## In the Court of Appeal of the Northwest Territories
**Citation: Mangelana v. McFadzen, 2006 NWTCA 06**

**Date:** 200609XX
**Docket:** A-1-AP 2005000015
**Registry:** Yellowknife

**Between:**

**Spencer Mangelana**

Appellant (Plaintiff)

- and -

**J. McFadzen, Helene Belanger, Lorrie Meissner, Inuvik Regional Health and Social Services Authority, operating facilities known as Tuktoyaktuk Health Centre and Inuvik Regional Hospital, Dr. Botha**

Respondents (Defendants)

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**Memorandum of Judgment**

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Appeal from the Judgment by
The Honourable Mr. Justice J.E. Richard
Reasons for Judgment Dated April 14, 2005

## Memorandum of Judgment

### The Court:

[1] Spencer Mangelana ("Mangelana") appeals the dismissal of his medical malpractice suit. He sued Dr. Botha, the Inuvik Regional Health and Social Services Authority ("Health Authority"), operating facilities known as the Inuvik Regional Hospital ("IRH") and the Tuktoyaktuk Health Centre ("THC"), and Nurses Meissner, McFadzen and Belanger (the "Respondent Nurses"). The Health Authority was added as a party based on its responsibility for the IRH, the THC and the Respondent Nurses. Mangelana claims that he developed an infection at the same time as, and perhaps as a result of, his tonsillectomy in July, 1992 and alleges that Dr. Botha, the surgeon who performed the tonsillectomy at the IRH, and the Respondent Nurses, who were stationed at the THC at the relevant time, each failed to diagnose and treat his infection. Mangelana alleges that their negligence caused his infection to progressively deteriorate to bilateral pneumonia and ultimately into adult respiratory distress syndrome ("ARDS").

[2] While the trial judge found that Dr Botha breached his duty of care, he nonetheless dismissed Mangelana's claim due to the apparent absence of evidence establishing a causal link. The claim against the Respondent Nurses was also dismissed: ***Mangelana v. McFadzen***, [2005] N.W.T.J. No. 31, 2005 NWTSC 41.

[3] Mangelana appeals the trial judge's assessment as to causation, from which there is no cross-appeal, as well as the trial judge's finding that the Respondent Nurses are not liable. On this latter point, should we decide to reverse the trial judge's decision on causation, Dr. Botha cross-appeals and joins Mangelana in arguing that the trial judge erred in finding the Respondent Nurses were not liable. Dr. Botha's cross-appeal seeks to have liability apportioned. While the trial judge conditionally assessed damages, no party appeals that assessment.

[4] We conclude that the trial judge erred in his approach to causation by failing to properly assess the evidence establishing a causal link between Dr. Botha's negligence and Mangelana's injuries. We also conclude that the trial judge erred in failing to impose liability against the Respondent Nurses, based on their failure to meet the standard of care expected of them.

**Background**

[5] In preparation for his tonsillectomy, Mangelana was admitted to the IRH on July 6, 1992, and underwent a physical examination that included a blood test and urinalysis. Dr. Botha did not conduct a preoperative examination of Mangelana, which would have included review of the blood test results. Had he done so, he would have ascertained that Mangelana's white blood cell count was above normal and consistent with the presence of an infection. While this reading may well have

influenced Dr. Botha to postpone the surgery, all experts who testified agreed that delaying the procedure was not inevitable in the circumstances.

[6] On July 7, 1992, Dr. Botha successfully performed an uneventful tonsillectomy on Mangelana, though some blood loss was experiencedby Mangelanalater that day. The medical notes reveal a significant elevation to Mangelana'svital signs, most notablyhis body temperature readings, on the evening following the tonsillectomy. The IRH staff responded by providing Mangelana with Tylenol, which would assist in reducing his body temperature but would otherwise have no effect on any underlying infection.

[7] The following morning, Mangelana's vital signs were closer to normal and he was discharged from the IRH later that day. Dr. Botha did not conduct a full assessment of Mangelana prior to his discharge. Mangelana returned to his home in Tuktoyaktuk that day, where he appeared visibly ill.

