REPUBLIC OF TRINIDAD AND TOBAGO

IN THE COURT OF APPEAL

Civil Appeal No. 087 of 2015
Claim No. CV 02051 of 2009
HCA 542 of 2005

BETWEEN

GULF VIEW MEDICAL CENTRE LIMITED
CRISEN JENDRA ROOPCHAND

Appellants

AND

KAREN TESHEIRA

Respondent

Civil Appeal No. 093 of 2015
Claim No. CV 02051 of 2009
HCA 542 of 2005

BETWEEN

GULF VIEW MEDICAL CENTRE LIMITED
CRISEN JENDRA ROOPCHAND

Appellants

AND

KAREN TESHEIRA

Respondent

PANEL: A. Mendonça, J.A.
P. Moosai, J.A.
J. Jones, J.A.

APPEARANCES:

Ms. M. O'Rourke Q.C. and Mr. A. Beharrylal instructed by Mr. W. Seenath for the first Appellant.

Mr. R. Kawalsingh instructed by Mr. R. Mungalsingh for the second Appellant.

Mr. D. Mendes S.C. instructed by Ms. M. Ferdinand for the Respondent.

DATE DELIVERED: 17th November, 2017.

I have read the Judgment of Jones, J.A. and I agree with it.

A. Mendonca
Justice of Appeal

I too agree.

P.Moosai
Justice of Appeal

JUDGMENT

Delivered by Jones, J.A.

1. Russel Tesheira ("the deceased") died on 13th April 2004 after undergoing a surgical procedure known as a Transurethral Resection of the Prostate ("TURP"). This case concerns his medical treatment after the successful completion of the TURP procedure. The appellants admit that the deceased died at around 11.30 pm on the day of surgery as a result of congestive cardiac failure and/ or irreversible shock and/or DIC and/or hemorrhage complicated by DIC and/or fluid overload.

2. DIC is a syndrome in which uncontrolled clotting in the blood circulation is activated. The clotting factors and platelets in the blood, vital in controlling bleeding, are consumed and bleeding results. Fluid overload refers to a condition where there is too much fluid in the blood, more than the heart can effectively cope with, and for patients with cardiac impairment if left unaddressed or unchecked may lead to heart failure.[1]

[1] These explanations were given by the expert anaesthetist and were unchallenged.

3. The first appellant, Gulf View Medical Centre, operates a private hospital ("the hospital") situate at Gulf View La Romaine offering to members of the public, for reward, medical treatment and/or access to such treatment. The second appellant, Crisen Jendra Roopchand, is a medical doctor who provided specialized anesthetic services at the hospital. The trial judge found the appellants to be negligent in the care and treatment of the deceased and that this negligence resulted in his death and awarded damages in the sum of $18,034,722.33. These appeals, heard together, are against the judge's findings on both liability and damages.

4. The action was brought by the respondent, Karen Tesheria, in her capacity as the widow and executrix of the estate of the deceased, on behalf of his estate and dependants under the Supreme Court of Judicature Act and the Compensation for Injuries Act respectively. Initially the action was commenced against the first and second appellants and Dr. Lester Goetz ("Goetz"), a specialist urologist, as defendants. The action against Goetz was settled prior to trial, without an admission of liability on his part, by way of an ex gratia payment. The judge ordered that the sum agreed to be paid by Goetz be deducted from the sum awarded by him to the respondent.

5. Although a joint defence was filed on behalf of the appellants and Goetz by the time of trial the appellants were separately represented. Despite filing witness statements the appellants placed no evidence before the trial judge. At the close of the respondent's case the appellants made a no case submission and, when called upon by the trial judge to do so, elected to call no evidence.

LIABILITY

6. The factual basis of the respondent's case on liability was drawn from the admissions made by the appellants in their defence and the further and better particulars to that defence supplied by them (collectively called "the defence"); the evidence of the

respondent and the contents of the deceased's medical records which, in the main, comprised contemporaneous notes made by the attending doctors and the nurses from the time the deceased was admitted to the hospital to the time of his death. The medical evidence was given by two expert witnesses: an anaesthetist and a haematologist.

The defence

7. Essentially the defence raised by the appellants was that they were not negligent and, at all times prior to and subsequent to the procedure, exercised due care and skill. They specifically aver that the first appellant always maintained adequate supplies of blood platelets, fresh frozen plasma, cryoprecipitate and other clotting agents; was able to obtain additional supplies immediately from the Mount Hope Hospital[2] and the National Blood Bank; and that at all material times Group O universal donor blood was available which could readily be transfused into any person with another blood group including the deceased. Insofar as the defence attributed blame for the death they alleged that the deceased contributed to his death by concealing that prior to the procedure he had taken aspirin and other drugs that thin the blood.

8. The appellants admit that they were aware that heavy bleeding was a risk of the TURP procedure and that the deceased was at all times at risk of excessive bleeding during and after the procedure. They also admit that in performing the TURP procedure they were under a duty to ensure that during or 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

[2] Another name for the Eric Williams Medical Sciences Complex.

deceased; and

(c) such transfusions as may have been necessary were carefully managed and carried out using such equipment tests and practices as would minimize the risk of or prevent the deceased experiencing fluid overload or other deleterious effect from same.

9. In addition the first appellant accepted that it was under a duty to:

(i) ensure that all staff, visiting consultants and specialists, including Goetz and the second appellant and its attending nurses, involved in the provision of medical treatment at the hospital, whether their employees or not, were "sufficient in number, properly qualified and reasonably competent to do so";

(ii) provide adequate and proper equipment, material and facilities so as to enable the safe and reliable delivery of medical care to persons attending the hospital for treatment."

10. In similar manner the second appellant accepted that, together with Goetz, he was 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.

11. With respect to the events of the day the appellants admit that the deceased was taken to his room at 1.10pm after the completion of the surgery. Excessive bleeding began at about 2.50 pm and the first appellant was informed of the deceased's bleeding at or around 2.50 pm and the second appellant at about 3.10 pm.

12. At around 3.30pm the deceased was taken to the operating theatre. From 4pm onwards other consultants, including a haematologist and an anaesthetist, were consulted. From 4 pm until his death the deceased was administered Vitamin K injections, Calcium Gluconate, fresh frozen plasma, whole fresh blood, Cryoprecipitate and packed cells. PT and PTT tests were ordered at around 4.00- 4.15pm and the results received between

4.45 pm and 5.00pm. These tests were again requested on or about 7.30 pm and the results received at approximately 45-60 minutes later.

13. The deceased's treatment was prescribed by two anesthetists one of whom was the second appellant. The first time that the deceased was transfused with blood after the surgery was around 4.30 pm. On the instructions of Goetz and/or the second appellant and/or the servants and agents of the first appellant between the period of 4.30 to 11.30 pm the deceased was transfused with 11 units of whole blood including 3 units of group O positive whole blood; 2 units of fresh frozen plasma and 3 units of cryoprecipitate.

14. No supplies of blood or blood products were ordered after the completion of the TURP but additional blood supplies were requested from the Eric Williams Medical Sciences Complex at around 5 pm. The complex made available 2 packs of whole blood, 2 packs of fresh frozen plasma and 3 packs of cryoprecipitate which were received at the hospital around 7.30 pm.

15. With respect to equipment the appellants admit that there was available at the hospital a central venous line and equipment to do CBC monitoring, auscultation of the chest, and chest x-rays. What was not available was equipment to test arterial blood gases.

The judge's findings

16. The judge found that the deceased died from complications that developed from excessive bleeding after the TURP procedure performed on him on 13th April 2004. According to the judge the deceased succumbed to a trilogy of complications: of hypovolemic shock leading to DIC and then TURP syndrome or fluid overload which ultimately led to his demise. He found that this condition could have been managed by timely transfusions of fresh whole blood and platelets, fresh frozen plasma and cryoprecipitate.

17. The judge concluded that by their defence the appellants admitted that it owed a specific duty of care to the deceased and the second appellant admitted that his duty went beyond simply administering anaesthesia. Having found that there was an admission that a duty of care was owed to the deceased he identified the two issues that remained for his determination to be: (i) whether the appellants breached their duty of care to the deceased; and (ii) whether that breach actually caused his death.

18. The judge determined that there was a breach of the requisite standard of care expected of the first appellant and that it failed to:

(i) make attempts to monitor and contain the deceased's post-surgical bleeding;

(ii) maintain appropriate supplies of blood and blood products and clotting agents sufficient to meet the risk of bleeding;

(iii) have the appropriate blood products readily available within half an hour on site;

He also found that the first appellant committed a cardinal sin in haematology by pumping O positive ("O+") blood into the deceased and that the level of testing was inadequate and incapable of assisting those treating the deceased as to the clotting ability of his blood.

