**THE REPUBLIC OF TRINIDAD AND TOBAGO**

**IN THE HIGH COURT OF JUSTICE**

**Claim No. CV2009-02051**

**IN THE MATTER OF**
**THE SUPREME COURT OF JUDICIATURE ACT**

**AND**

**IN THE MATTER OF THE COMPENSATION FOR INJURIES ACT**

**BETWEEN**

**KAREN TESHEIRA**

**(The Executrix of the Estate of Russell Tesheira)**

**Claimant**

**AND**

**GULF VIEW MEDICAL CENTRE LTD**

**CRISEN JENDRA ROOPCHAND**

**Defendant**

**Before the Honorable Mr. Justice V. Kokaram**

**Date of delivery: 27th March 2015**

**Appearances:**

**Mr. Douglas Mendes SC and Mr. Simon de la Bastide instructed by Ms. Marcelle Ferdinand for the Claimant**
**Ms. Mary O'Rourke QC and Mr. Anand Beharrylal instructed by Mr. Winston Seenath for the First Defendant**
**Mr. Roger Kawalsingh instructed by Mr. Ravi Mungalsingh for the Second Defendant**

# JUDGMENT

## Introduction

1. This is a medical negligence claim arising from the death of Mr. Russell Tesheira. He died due to complications which developed from his excessive bleeding after a TURP[1] was performed on him on 13th April 2004 at the Gulf View Medical Centre ("Gulf View") the first Defendant. Mr. Tesheira died mere hours after the TURP was completed by a team of specialists comprising a urologist Dr. Lester Goetz and an anaesthetist Dr. Crisen Jendra Roopchand, the second Defendant. Although his TURP was completed by 1:10p.m and he was resting in a private room on the ward, by about 3:30p.m something went wrong. The medical experts assert he had gone into hypovolemic shock and he was being rushed back into the operating theatre to arrest the heavy continuous post operative bleeding which was considered a risk in the performance of TURPs. There was heightened activity of preparing him for further surgery, conducting CBC and PTT tests, ordering and obtaining blood products and preparing them for transfusions, transfusing about 11 pints of blood products into Mr. Tesheira and conducting two further surgical procedures to arrest the bleeding. Despite this however, within an hour of the closure of the incision on the last procedure, Mr. Tesheira's heart stopped beating. He died during anaesthesia while receiving his last unit of blood. His wife Mrs. Karen Tesheira, the Claimant, who was waiting for her husband anxiously in the waiting room was simply told "Russell did not make it..." She left no doubt in a state of despair[2].

2. Mrs. Tesheira has brought this claim against Gulf View and Dr. Roopchand[3] in her personal and representative capacities for damages for negligence in which she has alleged that they were negligent in their care and medical treatment of her husband.[4]

[1] It is accepted by the parties that the Transurethral Resection of the Prostrate (TURP) is a surgical procedure that removes portions of the prostate gland through the penis. The prostate gland is about the size of a walnut and surrounds the neck of a man's bladder and uretha - the tube that carries urine from the bladder. The prostate gland is partly muscular and partly glandular with ducts opening into the prostatic portion of the uretha.
[2] In the witness box she was visibly upset at the recollection of her husband's death.
[3] Referred to as the Defendants collectively.

3. There is no doubt in this case that Mr. Tesheira succumbed to a "trilogy" of complications of hypovolemic shock leading to a condition known as Disseminated Intravascular Coagulation (DIC) and then TURP syndrome or fluid overload which led to his demise. His post operative bleeding was not addressed more than two hours after he was returned to his room. What was at first a manageable risk, over the space of a few hours mushroomed into a fatal chain of events. The problem with this patient was that there was uncontrolled clotting in the blood circulation where clotting factors and platelets in the blood were being consumed. This is known as DIC. This condition could have been managed by transfusions of fresh whole blood and platelets, fresh frozen plasma and cryoprecipitate. However failing to properly manage the subsequent transfusion with proper products can lead to TURP syndrome or fluid overload. The autopsy report into Mr. Tesheira's death which shows his death was caused by irreversible shock DIC also strongly suggests the onset of TURP syndrome or fluid overload[5].

4. However accepting that Mr. Tesheira died while a medical team was trying to save his life is one thing, but finding that they were negligent in his treatment and care, and if so, whether but for that treatment he would not have died, is quite another altogether. Indeed, the Defendants, Gulf View and the anaesthetist, Dr. Roopchand vigorously deny their responsibility for the death of Mr. Tesheira. The two issues that are the central focus of this trial is whether they breached their duty of care to Mr. Tesheira and whether that breach actually caused his death. Interwoven in these main issues are the questions of the material contribution to the cause of death, the roles played by these professionals and the evidence adduced by Mrs. Tesheira of an acceptable body of medical opinion representing the proper standard of care to be observed by these professionals.

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[4] Her claim against Dr. Lester Goetz who was previously a party to this action was withdrawn after the parties' compromised that claim. That agreement provided for an ex gratia payment to be made to the Claimant without any admission of liability on the part of Dr. Goetz, a release and discharge of Dr. Goetz by the Claimant for all claims and actions she may have against him arising or related or other complaint in this proceeding and a withdrawal of these parties of their respective appeals in relation to Dr. Goetz. See this Court's earlier decision dated 12th May 2012 on the effect of this compromise agreement.

[5] There were signs of fluid overload by the congestion of his liver, lung and spleen. One of the medical experts Dr. Pitt-Miller also pointed out that the report indicates the existence of fluid overload.

5. No doubt the medical personnel and specialists in this case make life and death decisions within seconds. The pressures of proper patient care and management are extremely high. Their Hippocratic Oath enjoins them to a sacred duty to save lives. At times members of the medical profession may appear to perform superhuman procedures and miracles but they cannot save everyone they treat nor can they guarantee success in every operating procedure. However what the law demands is that they exercise reasonable skill and care in their treatment of the patient and act in accordance with a practice accepted as proper by a responsible body of medical men and women skilled in that particular specialty. McNair J's "Bolam test[6]" has served to guide the Court in regulating the medical profession in the execution of their duties and their relationship with their patients. If I may adopt a phrase used by one of the experts in this case, it is "the gold standard" of conduct in the medical profession. It recognises on the one hand the expertise and specialist skill and knowledge required by hospitals and doctors and on the other the limitations of a Court in entering the operating theatre and "donning its own scrubs". The rationale of the Bolam test is to limit the liability of the medical profession from actions in negligence if their conduct ascribes to a practice that is accepted as proper by a responsible body of the medical profession skilled in that area of expertise. As Lord Denning observed it would be doing a disservice to the community at large if liability is to be imposed on hospitals and doctors for anything that goes wrong[7]. The problem with such a litigious climate may tend to make doctors think of their own safety than that of the welfare of patient, stifle initiative and intuition and shake their confidence in life and death situations. While the Court must insist on due and reasonable care for the patient it would not condemn the misadventure but similarly the Bolam test cannot act as a shield for the bravado or the cavalier.

6. In reality to apply the Bolam test to a great extent means that the level of professionalism and standard of care is largely self regulated. That is to say the medical professional's reliance upon a body of responsible peer professional opinion is sufficient to dispel the suggestion of negligence. The Court must however guard against the danger of self regulation in cases where there are differing professional opinions on a recommended course of treatment or

[6] **Bolam v Friern Hospital Management Committee** [1957] 2 All ER 118
[7] **Roe v Minister of Health** [1954] 2 QB 66 at p.87

management of a patient. In such a case the medical professional can adopt any view or practice for which there is a significant support in the profession and can be absolved of liability. Even where such a view or practice, behind which the medical professional shelters, is attendant with dangers and notorious risks. This is not to say that a Court must be swayed by sympathy for the patient. However, being overly deferential to "doctor knows best" comes at the expense of "opportunities to precipitate changes where required in professional standards" and the reality that patients do put their lives virtually in the doctor's hands. The Bolam test may not have intended these consequences and a Court must always scrupulously guard against practices that may develop in the profession not for the interest of the client but for the protection and convenience of the members of the profession. No such practice can in the true sense of the Bolam test be described as held by a "responsible body of medical men skilled in that particular art". To this extent the Court reserves the right to scrutinise professional practice and declare it negligent. If it can be demonstrated that even if the medical professional did so act in conformity with an accepted practice if that practice is demonstrated to be inherently wrong or illogical then it would not serve as an escape route for liability in negligence. This is the "Bolitho Gloss[8]". See **Bolitho v City and Hackney Health Authority** [1997] 4 All ER 771.

7. This "Bolitho gloss" to the traditional Bolam test is a welcome development in the law of medical negligence. It is applied in rare cases but really **Bolitho** should be viewed as an invitation to the medical profession not only to logically test their prevailing practices but ensure that the standards of the medical profession are not dated, that it is kept current and follows best practice. Where medical negligence claims are not resolved amicably, it should be seen as an opportunity to objectively justify the course of treatment, to demonstrate that the medical professional has acted responsibly in accord with a general or acceptable standard in the medical profession which can be logically tested and supported and where necessary pass the **Bolitho** test. In applying these tests the profession would be able to say in cases such as this one, what is the appropriate standard for dealing with the risk of post operative bleeding in a small private hospital, what are the justifiable risks and pre and post operative planning for those risks in performing a TURP, how should blood transfusions be

[8] See *Trumping Bolam: A critical legal analysis of Bolitho's Gloss, R Mulheron,* (2010) 69 CLJ 3, 609

managed efficiently and safely to a patient who has developed irregular coagulation. Certainly these explanations arm the Court with an objective overview of the medico-legal standards for this particular medical procedure to make a just determination on the responsibility of the medical profession. Such explanations or disclosure will also bring a sense of closure and ease to patients and their families with respect to the level of professionalism required and attained in such an important area of human activity.

8. However no explanations would be forthcoming from these Defendants on their performance of the post-operative treatment of a TURP in this case. Gulf View and Dr. Roopchand have offered no explanation personally or from any acceptable body of medical opinion of the permissible and acceptable steps they took to prepare for and deal with the standard risk of post-operative bleeding of this TURP. They have offered no evidence on the standard in the profession in private hospitals in the pre and post operative care of patients such as Mr. Tesheira in the transfusion of blood, dealing with post operative bleeding and the developed conditions of hypovolemic shock and DIC or TURP syndrome. Such explanations will not be forthcoming in this trial because after the close of the Claimant's case Gulf View and Dr. Roopchand have tactically, which they are entitled to do, elected not to call any evidence submitting that there is simply no case of negligence for them to answer.

9. The burden is always on Mrs. Tesheira to prove her case. The Defendants have vigorously asserted that there is no evidence of negligence as adduced by Mrs. Tesheira. Her expert witnesses in their view were contradictory, found wanting in their analysis and, in one respect entirely conceded a case of negligence against Gulf View. It was submitted that they were not demonstrably independent minded to assist the Court with objective evidence and failed to demonstrate that either the medical staff of Gulf View or Dr. Roopchand as an anaesthetist failed to discharge their duties toward Mr. Tesheira or that any such failure caused or materially contributed to his death.

10. At this stage in considering the no case submission, the Court must determine whether on a balance of probabilities, Mrs. Tesheira has on her evidence proven that the anaesthetist and Gulf View owed a duty of care in administrating medical treatment related to the TURP and

post-operative procedures to the deceased, acted in breach of that duty and which breach resulted in his death. However for a patient to be resting comfortably at one stage after surgery to later collapsing in shock in a matter of about two hours calls for an explanation. The authorities are clear that the Claimant is entitled to judgment even if there is a weak case so long as there is a scintilla of evidence to establish a case of negligence on a balance of probabilities or which has then been strengthened by the adverse inferences to be drawn from the Defendant's election not to call evidence.[9] Ironically in a trial which is about risks, taking a no case submission is inherent with its own risks as well.

11. In my judgment I am of the view that the evidence adduced by Mrs. Tesheira's expert witnesses of a haematologist Dr. Altheia Jones-Lecointe and an anaesthetist Dr. Phyllis Pitt-Miller properly demonstrates that the anaesthetist failed to determine if the deceased was taking aspirin before performing the TURP, failed to properly treat Mr. Tesheira's hypovolemic shock and prevent the onset of the condition of DIC and failed to properly monitor and manage his blood transfusions. The experts also satisfactorily demonstrate on a balance of probabilities that Gulf View failed to monitor his post operative recovery, failed to have on site and to make suitable arrangements for sufficient blood products appropriate for transfusions for dealing with excessive bleeding and the problems attendant with excessive bleeding. These actions led and materially contributed to Mr. Tesheira's death caused by DIC. The only expert evidence as to the steps that ought to have been taken to deal with the foreseeable risks and complications arising from post operative bleeding which is acceptable as proper practice by a responsible body of anaesthetists and hospitals have come from these experts. Despite the rigorous cross examination, their scientific knowledge was not questioned and they have sufficiently set out a reasonable body of medical opinion which suggests on a balance of probability that there was negligence on the part of both Gulf View and Dr. Roopchand in the pre-operative and post-operative care of Mr. Tesheira. The Claimant for the reasons set out in this judgment is therefore entitled to judgment. Her damages have been assessed in the sum of $18,034,772.33.

[9] See paragraphs 12-15 below.

**No case submission**

12. It is in exceptional cases that a court in a civil case would permit a no case submission to be made. However it should do so only where the Defendant elects to call no evidence. In that instance there will be a final disposition of the matter on its merits based upon the totality of the Claimant's evidence. See **Benham Ltd v Kythira Investments Ltd** [2003] EWCA Civ 1794. In **Benham** Simon Brown LJ suggested that there is a manifest unfairness in making such a submission where the Claimant is "being deprived of the opportunity of making a weak case stronger by eliciting favourable evidence from the Defendants' witnesses." See also **Graham v Chorley BC** [2006] P.I.Q.R. p24. However the Defendants now having elected not to call any evidence, it is a straightforward issue of determining whether the Claimant has established her case on a balance of probabilities. See **Guide v Baird** CV2007-04059 and **Miller v Cawley** [2002] EWCA 1100.

13. Simon Brown L.J. in **Benham** gave clear guidance on this:

> "Let me state my central conclusion as emphatically as I can. Rarely, if ever, should a judge trying a civil action without a jury entertain a submission of no case to answer. That clearly was the court's conclusion in **Alexander v Rayson** [1935] All ER 185 and I see no reason to take a different view today, the CPR notwithstanding. Almost without exception the dangers and difficulties involved will outweigh any supposed advantages … Any temptation to entertain a submission should almost invariably be resisted. The Judge in putting the Defendants to an election should ask "Have the claimants advanced a *prima facie* case, a case to answer, a scintilla of evidence, to support the inference for which they contend, sufficient to call for an explanation from the defendants? That it may be a weak case and unlikely to succeed unless assisted, rather than contradicted, by the defendant's evidence, or by adverse inferences to be drawn from the defendant's not calling any evidence, would not allow it to be dismissed on a no case submission."

13. See also **Youssef v Jordan** [2003] WL 23014828 where in a medical negligence claim a no case submission had failed on appeal and remitted to the judge to properly analyse the expert reports.

14. Senior Counsel for the Claimant had objected to this Court entertaining this no case submission, obviously with the warning of Simon Brown LJ in mind, that such a submission robs the Claimant of making his/her case stronger by the cross examination of the Defendants' witnesses. Specifically it was submitted that the CPR may prohibit the making of no case submissions in civil proceedings. Reference was made to CPR r 29.9 (2) which provides that a party who has served witness statements and does not intend to call that witness at the trial must give notice to that effect to the other parties no less than 21days before the trial. On the face of that rule it would appear that considerations of whether a Defendant would make a no case submission should be made at an earlier stage than in the middle of a trial. Perhaps it can be made at the Pre Trial Review after the exchange of witness statements. Certainly such a rule advances the salutary philosophy of the cards "face up" on the table approach in civil litigation which underlies the philosophy of the CPR. However what such a construction may unwittingly do, is constrain Defendants to undergo the expense and delay of a trial for much longer than necessary, when only after cross examination of the Claimant's witnesses it becomes obvious that there really is no case to answer. That result could not be said to accord with the principle of proportionality which is the active ingredient in the Overriding Objective.

15. I preferred to interpret CPR rule 29.9(2) in the context of the realities of civil litigation and had rejected the Claimant's submission for the following reasons: The Defendant has a right to make a no case submission fundamental to protect it from unmeritorious claims. A decision can often times not be made in advance of the cross examination of the Claimant's witnesses. For the Defendant to be put to election represents an efficient and effective management of the trial. Permitting a no case submission to be made without complying with r 29.9 (2) CPR may be restricted to a useful case management tool in preparing for a trial rather than debarring outright the making of a no case submission.[10]

**Adverse inferences**

16. Going hand in hand with a submission of no case to answer is the issue of whether adverse inferences can be made against a Defendant for failing to lead evidence which may bolster a

[10] See page 36 of Day 3 of Transcript.

weak case of the Claimant. This was the view of Simon Brown LJ in **Bentham** and is explained in the judgment of Brooke LJ in **Wisniewski (A Minor) v Central Manchester Health Authority** [1998] EWCA Civ 596: a claim also in medical negligence. In that case a baby boy suffered irreversible damage to his brain in the 13 minutes immediately prior to his birth at 5:40a.m because the umbilical cord was wrapped around his neck and had a knot in it as he moved down the birth canal. The judge had held that if the mother's care, who was admitted to hospital three hours earlier, had not been negligently mismanaged a doctor would have carried out a procedure known as artificial rupture of the membranes (ARM) shortly after 3:40a.m and this could have disclosed the presence of a substance called meconium and led to birth by caesarean section obviating the hazards of birth down the birth canal. The resident senior house officer who treated the mother declined to give evidence even though a written statement was tendered from him. The trial judge inferred from his absence that he would have proceeded to do the ARM and then performed a caesarean. The Court of Appeal upheld this reasoning and in reviewing a line of authority which shows that if a party does not call a witness who is not known to be unavailable and/or who has no good reason for not attending and if the other side has adduced some evidence on a relevant matter, then in the absence of that witness a judge is entitled to draw inferences adverse to that party and to find the matter proved.

17. The following principles were enunciated by Brown LJ in **Wisniewski**:

> "(1) In certain circumstances a court may be entitled to draw adverse inferences from the absence or silence of a witness who might be expected to have material evidence to give on an issue in an action.
>
> (2) If a court is willing to draw such inferences, they may go to strengthen the evidence adduced on that issue by the other party who might reasonably have been expected to call the witness.
>
> (3) There must, however, have been some evidence, however weak, adduced by the former on the matter in question before the court is entitled to draw the desired inference: in other words, there must be a case to answer on that issue.
>
> (4) If the reason for the witness's absence or silence satisfies the court, then no such adverse inference may be drawn. If, on the other hand, there is some credible

explanation given, even if it is not wholly satisfactory, the potentially detrimental effect of his/her absence or silence may be reduced or nullified."

18. In **Chapman v Copeland** (1966) 110 S.J. 569 in considering a no case submission as well Salmon LJ said that "...there was no obligation of the defendant at the end of the claimant's case to give evidence". However "if he chose not to do so he could not complain if on a very narrow balance of probability the evidence justified the court in drawing the inference of negligence against him." Indeed if the Defendants in this case elect to call no evidence and deprive this Court of positive evidence on matters such as whether blood products were adequately stored, or the transfusions were properly managed, or the post surgical bleeding was adequately monitored and regulated, the Defendants cannot complain if the Court draws from the facts which have been disclosed all reasonable inferences as to the facts which the Defendants have chosen to withhold. See **Herrington v British Railways Board** [1972] A.C. 877 per Lord Diplock. In this way a scintilla of evidence tending to support an inference may turn out in the absence of contrary evidence because the Defendants chose not to call any witnesses to sufficiently establish the Claimant's claim.

