my view the whole circumstances of this operation are more consistent with negligence on the part of Mr. Nevill than the absence of it.

I now pass to the third issue, whether there was negligence on the part of the second defendants. If it were a fact, as I have found it to be, that a pack was left in the body of Mrs. Cooper at this operation, it follows ex hypothesi that the count of the sister in charge, or of the dirty nurse, or both of them, was wrong. I have not been able to find any case where the standard of care required of the theatre sister has been expressly laid down, but I take it that it would be analogous to that of the Doctor, namely that she must exercise the care expected of an ordinary good and careful theatre sister. I cannot find any case in which a theatre sister, who has made a mistake in the count, has been absolved of negligence, except the sister in Mahon v. Osborne, who was exonerated by the jury. The Court of Appeal, however, described the jury's verdict as illogical. As the learned author of Nathan points out at p.86:

> "It may be said that the fact that a swab is overlooked at the end of an operation leads almost inevitably to the conclusion that the nurse or sister charged with the duty of counting has failed in that duty and has therefore been guilty of negligence for which the hospital employing her is liable".

The authority quoted for that proposition is the case of Urry v. Bierer, reported in the Times of 16th March, 1955. It would indeed require exceptional circumstances to free a theatre sister, or any member of the nursing staff from any suspicion of negligence in the event of an erroneous count and I cannot see that any such circumstances were present here. Mr. Braimbridge describes the conditions in the theatre at the time of the operation, when he happened to be there, as quite normal, in the sense that nobody was flustered or prevented from carrying out the usual routine. Mr.Braimbridge said that in the case of an emergency operation, particularly one such as this, everything has to be done "in double quick time", but he was careful to exclude from this the theatre sister's count.

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Judgment, 17th February 1958 - continued.

Indeed the greater the stress placed upon the surgeon, the greater in my view becomes the responsibility of the theatre staff to see that their routine duties are meticulously carried out. The count is the most important duty laid upon the sister, because although the surgeon may make a search himself, and may be reasonably sure in his own mind that he has removed everything, it is upon the sister's count that he will finally depend.

It sometimes happens that a theatre sister has to carry out the duties of an assistant surgeon, but she was relieved of those in the present case and she had a dirty nurse to help her in the counting of the packs. She herself has described the atmosphere in the theatre as quite normal for an emergency operation and she does not suggest that she became flurried. So far as she was concerned this was just another emergency operation. She says that after the patient had been removed from the theatre, she carried out a further careful check of the packs and found them to be correct and I do not doubt her word as to this, but of course, it is possible for a mistake, once made, to be carried through. In any event, as I have said previously if, in fact, a pack was left in, it follows that the count must have been wrong. I find accordingly that the plaintiff has established negligence on the part of Sister Banks and Nurse Smith and it follows that the second defendants are liable for such negligence.

On the fourth issue my finding is that both the defendants are to blame and if I were to assess the respective degree of negligence, I would say that the first defendant and the servants of the second defendant were equally to blame. There is, however, no claim for contribution in this case.

Finally it remains to consider the question of damages. The items of special damage have been agreed at Sh.5,189.80 so far as the medical expenses are concerned. There is a claim for loss of profit from a poultry farm, carried on by the plaintiffs, amounting to Sh.1,400/-. It is said that as a result of Mrs. Cooper's partial incapacity, she has been prevented from supervising the farm as effectively as she used to do in the past. I find it quite impossible, however, to award anything under this head, because Mr. Cooper is unable

to supply any figures as to the profits over other years and I have no basis upon which I can arrive at any figure. There is a claim by Mr. Cooper for damages for loss of consortium. In my view the only period in respect of which such a claim is maintainable is the period of 46 days which Mrs. Cooper spent in hospital as the result of the last operation. I award the first plaintiff Sh.1,000/- under this head.

So far as the second plaintiff is concerned, as a result of the leaving in of this pack she has undoubtedly gone through considerable pain and suffering. I have already mentioned the abdominal pains and vomiting which led up to her admission to the Maia Carberry Nursing Home. After her discharge the pains and vomiting became recurrent and the period up to her admission to hospital in October, 1956, was described by her as "a nightmare". She mentions one occasion after her admission to hospital and before the operation, when the pain became so intense that she got out of bed, put on her coat and shoes and decided to run out and throw herself under a car. She was, in fact, stopped by a nurse in time. Apart from the physical suffering, there is always in the case of abdominal pains, a considerable psychological effect, particularly when the cause of the pain has not been diagnosed. Mrs. Cooper says that after a time she came to suspect that she had a cancer. After the operation, when in hospital, she underwent a good deal of physical discomfort from a machine which was used for the purpose of draining the wound. She also suffered from a fistula. This closed itself before she left hospital but she had a discharging sinus from where the drainage tube had been left in. This eventually cleared up.

The effects of the removal of seven feet of intestine, approximately one-third of the whole, are not easy to assess. Mr. Barber expressed the view that she has probably still got sufficient for normal digestive purposes, but that the amount lost is about the borderline and that the loss of any further portion might have some effect on her digestive ability. He said that a patient might manage with half the normal length of small intestine, with little or no digestive disturbance, but that there would be the probability of more frequent bowel action than normally. Mrs. Cooper said that she still experienced periodical abdominal pains

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.29

Judgment, 17th February 1958 - continued.

and this has been confirmed by Dr. Thompson. He says that an X-Ray of the stomach and intestines after the operation was satisfactory and that these pains are probably due to adhesions and that they might continue for the rest of her life.

There was some discussion during the course of the case as to whether Mrs. Cooper's child-bearing capacity had been affected as the result of the leaving in of this pack. Dr. Thompson said that it would be impossible to determine whether Mrs. Cooper could now have a child without an examination under anaesthetic and he is of the opinion, having regard to all the operations which she had undergone, that this would be inadvisable. He added, however, that he would have advised her not to attempt to have a child, even before this last operation. I think, therefore, that any question of Mrs. Cooper's prospects as a mother must be left out of account in assessing the damages.

I assess the general damages to Mrs. Cooper at Shs.50,000/- (£2,500).

In conclusion I do not think that anybody who has listened to the evidence in this case could fail to be left with a feeling of admiration of the skill shown by the surgeon and all concerned in this operation to which Mrs. Cooper undoubedly owes her life. It is unfortunate that an isolated lapse from the high standard of care which it is clear from the evidence normally prevails at the New European Hospital should have had such serious consequences.

There will be judgment as follows:-

Against both defendants:

(a) for the first plaintiff for Shs.1,000/-

(b) for the second plaintiff for Shs.50,000/-

(c) for both plaintiffs for Shs.5,189/80 as prayed.

There will be an order of costs for this suit in favour of both plaintiffs, against both defendants.

B.R. MILES,
Judge.

17th February, 1958.

No.30

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.30

Decree,

17th February 1958.

D E C R E E

IN HER MAJESTY'S SUPREME COURT OF KENYA AT NAIROBI

CIVIL CASE NO. 808 OF 1957

1. L.Q.T. COOPER
2. MRS. R. COOPER .. .. PLAINTIFFS

versus

1. GERALD NEVILL
2. KENYA EUROPEAN HOSPITAL ASSOCIATION DEFENDANTS

D E C R E E

CLAIM for Shs.10,858/05 special damages, general damages interest and costs.

THIS SUIT coming on for hearing on the 27th, 28th, 29th, 30th and 31st January and on the 3rd, 4th and 5th February, 1958 and for judgment on the 17th February, 1958 before the Honourable Mr. Justice Miles in the presence of Counsel for the Plaintiffs and Counsel for the Defendants IT IS ORDERED

(i) That the Defendants do pay to the first Plaintiff the sum of Shs.1,000/-. and do pay to the second Plaintiff general damages amounting to Shs.50,000/-. and do pay to both Plaintiffs the sum of Shs. 5,189/80.

(ii) That the Defendants do also pay to the Plaintiffs the taxed costs of this suit, such costs to be certified by the Registrar of this Court.

GIVEN under my hand and the Seal of the Court this 17th day of February 1958.

Issued this 24th day of April 1958 by the Court.

P. HEIM

DEPUTY REGISTRAR
SUPREME COURT OF KENYA
AT NAIROBI.

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.31

Notice of Appeal (First Defendant), 3rd March 1958.

No.31

NOTICE OF APPEAL

TAKE NOTICE that G. Nevill, the First Defendant herein, being dissatisfied with the decision of the Honourable Mr. Justice Miles, given herein at Nairobi, on the 17th day of February 1958, intends to appeal to Her Majesty's Court of Appeal for Eastern Africa against the whole of the said decision.

DATED at NAIROBI this 3rd day of March, 1958.

(Sgd) A.E. Hunter
for DALY & FIGGIS
ADVOCATES FOR THE APPELLANT.

TO:-

The Registrar of the Supreme Court of Kenya at Nairobi.

And to: Messrs. Sirley & Kean,
Advocates for the 1st and 2nd Plaintiffs,
Nairobi.

And to: Messrs. Archer & Wilcock,
Advocates for the 2nd Defendant, Nairobi.

The address for service of the Appellant is care of

Messrs. Daly & Figgis, Advocates, Clarke's Chambers, Northey Street, P.O. Box 34, Nairobi.

Note:- A respondent served with this notice is required within fourteen days after such service to file in these proceedings and serve on the appellant a notice of his address for service for the purpose of the intended appeal, and within a further fourteen days to serve a copy thereof on every other respondent named in this notice who has filed notice of an address for service. In the event of non-compliance the appellant may proceed ex parte.

Filed the 3rd day of March 1958, at Nairobi.

(Sgd.) J. Chambers.
REGISTRAR,
SUPREME COURT OF KENYA.

No.32

In the Supreme Court of Kenya at Nairobi Eastern Africa

No.32

Notice of Appeal (Second Defendant), 1st March 1958.

NOTICE OF APPEAL

TAKE NOTICE that the Second Defendant, being dissatisfied with the decision of the Honourable Mr. Justice Miles given herein at Nairobi on the Seventeenth day of February 1958, intends to appeal to Her Majesty's Court of Appeal for Eastern Africa against the whole of the said decision.

DATED AT NAIROBI THIS 1ST DAY OF MARCH, 1958.

ARCHER & WILCOCK

Advocates for the Second Defendant.

TO, The Registrar of the Supreme Court of Kenya at Nairobi.

AND Messrs. Sirley & Kean, Advocates, Princes House, Government Road, Nairobi.

AND Messrs. Daly & Figgis, Advocates, Northey Street, Nairobi.

THE address for service of the Appellant is

care of Messrs. Archer & Wilcock, Advocates, Mutual Building, Hardinge Street, P.O. Box 10201, Nairobi.

NOTE: A respondent served with this notice is required within fourteen days after such service to file in these proceedings and serve on the Appellant a notice of his address for service of the purpose of the intended appeal, and within a further fourteen days to serve a copy thereof on every other respondent named in this notice who has filed notice of an address for service. In the event of non-compliance, the appellant may proceed ex parte.

FILED the 1st day of March 1958 at Nairobi.

(Sgd) J. CHAMBERS,

REGISTRAR
SUPREME COURT OF KENYA.

In the Court of Appeal for Eastern Africa

No.33

Order,

6th May 1958.