19. The judge determined that the second appellant was in breach of the relevant standard of care and was negligent in that he failed to:

(i) take any steps to arrest or control the deceased's bleeding post TURP;

(ii) act quickly to transfuse the relevant blood products;

(iii) 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;

(iv) manage properly the transfusion of blood and administering excessive amounts of blood and blood products; and

(v) properly monitor and record the deceased's fluid output or ensure adequate proper or sufficient monitoring to monitor his status during the transfusions of blood and other fluids.

20. In addition he found that the appellants failed to carry out PT or PTT tests or make a proper pre-assessment of the use of aspirin which, he said, related directly to the management of the blood loss. He concluded that but for these failures or omissions and actions by the appellants the deceased 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.

Challenges to the judge's findings on liability

21. The grounds of appeal filed on behalf of the appellants are wide and far ranging. Between them the appellants have filed 78 grounds of appeal. Of the first appellant's 60 grounds of appeal 6 deal with bias and were ultimately not pursued by this appellant. Understandably there is some overlap in the challenges to the judgment relied on by the appellants. In addition, in its oral submissions before us, the second appellant adopted the submissions of the first appellant where not in conflict with his case.

22. By way of general complaint the first appellant submits that contrary to the guidelines in the case of **English v Emery Reimbold and Strick Ltd. (Practice Note)** [3] the judge failed to give adequate reasons for his decision or address or give the appropriate weight to its main submissions. Insofar as the first appellant relies on this failure as a ground for setting aside the decision of the judge there is no merit in the submission.

[3] [2002] WLR 2409

23. The practice note arose out of three appeals to the Court of Appeal on the ground that the judges had failed to give adequate reasons for the decisions. In the first case the trial judge had accepted the conclusions of the defendant's expert but gave no reasons for that conclusion. In the second case the judge stated that he was particularly impressed by the defendants' expert, that he accepted his evidence throughout, but made no analysis or explanation of that evidence. In the final case the judge failed to give reasons for her decision on costs.

24. All three appeals were dismissed on the basis, taken from the headnote, that while a judicial decision which affected the substantive rights of the parties should be reasoned a judge was not required to deal with every argument or identify or explain every factor which weighed on the judge. However, as a matter of practice, the issues the resolution of which were vital to the conclusion should be identified and the manner in which they were resolved clearly explained so that the judgment enabled the parties and any appellate tribunal to readily analyse the reasoning essential to the decision.

25. Further an unsuccessful party should not seek to overturn a judgment for inadequacy of reasons unless, despite the advantage of considering the judgment with knowledge of the evidence and submissions at trial, that party was unable to understand why the judge had reached an adverse decision. In the first two cases the judges accepted that there were shortcomings in the judgments but were satisfied that they could follow the reasoning of the judge when considered in the light of the evidence and the submissions at trial. In the last case the judges were satisfied that the conclusion arrived at by the judge was one that was open to her.

26. The key element here therefore is the ability to analyze the decision in the light of the evidence and submissions made before the judge to ascertain whether the conclusions arrived at by the judge are supportable. This is the role of a Court of Appeal. The appeal succeeds not as a result of the judge's failure to explain every issue addressed by

the parties but where the judge fails to address a material aspect of the case that could affect the decision or comes to a conclusion that cannot be supported by the evidence or the relevant law. The failure of a judge to provide support for the conclusions arrived at, while clearly unsatisfactory, is of itself not fatal. It falls upon the appellants here therefore to go a step further and establish that there is no basis, in law or in fact, for the conclusions arrived at by the judge.

27. I do not propose to treat with all the grounds of appeal filed. Rather I propose to deal with only challenges relevant to the determination of these appeals. In the main these challenges are to the factual basis of the judge's findings, his findings on the duty of care owed to the deceased and the standard of care to be applied to the first appellant and his conclusions on negligence and causation. In treating with these challenges some of the secondary challenges, not necessarily determinative of these appeals, will be addressed.

28. In examining these challenges I of course bear in mind the strictures on a Court of Appeal where what is challenged is the exercise of a judge's findings of fact or credibility. It is only in rare occasions that a Court of Appeal will reverse findings of fact made by a judge of first instance: **Beacon Insurance Co. Ltd v Maharaj Bookstore Ltd**[4]. Cases in which there could be a successful challenge would include cases in which the judge came to findings in the absence of any evidence or where the judge misunderstood the evidence or arrived at a decision that no reasonable judge could have reached: per **Bereaux J.A** in **The Attorney General of Trinidad and Tobago v Anino Garcia**[5]**.**

29. The primary facts found by the judge, in the main, come from the medical notes and the evidence of the experts. Because the appellants challenge the judge's acceptance of the contents of the medical notes and the expert evidence it is necessary to treat with these

[4] [2014] UKPC 21
[5]Civil Appeal No 86 of 2011

challenges before identifying the facts upon which the judge came to the findings now challenged by the appellants.

The challenge to the medical notes

30. Fundamental to the appeal is the evidential status of the medical records. In particular the notes of the doctors and the nurses for 13th April 2004 contained, in the main, in 4 documents described as progress sheets and a document described as nurses' notes (hereinafter collectively referred to as "the medical notes"). The admissions of the appellants apart these medical notes together with the laboratory and other reports, including the autopsy report, contained in the medical records provide the only information from the appellants of the deceased's medical treatment and condition on that day.

31. The first appellant's challenge is to the use by the judge of the contents of these medical notes. The submissions of the first appellant are that:

(i) the judge fell into fundamental error as to the evidential status of the medical notes and their use in circumstances where none of the makers of the notes gave evidence. As hearsay documents they had evidential status only as to the recording at the time [of] recording but not as to the truth of the contents;

(ii) the judge ignored the fact that the notes contained opinion evidence and in the circumstances if the authors were unknown it would be impossible to assess whether the author had sufficient expertise and experience to be able to write the note and that it be relied on for the truth of its contents.

32. A submission had been made by the first appellant to the judge on the hearsay aspect of the medical records. This was not an objection dealt with by the judge in his judgment. The judge however referred to and relied heavily on the medical notes and other

documents in the medical records. He specifically draws conclusions of fact from their contents. It is clear therefore that he considered the contents of the medical records, and in particular the medical notes, not simply for the fact that they contained statements made by the appellants and Goetz at the time but for the truth of the contents and accepted that what was contained in the records was an accurate account of what occurred on that date.

33. The medical records for that day are identified in the respondent's list of documents and comprise the nurses' and the doctors' progress notes and a number of other reports purporting to originate from the first appellant all dated 13th April 2004. None of these latter documents give the time of their issue or any indication of the time when the actions described in them were ordered or performed. Among these documents are 9 laboratory reports identifying units of cross- matched blood. Also a part of the medical records is an autopsy report dated 14th April 2004.

34. Contained in the appellants' bundle of documents are copies of what the appellants refer to as blood tags. These also formed a part of the medical records considered by the experts. Like the laboratory reports these blood tags, although dated 13th April, do not contain any indication of the time on that day that they came into existence.

35. There was no objection made to the admissibility of the medical records and the first appellant admits that the judge was entitled to determine the weight to be placed on them. Ultimately, in the circumstances that applied in this case, it was open to the judge to determine whether or not what was said in the notes was true. In the absence of an explanation by the judge as to the basis for the exercise of his discretion in this regard, as a Court of Appeal, we are entitled to look at the matter afresh and come to our own conclusions on how the discretion ought to have been exercised: **Romauld James v The Attorney of Trinidad and Tobago**[6].

[6] Civil Appeal 154 of 2006

36. The medical records, and in particular the medical notes, formed a part of both the respondent's and the appellant's lists of documents. The respondent's bundle of documents included what was termed 'transcriptions' of the progress notes that were originally in manuscript. None of these documents were subjected to a notice to prove in accordance with **Part 28.18 of the Civil Proceedings Rules** ("the CPR") and in the circumstances the authenticity of these documents are deemed to have been admitted.

37. From the transcriptions it can be seen that the notes bear the name of Nurse Khan, with respect to the nurses' notes; and, with respect to the doctors' notes, the names of Goetz and the second appellant respectively. The authorship of the doctors' notes and the responsibility for the nurses' notes therefore are not in dispute.

38. The evidence of the respondent verifying the contents of the medical records, copies of which were obtained from the first appellant, was not challenged. These medical records were tendered into evidence through both of the experts. The evidence is that the copies of the records produced at trial were accurate copies of the original records of the deceased kept by the first appellant.

39. The determination of the evidential status of the notes first requires an examination of the purpose for which the notes were tendered at the time they were admitted. If sought to be admitted to prove the truth of what was being said in them then the notes would be hearsay and the contents admissible only as an exception to the hearsay rule or pursuant to a notice to admit such evidence under **Part 30** of **the CPR**.