**Basic medical facts**

19. As a starting point in analysing this claim, I think it is useful to set out a brief overview of some of the medical terminology and medical facts in this case. Indeed in the management of this case I granted permission to the parties to adduce expert evidence as it was obvious that there were basic medical terminology, procedures and human physiology which were matters of science beyond the experience of this Court. I am however mindful of the foundational rule on expert evidence:

"An expert's opinion is admissible to furnish the court with scientific information which is likely to be outside the experience and knowledge of a judge or jury. If on the proven fact a judge or jury can form their own conclusions without help then the opinion of an expert is unnecessary. In such a case if it's given dressed up in scientific jargon it may make judgment more difficult. The fact that an expert witness has impressive scientific qualifications does not by that fact alone make his opinion on matters of human nature and behaviour within the limits of normality any more helpful than that of the jurors

themselves but there is a danger that they may think it does." per Lord Mansfield **Folkes v Chadd** [1783] 3 Doug KB 340.

20. The critical factual issue in this claim is the handling and management of Mr. Tesheira's post operative bleeding. It was a risk that has been admitted by the Defendants as a standard risk of TURP procedures. TURP is a surgical procedure which carries with it a known risk of significant post-operative bleeding. For this reason a responsible team of medical professionals should anticipate post operative bleeding and plan for it. Some complications that can arise from excessive post-operative bleeding are hypovolemic shock, DIC and in treating these symptoms there is a risk of TURP syndrome.[11] I refer to these events as the trilogy of factors which is onset by improper management of excessive bleeding.

21. At times the cross examination of the experts in the case descended in areas of fact and law of which this Court is the sole arbiter. However in the area of medical science understanding the basic physiology of blood as it is described by Dr. Jones-Lecointe and Dr. Pitt-Miller in the unchallenged evidence in their respective medical reports and witness statements would assist in analysing the actions and omissions of the Defendants and underscore the steps that the experts recommended should have been observed in this case.

22. The constituent elements of blood comprise blood plasma (55%), red blood cells (approximately (44%) and white blood cells (less than (1%). Blood plasma is the yellow liquid component, in which the blood cells in the whole blood are suspended and contains, amongst other things, dissolved proteins and clotting factors. Blood serum is the blood plasma without the clotting factors, that is to say, the whole blood without the blood cells and the clotting factors. It is this clotting ability of the blood which will feature predominantly in this case.

23. The primary function of red blood cells is to carry oxygen from the lungs to the tissues around the body, and the primary role of the white blood cells is to defend the body from

[11] See evidence in chief of Dr. Pitt-Miller and Dr. Jones-Lecointe

infectious diseases and foreign bodies. The function of blood platelets is to achieve haemostasis in conjunction with the clotting factors in the blood. Haemostasis is described as the arrest of bleeding through normal rapid formation of a plug at the site of the vascular injury. There are two mechanisms in the blood which together achieve haemostasis, the first system known as primary haemostasis involves the adhesion and aggregation of blood platelets at the site of the wound/vascular injury to form a soft plug. The second system, known as secondary haemostasis, involves the activation of certain soluble proteins in the blood to form a solid mesh which traps the blood platelets. Drugs may affect the ability of the blood to clot. One such drug is aspirin and it is a drug which is recommended should have been noted prior to a surgical procedure. The experts corroborate one another that post operative bleeding can lead to hypovolemic shock which can lead to DIC and there is a risk of TURP syndrome or fluid overload.

Hypovolemic shock

24. Turning to each of the medical conditions in the sequence in which it developed leading to death, the first was hypovolemic shock. This is a condition in which the heart is unable to supply enough blood to the body due to blood loss or inadequate blood volume and has a number of clinical manifestations including changes to the patient's vital signs. Typically those vital signs are an increase in the pulse and respiratory rate and a decrease in the blood pressure. These changes may be subtle and difficult to detect when the patient enters into the first stages of hypovolemia. These changes may be especially difficult to detect where the patient like Mr. Tesheira has an athlete's heart. An athlete's heart is an enlarged heart of an athlete trained for endurance. It is characterized by a low heart rate, an increased pumping capacity, and a greater ability to deliver oxygen to skeletal muscles due to the greater pumping capacity of the heart. In those patients the pulse and blood pressure may be normal despite the substantial and dangerous loss of blood. Dr. Pitt-Miller would later explain in her cross examination this significance of an athlete's heart compensating for blood loss and masking the body's vital signs despite the dramatic loss of blood. Hypovolemic shock can cause DIC.

25. When a patient goes into hypovolemic shock due to blood loss the fluid of choice to be used to restore his/her circulatory volume is a combination of packed red cells and plasma. If packed red cells are not available a combination of fresh whole blood and plasma can also be used. Hypovolemia is a complication of TURP due to the use of cold irrigant solutions. The patient shivers to keep warm and becomes hypoxaemia. It is an early warning sign of hypovolemic shock.

Disseminated Intravascular Coagulation ("DIC")

26. DIC which is one of the causes of death in this case, is a syndrome in which uncontrolled clotting in the blood circulation is activated with the result that clotting factors (coagulation proteins) and platelets in the blood, both of which are vital in achieving haemostasis- the cessation of bleeding, were consumed. Hypothermia increases bleeding. This results in bleeding. In this condition blood platelets are not only reduced in number but their function is disordered. Among the many causes of DIC are hypovolemic shock, infection and incompatible transfusions. Where a patient develops DIC the condition is managed by transfusion of fresh whole blood to restore blood to the body lost through bleeding and blood products such as platelets, fresh frozen plasma and cryoprecipitate to replace the platelets and clotting factors consumed as a consequence of DIC. Whole blood transfusions are contra indicated because they contain no viable platelets.

27. Because of the nature of the case and the risk of excessive bleeding which actually occurred in this instance two important tests are routinely carried out to determine if a patient is developing DIC. CBC tests are Complete Blood Count tests. This will reveal the haemoglobin levels of the blood and platelets counts. As platelets perform a crucial role in haemostasis, low platelets counts would be a cause for concern about the bleeding complications that may arise with a patient.

28. Other important tests are PT (prothrombin time) PTT (partial prothrombin time) Tests. These are coagulation screening tests. As the name suggests this is a test done on the patient's blood to see how fast the blood coagulates or clots. This can detect blood clotting complications. The longer the patient's blood would take to clot above the normal control level which is

measured in seconds, reflects severe bleeding problems and it would be dangerous to perform surgery on a patient with high PT, PTT test results as it would involve a high risk of severe and uncontrollable bleeding.

TURP Syndrome/ fluid overload

29. In managing blood transfusions one must exercise care as there is a foreseeable risk that where too much fluid is pumped into the body a patient can develop fluid overload or TURP syndrome. This results from the absorption of large amounts of irrigants used during the TURP Procedure resulting in amongst other things fluid or circulatory overload. Fluid overload refers to a condition where there is too much fluid in the blood than the heart can effectively cope with as a result of the infusion of too much fluid or the infusions of fluid too fast. A fit person can usually deal with excessive fluid administration up to a pint however compensation for fluid overload is difficult or impossible for a patient with cardiac impairment. There is a 2% incidence of this syndrome which is associated with congestive heart failure pulmonary oedema hypertension and acute hyponatraemia. It is noted however that whereas the original TURP procedure which lasted more than 60 minutes carried the small risk of TURP syndrome the patient was further subjected to further surgical procedures for about 6 hours absorbing further fluids and products thereby increasing the risk of TURP syndrome. If left unaddressed fluid overload may lead to heart failure.

30. In this case what comes under sharp focus is the management and care of Mr. Tesheira by Gulf View and Dr. Roopchand in a procedure which carries the risk of post-operative bleeding and the failure to investigate and deal with a patient with high PTT rates, whose athlete's heart will mask the effects of blood loss, who went into a domino spiral of hypovolemic shock which led to DIC and in managing the post operative procedures to fluid overload eventually leading to death[12].

[12] See Dr. Pitt Miller paragraph 42 "Prior to the performance of the April 2004 TURP procedure the Medical Centre failed to identify or ignored indicators that the Deceased may have had bleeding tendency. After the April 2009 TURP procedure the deceased experienced post operative bleeding and was allowed to bleed to such an extent that he developed hypovolemic shock, a condition in which as a result of loss of blood or blood volume there is insufficient fluid in the body. In an attempt to treat that condition the Medical Centre poured a massive volume of

**A case synopsis**

31. With this medical background, the factual synopsis of the pre and post TURP treatment of Mr. Tesheira can be better appreciated. At the trial five witnesses gave evidence for the Claimant Mrs. Tesheira herself, two expert witnesses on liability haematologist Dr. Altheia Jones-Lecointe and anaesthetist Dr. Phyllis Pitt-Miller. There were two witnesses on damages Mrs. Margaret Chow and Mrs. Carolyn John. The Defendant elected not to call any evidence however they had filed their own witness statements. A subpoena which was issued by Gulf View for Dr. Goetz was abandoned at the Pre Trial Review.

32. The context of this medical negligence claim can be gleaned from the Claimant's statements of facts, the admissions of the Defendants in their pleadings, the witness statements and cross examination of the Claimant's expert witnesses. To a significant extent the scientific expertise and testimony of the experts were unchallenged as will be discussed later in this judgment. The documentary evidence tendered into evidence through the Claimant's witnesses on liability comprised the medical records of its treatment of Mr. Tesheira which his wife obtained from Gulf View.

33. Mr. Russell Tesheira was 53 years of age[13] when he died at Gulf View on 13th April 2004. He was the Vice President, Sales and Agencies and Administration of CLICO. He supported his wife Mrs. Karen Tesheira and their daughter Nicola and his daughter Coryse. He was described by his wife as a hard worker, active in sports such as football and exercised a lot. His doctor had given him advice to cut back on his smoking and drinking. However if there was any imminent health problems at that time, quite apart from that advice, was an early onset of coronary disease and that he was suffering from urinary blockage as a result of an overly enlarged prostate. The prostrate was approximately 60cc at the time of his surgery. It is this condition which affected his lifestyle the most and he sought treatment.

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fluid into the Deceased's body within a relatively short period of time, in an uncontrolled manner, and without regard for the risk of fluid overload. As a consequence the Deceased developed fluid overload, a condition in which there is too much fluid in the blood, and succumbed to same."

[13] He was born on 24th March 1951

34. Sometime in 1997 Mr. Tesheira began treatment for his enlarged prostate by Dr. Gregory Chen. Then from 2002 to 2004 he was treated by Dr. Goetz when the decision was made to undergo the TURP at Gulf View.

35. On 3rd February 2004 Mr Tesheira was admitted to Gulf View to perform the TURP. The attending physicians were Dr. Goetz and Dr. Roopchand. However the procedure was aborted due to the abnormal readings obtained from Mr. Tesheira's ECG performed by Dr. Roopchand. Mrs. Tesheira and Dr. Pitt-Miller would later say under cross examination that Dr. Roopchand acted quite properly in aborting the TURP at that time. There is no reported discussion however about Mr. Tesheira's aspirin or drug use by Dr. Roopchand and there is no repeat of his ECG when he later returned to do the TURP on 13th April 2004.

36. Mr. Tesheira was then referred to Dr. Ronald Henry (Cardiologist). By letter dated 15th March 2004 Dr. Henry advised Dr. Goetz that Mr. Tesheira was fit for general anaesthesia and that he had an athlete's heart. In his letter Dr Henry stated:

> "The above named patient has an abnormal ECG pattern, which is on the basis of athlete's heart. He has an exaggerated form of physiologic hypertrophy of the left ventricle due to his life long athletic conditioning.
>
> He does however also have early coronary disease with a 40 to 50% stenosis in the right coronary artery, which is currently asymptotic. He had previously defaulted from follow up, but is now on Crestor 10mg per day, long term and is fit for general anesthesia without special precaution. He maybe considered a standard risk."

37. This of course is no blanket authorization to conduct TURP on the patient but from a cardiologist's point of view he was a standard risk. Whether the Defendant ought properly to deal with the risk of post operative bleeding with a patient with an athlete's heart and early coronary disease is a matter for those who were entrusted with conducting the TURP - the Defendants and Dr. Goetz.

38. On 13th April 2004 Mr. Tesheira was admitted to Gulf View for the TURP at 9:30a.m. On that day there is no record of the intake of the patient nor interview by Dr. Roopchand to determine his fitness for surgery or whether there is any drug use that may impede the clotting ability of the blood. The surgery was performed by Dr. Goetz and Dr. Roopchand as the anaesthetist with the attending staff of Gulf View. The TURP was completed at 1:10p.m and he was wheeled back to his room for recovery. The critical window in this case is between 1:10p.m and 11:30p.m.

39. I should mention at this stage that there is no evidence as to the nature of the contractual relationship between the patient and Dr. Roopchand or between Gulf View and Dr. Roopchand for that matter. Mr. Tesheira in fact signed consent forms which were on the letter head of Gulf View. The lab reports, the fluid sheets, the progress notes of the doctors and the nurses were all filled in under the letter head of Gulf View. Dr. Goetz has as his place of business listed on his referral letter as both Gulf View and Medical Associates. Mrs. Tesheira in her evidence refers to the fact that Mr. Tesheira attended Gulf View to undergo the surgical procedures.[14] It is there that Dr. Roopchand appeared first in February 2004 and then in April 2004. I would think that if the Defendants were to make a proper case that Dr. Roopchand was an independent contractor and that Gulf View was in no way liable for his actions such a pleading would have been clearly stated or the evidence to that effect led. Simply to rely on an opinion by the experts in this case elicited hypothetically in cross examination about the contractual relationship between Gulf View and their specialists invites this Court to speculate on a critical feature of the Defendants relationship with one another. There is simply no such evidence forthcoming from them and from the simple evidence of Mrs Tesheira her husband attended Gulf View to undertake the TURP with his doctor Dr. Goetz.

40. At 1:10p.m this is what is recorded in the Nurses progress notes:

> "Returned to ward has fast irrigation in progress & IVI Dextrose Saline with 700mls in bag, Dressing site to penis is slightly blood stained U/Cath is draining blood stained urine-C.

[14] See paragraphs 3 and 10 of her evidence in chief.

Mitchell V/S P-80 R-24 B/P 110/80”

41. There is no notation on the progress of Mr. Tesheira or as to the condition of his bleeding until 1 hour and 40 minutes later.

42. This is what is recorded at 2:50p.m on the nurses’ progress notes.

    “Output draining heavily blood stained. Nr in charge informed for manual irrigation. Manual Irrigation was done. Output draining blood stained in colour. ”

43. Mrs. Tesheira in her cross examination stated that she observed blood (pink fluid) in her husband’s urine from the time he had returned to the ward. She noted that there were no nurses in the room during the time to monitor this blood loss save for a Ms. Campbell who looked like a junior attendant. Mr. Tesheira was hooked onto monitors which automatically recorded his vital signs but not his pulse or temperature. The experts advise that such monitoring would mask the actual internal workings of the body that was dealing with blood loss. For an hour while Mr. Tesheira was recovering in a private room at the ward after the surgery in the company of his wife, blood continued to flow through tubes that were connected to his affected area draining into a bucket at the foot of his bed. There is no charting by the nurses of the loss of blood.

44. Mrs. Tesheira had noted when her husband had arrived that he was shaking violently but was told by the staff that this was normal as the operating theatre was very cold. He then asked for something to drink. He was later offered a cup of milo. There was a bag taking fluid to the groin and the transparent tube at the groin leading to a bucket which took pink fluid. This would be explained by the specialists as the irrigants and the blood loss as a consequence of the surgery. Mrs. Tesheira observed the continuous flow of the pink fluid and the changing of the bags several times although she does not say how many times. Three quarters of the content in the bucket was thrown out in the toilet and then the nurse returned it to its position. There was no charting of the blood loss or an average taken based on the fluids. After more than an hour that the bleeding continued, then she observed semi solid particles in the blood

flow. She said the head nurse appeared and looked extremely concerned. Dr. Roopchand also came in to see Mr. Tesheira.

45. In the notes there is a notation "blood heavy" at 2:50p.m and manual irrigation was done by the nurses. They did not seek the assistance of Dr. Roopchand or Dr. Goetz. The experts would say that this was a critical failure by the nursing staff. Indeed it is not known what instructions were given to them. Presumably as the Defendants have elected to give no evidence, if no instructions were given why would the nurses elect to manually irrigate rather than escalate this to the attention of Dr. Goetz and Dr. Roopchand. Dr. Goetz's post operative instructions were (1) fast irrigation (2) histology (3) clear fluid orally and later soft diet (4) sit out in a chair later. There are no post operative instructions from Dr. Roopchand. If in fact Dr. Goetz's post operative instructions were "clear fluids orally" why would the nurse give Mr. Tesheira milo (not a clear fluid). It is either there was no instructions given or they failed to comply.

46. It was a full 20 minutes later at 3:10p.m when it is recorded that Dr. Goetz was informed in OT and Dr. Roopchand came to see the patient.

47. There is no explanation why the nurses acted at 3:10p.m and not earlier at 2:50p.m or even earlier than that. It is more probable based on this evidence that the nursing staff were not monitoring Mr. Tesheira's blood loss at all or that they were not doing so properly or at the very least very causal about it. A full two hours after the patient was bleeding, at 3:10p.m Dr. Roopchand arrived to see the patient but the blood continued to flow. "He observed the irrigating was still heavily blood stained then reported to Dr Goetz".

48. It is not disclosed how long it took Dr. Roopchand to communicate this to Dr Goetz. What we do know from the time lapse again is that Dr. Roopchand did not treat with this urgently. A full 20 minutes again elapsed before Dr. Goetz appeared on the scene. It is more probable than not that this lapse in time is suggestive that the bleeding was not being taken seriously by either Dr Roopchand as was the nurses earlier.

49. According to Mrs. Tesheira when Dr. Goetz arrived he announced he would try to stop the bleeding manually. Mr. Tesheira groaned and fell back into the bed. His last words to his wife were "Karen take my glasses I feel like I am passing out". In denial and fear she went to the adjoining bathroom where she heard her husband making grunting sounds she saw him lying on the bed and the nurse telling her to leave right away. Dr. Roopchand and Dr. Goetz rushed him back into the operating theatre and prepared him again for further procedures to arrest the bleeding. It may well have been at that time too little too late. Little did Mrs. Tesheira know that it would be the last time she would see her husband alive.

50. At 4:30p.m the deceased was transfused for the first time with blood and thereafter received 11 units of whole blood, 3 units of A positive, 3 units of Group O positive whole blood, 2 units of fresh frozen plasma and 3 units of cryoprecipitate. The deceased's blood group was A positive. CBC and PTT tests were conducted all indicating that the deceased's blood had developed problems in coagulation and he developed DIC.

51. A worried Mrs. Tesheira was taken to the entrance area of the operating theatre by one of the nurses when Dr. Goetz came out and asked if her husband was taking aspirin. She assumed so and he answered "well that is the problem that is why Russell is bleeding".

52. Blood products were requested for transfusion and there were requests from the National Blood Bank as well as of the wife and relatives for blood. Two further operations were conducted that evening. A cystoscopy and diathermy of the prostatic bed was performed but this did not result in any clotting of the blood. Later a repeat cystoscopy and diathermy was performed and the prostatic bed was packed via a Pfannenstiel approach the dorsal venous plexus was also ligated. Dr. Roopchand had to be relieved by another anaesthetist Dr. Chatoorgoon. In total about 11 pints of fluid were transfused into his body at regular intervals. In 6 ½ hours from 3:30p.m to 10:00p.m he was transfused with 3 units of haemaccel, 3 litres of Lacatated Ringers 11 units of whole blood, 2 units of FFp, 3 units of cryoprecipitate. It was described by the experts as a massive transfusion amounting to more than twice the average volume of blood in the human body. After the second procedure it is

recorded that the bleeding abated but within an hour of the closure of the incision Mr. Tesheira's heart stopped beating.