No.33

O R D E R

IN HER MAJESTY'S COURT OF APPEAL FOR EASTERN AFRICA AT NAIROBI

CIVIL APPLICATION NO. 2 OF 1958

IN THE MATTER OF AN INTENDED APPEAL

BETWEEN

1. G. NEVILL
2. KENYA EUROPEAN HOSPITAL ASSOCIATION APPLICANTS

AND

1. L.Q.T. COOPER
2. R. COOPER .. .. RESPONDENTS

(Intended Appeal from a Judgment of the Supreme Court of Kenya at Nairobi (Mr. Justice Miles) dated the 17th February 1958 in Civil Case No. 808 of 1957 between L.Q.T. Cooper and Another, Plaintiffs, and G. Nevill and Another, Defendants).

IN CHAMBERS this 6th day of May 1958.

Before the Honourable Mr. Justice Forbes, Justice of Appeal.

O R D E R

THIS APPLICATION coming on for consideration on the 6th day of May 1958, upon reading the said Application dated the 25th day of April 1958 filed by Messrs. Daly & Figgis, Advocates for the Applicants herein, and upon reading the Affidavit of Alexander Edward Hunter sworn on the 25th day of April 1958 in support thereof, and upon reading the letter dated the 29th day of April 1958 from Messrs. Sirley & Kean, Advocates for the Respondents herein IT IS ORDERED that the time to file the Record of Appeal herein be and is hereby extended for fourteen days AND IT IS FURTHER ORDERED that the Applicants do pay to the Respondents the costs of this Application.

GIVEN under my hand and the Seal of the Court at Nairobi the 6th day of May 1958.

(Sgd) M.D. DESAI.
ASSOCIATE REGISTRAR
H.M. COURT OF APPEAL FOR EASTERN AFRICA.

ISSUED at NAIROBI this 13th day of May 1958.

No.34

MEMORANDUM OF APPEAL

In the Court of Appeal for Eastern Africa

No.34

Memorandum of Appeal, 13th May 1958.

IN HER MAJESTY'S COURT OF APPEAL FOR EASTERN AFRICA

AT NAIROBI

CIVIL APPEAL NO. 38 OF 1958

BETWEEN

GERALD NEVILL and .. .. 1st APPELLANT
KENYA EUROPEAN HOSPITAL ASSOCIATION 2nd APPELLANT

AND

EDWARD QUENTIN TYRRELL COOPER and
ROSETTA COOPER .. .. RESPONDENTS

(Appeal from a Decree of Her Majesty's Supreme Court of Kenya at Nairobi (Mr. Justice Miles) dated the 17th day of February 1958 in Civil Suit No.808 of 1957

BETWEEN

L.Q.T. COOPER and
MRS. R. COOPER .. .. PLAINTIFFS

AND

G. NEVILL and
THE KENYA EUROPEAN HOSPITAL ASSOCIATION DEFENDANTS)

Gerald Nevill and the Kenya European Hospital Association, the Appellants above-named, appeal to Her Majesty's Court of Appeal for Eastern Africa against the whole of the decision above-mentioned on the following grounds, namely:-

1. The finding of the learned judge that the abdominal pack was left in the body of the second respondent during the operation performed upon her by the first appellant (hereinafter referred to as the second operation) was contrary to the weight of the evidence.

2. The learned judge, having attached significance to the fact that no case in medical text books had been cited to him, showing that a pack had remained dormant for over twelve months, failed to give any or any proper weight or consideration to -

In the Court of Appeal for Eastern Africa

No.34

Memorandum of Appeal,

13th May 1958 - continued.

(i) the fact that the second operation was performed twelve months and one week after the respondent's previous operation;

(ii) the evidence that the second operation could reasonably have disturbed the said pack, so as to cause the symptoms which resulted in the third operation;

(iii) the evidence of other instances where a foreign body had remained dormant in the body of a patient for more than twelve months, and for very long periods;

(iv) the fact that the opinions expressed in such text books are necessarily limited to cases where the presence of a foreign body has become manifest.

3. The learned judge misdirected himself in law in attaching considerable, or any, significance to the apparent assumption of Mr. Barber and Dr. Thompson that the said pack was left in the body in the second operation.

4. The learned judge failed to give due weight to the following matters in, or to be implied from, the evidence -

(i) that, if the said pack had no tape attached to it, it could not have been used in the second operation;

(ii) that such packs were used without tapes in the Princess Elizabeth Hospital in the year 1955;

(iii) that, in the second operation, there was a special and additional count of the packs after the said operation had been wholly concluded, whereas, in the previous operation, there was no evidence of any count except by the surgeon before the completion of the said operation.

5. The learned judge, in finding that the evidence as to the presence or absence of a tape on the said pack was inconclusive, failed -

(i) to consider that there was no evidence that there was such a tape, even although,

if present, it could have been easily seen;

(ii) to take into account that the only conclusive evidence, namely the pack itself, had been destroyed by the second respondent's own agents;

(iii) to direct himself as to the effect which such finding must have upon the onus of proof.

6. There was no evidence to support the finding of the learned judge that either of the appellants was negligent; alternatively, such finding was contrary to the weight of the evidence.

7. The learned judge, having held that the doctrine res ipsa loquitur did not apply, misdirected himself in law by attaching significance to the fact that the first appellant was not able to offer any explanation how the said pack came to be left in the body of the second respondent.

8. The learned judge, having considered the principles contained in the legal authorities cited to him, failed to apply them correctly to the facts disclosed in evidence and misdirected himself in law -

(i) in finding that, if a mopping or restraining pack was left in the body, it was negligence on the part of the first appellant;

(ii) in failing to consider that the overlooking of such a pack might reasonably be due to an accidental slip, not importing negligence;

(iii) in finding that, even if the counting of the said packs by the servants of the second appellant was inaccurate, their negligence was ipso facto established.

9. The following findings of the learned judge were respectively contrary to the evidence and amounted to misdirections -

(i) that there was no need for special haste towards the end of the operation;

In the Court of Appeal for Eastern Africa

No.34

Memorandum of Appeal,

13th May 1958 - continued.

(ii) that all the conditions which might reasonably excuse a surgeon's overlooking a pack were excluded by the first appellant in his evidence;

(iii) that there was no casual connection between the very great difficulties of the second operation and the first appellant's failure to remove the said pack;

(iv) that the first appellant did not make such search as was reasonable and necessary in the circumstances;

(v) that the first appellant failed to carry out his routine practice in this case with his usual care;

(vi) that there was no justification for departure from the normal routine;

(vii) that the counting of the said packs by the servants of the second appellant was faulty.

10. (i) The learned judge, having found that the first appellant was informed that the count of the packs was correct and that he would finally depend upon that count, misdirected himself by failing to consider, or otherwise to give effect to, such findings, when coming to a conclusion whether the first appellant had followed his normal routine and/or whether his negligence had been established.

(ii) The learned judge, having found that the servants of the second appellant had carried out the normal routine of counting the said packs and had made a special and additional count after the conclusion of the said operation, misdirected himself by failing to consider or give effect to such findings, when coming to a conclusion as to whether negligence had been established against the second appellant.

11. The general damages awarded to the first and second respondents respectively were excessive.

WHEREFORE each of the appellants prays that -

(i) this appeal may be allowed;

(ii) the decree of Her Majesty's Supreme Court of Kenya be set aside;

(iii) each may be awarded the respective costs of this appeal and of the proceedings in the Supreme Court;

(iv) each may have such further and other relief as may be just.

DATED at NAIROBI this 9th day of May 1958.

(Sgd) F.L. HUNTER
for DALY & FIGGIS.

(Sgd) C.A. FRASER
for ARCHER & WILCOCK.

ADVOCATES FOR THE APPELLANT.

TO: The Honourable Judges of Her Majesty's Court of Appeal for Eastern Africa.

AND TO: Messrs. Sirley & Kean, Advocates for the Respondents.

The address for service of the first appellant is c/o Daly & Figgis, Advocates, Nairobi.

The address for service of the second appellant is c/o Archer & Wilcock, Advocates, Nairobi.

Filed the 13th day of May 1958 at Nairobi.

(Sgd) P. DESAI

for REGISTRAR OF THE COURT OF APPEAL.

In the Court of Appeal for Eastern Africa

No.35

Judgment,

24th November 1958.

No.35

JUDGMENT

IN HER MAJESTY'S COURT OF APPEAL
FOR EASTERN AFRICA
AT NAIROBI.

CIVIL APPEAL NO.38 OF 1958

BETWEEN

1. GERALD NEVILL
2. KENYA EUROPEAN HOSPITAL ASSOCIATION .. .. APPELLANTS

AND

1. LEONARD QUENTIN TYRRELL COOPER
2. ROSETTA COOPER .. .. RESPONDENTS

(Appeal from a Decree of H.M. Supreme Court of Kenya at Nairobi (Mr. Justice Miles) dated 17th February, 1958 in

Civil Case No.808 of 1957

Between

1. Leonard Quentin Tyrrell Cooper
2. Rosetta Cooper .. .. Plaintiffs

And

1. Gerald Nevill
2. Kenya European Hospital Association .. .. Defendants)

JUDGMENT OF BRIGGS V-P.

This is an appeal from a decree of the Supreme Court of Kenya awarding damages and costs to the respondents.

The first appellant is a surgeon in private practice in Nairobi, and the second appellant is the authority controlling the Nairobi European Hospital. The respondents are husband and wife. On or about 1st February 1956 - the exact date is, curiously enough, left uncertain on the evidence - the first appellant operated on the second respondent at the hospital. The respondents alleged that

the first appellant and the hospital staff were negligent in the conduct of the operation and sued for damages, the first respondent for loss of consortium, the second for pain and suffering and personal injury, and both for special damages, interest and costs. Both appellants denied negligence. The Supreme Court after a trial lasting eight days awarded to the first respondent Sh.1,000/- general damages, to the second respondent Sh.50,000/- general damages, and to both respondents Sh.5,189.80 special damages and costs as against both appellants. The appellants contend on appeal to us that neither the surgeon nor the hospital staff should have been found negligent, and that the general damages awarded to the second respondent were excessive.

I take the following statement of the facts from the judgment of the learned trial Judge:-

"The operation was for a rupture of an ectopic tubal pregnancy.

The case for the plaintiffs is, that at the operation, an abdominal swab, or pack, was left in the body of the second plaintiff. It is alleged that the first defendant was negligent in failing to count the number of swabs used in the operation and to check that the correct number of swabs was removed, that he failed to instruct the nurse, or nurses, to keep a check on the number of swabs used and/or failed personally to counter-check the number of swabs and failed to observe that one swab remained in the body of the second plaintiff. The particulars of negligence against the servants of the second defendant allege failure to count the number of swabs used for the operation and failure to detect that one swab had not been removed, in accordance with instructions given by the first defendant, or in accordance with the usual practice.

The defence, on behalf of both defendants, is first a denial that any pack was left in at the operation performed by Mr. Nevill, and secondly a denial of negligence on the part of any of the defendants."

* * * * *

"On the 24th January, 1955 (Mrs. Cooper) was operated on by Mr. P.G. Preston, at the Princess

In the Court of Appeal for Eastern Africa

No.35

Judgment,

24th November 1958 - continued.

Elizabeth Hospital, Nairobi, for the removal of an obstruction in her fallopian tubes, which were blocked. The blocked parts were removed in that operation and the patent parts of the tubes re-implanted in the uterus. That operation was successful. Mrs. Cooper experienced no ill effect from the operation and her general health was satisfactory.