[8] On the morning of July 9, 1992, Mangelana attended the THC, complaining of a sore throat and difficulty breathing. Nurse Belanger assessed Mangelana, and consulted with Nurse Meissner,a senior nurse on staff. Importantly, Nurse Meissner asked whether Mangelanashould be placed on an antibiotic, to which Nurse Belanger responded that he was either already on an antibiotic or there was a good reason to explain why he was not. Both assertions turned out to be false and neither Nurse Belanger nor Nurse Meissner made any inquiries to ascertain the true state of affairs. Instead, Mangelana was given Tylenol and sent home with instructions to return if his symptoms continued.

[9] Mangelana returned to the THC later that day, at which time he was examined by Nurse McFadzen. Mangelana complained of headaches as well as fever and vomiting. His temperature was recorded as 37.5 degrees Celsius, which was above normal. His heart rate was 120, which was well over normal. Nurse McFadzen's notes indicated that Mangelana "felt warmer" and that he looked weak and tired: A.B. III, 1093. She also observed that he had swollen nodes in his neck area. Nurse McFadzen made a differential diagnosis: either Mangelana's symptomswere consistentwith normal recovery from the tonsillectomy, or they were indicative of a developing infection. Mangelana was given Gravol and Tylenol, and advised to return the next day if he remained feverish.

[10] On July 11, 1992, Mangelana's mother contacted the THC and explained that Mangelana's condition was not improving, as he remained feverish and continued vomiting. Mangelana returned to the THC and saw Nurse Meissner. Her notes indicate that Mangelana "appears more irritable at being ill than ill": A.B. III, 1095. Though his temperature was in the normal range, a blood sample was taken and sent out for analysis. Because the THC lacked the proper testing facilities, the analysis of Mangelana's blood sample was not known until he was later treated in Edmonton.However, once it was analyzed, the blood sample revealed a normal white blood cell count, though other anomalies were present.

[11] Mangelana returned to the THC on July 12, 1992. Following her examination, Nurse Meissner correctly diagnosed Mangelana as suffering from pneumonia, at which time he was given antibiotics. Later that day, Mangelana was flown to Inuvik, where a repeat blood test revealed a significant elevation to his white blood cell count. By that time, his pneumonia had extended to both

lungs. Mangelana's situation continued to deteriorate and he was transferred to Edmonton, where his illness later progressed to ARDS. Mangelana remained in the Edmonton hospital for approximately three months, during which time he sufferednumerous complications includingsepticemia, recurrent pneumothoraces requiring chest tubes, renal dysfunction, cholecystitis requiring removal of his gall bladder, and a grand mal seizure. He was released from the hospital in October, 1992.

**The Trial Judge's Decision**

[12] The trial judge held that Dr. Botha was negligent in three respects:

> (1) he failed to conduct a preoperative assessmentprior to performingthe surgery on July 7, 1992 (para. 49);
>
> (2) he failed to conduct a physical examination of Mangelana prior to his discharge from the IRH (para. 75); and
>
> (3) either the IRH nursing staff did not bring certain significant observations to Dr. Botha's attention on July7/8, in which case they failed to meet the standard of care expected of them, or Dr. Botha was advised in a timely fashion by the IRH nursing staff, in which case Dr. Botha failed to meet the required standard of care by failing to respond appropriately to this information (para. 55). While this latter finding was later referred to by the trial judge as "the collective negligence of the defendants", that liability cannot attach to the Respondent Nurses as they were not involved in Mangelana's treatment at the IRH.

[13] Despite his finding of negligence against Dr. Botha, the trial judge dismissed the claim for lack of any causal connection between Dr. Botha'snegligence and Mangelana's injuries.The heart of the trial judge's finding on causation is found at paras 111-121 of his decision:

> 111 In each of these three instances of negligence, I [am] unable to say that "but for" that negligence the plaintiff's injury would not have occurred. Also, I am unable to say that any of these instances of negligence "materially contributed" to the occurrence of the plaintiff's injury.
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> 112 From the opinion evidence of the expert witnesses, I find that pneumonia is a very rare complication of a tonsillectomy. It was not an expected occurrence.