40. Of course it was also open to the judge to exercise his discretion to admit the notes for the truth of the contents in the absence of a notice to that effect pursuant to **Part 30.8** of **the CPR.** If however the notes were being used merely to prove the fact that this was what was being said by the persons ultimately responsible for the deceased's care at the time then they were not hearsay and admissible for that purpose.

41. In the instant case because of the manner in which the case progressed it made no difference whether the notes were initially tendered for the truth of the contents or merely as a contemporaneous record of what was being said by the nurses, Goetz and the second defendant at the time since: (i) by and large the statements made in the notes accorded with the admissions already made by the appellants in their defence; and (ii) applying the principle stated in **Wizniewski (A Minor) v Central Manchester Health Authority**[7] the judge would have been entitled to draw inferences adverse to the appellants. One of the inferences open to the judge would have been that what was being said in the notes, or contained in the medical records, was true or was a true representation of what transpired on that day.

42. The law in this regard was restated by Brooke LJ in **Wizniewski** in this manner:

> "(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 or to weaken the evidence, if any, adduced by the 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

[7] [1998] EWCA Civ. 596

potentially detrimental effect of his/her absence or silence may be reduced or nullified."[8]

43. Usually, prior to trial, all that a Claimant in a medical negligence case would have to rely on with respect to the medical aspect of the case would be the medical records provided by the defendants. This would be a key component in a claimant's case. It would be evidence, not of the truth of what was contained therein, but of what the professionals said they observed, thought or did at the time. Initially these would be the documents upon which the claimant's experts would base their testimony and opinions.

44. Of course, in the normal course of events, a defendant would lead evidence as to what actually occurred and, in the course of that evidence, would be entitled to accept or challenge their record of what was said at the time. In those circumstances the judge would be entitled to come to a conclusion as to the veracity of the evidence of the defendant taking into consideration any conflicts between the contents of their records and the reasons given for such conflicts. In the case of a conflict and for the purpose of assessing credibility it would be for the judge to determine whether to give greater weight to what was said in the written record or to the oral evidence.

45. The appellants led no evidence for tactical reasons. In the case of **British Railways Board v Herrington**[9], referred to and applied in Wisniewski, the fact that for tactical reasons no evidence was led by the defence was not considered to be a credible explanation and in those circumstances the judge was entitled to draw inferences adverse to the defendant. According to Lord Diplock:[10]

"The appellants, who are a public corporation, elected to call no witnesses, thus depriving the court of any positive evidence as to whether the condition

[8] At page 25
[9] [1972]A.C. 877;
[10] at pages 930F-931B

> of the fence and the adjacent terrain had been noticed by any particular servant of theirs or as to what he or any of their other servants either thought or did about it. This is a legitimate tactical move under our adversarial system of litigation. But a defendant who adopts it cannot complain if the court draws from the facts which have been disclosed all reasonable inferences as to what are the facts which the defendant has chosen to withhold."

46. Although no evidence was given by the appellants, there was evidence pointing to negligence on their part: admissions made and sequence of events given by them in the defence; the evidence of the respondent with respect to the deceased's continuous and increasingly heavy bleeding; what the appellants and Goetz were saying at the time contained in the progress notes and the opinion evidence of the experts.

47. All of this was evidence pointing to the negligence of the appellants. In the absence of any evidence on behalf of the appellants, and a credible reason for not adducing evidence on what occurred on that date, the judge was entitled to draw reasonable inferences adverse to the appellants that had the effect of strengthening the respondent's case. One of these inferences was that what was stated in the progress notes was true and that the medical records accurately reflected the factual position at the time.

48. Accordingly, despite the fact that when admitted the notes could only properly have been admissible to show that this was what was said at the time by the persons responsible for the deceased's medical treatment, in the circumstances that applied in this case the judge was entitled to come to the conclusion, as he clearly did, that what was said in the medical notes was a true representation of what in fact occurred on that date and that the medical records comprised an accurate and complete record of the treatment accorded to the deceased on that date.

49. Insofar as the allegation that the notes contained opinion evidence is concerned the appellants have identified no areas of opinion in the notes. Certainly the nurses' notes contained no statements of opinion. They simply recorded what the writers said was observed or done during that period with respect to the deceased. In one instance however they purport to record what the second appellant observed. Nothing turns by that statement however. Insofar as the progress sheets of Goetz and the second appellant are concerned, if any opinions were contained in their notes, as medical doctors, they were both in a position to give opinion evidence with respect to areas within their expertise.

50. In the circumstances that transpired, the judge was entitled to consider the contents of the medical records, and in particular the medical notes, for the truth of what was stated in them. Insofar as he accepted the contents of the medical notes as true and the medical records as containing a complete and accurate record of what transpired on that day the judge cannot be faulted.

The challenge to the expert evidence

51. In the circumstances of this case the expert evidence served to: (i) put the medical records into evidence; (ii) explain the medical terms and procedures referred to in those records and put them into the appropriate medical context; (iii) provide the experts' opinion on the relevant standard of care to be applied; and (iv) offer their opinions on the acts or omissions that may have caused the deceased's death.

52. The judge accepted the evidence of the experts. He was of the opinion that 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 had come from these experts.

53. The first appellant alleges that the judge impermissibly allowed the experts to give evidence of fact and accepted their evidence on the factual basis of the respondent's case. Given the manner in which the case progressed, except for the limited evidence of the respondent, the only evidence of what occurred was provided by the deceased's medical records compiled and prepared by the appellants but placed into evidence through the experts.

54. While technically the first appellant is correct, the main evidence of the facts did come from the experts, but so far as this consisted of putting the appellants' records into evidence this was permissible. Further insofar as the experts in their evidence explained the processes described, or the terms used, in the medical records this simply amounted to an explanation of the facts already before the court and was a perfectly legitimate use of the experts' evidence. The judge was entitled to accept such evidence once he was satisfied as to the expertise and credibility of the experts.

55. The first appellant submits that the judge failed to properly apply the requirements of Part 33 of the CPR; erred in his conclusions on the collaboration in the preparation of the reports and failed to attach the appropriate weight to the similarities between the experts' witness statements and the role of the attorney in their preparation. A major complaint in this regard seems to be the failure of the judge to address the similarities in the witness statements identified in the schedule of comparisons provided by the first appellant.

56. Further the first appellant submits that the judge made two fundamental errors in assessing the experts' evidence: (i) he concluded wrongly that the core of the expert's evidence had not been challenged and (ii) he failed to properly assess each expert's relevant expertise and their answers as to the extent of the duty of care and on the

breach of that duty. This latter submission is more comprehensively dealt with later in this judgment when dealing with the nature and scope of the duty of care.

57. Both expert witnesses gave evidence by way of witness statements to which were annexed their reports. The reports were not in the format required by the CPR and each indicated that they had been done in collaboration with another person. They both stated in their witness statements, rather than in the reports, that they had been requested by the respondent to prepare written reports, in the case of the anaesthetist, Dr. Pitt-Miller, on the clinical aspects, and in the case of the haemotologist, Dr. Jones-Lecointe, on the haemotological aspects, of the standard of medical care that the deceased received at the hospital before, during and after the TURP procedure on the basis of information set out in the deceased's medical records. Attached to the witness statements were the medical records of the deceased.

58. Both experts were clear in their evidence and the reports that their opinions were based on the contents of the medical records. They both state, under cross-examination, that prior to writing their report they had no recourse to the pleadings or the witness statements in the case. While some issue was raised in the cross-examination of Dr. Jones-Lecointe as to whether she had sight of the witness statements of Goetz and the second appellant prior to writing her report it is evident from the exchange between attorneys reflected in the transcripts that this was an impossibility. As well under cross-examination both admit no knowledge at the time of writing the report of the relevant case law with respect to professional negligence.

59. Dr. Pitt-Miller, in her witness statement, indicated that in preparing the report she first prepared a draft and sent that draft to a colleague the former Professor of Anaesthesia at the University of the West Indies. She says that he gave his comments which she considered and having agreed with them incorporated them into the report. She says however that the views and conclusions stated in the report were her own.

60. Although not referred to in her witness statement Dr. Jones-Lecointe's report bore the name of a lecturer in haematology at the Faculty of Medical Sciences Mona Jamaica. Under cross-examination the witness indicated that the report, although written by her, had been sent to the lecturer for her opinion and comment.

61. The judge determined that the appellants' criticisms with respect to the expert evidence were hyperbolic and unfounded. He noted that no objections had been taken by either appellant with respect to the admissibility of the reports or witness statements. He was of the view that there could be no objection in principle or in the rules to the experts subsequently providing witness statements expanding upon or explaining conclusions arrived at by them in the report as long as the "fundamental relevance" of expert evidence was observed.

