SUPREME COURT OF QUEENSLAND

CITATION:	*Briant v Allan & Anor* [2002] QCA 157
PARTIES:	**MELANIE JOYCE BRIANT** **(plaintiff/respondent)** **v** **JOHN ALLAN** **(first defendant/appellant)** **and** **THE UNITING CHURCH IN AUSTRALIA PROPERTY TRUST (Q)** **(second defendant/not a party to appeal)**
FILE NO/S:	Appeal No 11587 of 2001 DC No 1649 of 1993
DIVISION:	Court of Appeal
PROCEEDING:	Application for Leave - s 118(3) *District Court Act* 1967 General Civil Appeal
ORIGINATING COURT:	District Court at Brisbane
DELIVERED ON:	10 May 2002
DELIVERED AT:	Brisbane
HEARING DATE:	23 April 2002
JUDGES:	de Jersey CJ, McPherson and Williams JJA Joint reasons for judgment of McPherson and Williams JJA; separate reasons of de Jersey CJ, concurring as to the orders made.
ORDER:	**Leave to appeal granted. Appeal allowed with costs. Judgment set aside. In lieu, judgment is given for the defendant in the action, together with costs of and incidental to the action, including reserved costs, if any.**
CATCHWORDS:	TORTS – NEGLIGENCE – MISCELLANEOUS FORMS OF NEGLIGENT CONDUCT – where trial judge found defendant doctor to have negligently cross-infected the plaintiff with herpes virus in the course of receiving artificial insemination – whether trial judge incorrectly identified the mechanism by which the contamination occurred EVIDENCE – BURDEN OF PROOF, PRESUMPTIONS, AND WEIGHT AND SUFFICIENCY OF EVIDENCE – GENERALLY – SUFFICIENCY – whether plaintiff produced adequate evidence to establish that the defendant had been negligent in not sterilising his medical equipment –

whether trial judge had based his conclusion that the defendant had used an unsterilised speculum on matters of inference or unwarranted speculation rather than fact –

TORTS – PROOF OF NEGLIGENCE – ONUS OF PROOF whether the plaintiff failed to discharge the onus of proof that rested upon her to prove her case on the balance of probabilities – whether a new trial was warranted because the critical findings made by the trial judge were based on inference rather than credibility

District Court Act 1967 (Qld), s118(3)

Devries v Australian National Railways Commission (1993) 177 CLR 472, considered
Rhesa Shipping SA v Edmunds (1985) 1 WLR 948, applied

COUNSEL: SC Williams QC, with DJ Morgan, for the appellant
M Grant-Taylor SC for the respondent

SOLICITORS: Flower & Hart for the appellant
Murphy Schmidt for the respondent

[1] **de JERSEY CJ:** The respondent sued the applicant medical practitioner for damages for alleged professional negligence. A learned District Court Judge found the negligence established, and gave judgment in the respondent's favour in the amount of $36,328.50. The appellant purported to appeal, overlooking the need first to obtain leave, the amount at issue being less than $50,000 (s 118(3) *District Court Act* 1967). Upon the hearing of the application for leave, the court entertained submissions going to the merits of the appeal. It is convenient to turn at once to the substance of the appeal.

[2] The applicant is a medical practitioner practising in the fields of obstetrics and gynaecology. The respondent retained his services to undergo artificial insemination. The applicant carried out a vaginal scan on 2 June 1990 using a vaginal ultrasound probe, and insemination procedures on 3rd and 4th June 1990 utilizing a vaginal speculum. On each occasion, in addition to the insertion of the implement into the respondent's vagina, the applicant's ungloved left hand came into contact with her vagina. On 15 June 1990 the respondent was admitted to the Nambour Hospital suffering from a primary case of the herpes simplex virus type one. She had first experienced relevant symptoms two to three days after insemination. The learned Judge found that she was probably infected during the treatment by the applicant. She had not previously suffered from the virus, and the evidence was that its mean incubation period is seven days.

[3] The Judge's process of reasoning, which has been criticized in submissions by counsel for the applicant, followed this path.

1. The donor semen was "according to the evidence, unlikely" to be the source of the respondent's infection. The relevant evidence came from Dr Michael Whitby, a consultant physician in infection. In his report dated 11 January 1999, he examined this possibility, at pages four to seven, expressing the conclusion upon which His Honour must have relied.