113 From the facts adduced at trial, and the (helpful) opinion evidence of the experts, I am unable to determine the cause or the genesis of the infection which led to the plaintiff's pneumonia, on a balance of probabilities.

114 There is simply no evidence that aspiration occurred during the tonsillectomy. Aspirations during surgery are normally detected, none was detected here.

115 There is no evidence upon which I can conclude, or even draw an inference, that the time of onset of the infection which led to the plaintiff's pneumonia was prior to July 12. Perhaps more importantly, I cannot say that that infection could have been detected prior to July 12. The evidence does not establish that there was a delay in diagnosing or treating the plaintiff's pneumonia.

116 As I have found, some of the defendants were negligent. However, in my view, as a matter of common sense and logic, those instances of negligence cannot constitute a foundation for a finding of liability for the plaintiff's injury.

117 None of these specific acts of negligence caused or contributed to the plaintiff's injury.

118 Had Dr. Botha personally performed a pre-operative assessment prior to the tonsillectomy, I cannot infer that events would have unfolded differently.

119 Had Dr. Botha done a physical examination of the plaintiff on the morning of his discharge, I cannot infer that events would have unfolded differently. There is no evidence to indicate that such a physical examination, or the ordering of more tests, would have led to the discovery of an early pneumonia or an infective source. To suggest it may have been discovered is speculation.

> 120 Had Dr. Botha and the Inuvik nurses communicated successfully about the temperature spike and other physical observations and had Dr. Botha attended to the plaintiff at those times as he says he "would have", I cannot infer that events would have unfolded differently.
>
> 121 I find that the plaintiff's action fails as the plaintiff has not established, on a balance of probabilities, a causal link between the defendants' acts of negligence and the plaintiff's injury.

[14] As for the Respondent Nurses, the trial judge found that they met the standard of care for nurses in the circumstances. While certain aspects of the communication process between the THC and the IRH were described as "wanting", the trial judge made no finding as to whether that deficiency constituted negligence in light of his conclusion on causation.

**Standard of Review**

[15] For questions of law, the standard of review is correctness; for questions of fact, or mixed law and fact where there is no extricable error of law, the standard of review is palpable and overriding error: ***Housen v. Nikolaisen***, [2002] 2 S.C.R. 235, 2002 SCC 33.

[16] The question of whether a health care provider satisfied the appropriate standard of care is one of mixed fact and law. However, once the facts have been established without overriding and palpable error, the standard of review is correctness: ***St-Jean v. Mercier***, [2002] 1 S.C.R. 491, 2002 SCC 15 at para. 49. In ***Meyers v. Stanley*** (2005), 363 A.R. 262, (*sub nom.* ***Meyers v. Moscovitz***) 2005 ABCA 114 at para. 19, the Alberta Court of Appeal stated:

> Determining the appropriate standard of care for a doctor in the circumstances is a matter of law because it is a legal test. Likewise, the test for causation is a matter of law: has the substandard conduct of the doctor caused the patient's injuries applying both "but for" and "foreseeability". Failure to establish and apply the correct test is an error of law.

[17] This Court, in ***Strichen v. Stewart*** (2005), 367 A.R. 18, 2005 ABCA 155 clarified at para. 4 that a palpable and overriding error is said to occur when: (a) it can be identified; (b) the error can be shown to be an error; and (c) "the error is one which either must have altered the result or may well have altered the result".

