IN THE HIGH COURT OF THE COOK ISLANDS
HELD AT RAROTONGA
CIVIL DIVISION

PLAINT NO. 80/99

BETWEEN HEALTH WATCH INCORPORATED a duly incorporated society having its registered office at Rarotonga
First Plaintiff

AND CASPER MATEARIKI & LOTIOLA MATEARIKI both of Atiu
Second Plaintiff

AND THE MEDICAL AND DENTAL COUNCIL OF THE COOK ISLANDS a body corporate established pursuant to Section 3 of the Medical and Dental Practice Act 1976
Defendant

Mr McAnally for First and Second Plaintiffs
Mr Lynch for Defendant
Date of Hearing: 28th and 29th November 2000
Date of Judgment: 29th November 2000

ORAL JUDGMENT OF GREIG CJ

This is an action brought by the Plaintiffs in respect of the consideration by and the findings of a Cook Islands Medical and Dental Council into what is described in their findings as an investigation into the death of Baby Casper on 2 November 1997. The proceedings are brought by a Statement of Claim and the allegations are now set out in an amended Statement of Claim dated 3 May 2000.

The defendant has done nothing more than file a Notice of Intention to Defend. Proceedings such as this are invariably dealt with by affidavits, affidavits which produce the record of the hearing and the other material evidence. In the most unusual case there might be of an application to cross-examine a witness but a case like this is never done on ordinary viva voce evidence.

I allowed this case to be done out of the ordinary in this way to deal with it rather than on a regular proper basis so the matter may be heard in appropriate order.

The reason that a matter such as this is not dealt with by the ordinary process of oral evidence is that a case like this is not an appeal. It is a review of the tribunal to see if it has gone wrong in the conduct of the hearing. It is not to second guess the tribunal. It is not to review the evidence and to decide whether a Court, this Court, might have come to different conclusion. The decision is about whether the tribunal on the evidence that was before it has acted regularly in hearing and dealing with the matter and then has come to a conclusion which was open to it and which has not been influenced improperly by irrelevant considerations or failure to take into account relevant considerations. In the case of a review the papers often make a claim that a tribunal has taken account of irrelevant considerations or failed to take account of relevant considerations or has behaved unreasonably.

It is not open to a party dissatisfied with the conduct or decision of a tribunal to attempt by a procedure, such as this claim, to have a Court rehear the evidence before the tribunal with a view to that Court coming to a different conclusion. Nor is it open to such a party to claim that merely because the tribunal has come to a view of the facts which is not in accordance with that party's view that the tribunal thereby has conducted its investigation improperly or has failed to come to a proper conclusion.

The First Plaintiff is a body corporate called Health Watch Incorporated. I have no information or evidence as to what the body is, what it does and what standard or status it might have in relation to a matter such as this. The amended Statement of Claim alleges and this is not denied, or dealt with on the part of the defendant that by letter dated 24 November 1997 it requested the defendant to enquire into the treatment of Baby Casper by Dr Raea. The Council's decision and findings dated 25 March 1998 refer to that letter and mention the request for the Medical Council to investigate. At the same time it appears that the parents of the baby also wrote to the Council about the matter.

The matter was first dealt with in an un-official way by the Secretary of Health and in his report dated 5 January 1998 which was addressed to the Chairman of the Medical Council, certain comments and findings were made to enquiries and information obtained from the doctor concerned and the nurse who had been involved in the matter.

The Secretary of Health came to the conclusion that Dr Raea "had done what he could for this child and I therefore reject the allegation that there was malpractice involved."

Dr Robert Woonton in his evidence before me today as Chairman of the Council said that he was not satisfied with that and decided that the Council should investigate the matter itself.

The events of this sad matter took place on the island of Mauke. The doctor was brought to Rarotonga as was the nurse and as were the parents and the Council set up an enquiry which sat on 3 days on the 26,27 and 29 January 1998.

The Council comprised the chairman, Dr Robert Woonton, Dr Losacker, Mr George Hosking who I understand is a member of the Dental profession and Mr Bobby Turua who is appointed by the Minister to represent the general public.

The representative of Health Watch Incorporated, the First Plaintiff sought to be present but that application was not accepted. There was present however Sir Thomas Davis, he seems to have been there in a watching capacity. In his evidence to me he clearly said that he represented the parents of the child and as I understood it also Health Watch. There was a reference to the presence of Sir Tom's grand daughter Jennifer Davis. She is a solicitor I am told. It appears neither Sir Tom or Miss Davis took any part in the giving of evidence before the Council or in giving submissions to it.

There is no transcript of the evidence before the tribunal. I am informed by Mr Lynch that the papers of the Council have been lost.

Sir Tom took some notes. These he later transcribed by typing them. He referred to his type written notes to refresh his memory and described to me what took place before the Council. Dr Woonton has also given evidence, clearly from memory, but that does not in any material respect differ from what Sir Tom has said. Dr Losacker has confirmed what Dr Woonton said.

In the absence of the transcript but with the evidence before me, I believe I have a clear idea of what took place. The Council heard the doctor, the nurse, the parents and the doctor who had attended the mother on the birth of the child.