53. At 11:40p.m it was recorded "Pupils were fixed and dilated. No central pulses. No cardiac sounds. No bleedings at site". Mr Tesheira died during anaesthesia while receiving his last unit of blood.

54. Mr. Tesheira's post mortem was performed by Professor Daisley. Dr. Goetz in his medical notes noted that "in view of the prolonged PT and PTT we suspected that he developed DIC from the massive blood transfusion and may have had irreversible shock". Professor Daisley recorded the cause of death as irreversible shock with DIC.

The Doctors/Nurses notes

55. The available records of this event when Dr. Goetz appeared to review Mr. Tesheira are from the nurses' notes and the doctors' notes. At 3:30p.m the nurses notes record the following:

**"Patient was seen by Dr. Goetz Appears to be quite comfortable.**
**BP 110/80**
**Bladder irrigation commence manually by Dr. L. Goetz**
**Patient then c/o feeling nauseated vomit small amount, skin cold and clammy, $O_2$ commence and. Dr. Roopchand was informed came immediately. Dr. Goetz then canulated patient on Rt Hand - Haemaccel commenced & IVI in progress N/S on the Left hand.**
**Patient was then taken to O.T immediately. Nr. Khan**
**Blood was requested for transfusion same was given in O.T.**
**Nr. Khan"**

This was described by Dr. Jones-Lecointe as quite possibly all happening at the same time. If that is so it indicates that a clear emergency had occurred at 3:30p.m. This was not explored in cross examination of Mrs. Tesheira but it seems to be an immediate event when bladder irrigation commenced.

56. Dr. Goetz's notes were very scant with regard to the times of events but his record shows the following:

**"PROGRESS SHEET DOCTORS**

**Russell Tesheira male 53 years**

**13/4/04 Post op**

**Patient in bed lying down and chatting in no distress**
**Output heavily blood stained**
**He felt nauseated and vomited**
**He was Immediately Returned to Main Theatre $O_2$ via face mask**
**2 wide bore I.V lines started Haemaccel and N/S**
**Crossed matched blood given.**

**His wife indicated that he takes aspirin up to the day before i.e. (12/04/04)**
**Discussed his problem with his wife's brother who is a doctor in USA he suggested AMICAR Irrigation (not available).**

**I spoke to Dr. Ramesh Mathura (Hematologist)**
**He advised on Fresh blood**
**Fresh frozen plasma**
**Cryoprecipitate**
**This was immediately organized**
**His PT and PTT were prolonged x 2**

**Dr. Carlyle Lalla was consulted (Specialist Physician) He recommended LFT's and cardiac enzymes -these were normal. A repeat Hb was 10.4g/dl**

**Operation #2 : Cystoscopy and Diathermy of the prostatic bed. General slight ooze.**
**No clots.**

**His urine appeared clearer at the time of receiving the FFP.**

**However the bleeding soon recurred while under anaesthesia**
**Dr. Chatoorgoon was asked to assist (consultant anaesthetist). He came and was able to maintain the BP and Pulse @ a stable level with blood transfusion.**
**Dr. Rampaul (consultant) was asked to assist which he did.**

**3rd operation : A repeat cystoscopy and Diathermy was performed and the prostatic bed was packed via a Pfannenesteil approach, the dorsal venous plexus was also ligate.**
**Dr. Rampual assisted.**
**The bleeding abated**

**During closure of the incision the patient died under general anaesthesia at 11:30p.m.**
**In view of the prolonged Pt, PTT we suspected that he developed a DIC from the massive blood transfusion (12 ½ units of blood including 4 units of fresh blood) and may have had irreversible shock.**

**Relatives informed and**
**Prof. H. Daisley agreed to perform the post mortem.**

**Signed: Dr. Lester Goetz"**

57. Dr. Roopchand's notes were also brief but reveal the following:

**"PROGRESS SHEET DOCTORS**
**Russell Tesheira, male 53years**
**13th April 2004.**

**Hb 10.4**

**10cc 10% Ca Gluconate then 7.30pm- 1 Amp then 9.00pm- 5cc**

**Gentamycin 80mg**

**Spectral Cardiac Test negative at 15 min**

**Morphine 10:00pm-3mg; 10:30pm-5mg; 11:00pm-5mg**

**Lasix 7:30pm-40mg; 8:30pm-40mg; 9:00pm-80mg; 9:30pm-80mg; 10:00pm, 80mg; 11:00pm-80mg**

**Nimbex 1 Amp then 6.30 1 amp then 8.30 1 amp**

**Hypnovel 2mg**

**Alfentanyl 2cc**

**1 Unit Haemaccel** **2nd Unit Haemaccel**

**1st Lit Ringers**

**2nd Lit Ringers**

**3rd Lit Ringers**

**Vit K 30mg & 20mg**

**3rd Unit Haemaccel**

**4.30 1 Unit Whole Blood**

**5.00 2nd Unit Whole A+**

**5.30 3rd Unit Whole Blood**

**5.40 4th Unit Whole Blood O+**

**7.30 pm 5th Unit O+** **4th lit Ringers not given**

**7.45p.m 6th Unit O** **8.00 7th Unit Fresh Whole Blood**

**2 Units A+ FFP** **8.30 8th Unit Fresh W B**

**3 Units Cryoppt** **9.00 9th Unit Fresh W B**

**Ca Gluconate 2nd Amp** **9.30 10th Fresh WB**

**10.00 11th Unit Fresh WB**

**Assisted by Dr. A. Chatoorgoon, Dr. C.Lalla, Dr. D. Ali**

**Monitors R hand & L hand Pulse O x S x 2**

**NIBPM R Arm E+$CO_2$ PNS**

**ECG**

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**11.30 END RESUSCITATION Frank Pulmonary Oedema**

**Unremitting -**

**Reverse trend - Manual 1 PPV**

**100% O+ - 50cc 80% NaBicarb (50meQ) Atropine 2mg**

**1 CC +3CC Adrenaline 1:1000**

**Sudden agonal unresponsive cardiac slowing + widening of QRS**

**11.40 Pupils Fixed and Dilated**

**No Central pulses**

**No cardiac sounds**

**No bleeding at any site - Pt. Deceased**

**Signature: Dr. Crisen J. Roopchand"**

58. From this record the experts testify that at 3:50p.m he suffered from this hypovolemic shock from this continuous loss of blood.

PTT/PTT Tests

59. At 3:30p.m PTT tests were carried out. The test results were as follows:

"Gulf View Medical Centre

Laboratory Report

| | |
|---|---|
| Name: Russell Tesheira | Date: 13/04/04 |
| Age: Sex: | Lab#: 4481/03 |
| Address: G.V.M.C. | Doctor: Dr. Goetz |

Test Requested: PT, PTT, INR

Checked by:

Typed by: Susana

_____

_

| | | |
|---|---|---|
| PT | : | 22 seconds |
| Normal Plasma | : | 13 seconds |
| Normal Control | : | 11 - 16 seconds |

| | | |
|---|---|---|
| PTT | : | 55 seconds |
| Normal Plasma | : | 30 seconds |
| Normal Control | : | 25 - 35 seconds |
| INR | : | 3.62 |

**********

"Gulf View Medical Centre
Laboratory Report

Name: Russell Tesheira Date: 23/03/04
Age: Sex: M Lab#: 4476/03
Address: G.V.M.C. Doctor: Dr. Roopchand

Test Requested: PT, PTT, INR
Checked by:
Typed by: Susana

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| | | |
|---|---|---|
| PT | : | 24 seconds |
| Normal Plasma | : | 13 seconds |
| Normal Control | : | 11 - 16 seconds |

| | | |
|---|---|---|
| PTT | : | 50 seconds |
| Normal Plasma | : | 30 seconds |
| Normal Control | : | 25 - 35 seconds |

INR : 3.95

60. From these records the following conclusions can be drawn:

(a) Dr. Roopchand did not review Mr. Tesheira until about two hours after his operation. He took 20 minutes to get Dr. Goetz to review the patient. He himself did not return and had to be called by Dr. Goetz to treat with the obvious emergency.

(b) Dr. Roopchand assumed responsibility for the care of Mr. Tesheira from 3:30p.m onwards together with Dr. Goetz.

(c) The wrong blood product was given to treat hypovolemic shock at 4:00p.m and it is only later in the night at 8:00p.m was he treated with the correct product which would have had the clotting agents. By that time the CBC results would have shown that the patient had developed DIC and clearly the attempt to prevent DIC from occurring through blood loss had by that time failed.

(d) The PT/PTT tests showed problems in coagulation. The results were way over the normal range and one is left to wonder why such a simple test would not have been done pre operatively. A haematologist was never part of the team prior to surgery to advise on post surgical care and preparing for the risk of post operative bleeding.

(e) The treatment of DIC now required careful planning and management of fluid transfusions as there was a foreseeable risk of fluid overload.

(f) There clearly was not enough of the correct blood type product on site at the hospital to deal with this emergency. One which was a foreseeable risk of the TURP surgery.

(g) The fluid of choice of fresh whole blood was only administered at 8:00p.m after receiving by that time over 6 pints of the wrong blood to deal with hypovolemic shock and when he had already developed DIC.

(h) It is uncertain from this record whether Gulf View did have the blood on site or whether Dr. Roopchand who was managing the fluids and transmissions did make the request in a timely manner. The experts suggest that this failure to administer the correct product is a strong indicator that the products were not on site. Gulf View simply had failed to make arrangements to get it from an external source.

(i) While Dr. Goetz is performing further surgical procedures and it is noted that at the last surgical procedure the bleeding finally abated, the transmission of fluids was

haphazard and poorly organised. This is contrary to what was suggested in cross examination that Mr. Tesheira bled to death or that it would not matter if all the blood in the Caribbean was available if he was bleeding continuously he still would have died.[15] It is also highly probable based on this record that even if Dr. Goetz was successful in arresting the bleeding the body was already injured by the mismanaged transfusion of fluids. His death as recorded as DIC and shock is strongly suggestive of this.

(j) Dr. Goetz concedes their suspicion that his death was caused by DIC and irreversible shock caused by the massive blood transfusion.

61. Dr. Pitt-Miller in her evidence demonstrated that there were tell tale signs of fluid overload:

"(a) Effusions

(i) pleural Right 1 litre, Left 600mls

(ii) oedema of the ankle

(b) Congestions

(i) Chronic passive venous of liver

(ii) Lungs

(iii) Spleen

(c) Biventricluar dilation

Mitral valve 115mm, Tricuspid valve 135mm.

Strongly indicated that the Deceased experienced fluid overload as a result of the fluids administered to him after the April 2004 TURP procedure and that such fluid overload was the direct cause of his death."

62. It is against this factual synopsis that the allegations of negligence have been made against Gulf View and Dr. Roopchand. From an analysis of the pleadings and the evidence the issues of duty, breach and causation have been satisfactorily established by Mrs. Tesheira.

[15] Approved Transcript Day 2 (9-Dec-14) line 69

**The pleadings of negligence**

63. The Defendants in their no case submission seem to misconstrue their own pleadings or were trying to construct a defence which simply was not evident on the pleadings. It is noted that there was a last ditch effort by Gulf View on the morning of the trial to re amend its Defence. Among other things it was being alleged for the first time that the Defendants owed separate duties of care and that it was not responsible for the actions of Dr. Roopchand. The application was withdrawn by Queens Counsel for Gulf View recognising that it was doomed to fail to cross the first threshold of promptness in CPR Part 20.3 (as amended).

64. However Gulf View has persisted in its closing submissions to insist that there is no duty of care on Gulf View in relation to their nursing staff. Similarly Counsel for Dr. Roopchand took the cue from Queens Counsel to assert that his duty was restricted to only that of administering anaesthesia. There is of course no quarrel with Dr. Roopchand in his administration of anaesthesia; this is not a "death by anaesthesia case". But these submissions have certainly contradicted their pleadings.

65. The pleadings form the super structure of this claim in medical negligence. The purpose of pleadings is "to mark out the parameters of the case that is being advanced by each party and to identify the issues and the extent of the dispute between the parties" **McPhilemy v Times Newspapers** [1999] EWCA Civ 1464 [16]. Apart from the basic chronology reflected in the case synopsis it is important to note that based on the pleadings (a) the Defendants both admitted it owed a specific duty of care to Mr. Tesheira (b) Dr. Roopchand admitted that his duty went beyond simply administering anaesthesia and indeed such was impliedly admitted by Counsel from some of his questions in his cross examination of Dr. Jones-Lecointe. For example aborting a TURP based on an irregular ECG pattern has nothing to do with administering anaesthesia. (c) There are alleged specific breaches against Gulf View and Dr. Roopchand when at the same time it is also pleaded that the Defendants worked as a team.

[16] See also**MI5 Investigations Ltd v Centurion Ltd** CA Civ 244/2008; PC 33/09 **Charmaine Bernard v Seebalack** at para 15, CA 238/11 **Real Time Systems Ltd v Renraw**

The pleaded duty of care

66. The Defendants admitted in their amended defence, the pleaded duty of care set out in paragraphs 6 and 7 of the amended Statement of Case that:

    a. Gulf View was under a duty:

        (i) to ensure that all staff, visiting consultants and specialists, including Dr. Roopchand and Dr. Goetz, and its attending nurses, involved in the provision of medical treatment at the Medical Centre, whether employees of Gulf View or not, were sufficient in number, properly qualified and reasonably competent so to do and

        (ii) to provide adequate and proper equipment, material and facilities so as to enable the safe and reliable delivery of medical care to persons attending Gulf View for medical and/or treatment;

        (iii) to maintain and have accessible for reference by medical professionals medical records of persons admitted to the use of its facilities, including the deceased.

    And that:

    > "At all material times, the Dr. Roopchand and Gulf View were under a duty individually and/or collaboratively to use diligence, care, knowledge, skill and caution in administering treatment to persons under their care, including the deceased."

67. Further in reference to paragraph 23 of the amended Statement of Case, the Defendants admit by paragraph 14 of the amended defence that they were all under a duty in performing the TURP procedure to ensure that during and after the performance of the procedure:

    a. Any bleeding of the deceased was carefully monitored and/or properly contained and/or otherwise so managed as to protect the deceased from excessive bleeding;

    b. There were sufficient materials equipment and personnel as to facilitate the safe transfusion of large quantities of blood and blood products to the deceased and;

    c. Such transfusions as may have been necessary were carefully managed and carried out using such equipment and practices as would minimise the risk of or

prevent the deceased experiencing fluid overload or other deleterious effect of same.

68. This represents a domino effect in this case of monitoring and containing excessive bleeding, having sufficient blood products and carefully managing such blood products to minimise the risk of fluid overload. One naturally leads into the other and both Defendants, Gulf View and Dr. Roopchand have admitted and accepted their responsibility in these roles.

69. Further in the further and better particulars Dr. Roopchand admitted that he administered the following fluids in the post TURP procedures (this went beyond simply anaesthesia):

> "Intravenous fluids, Calcium Gluconate, Lasix, Blood, Cryoprecipitate, Haemocel, Blood Extracts, Vitamin K and antibiotics. All treatment was prescribed by the two anaesthetists present, Dr. Chattergoon and the Third Named Defendant."[17]

70. The Defendants asserted the bleeding experienced by the deceased was a natural occurrence in that, in post TURP there was heavy bleeding. Having accepted that heavy bleeding is a standard risk the Defendants must accept that there are foreseeable risks of injury to a patient as a result of heavy bleeding, hypovolemic shock, DIC and TURP syndrome.

<u>The pleaded breach</u>

71. The pleaded particulars of negligence against Gulf View were as follows:

"PARTICULARS OF NEGLIGENCE OF THE FIRST DEFENDANT, ITS SERVANTS AND OR AGENTS

a. Failing to ensure that PT and PTT tests were conducted on the deceased immediately prior to the performance of the TURP procedure on the day of surgery;

[17] It corroborates Dr. Jones-Lecointe's view in cross examination that Dr. Roopchand based on the medical notes was part of the team that was responsible for Mr. Tesheira's care from 3:30p.m. See Day 2 of Transcript at page 110-112

b. Failing, in the persons of the Second and Third Defendants, to provide reasonably competent staff, and/or visiting consultants and/or specialists in the performance of the said procedure;

c. Permitting the said procedure to be performed by staff and/or visiting consultants and/or specialists, in the persons of the Second and Third Defendants, who were not reasonably competent in the performance thereof;

d. Failing, in the case of the Nurses, to provide reasonably competent staff to care for the deceased;

e. Failing, whether properly or at all, to, measure and/or monitor and/or make any assessment of an/or have any regard to and/or make any attempt to contain, the bleeding experienced by the deceased during the period from 1:10pm to 3:10pm on the day of surgery;

f. Failing to inform the Second Defendant and/or the Third Defendant soon enough after the completion of the TURP procedure, of the fact that the deceased was experiencing heavy and continuous bleeding;

g. Failing to monitor, whether properly or at all, the vital signs of the deceased during the period 1:10pm to 3:10pm on the day of surgery.

h. Failing to ensure and/or to take steps to ensure that the deceased's medical records, including the results of the deceased's INR readings, were brought to the attention of the Second and/or the Third Defendants prior to the said procedure;

i. Failing to ensure and/or take steps to ensure that deceased's medical records, including the results of the deceased's INR readings, were bought to the attention of the attending nurses prior to the procedure;

j. Failing to ensure and/or take steps to ensure among the Second and Third Defendants, and the head theatre nurse, proper communication in relation to the deceased's INR reading taken by the First Defendant on the 23rd day of March 2004.

k. Failing to maintain appropriate supplies of whole blood, blood platelets, fresh frozen plasma, cryoprecipitate and other clotting agents at the

Medical Centre, sufficient to meet the risk of the deceased experiencing excessive bleeding during and/or after the TURP procedure;

l. Failing to provide the equipment and personnel necessary to facilitate the safe transfusion of blood and blood products into the deceased during and after the TURP procedure;

m. Transfusing Group O-positive whole blood into the deceased and/or permitting and/or instructing same to be transfused into the deceased;

n. Failing to monitor and/or record the deceased's fluid output and to monitor and/or control the deceased's fluid balance during the transfusion of blood, blood products, and other fluids to the deceased after the completion of the TURP procedure, by CBC monitoring, use of a central venous pressure line, auscultation of the chest, testing of arterial blood gases, chest x-rays, or by any other means."

