[2013–14 Gib LR 300]

A. ROCCA (as administratrix of the estate of K. ROCCA) v. GIBRALTAR HEALTH AUTHORITY

SUPREME COURT (Prescott, J.): December 13th, 2013

Medicine—medical treatment—failure to provide proper treatment—hospital's failure to provide proper treatment for sepsis causing patient's death—53.5% chance of survival if given standard treatment even though patient hep. C positive and former alcoholic—survival rate not 69.5% as unreasonable to expect small hospital to have equipment for "goal-directed" sepsis treatment in 2004—no reduction in survival rate for patient's liver disease as unlikely disease advanced in relatively young patient with hep. C for only 15 years and recent abstinence from alcohol would have reduced liver inflammation

Tort—fatal accidents—loss of dependency—prospective loss of pecuniary benefit sufficient to support claim for loss of dependency—damages calculated by reference to reasonable expectation of pecuniary benefit—standard of proof not balance of probabilities but percentage prospect of receiving pecuniary benefit—husband and wife separated due to husband's alcohol problems 100% likely to reunite following successful treatment for addiction—former alcoholic 100% likely to return to some form of work (albeit not for 52 weeks p.a.) following successful treatment for addiction

The claimant brought proceedings against the defendant to recover damages for the death of her husband.

The claimant's husband was admitted to St. Bernard's Hospital suffering from chicken pox, vomiting, diarrhoea, cellulitis and seizures. He was 40 years old, had a history of drug and alcohol abuse and had been hepatitis C positive for about 15 years. His condition continued to worsen throughout the day of admission, but, despite his symptoms and repeated requests from nursing staff, he was not admitted to the intensive care unit or given appropriate treatment for sepsis. He died in the early hours of the next morning.

Mr. Rocca and the claimant had been married since 1992, with periods of separation and reconciliation since then, culminating in a non-molestation order being granted in 2004, after which he attended a rehabilitation centre to treat his addictions.

The defendant admitted a duty of care to Mr. Rocca, and that it had

been negligent in failing to provide timely or appropriate treatment, but denied that its negligence had been the cause of his death.

The claimant submitted that, based on the evidence of her expert witness, of two available treatments for sepsis, the "standard" therapy would have given Mr. Rocca a 53.5% chance of survival, and the newer, "goal-directed" therapy would have increased that chance to 69.5%. Even though he had a history of alcohol abuse and was hepatitis C positive, patients with those characteristics had specifically not been excluded from the study generating the figures, so these factors should not warrant a departure from those figures in his case. Those figures should not be reduced to take account of his liver disease, as it was unlikely that it was advanced at the time of his death as he was relatively young, had been hepatitis C positive for only 15 years, and chronic liver disease usually develops between 10–40 years after infection, he had been alcohol-free for 6 months, reducing any inflammation of the liver, and his sepsis was a complication of chicken pox, not liver damage. Since both therapies would have given him a chance of survival greater than 50%, on the balance of probabilities he would have survived had he been given timely and appropriate treatment and the defendant's negligence in failing to do so was the cause of his death.

The claimant submitted, in the alternative, that if medical science could not establish that "but for" the negligence of the defendant her husband would not have died, but could establish that the defendant's negligence was a more than negligible contribution to his death, the "but for" test would be modified and she would nevertheless succeed.

The claimant further submitted that she lost the pecuniary benefit of being her husband's dependant as the couple were about to reconcile fully. She was entitled to 80% of his lost earnings, which should be calculated by taking his final weekly salary at the time of his death, and applying that to every week between his death until he would have retired, aged 65.

The defendant submitted in reply that Mr. Rocca would not, on the balance of probabilities, have survived, even given appropriate and timely treatment. Based on the evidence of their expert witness, "goal-directed" therapy for sepsis required equipment which a hospital such as St. Bernard's could not be expected to have, and the 53.5% survival rate for standard treatment should be reduced to take account of the fact that Mr. Rocca was a hepatitis C sufferer and an alcoholic, and would therefore have had advanced liver disease making him more susceptible to sepsis and less likely to survive it, even when properly treated. The expert witness for the defendant put his chances of survival, if properly treated, at 45%. The defendant further submitted that if its negligence were found to have caused his death, the claimant was entitled to 80% of his lost earnings, which ought to be calculated by taking his average earnings whilst employed from 1991–2000, and reducing that figure by factoring in the average for the period 2000–2004 when he was unemployed, and applying that average from the time of his death until he would have retired, aged 50.

Held, allowing the claim:

(1) On the balance of probabilities, but for the defendant's negligence Mr. Rocca's would not have died. His chance of survival, had he been given appropriate and timely care, was 53.5%. Whilst it was unreasonable to expect the hospital to have the equipment necessary for carrying out "goal-directed" therapy, which would have put his chances of survival at 69.5%, he nevertheless should have received the standard therapy. It was not appropriate to reduce that figure to take account of Mr. Rocca's history of alcoholism and drug use, nor for his being hepatitis C positive, as the 53.5% survival rate included people with similar medical histories. Further, Mr. Rocca did not, on balance, have advanced liver disease at the time of his death, being only 5 years into the 30-year period over which hepatitis C usually led to chronic liver disease and he had been substance-free for 6 months, reducing any liver inflammation (paras. 45–46; paras. 49–50; para. 52).

(2) Mr. Rocca's death resulted in a loss of dependency to the claimant. It was not necessary to show that the claimant was receiving any pecuniary benefit at the time of her husband's death; prospective loss was sufficient. Damages would be calculated by reference to the reasonable expectation of pecuniary benefit; the standard of proof was not whether on the balance of probabilities the claimant would have received that benefit, but a percentage prospect of receiving it. In this case, that percentage prospect was 100%. Mr. Rocca and the claimant would have reunited had he survived. The marriage had suffered due to his addictions, and having dealt with these, reconciliation was inevitable (paras. 56–60).

(3) The claimant was entitled to damages for pre-trial loss totalling £47,720.97. As his dependant, she was entitled to 80% of Mr. Rocca's lost earnings. Had he survived, he was 100% likely to have returned to some form of work, but was not likely to have been able to remain in employment for 52 weeks of the year. An average of his earnings, from 1991–2000 (at which point Mr. Rocca ceased work due to his addictions) would be applied from the date of his death to trial, and interest added (paras. 64–66).

(4) The multiplicand for determining post trial loss was £5,774.49: 80% of his average annual earnings at the time of his death. On the basis that he was likely to have continued working until he was 60, the parties were to make further submissions on the multiplier to be applied (paras. 67–69).

Cases cited:

(1) *B* v. *Ministry of Defence* (2011), 117 B.M.L.R. 101; [2010] EWCA Civ 1317, referred to.

(2) *Bailey* v. *Ministry of Defence*, [2009] 1 W.L.R. 1052; (2008), 103 B.M.L.R. 134; [2008] EWCA Civ 883, referred to.

(3) *Bonnington Castings* v. *Wardlaw*, [1956] A.C. 613; [1956] 2 W.L.R. 707; [1956] 1 All E.R. 615; 1956 S.C. (H.L.) 26, referred to.