**Analysis**

[18] This appeals turns on the question of causation. The leading case regarding the degree of proof required to establish causation, particularly in the context of a medical malpractice claim, is ***Snell v. Farrell***, [1990] 2 S.C.R. 311. In ***Snell***, the Supreme Court noted that plaintiffs often face considerable difficulties in attempting to meet the burden of proof, since the defendanttypically is in a better position to know the cause of the injury than the plaintiff. While it was argued that the burden of proof should shift to the defendant in those circumstances, the Supreme Court confirmed that the onus remains with the plaintiff to demonstrate a causal connection between the defendant's conduct and the plaintiff's injury on a balance of probabilities. The Supreme Court noted, at 328, that "dissatisfaction with the traditional approach to causation stems to a large extent from its too rigid application by the courts in many cases." The Supreme Court determined that a plaintiff need not demonstrate a precise, scientific causal link in all cases and a trial judge may, using a robust and pragmatic approach, draw an inference as to causation where sufficient evidence has been tendered. This is particularly so in medical malpractice cases, when the facts often lie within the knowledgeof the defendant.

[19] ***Snell*** was later affirmed by the Supreme Court in ***Athey v. Leonati***, [1996] 3 S.C.R. 458. In that case the principles regarding the degree of proof required to establish causation were summarized as follows at para. 16:

> In *Snell v. Farrell*, *supra*, this Court recently confirmed that the plaintiff must prove that the defendant's tortious conduct caused or contributed to the plaintiff's injury. The causation test is not to be applied too rigidly. Causation need not be determined by scientific precision; as Lord Salmon stated in *Alphacell Ltd. v. Woodward*, [1972] 2 All E.R. 475, at p. 490, and as was quoted by Sopinka J. at p. 328, it is "essentially a practical question of fact which can best be answered by ordinary common sense". Although the burden of proof remains with the plaintiff, in some circumstances an inference of causation may be drawn from the evidence without positive scientific proof.
>
> It is not now necessary, nor has it ever been, for the plaintiff to establish that the defendant's negligence was the <u>sole cause</u> of the injury. There will frequently be a myriad of other background events which were necessary preconditions to the injury occurring. To borrow an example from Professor Fleming (*The Law of Torts* (8th ed. 1992) at p. 193), a "fire ignited in a wastepaper basket is . . . caused not only by the dropping of a lighted match, but also by the

> presence of combustible material and oxygen, a failure of the cleaner to empty the basket and so forth". As long as a defendant is part of the cause of an injury, the defendant is liable, even though his act alone was not enough to create the injury. There is no basis for a reduction of liability because of the existence of other preconditions: defendants remain liable for all injuries caused or contributed to by their negligence. [emphasis in original]

[20] The Supreme Court also confirmed in ***Athey*** that the basic test to establish causation is the "but for" test, which requires the plaintiff to prove that the injury would not have occurredbut for the negligence of the defendant. However, the "but for" test may be unworkable in certain circumstances. In those circumstances, a court may adopt the "material contribution" test, which is met "where the defendant's negligence 'materially contributed' to the occurrence of the injury,": see ***Athey***, para. 14 - 15. Justice Major, on behalf of the Court in ***Athey***, explained the appropriate analysis at para. 41:

> If the injuries sustained in the motor vehicle accidents caused or contributed to the disc herniation, then the defendants are fully liable for the damages flowing from the herniation. The plaintiffmust prove causation by meeting the "but for" or material contribution test. Future or hypothetical events can be factored into the calculation of damages according to degrees of probability, but causation of the injury must be determined to be proven or not proven. This has the following ramifications:
>
> 1. If the disc herniation would likelyhave occurredat the same time, without the injuries sustained in the accident, then causation is not proven.
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> 2. If it was necessary to have both the accidents and the pre-existing back condition for the herniation to occur, then causation is proven, since the herniation would not have occurred but for the accidents. Even if the accidents played a minor role, the defendant would be fully liable because the accidents were still a necessary contributing cause. [emphasis in original]
>
> 3. If the accidents alone could have been a sufficient cause, and the pre-existing back conditionalone could have been a sufficient cause, then it is unclear which was the cause-in-fact of the disc herniation. The trial

> judge must determine, on a balance of probabilities, whether the defendant's negligence materially contributed to the injury.