On the 1st February, 1956, the operation with which we are concerned in this case, was performed by Mr. Nevill, the first defendant, at the New European Hospital, for a rupture of an ectopic tubal pregnancy. What took place at this operation will have to be considered in detail hereafter.

Mrs. Cooper says that about a week after this operation, while she was still in hospital, she had an attack of vomiting. This may, perhaps, just have been the normal aftermath of a serious abdominal operation. On the night of 23rd April, however, Mrs. Cooper was taken ill at a dinner party. She complained of a pressure on the right side of her back and a feeling of nausea, which continued for some hours, and on the following day she went to see her doctor - Doctor Thompson - to whom she complained of vomiting and abdominal pain throughout the previous night. This he thought was due to adhesions. She was admitted to the Maia Carberry Nursing Home in May having had a recurrence. According to Dr. Thompson, she was free of symptoms after some two hours, and a clinical examination failed to reveal the cause. After her discharge from the Nursing Home, she was seen on a number of occasions by Dr. Thompson because she was complaining of occasional abdominal pains, which Dr. Thompson attributed to adhesions. These pains, however, gradually became aggravated and there was frequent vomiting; as a result of which Dr. Thompson admitted her to the New European Hospital for observation, on or about the 28th October, 1956. An X-ray photograph taken on admission revealed no evidence of an obstruction, but on the following day a further X-ray did show that there was an intestinal obstruction. It was accordingly decided that an operation was necessary and this was performed by Mr. W.C. Barber.

Mr. Barber states that on opening the abdomen he found an abscess cavity, centrally situated, surrounded by ahderent coils of small intestine. There was a localised peritonitis. Mr. Barber tried to determine which portion of the adherent intestine might be causing the obstruction. He first endeavoured to separate one or two adherent loops. On doing this, however, it was found that a leakage of bowel content resulted and since there were many adherent areas, Mr. Barber decided to remove the whole of the affected portion of the bowel. He accordingly cut away about seven feet of intestine. The whole length is some twenty-two feet. Mr. Barber says that he felt something in the piece of bowel he removed. The dissected portion was taken into the sluice in a bowl by Sister Banks, who was the 'dirty nurse' at the operation. Dr. Thompson then took the piece of intestine out of the bowl, placed it on the end of the tap and turned on the tap. There then emerged from the piece of bowel a piece of turkish towelling, measuring some 9" x 7" or 10" x 8", with hemmed edges. This was immediately recognised by all persons present as an abdominal pack. Mr. Barber thereupon decided to ring up Mr. Nevill on the telephone and he informed Mr. Nevill of his discovery. Mr. Barber told Mr. Nevill that if he were asked what was the cause of the trouble he would have to inform Mr. Cooper, and Mr. Nevill very properly agreed that this was the correct procedure."

It was common ground that the abdominal pack must have been left in Mrs. Cooper's body either at the first operation (Mr. Preston's) or at the second (Mr. Nevill's), and the first question for decision was at which operation this occurred. The learned trial Judge found on a balance of probabilities that it occurred at the second. This finding was attacked as contrary to the weight of the evidence and on the ground of certain alleged misdirections.

Mr. Salter for the appellants first pointed out that the areas involved in the two operations were similar. One or two packs of the type found had been used on the first operation. He submitted that it was established beyond doubt that all packs used in the European Hospital had a loop of tape

some six inches long sewn firmly to one corner of the hem, while at the Princess Elizabeth Hospital the similar packs did not always have such tapes, and were at least offered to surgeons, even if not used, without tapes. This I accept. Mr. Salter submitted that, if the pack found had no tape on it, there was a strong presumption that it came from the first operation. Since there was evidence that it was unlikely that a tape could become detached from the pack in the body, and occular examination of specimen packs exhibited confirms that the tapes are strongly sewn on, I accept this also. If the pack in question had been produced, had had no tape, and had appeared never to have had a tape, I think it would have been very difficult for the plaintiffs to succeed on this issue; but for reasons which will appear the pack was not produced. Mr. Salter then submitted that on the evidence the learned Judge should have found as a fact that there was no tape on the pack. During and after the third operation the pack was seen by Mr. Barber, Dr. Thompson, Sister Molloy, Sister King and Sister Banks. All of them gave evidence. The pack was washed out and spread out, and was handled in such a way that one would have expected every one of them to be able to see whether it had a tape or not. None of them said that it had a tape, but only Sister King said categorically that it had not; and she said so only in cross-examination, having said in chief that she did not think there was a tape on it. Such evidence must be examined closely. The passages are -

> "Mr. Barber, I think, held it up. I can't remember distinctly how he was holding it. I think it was a piece of towelling, it was discoloured. I should say it was roughly the same size as this (Exhibit 1). I don't think there was a tape on it. I did not look closely at it. I should think I would have seen a tape had there been one. I was very interested in it. It is very unusual. I can remember somebody saying it did not have a tape but I can't remember who."

and in cross-examination -

> "The remark about there being no tape was made when I saw it in the sluice. At that time I don't remember apart from Mr. Barber who else was there. I don't remember whether

> it was a male or female who said this. I remember noticing that it did not have a tape. I don't remember when I noticed it. I might have said myself that it had no tape or it may have been someone else but I don't remember. Nobody to my knowledge went to have a more careful look at it as a result of that remark. At that time the pack was opened out. Thinking back I have no doubt at its having a tape or not. It did not have a tape."

I think that on this the learned Judge was entitled to find as in effect he must have done, that Sister King's memory could not be relied upon. Mr. Salter submitted that it was for the plaintiffs to prove that there was a tape on the pack. The pack itself was thrown away some time after the operation, and Mr. Barber says that this was done with his permission. He might well have failed to appreciate how important it might be; but, looking back now, it is obvious that the absence of a tape, if there was none, would have been significant, and it is possible, though by no means certain, that scientific evidence might have proved that the material of the pack was of a kind used in one hospital and not used in the other. It is therefore most unfortunate that the pack was not forthcoming. Mr. Salter did not suggest that we should draw a presumption on the footing that material evidence had been withheld, but he argued that, in permitting destruction of the pack, Mr. Barber was acting as agent, not of the hospital authorities, but of Mrs. Cooper and that she must bear the consequences of its disappearance, in the sense that a finding of "no tape" should have been made on the oral evidence. I doubt if Mr. Barber, in giving the instructions, acted as Mrs. Cooper's agent, and I think no presumption arises from the loss of the pack. Sister Molloy and Sister Banks both said that, if there had been a tape, they thought they would have noticed it. The learned Judge said,

> "In my opinion, it would be unsafe for me to base my decision in this case upon the presence or absence of a tape on the pack which was found on the 29th October, 1956. The evidence is inconclusive one way or the other."

Mr. Salter submitted that this was passing over the matter too lightly, and that the weight of the

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evidence was against there being a tape. I think this overlooks one psychological factor which has some weight. The three hospital sisters were all aware of Mrs. Cooper's medical history. They were all aware that in the European Hospital tapes were regularly, and should have been invariably, used. They must have been aware that the matter might be a very serious one for their hospital. If they, or any one of them, had actually observed that this pack had no tape, I should have expected an immediate reaction of "Well, that lets us out" and I should have expected that the pack would have been preserved with the utmost care, even in face of a doctor's order that it be thrown away. I do not think it can properly be said that the learned Judge ought to have found that there was no tape.

There was evidence that after the second operation the unusual precaution was taken of making a second count of swabs after the patient left the theatre, and this evidence was accepted as true. Mr. Salter submitted that the learned Judge had not sufficiently considered this in relation to the first issue. I do not think it is established that the point was overlooked, and it is not in my view of much weight. The suggestion is that where two counts are made there is much less likelihood that a mistake will occur than when only the one routine count is made, as on the first operation. But this ignores two considerations, first that an error in the count at the second operation may have occurred when checking in the swabs, rather than when checking out, and secondly, that the unusually large number of packs used at the second operation increased the difficulty of this count and the chance of error. Mr. Preston's was a "cold" operation, and he used only one or two restraining packs and no mopping packs at all.

The other main body of evidence directed to showing that the pack was left in the body at the second operation was a considerable amount of expert evidence that a pack so left in would usually cause symptoms within a few weeks, or at most a few months, after the operation. This weighed substantially with the learned trial Judge. Mr. Salter submitted, however, that although this evidence pointed prima facie to the second operation there were also in the evidence contra-indications which the learned Judge had disregarded. There is noted in the books at least one case where an interval of a year elapsed

before symptoms were observed. There was evidence that it is possible for a foreign body to become encysted, or insulated from the general physical processes, and that if this occurs it may remain indefinitely quiescent, so that its presence may never be suspected at all. There was also evidence that a foreign body so encysted might be disturbed by a subsequent operation, and might thereafter cause symptoms at about the period which would be normal if it had been left in the body at the later operation. In this case the pack was actually inside the small intestine, having apparently penetrated it initially by causing an ulcer. Mr.Salter submitted that all the known facts in this case were consistent with the pack having been left in the body at the first operation, having become encysted, and having been disturbed by the second operation. I think this is perfectly correct. But there is no evidence that encystment of a foreign body such as a pack is of frequent occurrence. It is the exceptional, not the ordinary case.

Mr. Salter's final point on this aspect of the case was that the learned Judge had misdirected himself in attaching considerable importance, as I think he undoubtedly did, to the admitted fact that after the third operation Mr. Barber and Dr.Thompson both assumed at once that the pack had been left in at the second operation, not at the first. Mr. Salter submitted that the correct approach to this evidence was that Mr. Barber and Dr. Thompson were both entitled to give their opinions on this point as experts, but that those opinions were no more likely to be correct than the opinions of any other experts. Dr. Thompson is a general practitioner, though no doubt of great experience and ability as such. He had never before seen a case of a pack left in a patient. To that extent, his opinion was perhaps of less value than those of the other experts. It may also be said that both Mr. Barber and Dr. Thompson apparently formed their opinions on the spot and without long or detailed consideration, and this may take something from the weight of those opinions. However that may be, I think Mr. Salter's criticism of the learned Judge's approach to this evidence is justified.

But, as regards the other matters raised on this issue, I see no ground for any suggestion that the learned Judge either overlooked any of the relevant evidence or misdirected himself as to its effect.

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He rightly held that the onus lay on the plaintiffs, and that the question must be decided on the balance of probabilities. He found on this basis that the pack was left in Mrs. Cooper's body at the time of the second operation. I think it is open to us to review that finding as res integra and I approach the issue on that basis; but I respectfully agree with the learned trial Judge that the weight of the evidence was sufficient to justify a finding for the plaintiffs.