(4) *Cookson* v. *Knowles*, [1979] A.C. 556; [1978] 2 W.L.R. 978; [1978] 2 All E.R. 604; [1978] 2 Lloyd's Rep. 315, referred to.
(5) *Dalton* v. *South E. Ry. Co*. (1858), 4 C.B.N.S. 296; 140 E.R. 1098, referred to.
(6) *Davies* v. *Taylor*, [1974] A.C. 207; [1972] 3 W.L.R. 801; [1972] 3 All E.R. 836, applied.
(7) *Franklin* v. *South E. Ry. Co*. (1858), 3 H. & N. 211; 157 E.R. 448, referred to.
(8) *Malyon* v. *Plummer*, [1964] 1 Q.B. 330; [1963] 2 W.L.R. 1213; [1963] 2 All E.R. 344, *dictum* of Diplock, J. considered.
(9) *Stanley* v. *Saddique*, [1992] Q.B. 1; [1991] 2 W.L.R. 459; [1991] 1 All E.R. 529; *dictum* of Purchas, L.J. considered.

C. Gomez for the claimant;
O. Smith for the defendant.

1 **PRESCOTT, J.:** This is a claim brought by the widow and administratrix of Keith Rocca, who died following admission to St. Bernard's Hospital on June 14th, 2004. The claim is brought for the benefit of the dependants pursuant to the Contract and Tort Act 1960, s.6.

Background

2 On June 13th, Mr. Rocca was suffering from chicken pox, and had been for the preceding four days. It is highly likely he contracted the disease from his young son, who was being hospitalized for the disease. Mr. Rocca telephoned his father and asked him to call for a doctor; as a result Dr. Nerney carried out a home visit on the morning of June 13th, 2004.

3 Dr. Nerney noted that Mr. Rocca had a history of suffering from hepatitis C, was vomiting and suffering from diarrhoea, and presented with cellulitis on his left thigh. He gave Mr. Rocca a letter of admission to St. Bernard's Hospital. Mr. Rocca called for the St. John Ambulance to effect the transfer. On the way to hospital, Mr. Rocca had a minor seizure, and the ambulance crew passed this fact on to the Accident and Emergency Department ("A&E").

4 Upon arrival at A&E, Mr. Rocca was assessed by Nurse Peacock at 9.30 a.m. She recorded blood pressure at 97/15 mm Hg, pulse at 74 beats per minute, temperature at 36.2°C, SpO2 at 98% and respiratory rate at 18 breaths per minute. In addition she noted that the left leg was very red and she suspected cellulitis.

5 Fifteen minutes later, Nurse Peacock—by telephone—informed Dr. Monzon of Mr. Rocca's condition. Dr. Monzon instructed that Mr. Rocca be given fluids, diclofenac and omeprazole. He directed that blood and

liver function tests be carried out. Staff Nurse King then took blood and sent it for testing. Prior to 10.30 a.m., a chest X-ray was also requested.

6 At 10.25 a.m., Dr. Monzon examined Mr. Rocca and noted he had watery diarrhoea, vomiting, chills, malaise, abdominal pain, a painful left thigh, a rash with some infected spots and a mild bacterial wheeze. The doctor decided to admit him to hospital for treatment with antibiotics and intravenous fluids.

7 At 11:20 a.m., Mr. Rocca was admitted to the surgical ward, as there were no beds available on the general medical ward. From the time of his initial assessment to the time of his admission, his blood pressure dropped by a further 12 mm Hg; this notwithstanding, the medical staff were of the view that Mr. Rocca was not seriously unwell because he appeared to show signs of mobility, vitality and coherent speech.

8 At 1.15 p.m. Mr. Rocca collapsed and fell whilst trying to get up to go to the toilet. Whilst being attended to by the nurse immediately after his fall, he appeared to have a second minor seizure lasting six seconds. His blood pressure was continuing to drop, and Dr. Monzon was informed and asked to attend.

9 Dr. Monzon arrived at approximately 1.30 p.m. and reviewed Mr. Rocca's notes and electrocardiogram but did not examine him. Due to the nurses' concern that Mr. Rocca might be an infection risk, he was transferred to John Ward—the general medical ward—at 2.30 p.m. At some point prior to 3 p.m., Dr. Monzon was informed of Mr. Rocca's transfer, as well as the fact that his blood pressure continued to be unusually low at 63/38 mm Hg, and had a pulse of 96 beats per minute. At 3.30 p.m., it was noted that Mr. Rocca's blood pressure was 63/39 mm Hg, and he had a pulse of 95 beats per minute.

10 By 5 p.m., Mr. Rocca was in an agitated state, and his blood pressure was extremely low. Staff Nurse Perez was monitoring Mr. Rocca almost constantly, and when his blood pressure dropped so low as to be unrecordable, she asked Dr. Monzon to come to the ward. Another electrocardiogram was ordered, and Dr. Monzon came to the ward to review this and examine Mr. Rocca. At 7 p.m., Dr. Monzon requested Mr. Rocca be given a further chest X-ray and oxygen, but refused Staff Nurse Perez's request that he be moved to the Intensive Care Unit ("ICU"). At 7.30 p.m., Dr. Monzon left the ward, and did not examine the chest X-ray until approximately an hour later.

11 At 8 p.m., the night shift, Staff Nurse Noguera took over from Staff Nurse Perez and both agreed that Mr. Rocca ought to be admitted to the ICU. Staff Nurse Noguera pursued this through the evening with both Dr. Monzon and the clinical manager.

12 By 9.20 p.m., Mr. Rocca was complaining of back pain and dysphagia, and it was noted that his left leg was turning purplish in colour, and that the rash was also spreading to his right leg. Mr. Rocca complained he was unable to move. At this time his blood pressure was 50/38 mm Hg, his pulse was 128 beats per minute and his SpO_2 was 80%. By 9.30 p.m., when he was seen by Dr. Monzon, his blood pressure was 50/35 mm Hg, and his SpO_2 was 96%. He had a scattered blue patchy rash with a decreased temperature when compared to the right leg. Despite all this, Dr. Monzon did not appear to be concerned about the low blood pressure and elevated pulse, but bleeped Dr. Merida to check whether there was an arterial embolism as he was concerned about the temperature of the left leg. He then left the ward.

13 At about 9.45 p.m., Dr. Merida, having examined Mr. Rocca, informed Dr. Monzon that Mr. Rocca's legs were in an ischemic condition, that Mr. Rocca could be in septic shock, and that he should be transferred to the ICU. Dr. Monzon refused to authorize transfer until such time as Dr. Borge had seen Mr. Rocca. Some time between 9.50 p.m. and 10 p.m., Dr. Monzon in fact saw Mr. Rocca, and noted that his left leg was more cyanosed.

14 Sometime between 10 p.m. and 10.20 p.m., both Dr. Monzon and Dr. Borge examined Mr. Rocca, and agreed that a transfer to a Spanish hospital should be made. It was only on the intervention of Staff Nurse Peralta, at the behest of Staff Nurse Noguera, that Mr. Rocca was finally transferred to the ICU at 11.15 p.m. Once in the ICU, Mr. Rocca was given inotropic support, and Dr. Merida requested the attendance of the anaesthetist. Upon arrival, the anaesthetist noted that Mr. Rocca was anxious, confused and covered with a purpuric rash over most of his body.