72. The pleaded particulars of negligence against Dr. Roopchand were as follows:

"PARTICULARS OF NEGLIGENCE OF THE THIRD DEFENDANT

a. Failing to request, consult or to have due or any regard to the medical records of the deceased including the deceased's INR readings obtained on the 23rd day of March or the 13th day of April 2004;

b. Failing to communicate adequately or at all with the First and Second Defendants in relation to the medical records of the deceased including the deceased's INR reading of the 23rd day of March 2004 and/or of the 13th day of April, 2004;

c. Permitting the First and/or Second Defendant to perform the TURP on the deceased when it was unsafe to do so;

d. Failing, during the period from 1:10pm to 3:10pm on the day of surgery, and whether properly or at all, to monitor, and/or have any proper regard to and/or make any proper assessment of the deceased's medical condition;

e. Failing, during the period from 1:10pm to 3:10pm on the day of surgery, to take any steps to contain and/or control the bleeding experienced by the deceased during that period;
f. Failing to act quickly enough in transfusing the relevant blood and blood products into the Deceased;
g. Administering and/or transfusing excessive amounts of blood and blood products to the deceased after and/or during the TURP procedure;
h. Transfusing Group O-positive whole blood into the deceased and/or permitting and/or instructing same to be transfused into the deceased;
i. Failing adequately or at all to monitor the deceased complete blood count ("CBC"), electrolytes, fluids status and cardio pulmonary status during and/or after the TURP procedure;
j. Failing to manage and/or monitor, whether properly or at all, the transfusion of blood, blood products, and other fluids to the deceased after the completion of the TURP procedure;
k. Failing to monitor and/or record the deceased's fluid output and to monitor and/or control the deceased's fluid balance during the transfusion of blood, blood products, and other fluids to the deceased after the completion of the TURP procedure, by CBC monitoring, use of a central venous pressure line, auscultation of the chest, testing of arterial blood gases, chest x-rays, or by any other means;
l. Failing to ensure adequate, proper, sufficient or any CBC monitoring, central line monitoring, arterial blood gases and chest X-ray monitoring in order the better to manage the deceased's cardio pulmonary and hemo dynamic status during the transfusion of blood, blood products and other fluids to the deceased;
m. Failing the ensure immediately prior to the performance of the TURP procedure that there were adequate supplies of blood, blood platelets, fresh frozen plasma, cryoprecipitate and other clotting agents at the Medical Centre;
n. Failing to ensure prior to the performance of the TURP procedure that there was available at the Medical Centre the equipment and personnel necessary to facilitate the safe transfusion of blood and blood products to the deceased during and after the TURP procedure;

o. Failing to administer direct platelet plasma and cryoprecipitate transfusions in a proper quantity during the TURP procedure;
p. Failing to take any or any adequate steps to prevent the deceased from succumbing to excessive bleeding."

73. Indeed the Defendants in their Defence asserted that Gulf View always maintained adequate blood supplies and was able to obtain additional supplies immediately from Mt. Hope Hospital and National Blood Bank. That they took all possible steps to stem the bleeding and obtained additional help from a consultant other than those at Gulf View in order to try to do so. That he was closely monitored by the nursing staff after the surgery.

74. The Defendants also pleaded contributory negligence but this has not been pursued in closing submissions. But importantly the Defendants asserted in their amended defence that Mr. Tesheira concealed from them that he was taking aspirin which was a thinner of the blood. It does point therefore to an acute awareness of the effect aspirin can have on the clotting ability of the blood and the dangerous effect it could have with respect to this surgery. This points to a question as to whether proper steps were taken to ascertain whether Mr. Tesheira was taking aspirin before conducting the TURP in the first place.[18]

75. Surely in light of these pleadings Dr. Roopchand's case was never limited to his role as an anaesthetist but accepted his duty in monitoring and managing the blood products for Mr. Tesheira. Similarly Gulf View has admitted its duty in obtaining, keeping adequate supplies of blood and managing the transfusion of blood products. It simply does not matter in this case what anaesthesia was administered or how aspects of his duties as an anaesthetist were carried out apart from these duties which he has admitted he executed. Having accepted those duties they must execute it in accordance with requisite standard of care and diligence accepted in their medical profession.

[18] See cross examination of Dr. Jones-Lecointe page 99 (Approved Transcript Day 2)

**The issues**

76. The issues for determination at this trial were filed by the Claimant. These were discussed at a pre-trial review and this Court determined that these issues conveniently set out all the issues arising from the pleaded case which require investigation. Notably absent from these issues (and for that matter any other statement of issues filed by any other party) was a dispute as to whether the Defendants owed any duty of care at all or whether there was a dispute about the nature of Gulf View's relationship with Dr. Roopchand or whether Dr. Roopchand's duty was limited only to his role in administration of anaesthesia. Indeed if this was the case Dr. Roopchand could have been relieved from this case a long time ago as there is no complaint made about him in the administration of anaesthesia it was all about the management of Mr. Tesheira where there is a risk of post-operative bleeding and what steps were not taken and what were taken which led to or triggered hypovolemic shock, DIC, TURP syndrome and death.

77. These issues are as follows:

"**A. Pre-operative Care**

1. **The screening issue / Tests**

(a) Did the Defendants or either of them conduct coagulation screening tests ("PT/PTT tests") on blood taken from the Deceased on 23rd March 2004 which indicated an INR of 3.95?

(b) If the answer to 1(a) is 'Yes', were the Defendants or either of them negligent in proceeding with the TURP procedure on 13th April 2004 without repeating the PT/PTT tests immediately prior to the TURP procedure for the purpose of ensuring that the ability of the Deceased's blood to clot at that time was such that it was safe to proceed with the TURP procedure.

(i) Did common medical practice require that in those circumstances such tests be repeated for that purpose just prior to the commencement of the TURP procedure?

(ii) In those circumstances would a competent anaesthetist/ hospital exercising ordinary skill have repeated those tests for that purpose at that time?

(c) If the answer to 1(b) is 'Yes', did such negligence cause the death of the Deceased?

(i) Would the death of the Deceased have occurred in the absence of such negligence?

(ii) Did such negligence materially contribute to the death of the Deceased?

2. (a) Assuming that no PT/PTT tests were carried out on blood taken from the Deceased prior to the TURP procedure, was the failure of the Defendants or either of them to carry out such tests on the day of and immediately prior to the TURP procedure negligent?

(i) Did common medical practice require that such tests be carried out at that time?

(ii) Would a competent anaesthetist/ hospital exercising ordinary skill have carried out those tests or required same to be carried out at that time?

(b) If the answer to 2(a) is 'Yes', did such negligence cause the death of the Deceased?

(i) Would the death of the Deceased have occurred in the absence of such negligence?

(ii) Did such negligence materially contribute to the death of the Deceased?

3. **The screening issue/ aspirin**

(a) Was the Deceased taking aspirin or any anticoagulant medication during a period prior and leading up to the TURP procedure?

(b) If the answer to 3(a) is 'Yes', were the Defendants or either of them negligent in failing to ask the Deceased just prior to the performance of the TURP

procedure whether he was taking aspirin or whether he was taking any anticoagulant medication?

(i) Did common medical practice require that such a question be asked of the Deceased at that time?

(ii) Would a competent anaesthetist/hospital exercising ordinary skill have asked that question at that time?

(c) If the answer to 2(b) is 'Yes', did such negligence cause the death of the Deceased?

(i) Would the death of the Deceased have occurred in the absence of such negligence?

(ii) Did such negligence materially contribute to the death of the Deceased?

4. **The blood products issue**

(a) Were the Defendants or either of them negligent in failing, prior to and during the performance of the TURP procedure, to take the appropriate steps to ensure that sufficient blood products would be available to be administered to the Deceased in the event of excessive bleeding during or after the performance of the TURP procedure?

(i) According to common medical practice what steps should the Defendants or either of them have taken to ensure that sufficient blood products were available to be administered to the Deceased in the event of excessive bleeding during or after the performance of the TURP procedure?

(ii) What steps would the competent anaesthetist/ hospital exercising ordinary skill have taken to ensure that sufficient blood products were available for that purpose?

(iii) What steps, if any, did the Defendants or either of them in fact take prior to and during the TURP procedure to ensure that sufficient blood products were available to be administered to the Deceased in the event of

excessive bleeding during or after the performance of the TURP procedure?

(iv) Were such steps as may have been taken by the Defendants in that regard in accordance with or contrary to common medical practice? Were they in accordance with or contrary to the steps which would have been taken by the competent anaesthetist/hospital exercising ordinary skill?

(b) If the answer to 4(a) is 'Yes', did such negligence cause the death of the Deceased?

(i) Would the death of the Deceased have occurred in the absence of such negligence?

(ii) Did such negligence materially contribute to the death of the Deceased?

**B. Post-operative Care**

5. **The hypovolemic shock issue**

(a) Were the Defendants or either of them negligent in failing to monitor and/or to record and/or to measure properly the Deceased's bleeding and/or the Deceased's vital signs during the period commencing on the completion of the TURP procedure and ending upon the Deceased going into hypovolemic shock? Were the Defendants or either of them negligent in failing to prevent the Deceased from going into hypovolemic shock after the TURP procedure?

(i) According to common medical practice what steps should the Defendants or either of them have taken to monitor and/or to record and/or to measure the Deceased's bleeding and/or his vital signs during the period commencing upon the completion of the TURP procedure and ending upon him going into hypovolemic shock?

(ii) What steps would the competent anaesthetist/hospital exercising ordinary skill have taken to monitor, record, and measure such bleeding and vital signs during that period?

(iii) What steps, if any, were in fact taken by the Defendants or either of them to monitor record and measure the Deceased's bleeding and/or the Deceased's vital signs during the said period?

(iv) Were such steps as may have been taken by the Defendants in that regard in accordance with or contrary to common medical practice? Were they in accordance with or contrary to the steps which would have been taken by the competent anaesthetist/hospital exercising ordinary skill?

(b) If the answer to 5(a) is 'Yes', did such negligence cause the death of the Deceased?

(i) Would the death of the Deceased have occurred in the absence of such negligence?

(ii) Did such negligence materially contribute to the death of the Deceased?

6. (a) Was the Third Defendant negligent in his treatment of the condition of hypovolemic shock which the Deceased developed after the completion of the TURP procedure? In particular: was the Third Defendant negligent in failing to transfuse the Deceased with the appropriate products upon him developing that condition? Was the Third Defendant or either of them negligent in failing to act quickly enough in transfusing the Deceased with the appropriate blood products upon him developing that condition?

(i) According to common medical practice what treatment should the Third Defendant have administered to the Deceased in respect of the condition of hypovolemic shock which he developed after the completion of the TURP procedure?

(ii) What treatment would the competent anaesthetist exercising ordinary skill have administered to the Deceased for that condition?

(iii) What treatment was in fact administered by the Third Defendant in treating that condition?

(iv) Was such treatment as may have been administered by the Third Defendant in that regard in accordance with or contrary to common

medical practice? Was it in accordance with the treatment that would have been administered for that condition by the competent anaesthetist exercising ordinary skill?

(c) If the answer to 6(a) is 'Yes', did such negligence cause the death of the Deceased?

(i) Would the death of the Deceased have occurred in the absence of such negligence?

(ii) Did such negligence materially contribute to the death of the Deceased?

7. **The DIC issue**

(a) Did the Deceased develop the condition disseminated intravascular coagulation ("DIC")?

(b) If the answer to 7(a) is 'Yes', was the Third Defendant negligent in administering, or failing to administer, appropriate medical treatment to the Deceased for that condition?

(i) When would a competent anaesthetist doctor have diagnosed the Deceased as having DIC? When did the Third Defendant diagnose the Deceased as having that condition?

(ii) According to common medical practice what treatment should have been administered to the Deceased for DIC which he developed subsequent to the completion of the TURP procedure?

(iii) What treatment would the competent anaesthetist/medical doctor have administered to the Deceased for that condition?

(iv) What treatment did the Third Defendant administer to the Deceased after the point in time when a competent anaesthetist would have diagnosed the Deceased with DIC?

(v) Was the treatment in accordance with or contrary to common medical practice? Was it in accordance with the treatment that would have been administered for that condition by the competent anaesthetist exercising ordinary skill?

(b) If the answer to 7(a) is 'Yes', did such negligence cause the death of the Deceased?

(iii) Would the death of the Deceased have occurred in the absence of such negligence?

(iv) Did such negligence materially contribute to the death of the Deceased?

8. **The management of blood transfusions issues**

(a) Was the Third Defendant negligent in transfusing blood products and other fluids to the Deceased after the TURP procedure, and/or negligent in his management control or monitoring of such transfusions?

(i) According to common medical practice what measures/steps should be taken in transfusing large volumes of blood products and other fluids to a patient, and in particular, a patient that is suffering excessive bleeding due to DIC?

(ii) What steps would a competent anaesthetist exercising ordinary skill have taken in transfusing large volumes of blood products and fluids to such a patient?

(iii) What steps/measures were in fact taken by the Third Defendant in transfusing blood products and fluids to the Deceased after the TURP procedure?

(iv) Were such steps as may have been taken by the Third Defendant in that regard in accordance with or contrary to common medical practice? Were they in accordance with or contrary to the steps which would have been taken by the competent anaesthetist exercising ordinary skill?

(b) If the answer to 8(a) is 'Yes', did such negligence cause the death of the Deceased?

(v) Would the death of the Deceased have occurred in the absence of such negligence?

(vi) Did such negligence materially contribute to the death of the Deceased?

**C. Damages**

In the event that the Claimant establishes that the Deceased's death was caused by negligence on the part of the Defendants or either of them:

(i) the quantum of damages to be awarded to the Claimant, as Executrix of the Deceased, in respect of her claim brought (in that capacity) against the Defendants pursuant to the provisions of the Supreme Court of Judicature Act;

(ii) the quantum of damages to be awarded to the Deceased's dependants, namely, the Claimant and Ms. Nicola Tesheira, in respect of the claim brought by the Claimant (in her capacity as Executrix of the Deceased's estate) for their benefit pursuant to the provisions of the Compensation for Injuries Act."

**The Bolam test of medical negligence: the gold standard of care**

78. Undoubtedly no medical practitioner guarantees success in every procedure. There may be differing medical opinions in the treatment of patients. However the standard of care by which the medical profession is adjudged is that standard of a fair, reasonable and competent degree of skill. His actions are not adjudged by the ordinary man but the standard of the ordinary skilled man exercising and professing to have that special skill. It is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that specialty/particular art. A doctor is therefore not negligent if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art or that in acting in accordance with such a practice merely because there is a body of opinion that takes a contrary view. Mc Nair J in **Bolam v Friern Hospital Management Committee** [1957] 2 All ER 118. I was pleased to hear Dr. Pitt-Miller refer to it in her own readings as "a gold standard"[19]. Indeed it is, and the alleged negligent act is to be adjudged against responsible medical opinion, and recognising the fact that reasonable doctors may differ.

79. In **Hunter v Hanley** 1955 SLT 231 at 217 it was stated that:

> "In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men … The true test for establishing negligence in diagnosis or

[19] See Day 2 of Transcript at page 17 line 17.

treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care …"

80. **Maynard v West Midlands Regional Health Authority** [1985] 1 All ER 635 Lord Scarman commented:

> "It is not enough to show that there is a body of competent professional opinion which considers that theirs was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. …
>
> Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other, but that is no basis for a conclusion of negligence.
>
> … I have to say that a judge's 'preference' for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his judgment he stated the law correctly. *For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another*. Failure to exercise the ordinary skill of a doctor (in the appropriate specialty, if he be a specialist) is necessary" (emphasis added).

81. Our Courts have consistently applied the Bolam standard. See the recent Court of Appeal decisions of Mendonca JA in **Deonarine v Ramlal** Civ App 28 of 2003 and **SWRHA v Harrilal** Civ App 60 of 2008.

> "In accordance with the Bolam test, for a plaintiff to succeed he must show that the medical practitioner failed to exercise a reasonable degree of skill and care. The medical practitioner can therefore be held liable if he failed to act in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art. However as is evident from the passage quoted from the **Bolam** case, it is not sufficient

for the plaintiff to adduce evidence to show that there is a body of medical opinion that considers the practice adopted by the medical practitioner to be wrong if there also existed a body of equally competent opinion that considered it acceptable (see ***Maynard v West Midlands Regional Health Authority*** [1985] 1 All E.R. 635 In ***Sidaway v The Board of Governors of the Bethlem Royal Hospital***, supra, Lord Scarman put it this way (at 881F):

> "A doctor is not negligent if he acts in accordance with the practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice."[20]

82. Mendonca JA went on to add:

> "As I pointed out earlier in this judgment, it is not sufficient for a plaintiff to succeed to simply show that there was a body of opinion that may not have approved of the practice of the medical practitioner if there also existed a body of equally competent opinion that supported it. But the Court is not bound to hold that a defendant escapes liability for negligence just because he leads evidence from a number of medical experts who support the decision taken by the defendant. This was held to be so in ***Bolitho v City and Hackney Health Authority*** [1997] 4 All E.R. 771. In that case Lord Browne-Wilkinson stated (at p. 778):
>
> > "…the Court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice."
> >
> > In Bolam's case … Mc Nair J. stated that the defendant had to have acted in accordance with the practice accepted as proper by 'responsible body of medical men'. … Later he referred to a 'standard of practice recognised as proper by a competent reasonable body of opinion' …. Again, in the passage which I have cited from Maynard's case, Lord Scarman refers to a 'respectable' body of professional opinion. The use of these adjectives – responsible, reasonable and respectable – all show that the court has to be satisfied that the exponents of the

[20] Per Mendonca JA in **SWRHA v Harrilal** para 19

body of opinion relied on can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."

83. However one should exercise care in the application of the Bolam test that it does not lead to this self regulation going beyond its common sense limits. This was noted in the Law of Tort "where the Bolam test has been criticized for implying two propositions which really go beyond McNair's statement. First on points where professional opinions differ the defendant may adopt any view for which there is significant support in the profession. Second that professional opinion so supported is conclusive and so the defendant may shelter behind it even where its dangers are notorious. Neither proposition is obvious and have been under attack in recent years."[21]

84. For this reason the Court retains the right to scrutinize professional practice and where appropriate declare it negligent if it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is either reasonable or responsible. In **Bolitho** it was established that a doctor could be liable for negligence in respect of diagnosis and treatment despite a body of professional opinion sanctioning his conduct where it had not been demonstrated to the judge's satisfaction that the body of opinion relied on was reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field were of a particular opinion would demonstrate the reasonableness of that opinion. However, in a rare case, if it could be demonstrated that the professional opinion was not capable of withstanding logical analysis, the judge would be entitled to hold that the body of opinion was not reasonable or responsible. Accordingly the final arbiter as to whether there has been professional negligence is the court and not the medical profession. It is for the court to decide whether the requisite logical basis for a defendant's expert medical opinion is absent.

[21] See *Law of Tort* Chap 16 para 16.43

85. Armed with this "Bolitho gloss" to the Bolam test, a court would be more ready to find that the body of opinion was not capable of withstanding logical analysis if there was a dubious expert whose professional views existed at the fringe of medical consciousness, see **Khoo v. Gunapathy d/o Muniandy** [2002] 2 S.L.R. 414, at [63]. Another example would be "a residual adherence to out-of-date ideas" which "on examination do not really stand up to analysis" see **Hucks v. Cole** [1993] 4 Med. L.R. 393.

86. Such a discretion is understandably exercised in a rare case nevertheless the limits of the application of **Bolitho** are evolving. See Mendonca JA in **Deonarine**.

87. A useful summary of this gold standard was set out in **Boyce v Lorde** [2012] 3 LRC 167 as follows:

> "(a) The duty of care is determined by the state of medical knowledge and practice at the time of the alleged negligence.
>
> (b) A departure from the normal practice will not of itself be necessarily negligent.
>
> (c) In order to find negligence it has to be shown on the evidence that there is in fact a standard of practice in relation to the activity under discussion, that the defendant has not adopted this standard approach and that the deviation from the standard is one which no person or ordinary skill would have undertaken if acting with ordinary care.
>
> (d) The standard of care is that of the reasonably competent practitioner in the relevant post having the relevant qualifications seniority or specialist practice.
>
> (e) The defendant needs to show that he followed a course regarded as proper by a reasonable body of medical men or a competent reasonable body of opinion. The Court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis and in assessing this the judge must ascertain whether the experts have directed their minds to the question of comparative risks and benefits and reached a defensible conclusion on the matter.
>
> (f) A doctor should not make unsubstantial assumptions about a patients' condition."[22]

[22] See also a useful decision in **Kusum Sharma v Abtra Hospital** [2010] SLRC 70

**Responsibility of hospital authorities**

88. It was not submitted by Senior Counsel for the Claimant directly that Gulf View was responsible for the actions of Dr. Roopchand as its servant or agent. He submitted that it is wrong for Gulf View to limit the plea of negligence as restricted to its nursing staff only. However indeed in the pleadings of negligence against Gulf View it was a plea in relation to both Gulf View "its servants or agents". In the absence of evidence as to the contractual relationship between Gulf View and Dr. Roopchand I am also entitled to draw an inference that he was the agent of Gulf View. Indeed many specialists assisted in Mr. Tesheira's surgery at Gulf View. It was never disclosed by the Defendants failing to call evidence whether they were volunteers or acting as agents of Gulf View. Dr. Roopchand stands in no different capacity. As such a non delegable duty of care may be presumed to have arisen in this case.