62. With respect to the schedule of comparisons the judge said that he reviewed it and found it helpful as an exercise to determine how the experts corroborated each other on the material aspects of the management of the patient and the standard of care that ought to have been followed. He considered the similarities but was of the view that the issue was whether this was of any moment after he had the benefit of seeing the witnesses in the witness box and judging for himself whether they owned their written product and whether they could justify it or whether their reports and testimonies were "fudged".

63. After hearing their evidence the judge concluded that, insofar as any collaboration was concerned, the reports were independently produced uninfluenced by counsel, the respondent or each other. Insofar as the reports were a joint product he was of the opinion that both of the experts displayed the intellect to claim ownership for the ideas and conclusions of the report. Based on their responses under cross-examination, he was of the view that the experts sought to provide independent assistance to the court by way of objective unbiased opinion.

64. The judge was satisfied that the witness statements merely elaborated on what was contained in the reports and that there was nothing on the face of it objectionable to them being assisted by an attorney in the preparation of their witness statements. He was of the opinion that ultimately it was for him to determine what weight was to be attached to experts' reports which did not comply faithfully with Part 33 or whose witness statements bore striking similarities.

65. Contrary to the submissions of the first appellant the judge did consider the schedule identifying the similarities between the experts' witness statements. But, as he was entitled to do, determined that, rather than displaying inappropriate collaboration, the similarities presented independent corroboration of each other on the material aspects of the management of the deceased and the standard of care that ought to have been followed. From the totality of the evidence given by them the judge determined that the evidence given by them was sound and could be relied on. This was a conclusion that, having seen and assessed the witnesses, the judge was entitled to make. His conclusions cannot be faulted and I see no reason to depart from them. At the end of the day the judge accepted the evidence of both experts. He found them to be credible and to have the necessary expertise to render the opinions and arrive at the conclusions made by them in the case.

66. It was for the judge to determine what weight he put on their evidence. In determining the weight the judge took into consideration the objections made by the appellants and factored them against what he described as the cogency and relevance of the reports. In this regard he had regard to the guidance provided by the Court of Appeal in the case of **Kelsick v Kurvilla and Others**[11]**.** In that case the Court was of the view that the factors of cogency and usefulness/ helpfulness were not only relevant to the grant of permission to adduce expert evidence but were also relevant in analyzing the expert

[11] Civil Appeal 277 of 2002

evidence and determining the matter on its merits. The judge concluded that the evidence of the experts in this case was credible and both cogent and useful.

67. In the course of its submissions before us, and before the judge, the first appellant made reference to the guidelines given in **The Ikarian Reefer**[12] case with respect to an expert's duty to the court and the manner in which it is to be carried out. These guidelines are repeated at Part 33.2 of the CPR.

68. It was clear that, given the evidence of the experts as disclosed by their witness statements and their answers under cross-examination, the judge was satisfied that, in accordance with Part 33.2 of the CPR, the experts were acting in accordance with their duty to present to the court evidence that was independent and uninfluenced as to form or content by the exigencies of litigation and provided to the court objective and unbiased opinion in relation to the matters within their expertise.

69. With respect to the contents of the reports despite the fact that the reports did not, in terms of their form, in all respects comply with the requirements of Part 33.10 it is clear that when considered together with their witness statements and their cross-examination complied with the requirements of the rule.

70. While the evidence of the experts was challenged in cross-examination this challenge was limited. There was no challenge to the medical records nor to the explanation of the medical terms and procedures given by the experts. Neither was there any challenge to their expertise in their particular field. Insofar as the duty and standard of care was concerned the cross-examination by the first appellant was directed only to nursing care and, to a lesser extent, hospital administration and was in support of the position taken by that appellant in its submissions that the duty of care admitted was only with respect to the nursing care and the hospital administration provided by it. It is in this regard that the expert anesthetist made the concessions relied on by the first appellant.

[12] [1995]1 Lloyds Rep 455

71. These concessions treated with the need for the nursing and the laboratory staff to be instructed by Goetz and/or the second appellant on what was required of them. These concessions were not concessions made by a party to the litigation and, in any event as we shall see when treating with the first appellant's duty of care, related to issues of law and not fact.

72. In similar manner the cross-examination by the second appellant was directed towards limiting the duty of care to his role surrounding and peripheral to the administration of the anaesthestic during the TURP procedure. The strategy of both appellants in their cross-examination seemed to be not to challenge the basis of the experts' opinion but rather to get the experts to accept that, as a result of a limited scope of their duty of care, they were not at fault.

73. At the end of the day therefore the judge's acceptance of the experts' report and their evidence cannot be faulted. He considered the evidence of the experts as a whole and determined that the evidence substantially complied with Part 33 of the CPR. Further, given the thrust of the cross-examination and the failure of the appellants to adduce expert evidence challenging any of the opinions arrived at, the judge was correct when he concluded that the core of the evidence given by the experts remained intact.

74. At the end of the day therefore there is no merit in the appellants' challenges to the factual basis of the respondent's case. Neither is there merit in their challenge to the acceptance by the judge of the evidence of the experts.

The factual basis of the respondent's case

75. At the time of his death the deceased was 53 years old. His blood type was A positive ("A+"). The deceased's admission to the hospital on 13th April to do the TURP procedure was the second time that there had been an attempt to perform this procedure on him by the appellants and Goetz. The first attempt was on 3rd February 2004. The

procedure was aborted on that date due to the deceased's abnormal electrocardiogram ("ECG") results. The deceased was referred to his cardiologist by the second appellant for advice on whether he was medically fit to have the procedure performed on him.

76. By letter dated 15th March 2004 the cardiologist advised that (i) the deceased's abnormal ECG pattern was on the basis of athletes heart and that he had early coronary disease that was currently asymptotic; and (ii) he had originally defaulted on follow up but was now on a daily dosage of Crestor. The cardiologist concluded that the deceased was fit for general anesthesia without special precaution and "may be considered a standard risk".

77. The term 'athletes heart' used by the cardiologist refers to an enlarged heart of an athlete that has been trained for endurance. It is characterized by a low heart rate, an increased pumping ability and a greater ability to deliver oxygen to the sketetal muscles due to the greater pumping capacity of the heart. The effect of this condition is to mask an early detection of hypovolemic shock that occurs when the heart is unable to supply enough blood to the body due to blood loss or inadequate blood volume.

78. On 13th of April 2004 the deceased was again admitted to the hospital under the care of Goetz and the second appellant to have the TURP performed. There is no record of his being specifically asked whether he was taking aspirin. The only blood test that was done on the deceased prior to the 13th April was on 28th January. In particular no prothrombin and partial prothrombin tests ("PT or PTT tests") were done on the deceased prior to the procedure. These are coagulation screening tests which indicate the time it takes for the blood to clot.

79. The TURP procedure was performed on the deceased by Goetz, as the surgeon, and the second appellant, as the anaesthetist, and the servants and/or agents of the hospital as attending medical staff. The TURP was successfully completed at 1.10 pm on that day with no complications. Post operation instructions were given by Goetz for "fast

irrigation; histology; clear fluids orally-soft diet" and for the deceased to sit out in a chair later.

80. At around 3.30 that afternoon the deceased was rushed back into the operating theatre and died that night at around 11.30 while on the operating table. While in the operating theatre for the second time two further operations were performed on him. The primary information on what occurred between 1.10pm-3.30pm is obtained from the nurses' notes and the evidence of the respondent. The primary information as to what occurred after the deceased was rushed back to the operating theatre to his death comes from the notes of Goetz and the second appellant.

81. The nurses' notes record observations made at 1.10; 2.50; 3.10 and 3.30 that afternoon. For most of that period the respondent was in the room with the deceased. Also in the room with the deceased for that period was a member of the first appellant's nursing staff described by the respondent as an assistant nurse.

82. According to the respondent when the deceased returned to the room at 1.10pm he was shaking violently for several minutes. She was advised by the nurses that this was normal as the operating theatre was cold. He was attached to monitors and, pursuant to Goetz's instructions, was undergoing fast irrigation, that is, a liquid, saline, was being pumped into and urine drained out of him by means of clear tubes. The nurses' 1.10 pm note stated that his urine was blood stained.

83. This is confirmed by the respondent. According to the respondent clear fluid was going into him from a bag and blood stained fluid flowing from him into a bucket. The empty bag was replaced with full ones of fluid from time to time. After about an hour, when the bucket was about three- quarters full, the contents were emptied into the toilet. Soon thereafter the respondent observed semi-solid particles in the pink liquid flowing into the bucket. This caused some concern to the nurse in the room and the head nurse was summoned.