15 At about 12.20 a.m., Mr. Rocca went into cardiac arrest. He was pronounced dead at 1.00 a.m.

16 The defendant commissioned an independent inquiry into the death of Mr. Rocca. Jonathan Asbridge, Alastair Wilson and David Goldberg conducted the inquiry, and on December 1st, 2004, some six months after Mr. Rocca's demise, they produced a report which has come to be known, during the course of this hearing, as the Asbridge Report. Counsel for the defendant cautions against placing excessive reliance on this report, given that it is not expert evidence, it is not witness statement evidence, and is not verified by an appropriate statement of truth. All that may be so, but the report is also an independent document resultant from an extensive inquiry conducted shortly after Mr. Rocca's demise by duly qualified professionals, and it sets out the most accurate timeline and record of facts available from which both parties have drawn. Exercising the necessary caution, I therefore place such reliance upon it as I consider appropriate in the circumstances. The Asbridge Report found—

> "not only a series of events which conspired to deny Mr. Rocca timely and appropriate care but, as significantly, a culture of mediocre medical governance, the absence of visible supportive nursing leadership and a fragmented approach to clinical care devoid of the concepts of accountability by any of the professionals concerned."

17 The coroner requested a post-mortem be carried out, but due to the fear of infection—given that Mr. Rocca was a hepatitis C sufferer—this was not carried out. Blood tests were carried out, and the pathology results indicated a bacterial infection with a raised blood count. It is not in dispute that bacterial infection is a common complication of chicken pox.

18 On July 27th, 2007, a jury in the Coroner's inquest touching on the death of Keith Rocca returned a verdict of death by natural causes.

19 The defendant admits that at the relevant time, Mr. Rocca was a patient under its care, and that it owed Mr. Rocca a duty of care. It admits that it was negligent and breached the duty of care owed to Mr. Rocca by failing to provide timely or appropriate treatment, but it contends that—

> ". . . any such breach of duty was not causative of the death of Mr. Rocca. Even if Mr. Rocca had been subject to early review by a consultant or earlier treatment at the ICU, it is the defendant's case that as a result of his various underlying conditions, he would not have survived."

The issue before me is therefore one of causation.

20 It is submitted for the claimant that the breach occurred shortly after arrival at the hospital, when medical staff failed to appreciate the significance and severity of Mr. Rocca's symptoms, whereas for the defendant it is said that the breach occurred at 11.00 a.m., when medical staff failed, at that point, to transfer him to the ICU. Given the narrow issue and for the reasons which follow, I do not consider that much turns upon whether the breach occurred at 9.30 a.m. or 11.00 a.m.

21 It is not in dispute that at the time of his admission, Mr. Rocca was suffering from chicken pox, and that the likely transmitter of that disease to him was his very young son who at the time was being hospitalized for complications arising from that disease. It is not in dispute that Mr. Rocca had a history of drug and alcohol abuse. It is also not in dispute that Mr. Rocca was hepatitis C positive, and had been for approximately 15 years, although during that time he had been asymptomatic.

Causation

22 It is a trite proposition, and not in dispute, that it is for the claimant to prove that the death would not have occurred but for the negligence of the defendant. It is necessary to determine whether the claimant has proved,

on a balance of probabilities, that Mr. Rocca would have survived had he received appropriate and timely treatment.

23 The claimant submits that, upon the evidence, the court can be sure to the necessary standard of proof that Mr. Rocca would have survived but for the defendant's negligence. However, according to the claimant's skeleton argument, she submits that in the event that the court finds that—

> ". . . medical science cannot establish the probability that 'but for' an act of negligence the injury would not have happened, but can establish that the contribution of the negligent cause was more than negligible, the 'but for' test is modified and a claimant will succeed."

The claimant relies on the cases of *Bailey* v. *Ministry of Defence* (2) and *Bonnington Castings Ltd.* v. *Wardlaw* (3) in support. The defendant submits that those cases do not apply to these facts, and he seeks to distinguish them by reliance on the case of *B* v. *Ministry of Defence* (1). I will deal first with the evidence and return to the legal submissions if necessary.

24 The court has been assisted by two experts, Dr. Teare, for the claimant, and Professor Geddes, for the defendant. I am grateful to both for their candid assistance. Dr. Teare is a clinical microbiologist with 25 years' consultant experience in the clinical management of patients with infections. Her extensive experience and qualifications are set out at appendix 1 of the medical report she prepared on August 21st, 2011 ("Dr. Teare's report") and I do not propose to rehearse them, save to note in summary that she is a fellow of the Royal College of Pathologists, contributes to infection prevention and control medical literature, has been Director of Infection Prevention and Control in Mid-Essex Hospitals NHS Trust since 1998, has been the Infection Control doctor for Mid-Essex Primary Care Trust since 2007, is a member of the East of England Task Group on Health Care Associated Infection, is the Infection Prevention Representative on the British Infection Association's Clinical Services Committee, on a day-to-day basis she sees patients with infections, and advises on management both in hospital and in the community, and has evening and weekend clinical on-call responsibilities on a 1-in-2 basis.

25 Professor Geddes's experience and qualifications appear at para. 1 of the medical report he prepared on October 27th, 2010 ("Professor Geddes's report"). In summary, he has been retired since 1999—prior to that, since 1967, he was a consultant physician in infectious diseases. In 1991, he was appointed Professor of Infectious Diseases in the University of Birmingham, has been Consultant Adviser in Infectious Diseases to the Chief Medical Officer of the Department of Health, President of the International Society for Infectious Diseases, has published almost 200 papers on topics related to infectious diseases, and has written chapters on infectious diseases for several textbooks.

26 Both experts agree that the onset of septic shock is the culmination of a progressive condition, or continuum made up of four stages, known as:

(a) SIRS (systematic inflammatory response syndrome);

(b) sepsis;

(c) severe sepsis; and

(d) septic shock.

Dr. Teare explains that:

(a) SIRS is a non-specific clinical response, defined as two or more of:

(i) temperature: < 36°C or > 38°C

(ii) heart rate: > 90 beats per minute

(iii) respiratory rate: > 20 breaths per minute

(iv) white blood cell count: >12,000 per μL or < 4,000 per μL;

(b) sepsis is a process in which the uncontrolled systematic response to infection may lead to organ dysfunction or failure, and the key feature is early recognition that infection is evolving from a locally based process to the involvement of the whole body;

(c) severe sepsis is infection-induced organ dysfunction or hypoperfusion abnormalities; and

(d) septic shock is sepsis with low blood pressure, hypotension not reversed with fluid resuscitation, and associated with organ dysfunction and hypoperfusion abnormalities.

27 Both experts agree that when Mr. Rocca was seen by his GP at 7.30 a.m., in all probability he was at the stage of sepsis. Both agree that on a balance of probabilities, the origin of the sepsis was secondary bacterial infection of his chicken pox lesions, with the focus of infection being the left leg.

28 There is some discrepancy of opinion between the experts as to when Mr. Rocca entered the septic shock stage. Dr. Teare believes it was by 1.15 p.m., whilst Professor Geddes believes it was around 6 p.m. That said, both are of the view that it would have been preferable for Mr. Rocca to have been admitted to the ICU upon admission to hospital. Both agree, however, that it would have been acceptable not to have admitted him to the ICU immediately upon arrival, provided there was an initial diagnosis and comprehensive management plan in place, which would necessarily have included re-hydration, intravenous antibiotics, ventilatory support and careful assessment of the patient's response. Both experts agree, without a shadow of a doubt, that crucial to the successful treatment of sepsis is early diagnosis followed by immediate appropriate management.