It need hardly be said that both Mr. Preston and Mr. Nevill gave the most positive evidence of their belief that the pack had not been left in the body at the respective operations conducted by them. I find that on this point Mr. Nevill's evidence is shown to have been erroneous; but the learned trial Judge did not regard this as throwing the slightest doubt on Mr. Nevill's general veracity, and I agree with him. Except that on the point already mentioned he considered Sister King's evidence to be unreliable, he accepted all the witnesses as witnesses of truth, and in my opinion he was right in doing so. The conviction shared by Mr. Nevill and the witnesses who assisted him, that no mistake had been made in the course of the second operation, explains one aspect of the evidence in this case which is perhaps unusual in swab cases, though a somewhat similar point arose in van Wyk v. Lewis, (1924) A.D. 438. In the ordinary swab case there is no disagreement that the swab was left in the body at the one operation to be considered, and the only questions in issue are how and why, and whether with or without negligence. In such a case the closest attention must be given by the defendants and their advisers to the question how the acknowledged mistake arose. In this case that question never attained the same prominence, for the defendants' primary case was that there had been no mistake at all. In that respect they were wrong, and it may be said at once that no explanation of the presence of the pack was ever expressly put forward by them. The Court below was left, and we are left, to consider the possibilities which arise from the circumstances and to draw such inferences from the evidence as seem appropriate.

In the Court below there was considerable argument on the law applicable to this case, and in particular on the question whether the doctrine of res ipsa loquitur governed it. I think it is

unnecessary for us to consider this question. Before us counsel were in agreement that, since all the evidence on both sides was on record, the questions for decision were simply whether, having regard to their proved acts or omissions and to the circumstances of the operation, (a) the surgeon, or (b) a member of the hospital staff, or both, had failed in their respective duties to the patient. It should be noted at this point that the assistant surgeon to Mr. Nevill on this operation was a Dr. Wilson, who was at that time employed by Mr.Nevill as an assistant in his practice. Dr. Wilson is a well-qualified and sufficiently experienced surgeon, but naturally not of the same professional attainments as Mr. Nevill. It was at all times common ground that, if Dr. Wilson was negligent in the conduct of the operation, Mr. Nevill was responsible for that negligence on the principle respondeat superior. Accordingly question (a) above concerns the acts and omissions of Dr. Wilson as well as those of Mr. Nevill himself. Dr. Wilson was in the United Kingdom at the time of the trial, and did not give evidence.

It may also be convenient to remark at this stage that evidence was given at the trial of the high professional skill of Mr. Nevill as a surgeon. In a sense this may have been unnecessary. His professional qualifications speak for themselves. But Mrs. Kean for the respondents submitted that such evidence was inadmissible, on the authority of Bevan on Negligence, 4th ed. 1359, where it is stated,

> "Where a specific act of malpractice is charged, evidence that the defendant is of skill in his profession is not admissible. The very nature of the charge involves either that he is of skill generally and did not exercise it, or that he represented himself to have skill which he did not in fact possess; the inquiry is not what he was able to do, but what he actually did. There is a difference where the quality of the act is in dispute. Is the specific thing charged malpractice or not? Then evidence of skill is admissible. If the thing done is admittedly malpractice, then whether the practitioner had the skill which, by hypothesis, he did not use is irrelevant. Prima facie to sew up a sponge or an instrument in a patient after an operation is negligence. Very great care and method is to be observed in accounting

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for all appliances used, and this in proportion to the easiness with which they may escape observation; but even here the fact that some needle or portion of an instrument has been left in a wound is not conclusive, but the conclusion from the fact must be determined by a jury on a view of the whole circumstances."

I think it will appear later that on this authority the evidence was admissible, since the Supreme Court was obliged to consider the quality of some of Mr. Nevill's acts and the validity of some of his decisions; but in any event it was admissible on the first issue, as showing that it was improbable that Mr. Nevill left a swab in the body. In my view nothing turns on this. No-one ever questioned Mr. Nevill's general skill in his profession.

As regards the origin and circumstances of the second operation, I quote again from the judgment of the learned trial Judge:

> "Mrs. Cooper was brought into hospital somewhere in the neighbourhood of 2.30 p.m. She was first seen by Dr. Lawes who subsequently acted as anaesthetist at 2.40 p.m. She had apparently been removed to hospital as a result of prompt action by Dr. Gillespie and Dr. Spiers. Her condition on arrival was described by Dr. Lawes as follows: 'She was comatose, pulseless, no blood pressure, grey-faced, cold and sweating with sighing respirations and the heart could just be heard with a stethescope. In short, she was dying.' Dr. Lawes took a sample of blood from a vein in the neck, which was the only one available to a needle, and this was sent to the laboratory for grouping and cross-matching with blood in the blood bank. He states that while blood was being made available, she was given three pints of saline and artificial plasma under pressure in ten minutes. Altogether six and a half pints of blood were given to her between then and 4 p.m. At 3 p.m. he telephoned Mr. Nevill, who arrived shortly after, and at this time she was, to use Dr. Lawes's words, 'just becoming an operable risk.' Mr. Nevill describes her condition at that time as 'not in any sense of the word a reasonable operative risk.' Nevertheless, it was decided that an immediate operation was essential, as being the only hope of stopping the

haemorrhage which was killing her. At first it was doubtful whether it would even be safe to move the patient into the theatre, but ultimately it was decided to do so. It was, however, considered unsafe to move her on to the operating table and the operation had to be conducted upon the patient in her bed. The disadvantages of this are obvious. The two main ones are, of course, that first a bed is considerably wider than the operating table, with the result that the surgeon cannot get as near to a patient as is desirable and secondly that he has to operate throughout in a stooping position, with consequent additional fatigue. In normal operations, what is known as a 'Mayo' tray containing instruments, is placed over the patient's legs on the operating table, but this is impracticable if the patient is in bed. This was the first occasion on which Mr. Nevill had ever operated on a patient in bed."

* * * * *

"To come to the operation itself. Mr. Nevill states that he made a mid-line incision. There was no bleeding from the body, which is an unusual circumstance and indicates the gravity of the patient's condition. He found the abdominal cavity full of blood. He placed his left hand deep into the pelvis and felt that the left cornu of the uterus had burst. He siezed this, which was the bleeding point, between his finger and thumb and held firm to control any further bleeding. The bleeding was in fact stopped within 30 seconds or so. Blood was then sucked out of the abdominal cavity and placed in specially prepared bottles for the purpose of auto-transfusion. There were some four pints removed in this manner. There was still a quantity of blood in the abdomen. This was removed by Mr.Nevill and Dr. Wilson by using mopping packs. Two or three pints were removed in this manner. No clips were attached to these mopping packs. Mr. Nevill is positive that he did not release hold of any mopping pack that he used because this would not be the normal practice. He could not say for certain whether Dr. Wilson did or not, but it would be most unlikely. The sucking and mopping took from five to eight minutes. For the purpose of sewing the

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ruptured part and in order to keep the field of work clear, Mr. Nevill packed back all the intestines, using two or three packs. These had both tapes and Spencer-Wells forceps. He then sewed up the uterus. The foetus which had caused the trouble was lying free in the pelvic cavity and beside it was the plastic tube which had been used in order to achieve pregnancy. He then checked the pelvic cavity to see that it was free of blood clots, and that there was no other bleeding from the ruptured uterus, which he had stitched. The stage was then reached when he was ready to terminate the operation. Mr. Nevill's account of his actions at this point is as follows:

> ' having checked that the pelvic cavity was clear I then removed the packing swabs which I had placed, checking carefully the area involved; removing at the same time considerable quantities of blood which were oozing down from the upper parts of the abdomen. When I was sure that I had done all that I should do in the way of routine checking for packs, I was ready to sew up. While I was checking inside, the theatre staff, under the direction of Sister Banks, was checking up outside, in our routine procedure to ensure against leaving swabs behind. I was assured that the swab count was correct. Sister Banks assured me. You do not sew up until you are informed and until you have completed your own check.'

Later on he says:

> ' My absolute routine is that I personally always remove the packs which I know that I have placed in the abdomen or my assistant had placed. It is my responsibility. I then always check the operation area to make sure that no others or any foreign body could have crept in by mistake.'

Neither Mr. Nevill or Sister Banks could remember in this particular instance, whether she volunteered the information that the count was correct or whether Mr. Nevill first asked the question. Both she and Mr. Nevill are

positive that the information was given and I have no hesitation in accepting that. In cross-examination Mr. Nevill said that he knew where he had put the two or three packs. They were in an obvious position and he would not have needed any guidance to them. He went on to say:

> ' In this case I did carry out my routine check. We did the best we could.'

He then explained his routine check in rather more detail.

> ' I remove the swabs that I know I have placed in position. I look to see, within reasonable limitations, that there are no other swabs visible. I feel with my hand into all reasonable places where a swab might hide itself and when I am absolutely certain that there are no foreign bodies inside the abdomen, I question Sister about her swab count, unless it may be that she has already told me her swabs are correct, in which case the question would be superfluous.'

Mr. Nevill also said:

> ' I never do rely completely on the theatre Sister's count. I rely on my own count in addition.'

He emphasised that he carried out this routine in the present case and that this was not a case which made the routine check impossible.

The operation was completely successful, in that it achieved its object, which was the saving of Mrs. Cooper's life. The operation was described by Mr. Barber as 'extremely difficult and hazardous', and there is no doubt that it was a brilliant piece of surgery. Mr. Nevill himself described it as an 'incredibly difficult and delicate operation', and he said that he had never been faced with conditions such as those in his whole career. Mr. Braimbridge said that he had only known one other case of an operation of this kind being performed on a patient in the condition of Mrs. Cooper. Mr. Nevill readily agreed that the

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credit was not his alone, but was to be shared by all who had dealt with Mrs. Cooper, both before and after her admission to hospital on the day in question."

To complete the picture, I think two more passages from Mr. Nevill's evidence should be quoted.

"I could not give an assessment about each individual pack which I used for mopping. It would have been far too dangerous to check on that point. All packs at the European Hospital have tapes - we don't have to consider that point. It was inserted to get the blood out of the cavity as quickly as possible. I don't think there was anything to prevent me seeing a pack used for mopping if it had remained there. There was still blood seeping about. I used my hand to go into corners I could not see within reason. We were moving very swiftly all the time because our patient had been critically ill to start with and all operative manipulations, however gentle, cause an increase in surgical shock, and we knew that the slightest increase in this shock would kill our patient."

* * * * *

"The state of the patient before I start to sew up is something which concerns me. Whether Mrs. Cooper was better at the start of the sewing up would be something that concerned me at the time. My note reads 'patient much better at this time.' No mention of 'coming round.' I specifically remember carrying out the steps that I have detailed in this particular operation. You have an incision of about 5 inches in the lower part of the abdomen. We had packed away the intestines as described upwards. I checked the pelvic cavity very carefully. There one is coming out of the abdomen and checking up as it were 'behind you.' The pelvis is clear. You then remove the restraining packs and as you do that you observe that there is nothing behind in the same area and as you do it the intestines tend to fall downwards. We had by this time removed all the packs that we were aware of but there was a certain amount of blood coming down from the corners and very gently one collects that blood under vision. When we thought all was safe I felt around in that same area,

i.e. the area immediately adjacent to the wound in which I had been working and slightly out into either flank. The 'feeling around' would not take more than 30 seconds. 'We' means 'I'."