89. The Court of Appeal in **SWRHA v Harrilal** held that it is settled that a hospital is liable for the negligent acts of its professional servants which occur in the course of their employment relying upon the judgment of Denning LJ in **Cassidy v Minster of Health** [1951] 2 KB 343. This minority view of Denning LJ is vast gaining currency. In that case as he was in **Roe v Ministry of Health** [1954] 2 QB 66 Denny LJ was anxious to establish that hospital authorities would be liable when negligence occurred especially in situations in which teams of medical staff have been involved some members of which had been employed under contracts of service while others had been outside consultants acting in effect as independent contractors. The Court of appeal in **SWRHA v Harrilal** dealt with a public hospital and not a private institution. See also **Millen v University of the West Indies Board of Management** [1986] 44 WIR 274. However Lord Denning notes in **Cassidy** "Clearly if he is a paying patient paying them directly for their treatment of him they must take reasonable care of him..." In **Roe** Lord Denning opined "hospital authorities are responsible for the whole of their staff not only for the nurses and doctors but also for the anaesthetists and the surgeons. It does not matter whether they are permanent or temporary, resident or visiting, whole time or part time....the only exception is the case of consultants or anaesthetists selected and employed by the patient himself."

90. Lady Justice Smith in **Farraj v King Healthcare** [2009] EWCA Civ 1203 confirmed the development of Denning LJ analysis in **Cassidy** and **Roe** in concluding that English law has now reached a stage that generally a hospital owes a non delegable duty to its patients to ensure they are treated with skill and care regardless of employment status of the person who is treating him:

> "The rationale for this is that the hospital undertakes the care, supervision and control of its patients who are in special need of care. Patients are a vulnerable class of persons who place themselves in the care and under the control of the hospital and as a result the hospital assumes a particular responsibility for their well being and safety. It is therefore fair, just and reasonable that a hospital should owe this duty."

91. There is certainly no evidence of Dr. Roopchand being selected or employed by the patient. Looked at simply Mr. Tesheira's urologist may have been Dr. Goetz but he attended Gulf View to undergo the operation. Put simply to repeat Lord Denning's question "While I was in your hands something has been done to me which has wrecked my life. Please explain how it has come to pass."[23] It would be wrong in the context of the pleading in the Statement of Case to restrict the analysis of Gulf's liability to only its nurses. But even so I have still found the nursing staff negligent in the management of Mr. Tesheira and but for their negligence Mr. Tesheira on a balance of probabilities would not have gone into hypovolemic shock.

**The "But for" test and Causation**

92. It was submitted by the Defendants that Mrs. Tesheira could not demonstrate that any alleged breaches caused the death of Mr. Tesheira. It was forcefully argued that symptoms of hypovolemic shock, DIC and TURP syndrome are new aspects of her case and she is manufacturing a new case for the Defendants to answer. This was somewhat a strange argument having regard to the articulation of the issues set out earlier in this judgment.

[23] **Roe v Ministry of Health** [1954] 2 QB 66 at pg 8

93. Liability will only arise if the Claimant can establish on a balance of probabilities that "but for" the negligence of the Defendants the injury would not have occurred. In **Bailey v Minister of Defence** [2008] EWCA Civ 883 Waller LJ felt compelled to conclude that in cumulative causes cases where there are some non tortious and other tortious acts leading to a death or injury the test is modified and the "but for" test has not been applied. The line of authorities developed around those difficult cases dealing with occupational diseases such as mesothelioma or dermatitis where it was difficult for Claimants with established medical science to pinpoint how the disease developed. See **Fairchild v Glenhaven Funeral Services** [2002] UKHL 22, **McGhee v National Coal Board** [1972] 3 All ER 1008**, Bonnington Castings Ltd v Wardlaw** [1956] AC 613 and **Hotson v East Berkshire Area Health Authority** [1987] AC 750. Waller LJ in **Bailey** reviewed these authorities and summarised the position:

> "If the evidence demonstrates on a balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the claimant will have failed to establish the tortious cause contributed. Holson exemplifies such a situation. If the evidence demonstrates that "but for" the contribution of the tortious cause the injury would probably not have occurred, the claimant will (obviously) have discharged the burden. In a case where 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 the claimant will succeed".

94. In **Bailey** the claimant was originally a patient of the Royal Haslar Hospital when a procedure was performed to treat a possible gall stone. After the procedure her condition deteriorated and she underwent further treatment in other hospitals until she aspirated her vomit which led to cardiac arrest and hypoxic brain damage. The Court of appeal held that the trial judge was correct to hold that the case was a cumulative cause case and that the two causes for her death had each materially contributed to her death. See **also Wilsher v Essex** [1988] AC 1074 and **Sidaway v Board of Governors of the Bethlem Royal Hospital** [1985] AC 871.

95. In the recent judgment of the Supreme Court in **Sienkiewicz v Knowsley Metropolitan** [2011] 2 AC 229 Lord Phillips outlined a useful discourse on the theory of causation, the development of the exception to the "but for" test and the utility of epidemiological studies or evidence that a particular injury or disease usually follows a particular type of bodily insult.

> "It is a basic principle of the law of tort that the claimant will only have a cause of action if he can prove on a balance of probabilities that the defendants' tortious conduct caused the damage in respect of which compensation is claimed. He must show that but for the defendants tortious conduct he would not have suffered the damage. This broad test of balance of probabilities means that in some cases a defendant will be held liable for damage which he did not in fact cause. Equally there will be cases where the defendant escapes liability notwithstanding that he has caused the damage, because the claimant is unable to discharge the burden of proving causation. There is an important exception to the but for test. Where disease is caused by cumulative effect of the inhalation of dust part of which is attributable to breach of duty on the part of the defendant and part of which involves no breach of duty the defendant will be liable on the ground that his breach of duty has made a material contribution to the disease".

96. See also the treatment of causation in **Boyce v Lorde** [2012] 3 LRC 167 and **Nora O'Donovan v Cork County Council** [1967] I.R 173. I accept that but for the careless management of Mr. Tesheira's blood loss he would not have died. The crux of the dispute really boils down to this: Did Mr. Tesheira die because the surgeon could not stop the bleeding or did he die because of the mismanagement of his haematological state post the TURP procedure? I imagine analogies abound: How could the pilot land the aircraft safely if his co pilot gives him the wrong readings. How could the surgeon operate on a patient whose body is deteriorating through massive blood transfusions. It might well have been in the end an impossible and futile task due to the mismanagement of Mr Tesheira's post operative bleeding. There is in my view reasonable cause to believe that this was the causative factor for the death due to DIC and irreversible shock. In any event it calls for an answer to which there is none and the Court is entitled to draw an adverse inference on causation against these Defendants. Although it is not necessary to found liability on Gulf View on this proposition

(as I have found that its breach caused the death) it is entirely open to the Court to additionally draw this inference.

**Assessment of the Evidence**

**The Expert Evidence**

97. Much criticism has been made by the Defendants about the lack of credibility of the experts and that no weight is to be ascribed to the expert reports of Dr. Pitt-Miller and Dr. Jones-Lecointe. Both Counsels for the Defendants were scathing in their criticisms of the experts' lack of independence, their seeming lack of appreciation of the legal issues involved or the Claimant's case, the concessions made by Dr. Pitt-Miller in cross examination, and alleging a collaboration in giving their evidence in chief with their lawyers. In my view these criticisms were hyperbolic and unfounded.

98. First on considering an application by the Claimant to adduce expert evidence of these witnesses I ordered that permission be granted to the Claimant to adduce their expert report and to file witness statements. I considered their medical reports and saw the need to have such experts testify at this trial to assist the Court in determining the issues raised by the parties. There were no objections taken to these reports or witness statements. The evidential objections taken previously by attorney on record were abandoned at the Pre Trial Review. No Defendant sought to adduce their own expert evidence until belatedly at the eve of the trial. The Second Defendant through a change of counsel requested permission to adduce evidence of a Dr. Arjoon Narinesingh. Gulf View orally requested and was granted permission to produce evidence in the form of Anand Chattergoon. Dr. Narinesingh filed his expert evidence, Gulf View for reasons best known only to themselves did not. I tried at pre trial reviews to obtain consensus from the experts to answer certain questions however this also proved impossible. I will comment on this later in my judgment. The upshot of this was that this Court only had before it the benefit of two experts for the Claimant an anaesthetist and a hematologist who amplified their reports in witness statements.

99. CPR 33 admittedly does not expressly provide for experts giving their evidence in witness statements but of providing their expert reports. I cannot see any objection in principle or in

the rules however for the experts to subsequently provide their witness statements expanding upon or explaining the conclusions made in the report so long as the fundamental relevance of expert evidence is observed. Indeed I had given these experts permission to file witness statements as well. I must add the manner in which they gave their evidence in chief in "layman friendly terms" was extremely helpful to this Court to understand some critical medical data. It is now more so important having regard to the silence from the Defendants on their own medical notes, medical records and their own procedures.

100. Queens Counsel for Gulf View sought further, coming short of making any allegation of misconduct, of criticizing the role of junior counsel in preparing the experts witness reports (presumably a reference to the expert witness statements). Seemingly she suggests that the quality of the evidence was tainted and the impartiality of these experts were skewed by the interaction with junior counsel. These submissions were made on the basis of her questions in cross examination as to the manner in which the witness statements were prepared. Both experts testified that they submitted their drafts to junior counsel and attended one or two meetings and then finalized their product. The witness statements themselves on the face contain many similarities and Queens Counsel has pounced on these similarities in excited detail in their closing submission submitting a matrix of similar content referencing line by line with paragraph by paragraph.

101. I have reviewed this matrix and found it helpful as an exercise to determine how these experts corroborated each other on material aspects of the management of the patient and the standard of care that ought to have been followed. The issue really is whether the coincidence of text (as quoted chapter and verse by the Defendant) is really of any moment after this Court has had the benefit of seeing these witnesses give their testimony in the witness box to judge for itself whether they owned their written product and whether they could justify it or whether their reports and testimonies was "fudged".

102. I have had the benefit of seeing these experts give their evidence in the witness box. I have seen the manner in which they thought about the questions and responded. I have heard them say quite frankly that they were here to assist the Court and hold no brief for Mrs.

Tesheira. Indeed one of the witnesses was frank enough to make a number of concessions about her report which I detected not by way of trying to confess that her original conclusions were meant to mislead this Court but by thoughtful responses to questions being asked of her. But the core of their evidence has not really been challenged and in fact remains very much intact. It is however with deep regret and indeed it is unfortunate that this Court must determine the serious issues in this case as it were with one hand behind its back without the benefit of hearing from the Defendants and their experts.

103. In deference to the Defendants who made in my view too much about this matter I make the following remarks:

(a) I have already determined that these experts' reports were properly to be adduced as expert reports. There is no challenge to this ruling.

(b) There is no issue about these witnesses collaborating on their expert reports. Their reports were independently produced uninfluenced by counsel, the claimant or each other. Insofar as Dr. Pitt-Miller's and Dr. Jones-Lecointe's reports were a joint product they displayed the intellect to claim ownership for the ideas and conclusions of the report. These reports are their core evidence.

(c) Insofar as their witness statements are concerned they elaborated on these expert reports. No doubt they were aided by attorney for the Claimant. There is nothing objectionable in this on its face. The local bar is yet to and should develop standards to assist advocates in their duties in relation to the drafting and preparation of witness statements. It must after all be the independent product of the witness and should as far as possible be in their own words. Advocates should play no role in making suggestions as to what evidence should be included but should ask for explanations. However I have found in practice that it is becoming unhelpful to throw Part 33 at an expert witness and demand that he/she complies with it without guidance. In those cases the expert reports produced may be unhelpful. Part 33 suggests the expert can apply for directions. Perhaps experts should retain their own attorneys. Of course in this case there is no issue with the facts that the expert reports were produced without

the aid of an attorney it simply did not comply with some of the procedural requirements of Part 33.[24]

(d) Ultimately it is for the Court to determine what weight is to be ascribed to such expert reports which does not comply faithfully with Part 33. Similarly as well to witness statements that bear striking similarities to one another. To the extent that two witnesses considered the same material and arrive at the same or similar opinion that cannot be avoided. The ultimate test lies in cross examining them on their conclusions to determine if they hold true to those conclusions and determine any internal and external inconsistencies in their witness statements and the contemporaneous documents and pleadings in this case.

(e) However the Court is the final arbiter of facts and would not be swayed by the experts' views of the facts.

(f) There are some important medical terms and medical effects which only experts can shed light upon. To this extent these witnesses were extremely helpful. Jamadar JA judgment in **Kelsick v NWRHA and anor** CA CIV 277/2012 is instructive:

> "The trial judge is the primary finder of fact in a case such as this. Before issues of negligence can be considered the relevant findings of fact and conclusions of inference on issues such as causation must be determined. Where (as in this case) there are multiple potentially overlapping options, and the medical evidence and derived inferences are critical to liability, and the Defendants are all potentially implicated, a trial judge can only benefit from an impartial and relevant medical expert whose primary duty is to assist the court in objectively resolving these issues. In our opinion, on the basis of the various claims and defences, and on the respective cases stated, denied and implied, and also on the basis of the medical reports and correspondence intended to be relied upon or agreed, this case is a fit case for the use of a relevant medical expert witness and of medical expert evidence."

(g) I have considered the possibility of ignoring these witnesses totally as suggested by the Defendants but I simply cannot when I examine their cross examination and some

[24] Part 33.1 (1), 33.1 (2), 33.2 (4) (5) (6) and 33.10. Those did not affect the overall quality of the reports which after being tested in cross examination demonstrated impartiality and a sense of duty to the Court.

basic medical theory espoused by these witnesses which are unchallenged and which ascribes a certain standard of care lacking in this case.

104. On that score these experts' reports and their witness statements in essence fulfilled the real value and benefit of experts in their cogency and relevance. In **Kelsick** Jamadar JA had this to say about expert evidence:

"In determining whether permission should be granted to use expert evidence and what expert evidence is reasonably required to resolve the issues that arise for determination, a court ought to weigh in the balance the likelihood of the following (assuming admissibility): (i) how cogent the proposed expert evidence will be; and (ii) how useful or helpful it will be to resolving the issues that arise for determination. In determining whether this evidence is reasonably required to resolve the proceedings justly, the following factors that allow one to assess proportionality should also be weighed in the balance: (iii) the cost, time and resources involved in obtaining that evidence, proportionate to the quantum involved, the importance of the case, the complexity of the issues, the financial position of each party involved in the litigation, and the court resources likely to be allocated to the matter (in the context of the court's other obligations); Depending on the particular circumstances of each case additional factors may also be relevant, as such: (iv) fairness; (v) prejudice; (vi) bonafides; and (vii) the due administration of justice.

Under cogency, the objectivity, impartiality and independence of the proposed expert, together with the qualifications and experience of the proposed expert, in relation to both the specific subject under consideration and the particular issues to be resolved, are material considerations. At this stage of the proceedings a trial judge is simply required to assess how cogent the expert evidence is likely to be. That is, how convincing and compelling it is likely to be based on the stated considerations. Under usefulness or helpfulness, the technical nature of the evidence to be reconciled and the focus of the issues to be determined, as well as the familiarity of the expert with the areas under scrutiny, are material considerations, especially when that expertise is relevant for necessary fact and/or inferential findings. As with cogency, at this stage of the

proceedings the trial judge is only required to assess the likelihood of usefulness or helpfulness.

In summary, for expert evidence to be appropriate in light of the CPR, 1998, and for permission to be granted to use it, that evidence ought to be relevant to matters in dispute, reasonably required to resolve the proceedings and the proposed expert must be impartial and independent and have expertise and experience which is relevant to the issues to be decided. In addition, the use of expert evidence must also be proportionate in light of the factors set out in Part 1.1, CPR, 1998. Economic considerations, fairness, prejudice, bona fides and the due administration of justice are always matters that may have to be considered depending on the circumstances of each case.

In our opinion the trial judge may have, in so doing, lost sight of the real purpose and value of expert evidence and reports under the CPR, 1998. Expert evidence and reports are not simply partisan, however they come into being. They are only and always primarily for the benefit of the court. In this regard, it matters not who seeks permission to obtain expert evidence or reports. What matters, is whether the evidence and reports are reasonably required (Part 33.4) to help the court (Part 33.1 (1)) resolve the proceedings justly (Part 33.4)."

105. Both witnesses were approached by the Claimant to peruse medical records of the TURP procedure performed on the Deceased and to provide a written report on the clinical aspect of the standard of care the deceased received before, during and after his surgery. There was no brief given to them by the Claimant they had no personal relationship with the Claimant and there was no motivation to fabricate evidence. Indeed the last paragraph of Dr. Jones-Lecointe's report is instructive as she bemoaned the fact that she had to draw conclusions that were adverse against a colleague.[25] I am satisfied based upon the experts' responses under cross examination that they sought to provide independent assistance to the Court by way of an objective unbiased opinion. See **Ikarian Reefer** Lloyds L Rep [1993] Vol 268.

[25] "There is an inevitable sense of unease when a patient dies and one is asked to evaluate the work of a medical colleague. "There but for the grace of God go I", are the words that spring to mind. A wider public responsibility informs the above comments and the following considered opinion."

106. I have reviewed the evidence of the two experts and the critical evidence which remains helpful in this case are as follows.

Dr. Phyllis Pitt-Miller

107. Qualification of Dr. Pitt-Miller: Dr. Pitt-Miller's qualifications were never in question. She is a Retired Professor of Clinical Anesthesia and Intensive Care at the University of West Indies. She is a well qualified anaesthetist with long standing service in the medical profession in this country. Amongst her achievements was that she received in 1994 a Chaconia Gold Medal for Long and Meritorious Service to Medicine and Deputy Chairman of the NCRHA. Her CV was attached to her witness statement. Amongst her many publications included Promoting Rational Blood Use by the Clinician, Anaesthetics Protocols for Trinidad and Tobago Ministry of Health Drug Formulary - A Guide to Rational Drug Prescription; Deaths within 24 hours of surgical procedures at the Port-of-Spain General Hospital. In March 1985 amongst her many presentations was "Management of DIC Disorder". She was quite familiar with TURP having anaesthetized for the first in this country and having done so recently before the trial.

108. By no means is the opinion of such a person with this record to be taken lightly. Her intellectual contribution to her specialty on the medical profession in this country was never put in doubt or questioned under cross examination. Indeed the focus of the attention of the cross examination appeared to focus on her lack of independence in arriving at her conclusions on the medical treatment of Mr. Tesheira and to acknowledge areas of expertise of which she could not comment. Where she was corralled into commenting on the utility of her reference in the witness statement as to "medical team" her concessions is that in most cases in her witness statement where the context does not provide, it does not refer to nurses. But this must be viewed in the context of the pleadings in this case.

The preparation of the Expert Report

109. The Defendant places much emphasis on the fact that the medical report was a joint report signed by Dr. Moseley and herself. Dr. Moseley is an anaesthetist by profession the former Professor of Anaesthesia at the University of the West Indies and her colleague. Dr.