[21] In the present case, the trial judge correctly identified the applicable principles when assessing causation; he made certain fact findings, correctly cited ***Snell***, and directed himself to adopt a "robust and pragmatic approach." The trial judge concluded that neither the "but for" test nor the "material contribution" test was met in the circumstances.

[22] Mangelana challenges the trial judge's conclusions on the factual evidence, and submits that the trial judge misapprehended the evidence regarding the presence of an infection prior to July 12, 1992. Mangelana further argues that the trial judge was obligated to make a determination as to the specific cause of the infection.

*Errors in Trial Judge's Conclusions from the Factual Findings*

[23] The trial judge's conclusions from the evidence, as referenced in para. 115, was that there was "no evidence from which [the trial judge could] conclude, or even draw an inference, that the time of onset of the infection which led to the plaintiff's pneumonia was prior to July 12. Perhaps more importantly, [the trial judge could not] say that that infection could have been detected prior to July 12. The evidence does not establish that there was a delay in diagnosingor treatingthe plaintiff's pneumonia." The trial judge made several palpable and overriding errors in reaching these conclusions.

Onset of the Infection

[24] First, the expert evidence overwhelmingly establishes that an infection was a necessary condition for pneumonia to develop, and that an infection must have been present in Mangelana's system well in advance of July 12, 1992 in order for pneumonia to develop by that date. The trial judge was clearly wrong to suggest that there was no evidence on this point, and to conclude that there was insufficient evidence that would allow him to draw this inference.

Signs of Infection Prior to July 12, 1992

[25] Second, the trial judge's analysis suggests that there were no signs as to the presence of an infection prior to July 12, 1992. However, the evidence plainly establishesthat Mangelanadisplayed various signs and symptoms that were consistent with, and indicative of, an infection prior to July 12, 1992. This evidence includes:

> (a) the elevated white blood cell count from Mangelana's blood test taken during his admission to the IRH;

(b) Mangelana's elevated vital signs subsequent to the surgery;

(c) Mangelana's visual presentation upon his return to Tuktoyaktuk; and

(d) the numerous symptoms (fever, vomiting, headaches, swollen nodes, increased vital signs) that Mangelana consistently exhibited during his four appearances at the THC.

While some of the symptoms identified at the THC may have been consistent with Mangelana's post-surgery recovery from the tonsillectomy, most of these symptoms would not be expectedto last more than a day or two following that procedure. Their continued presence, combined with other signs, provides additional support for the existence of an infection. Certainly, Dr. Botha acknowledged many of the symptoms exhibited by Mangelana prior to July 12, 1992 indicated that he was fighting an infection: A.B. II, 552 - 54. Moreover, the medical notes from the THC and the Respondent Nurses' testimony revealed their suspicions that Mangelana was suffering from an underlying infection. The trial judge was clearly wrong to conclude there was no evidence that Mangelana presented with signs of an infection prior to July 12, 1992.

[26] The Respondent Nurses argued that the trial judge may have concluded that the chain of causation was interrupted by normal white blood cell findings on July 11, 1992. There are four problems with that argument. First the trial judge did not consider the July 11 results to be an irreconcilable anomaly. His reasoning on this point is merely conclusory in that it consists of the statement that the facts do not support causation, though he offers no analysis.

[27] The second problem is that the July 11 blood test results are unreliable. Dr. Douchettestified that the low hemoglobin reading contained in the July 11 blood sample was consistent with a considerable loss of blood (see A.B. 1, 309 - 10); however, Mangelana did not have any internal bleeding and the July 12 blood sample showed his hemoglobin results to be normal. Dr. Butcher suggested that it was more likely that the July 11 test results were erroneous, perhapsdue to potential deterioration of the blood sample during transport or lab error: see A.B. II, 736 - 38.