Against that background, I would set the words of Scott L.J. in Mahon v. Osborne, (1939) 1 A.E.R. 535, at p.548, in describing "the well-established legal measure of a professional man's duty." He said,

> "If he professes an art, he must be reasonably skilled in it. There is no doubt that the defendant surgeon was that. He must also be careful, but the standard of care which the law requires is not insurance against accidental slips. It is such a degree of care as a normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances of the case in question. It is not every slip or mistake which imports negligence, and, in applying the duty of care to the case of a surgeon, it is peculiarly necessary to have regard to the different kinds of circumstances that may present themselves for urgent attention. I will mention a few, applicable to a major abdominal operation, (i) the multiform difficulties presented by the particular circumstances of the operation, (ii) the condition of the patient, and the whole set of problems arising out of the risks to which he is being exposed, (iii) the difficulty of the surgeon's choice between risks, (iv) the paramount need of his discretion being unfettered, if he thinks it right, to take one risk to avoid a greater, (v) at the penultimate stage (swab removal), he may, particularly where the patient has been taking the anaesthetic badly, and is suffering from shock, be so anxious on surgical grounds to bring the operation to an end as rapidly as possible, that, in the exercise of his discretion, perhaps unconsciously exercised, as soon as he has completed the removal of all swabs of which he is at that moment aware, he asks the sister for the count, and forthwith starts to close the wound."

The facts in Mahon v. Osborne were in many ways similar to the facts in this case, and much of the

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expert evidence was on similar lines. I have paid due heed to the warnings given by Scott and MacKinnon L.JJ. against treating decisions on fact as if they laid down rules of law; but the evidence in this case makes it clear that each of the five special circumstances to which Scott L.J. referred was of material importance in this case. It seems to have been Scrutton L.J. (in James v Dunlop, (1931) British Medical Journal, Apr. 25,) who first remarked that it is the duty of the surgeon to put in swabs, and it is his duty to take them out. This was repeated in Mahon v Osborne by Mackinnon L.J., at p.556, and by Goddard L.J., as he then was, at p.559, but it must be remembered in what sense the words were used. MacKinnon L.J. amplifies the matter by pointing out (p.554) that in James v Dunlop the plaintiff had led expert evidence that the surgeon's search for swabs had been inadequate in the circumstances, and that the dictum of Scrutton L.J. laid down no rule of law, but referred only to the facts of the case before him. MacKinnon L.J. further held that it was a misdirection to treat the dictum as a rule of law in the absence of such expert evidence. Having described the evidence, the difficulties encountered, and the precautions taken, he said, at p.557,

> "... it might well be thought that there was no evidence upon which a reasonable jury could find that the defendant had been negligent."

But that was subject to the further question whether there should have been, and had not been, a search by touch, on which he considered there had been evidence to go to a jury. Goddard L.J. in his minority judgment said, (p.561)

> "There can be no possible question but that neither swabs nor instruments are ordinarily left in the patient's body, and no one would venture to say it is proper, though in particular circumstances it may be excusable, so to leave them. If, therefore, a swab is left in the patient's body, it seems to me clear that the surgeon is called upon for an explanation. That is, he is called upon to show, not necessarily why he missed it, but that he exercised due care to prevent its being left there."

Both these approaches seem to me entirely consonant, as regards the law, with that of Scott L.J. Any difficulty or disagreement appears to have arisen only from different views of the facts. I treat the passage cited from Goddard L.J. as representing the law applicable to this case, and I emphasize the point that it is not always necessary to show why or how the swab was missed. As regards the need for such search as is in the circumstances proper, I think it is unnecessary to consider whether common sense has brought into being a new rule of law, or whether, if expert evidence were absent, the Court would be entitled to form its own view. Here the attention of the parties was fully applied to the question, the experts gave detailed evidence on it, and I think it will appear that, as regards the first appellant, the really essential question is simply this. On the evidence and in the circumstances was the search for packs made by the first appellant a proper search or not? Obviously Mr. Nevill cannot show satisfactorily how or why the pack was inserted and not removed. If he had had any direct knowledge on the point it would have been removed. The question here is whether it was excusable both to be ignorant of its presence and to fail to find and remove it.

I think a good deal may turn in this case on the question whether the pack was a restraining pack or a mopping pack. The learned trial Judge dealt with the matter as follows,

> "There is no direct evidence as to whether the pack in question, which was found in the body, was one of the two or three 'restraining' packs, or whether it was one of those used for mopping. The total number of packs used in the whole operation was stated to be in the region of twenty. This is a large number, but was necessitated by the very great amount of blood which had to be removed from the abdominal cavity. To my mind the probabilities are that it was one of the restraining packs, because it is not the normal, and in fact would be improper procedure, for a surgeon to release hold of a mopping pack. Mr. Nevill is confident that he did no such thing. In the mopping he was assisted by Dr. Wilson, and although he kept a close observation on Dr. Wilson, he is unable to say with any certainty, whether Dr. Wilson left a mopping pack in the

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body. If he did so, that would undoubtedly be negligence and it is conceded that Mr. Nevill is responsible for negligence, if there was any, on the part of Dr. Wilson. If it was a restraining pack, it must follow that the forceps somehow or other became detached without anybody noticing it."

Speculation is often unprofitable, but I think it is useful in this case to consider some of the ways, whether more or less improbable, in which the mistake may have arisen. There are in this case two matters to be explained, each unusual and exceptional in itself, the surgeon's failure to find the pack, and the nursing sister's wrong count. The odds against each of these occurrences at any operation are long, and the odds against both occurring at the same operation through unrelated causes must be mathematically so great that one is tempted to seek an explanation on the basis of a single cause producing both results. If such an explanation can be found, the hypothesis would appear to be inherently more probable than any based on unrelated causes. The learned Judge's view of the probabilities seems to me on this basis to be open to criticism. Only two or three restraining packs were used, that is, the small number normal in any ordinary abdominal case, and they were used with forceps attached. It must be assumed, on the learned Judge's hypothesis, (a) that a forceps fell off unnoticed, (b) that Mr. Nevill miscounted the two or three restraining packs, which it was second nature to him to memorize, and which he said were all in clear view and (c) that the miscount by the sister was due to some other unrelated cause. On the other hand about twenty mopping packs were used, some of them perhaps more than once, in an abdomen full of blood. No Spencer-Wells clips were used on the mopping packs, and this was proved to be good surgical practice, although some surgeons use them for some operations. The surgeon did not keep a mental count of the mopping packs, and it was proved that it was not his duty to do so. The mopping was done at the highest possible speed, for it was essential to clear the operational area and sew up the ruptured uterus as soon as possible. The learned Judge states that it would have been improper procedure for Mr. Nevill or Dr. Wilson to release his hold on a mopping pack. Mr. Ormerod's and Mr. Braimbridge's evidence shows that this may not have been a rule of universal application; but

that may for the moment be disregarded. The learned Judge concludes that, if a mopping pack was left in the body, Mr. Nevill, either personally or vicariously through Dr. Wilson, must have been negligent by releasing his hold on it. I think this was an incorrect assumption on which the whole case against the first appellant may turn, but before explaining my reasons for this I find it necessary to diverge to another subject.

The system in force at the European Hospital for checking and counting packs was described by the learned Judge in these terms,

> "The packs are made in the work-room at the hospital and tapes sewn on there. Soiled packs are washed in the hospital premises. After washing, boiling and drying, they are put into a special drawer to await the sister, or whoever is going to check them into the store cupboard. This is done by one of the theatre staff. Before being put into the cupboard, packs are tested to make sure that they each have a tape and that this is securely sewn on. The packs are then rolled into bundles of three and placed in a storage cupboard. At a later stage they are taken out of the cupboard and put into drums for the purpose of sterilisation. At this stage they are again checked to make sure that there is a tape on each of them and that they are in bundles of three. Before an operation the sister who is laying out the trolley takes what is known as a laparotomy bundle out of the drum with forceps and lays it on a trolley. The bundle consists of four dressing towels for towelling up the patient and a large abdominal sheet which goes on after the towels, two bundles each of twelve gauze swabs, one roll of three packs and one roll of wool for dressing. The sister who is taking the case, first of all breaks one bundle of twelve swabs and checks to see if the number is correct, separating each one. She places six on the top of the trolley. If it is anticipated that packs are going to be used, the bundle of three is taken from the bottom of the trolley (the trolley consists of two shelves) and placed on the top. The pack is then unrolled and the packs are checked one by one. If it is known at this stage that more than one bundle of

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packs is likely to be used, extra bundles are taken out of another drum, labelled 'abdominal packs.' When the trolley is being laid, they would be put at the side of the laparotomy bundle, but when the sister who is taking the case is scrubbed up she puts the extra packs on the bottom of the trolley and only leaves on the top those actually in use. If the three packs in use are exhausted, another bundle is taken from the bottom of the trolley and checked in the same way. At no stage in the operation is more than one bundle of three packs on the top of the trolley. If a pack is going to be used for 'restraining purposes', the Spencer-Wells clip may be attached, either by the surgeon or the theatre sister in charge. When the surgeon has finished using a 'restraining pack' he hands it back to the sister who takes off the forcep and either puts the pack into the bowl of hot saline solution which is by her or discards it. If she discards it, she puts it into what is known as a 'run-around bowl' on the floor. When the surgeon has finished with a mopping pack, he may discard it by putting it into another 'run-around bowl' by his feet. The sister may then either put it into the saline bowl, or discard it. When packs are discarded they are picked up by the 'dirty nurse' with forceps as they are discarded and placed on a mackintosh sheet on the floor, where the sister in charge can keep an eye on them. The packs are invariably laid out in threes, side by side. When there are three packs on the sheet, the 'dirty nurse' reports 'I have three packs sister' and the sister looks over and checks. When the packs have been checked, the 'dirty nurse' puts them together in threes on the mackintosh. If more than three are used the 'dirty nurse' counts them in threes, leaving the three in the bundle. The second bundle goes at the side of the first and so on. At the end of the operation the sister in charge looks over to the mackintosh and asks the 'dirty nurse' how many swabs she has. On receiving the number, the sister checks herself and checks with the clean swabs on her trolley, to make sure that the total amounts to twelve. Similarly in the case of the packs, the 'dirty nurse' tells her how many completed bundles of three she has and gives the number of any odd ones over. This

> is then checked by the sister with those on the trolley. Prior to sewing up the wound, the surgeon either asks the sister in charge whether the swabs, including of course, the packs, are correct, or it may be that the sister herself volunteers the information. He does not sew up until he has received an assurance that the count is correct. None of the experienced surgeons who gave evidence in this case had any fault to find with this system and I see no reason to dissent from this view. It is not in fact the case for the plaintiffs that the system was an improper one. All such systems, however, are in the last resort dependent on the human element and as such liable to human fallibility."

I respectfully agree, and in this case the count of packs was wrong. No small gauze swabs were used, and nothing turns on them. In considering how the count came to be wrong, a number of points must be borne in mind, (i) the packs and swabs removed and those still held unused at the end of the operation were counted twice - an exceptional precaution - and were twice found to agree with the sister's count of packs and swabs made available for the operation; (ii) the second count was made at leisure after the patient had been removed from the theatre, and after a warning by Sister Banks to the "dirty nurse" to be careful; (iii) only a single count was made by Sister Banks of the "incoming" packs; (iv) that count was in part made in the pressure of the operation in progress; (v) it was made piecemeal, since not enough packs were on the trolley at the beginning of the operation and more bundles were brought in and counted from time to time; (On these points see the evidence of Sister Banks) (vi) these packs were made of Turkish towelling, were used and laundered repeatedly, and presumably would grow thin with long use. From this I think it may be said that it is more likely that the incoming count was wrong than the outgoing, and that the only probable source of error disclosed on the evidence is that one of the bundles contained not three, but four, packs. The nursing staff witnesses were cross-examined as to this possibility. They were only able to say that they had not known such a thing to happen, but if it did it would be a very serious matter. It would of course reflect on those who prepared the packs and put them in the sterilizing drum, as well as

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on the theatre sister, if she failed to discover the mistake. It appears to me that two old and thin packs, with the tape of one between them, might easily feel and look like one fairly new and thick one, and might be miscounted in haste. This possibility was considered in Mahon v Osborne (pp. 547, 556 and 565), but there were there special reasons, not applicable to this case, for rejecting it, in particular the way the pack was folded when found. I think the learned Judges may have been impressed, as I am, by the point of a single possible cause leading to both errors. If the sister counting in the packs could be misled into thinking two packs were one, it seems not improbable that she might hand those two together to the surgeon (or his assistant) and that he might be similarly misled. If the surgeon had removed the two packs separately, there would later have been a surplus pack on counting out, which might have caused much embarrassment to the nursing staff. But that did not occur.