Moseley gave his comments and suggested amendments to the draft report she sent to him and having agreed with his input she signed the report. I am satisfied after the rigorous cross examination under which Dr. Pitt-Miller was put on her report that this report can only be sensibly viewed as the product of her own mature and reasoned deliberations against the backdrop of her extensive knowledge and expertise. She came across to me to be a forthright and straightforward person I detected no hint of dishonesty in passing off someone else's opinion as her own. She struck me as someone quite independent-minded, careful in her thinking process and in drawing conclusions.

110. Like Dr. Jones-Lecointe, her opinion was based upon the medical records given to her which were exhibited to her witness statement and by no means was a product of influence by any attorney or the Claimant. This is made clear in her cross examination.

Pre-operative care

- Dr. Pitt-Miller noted that as the medical procedure done on the deceased carried a high risk of post-operative bleeding it was the duty of the medical team to inquire of the patient of his medical history specifically whether or not he/she was taking aspirin, Plavix or any other medication that would affect the blood's ability to clot. This evidence has not been contradicted or shaken whatever under cross examination. In fact the only concession she made throughout her evidence is that where she spoke about a medical team she would make a distinction between nursing staff and the role of clinicians where the context so provides. I will come to this later.

- She further states that it is not sufficient for the patient to be asked prior to the surgery what medication he/she is taking as the patient's perception of what is being asked may differ from that of the medical practitioner and may overlook 'over the counter' drugs such as aspirin as being described as medication. However she found no inclination that he was asked specifically by the medical team treating with him whether he was taking aspirin. There is in fact, which cannot be disputed, no pre operative assessment done on Mr. Tesheira by Dr. Roopchand. This is to be contrasted to the February 2004 aborted procedure in which there is recorded a "basic pre operative assessment" was conducted by Dr. Roopchand.

- The patient should have been told / instructed to cease his aspirin use 7 days prior to undergoing the surgery and in the instance where this information came to light just prior to the surgery being performed, it would have been best to postpone the surgery unless it was deemed an emergency situation.

PT PTT tests

- In instances where a TURP is to be performed certain blood tests including PT and PTT should be carried out on the patient prior to the surgery. Although it is not a routine procedure to do these tests prior to all operations, she believes it should be done in small hospitals which do not have a blood bank on site or where the emergency supplies of blood products are unpredictable in the event of bleeding or operations which carry the risk of bleeding.

- The Deceased had a low platelet count in January 2004 and this should have been an indicator that the Deceased may have bleeding complications. In light of these findings a further blood test should have been done closer to the rescheduled date of the surgery or in the alternative PT and PPT tests should have been carried out on the Deceased prior to the TURP procedure to ensure that his low platelet count did not indicate blood clotting complications. There really was no evidence in this case to demonstrate why a simple matter such as a CBC or PTT test could not have been done prior to surgery. Indeed this case demonstrates the utility of conducting such tests prior to a TURP which carried a risk of post operative bleeding and to fail to conduct those tests really falls below the gold standard of the Bolam test (or the "Bolitho gloss".).

- The PTT tests when they were eventually done show that the Deceased had severe bleeding or clotting problems. Standard medical practice requires that there be at least 2 units of grouped and cross matched packed red blood cells in refrigerated storage when conducting a surgical procedure of this nature in a small hospital. Further given the pre-existing condition of the Deceased (athlete's heart) and the type of surgery to be performed 2 units of blood should have been available to the Deceased.

- There are three indicators suggesting the need to have at least two units of grouped and cross matched packed red blood cells in storage. The risk of post-operative bleeding, the significant risk of heavy peri and post operative bleeding where the prostrate was more than 60ccs. The Deceased's low platelet count.

Post operative management

- After a procedure such as the one undergone by the Deceased, standard medical practice required that the patient is monitored with recordings of his vital signs every 5 minutes for the first 30 minutes and every 10 minutes for the next 30 minutes followed by every 15 minutes during the second hour post-surgery. The nurses should have ensured that this was done. Rather the post-operative monitoring did not record any monitoring for a period of 1 hour and 40 minutes after the surgery. The regular monitoring of the Deceased may have prevented him from developing hypovolemic shock.

- Also of importance was the fact that Dr. Pitt-Miller noted that Mr. Tesheira would have lost a significant amount of blood in the surgery and no note has been made of this. She suggests that the blood put aside should have been used in the surgery. In any event because of the condition of an athlete's heart it is likely that the body would mask hypovolemic shock. This was confirmed in cross examination. This called for careful monitoring of Mr. Tesheira. There are no instructions on the record to suggest that this was done or if instructed. Instead the evidence reveals he was allowed to continue bleeding for more than one hour until it was too late.

- It is clear to this Court that neither the nurses or Dr. Roopchand detected this excessive bleeding in time. They either failed to monitor his blood loss in surgery or properly monitor his blood loss post surgery. It was a quite lax attitude to one who had an athlete's heart which may mask an episode of hypovolemic shock if he was losing blood. No interest at all was made of emptying a bucket of fluid blood in the bathroom with absolutely no recordings of the blood loss or alarm raised by the nursing staff.

- The Deceased experienced post -operative bleeding and showed symptoms of hypovolemic shock.

Post operative management of hypovolemic shock.

- It is the unchallenged and undisputed medical evidence that a patient going into hypovolemic shock needed a combination of packed red cells and plasma or fresh whole blood and plasma. This carries haemoglobin and has oxygen carrying capacity. In the first hour after developing shock he did not receive any blood products. Rather crystalloids/colloids were used and Dr. Pitt-Miller considers this to be a poor substitute for packed red cells as it takes three units of such fluid to replace one unit of blood, thereby increasing the risk of fluid overload. Immediately by using these poor substitutes it is much like pouring poor quality oil into an engine and expecting it to perform in the same manner as rich quality and also running the risk of overloading the engine with fluids. By 5:00p.m the PTT result in a diagnosis of DIC should have been made which called for an immediate transfusion of blood products. However it is only at 7:45p.m those products were transfused to him. The delay in transfusing strongly suggests that the blood products were not available. The records reveal that there was cross matched blood and the inference that can be drawn here without any explanation from the Defendants themselves is either the staff delayed in getting the blood products to the patient or Dr. Roopchand delayed in making the request.

- The transfusion of O positive whole blood to the Deceased who was A positive was a serious error on the part of the medical team and may have itself caused the DIC and destroyed the Deceased red blood cells. Such decision to use a different blood type on a patient should only be reserved for life threatening instances and where the patient's blood type is unavailable. The Deceased's blood type though low was still acceptable and there was no justification for taking the extreme and dangerous step of transfusing him with the O positive whole blood.

- The 6 litres of crystalloids and colloids and the 11 units of blood transfused to the Deceased amounts to a massive transfusion of more than twice the average volume of fluid in the human body. This results in a risk of fluid overload. Fluid overload could lead to heart failure if not monitored. Further it poses more of a problem for patients with existing cardiac impairment. The Deceased's pre-existing condition in addition to

TURP syndrome put him at a greater risk of developing fluid overload in the event that the post-operative transfusion of fluid was not monitored properly.

- The steps to be taken prevent fluid overload were:

    - regularly and meticulously assessing the amount of fluid given to the Deceased,
    - use of a central venous pressure line and an intra-arterial line for further monitoring,
    - use of a pulse oximeter to measure oxygen levels in the Deceased's blood,
    - monitoring the Deceased for jugular venous distension,
    - listening to the lungs for clicking noises,
    - listening to the heart for a third heart sound,
    - chest x-rays.

  Standard medical practice requires that these steps be carried out and recorded by the surgeon and anaesthetist.

Cross examination of Dr. Pitt-Miller

111. Dr. Pitt-Miller was heavily criticized for concessions made in her cross examination. However this is what I have noted about her cross examination. She did not view Mr. Tesheira's medical records prior to 2004. She was not involved in the training of nurses. There was no specific commentary on the nursing staff in the report. She felt that her contribution could have been on the role of the anesthetist. She deleted reference to medical team in many cases and felt more comfortable with a reference to clinicians and surgeons. She is aware that 2 units of blood were grouped but not sure if it was cross matched. Nurses ought to have been told how to monitor patients with athlete's heart. She did not know the time of the request for blood products and the time of receiving that is why she used the word medical centre. She conceded that the nurses were not as inadequate as first indicated.

112. She also testified in response to the cross examination of Mr. Kawalsingh that Mr. Tesheira did not die from complications associated with administering anesthesia. The role of

the anaesthetist is to adequately prepare pre-operative assessment, adequately assess the patient pre operatively monitor that patient and the anaesthetist has a role in post-operative period during recovery. The anaesthetist acted properly in abandoning the first surgery. She cannot fault Dr. Roopchand for the administration of spinal anesthesia. There is no spinal haematoma. Failing to record monitoring does not mean that he did not monitor. Anaesthetists cannot stop bleeding but his role is to get fluids, organize blood and stabilize the patient. The anaesthetist's role is to resuscitate the patient and keep him stable.

Conclusions on Dr. Pitt-Miller's evidence

113. She is clear in her opinion of the domino effect of not detecting the early signs of hypovolemic shock and how that episode ought to have been handled and managed. Although she is more comfortable with her comments on the anaesthetist and surgeon she clearly can only make her comments from the medical records which do not tell her what the nurses were doing. She can say what should have been done and it is for this Court to determine as a matter of principle applying the Bolam test and Bolitho gloss whether Gulf View in accepting the duty to manage the patient whether they failed to do so in accord with the standard practice as extensively explained by Dr. Pitt-Miller.

114. It is clear that whereas one may say that a TURP carries a risk of post operative surgery as in any surgery, there is no evidence to suggest that the TURP is a minor surgery. From all accounts there was an unaccountable loss of blood clearly in the operating theatre in the original TURP which was left to linger on for 1 hour unabated in the ward leading to the problem from which the treatment by these Defendants was thoroughly mismanaged. It was also not an ordinary patient and the athlete's heart was a clear indicator that close monitoring and specific instructions were required.

115. I am still of the view that the failure to conduct blood screening tests prior to this surgical procedure is quite an illogical procedure for the obvious reasons as manifested itself in this case. It will assist the medical team to determine how to treat with a patient post operatively if they have an idea of the patient's blood clotting ability.

**Expert Evidence of Dr. Althea Jones-Le Cointe**

116. Dr. Jones-Lecointe was an experienced professional with a vast expertise in her field of haematology. She is a Consultant Haematologist and Senior Lecture of the Department of Paraclinical Sciences at the Faculty of Medical Sciences UWI. She held a BSC and PHd from University of College London and MBBS UWI and FRCPath Haematology UK 2001. She is the only full time haematologist teaching at UWI between 1994 to 2008. Importantly she trained nurses and had a clinical practice in Sangre Grande Hospital and Augustus Long. The evidence of Dr. Jones-Lecointe examined the haematological aspects of the pre and post operative care and was instrumental in establishing what was required in operations where there is a risk of post-operative bleeding

117. In contrast to Dr. Pitt-Miller, Dr. Jones-Lecointe was testy in cross examination, at times argumentative and very opinionated. Argumentative to the extent that she was clearly mistaken with regard to seeing the witness statements before preparing the reports and having typed up the witness statement herself. I was not sure whether she was confusing the expert report with her witness statement which would make sense of her explanation of how her "witness statement" was drafted. With this in mind I have reviewed her evidence with some caution. However from my observation of her in the witness box I view this more as a result of the nature of the rigorous cross examination and at time unfair questions which saw her become more of the lecturer being challenged by a student rather than hostility of an advocate for a cause. She recognized her duty of impartiality and she too with her intelligence and clear experience in this field demonstrated her capability of giving to this Court reliable and sound medical evidence. To the extent that her evidence may be similar to Dr. Pitt-Miller's I did not detect any attempt to lie or fabricate a story.

<u>Pre operative precautions</u>

- There were two aspects which should have been investigated. The taking of aspirin and the conduct of PTT tests. She corroborates the reasons for these as suggested by Dr. Pitt-Miller.

- The clinical procedure TURP is known to carry post-operative bleeding and as such the necessary preparatory steps ought to be taken in the event that such bleeding occurs.

- It was incumbent on the medical team to inquire specifically of the patient whether he/she is taking aspirin or any other medication which would affect haemostasis. Haemostasis being the arrest of bleeding through the normal, rapid formation of a localized 'plug' at the site of vascular injury. Where it is known that the patient has been using aspirin, the standard practice is to instruct the patient to stop taking aspirin 7 days prior to the date of the surgery. Although aspirin on its own would not have caused post-operative bleeding, it is likely that it would have exacerbated such complications.

- The requisite PT and PTT tests ought to have been carried out prior to surgery as it would have given the medical team an indication as to the time it takes the blood to clot. These tests though not routine are particularly important in institutions where a surgery such as TURP is performed and the institution itself does not have a blood bank on site. The conflicting dates on the laboratory report as to when the PT and PTT test were done regardless of what the correct date is, shows that the medical team subjected the Deceased to unwarranted and unacceptable risk. Further the lack of a contemporaneous CBC test before the surgery did not give a proper indication of the Deceased's present blood count at the time of surgery.

- One of the preparatory steps to be taken prior to a TURP surgery is to ensure that the appropriate blood and blood products are readily available in the event that there is significant blood loss. In order to do this the patient's blood type must be determined before the surgery, patient's blood is screened for antibodies, patient's blood is cross matched with screened compatible donors and two units of the cross matched donor's red blood cells must be readily available.

- The excessive blood loss of the Deceased in the 2 hours and 20 minutes post his operation resulted in him going in hypovolemic shock. Given the pre-existing condition of the Deceased (enlarged prostate) and the surgery he underwent, heavy

bleeding was likely and he should have been closely monitored for the first two hours after his surgery with records being made of his vital signs. This would have allowed the medical team to assess the Deceased's cardio vascular response to his ongoing blood loss.

- The 20 minute lapse in time after the medical team was informed by the nursing staff that the Deceased was experiencing heavy bleeding amounts to a failure to provide the standard of medical care reasonably expected by the medical team and created an unacceptable and unnecessary risk of harm to the Deceased. Had the Deceased been properly monitored and the necessary steps taken to arrest his bleeding it may have prevented him from going into hypovolemic shock. It is the hypovolemic shock that caused the Deceased to develop Disseminated Intravascular Coagulation (DIC) which is a syndrome in which uncontrolled clotting in the blood circulation is activated with the result that clotting factors and platelets in the blood are consumed. With respect to DIC the transfusion of whole blood is contra indicated as whole blood does not contain any viable platelets and this whole blood has a diluting effect on existing platelets which exacerbates bleedings.

- The fact that the Deceased was not transfused with whole blood cells is an indicator that it was not readily available at the institution because if they were it would be erroneous on the part of the medical team not to use this for the transfusion. Instead he was transfused with colloids and crystalloids which are helpful to restore blood loss but are not substitutes for blood and blood products.

- Had the medical team properly monitored the Deceased he would not have gone into hypovolemic shock. Had the medical team properly prepared for post-surgery care, the transfusions to the Deceased would have been provided in a timely manner. Had the proper blood products been used when the Deceased developed DIC the fluid overload would not have occurred.

**Cross examination of Dr. Jones-Lecointe**

118. Under cross examination Dr. Jones-Lecointe was quite clear what she meant by the concept of "the medical team". She was only prepared to give evidence based upon the

written records of the doctors and nurses. To the extent that she was shown witness statements from a Nurse Khan and Dr. Roopchand she was quite clear that she would not be drawn into speculating on what happened as she, like this Court admittedly as a result of the Defendants failure to explain these events, can only draw her conclusions from the documentary evidence. Indeed it is on this point of the medical records that I thought the taking of this no case submission quite unusual as in cross examination it was suggested by counsel for Dr. Roopchand that the doctors may not have recorded everything in their notes. If that is indeed so and there are facts which in their knowledge can fill the gaps and properly explain the matters of instructions to nurses, monitoring the patient, the risk of bleeding, the time it took to deal with his hypovolemic shock, the whereabouts of blood products, then they had a duty and obligation to provide that evidence to this Court. In its absence the Court is entitled to draw adverse inferences against the Defendants. Indeed the Court of Appeal in **Boyce (ibid)** commented "while in our opinion the absence of notes and the inadequacy of written instructions were not in themselves evidence of negligence it leaves open the question whether and the possibility that the appellant had in fact not followed the relevant procedures and had not conducted the appropriate examination"[26]

119. Dr. Jones-Lecointe was quite firm in her view on the failure to properly organize blood products for Mr. Tesheira prior to the surgery.[27] She made a useful point that the blood that was used in fact came from Mt. Hope General Hospital when there are blood bank stations at various points in the country and more importantly available in San Fernando General Hospital. It strongly suggests that Gulf View was totally unprepared for this event.

120. She demonstrated by her knowledge of the time it takes to conduct CBC and PTT tests that the reaction times of the personnel in Gulf View was slow. Indeed the lab support at Gulf View was observed to have been weak. This too was observed by Dr. Pitt-Miller.

[26] Indeed the Court of Appeal in **Boyce** commented "while in our opinion the absence of notes and the inadequacy of written instructions were not in themselves evidence of negligence it leaves open the question whether and the possibility that the appellant had in fact not followed the relevant procedures and had not conducted the appropriate examination."
[27] See pages Approved Transcript Day 289, 101-102.

121. She usefully pointed out the realities of the hospital system:

"Your Honour could I just say that one of the problems that arose here was that when the blood was taken for cross match, there is a quick cross match that you can do and the blood could have been ready in a shorter time and delivered to the patient. The patient had a blood count done at the time let's say it was quarter to the hour you can get a CBC result which tells you the haemoglobin and the platelet count by ten to four. So in trying to make this whole thing just the responsibility of the surgeon and the anaesthetist I think that the laboratory support was weak..."[28]

122. I have examined in detail the evidence of the experts, as the linchpin of the Defendants' submission lies in the inadequacy of the experts' evidence and that this Court should attach very little weight to it. I have also adopted the guidance of **Anino Garcia v AG** CA Civ 86/2011 in the assessment of the credibility of these experts as witnesses. For the reasons set out above it is obvious that I cannot accede to the Defendants' submission. The question now is whether this evidence supports a case of breach of duty and causation. The inference is inescapable that at the very least this evidence calls for an explanation. Standing on its own it makes out a case on a balance of probabilities of negligence on the part of both Gulf View and Dr. Roopchand.

**Duty**

123. As discussed above there is no issue as to the existence of a duty of care. The pleaded duty was admitted by these Defendants and it included critically the monitoring of Mr. Tesheira's blood loss, the containment of his blood loss, the management of the patient in post operative care to safely transfuse large quantities of blood products, and carefully manage same. There simply is no plea by Gulf View that its duty or role was limited to support service or of providing accommodation, operating facilities or nursing care. To suggest as the Defendants did that there is an issue estoppel arising from this Court's earlier ruling on a procedural matter without having considered the evidence is plainly disingenuous. The issues for determination at this trial have been properly identified in advance of this trial, no predetermination of the Defendants duty had been made in this

[28] See Transcript Day 2 page 117 Line 40 to page 118 Line 6

Court's earlier ruling. The cross examination therefore of the experts to the effect that decisions were made by clinicians and not nursing staff are really irrelevant in that it does not advance the Defendants' case against the backdrop of its accepted duties of care.

124. The standard of care to be observed in executing these duties by these Defendants is the Bolam gold standard of the ordinary competent specialist or medical practitioner or hospital undertaking these duties, with the Bolitho gloss as discussed earlier in this judgment.