2. The Judge accepted the respondent's evidence that she had had no sexual relations with anyone other than her husband since meeting him in 1983, and that she and her husband had not had sexual relations for at least a fortnight after the applicant's treatment. Clinical tests of the respondent's husband "tended to exclude him as being the source of the infection in any event".
3. As His Honour found, there is generally, among patients seeking artificial insemination, a high incidence of such infection, which the individual patient would be reluctant to disclose, for various reasons including embarrassment. On each of the days the treatment was given, the respondent was not the first patient seen by the applicant. While the applicant asserted, in his evidence, that none of the other patients treated at around the time of the treatment given to the respondent, carried the virus, the Judge interpreted that as meaning that none carried observable active lesions. Although the Judge accepted that the applicant believed that none of the previously treated patients bore the virus, he found that cross-infection from another patient to the respondent did occur. The mechanism of cross-infection was the subject of detailed consideration, the Judge dealing with three possibilities: contact between the vagina and the applicant's ungloved hand, contact with the probe and contact with the speculum.
4. For reasons which need not now be further explored, the learned Judge excluded contact between the vagina and the applicant's ungloved hand or the probe as being the likely explanation for the infection. He did however conclude that it was contact with the speculum which most likely led to the infection.
5. The system obtaining in the applicant's rooms involved the use of sterilized specula. Following use on a patient, a speculum would be placed in a bucket of sterilizing solution, scrubbed, autoclaved, and then placed in a drawer for subsequent use. The applicant was, as the Judge observed, "dogmatic" in his insistence that this procedure was followed in the treatment of the respondent. The Judge relied on the circumstances that, on the evidence of the respondent which he accepted, the applicant, before using the speculum, took it from a metal tray, not a wooden drawer, and then placed it under running water, which on the applicant's evidence was not his usual practice. There was some evidence that over this weekend, there may have been an absence of staff to clean specula, leading to an accumulation of used specula. Third and 4th June 1990, when the applicant introduced a specula into the respondent, fell on a Sunday and a Monday. The Judge inferred that the speculum used on the applicant bore the virus which entered the respondent's system via a lesion in the mucosa.

[4] There was substantial criticism levelled by counsel for the applicant at His Honour's process of reasoning. One particular criticism which bears mention was that the scenario upon which the Judge ultimately relied was not expressly put to the applicant during his oral evidence. While the prospect of contamination by contact with the speculum was not directly raised with the applicant, the circumstances basing the inference drawn by the Judge were explored in the evidence – particularly, the taking of the speculum from a tray not the drawer, the placing of the speculum under a running tap prior to use, the availability of cleaning services over the weekend, and the extent of consultations with patients at that time.

[5] In relation to the placing of the speculum under the tap, the respondent gave evidence that the purpose was to warm the speculum in advance of its insertion,

relying upon what the applicant said to her as he advanced towards her prior to inserting the speculum. The applicant denied placing the speculum under the tap. What the Judge did was to accept the respondent's evidence that that occurred, but reject her explanation of the purpose drawn from what the applicant said. The Judge concluded that the applicant washed the speculum in the misconceived hope that it would therefore be sufficiently sanitized prior to use. I return to the legitimacy of that conclusion.

[6] The prospect of contamination via the speculum was however sufficiently raised in the evidence, and further, was dealt with in closing addresses. It is not a case where the Judge relied on a scenario entirely of his own deduction without notice to the parties.

[7] The submission ultimately advanced for the applicant was that the learned Judge approached his selection of the evidence to be accepted, and rejected, in a somewhat contrived way, as if to fit a particular theory which, if justified by the evidence, would explain the infection. The criticism ran that the Judge wrongly ignored competing possibilities, having concluded they were unlikely causes, and in the end was left, as it were, with the speculum, proceeding subconsciously then to mould his acceptance or rejection of the evidence with a view to sustaining that possibility as the cause in fact.

[8] On the other hand, it was submitted for the respondent that the learned Judge's conclusions were reasonably open, with no ground demonstrated upon which this court could properly intervene, acknowledging, for example, *Devries v Australian National Railways Commission* (1993) 177 CLR 472.

[9] Critical to His Honour's conclusions were these findings:

(a) that the appellant placed the speculum under a running tap, not to warm it, but to clean it;

(b) that he was moved to do that in the absence of a properly sterilized speculum because of the extent to which the available stocks had previously been used but not sterilized; and

(c) that the appellant took the speculum from a metal surface or tray, not the drawer in the usual way.