I return to the question whether a mopping pack or a restraining pack was left in the body. The incision was about five inches long. During the initial removal of blood from the abdomen Mr. Nevill's left hand was occupying part of the incision and holding the ruptured portion of the uterus. Pumping out and later mopping had to be done through the remainder. It would seem probable that mopping packs would be pushed in and pulled out again when soaked with blood and would not be in clear view all the time, except, perhaps, as to the part held. If two packs were handed together to Mr. Nevill or Dr. Wilson, and if a corner of one as well as its tape was folded inwards, and if the surgeon's grip was only on the corner of one, it would seem possible that the other might detach itself unseen as it became wet in the body and might never be seen again. The amount of blood in the abdomen was a quite unusual circumstance. If what I have outlined in fact occurred, the lost pack, once out of sight, may have been remote from the immediate area of the operation. The process of packing back the organs to expose the uterus for sewing, the natural movement of the intestines, and the seepage of blood from the upper part of the body, which could not be controlled by tilting because the patient was on a bed, may all have served to render it invisible and beyond the range of the tactile search which Mr. Nevill made. I appreciate that much of this is speculation; but on the evidence I think it could have occurred and, if the

inherent improbability of the coincidence of independent causes is borne in mind, I think it is a more probable, or less improbable, hypothesis than that put forward by the learned Judge, or any other I can think of. The learned Judge did not consider this possibility at all. If he had, he might not have found, as he did, that, if this was a mopping pack, negligence by one of the surgeons was established beyond doubt. I give my own opinion at once that, if the two mistakes arose in the way I have indicated, it is doubtful whether Sister Banks personally was guilty of negligence, and the surgeon who received and lost the pack, whichever of them it was, was definitely not guilty of negligence in losing control of it. I defer consideration of the search.

In dealing with the final stages of the operation the learned Judge said,

> "It is, of course, not an uncommon occurrence in abdominal operations that the movement of the intestines is so great that this may cause the pack to be displaced, but Mr. Nevill says that the movement in this case was comparatively slight and was not more than an inch or so. Furthermore, he was particularly insistent that he remembered where he had put the packs and that they were in an obvious position. It is not suggested that the final stages of the operation had to be accelerated in this case because the patient was showing signs of collapse. On the contrary, the evidence indicates that towards the end of the operation, which lasted about half an hour, the condition of the patient had very slightly improved, no doubt owing to the stopping of the bleeding and the transfusion. There was, therefore, no need for special haste at this stage apart from the general overriding necessity for speed in an operation of this kind. It cannot be said either that Mr. Nevill did not have the assistance of an ample staff. It seems to me that all the conditions which might reasonably excuse a surgeon overlooking a pack were excluded by Mr. Nevill in his evidence. Making all allowances for the very great difficulties of this particular operation, and I have endeavoured not to minimise them, I cannot see that there was any causal connection between these difficulties and Mr. Nevill's failure to remove the packs. He said over and over again

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in his evidence that he carried out his normal routine. In my opinion, the evidence points to the fact that Mr. Nevill did not make such a search as was reasonable and necessary in the circumstances, and that he failed to carry out his routine practice in this case with his usual care. He had only two or three packs to remember, they had not moved appreciably free from the position in which they were originally placed, and they were after all, not inconspicuous objects. It seems to me that Mr. Nevill is in fact convicted of negligence out of his own mouth."

With respect, I think this passage indicates a misunderstanding of the true effect of the evidence. The first two sentences refer, of course, to the circumstances relative to the restraining packs, and in that sense are correct. As to the need for speed in terminating the operation, I think the learned Judge has failed to appreciate several material points. He speaks of the "general overriding necessity for speed in an operation of this kind", but suggests that the patient was so far recovered that a search for packs could have been made at some length and more or less at leisure. The evidence is entirely to the contrary. The plaintiffs' expert, Mr. Barber, said,

> "I keep the mental count in my mind and I expect to find the same number when I remove them at the end of the operation. I think if one knows in a big operation that one has used a number of packs I do subconsciously feel round the area in which I have been working but I can't say that this is a conscious search. I do this because I might be afraid I might leave one behind. This feeling takes a second or two. I do not make a general search of the whole abdomen for packs. It might take half a minute to do that. Packs always move in the course of an operation further from the original manipulations and partly as the result of movements of the intestine brought about by the patient's breathing. This happens in every case. The count carried out by the sister is fallible. This is well known to surgeons. A Spencer-Wells has disappeared inside the abdominal cavity too. I think that every surgeon knows that there have been cases on record of an instrument being left in the abdominal cavity. I

can't recall a clip being detached from the tape."

* * * * *

"I don't think that if the surgeon and staff followed the system I have described they could do any more."

But the most important evidence was, I think, that of Mr. Ormerod, whose status as an independent expert is beyond argument. I must quote him at some length. He said,

"I have had a description of the operation by Mr. Nevill given to me. I am familiar with Mrs. Cooper's condition at the time. I don't think it exists except as an emergency operation. As a surgeon I would describe it as an operation of extreme difficulty. I would say it is one of the most difficult emergencies of surgery. The patient is quite often in a moribund condition and literally loses a very high fraction of her total blood volume."

* * * * *

"The nursing staff if they carried out their part of the routine check of the swabs and reported to the surgeon that the check was correct and the surgeon had made a rapid examination of the site in which he had been working and in which he knew he had deliberately placed a swab, I would say that under those conditions the surgeon could not be held responsible for any degree of carelessness."

I note the word "rapid". Again,

"This operation is one which requires a high degree of combination of dexterity and speed. With a moribund patient the life of the patient depends on those qualities in the surgeon. If the patient was 'much better' before the abdomen was closed, I would say that that indicated that the surgeon had in fact achieved the object he set out to achieve. He had succeeded in stopping the source of bleeding but that would not give the surgeon any right to take any liberties which might extend the time of the operation because such appearances of improvement are often only temporary appearnaces, i.e. having known the condition of

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the patient a few minutes before the improvement, no surgeon of experience would trade on that improvement. Definitely he would not be justified in slowing the operation up. Speed is of paramount importance. I think in the hands of an inexperienced and slow surgeon such a patient might die on the table."

* * * * *

"He would make an inspection by eye and he would feel with one hand the area in which he had been working. Under ordinary cold conditions it would be possible to make a search which would be thorough. I would say that it would take the best part of a minute if the area of operation is easily visible. In emergency conditions there would be a very considerable difference. I would expect an ordinary careful surgeon in those particular conditions and under the conditions of this operation where the abdomen has recently been full of blood and doubtless is still obscured by blood clots which have a habit of reappearing right up to the last minute, I would expect him to feel in the position where he thought or remembered he had put a pack. I would then expect him to turn to the sister in charge and ask her if she was satisfied. I think he would always ask. If she volunteered the information that would render the question unnecessary. I would then expect him to close the abdomen as rapidly as possible. I think Mr. Nevill went as far as he possibly could."

* * * * *

"I think you have to take into account the whole context. You are working under conditions of stress. You are very much in the position of a captain at sea in a storm. Your routine tends to be a bit displaced. I did not say it would not be negligence on the part of the surgeon if a swab were overlooked in the body of Mrs. Cooper. I said it might not. It is possible that in attempting to get a clear view of the area he would pack a swab down and forget where he put it under those conditions of stress. He might even fail to remember that he had put it there. That would be a packing swab. I think he would only be excused under conditions of extreme stress in failing to remember that he had in fact put it

there. I can conceive another set of circumstances. I can imagine that a swab might be placed in a certain position and during the manipulations which are necessary in this particular operation that swab could be displaced and it could become surrounded by coils of the gut. That would be any form of swab or pack. While he is mopping a mop would not and should not leave the surgeon's hand. I can conceive that suddenly he might decide to use it in another form, for packing. In a woman who is so dangerously ill it would be very meddlesome surgery to rummage among those coils because that would be attended by further shock. There is nothing else."

* * * * *

"You cannot conceive the difficulties in an operation of this kind in which the surgeon has one objective and to insist on the routine 'cold' checks being carried out and to insist that no accident shall take place under those conditions is a tremendous lot to ask. If a pack was left in in the circumstances described by Mr. Nevill it was an accident."

* * * * *

"Having an assistant surgeon might in some respects lower the time factor of such an operation. It might enable the surgeon to proceed more quickly although the responsibility for carrying out all procedures is still the responsibility of the surgeon doing the operation; with the aid of a good assistant he might be able to go a little bit faster. It would never be a question of his going a little bit 'easier.' His responsibility remains the same. When I refer to a swab being 'displaced' it would be I think one placed as a pack. The time of doing a check will depend on the efficient way the swabs have been laid out on the floor. I think the check might be more difficult in an emergency particularly of this nature than in a cold operation. I think there is more chance of accidental error on the part of the theatre sister rather than the surgeon or a combination of both. Under the conditions of this operation the atmosphere for the theatre sister and her difficulties are parallel with the surgeon's difficulties. She is in a harassed position. She is very often harassed by

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the surgeon himself. There would be a temptation for the surgeon to perform his check more quickly for the sake of the patient in an emergency. Under these circumstances if a surgeon has a mental note of the number and is assured by the theatre sister that the count is correct, I would say he is not required to do more than that. His mind would be at rest. I would say in this particular instance it compared very favourably with the ordinary practice of a careful surgeon. If in addition he makes a visual check and does something with his hand he has done all he could do. I do not think a reasonably careful surgeon could have done anything else. In the difficult circumstances he achieved considerable success."

Dr. Braimbridge's and Mr. Nevill's evidence is to the same effect. I think the learned Judge has failed entirely to appreciate that the patient was in a condition of collapse, not merely towards the end, but during the whole of the operation. So far from a sudden need arising to get her to bed quickly, she had never been well enough to be moved from her bed. The improvement in her condition was simply this, that she was no longer actually dying, but might possibly survive. The need for "special haste" was present throughout and never diminished.