**Breach and Causation**

**Gulf View**

125. Insofar as Gulf View is concerned it has admitted to be under a duty to ensure that Mr. Tesheira's bleeding was carefully monitored, and his transfusion was managed and contained. The evidence demonstrates that there was a breach of the requisite standard of care expected of such an institution adjudged against a body of responsible practice as set out by Dr. Pitt-Miller and Dr. Jones-Lecointe.

Gulf View failed in my view:

(a) To make attempts to monitor and contain the post surgical bleeding as indicated earlier in this judgment. The lapse in time while Mr. Tesheira was bleeding post operatively is basic carelessness. Even if one is to accept that Mr. Tesheira was bleeding heavily at 2:50p.m even though this is a record of an observation and not necessarily conclusive that heavy bleeding had not occurred prior to that time. At around 3:30p.m when Dr. Goetz was manually irrigating Mr. Tesheira he showed signs of hypovolemic shock. The standard of care to be exercised is that of the ordinary competent specialist in containing and managing such bleeding. It was according to Dr. Jones-Lecointe "an unacceptable and unnecessary risk of harm to the deceased". I am satisfied that but for this failure to monitor and contain the post surgical bleeding he would not have developed hypovolemic shock.

(b) To maintain appropriate supplies of blood and blood products and clotting agents sufficient to meet the risk of bleeding. The undisputed evidence of Dr. Jones-Lecointe is that the preferred fluid to prevent bleeding and to increase the chance of haematosis is fresh whole blood. But this was not administered until 8:00p.m that night.

(c) I also accept that the failure to have the appropriate products readily available within half hour exposed Mr. Tesheira to the unnecessary risk to hypovolemic shock which later developed to DIC and later fluid overload. But for the receipt of timely transfusions of the correct blood that is packed red cells within half hour, or cryoprecipitate and fresh frozen plasma Mr. Tesheira would not have developed hypovolemic shock or that it would have progressed to DIC or it would have progressed further to fluid overload.

(d) Gulf View committed a cardinal sin in haematology by pumping O positive blood into Mr. Tesheira. The appropriate products were not available. This was not only carelessness but simply dangerous. It is very likely that this was a direct causative link to his fluid overload as O positive blood has no recuperative value for Mr. Tesheira in his condition of DIC. This resulted in the destruction of the red blood cells in his blood. The standard of care fell woefully short of what was required by the normal competent specialist exercising the skill in undertaking that task. The basic steps according to the normal competent specialist exercising the requisite skill in that undertaking was suitably explained by Dr. Pitt-Miller. These steps were not followed. The level of testing was inadequate and incapable of assisting those treating Mr. Tesheira as to the clotting ability of his blood.

**Dr. Roopchand**

126. Dr. Roopchand clearly admitted his duty of care to Mr. Tesheira as discussed earlier. Indeed from his role with Dr. Goetz in aborting the first TURP and in assisting Dr. Goetz when Mr. Tesheira experienced hypovolemic shock his duties extended beyond merely administering anaesthesia. The evidence demonstrates that Dr. Roopchand was in breach of the Bolam gold standard of care.

127. Dr. Roopchand:

(a) Failed to take any steps to arrest or control his bleeding post TURP. Mr. Tesheira was bleeding continuously from 1:10p.m and bled heavily and excessively from 2:50p.m (at least as recorded by the reporting nurse) to 3:30pm. In a full 40 minutes of heavy bleeding nothing was done. When Dr. Jones-Lecointe pointed out from her experience how quickly a cross match of blood can be done, CBC tests conducted, Mr. Tesheira's condition could have been assessed a long time before he went into hypovolemic shock. Dr. Jones-Lecointe's evidence is quite clear that this failure to act was a serious breach to deliver the standard of care expected of him and exposed Mr. Tesheira to an unnecessary risk. Dr. Roopchand and Gulf View failed to carry out PT/PTT tests or make proper pre-assessment of the use of aspirin which relates directly to the management of blood loss.

(b) Failed to act quickly to transfuse the relevant blood products. The question that still remains unanswered by Dr. Roopchand or Gulf View is where was the whole blood or plasma or packed red cells and plasma? Those were according to both experts, the only acceptable products which could have treated hypovolemic shock. Instead at 4:30p.m an hour after he developed hypovolemic shock he was being transfused with crystalloids and colloids. It is more probable that the suitable products were simply not on site at Gulf View.

(c) Failed to ensure that prior to the TURP procedure there were adequate supplies of packed red cells or whole blood to treat hypovolemic shock or fresh frozen plasma and cryoprecipitate to treat DIC. Dr. Jones-Lecointe doubted whether any blood was cross matched prior to surgery. Dr. Pitt-Miller also had her doubts. The nurses' recording that the request for blood was made at 3:30p.m. It is more probable than not that the products were not there as it took unusually long in Dr. Jones-Lecointe's view for the first transfusion at 4:30p.m. Then when Mr. Tesheira developed DIC based on the tests issued at 4:20p.m, Mr. Tesheira was only being administered the recommended products to treat DIC fresh frozen plasma and cryoprecipitate until

7:45p.m. Again this is indicative that Gulf View was simply not ready for this and Dr. Roopchand had failed to prepare adequately for the TURP.

(d) Failed to manage properly the transfusion of blood and administering excessive amounts of blood and blood products. From Dr. Roopchand's very own records at almost half an hour intervals from 4:30p.m Mr. Tesheira was being continuously transfused with the wrong blood. Instead of fresh whole blood he was administered 5 units of whole blood. Instead of receiving fresh frozen plasma and cryoprecipitate when he developed DIC he received this three hours later. Instead of the right type of blood he is administered three units of O positive. This according to Dr. Jones-Lecointe completely destroys his A red cells.

(e) Failed to properly monitor and record Mr. Tesheira's fluid output or ensure adequate proper or sufficient monitoring to monitor his status during the transfusion of blood and other fluids. There was a risk of fluid overload or TURP syndrome coming out of the TURP procedure. However it was double the risk when the 19 units of fluid and blood products cumulatively were transfused haphazardly. This according to the evidence of Dr. Pitt-Miller would lead to fluid overload. There was according to both Dr. Pitt-Miller and Dr. Jones-Lecointe inadequate monitoring during these procedures. The experts repeatedly called for the temperature and pulse recordings and the use of an oximeter.

128. But for these failures or omissions and actions by Gulf View and Dr. Roopchand, Mr. Tesheira would not have gone into hypovolemic shock, he would not have developed DIC, he would not have developed TURP syndrome and died of irreversible shock and DIC.

**Conclusion on Liability**

129. From these findings, the Defendants both failed to discharge their duties to the requisite standard of care expected of specialists and hospital authorities in managing the risk of post operative bleeding arising out of a TURP procedure. That mismanagement led to the development of hypovolemic shock which led to DIC, fluid overload and his ultimate death.

Returning to the issues: The Defendants were negligent in relation to pre operative care by the Defendants' failure to carry out PTT/PT tests or enquire into the taking of aspirin prior to surgery by failing to take appropriate steps to have available blood products. In relation to hypovolemic shock: the Defendants failed to monitor/record the deceased's post operative bleeding and prevent hypovolemic shock; failing to properly treat that condition. In relation to DIC: by the second Defendant's failure to appropriately treat with that condition including administering the correct products, and failure to properly manage the deceased transfusions. These cumulatively resulted in Mr. Tesheira's death. No submissions were made on the issue of contribution. There is no evidence forthcoming from the Defendants to provide any explanation for these events. I have found both parties negligent and there will be judgment against both Gulf View and Dr. Roopchand. I therefore answer the questions in the list of issues[29] above in the affirmative. I proceed to assess the damages.

**Damages**

130. Mr. Tesheira would have celebrated his 64th birthday two days ago had he not died during the post operative procedures of his TURP in 2004 at Gulf View. He would probably have been enjoying his retirement with his family, his wife now a lecturer at the University of the West Indies and their daughter Nicola who was then 17 years would be 28 today. Mr. Tesheira would have seen Nicola continue her studies and graduate from St Joseph's Convent Port of Spain in 2005. Enroll at the State University New York where she would graduate with a Bachelor of Science degree cum laude in 2008. Pursue her studies in medicine and by 2013 was expected to complete her clinical clerkship at the Richmond University Medical Centre in West New Brighton, Staten Island, New York City. Ironically Nicola would now be qualified as a medical doctor. Another daughter was Coryse who would be about 31 years of age today.

131. Mrs. Tesheira is entitled to damages on behalf of the estate of Mr. Tesheira under the provisions of the **Supreme Court of Judicature Act** Chap 4:01 and on behalf of his

[29] Issue 2() (i) to ii) Yes Issue 3(a), b) (i)(II), (C) (i)(ii) Yes. Issue 4(a) Yes 4(b) yes. Issue 5(a) Yes (b) Yes. Issue 6(a) Yes (b) Yes. Issue 7(a) Yes (b) Yes. (c) Yes Issue 8 (a) Yes (b) Yes. The steps and measures that a competent anaesthetist or hospital exercising ordinary skill would take and the steps and measures actually taken which were at not in accord with the common medical practice has been explained in this judgment.

dependents pursuant to the **Compensation for Injuries Act Chap. 8:05.** For this purposes of this claim the dependents are his wife and his daughter Nicola.

132. Whereas both parties have agreed that the multiplier/multiplicand approach is the appropriate method of computing damages, the main dispute concerns the calculation of the multiplicand in other words what would have been Mr. Tesheira's net earnings (less his living expenses) that would have enured to his benefit but for his death. It was submitted by the Defendants that the documentary evidence to demonstrate Mr. Tesheira's earnings was neither produced or are not reliable to properly determine what his earnings would have been after his death. Further it was submitted that as there was a high fluctuation in his actual earnings over the years which was not accounted for as well as a production bonus which was subject to its own uncertainties, an average net income of $50,000.00 per month should be the figure to be used in assessing the Deceased loss of earnings for the lost years.

133. It was further contended that based on the value of his estate as being ascribed in the probate of Mr. Tesheira's estate at $2.5million it suggests that he would have probably spent about 85% of his income and was left with less than 15%. Based on the figures provided that would equate to an expenditure in the millions squandering any savings he would have accumulated over the years. It is suggested that he was perhaps an extravagant spender or his income was overstated or that his income was hidden or passed to his wife on the survivorship.

134. In my view the Defendants have grossly underestimated the value of Mr Tesheira's net earnings. In 1993 he was appointed Vice President Sales and Agencies and Administration with CLICO. He was described by his wife as one who worked hard. She had to encourage him to buy things for himself, notwithstanding that he enjoyed gambling and owned "half of a racing horse". Mrs. Margaret Chow the Managing Director's Executive Assistant of CLICO testified that at the time of his death he was responsible for a sales force of 448 sales agents and 108 administrative personnel. He was successful in increasing the annualized premium income earned by CLICO from $917,815,838.41 in 2001 to $3,012,034,505.41 in

2003. Due to his success in increasing CLICO's annualized premium income he was well known and had an established reputation in the local insurance industry.

135. CLICO was a subsidiary of CL Financial Limited and a member of the CLF Group. In early 2009 CLICO as well as the CLF Group experienced severe financial difficulties and there was a drastic decline in its business and economic performance in 2009. This led to a drastic decline in the total income earned for the years 2008 to 2010. Due to these difficulties members of the sales force and management left employment and found jobs at the senior management level with other insurance companies. It is not in dispute that from 2009 Mr. Tesheira may have either retired, left the company or would have continued to the normal retirement age but admittedly at a reduced income. It is also likely that at retirement at 60 Nicola would still have been pursuing her studies but Mrs. Tesheira would have advanced in her career. There can be no dispute however that for the period 2004 to 2008 based upon the evidence of the administrators of CLICO that it was in a state of buoyancy. His salary from the date of his appointment in this senior management position rose from $280,338.91 to $4,086,137,66.00 which included a production bonus. That bonus increased from $29,600.00 in 1994 to $3,340,698.58 in 2003. Mrs. Tesheira received his last bonus payment for 2003 and a portion of 2004 in the sum of $3.8million. These production bonuses were his reward for the sales generated by the company's agency force for which he was responsible. In his letter of appointment "one of your main responsibilities is the achievement of the Company's sales quota through the efforts of the agency force which falls under your direction." What was achieved by the sales force over that period is by no means a small feat and to pluck a figure of $50,000.00 as an estimate of Mr. Tesheira's earnings is a gross undervalue. However there is no evidence to suggest that his bonus was linked to his own performance. If indeed it was there would be some warrant for looking at skepticism at the bonus paid to his successors. However under cross examination Mrs. Chow explained the direct link of bonuses paid to the performance of the Company's sales force. She did not however explain Mr. Tesheira's role in that performance, no doubt he would have contributed.

136. I am satisfied with the evidence produced by the employees of CLICO (Margaret Chow and Carolyn John) of Mr. Tesheira's gross earnings while he was alive. The spreadsheet

revealing his basic salary, vacations, allowances ,entertainment, pension life benefits, health benefits, overseas travel, convention benefits, motor vehicle benefits, mortgage subsidies, motor vehicle expense, production bonuses paid were all from the records of the company. Its authenticity was not challenged.

137. The **Harris v Empress Motors** [1983] 3 All ER 561 and **Coward v Comex Houlder Driving** (unreported) CA transcript 1988/622 approach for calculations of multiplicands based on a percentage approach may be inapplicable for high income earners. Senior Counsel for the Claimant has submitted that a better indicator of his lost income would be the amount that his successor in that same position earned over the years. There was no suggestion that Mr. Tesheira would not have been entitled to receive his allowances and bonuses in the lost years. The only issue is whether it is sufficiently reliable to utilize the sums actually earned by his successor as the actual earnings that would have been payable. Mrs. Chow in her evidence suggest that this is what would have been paid to Mr. Tesheira. I have not seen any cross examination to detract from this aspect of the evidence. This in my view would form a reliable basis upon which to adjudge Mr. Tesheira's income in the lost years. Indeed from all accounts Mr. Tesheira enjoyed a high standard of living. There is no doubt based on this track record that his gross earnings were in the millions.

<u>The Survivorship Action</u>

138. The estate of the Deceased may recover loss under the Supreme Court of Judicature Act under four main heads namely:

- Damages for pain and suffering (Non pecuniary loss)
- Loss of expectation of life (non-pecuniary loss)
- Loss of earnings (future pecuniary loss)
- Special damages

139. The Claimant makes no submission in respect of damages for pain and suffering (although there is evidence to support this) and likewise special damages and as such there is no need to consider these heads of loss.

140. I also agree with the parties that the conventional award of loss of expectation of life is $20,000.00. See **Tota Maharaj v Autocenter Ltd and ors** HCA 46 of 2003 per Rajkumar J.

Lost years

141. The head of loss in dispute amongst the parties and therefore requiring special consideration is that of loss of prospective earnings during the lost years. This is the portion of the earnings Mr. Tesheira would have earned from the time of death to the time he would have normally retired bearing in mind his living expenses which he would have expended both on himself and his dependants during that period. It seeks to compensate Mr. Tesheira's estate for the earnings he would have received had he lived and of which the estate has been deprived. The House of Lords in the case of **Pickett v British Rail Engineering Limited** [1980] AC 136 establishes that a cause of action to recover earnings for the "lost years" which the Deceased would have been able to bring had he been alive, survives his death. It was held that:

> *"The damages awarded to a plaintiff whose life expectancy was diminished were therefore to include damages for economic loss resulting from his diminished earning capacity for the whole period of the plaintiff's pre-accident expectancy of earning life and not merely the period of his likely survival. Those damages were to be assessed objectively, disregarding loss of financial expectations which were too remote or unpredictable and speculative, and after deducting the plaintiff's own living expenses which he would have expended during the 'lost years', since they would not have formed part of his estate."*

142. See **Gammell v Wilson** [1981] 1 All ER 578. **Robert Cardenas v MikiZimmer and anor** CV 2011-02493, **John v Securiserve Litd and anor.** CV2008-01892**.** In calculating the loss of earnings the common approach is to adopt the multiplicand and multiplier method.

The Multiplier

143. Mr. Tesheira would have continued to work and earn an income until a retirement age of 60. There was no immediate life threatening medical conditions and his wife reflected on his active sports life. In determining the appropriate multiplier, the Courts have examined the potential earning years of the deceased and reflected on the uncertainties of the future

employment. In **Anna Peters v Andre Ramjohn and anor** CV2007-01972 the Court used a multiplier of 6 for a 51 year old security guard who was injured resulting from an accident. The Court bore in mind the nature of his job and its inherent risks in assessing the multiplier. Similarly in **Mario Pizzeria Limited v Hardeo Ramjit** Civ App 146 of 2003 **and John v Secuiserve Limited** CV2008-01893 the court used multipliers of 9 and 11 respectively taking into consideration the age, type of work and other factors in relation to the respective Claimants who were aged 49 and 47 respectively. In **Dyial Lutchman v Balgobin** CV2007-02060 a multiplier of 3 was used for a 50 year old cable man.

144. In the instant case the Deceased was 53 years at the date of death. He was on course to retire upon attaining age 60[30]. Apart from this CLICO encountered financial hardships in or around 2009. I take into account as well that with such an earning potential it may have been likely that he would have found suitable alternative employment as some of CLICOs employees did. I agree with Senior Counsel for the Claimant that an appropriate multiplier in these circumstances would be 5, representing the years 2004-2008. Although the official collapse of CLICO occurred in early 2009, the effects of such collapse may have been felt as early as 2008 as is evident by the lack of production bonus paid out to the Deceased's successor, an observation the court must take into consideration.

The Multiplicand

145. In determining the multiplicand the earnings to be considered are the net annual income of Mr. Tesheira save for his annual living expenses and any tax he would have been required to pay. Both parties rely on the principles set out by Lord Justice O'Connor in **Harris v Empress Motors Ltd** [1983] 3 All ER 561 at page 575 in assessing the amount of recoverable damages and arriving at the multiplicand:

1) The ingredients that go to make up 'living expenses' are the same whether the victim be young or old, single or married, with or without dependents.

(2) The sum to be deducted as living expenses is the proportion of the victims' net earnings that he spends to maintain himself at the standard of life appropriate to his case.

[30] See the schedule annexed to Margaret Chow's witness statement which identifies the pension age as 60.

(3) Any sums expended to maintain or benefit others do not form part of the victim's living expenses and are not to be deducted from the net earnings.

146. Both parties have speculated on what the multiplicand may be. The Defendants have plucked the figure of $50,000.00 having regard to the uncertainties of his salary and bonuses post 2004 and Mrs. Tesheira has used the actual earnings of her husband's successor.

147. The difficulty with this approach used by Mrs. Tesheira lies in the fact that the proposed sums were actually earnings of another employee in her husband's position. In his submissions, Counsel for the Second Defendant submit that because of the fluctuation of income of the Deceased, the comparison to his replacement's income earning capability cannot be substantiated as there is no certainty that the deceased would have produced a similar outcome.

148. While there may be some merit in this criticism, the Schedule exhibited to the witness statement of Margaret Chow (the Schedule) shows a steady and consistent escalation of the earnings of the Deceased more so in the 5 years immediately preceding his death. This escalation in salary and bonuses continued after his death. It is likely on this evidence that in the years after his death his salary would also have increased until it reached its peak in 2008 and then decrease until the financial crisis of the company. It is legitimate for the Court to take into account events that have occurred since the time of death but prior to trial. This is a realistic view of the deceased's earning capacity in the "lost years". Certainly if there are negotiated wage increases for employees the estate should benefit from this increase as the employee would have earned it but for his death. In this regard I found the authorities relied upon by Senior Counsel for Mrs. Tesheira quite helpful. See McGregor on Damages 17$^{th}$ ed para 36-631, the **Swinefleet** (1947) LIL Rep 116, **Williamson v Thorncraft** [1945] 2 KB 658.