Both are agreed that the defendant did not provide timely or appropriate treatment to Mr. Rocca.

29 Dr. Teare's evidence is that Mr. Rocca would have survived, had he been treated according to established practice. I do not ignore Mr. Smith's submission that in her conclusion to the document entitled "defendant's agenda," Dr. Teare stated that "Mr. Rocca *may*, on a balance of probabilities, have survived if he had been given appropriate monitoring and management" [Emphasis supplied.], but when challenged in cross-examination, Dr. Teare immediately said that she should have written "would," and if she had the chance to write it again she would use the word "would." Given that Dr. Teare struck me as a witness highly confident in her opinion of Mr. Rocca's chance of survival, I do not find the use of the word "may" weakens her evidence or dilutes the message she intended to convey, particularly when it is considered that the concluding paragraph in the "opinion" section of her medical report of August 21st, 2011 states: "On the balance of probability, if secondary bacterial infection had been diagnosed on admission and Mr. Rocca treated in accordance with established practice of such patients . . . Mr. Rocca *would* have survived." [Emphasis supplied.]

30 In support of her views, Dr. Teare relies on Rivers *et al*., *Early Goal-Directed Therapy in the Treatment of Severe Sepsis and Septic Shock*, 345(19) *The New England Journal of Medicine* 1368 (2001) ("the Rivers Report"). In the course of the study leading to the publishing of the Rivers Report, goal-directed therapy was used—

> ". . . for severe sepsis and septic shock in the intensive care unit. This approach involves adjustments of cardiac preload, afterload, and contractility to balance oxygen delivery with oxygen demand. The purpose of this study was to evaluate the efficacy of early goal-directed therapy before admission to the intensive care unit."

Patients who arrived at A&E were selected at random to receive either six hours of goal-directed therapy or standard therapy before admission to the ICU. There were no significant differences between the groups in relation to base-line characteristics, and it is important to note that patients with hepatitis C and/or alcoholics were not excluded from either of the catchment groups. The Rivers Report found that in-hospital mortality was 30.5% in the group assigned to early goal-directed therapy, as compared to 46.5% in the group assigned to standard therapy.

31 The Rivers Report identifies the first six hours after diagnosis as the golden hours, *i.e.* the time during which appropriate treatment and management are to make the most difference. Dr. Teare explained that following publication of the Rivers Report, many hospitals issued in-house guidelines for the recognition and treatment of sepsis, and by 2004 she would have expected a similar guideline to have been in place in

St. Bernard's Hospital. One such guideline is to be found at p.245 of trial bundle 2. That identified six signs of SIRS which a hospital should be aware of, advising that if two or more of those signs were present, the patient would be in sepsis. The guidelines then went on to advise treatment. I would say, as an aside, that although Dr. Teare accepted that upon arrival at hospital, four of the six vital signs readily ascertainable (*i.e.* respiratory rate, temperature, heart rate and mental state) did not trigger a sepsis concern (Mr. Rocca's glucose and white blood cell count results would have been two of the six signs which would have alerted sepsis, but although tests were carried out, it is not known how long those results took to materialize), she was adamant that an assessment of his clinical presentation—vomiting, fever, seizure, prior possible disorientation, and a leg being red and swollen to twice its size—would most definitely have triggered the concern for sepsis, and should put him on the sepsis pathway which would have required appropriate treatment without the need to wait for laboratory results. Be that as it may, according to the statistics relied on by Dr. Teare, had Mr. Rocca received standard therapy, he would have had a 53.5% chance of survival, and had he received goal-directed therapy, he would have had a 69.5% chance of survival.

32 Professor Geddes's view, as set out in the medical report he prepared on October 27th, 2010, is that—

> "As Mr. Rocca was a carrier of the hepatitis C viruses, this, plus the effects of alcohol abuse and probably also drug abuse, on the balance of probabilities would have caused chronic liver disease (cirrhosis) and he would therefore have been more susceptible to bacterial infections, and it would have been more difficult to control such infections . . . If Mr. Rocca had been managed appropriately in an ICU from the time of his admission to hospital, and did not have chronic liver disease due to hepatitis C infection and also alcohol abuse, on the balance of probabilities (60:40), he would have survived. However, as Mr. Rocca probably did have advanced liver disease due to hepatitis C infection and also prolonged alcohol abuse, on the balance of probabilities (55:45), he would not have survived."

33 Despite the difference in the statistics relied on by the doctors, both experts agree that the liver involves the clearance of bacteria from the body, and that liver disease can adversely affect the response of an individual to infection. Professor Geddes explained that the liver was of great importance to the functioning of the human body, because it has many functions including the manufacture of substances or chemicals which are necessary for the effective response to infection it also produces factors essential for blood clotting.

34 Whilst neither expert could say for certain whether hepatitis C and drug and alcohol abuse would have resulted in Mr. Rocca having suffered

liver disease, both were agreed that, on a balance of probabilities, Mr. Rocca did have liver disease. Dr. Teare, however, was quite entrenched in her view that liver disease of itself would not necessarily adversely compromise an individual's response to infection. She explained that it would depend upon the extent and severity of the liver disease, in her view: "Each individual patient will be affected by a range of factors, including age, co-morbidity, severity of disease and early appropriate management."

35 In support of his opinion that Mr. Rocca had advanced liver disease, and that that disease compromised his response to fight infection, Professor Geddes relies on the following:

(i) "Some 85–90% of asymptomatic patients [carrying the hepatitis C virus] develop chronic liver disease" (Kumar & Clark, *Clinical Medicine*, 8th ed., at 323 (2012)). In principle, Dr. Teare agrees with this statement, but she qualified her agreement by pointing out that this is a statement made by an epidemiologist. In her view, statistically speaking, it would be true that had Mr. Rocca lived to the age of 80, he would have had an 85–90% chance of developing liver disease over the course of his lifetime, but he was relatively young (40) at the time of his death, and it is impossible to define the extent and severity of any liver disease. I find this qualification persuasive. Assuming, as I do, that Mr. Rocca did have liver disease, given that he was about half way through predictable life expectancy, it cannot be said with any certainty that the liver disease he had at age 40 would have been severe or advanced. Professor Geddes seems to agree broadly, his view in cross examination was that everyone was different: "Some people may escape cirrhosis altogether, but others develop it very quickly." He suggested that the likelihood would be that cirrhosis would develop over a period of between 10 and 40 years. I remind myself that Mr. Rocca had had hepatitis C for a period of 15 years. Had he developed cirrhosis yet? Or would it perhaps develop over the next 25 years of Professor Geddes's 10–40 year bracket? If he had developed it, was it in its early stages, and therefore mild, or had it quickly become acute?

(ii) O'Brien *et al*., *Alcohol dependence is independently associated with sepsis, septic shock, and hospital mortality among adult intensive care unit patients*, 35(2) *Critical Care Medicine* 345 (2007). Dr. Teare drew attention to a passage further on in the report, which reads as follows:

> "In analyses for hospital mortality, liver disease and sepsis modified the association between alcohol dependence and death. The greatest risk-adjusted odds of death were observed in patients having all three diagnoses."