84. At 2.50 pm the nurses' notes record that the deceased's output was heavily blood stained. Manual irrigation was done. The output continued to be blood stained in colour. At 3.10 pm Goetz was informed in the operating theatre and the second appellant came to see the patient. The notes state that the second appellant observed that the irrigation was still heavily blood stained and then reported to Goetz. The respondent confirms that the second appellant came into the room and advised that Goetz be called. According to the respondent this was the first time that either of the appellants had come to see the deceased after the procedure.

85. The nurses' notes records that at 3.30pm the deceased was seen by Goetz. The respondent confirms that this was about 20 minutes after the second appellant had first visited. According to the nurses' notes at that time the deceased appeared to be quite comfortable. Goetz manually irrigated the deceased. The deceased then complained of feeling nauseous and vomited. His skin became cold and clammy. "Oxygen commenced and the second appellant informed and came immediately. Haemaccel commenced and normal saline on the left hand". The deceased was then taken to the operating theatre. According to the nurses' note, blood was requested for transfusion and, the same was given to the deceased in the operating theatre.

86. Goetz's notes for this period contain no timelines. Post operation Goetz indicates that the patient was lying in bed chatting in no distress. His output was heavily blood stained. He felt nauseated and vomited and immediately returned to the theatre. According to Goetz's notes oxygen was given to the deceased on his return to the theatre and two wide bore IV lines started. It then states: "Haemaccel and N/S[13] Cross matched blood given".

[13] normal saline

87. Thereafter Goetz's notes refer to a conversation with the respondent about the deceased taking aspirin and a discussion on the telephone with the respondent's brother abroad. According to Goetz's note the respondent indicated that the deceased had taken aspirin up to the day before. The respondent admits these conversations but denies any confirmation by her that the deceased had been taking aspirin. According to Goetz's notes sometime thereafter advice was received from a specialist hematologist that fresh blood, fresh frozen plasma and cryoprecipitate be administered and this was immediately organized.

88. The appellants admit that no additional supplies of blood were ordered from the Eric Williams Medical Complex after the TURP procedure until around 5 pm at which time additional blood and blood products were requested. No platelets were available but 2 packs of partially packed cells, 2 packs of fresh frozen plasma and 3 packs of cryoprecipitate were received from the Complex at around 7.30 pm.

89. Unlike Goetz's notes the second appellant's progress notes give some timelines with respect to the transfusions given to the deceased. According to these notes prior to 4.30 pm the deceased was given 3 litres of ringers and 3 units of Haemaccel. The first transfusion of blood was administered at 4.30 pm. This was one unit of whole blood. Between 4.30 and 10.00, according to the second appellant's notes, the deceased was transfused with 11 units of whole blood which included 3 units of O + blood and 5 units of fresh whole blood.

90. The first time that fresh frozen blood and cryoprecipitate was given to the deceased was at 7.45 pm. The deceased, at that time, was given 2 units A+ FFP[14] and 3 units of cryoprecipitate. The first indication, from the second appellant's notes, that fresh whole

[14] fresh frozen plasma

blood was given to the deceased was at 8pm that night. Thereafter he received 5 units of fresh whole blood.

91. Results of a complete blood test ("CBC") were received at 4.20 pm. PT and PTTs, were ordered at 4-4.45 pm and again at 7.30 pm. The results of these tests were received between 4.45 pm and 5pm and between 8.15pm and 8.30pm.

92. The notes of both Goetz and the second appellant confirm that the deceased died at around 11.30 that night. According to Goetz's notes the deceased's bleeding was abated during the third operation. The deceased died during the closure of the incision and while he was under general anaesthesia. Goetz stated:

> "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."

93. In his letter to the pathologist requesting the postmortem report Goetz advised that (a) the deceased's wife noted that he took aspirin the day before surgery; (b) that prior to his death the deceased's prostate was packed and the dorsal vein was ligated and this controlled the bleeding and (c) within one hour, during the closure of the wound, while under general anaesthesia the deceased's heart stopped beating. He died during anaesthesia and while receiving his last unit of blood and (d) identified the cause of death as irreversible shock with DIC.

94. The autopsy report is dated the following day. In it the pathologist refers to the deceased's clinical history as provided to him by Goetz's letter. He identifies and details his findings. Under the sub-heading Autopsy Report he states;

"**1) Status post-prostate surgery (TURP) recent, 13 /04/04 with**

(a) Heamorrhage complicated by

i) Disseminated intravascular coagulation (coagulopathy)

Prothrombin time (PT) 24secs; PTC 13secs; Partial thromboplastin

time (PTT) 50secs; PTTC 30secs.

ii) Thrombosis multiple, small of renal parenchyma

2) Atherosclerosis of

(a) Coronary artery. LAD 25% stenosed complicated by

i) Acute myocardial infarction, recent

ii) Myocardial fibrosis 2cm, at apex interventricular septum

(b) Abdominal aorta, supra renal region severe

3) Congestive cardiac failure as evidence by

(a) Effusions

i) Pleural right 1 litre, left 600 mls

ii) edema of ankle

(b) Congestion

i) Chronic passive venous of liver

ii) Lungs

iii) Spleen

(c) Biventricular dilation

Mitral valve 115mm, Tricuspid valve 135mm

4) Iiopathic Cardiomegaly, left ventricle 16mm.

The expert medical evidence

95. Except with respect to the time when the deceased was returned to theatre the experts' interpretation of the facts contained in the medical notes were not disputed by the appellants. Neither expert however accepted the suggestion by the first appellant that the deceased was returned to the operating theatre at 3.45pm rather than at 3.30 pm. In

any event the appellants in their defence admitted that the deceased was returned to the operating theatre at 3.30pm.

96. On the question of liability in a negligence suit an expert witness has two principal functions: an explanatory function by which the technical issues and terms are explained and to provide technical assistance to the court in the discharge of its duty to determine whether the acts or omissions complained of amount to negligence.

97. This explanatory or didactic function of expert evidence:

> "generally involves explaining the nature of the patient's original condition, the nature of the treatment given, the consequences of the treatment and (where possible) how those consequences flowed from the treatment given. This aspect of the expert evidence may be largely or totally uncontroversial…….. At this stage of the inquiry the court is largely in the hands of the expert witness. It cannot come to conclusions or diagnoses which are not supported by at least one of the experts."[15]

98. With respect to the second function it is the expert's role to assist the court in identifying the relevant standard of care to be applied and technical assistance with respect to whether these standards were met and, if not, its effect on the resulting injury. "Ultimately however it is for the court to decide, on the totality of the evidence and applying the Bolam test, and the necessary logical analysis, whether the defendant exercised the requisite degree of skill and care."

99. The Bolam test mentioned here is a reference to the case of **Bolam v Friern Hospital Management Committee**[16]. This case treats with the standard of care relevant to a finding of medical negligence. The test being those practices adopted, at the particular time, by reasonably competent medical practitioners professing to have that special skill. Of primary concern here is the technical assistance rendered to the judge by the

[15] Jackson & Powell on Professional Negligence fifth ed. at page 807- 808 at paragraph 12-111 to 12-112
[16] [1957] 2 All ER 118

experts in identifying the relevant standards of care to be applied to the treatment given the deceased; whether the standards were met and, if not, the effect on the resulting injury.

100. The evidence of the experts comprised the only medical evidence before the judge and was accepted by him. Their evidence treated with the standard of care that ought to have been provided by reasonable competent medical practitioners in the specialist fields of anaesthestics and haemotology. It is to be noted that the experts called in by Goetz and /or the appellants during the emergency included specialist practitioners in the fields of anaesthestics and haemotology.

101. The anaesthetist's pre- operative role, according to Dr. Pitt-Miller, included taking a medical history. This involved, among other things, specifically asking whether the patient is taking aspirin. Post operatively, she states, in a situation of unusually heavy bleeding the role of the anaesthetist is "to resuscitate the patient: ensure that the patient's blood pressure, pulse and other vital functions are functioning, so that the surgeon can in fact stop the bleeding. So his role in that situation would be to organize fluids, get bloods etcetera etcetera."

102. From the medical records both experts concluded that the deceased first went into hypovolemic shock as a result of blood loss, then developed DIC and then died from the fluid overload brought on by the massive amounts of fluids used to treat the deceased's DIC administered between 4.30 and 10.00 pm. In her report Dr. Jones-Lecointe identifies hypovolemic shock, infection and incompatible transfusion to be among the many causes of DIC.