149. The Court of Appeal was faced with a similar situation in the case of **Ramnarine Singh and ors v Ansola** Civ. App. 169 of 2008 albeit in a personal injuries claim and nevertheless used the standard multiplicand/ multiplier method. In that case the Claimant was a self-employed upholsterer/joiner and thereby did not earn a fixed/basic salary. The trial judge in that case used the multiplicand/multiplier method. Counsel for the Defendant submitted that

given the uncertainty as to his earnings both past and future the Court should have awarded a Blamire award[31] which would have been the fairest means of compensation for loss of future earnings or in the alternative that the multiplicand/ multiplier was too high. The Court of Appeal found that the two cases were different from each other and upheld the trial judge's decision to use the multiplicand/ multiplier method. His Lordship said:

> "The critical question before the Judge in this case was what was the future earnings of the Plaintiff had he not been injured. There is no real uncertainty as to the likely future pattern of the Plaintiff's earnings. ...In every case there will be the possibility that things may not remain the same in the future. As Counsel for the owner submitted, there is a possibility that the Plaintiff's income may fall and that he may have no work at times or may go bust or be unemployed. This is so in all cases and the way that the Courts deal with such possibilities is to make an adjustment in either the multiplier or the multiplicand."

150. Apart from observing that Mr. Tesheira's income fluctuated from year to year as was shown with his successor and thus he was not the recipient of a fixed salary, there is no real uncertainty as to the likely future pattern of his earnings. It is now plain what could have been earned albeit by his successor. To the extent however that as the successor would have been in charge of the sales force and responsible for the generation of sales of the Company as well as to reflect the inherent uncertainties with some of the other bonuses such as 'entertainment', 'conventions' to name a few. I would discount the earnings post Mr. Tesheira's death by 15%. The sums would be subject to tax.

<u>The available surplus</u>

151. In an award for the lost years, the living expenses of the deceased would be deducted from his net earnings that is the cost of housing, heating, food, clothing and necessary traveling insurances. See **White v London Transport Executive** [1982] 1 All ER 410.

152. However in dealing with Mr. Tesheira whose life is settled and fairly predictable, an older married man earning a high income, he is likely to have a large surplus, in spite of the observation made about the small value quoted in the probate of his estate. The determination

[31] This award got its name from the case of **Blamire v South Cumbria Health Authority** [1993] 2 PIQR Q1.

of what he would have spent is not as speculative as in the cases of **White** and **Gamell**. It is expected with such a large income that a fairly small percentage would have yielded a high amount to be utilized on his living expenses. The appropriate deduction for living expense should be no more than one third. The multiplicand would then therefore be the available surplus of two-thirds of the net income.

153. I therefore hold that the lost years would cover the period 2004 to 2008 and is to be calculated as follows:

| | | | |
|---|---|---|---|
| 2004: | Total Earnings | 5,488,756.41 | |
| | 25% deduction (tax) | 3,079,603.00 | |
| | 15% (discount) | 2,617,662.55 | |
| | 33% LE (living expenses) | 1,753,833.91 | |
| | Net sum | | **1,753,833.91** |
| 2005: | Total Earnings | 10,600,919.15 | |
| | 25% deduction (tax) | 7,950,689.36 | |
| | 15% discount | 6,758,085.96 | |
| | 33% LE | 4,527,917.60 | |
| | Net sum | | **4,527,917.60** |
| 2006: | Total Earnings | 11,633,096.47 | |
| | 25% deduction (tax) | 8,724,822.36 | |
| | 15% discount | 7,416,099.01 | |
| | 33% LE | 4,968,786.34 | |
| | Net sum | | **4,968,786.34** |
| 2007: | Total Earnings | 10,475,425.06 | |

| | | | |
|---|---|---|---|
| | 25% deduction (tax) | 7,856,568.80 | |
| | 15% discount | 6,678,083.48 | |
| | 33% LE | 4,474,315.93 | |
| | Net sum | | **4,474,315.93** |
| 2008: | Total Earnings | 904,196.78 | |
| | 25% deduction (tax) | 678,147.58 | |
| | 15% discount | 576,425.44 | |
| | 33% LE | 386,205.04 | |
| | Net sum | | **386,205.04** |
| | | | **16,111,058.82** |

**The Dependency Action**

154. The Compensation for Injuries Act Chap 8:05 seeks to compensate the dependents of the Deceased upon his/her death. Section 3 of the Act states:

> *"3. Whenever the death of any person is caused by some wrongful act, neglect, or default, and the act, neglect or default is such as would before the commencement of this Act (if death had not ensued) have entitled the party injured to maintain an action and recover damages in respect thereof, then and in every such case the person who would have been liable if death had not ensued shall be liable to an action for damages, notwithstanding the death of the person injured, and although the death shall have been under such circumstances as amount in law to an arrestable offence."*

155. In fatal accident claims if the tortfeasor is found to be negligent he/she becomes liable for the sustenance and maintenance of the dependants of the deceased. This is so as the death of the deceased brings an end to the income he would have earned which would have been used to maintain his dependants and thus legislation has stepped in once again to ensure that these dependants are not left undone as a result of the negligence of the tortfeasor.

156. In assessing the sum to be awarded Dean-Armorer J in **Samuel v Surajh** HCA 2656 of 1998 said:

> *"The Court is bound by the principle in* ***Cookson v. Knowles [1978] 2 ALLER. 604****, where the House of Lords prescribed the division of the award into two parts namely pre-trial and post-trial loss. Interest is awarded only on the award for pre-trial loss. See too C.A. # 49/89* ***Southern Contracting Co. Ltd v. Esther Diaram and Others****.*
>
> *In keeping with the decision of the House of Lords in* ***Cookson v. Knowles (Supra)****, the Court ought to take into account the decreasing value of the dollar in making the award for post-trial loss."*

157. The principle in **Cookson** referred to above, was outlined by Lord Denning initially in the Court of Appeal his analysis at page 920:

> *"The practice has been for years (as we said in Jefford v. Gee [1970] 2 Q.B. 130) to "award one lump sum calculated by taking the yearly pecuniary loss and multiplying it by the numbers of years' purchase." That practice was convenient when there was little inflation. But now that inflation has become rampant and looks like continuing, the practice should be altered. The pecuniary loss to the widow and children should be divided into two parts: the one part being from the date of death to the date of trial; the other part being from the date of trial onwards into the future. That is the way in which the loss of earnings are divided in cases of personal injuries when the injured man sues. His loss of earnings is divided into two parts: the first part being included in the special damages up to the date of trial; the second part being the loss of future earnings from the date of trial onwards. Likewise now in Fatal Accidents Acts cases. Otherwise you would get injustice done to the defendants...The correct way, in times of inflation, is to divide the award into two parts: the first part being the actual pecuniary loss up to the date of trial: the second part being future pecuniary loss from the date of trial onwards. The first part can be calculated arithmetically, just like special damages. The second part should be calculated by taking the earnings which the deceased would have been receiving at the date of trial, and then using an appropriate multiplier."*

158. Further, this same principle was affirmed by Lord Diplock of the House of Lords in his summation of the assessment of damages said:

1. In the normal fatal accident case, the damages ought, as a general rule, to be split into two parts: (a) the pecuniary loss which it is estimated the dependants have already sustained from the date of death up to the date of trial ("the pre-trial loss"), and (b) the pecuniary loss which it is estimated they will sustain from the trial onwards ("the future loss").
2. Interest on the pre-trial loss should be awarded for a period between the date of death and the date of trial at half the short term interest rates current during that period.
3. For the purpose of calculating the future loss, the "dependency" used as the multiplicand should be the figure to which it is estimated the annual dependency would have amounted by the date of trial.
4. No interest should be awarded on the future loss.
5. No other allowance should be made for the prospective continuing inflation after the date of trial.

<u>The Multiplier</u>

159. With respect to the multiplier, this is calculated from the number of years the dependency would have continued had the Deceased lived. In the case of **Mallet v McMonagle** [1970] A.C. 166 Lord Diplock at page 170 said:

*"The starting point in any estimate of the number of years that a dependency would have endured is the number of years between the date of the deceased's death and that at which he would have reached normal retiring age. That falls to be reduced to take account of the chance, not only that he might not have lived until retiring age, but also the chance that by illness or injury he might have been disabled from gainful occupation."*

160. Thus this figure starts from the date of the Deceased's death. However it is a figure susceptible to change based on the vagaries of life that may arise from the facts surrounding the Deceased, his age, his lifestyle amongst other factors. In **Corbett v Barking, Havering**

**and Brentwood Health Authority** [1991] 2 Q.B 408 Purchas LJ set out in a clear and helpful way several of the factors that will be relevant to the assessment of the multiplier in a typical fatal accidents claim:

*"The use of the multiplier/multiplicand approach for the capitalisation of damages "in futuro" to be compensated by a once-for-all lump sum provision is an adequate and well known instrument; but, like all instruments, it must be used in an appropriate manner. In every assessment of damages 'in futuro' to be compensated by an immediate payment there are at least five essential elements: (1) the likelihood of the provider of the support continuing to exist; (2) the likelihood of the dependant being alive to benefit from that support; (3) the possibility of the providing capacity of the provider being affected by the changes and chances of life in either a positive or in a negative manner; (4) the possibility of the needs of the dependant being altered by the changes and chances of life, again in a positive or negative way; (5) an actuarial discount to compensate (a) for the immediate receipt of compensatory damages in advance of the date where the loss would in fact have been incurred, and (b) the requirement that the capital should be exhausted at the end of the period of the dependency …*

*As a general rule in order to arrive at the multiplier it is necessary to take the following step: (a) consider the combined effect of (1) and (3) in order to arrive at the number of years during which the provision of the support is likely to be available if needed by the dependant; (b) consider the combined effects of (2) and (4) in order to arrive at the number of years during which the dependant is likely to need the support; (c) apply (5) to the lesser of (a) and (b) above, with an added but usually minor discount to take account of an outside chance that choice between (a) and (b) might in the event prove to be wrong."*

161. However the point of adding an actuarial discount to compensate must be read in conjunction with the decision of Lord Lloyd in the case of **Wells v Wells** [1998] 3 All ER 481. In that case Lord Lloyd held that a multiplier should not be discounted based on the argument of possible vicissitudes of life. He said at page 497:

*"There is no purpose in the courts making as accurate a prediction as they can of the plaintiff's future needs if the resulting sum is arbitrarily reduced for no better reason than that the prediction might be wrong. A prediction remains a prediction. Contingencies should be taken into account where they work in one direction but not where they cancel out. There is no more logic or justice in reducing the whole life multiplier by 15% or 20% on an agreed expectation of life than there would be in increasing it by the same amount … The whole point of agreeing a life expectancy, if it can be done, is to exclude any further speculation."*

162. In the instance I would also use a multiplier of 5 reflecting the remaining working years had Mr. Tesheira survived the operation. There is no great prediction on his dependency which would have fallen in 2009 post the CLICO decline.

Multiplicand

163. The multiplicand is generally the net annual value of dependency recoverable by the dependents commencing from the date of death of the deceased. The more common method in assessing the value of dependency has been to express the multiplicand as a fraction or percentage of the Deceased's annual earnings. This methodology was explained by O'Connor LJ in the case of ***Harris v Empress Motors Ltd*** [1984] 1 WLR 212 where he said:

*"In the course of time the courts have worked out a simple solution to the … problem of calculating the net dependency under the Fatal Accidents Acts in cases where the dependents are wife and children. In times past the calculation called for a tedious inquiry into how much housekeeping money was paid to the wife, who paid how much for the children's shoes, etc. This has all been swept away and the modern practice is to deduct a percentage from the net income figure to represent what the deceased would have spent exclusively on himself. The percentages have become conventional in the sense that they are used unless there is striking evidence to make the conventional figure inappropriate because there is no departure from the principle that each case must be decided on its own facts. Where the family unit was husband and wife the conventional figure is 33% and the rationale of this is that broadly speaking the net income was spent as to one-third for the benefit of each and one third for their joint benefit … Where there are children the deduction falls to 25%."*

164. Therefore in assessing the value of dependency the conventional percentage used where the Deceased has left both a widow and children as dependents would be 75% of his earnings. This rule will oftentimes only be departed from where there appears to be some unusual feature or striking evidence that will make such an approach inappropriate

165. Parker LJ in **Owen v Martin** [1992] PIQR *Q151* in expressing his views on the judgment of O'Connor in **Harris** said:

*"That O'Connor LJ did not intend to lay down any rule that in the absence of striking evidence to the contrary two thirds of net income must be regarded as the value of the dependency I have no doubt. If he did he would clearly have been wrong.*

*It is clear that the value of the dependency cannot be taken at such an arbitrary figure and must always depend on facts. See Shiels v Cruickshank [1953] 1 All ER 874, [1953] 1 WLR (HL) 533, Mallett v McMonagle[1970] AC 166, [1969] 2 All ER 178, per Lord Diplock at 176 D-G, Taylor v O'Connor [1977] AC 115 where the figure taken amounted to about 50 percent and there was no hint of a two thirds rule, and Coward v Comex Houlder Diving Ltd unreported CA transcript 1988/622, where the extent of the normal rule was discussed and the matter dealt with as a question of fact.*
*I cite for its particular value in the present case from Lord Diplock's speech in Mallett v McMonagle at page 176 where he said:*

*"The role of the court in making an assessment of damages which it depends upon its view as to what will be and what would have been is to be contrasted with its ordinary function in civil actions of determining what was. In determining what did happen in the past a court decides on the balance of probabilities. Anything that is more probable than not it treats as certain. But in assessing damages which depend upon its view as to what will happen in the future or would have happened in the future if something had not happened in the past, the court must make an estimate as to what are the chances that a particular thing will or would have happened and reflect those chances, whether they are more or less than even, in the amount of damages which it awards."*

166. I am not convinced in this case that Mrs. Tesheira properly set out the value of the dependency of herself and her daughter. Save for general lists of expenses and bald statements of receiving lump sums there is no supporting documentation. I would adopt the conventional method of applying a percentage of the earnings of the deceased. Because of the fluctuation in the earnings and the uncertainty referred to earlier I would also utilize the earnings of the successor and deduct it by a further 15%.[32]

| | | | |
|---|---|---|---|
| 2004: | Net Earnings[33] | 2,617,662.55 | |
| | 25% | | **1,963,251.91** |
| 2005: | Net Earnings | 6,758,085.96 | |
| | 25% | | **5,068,564.47** |
| 2006: | Net Earnings | 7,416,099.01 | |
| | 25% | | **5,562,074.26** |
| Net | Net | 6,678,083.48 | |
| | 25% | | **5,008,562.61** |
| 2008: | Net Earnings | 576,425.44 | |
| | 25% | | **432,319.08** |
| | | | **18,034,772.33** |

Interface between Judicature Act and Compensation for Injuries Act

167. To prevent the duplication of the awards under these distinct actions the Court is required to take into account, any benefit the dependents would receive from the estate under the Supreme Court of Judicature Act. See **Ramnarine v Hospedales** H.C.S. 953/1984. See

[32] **Mc Gregor on Damages** 18th Ed. pg 1526 para 36-075 said: *"Where a man who is both a husband and a father is killed it is usual first to calculate the family dependency and then to apportion the resulting figure between the wife and each child separately. Thus the main calculation is of the value of the dependency of all taken together."*
[33] Total earnings less 25% tax less 15% discount.

**Pickett v British Rail Engineering Ltd; British Rail Engineering Ltd v Pickett** - [1979] 1 All ER 774 from the dicta of Lord Wilberforce in setting off one claim against the other. His Lordship in that case said:

> *In cases, probably the normal, where a man's actual dependants coincide with those for whom he provides out of the damages he receives, whatever they obtain by inheritance will simply be set off against their own claim. If on the other hand this coincidence is lacking, there might be duplication of recovery. To that extent injustice may be caused to the wrongdoer. But if there is a choice between taking a view of the law which mitigates a clear and recognised injustice in cases of normal occurrence, at the cost of the possibility in fewer cases of excess payments being made, or leaving the law as it is, I think that our duty is clear. We should carry the judicial process of seeking a just principle as far as we can, confident that a wise legislator will correct resultant anomalies.*

168. This approach was used by Dean Armorer J in **Samuel** (ibid). In that case the judge apportioned two thirds of the share awarded to the daughter being the only child of the Deceased in the dependency claim and offset it against the estate claim.

169. In this case the estate claim is valued at $16,131,058.82 the dependency claim is valued at $18,034,772.33. Accordingly the Court will award the sum of $18,034,772.33 (total estate + balance of dependency) as damages under these claims. I will apportion the remainder of the dependency 2/3 to the wife 1/3 to Nicola[34]; thus $1,269,142.34 and $634,571.17 respectively.

Interest

170. No interest is awarded on damages for the lost years.

**Award**

171. A: Damages under Supreme Court of Judicature Act

Loss of expectation of life: $20,000.00

[34] The dependency of the wife will continue for a longer period than the daughter.

Damages for the lost years of $16,111,058.82

Total $16,131,058.82

B: Damages under Compensation for Injuries Act $1,269,142.34 and $634,571.17 ($1,269,142.34 for Mrs. Tesheira and $634,571.17 for Nicola).

172. Again to avoid a double recovery this sum is reduced by the amount recovered in the Claimant's settlement with Dr. Goetz.

**Conclusion**

173. Gulf View and Dr. Roopchand were negligent in their management of the risk of post operative bleeding arising out of the TURP performed on 13th April 2004. There will be judgment against them for the total sum of $18,034,772.33.[35] I will hear Counsel on the quantification of costs on the prescribed scale.

174. Medical science has conferred great benefits but it is attendant by considerable risks. The law of negligence has developed around the management of those risks that are foreseeable. Doctors faced with emergencies ordinarily will try their best to redeem the patient however they must where it is within their power to do so make reasonable attempts to prevent such emergencies from occurring in the first place and carefully manage those risks by the Bolam gold standard.

175. I have taken note that in managing this case unfortunately some basic medical questions in this case were not answered jointly by the experts for both parties. In medical negligence claims experts of the parties should as far as possible collaborate and agree on certain scientific/ medical issues. It is useful even at a pre trial stage for the experts to be engaged in "hot tubbing" to arrive at some consensus on medical opinion. Further I have commented in earlier judgements on the utility of "procedural consensus" amongst attorneys. Such an approach would have considerably reduced the length of these proceedings when I asked as

[35] Less the sum paid by Dr. GoetzSee this Court's earlier ruling on the effect of the compromise agreement and that to avoid a double recovery the ex gratia sum paid by Dr Goetz should be taken into account in the final award.

far back as 2009 on whether there could be consensus on extensions of time for filing witness statements and on attending mediation. I have also taken note of Mrs. Tesheira's evidence and her interaction with Gulf View after the death of her husband. From the evidence there has been no expression of regret from those with whom she entrusted the care of her husband instead the reaction was quite the opposite with cold and unhelpful responses. The medical profession should recognise the human element in these types of cases and to a large extent grieving victims and families simply want an explanation, information and acknowledgement of human error, an apology. To this extent some jurisdictions notably some states in the United States and Canada have implemented "Apology legislation". Such legislation enables medical professionals and hospital authorities to say "sorry" without the apology being used as evidence of wrongdoing. It recognises that apology is a part of meaningful disclosure and consistent with the principles of honesty and transparency that are integral to a system of shared accountability. It underscores how important apology and disclosure are in addressing medical errors. Such legislation can go a long way to the settlement of medical claims. At the very least it can focus minds on the need to provide sincere expressions of regret and remorse satisfying an emotional need of affected parties if not at least serving as a reminder of the fallibility of humans**.**

**Vasheist Kokaram**

**Judge**