[10] McPherson and Williams JJA comprehensively address the availability of those findings in their reasons for judgment. None is sufficiently supported by the evidence, for the reasons they express, and I am satisfied none could be, which excludes the need for a further trial. This is a case where the respondent did not, and apparently could not, establish the probable cause of her infection. As said in *Rhesa Shipping SA v Edmunds* (1985) 1 WLR 948, 955-6 per Lord Brandon:

> "No judge likes to decide cases on burden of proof if he can legitimately avoid having to do so. There are cases, however, in which, owing to the unsatisfactory state of the evidence or otherwise, deciding on the burden of proof is the only just course for him to take."

[11] The appeal should be allowed and judgment entered for the defendant. I agree with the orders proposed by their Honours, and with their reasons.

[12] **McPHERSON and WILLIAMS JJA**: The relevant facts are set out in the reasons of the Chief Justice and there is no need to repeat them here. The reasoning by

which the learned trial judge was led to conclude that the defendant had negligently cross-infected the plaintiff with herpes virus started with the acknowledged fact that the incubation period for the virus is some seven or so days after infection. The plaintiff first noticed symptoms some two or three days after the artificial insemination procedures were carried out on her by the defendant on 3 June and 4 June 1990. It was diagnosed as a primary case of herpes simplex type 1 on 15 June 1990, and the diagnosis was confirmed on the following day. His Honour found on the balance of probabilities that the plaintiff was contaminated in the course of the treatment she received from the defendant.

[13] The next step in the reasoning was to identify the mechanism by which the contamination occurred and, having done so, to determine if it involved negligence on the part of the defendant. The plaintiff's primary case was that the contamination had taken place by transfer from the defendant's ungloved hands; but this hypothesis was rejected on the ground that washing hands between patients was so much a matter of routine that its absence was "close to unimaginable" in the case of a responsible practitioner like the defendant. Having eliminated other potential means or sources of infection as improbable, his Honour concluded that the virus had been transferred by using on the plaintiff an unsterilised speculum in the course of treatment by the defendant on 3 or 4 June 1990. In employing, as his Honour found, a speculum previously used on an infected patient without adequately sterilising it, the defendant was held to have been negligent; and, indeed, the trial judge went so far as to find that the defendant knew that the speculum in question had not been properly sterilised but nevertheless decided to use it on the plaintiff.

[14] The logic of this process of reasoning may be vulnerable to attack at more than one point in the chain, but it is essentially the last step that the defendant sought to challenge on appeal. The critical finding in the reasons appears in para [41], where his Honour said:

> "I accept Mrs Briant's evidence that the speculum was put under running water by Dr Allan, although this was not his usual practice. The most probable scenario is that to Dr Allan's knowledge the specula had not been through the rigorous sterilising process, used specula having accumulated over the Saturday and possibly the Sunday, and, pressed for time (patients were seen at about five minute intervals) Dr Allan adopted a process of cleaning which he no doubt hoped would be adequate but regrettably was not. I regret to say such finding involves my rejecting Dr Allan's evidence to the contrary."

[15] This conclusion must be considered in the context of other evidence at the trial and the findings based upon it. The defendant was at the forensic disadvantage of not being able to recall specifically what he did on either of the two occasions on which he treated the plaintiff in 1990. His evidence and defence were based partly on what he routinely did, and partly on what he claimed was his well merited reputation for being punctilious in matters of hygiene. It is doubtful if the latter consideration is entitled to much, if any, weight at all in determining the issue of negligence at the trial. On the other hand, he and his two receptionists, one of whom was a Mrs Walsh, gave evidence concerning the defendant's constant insistence on hygiene and also about the system adopted in his practice to avoid cross-infection arising from the use of speculums on successive patients.

[16] The procedure was that having used a particular speculum on a patient, the defendant immediately placed it in a bucket of sterilising fluid in his consulting room. From there, at intervals, the receptionists retrieved the instruments, took them away and scrubbed them, and then placed them in an autoclave for some 30 minutes or so. When cleansed in this way the instruments were returned to the doctor's consulting room, where they were placed in a drawer or drawers in the specially built wooden couch on which patients reclined during treatment.

[17] No one doubts that the procedure, if followed, would have sufficed to prevent cross-infection taking place from some other already infected patient. The plaintiff's case is, however, that it is not what happened on either of the two occasions on which she was treated on 3 and 4 June. On those dates the speculum used on her by the defendant came, she claimed, not from the drawer in the couch but from the lower shelf of what she described as a metal trolley located under the couch. She claimed he took the speculum to an adjoining room and ran it under water before using it on her. On this basis, the hypotheses advanced are that the speculum in question had been used on an earlier (and infected) patient that morning; that it had not been sterilised or placed in the bucket of sterilising fluid; and that the defendant had simply adopted the expedient, which his Honour correctly stigmatised as "inadequate", of washing it under a running tap in order to disinfect it.