103. According to Dr. Jones-Lecointe: " (a) if the medical Team had monitored the Deceased properly after surgery he would not have developed hypovolemic shock; (b) if the Medical team had prepared properly for a surgical procedure known to carry a risk of bleeding so as to allow the timely transfusion of appropriate blood products if required,

the progression of hypovolemic shock and the development of DIC in the deceased would have been prevented; and (iii) if the DIC which the Deceased developed had been properly managed by the Medical Team through the administration of appropriate blood products(ie packed red cells, cryoprecipitate and/or fresh frozen plasma) and through regular PT, PTT and CBC tests, the fluid overload which the Deceased developed (and which was the proximate cause of the Deceased's death) would have not occurred."

104. Dr. Pitt- Miller treats with the chain of events causing the deceased's death in this way: prior to the TURP procedure the medical centre failed to identify or ignored indicators that the deceased may have had bleeding tendency. After the procedure he 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 the 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 fluid into the deceased's body within a relatively short space of time in an uncontrolled manner. As a consequence the deceased developed fluid overload and succumbed to same.

105. Insofar as the deceased's pre-operative care was concerned both experts were of the opinion that the relevant standard of care required that prior to surgery:

(i) the deceased ought to have been specifically asked whether he was taking aspirin. According to Dr. Pitt-Miller given the nature of the TURP procedure and the known risk of post operative bleeding the anaesthetist ought to ensure that the patient had no bleeding tendency. To this end a detailed medical history of the patient should be taken and in particular a specific enquiry ought to be made with respect to aspirin, plavix or other medication that are known to affect the ability of the blood to clot. Dr. Jones- Lecointe limits this enquiry to the use of aspirin. According to

both experts the use of aspirin would not of itself cause bleeding complications but could exacerbate such complications.

(ii) Blood tests ought to have been done. According to Dr. Pitt-Miller, in the light of the low platelet count revealed by the CBC[17] test done in January 2004 prior to the aborted TURP, a further CBC test ought to have been done closer to the date of the procedure to ascertain whether the deceased's platelet count remained low. In the event that the surgery could not be postponed coagulation screening tests, PT and PTT tests, ought to have been done just prior to surgery to ensure that the low platelet count did not indicate or was not accompanied by blood clotting complications. According to Dr. Jones-Lecointe in the circumstances of the procedure being performed in a small hospital with no on site blood bank facilities these tests ought to have included PT and PTT tests;

(iii) at least two units of blood comprising grouped and cross matched red blood cells or packed red cells should have been readily available for use on the patient. According to Dr. Pitt-Miller it is standard medical practice to ensure that this blood is available at the time of surgery in refrigerated storage at the hospital in the event that it is necessary to transfuse the patient as a result of bleeding. The evidence of Dr. Jones-Lecointe was that in a small hospital with no blood bank standard medical practice required that this blood be readily available to the patient or available within half an hour of a transfusion request.

106. In addition, according to Dr. Pitt-Miller, in any event given the outside possibility of a pre-operative bleeding problem as presented in this case the first appellant ought at the

[17] complete blood count

very least to have taken steps to ensure that at the time of surgery fresh frozen plasma and cryoprecipitate was readily available at the hospital or could be obtained within half an hour of being required. According to both experts transfusions of these products, and fresh whole blood according to Dr. Pitt-Miller, was the appropriate treatment in the event that the patient developed DIC as they would replace the platelets and clotting factors consumed as a consequence of the DIC.

107. The experts' evidence of the relevant post operative care treated with the deceased's deteriorating medical condition. Both experts were of the opinion that given the nature of the procedure and the inherent risk of bleeding the relevant standard of medical care required that there be proper monitoring of the deceased after surgery. The monitoring required was with respect to the deceased's initial post-operative bleeding and the risk of fluid overload.

108. With respect to the initial post-operative bleeding according to the evidence of Dr. Pitt-Miller it is standard medical practice that after surgical procedures as TURP that the patient is monitored and vital signs recorded every 5 minutes for the first 30 minutes, every 10 minutes for the next 30 minutes and every 15 minutes during the second hour after surgery. According to her, given that the deceased could have been expected to have lost a significant amount of blood during surgery; that he was experiencing post-operative bleeding at the time of his return to the ward and due to his having an athletes heart, he might not have showed some of the typical clinical signs of hypovolemic shock.

109. Standard medical practice therefore required the doctors, Goetz and the second appellant, through written instructions to the nursing staff and/or the nursing staff to have ensured that:

    (i) the deceased's vital signs were monitored and recorded every 5-10 minutes for the first hour after surgery;

(ii) a pulse oximeter monitor was attached to the deceased and his oxygen saturation level and pulse wave form monitored continuously and his oxygen saturation level recorded at the same time as his vital signs;

(iii) any changes in the deceased's vital signs, oxygen tension or wave form which indicated the onset of hypovolemic shock or significant blood loss were communicated to Goetz and the second appellant;

(iv) a rough estimate of the quantity of blood loss of the deceased be made and recorded every 15 minutes during the first hour by reference to the amount of fluid administered to and drained from the deceased; and

(v) upon it being estimated that after surgery the deceased had lost more than a certain amount of blood as specified by Goetz he and the second appellant be informed of the fact and immediate action taken to arrest or control the bleeding.

110. Monitoring in this manner, according to Dr. Jones-Lecointe, would have enabled an assessment of the deceased's cardio vascular response to his ongoing blood loss. The evidence of both experts is that had proper post operative monitoring been done, in accordance with the above requirements, then steps would have been taken to arrest his bleeding and it is likely that the deceased would not have developed hypovolemic shock and would have made a successful recovery from the TURP procedure.

111. With respect to the risk of fluid overload, according to Dr. Pitt-Miller, the fact of the deceased's early coronary disease meant that there was a significant risk of his developing fluid overload in the event that the post operative transfusion of fluid was not monitored and managed carefully. This risk, she says, was further increased by the risk of the deceased developing what is commonly known as TURP syndrome. This occurs as a result of the absorption of large amounts of irritants used during the TURP

procedure and can result in fluid or circulatory overload. This syndrome, she says, is associated with congestive heart failure.

112. According to Dr. Pitt-Miller it was standard medical practice during and after the TURP procedure, in particular during the period when the deceased was being transfused with large volumes of fluids, for Goetz and/or the second appellant to have taken the following basic steps to prevent and detect fluid overload:

(i) a regular and meticulous assessment of the amount of fluid administered to and drained from the deceased;

(ii) insertion of a central venous pressure line to determine whether there is too much or too little fluid in the body;

(iii) an intra- arterial line to accurately monitor changes in blood pressure and indirectly cardiac output and to provide for the monitoring of blood gases;

(iv) the use of a pulse oximeter to measure oxygen levels;

(v) monitoring of the deceased for jugular venous distension;

(vi) auscultation of the chest;

(vii) listening to the heart for a third heart sound;

(viii) arterial blood gas tests; and

(ix) chest x-rays.

113. Both experts were of the opinion that by 3.30 pm or shortly thereafter the deceased showed symptoms of hypovolemic shock. In the present case, Dr. Jones-Lecointe stated, this condition was evidenced by the deceased's symptoms of feeling nauseous, vomiting and cold and clammy skin.

114. In the event of the patient going into hypovolemic shock due to blood loss, Dr. Pitt-Miller was of the view that, the appropriate treatment is a combination of packed red

blood cells and plasma or whole blood and plasma. Plasma is the liquid component contained in whole blood in which the blood cells in the whole blood are suspended.

115. During the period 3.30 to 4.30pm the deceased was transfused with ringers and haemaccel. These were not blood or blood products but crystalloids and colloids. According to Dr. Pitt-Miller the use of crystalloids and colloids are a poor substitute for blood as it takes 3 units of such fluid to replace each unit of blood lost thereby creating a material risk of fluid overload.

116. Both experts were of the opinion that the fact that after showing signs of hypovolemic shock at 3.30pm it took one hour for the deceased to be transfused with his first unit of whole blood strongly suggested that the 2 units of whole blood or packed blood cells required to be available at the time of surgery were not available at the time or if they were the failure to transfuse them constituted a serious error on the part of the medical team.

117. According to the experts the results of the PT and PTT tests requested at 4.00-4.15 pm and received at approximately 4.45-5.00pm were clear indicators that the deceased had developed DIC. They were of the view that the diagnosis of DIC ought to have been made at this time. The appropriate treatment for the DIC was management by transfusions of red cell concentrates, fresh frozen plasma and cryoprecipitate, which would serve to restore blood volume and replace the clotting factors in the blood. The deceased was however not transfused with any of these products until approximately 3 hours after the diagnosis of DIC ought to have been made.

118. In addition, Dr. Pitt-Miller states, the transfusion of O+ blood was a serious error as such a transfusion may itself cause DIC and also result in the destruction of the deceased's red blood cells. According to her a transfusion of O + blood into a patient with A+ blood was to be reserved for desperate emergencies only where the patient's haemoglobin is so low as to be life threatening and where no A+ whole blood or packed

red cells are available. According to her at that time the deceased's haemoglobin level although low was acceptable and not life threatening.