As regards the extent of Mr. Nevill's search for packs, his own evidence has already been quoted, and was accepted as true. The essential points, as I see them are four. First, he made both a visual and a tactile search. Secondly, it would have been bad surgical practice, and probably fatal to the patient, to carry out a general search of the abdominal cavity. Thirdly, he made and relied on his own mental count of restraining packs, and he was under no duty to memorize the mopping packs. Fourthly, he relied on the Sister's count, and the sister in question was one of whose efficiency he had good reason to be confident. See Mahon v. Osborne at p.553. The learned Judge's references to "normal routine" ignore that normal routine is something which must depend on the circumstances of the individual operation. What might be normal in one case might be dangerous and wrong in another. I think also that the learned Judge has assumed wrongly that a "normal routine search" must in this case inevitably have resulted in the discovery of

all restraining packs at least. I am not satisfied on the expert evidence that that is correct. In any event, it overlooks the point that a mopping pack might have been lost without negligence, and might not have been recovered by the most extensive search which could properly be made.

I think the last sentence of the passage quoted shows that the learned Judge, though he set out correctly the law applicable to the case, did not in the event apply that law to the evidence. The "conditions which might reasonably excuse a surgeon overlooking a pack" were not excluded, but were shown by the expert evidence to be present and numerous. To say that there was "no causal connection" between the difficulties of the operation and the failure to remove the pack is, I think, to disregard the essential point that it is not always, if ever, necessary for the surgeon to show how he came to overlook the pack: it is enough if he shows that he took all proper precautions, and used due care and attention to prevent a pack being overlooked. In that sense, and having regard to the expert and factual evidence, I am clearly of opinion that, so far from being convicted out of his own mouth, Mr. Nevill gave a proper account of the circumstances and conduct of the operation, which was accepted as true, and which showed that the mishap was not due to negligence on his part.

The learned Judge cites a passage from the judgment of Scrutton L.J. in Dunlop v James and says that the observations there made "are all particularly relevant to the present case." This may be partly true, but it ignores the special circumstances which arose in the present case and did not arise in that one. The Court of Appeal in Dunlop v James was concerned only with the question whether a jury's verdict was supportable. Even so, the almost contemptuous dismissal of the theory of a "perambulating swab" seems strange in view of the expert evidence in every swab case which I have read.

The learned Judge summarizes his findings on the issue of negligence in the surgeons in these words,

> "To sum up, if the pack was a mopping pack it was negligence on the part of the person who used it, whether it was Mr. Nevill or Dr.

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Wilson, to lose control of it and leave it in the body. If it was a restraining pack, having regard to the small number used and their obvious position, the absence of movement and the lack of any particular need for haste at the conclusion of the operation immediately prior to sewing up, it was negligence on the part of Mr. Nevill, not to remove it, the responsibility being, as he admits, upon him to do so, and there being no justification for departure from the normal routine. In my view the whole circumstances of this operation are more consistent with negligence on the part of Mr. Nevill than the absence of it."

I would summarize my own views by saying that, if this was a mopping pack, its loss may have occurred without negligence and is not proved to have been due to negligence. If it was a restraining pack, it may still in the special circumstances of this operation have been lost without raising any strong inference of negligence, and the evidence shows that Mr. Nevill used due care and attention to avoid the mistake which occurred, and in particular that his search was as extensive as was proper in the circumstances. It is somewhat ironic to consider that Mrs. Cooper was not a patient of Mr. Nevill before the emergency arose, that if he had declined to operate, or delayed doing so in the hope that conditions might become easier, she would probably have died, and that if she had died before, during or shortly after the operation no word of criticism of his conduct would ever have been uttered. I would allow the appeal by the first appellant, set aside the judgment and decree as against him, and order that the respondents do pay his costs in both Courts. I would certify for costs of two counsel, one of them being Queen's Counsel, in the Supreme Court, and for costs of two counsel in this Court. Any costs paid by him under the decree set aside should be refunded.

I turn now to the case of the second appellants. For the reasons given, I respectfully agree with the learned Judge's finding that the count of the sister in charge, or of the "dirty nurse", or of both, was wrong, and that this is a circumstance which calls for explanation on the part of the second appellants. It is, I think, possible that Sister Banks was not personally negligent, if an extra pack was included in one bundle and not observed. The "dirty nurse"

was certainly not negligent, if that occurred. But if it did, the second appellants are in no better position, for both the person who made up the bundle and the person who checked it into the sterilizing drum were under a duty to see that an extra pack was not so included in a bundle, and there were no circumstances of stress affecting them which might have excused error. For the negligence of both those persons the second appellants would be liable.

If, however, the theatre sister or the "dirty nurse" was alone responsible for the error, it is necessary to consider whether the error could in the circumstances be excused. This was, of course, an emergency operation in the technical sense, but such operations are of daily occurrence in a hospital, and theatre routine is designed to deal with them as calmly and as efficiently as with a "cold" operation. There was an ample and fully-trained staff. The particular problems which face a surgeon in an exceptionally difficult and critical operation like this do not necessarily in any way disturb the ordinary routine of the theatre staff. It is true that Mr. Ormerod says that in an operation such as this the sister may be "harassed", the count is more difficult, and error may be excused. But Sister Banks did not suggest that she was in any way unable to carry out her usual routine, except as regards the inconvenience of not having the Mayo tray over the bed and differences in wrapping up the patient. She had to work fast, but there is nothing unusual in this. All the evidence is that during the operation she was working calmly and apparently efficiently. The count is a purely mechanical matter. It calls for no special skill or judgment, and where a large number of packs is used it must always be done with exceptional care to ensure accuracy. I am far from saying that a miscount could never occur without negligence. It might be explainable in all sorts of special ways. But no such explanation at all is put forward here or, so far as I can see, can be suggested on the evidence. I respectfully agree with the conclusion of the learned trial Judge that the miscount can only be attributed to negligence on the part of one or more of the staff for whose acts and omissions the second appellants are responsible in law. They have not, in my opinion, satisfied the test applied by Singleton L.J., in Southport Corporation v Esso Petroleum Co. Ltd., (1954) 2 A.E.R. 561, at p.569,

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where he said, "If the defendants have produced a reasonable explanation, equally consistent with negligence or no negligence, the burden of proving that the defendants were negligent and that their negligence caused the damage rests upon the plaintiff." On the further point whether the negligence caused the damage in this case, there was evidence that, if the sister's count had been right and she had said that one pack was missing, a further search would have been made by Mr. Nevill and continued until the missing pack was found. It is true that in that case the patient might have died, but in spite of this I think the miscount was in law a cause of the damage.

The next question is that of the general damages awarded to Mrs. Cooper. The amount, as I have stated, was Sh.50,000/-. The learned trial Judge dealt with the matter thus,

> "So far as the second plaintiff is concerned, as a result of the leaving in of this pack she has undoubtedly gone through considerable pain and suffering. I have already mentioned the abdominal pains and vomiting which led up to her admission to the Maia Carberry Nursing Home. After her discharge the pains and vomiting became recurrent and the period up to her admission to hospital in October, 1956, was described by her as 'a nightmare.' She mentions one occasion after her admission to hospital and before the operation, when the pain became so intense that she got out of bed, put on her coat and shoes and decided to run out and throw herself under a car. She was, in fact, stopped by a nurse in time. Apart from the physical suffering, there is always in the case of abdominal pains, a considerable psychological effect, particularly when the cause of the pain has not been diagnosed. Mrs.Cooper says that after a time she came to suspect that she had a cancer. After the operation, when in hospital, she underwent a good deal of physical discomfort from a machine which was used for the purpose of draining the wound. She also suffered from a fistula. This closed itself before she left hospital but she had a discharging sinus from where the drainage tube had been left in. This eventually cleared up.

The effects of the removal of seven feet of

intestine, approximately one-third of the whole, are not easy to assess. Mr. Barber expressed the view that she has probably still got sufficient for normal digestive purposes, but that the amount lost is about the borderline and that the loss of any further portion might have some effect on her digestive ability. He said that a patient might manage with half the normal length of small intestine, with little or no digestive disturbance, but that there would be the probability of more frequent bowel action than normally. Mrs. Cooper said that she still experienced periodical abdominal pains and this has been confirmed by Dr. Thompson. He says than an X-ray of the stomach and intestines after the operation was satisfactory and that these pains are probably due to adhesions and that they might continue for the rest of her life.

There was some discussion during the course of the case as to whether Mrs. Cooper's childbearing capacity had been affected as the result of the leaving in of this pack. Dr. Thompson said that it would be impossible to determine whether Mrs. Cooper could now have a child without an examination under anaesthetic and he is of the opinion, having regard to all the operations which she had undergone, that this would be inadvisable. He added, however, that he would have advised her not to attempt to have a child, even before this last operation. I think, therefore, that any question of Mrs. Cooper's prospects as a mother must be left out of account in assessing the damages."

It may thus be said that the only proved permanent injury which can be said to have resulted from the second or third operation, or from both of them, is occasional pains caused by adhesions, and there is no reason to think that these are severe. It was not suggested before us that Mrs. Cooper's inability safely to bear a child was in any way attributable to the matters in issue in this suit. As regards the removal of seven feet of the smaller intestine, there was some slight difference of expert opinion. Mr. Barber thought she could compensate satisfactorily with the remaining two-thirds, but that if she had to have any more removed she might have digestive trouble. Dr. Thompson said she had recovered from the third operation, but had some

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residual symptoms of occasional loose stools and abdominal pains. The latter probably result from adhesions and the former do not appear to be of any gravity. Mr. Braimbridge was clearly of opinion that the loss of seven feet of intestine was quite immaterial to health. Mrs. Kean argued that Mrs. Cooper had been obliged to alter her diet and her way of life. The learned Judge does not appear to have been impressed by this, since he does not mention it. I am not impressed either. I think that any potential consequences of the possible removal of more of the intestine are an altogether too remote head of damage, and I regard the actual consequences to future health of the removal of seven feet as comparatively trivial. The damages fell to be assessed, as I see the matter, on the basis of past pain and suffering, with some allowance for future pain from adhesions and for inconvenience from loose stools.

On this basis, I find myself obliged to regard the assessment of the learned trial Judge as a "wholly erroneous estimate", and one so disproportionate to the general level of damages awarded in such cases that it ought to be reduced. See Rushton v National Coal Board, (1952) 1 Q.B. 495. While admittedly no arithmetical calculation is possible, I think that for the pain and suffering and the minor permanent consequences involved a sum of Sh.15,000/- would be sufficient compensation. I would only add that the case of Urry v Bierer, The Times, 16th March, 1955, where £3,000 general damages were given, stands on a wholly different footing from this. In that case a third operation had yet to be undergone, and the inability to have a child, though psychological in origin, was a direct result of the operation in question.

I would allow the appeal of the second appellants so far only as it relates to the general damages awarded to Mrs. Cooper. I would vary the judgment and decree of the Supreme Court by reducing those damages from Sh.50,000/- to Sh.15,000/-.

The question of cost is somewhat complicated owing to the different positions of the two plaintiffs/respondents and the two defendants/appellants. In the Supreme Court the plaintiffs must be deemed, in the absence of any agreement made prior to the commencement of the action, to be liable each for one-half of the amount of their own advocate's

costs. Their party and party costs have apparently been taxed at Sh.10,817/- as against both the defendants, who were separately represented. Those costs must be retaxed, first, in order to excise any amounts separately charged in respect of matters relating only to the first defendant, e.g. letters to and attendances on his advocates, and secondly, in order to allow the taxing-officer to review the exercise of his discretion as to any discretionary or variable items, e.g. the instructions fee, having regard to the much reduced sum recovered. Those costs will be paid by the second appellants. For purposes of set-off they will be payable as to one-half to each of the plaintiffs. In this Court the first respondent has been successful as against the second appellants. Accordingly the respondents' costs must be taxed, as if they had both succeeded, and the second appellants must pay to the first respondent one-half of the amount so taxed. On the other hand the second appellants have succeeded as against the second respondent and she must pay their costs of the appeal. In their case I would not certify for costs of two counsel. If costs of leading counsel in this Court were shared between the appellants they must be apportioned. As regards the second respondent the amounts due for costs in the two Courts may be set off against one another and against the damages payable to the second respondent, i.e. the sum of Sh.15,000/- plus half the amount of the special damages. I would order accordingly.