[28] The third problem with this argument is that if the results are accurate, they are still consistent with an infection. The expert evidence explained that an infection can overwhelm the body's increased production of white blood cell production and when this happens, a normal white blood cell count will result. In light of Mangelana's diagnosis of pneumonia the following day, this phenomenon is likely to have occurred on July 11, 1992.

[29] Finally, other indicators (such as Mangelana's subjective symptoms) suggest that Mangelana's vital signs on July 11, 1992 were not normal and that he was suffering from an infection. Moreover, Mangelana was consistently taking Tylenol at the direction of the Respondent

Nurses, which would have masked certain symptoms of infection and which should have been taken into account when assessing Mangelana's condition.

Delay in Identification and Treatment by Dr. Botha

[30] The trial judge also concluded that there was no delay in identifying and treating Mangelana's infection. Given the above analysis that an infection was present and its symptoms were discernible prior to July 12, 1992, the trial judge's conclusion on this point is also an error.

[31] Had Dr. Botha been aware of the elevated white blood cell count from Mangelana's blood test taken prior to his surgery, and the spike in Mangelana's vital signs following his surgery (which would have come to his attention had he not been negligent) it is our view that Dr. Botha would have ascertained Mangelana's underlying infection. This is supported by the experts' testimony that this information warranted Mangelana being kept at the IRH until further tests were taken that would have eliminated any suspicion of an infection. Had these additional tests been ordered, we are satisfied that they would have revealed the presence of an infection and Mangelana would then have been treated appropriately. In addition, the evidence also established that had the infection been diagnosed and treated on a timely basis, Mangelana's outcome would have been different or the consequences of the infection would likely have been less severe.

Failure to Make Finding on Cause of the Infection

[32] Mangelana further objects to the trial judge's failure to make a finding as to the cause of the infection itself. At trial, Mangelana advanced two possible causes for the infection: (1) Mangelana acquired a community-based infection prior to the surgery, which remained undetected and was exacerbated by the surgery; (2) aspiration occurred during, or shortly after, the surgery, resulting in foreign substances entering Mangelana's lungs and developing an infection. Despite the expert evidence, most of which supported the aspiration theory, the trial judge was unable to decide which was the source of the pneumonia.

[33] From our review of the evidence, the infection that led to pneumonia was either present before the surgery or developed shortly after. In light of this analysis, we conclude that it was not necessary for the trial judge to make a finding as to the precise source of the infection in order to properly assess causation. Regardless of its source, an infection was clearly present, ascertainable and treatable. In these circumstances, Mangelana need only establish that the failure to detect that infection on a timely basis caused or contributed to his injury. In our estimation, Mangelana has met this burden.

**The Respondent Nurses' Negligence**

[34] Having determined that Dr. Botha is liable for Mangelana's injuries, we must also consider whether the trial judge erred in his finding that the Respondent Nurses were not negligent. In our view, the trial judge committed a palpable error in his assessment.

[35] The standard of care to be expected from the Respondent Nurses is the standard of the reasonable nurse in the circumstances: E. Picard and G. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Scarborough: Carswell, 1996) at p. 357.

[36] Each of the Respondent Nurses breached this standard in their assessment of Mangelana on July 9, 1992. In the course of their assessments, the Respondent Nurses came to suspect the potential presence of an infection. In the morning, Nurse Belanger consulted with Nurse Meissner, at which point the suggestion was made that Mangelana be provided antibiotics to address a possible infection. The likelihood of a developing infection became more apparent later that day when Nurse McFadzen's differential diagnosis specifically included the possibility of an infection.

[37] In light of these concerns, it was the responsibility of each of the Respondent Nurses to take further steps to either confirm or rule out their suspicions of an infection. They failed to do so. The advice given by Nurse Belanger (i.e., that Mangelana was either already on antibiotics or there was a good reason why he was not on an antibiotic) was not only wrong, it disclosed doubt as to the true state of affairs. In light of that doubt, it was incumbent on both nurses to ascertain whether Mangelana was on antibiotics and, if not, why he was not. Neither did so, and Mangelanawas simply sent home after being provided Tylenol. Similarly, Nurse McFadzen failed to effectively follow up on her differential diagnosis later that day. Mangelana was again provided Tylenol and sent him home with instructions to return should he continue to feel feverish.