Having stressed that the extent and severity of Mr. Rocca's liver disease was undefined, Dr. Teare made the point that her understanding was that

Mr. Rocca had, in recent times, abstained from alcohol. He was therefore not alcohol dependent, and in any event, in his case, any alcohol dependence there may have been could not be associated with sepsis or septic shock because not disputed that Mr. Rocca's sepsis had developed as a secondary infection as a result of chicken pox. She stated further that damage to the liver from alcoholic intake can be reversible.

(iii) "The patients with alcoholic hepatitis and concomitant sepsis have a very poor prognosis" (E.H. Forrest, *A clinical approach to alcoholic hepatitis,* 37(1) *Journal of the Royal College of Physicians of Edinburgh*, at 3 (2007), "the Forrest Report"). When asked to comment on this, Dr. Teare distinguished the Forrest Report from the present case on the basis that it related to hepatitic patients who were suffering from concomitant sepsis. Mr. Rocca suffered sepsis not as a result of his liver disease, but as a result of a secondary infection stemming from chicken pox. In her view, the Forrest Report was referring to patients who were in an advanced stage of alcoholic hepatitis, and who developed sepsis as a result of that liver disease, so that the scenario in the Forrest Report was in no way related to Mr. Rocca's case. She said that a person who has advanced alcoholic hepatitis would get sepsis precisely because the liver is so diseased that it would fail, and the prognosis would be so poor in large measure because the liver had failed. In cross-examination, Professor Geddes was asked: "So when you have alcoholic hepatitis and concomitant sepsis the prognosis is poor?" He replied "Yes." He was then asked: "But that doesn't apply to someone like Mr. Rocca?" And he replied "Correct." It is true to say that later on in cross-examination, Professor Geddes stated that he would continue to rely on the Forrest Report if Mr. Rocca had continued to drink up until his death, but not otherwise. Whilst I accept that is his view, I find that statement difficult to reconcile with the undisputed view that the Forrest Report relates to people with alcoholic hepatitis *and* concomitant sepsis. Given that it is agreed that Mr. Rocca did not have alcoholic hepatitis concomitant with sepsis, the Forrest Report, in my view, must become otiose.

(iv) His view, made apparent in cross-examination, that the extent and severity of liver disease was based upon the premise that there were two, possibly three, poisons (*i.e*. alcohol, drugs and hepatitis C) working on the liver.

36 In Professor Geddes's view, hepatitis C was a permanent condition not eradicated by a reduction or abstinence from alcohol intake, but excessive intake of alcohol would inflame the liver. He explained that if intake were to be suspended for a number of months, the inflammation of the liver would subside. Upon inflammation subsiding, liver function would improve. As I understand it, therefore, if Mr. Rocca was not alcohol dependent at death and had not been for some time prior, the risk of death from chicken pox and the secondary sepsis would be reduced. It is

relevant to consider, therefore, whether Mr. Rocca was alcohol dependent at death.

37 It is submitted for the claimant that at the time of his death, Mr. Rocca had been substance (*i.e.* drug and alcohol) free for a period of approximately six months. Counsel for the defendant disputes this, and submits that Mrs. Rocca's evidence regarding quantum, her relationship with Mr. Rocca, and his attempts to shake substance abuse, is unreliable and inconsistent. In her witness statement of July 27th, 2012, Mrs. Rocca sets out the relevant chronology, which I summarize as follows:

(i) Mr. and Mrs. Rocca married in May 1992. There are three children of the marriage, born in October 1992, April 1998 and January 2003.

(ii) During the course of the marriage, Mr. Rocca had a substance abuse problem, and made various attempts at rehabilitation by attending various clinics.

(iii) The marriage had been a difficult one, marked by periods of separation and reconciliation.

(iii) In April 2003, Mrs. Rocca applied for a non-molestation order, which was granted in November 2003.

(v) The non-molestation order was the trigger which motivated Mr. Rocca to address his addictions successfully.

(vi) Some time in 2003, after the grant of the non-molestation order, Mr. Rocca admitted himself to Bruce's Farm, a rehabilitation centre in Gibraltar, for a three-month programme.

(vii) Thereafter, the parties began communicating, and also interacting, as a family.

(viii) Mrs. Rocca describes a further three months passing, and Mr. Rocca remaining "clean and sober from drink and drugs." She remembers him being supportive as she had undergone surgery, and "committed to his family and to his well-being as he had never done before."

(ix) In 2004, before Mr. Rocca died, Mrs. Rocca received notice that she was to have surgery in the United Kingdom.

38 Cross-examination explored the six-month period during which Mrs. Rocca alleged her late husband had abstained from drink and drugs. Mrs. Rocca confirmed that the non-molestation order had been the trigger for Mr. Rocca's final attempt at reform, and his admission to Bruce's Farm. Thereafter, she was asked to calculate dates starting with the date upon which the non-molestation order was sought, and she did so largely agreeing with suggestions made to her, quite properly, in cross-examination. There was clearly some confusion with whether the dates were being calculated from April, which is when the order was sought, or

November, which is when the order was granted. If the dates were taken as having started around April, then three months in Bruce's Farm followed by a further three months after release would take us to approximately October 2003, and that leaves the period from October 2003 to June 2004 unaccountable. But if the dates were taken as having started at November 25th, 2003 that would take us approximately to May 2004. As I understand Mrs. Rocca's evidence-in-chief, the grant of the non-molestation order in November prompted Mr. Rocca's decision to admit himself to Bruce's Farm, which he did during their separation period in 2003. My further understanding, both from evidence-in-chief and clarifications during cross-examination, was that Mr. Rocca went to Bruce's Farm after the grant of the non-molestation order of 25th November 2003—this would foreseeably have been end of November/beginning of December 2003. If he was substance free for six months from admission to Bruce's Farm, that would take him to around May/June 2004.

39 I observed Mrs. Rocca carefully as she gave evidence, and whilst I accept that demeanour is not a reliable indication of honest testimony, I found, on a balance of probabilities, that Mrs. Rocca was not being deceitful or misleading in her evidence on this issue. It is true that at times she appeared to be unsure of her answers and commented she might have made a mistake in her evidence, and suggested there might be errors in her witness statement, but not because of this do I doubt her unshakeable assertion that her husband had been substance free since admission to Bruce's Farm six months prior to his death. It was when she was asked on various occasions to put a date to that time period by reference to the seeking/granting of the non-molestation order that she became a little confused. However, the very definite sense I got was that she was nervous, not because she was lying or attempting to mislead but because the period immediately before and after her husband's death, had been a very difficult period for her and she found it difficult to recall with precision under cross-examination.