F.A. BRIGGS,
VICE-PRESIDENT.

JUDGMENT OF GOULD J.A.

I am in full agreement with the reasoning and conclusions expressed in the judgment of the learned Vice-President and consider that there is nothing I can usefully add.

T.J. GOULD,
JUSTICE OF APPEAL.

JUDGMENT OF CORRIE AG. J.A.

I also agree.

O.C.K. CORRIE,
AG. JUSTICE OF APPEAL.

NAIROBI.
24th November, 1958.

I certify that this is a true copy of the original.
(Sgd)S. HARLAND
REGISTRAR. 12-12-1958.

In the Court of Appeal for Eastern Africa

No.36

Order,

24th November 1958.

No.36

ORDER

IN HER MAJESTY'S COURT OF APPEAL FOR EASTERN AFRICA AT NAIROBI

CIVIL APPEAL NO.38 of 1958

BETWEEN

1. GERALD NEVILL
2. KENYA EUROPEAN HOSPITAL ASSOCIATION APPELLANTS

AND

1. LEONARD QUENTIN TYRRELL COOPER
2. ROSETTA COOPER RESPONDENTS

(Appeal from a Decree of H.M. Supreme Court of Kenya at Nairobi (Mr. Justice Miles) dated 17th February, 1958, in

Civil Case No.808 of 1957

Between

1. Leonard Quentin Tyrrell Cooper
2. Rosetta Cooper Plaintiffs

and

1. Gerald Nevill
2. Kenya European Hospital Association Defendants)

In Court this 24th day of November 1958.

Before the Honourable the Vice-President (Mr. Justice Briggs)

the Honourable Mr. Justice Gould, a Justice of Appeal

and the Honourable Sir Owen Corrie, Acting Justice of Appeal.

ORDER

THIS APPEAL coming on for hearing on the 3rd, 4th and 5th November 1958 in the presence of Clive Salter Esquire of Her Majesty's Counsel and A.E. Hunter Esquire of Counsel for the 1st Appellant and the said Clive Salter Esquire and R.D. Croft Wilcock Esquire of Counsel for the 2nd Appellant and Mrs.L. Kean of Counsel for the 1st and 2nd Respondents when it was ordered that this appeal do stand for judgment AND the same coming this day for judgment IT

IS ORDERED that the Appeal of the First Appellant be allowed and that the Appeal of the Second Appellant be allowed so far only as it relates to the general damages awarded to the Second Respondent the said general damages being reduced from Shs.50,000/- to Shs.15,000/-.

AND IT IS FURTHER ORDERED that the first Appellant do have his costs against both Respondents in this Court and in the Court below, Certified for two counsel in this Court and for Queen's Counsel and Junior Counsel in the Court below AND the Second Appellant do pay to the Respondents the costs in Court below such costs to be retaxed, and in this Court the Respondents will have their costs as taxed against the Second Appellant save that the Second Appellant will only pay to the First Respondent one-half of the amount so taxed AND the Second Appellant will have their costs as taxed against the Respondents save that the Second Respondent will pay such costs to the Second Appellant.

Given under my hand and the Seal of the Court at Nairobi this 24th day of November 1958.

F. HARLAND,
REGISTRAR.

ISSUED this 13th day of January 1959.

In the Court of Appeal for Eastern Africa

No.36

Order,

24th November 1958 - continued.

No.37

No.37

Order on Application for final leave to appeal,

29th September 1959.

ORDER ON APPLICATION FOR FINAL LEAVE TO APPEAL

IN HER MAJESTY'S COURT OF APPEAL FOR EASTERN AFRICA AT NAIROBI.

CIVIL APPLICATION NO.2 OF 1959

(In the matter of an Intended Appeal to Her Majesty in Council)

BETWEEN

ROSETTA COOPER .. .. .. APPLICANT

AND

1. GERALD NEVILL
2. KENYA EUROPEAN HOSPITAL ASSOCIATION RESPONDENTS

(Intended Appeal from a Judgment and Order of H.M. Court of Appeal for Eastern Africa at Nairobi dated the 24th of November, 1958, in

In the Court of Appeal for Eastern Africa

No.37

Order on Application for final leave to appeal,

29th September 1959 - continued.

Civil Appeal No.38 of 1958

Between

Gerald Nevill
Kenya European Hospital Association Appellants

And

Edward Quentin Tyrrell Cooper
Rosetta Cooper Respondents

In Chambers this 22nd day of September 1959.

Before the Honourable Mr. Justice Windham, a Justice of Appeal.

UPON the application presented to this Court on the 7th day of September, 1959 by the above named applicant for final leave to appeal to Her Majesty in Council AND UPON READING the affidavit of Michael Kean sworn on the 7th September, 1959 in support thereof AND UPON HEARING COUNSEL for the applicant and for the Respondents IT IS ORDERED that the application for final leave to appeal to Her Majesty in Council be and is hereby granted AND IT IS DIRECTED that the record including this Order, be despatched to England within a fortnight from today AND IT IS FURTHER ORDERED that the costs of this application do abide the result of the appeal.

DATED at Nairobi this 29th day of September, 1959.

REGISTRAR.

Issued this 29th day of September, 1959.

E X H I B I T S

Exhibits

No.2

Letter - L.Q.T. Cooper to G.E. Neville,

4th December 1956.

EXHIBIT NO.2 - LETTER, L.Q.T. COOPER TO G.E. NEVILLE

CIVIL CASE NO.808 OF 1957

EXHIBIT NO. 2:

P.O. Box 6542,
NAIROBI.

4th December, 1956.

Dear Mr. Neville,

I am writing this personal letter to you since I feel that you would prefer that its contents should, at this stage at any rate be dealt with in this way.

As you may perhaps be aware, in the months which followed the emergency operation which you performed upon my wife on 1st February of this year, she suffered considerable pain. She was at one stage admitted to the Maia Carberry Nursing Home for observation and was also examined by Dr. Thompson, but without any cause of the pain being discovered.

On the 29th October the pain became extremely severe. She was admitted to the New European Hospital, and, after being kept under observation for a few days was operated on by Mr. Barber.

I telephoned Mr. Barber after the operation and he asked me to come and see him. I did so. And he told me that his operation had revealed the trouble to be an abdominal obstruction, caused by the fact that a swab had been left in my wife after the last operation. Apparently he had informed you of this and you had agreed that I should be told.

I would like to make it entirely clear at this stage that I have no wish to be vindictive over this or to cause you any embarrassment and that I am grateful to you for the otherwise successful outcome of your emergency operation.

The position is, however, that as a result of what has happened my wife has had a great deal of suffering and I have been and will be put to a great deal of expense. I feel in the circumstances that I have no alternative but to look to you for recompense.

Exhibits

No.2

Letter - L.Q.T. Cooper to G.E. Neville,

4th December 1956 - continued.

I shall be grateful if you will let me know that you accept the position as I have set it out above and tell me in what way you prefer that I should deal with the matter. I have deliberately not put it in the hands of my Advocate so far, but am, of course, prepared to do so if you feel you would rather have it dealt with formally from the start.

I imagine that you are insured against occurrences of this nature but you will doubtless let me know this when you reply.

Yours sincerely,

Sgd. L.Q.T. Cooper.

No.3

Letter - G.E. Neville to F.A.Thompson,

17th March 1956.

EXHIBIT NO.3 - LETTER, G.E. NEVILLE TO F.A. THOMPSON

CIVIL CASE NO.808 OF 1957

Exhibit No. 3:

GERALD E. NEVILL.
M.Ch. F.R.C.S.

P.O. Box 384,
Nairobi,
Kenya.

Sirona House,
Sadler Street,
Telephone 2498.

17th March, 1956.

Dr. F.A. Thompson,
Mutual Buildings,
P.O. Box 2223,
NAIROBI.

Dear Dr. Thompson,

Herewith a report on Mrs. Quentin Cooper who, I understand, is normally your patient.

She was sent down on 1.2.56 by Dr.R.C.Spiers of Limuru, in a completely moribund condition, escorted by Dr. Spiers and Dr. Gillespie.

She arrived, almost dead, pulseless, grey-blue in colour with a very occasional breath, having had a sudden onset of abdominal pain some 4 hours earlier.

She was, of course, a very obvious ectopic and seemed to be about to die.

Exhibits

No.3

Letter - G.E. Neville to F.A.Thompson,

17th March 1956 - continued.

Dr. Lawes, luckily for everybody, was at the Hospital and started straight away with transfusions, first with saline and immediately afterwards Dextran. By this time we had been able to get hold of some Group O blood from the Bank and we gave her a total of 6½ pints of this within an hour of her arriving in the Hospital. By this time there was a degree of recovery of life and we got her along to the theatre in her own bed.

There she was given the smallest general anaesthetic you could have imagined and we opened up her lower abdomen. She was still so dead that there was no bleeding from the wound.

However, the belly cavity was absolutely full of blood. We sucked out four pints into bottles for autotransfusion but in fact we did not actually use these. We estimated that there were some two to three pints extra in clots piled into a dish and there was more inside her abdomen which we never got out; this was a pretty serious degree of exsanguination.

The cause of the whole trouble was a rupture of her uterus right across the top of the fundus, down through the left cornu and the left side of the uterus in a vertical manner; this split had been caused by a 3½ month foetus which must have been impregnated in the actual cornu itself.

We removed the remains of the tube and stitched over the split leaving her with a relatively normal uterus as far as this side was concerned.

The other side showed a very much forshortened tube in the middle of which there was a small piece of polythene tubing; this we discovered afterwards, had been inserted by Mr. P.G. Preston about a year previously in an effort to get her pregnant.

The cause of all the trouble, a foetus of some 3½ months gestation, we found lying free complete in its sac low down in the Pouch of Douglas. Beside it was another piece of tubing some 3 inches long; this we took and put in a tin for further reference.

By this time the patient was very much better and in fact was coming round, so we were quite happy about stitching up her wound, and that was all there was to it.

She had a stormy passage for a few days, a mild degree of ileus and a mild degree of jaundice

Exhibits

No.3

Letter - G.E. Neville to F.A.Thompson, 17th March 1956 - continued.

showing that one of the bottles of blood had not agreed with her entirely. However it all eventually settled down and she was able to go home within two and a half weeks.

When I last saw her on 2.3.56 she was doing fine, her wound had completely healed very neatly and she had no further trouble except for a small ulcer on her leg where something must have banged it in the heat of the moment. However, that was almost healed and need not worry her any further. 10

I have sent a copy of this report to Dr.Spiers and Mr. Preston has been informed so he is well aware of what has gone on.

If it had not been for the speed of action of Dr. Spiers and Dr. Gillespie from Limuru, Mrs. Cooper would not have lived to tell the tale.

Yours sincerely,

Sgd. Gerald Nevill.