[38] The additional procedures and steps available to the Respondent Nurses, which are not complex and are to be expected of nurses carrying out those functions in these circumstances, are included in the standard of care attributable to the Respondent Nurses. For example, simply tapping on Mangelana's back or listening to his breathing through a stethoscope may well have revealed a chest infection leading to pneumonia.

[39] Furthermore, the Respondent Nurses, who did not have a copy of Mangelana's discharge notes or care plan, could have communicated their findings to Dr. Botha and sought his instructions for Mangelana's care. Nurse Meissner and Nurse Belanger's uncertainty required them to ascertain the true state of affairs, which could most easily have been achieved by contacting Dr. Botha at the IRH to confirm Mangelana's medication. Similarly, Nurse McFadzen could readily have sought Dr. Botha's direction in light of her differential diagnosis. There is no evidence that Dr. Botha was contacted by any of the Respondent Nurses until at least July 11, 1992.

[40] Finally, none of the Respondent Nurses took the initiative by providing Mangelana with general antibiotics to address a potential infection. While the evidence indicates that antibiotics

should typically not be given unless a clinical diagnosis has been made or on the instructions of a doctor, because of their remote location, the Respondent Nurses had the discretion to prescribe antibiotics depending on the circumstances. Given that the RespondentNurses failed to confirm their suspicions or to seek direction from Dr. Botha, the Respondent Nurses should have, at a minimum, provided Mangelana with antibiotics to address any potential infection. There is nothing in the evidence to suggest that Mangelana would have incurred any potential adverse effect had the Respondent Nurses taken this course of action.

[41] Despite this evidence, the trial judge concluded that the Respondent Nurses met the standard of care in the circumstances. In doing so, he was clearly wrong, and we concludethat the Respondent Nurses were negligent in their care of Mangelana

[42] Despite the RespondentNurses' negligence, Dr. Botha was most responsible for Mangelana's increased injuries. His failure to perform either an appropriate preoperative examination or post operative examination are the major precipitators of a chain of events that led to Mangelana's ultimate injury. We assess liability on the basis of 80% to Dr. Botha and 20% to the Respondent Nurses. We conclude that the contribution of Dr. Botha's negligence to the injuries suffered by Mangelana was far greater than the Respondent Nurses' negligence. His negligence preceded any contact by the Respondent Nurses and set the stage for the errors they committed. Had Dr. Botha conducted the pre and post operative examinations of Mangelana as he should have, he would have treated the infection and Mangelana would have suffered little or no injury. By the time the Respondent Nurses were negligent in their treatment of Mangelana, it was too late to prevent all injury, although even at that stage proper treatment likely would have reduced the injuryhe suffered.
[43] A split of liability on the basis of 80% to Dr. Botha and 20% to the Respondent Nurses reflects their relative contributions to the injury suffered by Mangelana.

**Conclusion**

[44] Mangelana's appeal is allowed and he is awarded the damages conditionally assessedat trial, which were not appealed. Mangelana is also entitled to costs at trial and at this appeal. Dr. Botha's cross-appeal is also allowed.

Appeal heard on June 27, 2006

Memorandum filed at Yellowknife, Northwest Territories
this day of September, 2006.

Authorized to sign for: Fruman J.A.

Ritter J.A.

Authorized to sign for: Veale J.A.

**Appearances:**

Joseph V. Miller and Sheila J. Torrance
for the Appellant

Garth Malakoe and Terry Nguyen
for the Respondents, J. McFadzen, Helene Belanger, Lorrie Meissner, and Inuvik Regional Health and Social Services Authority, operating facilities known as Tuktoyaktuk Health Centre and the Inuvik Regional Hospital

Jonathan P. Rossall and Alexis Moulton
for the Respondent, Dr. Botha