119. Further, according to Dr. Pitt-Miller, the transfusion of 6 units of whole blood without the transfusion of clotting agents, that is fresh frozen plasma and cryoprecipitate, over the period 4.30 to 7.45 pm was, contra indicated as whole blood, unless fresh, does not have sufficient clotting factors and would have the effect of diluting the platelets in the deceased's blood thereby exacerbating the deceased's bleeding. Further there is a significant risk of fluid overload when transfusing a large volume of fluid to a patient if the transfusion process is not monitored and managed in the manner recommended.

120. The medical records, according to Dr. Pitt-Miller, contain no evidence that there was any checking done for fluid overload clinically or by monitoring except that there is evidence that at 10.00 pm 2 pulse oximeters were used to monitor the deceased. In particular, according to Dr. Pitt-Miller's report, during this period the records do not reveal that any pulse oximetry or an ECG was done. Neither does the second appellant indicate if he auscultated the chest, checked for capillary refill or assessed peripheral vasoconstriction.

121. Standard medical practice, according to Dr. Pitt-Miller, required that these steps, if taken, be recorded by the surgeon and the anaesthetist in their respective notes. She states in her report that while the initial failure to record these actions could be explained by the urgency of the situation the necessary information ought to have been filled in later with a note that it was being done after the event. In her opinion the massive volume of fluids that were administered to the deceased in the space of 6.5 hours itself suggests that the transfusions of those fluids were not properly monitored and managed.

122. Further the fact that the deceased received massive transfusions of fluid: 3 units haemaccel, 3 litres ringers, 11 units of whole blood, 2 units of fresh frozen plasma and 3 units of cryoprecipitate represented, in her view, a massive fluid transfusion amounting to more than twice the average volume of blood in the human body. In Dr. Pitt-Miller's opinion the post mortem findings identified under the sub-heading Autopsy Report strongly indicated that the deceased experienced fluid overload as a result of the fluids administered to him after the TURP procedure and that such fluid overload was the direct cause of his death. Dr. Jones- Lecointe was also of the opinion that fluid overload was the proximate cause of the deceased's death.

The other challenges to the judge's findings

The nature and scope of the duty of care

123. Essentially the submissions of the first appellant are that the judge:

(i) failed to understand and apply the relevant case law that established that where a patient himself selects and employs a doctor or surgeon the hospital cannot be liable for that doctor's or surgeon's negligence.

(ii) incorrectly construed the duty of care admitted by the first appellant which was that its duty was limited to the provision of nursing care; and

(iii) failed to properly grasp and differentiate between the different duties of care owed by the respective parties.

124. This is the crux of the case presented by the first appellant before us and before the judge. Similar submissions are made by the second appellant with respect to the judge's finding that the duty of care owed by the second appellant was not simply in his role of administering anaesthesia. Further the appellants submit that the judge's finding of a

joint duty of care is contrary to his earlier determination that the appellants and Goetz were concurrent tortfeasors.

125. The judge found that as a result of the admissions in the defence as to the duty of care the appellants accepted that they had a duty to ensure that during or after the performance of the TURP: (a) any bleeding of the deceased was carefully monitored and/or properly contained and/or otherwise so managed to protect the deceased from excessive bleeding; (b) there were sufficient materials, equipment and personnel 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, tests and practices as would minimize the risk of or prevent the deceased from experiencing fluid overload or other deleterious effect of same.

126. He was of the opinion that by this admission both appellants admitted and accepted their responsibility in the roles of monitoring and containing excessive bleeding, having sufficient blood and blood products available and carefully managing the transfusions of such blood and blood products to minimize the risk of fluid overload.

127. The appellants submit that this admission must be interpreted in the light of the pleadings as a whole, and in particular, having regard to the individual breaches of duty alleged against each of them. Had that been done by the judge, they submit, it would be clear that the scope of their duties was different and that they and Goetz each carried out specific functions. Therefore to treat the appellants as having the same duty of care, as the judge did, was wrong.

128. The judge was of the opinion that this was not a submission that the appellants could make given their defence. According to the judge the appellants seemed to misconstrue their own pleadings or were trying to construct a defence that simply was not there. In this regard the judge was correct. To seek to limit the admitted duty of care by reference

to the breaches of that duty of care alleged by the respondent to have been committed is an artificial limitation and does not accord with the appellants' pleaded case.

129. The defence itself makes no distinction with respect to the duty of care owed by each appellant individually. It does not seek to limit the scope of the duty admitted by the appellants. The position taken by the appellants in the defence was not to deny the duty of care or disclaim responsibility for certain aspects of it but rather their case was that they had met the relevant standard of care.

130. With respect to ascertaining the nature and extent of the duty of care admitted by them, it is the nature of the appellants' denials to the allegations made in the particulars of negligence that are of more relevance. For example, in response to the allegation in the statement of case that it permitted the procedure to be performed by staff and/or visiting consultants and/or specialists in the person of the second appellant and Goetz who were not reasonably competent in its performance, the first appellant does not assert that it was not responsible for the actions of the second appellant and Goetz but rather asserts that the second appellant and Goetz were both specialists with over 16 years experience and very competent in their respective fields. Rather than deny responsibility for the doctors' performance therefore the first appellant merely asserts and confirms the competence of the doctors.

131. Similarly, in answer to the allegation that it transfused Group O+ whole blood into the deceased and/or permitted the same to be transfused into the deceased, the response of the first appellant is not that this was not within the scope of its duty and/or that its servants and/or agents were acting on the instructions of Goetz or the second appellant, as was suggested by it in the course of the cross-examination of the experts, but rather it relied on the fact that the blood group O was available and could be readily transfused into any person with another blood group including the deceased who was A+. The position of the first appellant therefore was not to deny that the blood group O was

transfused into the deceased or its responsibility in this regard but maintained that this was the proper action to take in the circumstances.

132. With respect to the second appellant the allegations of negligence made against him was that: he failed to act quickly enough in transfusing the relevant blood and blood products into the deceased; stem the bleeding; ensure that there was adequate supplies of blood, blood platelets, fresh frozen plasma and other clotting materials at the medical center or that he administered and transfused excessive amounts of blood and blood products to the deceased. His response was, not that this was not within the scope of his duty but, simply that he together with the other defendants: "took all possible steps to stem the bleeding and obtained additional help from consultants other than those at the first named defendant in order to do so" and that "all of the necessary blood that would have been required for any emergency procedure on the deceased was sourced from all available sources in Trinidad and Tobago and was readily available." Again there is no disclaimer that the duty was not his but rather the second defendant maintained the position that all that could have been done had been done.

133. Not only was there no distinction made in the defence between the individual roles of each of the appellants or Goetz but the responses to the allegations of negligence were consistent with the admission made by them as to their duty of care to the deceased. Nowhere in the defence is it sought to limit the scope of the first appellant's duty of care to the provision of the nursing staff or to hospital administration or the duty of care of the second appellant simply to his role in administering the anaesthetic during the operation and ensuring that the patient comes out of the operation successfully.

134. Indeed an examination of the defence as pleaded shows that, except for the allegation that INR tests were taken prior to the 13th April, the appellants' position was not a denial of the particulars of negligence on the basis that the actions were not taken but rather (a) to assert the actions taken were not negligent but were the correct response in

the circumstances and (b) to place blame on the deceased. In principle therefore, the question of the deceased's contributory negligence apart, the thrust of the defence was to assert that they acted in accordance with proper practice.

135. The judge therefore was correct when he concluded that:

> " …….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. Tesheria. Similarly Gulf View has admitted its duty in obtaining, keeping adequate supplies of blood and managing the transfusion of blood products. …….. Having accepted those duties they must execute it in accordance with the requisite standard of care and diligence accepted in their medical profession."

136. The second appellant submits that determining that the extent of the duty of care was to be resolved on a point of pleading or an admission the judge was wrong. According to the second appellant the extent of his duty of care can only be settled through a proper assessment of the expert evidence and, in particular, the evidence of Dr. Pitt-Miller that clearly demarcated his duties to be limited to his function during the TURP procedure. I do not accept this submission.

137. The fact is that the parties' pleadings define the issues for the court's determination. It is the pleadings that determine what the parties need to prove, disprove or argue. The admission by the appellants of the extent of their duty of care to the deceased therefore meant that the respondent was not required to prove that issue. The judge was therefore correct in his determination that the issue of the appellants' duty of care was to be determined by their admissions in the defence and, accordingly, the central focus of the case was whether the appellants breached their duty of care to the deceased and whether that breach actually caused his death.