[18] The problem for the plaintiff is that the evidence at trial fails to provide a legitimate basis for the findings needed to support it. If the defendant was at a disadvantage in recollecting what had happened on these two occasions some 10 years before, the plaintiff was no less disadvantaged by not being able to see much of what was happening. She was of course lying on the couch, and could not in fact see the defendant washing the speculum in the adjoining room. Above all, her claim that he was washing it in a feckless attempt to disinfect it is plainly a matter of inference on her part and not of observation. All she observed was that when the defendant went into the next room taking the speculum with him, she heard running water, and assumed that he was washing it. The conclusion that he was washing it because it might be infected was a further inference that it was not open to her or his Honour to make on the available evidence. In fact, according to her own testimony at the trial, the defendant said on returning with the speculum that he would not want to burn her with it. Under cross-examination she said she believed that what he had done was to warm it. Having regard to the part of her anatomy where it was to be put, and the fact that it was June, it would not have been at all surprising if, to avoid the discomfort or shock of a cold instrument, the defendant had warmed it by placing it in or under hot water. There was no reason to suppose that he did so as a method of disinfecting it.

[19] One foundation on which his Honour's critical finding of negligence is based is therefore not sustained or sustainable on the evidence. There is an equally, if not more plausible explanation for his having put the instrument under a running tap, if that is what the defendant in fact did. The finding that he did so in a futile effort to decontaminate an infected speculum was, however, not the central issue of fact to be determined. That issue, in the context of the evidence given about the sterilising routine that was habitually followed in his practice, was whether the defendant took the speculum from among the sterilised equipment in the couch drawer; or, as the plaintiff claimed, from the lower shelf of a metal trolley, or, as she later said, a metal surface. The evidence of the defendant and his receptionists was that there was no metal trolley in the room at any time. The question then moved to whether

there was some other metal surface from which a used, unsterilised and infected speculum had or might have been taken by the defendant.

[20] It may at once be said that even if the speculum in question was taken from such a metal surface, it did not establish that it was either unsterilised or infected with herpes virus. The most that can be said is that it was not taken from the drawer where other such sterilised instruments were usually kept. It did not show that it was unsterilised. That is a serious weakness in the proof of the plaintiff's case of negligence against the defendant. At the best for her, the fact that the speculum did not come from the drawer adds a little, but not much, to the hypothesis that it was not sterilised and might have been contaminated by having been used on an earlier patient who was infected with the virus.

[21] It is a curious feature of the case that nowhere in his reasons did the trial judge say that he specifically accepted the evidence of the plaintiff that the speculum used on her was in fact taken from a metal surface. Had he done so, such a finding might have been difficult to displace as being one that depended on his impression of seeing and hearing the witness, in relation to which a trial judge has acknowledged advantages over an appellate court. Instead, his Honour appears to have based his conclusion on this issue entirely on matters of inference. He said [38]:

> "In my view, it is most likely that a speculum used on Mrs Briant was taken by Dr Allan from a metal tray rather than from the drawer. Specula in the drawer would most likely be sterilised. The same could not necessarily be said of a speculum taken from a metal tray."

Saying "not necessarily" simply left the issue at the level of a possibility, which would not be sufficient to establish a case against the defendant on the balance of probabilities.

[22] Earlier in para [37] his Honour had said "some support" for the plaintiff's evidence that the defendant had on "each occasion" taken a speculum from a metal tray appeared "fortuitously" from Mrs Walsh's evidence that, after sterilisation, the sterilised speculums were brought back into the room on a metal tray. The plaintiff did not refer in her evidence to a metal tray as such, but to a metal surface; but, even if this distinction is disregarded as mere quibble, the further hypothesis is needed that the tray on that occasion must have been left in the room, and not taken away for the next round of sterilisation of the instruments; and that, seeing it still there, the defendant must, regardless of the risks of contamination, have seized on it as a convenient place to leave a used speculum preparatory to re-using it on a following patent. Even if he intended to re-use it, one would have thought it more likely that he would have placed it in the bucket of sterilising fluid that was available for that purpose. By virtue of his training and experience, he was acutely conscious not only of herpes but of other and more serious viruses that are said to lurk in the anatomical "zoo", as one medical witness chose to describe it.