40 Mrs. Rocca explained that around the time of her husband's death she had been called to the United Kingdom to undergo major surgery on her hip, which at the time was the latest in a series of surgeries she had undergone since the age of five. Her youngest son had been suffering from a severe episode of chicken pox in respect of which he had to be hospitalized, her husband passed away suddenly and unexpectedly at a time when relations between them had improved. After her husband's death, she suffered a severe depression, went into premature menopause, lost her hair and had difficulty coping with daily life. I do not find it surprising that during all of those periods she did not make an accurate mental note of the date when her husband entered Bruce's Farm; at the time it would have been of no consequence. Counsel for the defendant suggests that the explanations, highlighted above, which were offered by

Mrs. Rocca in re-examination are simply an attempt to explain away inconsistencies in her evidence, not least because they were not mentioned in cross-examination or in her witness statement. The claimant said that her counsel was under instructions not to delve into her personal life as this caused her distress. In any event, I find there is reference in her witness statement: "After Keith's death I got extremely depressed (para. 69)," "I have been deeply affected by Keith's death. I feel emotionally destroyed and I do not know how I should focus on society and keep our family together without Keith (para. 71)," "I have been treated for this trauma by psychologists in Gibraltar and Spain (para. 74)," "I was diagnosed with premature menopause at the age of 33 (para. 34)" and "additionally, I have had to take pills to regulate my sleeping patterns because I am not able to sleep at night. I also suffer from depression and take anti-depressants on a daily basis (para. 76)."

41 Mrs. Rocca's evidence that her husband was substance-free for six months or so prior to death is, to a certain degree, corroborated by the fact—which has not been challenged—that Mr. Rocca, for the first time ever, completed a three month therapy session in Bruce's Farm, and by the fact that there is no evidence that, post-release from Bruce's Farm, Mr. Rocca was substance dependent—quite the contrary. It is, in my view, also corroborated by the bilirubin results. Dr. Teare accepted that the bilirubin readings were a little high (52.8 µmol/L), but rather than jumping to the automatic conclusion that this was an indication of liver disease, she stated that there would be higher bilirubin readings as result of the sepsis. This did not appear to be contradicted by Professor Geddes, whose view was that after excessive drinking, bilirubin levels could exceed the 80 µmol/L mark (which would be a clear indication of liver disease), and whilst one could not say for certain that Mr. Rocca's readings did not go above 80 µmol/L, from actual tests results they did not. In any event, of particular relevance, he said that the bilirubin readings only related to the issue of alcohol, not hepatitis C. I take the view, therefore, that on or around the time of death, given that the readings were below 80 µmol/L, the medical indication is that alcohol was not a factor. For these and all the above reasons, I find that on a balance of probabilities, at the time of his death, Mr. Rocca was not alcohol dependent and had not been for the preceding six months.

42 On the basis of this finding, any liver disease at the time of death attributable to hepatitis C was not compounded by substance abuse, so liver function would be less compromised than if there had been a current substance dependence problem, and, given that the extent and severity of the liver disease has not been defined, what were Mr. Rocca's chances of survival had he received the timely and appropriate treatment he should have?

43 As already discussed, Dr. Teare's view is that had Mr. Rocca received standard therapy, he would have had a 53.5% chance of survival, and had he received goal-directed therapy, he would have had a 69.5% chance of survival. There is no dispute that the standard treatment for sepsis, which relies on basic principles of treatment which have been in place long before the Rivers Report, should have been available at St. Bernard's Hospital. It is submitted for the defendant that it is unrealistic to expect there to have been goal-directed therapy (as opposed to standard, which both experts agree hospitals should have been aware of long before publication of the Rivers Report) available in St. Bernard's Hospital at the time, because, as Professor Geddes explained, goal-directed therapy relies upon use being made of a computerized spectrophotometer. Professor Geddes explained that goal-directed therapy involved putting a catheter into the patient's heart and linking it up to the spectrophotometer, which is a complex machine requiring expert interpretation. He explained he would not expect to find a computerized spectrophotometer in a small hospital such as St. Bernard's, and certainly not in 2004, it would be more likely to be found in a "large, complex hospital." He hazarded a guess that there would not have been such a machine available in St. Bernard's at the time. The defendant has neither confirmed nor denied whether such a machine was available at the time. Professor Geddes stated that he had never come across a computerized spectrophotometer, but given that the Rivers Report, recommending goal-directed therapy, was published in 2001, and Professor Geddes retired from practice in 1999, this is perhaps not entirely surprising. Dr. Teare was not asked either in examination-in-chief or cross-examination about whether a computerized spectrophotometer was an indispensable part of the goal-directed therapy programme.

44 The day after Professor Geddes had finished giving evidence, Mr. Gomez, in his closing submissions, informed the court that he had taken instructions from Dr. Teare who flew back to the United Kingdom that day, and her view was that the spectrophotometer was not a *sine qua non* of the goal-directed procedure, that the goal-directed procedure was concerned with the balance of oxygen supply and demand, and that there were different ways to assess oxygen levels. Whilst I do not question the accuracy of Mr. Gomez's instructions or his relaying of them, I must treat this statement with some caution. Dr. Teare is not Mr. Gomez's client, Dr. Teare's comments via Mr. Gomez are not evidence, and Mr. Smith has not had the opportunity to challenge those statements through cross-examination or, indeed, even put them to his expert. Rather, I turn to the Rivers Report for guidance on this issue. Having considered the Rivers Report carefully, I can find no reference in the Rivers Report to the effect that the spectrophotometer was not a necessary part of the goal-directed therapy procedure. What it does say on the issue is—

> "After arterial and central venous catheterization, patients in the standard-therapy group were treated at the clinicians' discretion according to a protocol for hemodynamic support . . . with critical-care consultation, and were admitted for inpatient care as soon as possible . . . The patients assigned to early goal-directed therapy received a central venous catheter capable of measuring central venous oxygen saturation . . . it was connected to a computerized spectrophotometer for continuous monitoring."

45 I share Professor Geddes's view that in all probability there was not such a sophisticated machine as a computerized spectrophotometer available at St. Bernard's Hospital in 2004, and whilst I cannot tell from the Rivers Report whether connection to the spectrophotometer is a vital part of all goal-directed therapy treatments, evidently it did form an integral part of the goal-directed therapy in the Rivers study and the statistics which emerged as a result were based, *inter alia*, on the connection to the spectrophotometer. This uncertainty leads me to the conclusion that it would not be safe to rely on the statistics derived from the goal-directed therapy treatment, and so I must confine Dr. Teare's percentage of Mr. Rocca's chances of success around the standard treatment results, which would be in the region of 53.5%. Her view, as expressed in her report, is that—

> "On the balance of probability, if secondary bacterial infection had been diagnosed on admission to hospital, and Mr. Rocca treated in accordance with established practice for such patients (for example early transfer to intensive care, monitoring of vital functions, early circulatory and ventilatory support, support for failing organ systems and high dose intravenous antibiotics), he would have survived."

46 It was submitted for the defendant that Dr. Teare's 53.5% rating of chance of survival should be reduced to take account of the fact that Mr. Rocca had advanced liver disease. I am not persuaded by this submission, because—

(i) we cannot know the extent and severity of the liver disease, and cannot assume it was advanced;

(ii) it has been established that the liver disease suffered by Mr. Rocca at the time of his death stemmed from hepatitis C and not substance abuse;

(iii) given that Mr. Rocca was substance free for six months prior to death, any inflammation which may have been present as a result of substance abuse would have subsided, resulting in improved liver function; and

(iv) crucially, not only did the Rivers Report not exclude hepatitis C sufferers and alcohol abusers form its eligibility group, but it is evident from table 1 of the Rivers Report that the group of patients participating

in the trial specifically included alcohol users and people with liver disease.