The general outline of the events was that the baby had been born in Rarotonga and after about 4 weeks was taken to the island of Mauke. Towards the end of October the child became ill and was taken to the hospital and was seen by the doctor. The doctor saw the child again and gave it some treatment. It was diagnosed of a suspected flu, consideration of anaemia and a treatment was given including an injection of Neo Cytamen and some amoxil syrup. The child became worse and was brought into the hospital again and finally died.

There was a number of suggestions made that the doctor had not been able to be reached on one or two occasions, that he had used the drug Neo Cytamen which was old. A suggestion was made that it was some 8 years out of date. However there is no suggestion that that treatment caused any harm to the child. It was accepted that there was a suggestion of some bleeding after the injection. This was not brought to the attention of the doctor and it appears it was not of a nature that caused any real concern to the Council.

There was a suggestion that the parents had told the Council that on one occasion, it seems a Sunday morning, that the doctor had smelled of alcohol or was drunk. All of this material was before the Council. As I have said the Council met on three days in January 1998 hearing those witnesses. The Council then had three further meetings among themselves to deliberate and to come to a conclusion. Their conclusion was reached on 25 March 1998. They made five observations as follows:

"1. We could not establish the cause of death on clinical evidence without a post mortem.

2. The bleeding noted by the parents from the injection site by itself could not have caused the death of the baby.

3. Dr Raea was not informed of the bleeding complications either by the parents or the nurse.

4. There was no evidence provided to the Council to suggest Dr Raea failed to provide medical attention to the baby.

5. The Council is satisfied that the treatment and management of Baby Casper was within the standard medical practice available on Mauke."

Their conclusion was that no failure or blame could be apportioned to any particular party involved in the death of Baby Casper. The Council expressed their deep regret for the loss of their child. I would repeat that from the Court's point of view.

There is actually no express finding by the Council that there was no misconduct of a professional kind or any misconduct on the part of any person involved in the death.

Council is, as I have noted, made up of three professional personnel and a member of the public and they are of course familiar with the practice of the profession in the Cook Islands and in particular the south islands such as Mauke.

Evidence was given to me today that there are difficulties in providing complete treatment available to all in the south islands. The information was that the doctor in this case had done what he could with what was available to him. Dr Woonton suggested that he himself would have probably done the same in the circumstances. No doubt he would not have done the same in Rarotonga in the hospital facilities here.

I am satisfied without any doubt of any kind that the Council carefully considered the material that was put before it. It has before it the evidence that has been repeated to me of what might be considered in some circumstances a failure on the part of a

medical practitioner. The Council came to the conclusion on the whole of that, after their careful deliberation that there was no failure, that there was treatment afforded and that it was in accordance with the normal practice. It is implicit in what it said that there was no misconduct. It is no real help to keep repeating that there was some evidence of influence of liquor on one occasion on the part of the doctor or that some of the medicine used was out of date. The question before the tribunal was whether the doctor did his best in the circumstances, they concluded that he did. The Council had before it all the evidence the applicant has rehearsed in this Court, it was considered and the Council ruled as it did.

Because the Council did not mention some item or items of evidence or did not deal with it in the way the applicant would have liked it does not follow that the Council was wrong or failed to take it into account.

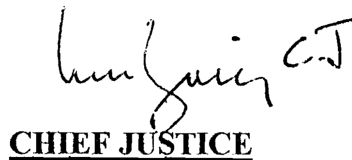
I am satisfied that there are no grounds for any review of the tribunal hearing or the conclusion that it made on the grounds that have been raised.

It was claimed that the Council had breached its statutory duty in not allowing the First Plaintiff to attend its hearing. The relevant provision is S 28(3) of the Medical and Dental Practices Act 1976. That provides that the complainant is entitled to be present throughout the enquiry held by the Council into a complaint. The First Plaintiff alleges it was a complainant in this case. That has not been denied. It is clear to me however that the First Plaintiff would not have put to the Council anything that was not before the Council and which would have influenced its decision.

Mr conclusion is that although technically there was a breach of the statutory requirement it was not a matter that would have affected the decision and it was not a matter which required the case to be heard again. I do note however that Council must allow the complainant to be present. It may be in the relative informality that appears to prevail with the Council that a body like Health Watch Incorporated which has taken some active steps in the action ought to be allowed to be present and to take an active part in the proceedings.

In the result then the action must fail and all the applications are dismissed.

Mr Lynch for the defendants has applied for costs. Costs normally follow the event; the loser pays the costs. And in a case like this the Plaintiffs have brought the proceedings, they have failed. The defendant has had to take some steps to instruct counsel and to appear in this case. As I have noted, the defendant has taken no steps in the pleadings. Apart from the report it has produced no documentation by way of affidavit or otherwise. We have been engaged half a day. On the other hand the First Plaintiff is a public lobby group, a non governmental organisation, which assisted the parents to bring their claims. The Second Plaintiffs are the parents of the child. I do not accept they have any substantial means. Sadly of course they are parents who have lost a child. In the particular circumstances of this case the costs should lie where they fall, each party should pay their own costs, I make no order as to costs.



CHIEF JUSTICE