[23] However that may be, his Honour looked around for other evidence to confirm the testimony of the plaintiff that it must have been by this means that a contaminated speculum came to be used on her on one or both of the occasions when she was treated. He concluded that confirmation could be found in the state of affairs prevailing in the defendant's practice on the two days on which the plaintiff was treated by the defendant, or perhaps on the day immediately preceding it. That day was Saturday 2 June, and the plaintiff received her treatment on Sunday 3 and

Monday 4 June. The evidence of the receptionists was that they only sometimes worked at weekends, and they were inclined to doubt whether they carried out the sterilisation routine on those occasions. Hence his Honour's conclusion in para [41] that "used specula … accumulated over the Saturday and possibly the Sunday and, pressed for time (patients were seen at about five minute intervals), Dr Allan adopted a process of cleaning which he no doubt hoped would be adequate but regrettably was not".

[24] We regret to say that in our opinion this amounts to unwarranted speculation going well beyond the limits of legitimate inference or even bare hypothesis. The plaintiff said that patients were being seen at five to 10 minute intervals, which the defendant described as almost a physical impossibility. When reduced to intervals of five minutes, that must surely be correct. The evidence from the defendant was that he had roughly 30 speculums available for use. This would be an adequate supply for at least the three days of a weekend and beyond, assuming, as the evidence at one point suggested, he treated between six and 10 patients during the morning of a weekend. It is almost impossible on the available evidence to arrive at any useful average because the patients came, and with little advance or recorded notice, according to the advent of their periodic fertility cycle. This represents a real weakness in the proof of the plaintiff's case, and it was not something in respect of which any onus of disproof rested on the defendant.

[25] As is obvious from the above analysis the plaintiff did not differentiate between the treatment she received on each of the two days, 3 and 4 June. The account of the procedure recorded in her statement (which became her evidence in chief) describes one incident of treatment and the inference one is asked to draw is that precisely the same events occurred on each day. That is somewhat surprising given that the 3rd was Sunday and the 4th was a Monday. One would ordinarily expect, for example, that the number of instruments available, and possibly their location, would differ as between the two days. The plaintiff's evidence appears to concentrate on the Sunday, because that is the day her husband says he was present. But her case is not strengthened by her husband's evidence; the learned trial judge said of his evidence:

> "I do not treat the plaintiff's husband as effectively providing support for that proposition because his evidence appeared to be contrived and was given in circumstances which make it obvious he had discussed the matter inappropriately with his wife during a break in the proceedings."

That observation was made with particular reference to the taking of the speculum from a metal trolley. See, on this, *Rhesa Shipping Co SA v Edmunds* [1985] 1 WLR 948, 955-956.

[26] In making his findings the learned trial judge also did not differentiate between the 3rd and 4th June. If there was inappropriate washing of a dirty speculum it would be surprising if it occurred in exactly the same way on each of two successive days. The inability to particularise the day on which the incident relied on as establishing negligence occurred highlights the speculative nature of the finding made. Further, it is not without significance to note that in early correspondence, particularly with the Medical Board, the plaintiff made no mention of the defendants washing a speculum or suggesting that it may have been a possible cause of her infection.

[27] It was the defendant's submission on appeal that the evidence had been rationalised to fit a conclusion of negligence already reached by the learned judge based on the coincidence of time between the treatment and the infection. Whether or not that is so, it seems to us that it fell well short of supporting several essential links in the chain of reasoning which led to that conclusion. It was not established that there was a metal trolley or even a metal tray in the consulting room on either occasion when the plaintiff was treated; or that so many patients had been treated as to exhaust the available supply of sterilised speculums; or that the defendant had re-used an infected speculum, knowingly or otherwise, and then simply washed it in water as a measure of sterilisation. In the absence of compelling evidence of each of these matters, they remained in the realm of speculation and never became susceptible of legitimate inference in favour of the plaintiff. It follows that, in our respectful opinion, the plaintiff failed to discharge the onus of proof that rested upon her to prove her case on a balance of probabilities. It may be added that, although it was unlikely that the virus was transmitted through the serum, it always remained a possible explanation of what occurred.

[28] For these reasons, we are not satisfied that his Honour was justified in finding negligence against the defendant. Because the critical findings made by the trial judge were based on inference rather than credibility, we are of the view that a new trial would not be warranted on the evidence adduced by the plaintiff at this trial.

[29] We would therefore grant leave to appeal; allow the appeal with costs; and set aside the judgment against the defendant together with the finding of negligence in support of it. There should be judgment for the defendant in the action together with costs, including reserved costs if any.