In my view therefore it is not appropriate to make a downward adjustment of the 53.5% chance of survival.

47 For his part, Professor Geddes, in his medical report, pitches the chances of survival at 60%, "if he did not have chronic liver disease due to hepatitis C infection and also alcohol abuse." However, given that in his view "Mr. Rocca probably did have advanced liver disease due to hepatitis C infection and also prolonged alcohol abuse, on the balance of probabilities (55/45) he would not have survived." In cross-examination, Professor Geddes seemed to place a "healthy" person's chance of survival at 65%, even higher than he had in his report, although he stated he stood by his report. He explained that if a person had a compromised liver, their chance of survival would drop by 20% to 45%. That, said Professor Geddes, was because of the view that the amount of percentage drop due to a damaged liver would depend on the extent of damage to the liver. The lack of data concerning the degree of damage to the liver was an issue which concerned both experts.

48 In any event, it is evident that Professor Geddes bases his prediction of a 45% chance of survival on Mr. Rocca having advanced liver disease caused by hepatitis C, alcohol abuse and possibly drug abuse—the "three poisons" referred to at paras. 10.5 and 11.4 of the medical report and in cross-examination.

49 Given that—

(i) Professor Geddes "was not aware until yesterday that [Mr. Rocca] had stopped drinking, that information was not available to [him] when [he] wrote this report, [he] assumed [Mr. Rocca] was continuing to drink";

(ii) Professor Geddes was of the view that if Mr. Rocca "stopped drinking for a number of months, acute inflammation would subside and if acute inflammation subsided liver function would improve";

(iii) at the time of death, Mr. Rocca had been substance free for six months, so that there was only one poison affecting the liver, hepatitis C;

(iv) both experts agree that the ability of the liver to assist in the combat of infection would depend upon how damaged it was; and

(v) the extent and severity of liver damage is not known, so the 45% chance of survival relied upon by Professor Geddes is not as firm as it appears at first blush.

50 My view that Professor Geddes' percentage rating of the chances of survival should be displaced in favour of a more elevated percentage is reinforced by certain poignant statements he made in cross-examination:

(i) When asked to comment on para. 33 of the particulars of claim—that in the claimant's view death was caused as a result of the failings and omissions of the defendant and its staff—he replied: "I agree."

(ii) "I think lack of adequate care contributed to Mr Rocca's death."

(iii) When asked, "To what extent did failure to put him on adequate treatment contribute to his death?" He replied: "That was why he died."

(iv) "I accept this was a potentially preventable death."

(v) "I do accept that Mr. Rocca had a chance of surviving."

The incontrovertible nature of these comments, in particular that at (iii), further persuades me that it cannot be safely said that no matter what treatment Mr. Rocca would have received, he would have died in any event.

51 Dr. Teare struck me as more consistent in her views. I do not accept the defendant's submissions that she was a witness reluctant to give quick and precise answers; I found her answers to be honest and full. Nor do I accept that that her medical background made her ill-placed to provide a clinical judgment. She explained that apart from being a clinical microbiologist she sees patients with infection on a day-to-day basis and has weekend and evening on-call responsibilities. She is still practising, whilst Professor Geddes has been retired for 14 years. Professor Geddes was also honest and helpful, but for the reasons given, his opinion struck me as less robust. I prefer the evidence of Dr. Teare over that of Professor Geddes.

52 I appreciate quite acutely that the percentage margins between the two experts are narrow; this is a close call with little elbow-room. To make matters more difficult, there is the glaring absence of the post-mortem which, in the opinion of both experts, would have provided the certainty that is sadly missing from this case. In a case such as this, emotions run high and it is perhaps forgivable to feel a sense of outrage at the standard of care provided to Mr. Rocca. The issue before me, however, is not whether the hospital was negligent—they have rightly accepted they were—it is whether that negligence caused the death. Consideration of that question must be and is devoid of all emotion. The answers are not easily identifiable, but what is clear to me is that upon the evidence, it cannot be said that at the time of Mr. Rocca's death he had liver disease of the extent and severity as to compromise his ability to fight the infection which was ravaging his body and that, as a consequence, had he been given appropriate treatment he would not have survived. Having considered all of the above very carefully, I am of the view that on a balance of probabilities, albeit slim, Mr. Rocca would have survived but for the negligence of the defendant.

53 Given my findings, I do not deal with the alternative test for causation raised by the claimant. I now turn to consider quantification of damages.

Background

54 By way of background, I remind myself that Mr. and Mrs. Rocca married on May 22nd, 1992. Mr. Rocca died on June 14th, 2003, and at the date of his death he was aged 40. At the date of Mr. Rocca's death, Mrs. Rocca was aged 32, he had three dependent children.

55 On May 7th, 2008, the claimant filed a schedule of loss. On September 5th, the defendant filed a counter-schedule of loss. On December 21st, 2012, the defendant was served with the witness statement of the claimant, dated July 27th, 2008. On September 6th, the defendant's solicitors received a letter from the claimant's solicitors, enclosing a letter from the Income Tax Dept., dated August 29th, 2013, which purported to set out Mr. Rocca's earning history. On November 4th, 2013, the defendant served a revised counter-schedule of loss. On November 14th, 2013, the claimant served a revised schedule of loss. I take account of all these documents.

56 It is not in dispute that "there is no need to show that the dependant was receiving pecuniary benefit at the time of the death, a purely prospective loss being sufficient" (*McGregor on Damages*, 18th ed., at para. 36–029 (2009)).

57 It is not in dispute that damages which dependants can expect to receive are to be calculated in reference to a reasonable expectation of pecuniary benefit as of right or otherwise from the continuance of life (see *Franklin* v. *South E. Ry. Co.* (7) and *Dalton* v. *South E. Ry. Co*. (5)).

58 It is not in dispute that the standard of proof is not the balance of probabilities, but that of percentage prospects. In *Davies* v. *Taylor* (6), Lord Reid gives the example of two cases of a widow who had separated from her husband before he was killed. He said ([1974] A.C. at 212):

> "In one case it is estimated that the chance that she would have returned to him is a 60 per cent. probability (more likely than not) but in the other the estimate of that chance is a 40 per cent. probability (quite likely but less than an even chance). In each case the tribunal would determine what its award would have been if the spouses had been living together when the husband was killed, and then discount it or scale it down to take account of the probability of her not returning to him."

It is necessary to evaluate the prospect chance or probability of support by taking all significant factors into account, and it is necessary that the chance be substantial and nor merely speculative. As Lord Simon said in

the same case (*ibid*., at 220): "If a possibility is conceivable but fanciful, the law disregards it entirely, on the maxim de minimis non curat lex."

59 In determining whether there is a loss of dependency, two principle considerations are relevant on the facts of this case:

(i) Would the parties have reunited? And if so, how can that chance be rated?

(ii) Would Mr. Rocca have returned to work? And if so how can that chance be rated?

60 As regards (i) above, upon the evidence of the claimant, I am satisfied that Mr. Rocca, having completed the three-month programme at Bruce's Farm, was substance free for a further three months thereafter until the time of his death. Mrs. Rocca's evidence is that during that time the parties were working towards rebuilding a relationship between them and rebuilding their family unit with the children. They were in regular communication, making plans for the future and spending quality time together as a family. Mrs. Rocca describes this as their happiest times. I do not ignore the fact that in November 2003, a non-molestation order issued against Mr. Rocca but, having considered and heard all the evidence, I am of the view that that order, including its provision indicating judicial separation, was the catalyst which caused Mr. Rocca to take stock of his life and motivate him towards change. I accept Mrs. Rocca's evidence on this point, which in my view is reinforced by the clear sense I was left with, having heard Mrs. Rocca, that the only rift in the marriage from the start had been her husband's abuse problems, but that throughout, there was an affection between them which was constant and evident from their persistent and continued attempts to reconcile and from the birth of their third child which came about after such a period of reconciliation. This indicates a long-term commitment to each other despite the very significant difficulties they faced. In light of the foregoing, and given that at the time of death Mr. Rocca was substance free, I assess the possibility of them reconciling at 100%. On this point, therefore, in so far as the widow is concerned, there is a definite loss of dependency with no reduction.

61 As regards (ii) above, given that it is not in dispute that Mr. Rocca was not working at the time of his death it is necessary to assess the percentage chance of his returning to work. In attempting to determine Mr. Rocca's chance of returning to work, it is helpful to look at past history, but always with a degree of caution that one should not be unconditionally bound by what has happened in the past. In the words of Diplock, L.J. in *Malyon* v. *Plummer* (8), as quoted by Purchas, L.J. in *Stanley* v. *Saddique* (9) ([1992] Q.B. at 11):

> ". . . [T]he most reliable guide as to what would happen in the future if the deceased had lived is what did in fact happen in the past when

> he was alive . . . But the fact that it is convenient to have recourse to the past for guidance as to what would have been likely to happen in a hypothetical future which owing to the death of the deceased will never occur, must not blind one to the fact that one is estimating a loss which will be sustained in the future."

62 I take account of Mr. Rocca's previous employment history, as set out in the letter from the Income Tax Office of August 29th, 2013. I rely on that letter as independent evidence of Mr. Rocca's past earning and working history for the period 1991–2000. Upon the evidence, I accept that the periods of break in employment between 1991 and 2000 were due to Mr. Rocca's struggle with substance addiction. I find that from 2000 until his death in 2004, Mr. Rocca did not work because of his addictions and attempts to conquer them (apart from the period immediately preceding his death, when I accept he did not work because he was looking after the family during the period surrounding his wife's surgery). Clearly, Mr. Rocca's attempts at regular and consistent employment were sporadic. I accept this was because he was battling with addictions. Given that he was addiction free for six months before his death, as far as we know the longest period he had ever been substance free, I draw the inference that there was therefore no impediment to his having returned to work, and in all probability he would have done so once Mrs. Rocca was sufficiently recovered from her surgery to be able to take over the care of the children from him. On the facts as I have found them, I find that Mr. Rocca would have returned to work, and therefore no discount attaches in this respect.

63 It is not in dispute that damages in a case such as this one ought to be split into two parts: the pecuniary loss it is estimated the dependants had suffered from date of loss to date of trial, and the pecuniary loss it is estimated they would suffer from the trial onwards (see *Cookson* v. *Knowles* (4)).

Pre-trial loss

64 It is not in dispute that the dependants would be entitled to 80% of Mr. Rocca's pre-trial earnings. The claimant urged the court to approach this calculation by having regard to Mr. Rocca's final salary for the year 2000, during which year he worked for 35 weeks, and compound that to 52 weeks, and the current salary as at today's date which Mr. Rocca would have expected to have earned. The defendant submitted that the correct approach is to assess Mr. Rocca's average take-home pay in the period whilst he was in employment from 1991 to 2000, and then reduce this by factoring in to the average the period of four years between 2000 and 2004 when he was not employed. I favour neither of these approaches.

65 I am satisfied that shortly after his death, Mr. Rocca would have returned to work given that he had reformed, however, given his historic

battles with addiction, I cannot be satisfied that he would have maintained that reform and sustained employment without interruption for 52 weeks of the year. To do as the claimant suggests would be to take a snapshot of Mr. Rocca's earning history, which by its very nature would not give an accurate reflection of his past working life, and moreover it would suggest that Mr. Rocca worked for the full 52 weeks in a year every year, whilst in reality during the period 1991 to 2000 he only worked a full 52 weeks for 3 out of almost 10 years. To do as the defendant suggests and dilute the average earnings over a 13-year period instead of 9.5 years, likewise gives an inaccurate picture because during 2000–2004 there was no attempt to work due to attempts at reform, and on the date of death Mr. Rocca had reformed and was about to resume work. In attempting the difficult task of assessing how consistent future employment is likely to have been, it is important to draw guidance from the past and add to that a flavour of the likely future based on the indicators available. My preferred approach is to take an average of what Mr. Rocca earned whilst in employment from 1991–2000, without dilutions.

66 Thus a study of the figures taken from the Income Tax Office letter of August 29th, 2013 shows an average net weekly pay of £93.97. The value of the dependency in respect of pre-trial loss is therefore:

(i) £93.97 x 52 weeks x 9.5 years = £46,421.18.

(ii) The dependants would be entitled to 80% of that total net income from the period June 14th, 2003 to trial: 80% of £46,421.18 = £37,136.94.

(iii) To that must be added interest, which it is not disputed would be at the half rate of 3% over 9.5 years yielding a percentage of 28.5%: 28.5% of £37,136.94 = £10,584.03.

(iv) The total pre-trial loss is therefore: £37,136.94 + £10,584.03 = £47,720.97.

Post-trial loss

67 In my view, the correct approach for the calculation of the multiplicand, bearing in mind Mr. Rocca's previous employment history and my comments in that regard above, is to take 80% (the amount to which the dependants would have been entitled) of his average annual net earnings at death. Using the figures above, this would result in a multiplicand of £5,774.49, made up as follows: £138.81 x 52 = £7,218.12 x 80% = £5,774.49

68 The defendant suggested that given Mr. Rocca's work history and general sate of health, he was unlikely to work past the age of 50. The claimant submitted that Mr. Rocca would have worked to age 65, the enforced retirement age for industrial skilled or unskilled workers. Whilst it is true that Mr. Rocca was a historic drug and alcohol abuser and a

sufferer of hepatitis C, the evidence is that he had kicked the drug and alcohol habit and that he was asymptomatic in relation to the hepatitis C, therefore within the confines of his condition it is fair to say that he was relatively healthy. It is also fair to say that had he lived on, in all probability, the hepatitis C would have compromised his liver further at some point in the next 25 years from June 2004, and this could have had an impact upon his working life, as would a return to substance abuse if he failed to sustain his reform. Taking all the relevant factors into consideration and adopting a common sense approach, I consider it likely Mr. Rocca would have worked until the age of 55 to 60.

69 In so far as the multiplier is concerned, the parties appear to have adopted different approaches for the calculation of the multiplier which I have difficulty reconciling. Bearing in mind my findings that Mr. Rocca would have worked until age 60 and that the multiplicand should be £5,774.49, I invite the parties to address me on the appropriate multiplier to apply to the multiplicand I have identified.

Orders accordingly.