138. In any event as we have seen the evidence of Dr. Pitt -Miller does not limit the second appellant's duties in the manner alleged by him but rather details duties of an anaesthetist other than functions performed during the actual operation. These duties include: pre-operatively taking a medical history of the patient including specifically asking whether the patient is taking aspirin and post-operatively resuscitating the patient, ensuring that the patient's blood pressure, pulse and other vital functions are functioning and organising fluids.

139. In any event this appellant also participated in the two further operations performed on the deceased on his return to the operating theatre. It is during the performance of one of these operations, after the cessation of bleeding and while the deceased was under anaesthesia, that the deceased died. It is difficult therefore to conceive that the second appellant's responsibility to the deceased ended upon the successful completion of the TURP. This also flies in the face of the admissions made by the second appellant in his defence that the transfusions were done on the instructions of Goetz and/or himself and/or the servants and/or agents of the first appellant.

140. The first appellant submits that the judge failed to understand and apply the relevant case law that established that where a patient himself selects and employs a doctor or surgeon the hospital cannot be liable for that doctor's or surgeon's negligence. In not applying the principle to the instant case however the judge was right.

141. The cases referred to by the first appellant: **Cassidy v Ministry of Health[18]; Roe v Minister of Health[19]** and **Ellis v Wallsend[20]** all treat with the duty of care owed by a hospital with respect to the actions of doctors and surgeons employed by it under a contract of service or a contract for services and arising in the course of the performance of their professional duties. These cases establish that where the hospital had engaged

[18] [1951] 2KB 343
[19] [1954] 2WLR 915
[20] [1990] 2 Med L R 103

the consultant it was responsible for the actions of that consultant. In those circumstances it mattered not whether the engagement was under a contract of service or a contract for services.

142. According to Denning LJ in **Cassidy**:

> "I take it to be clear law, as well as good sense, that, where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for services."[21]

In all three cases however it was recognized and accepted that the hospital's duty of care did not extend to consultants selected and employed by the patient himself.

143. The responsibility of a hospital with respect to the actions of consultants therefore lies in the terms of engagement of that consultant. There was nothing before the judge of the terms of engagement of either Goetz or the second appellant by the deceased or, indeed, between the first appellant and the doctors. The pleadings did not identify the nature of these arrangements. According to the statement of case the respondent had no knowledge of the terms and conditions under which the first appellant offered its premises and facilities for use by members of the medical profession including the second appellant and Goetz. Nothing in the defence treated with this issue.

144. The respondent gave no evidence of the terms of engagement of either Goetz or the second appellant. Her evidence under cross-examination was that she simply did not know. Her evidence in chief was limited to the fact that: (i) the deceased had a pre-existing relationship with Goetz and had on two earlier occasions, in 2000 and 2003, attended the hospital for the purpose of having medical procedures performed by Goetz; and (ii) communications between the deceased and Goetz as to the scheduling of

[21] at page 363

surgery appointments with respect to the TURP procedure was done through the first appellant's staff.

145. Under cross-examination she accepted that the deceased went into the hospital on the recommendation of Goetz; that she had seen the first appellant's reply to the pre-action protocol letter in which it indicated that Goetz was an independent medical practitioner and that with respect to the aborted February procedure Goetz had charged for the cancelled operation. None of these admissions however shed any light on the arrangements between the deceased and Goetz and/or the second appellant with respect to the TURP procedure actually performed.

146. Heavy weather is made by the first appellant of the fact that the judge failed to consider and accept the unequivocal and unchallenged evidence of Dr. Pitt-Miller that the system that applies in private medical centres in Trinidad is that clinicians are independent contractors with privileges. While the evidence of Dr. Pitt- Miller in this regard is indeed unchallenged it was not unequivocal on that point or, indeed, as represented by the first appellant.

147. The evidence of Dr. Pitt- Miller under cross-examination was simply that she had on two occasions operated out of another private hospital and had 'privileges' there. She was aware that on the website of that private hospital they specified that clinicians who have privileges there are independent contractors and that she is familiar with that being the system that applies in private medical centres in Trinidad. The judge was correct to disregard this evidence. This was pure conjecture by the witness solicited in cross-examination. This evidence, particularly in the context of her evidence that she had never operated out of the hospital, does not deal with the contractual relationship between the first appellant and Goetz or the second appellant nor does it seek to treat with the terms and conditions under which the hospital facilities or the medical

treatment had been made available to the deceased. All of these features would have been critical to ascertain whether the cases relied on by the appellants applied.

148. This was information solely within the knowledge of the appellants and the appellants chose not to place it before the judge. According to the judge if the appellants were to make a proper case that the second appellant was an independent contractor and that the first appellant was in no way liable for his actions such a pleading would have been clearly stated and evidence to that effect led. In the absence of any such evidence the judge was of the opinion that he was entitled to draw the inference that the second appellant was the agent of the first appellant and to presume that a non- delegable duty of care arose in the case.

149. The appellants submit that the judge erred in that he determined that it was for the appellants to establish the nature of the contractual arrangements between the doctors and the first appellant. There is no merit in this submission. The fact is that the respondent had the burden to establish that a duty of care existed between the appellants and the deceased. By virtue of the admissions made in the defence that burden was met. It was therefore for the appellants to dispel the respondent's case in this regard by bringing the case in line with the independent contractor cases relied on by them. The judge was therefore correct when he determined that if they wished to rely on the cases it was for them to plead such and adduce the relevant evidence.

150. Before us the respondent submits that the duty established by the statement of case, and admitted by the appellants, amounted to a non-delegable duty on the part of the first appellant to the deceased. As framed, the respondent submits, the first appellant was not simply under a duty to be careful when performing certain acts or roles but it had a duty to ensure that those roles or acts were performed, whether by its servants or by

independent contractors or by volunteers or by some other third party, and that they were performed carefully.

151. The concept of non-delegable duty has been explained by Lord Sumption in the case of **Woodland v Essex County Council**[22] in this manner:

> "The law of negligence is generally fault based. Generally speaking a defendant is personally liable only for doing negligently that which he does at all, or for omissions which are in reality a negligent way of doing that which he does at all. The law does not in the ordinary course impose personal (as opposed to vicarious) liability for what others do or fail to do. This is because as Cory J observed, delivering the judgment of the majority in the Supreme Court of Canada in Lewis v British Columbia [1997] 3 SCR 1145 at para 17, a common law duty of care " does not usually demand compliance with a specific obligation. It is only when an act is undertaken by a party that a general duty arises to perform the act with reasonable care." The expression "non-delegable duty" has become the conventional way of describing those cases in which the ordinary principle is displaced and the duty owed extends beyond being careful to procuring the careful performance of work delegated to others."

152. In **Woodland** Lord Sumption identifies two categories of non-delegable duty. As in that case it is the second category of non-delegable duty that is on point here. There are three characteristics which Lord Sumption says are critical to this second category: (i) the duty arises not from the negligent character of the act itself but because of an antecedent relationship between the defendant and the claimant; (ii) the duty is a positive or affirmative duty to protect a particular class of persons against a particular class of risks,

[22] [2013] UKSC 66 at para 5

and not simply a duty to refrain from acting in a way that foreseeably causes injury and (iii) the duty is by virtue of that relationship personal to the defendant.

> "The work required to perform such a duty may well be delegable, and usually is. But the duty itself remains the defendant's. Its delegation makes no difference to his legal responsibility for the proper performance of a duty which is in law his own. In these cases, the defendant is assuming a liability analogous to that assumed by a person who contracts to do work carefully. The contracting party will normally be taken to contract that the work will be done carefully by whomever he may get to do it: see Photo Production Ltd. v Securicor Transport Ltd. [1980] AC 827 at 848 (Lord Diplock)."[23]

153. According to Lord Diplock in the **Photo Production case**:

> "Where what is promised will be done involves the doing of a physical act, performance of the promise necessitates procuring a natural person to do it; but the legal relationship between the promisor and the natural person by whom the act is done, whether it is that of master and servant, or principal and agent, or of parties to an independent subcontract, is generally irrelevant. If that person fails to do it in the manner in which the promisor has promised to procure it to be done, as, for instance, with reasonable skill and care, the promisor has failed to fulfil his own primary obligation. This is to be distinguished from "vicarious liability" - a legal concept which does depend upon the existence of a particular legal relationship between the natural person by whom a tortious act was done and the person sought to be made vicariously liable for it. In the interests of clarity the expression should, in my view, be confined to liability for tort."

[23] para 7 of the judgment

154. In the instant case, although they apply, it is not necessary to see whether the three essential characteristics critical to the second category identified by Lord Sumption are present. By its defence the first appellant accepted that it had a personal duty to the deceased to ensure that (a) any bleeding of the deceased was carefully monitored, and /or properly contained and/or otherwise so managed so as to protect the deceased from excessive bleeding; (b) there were sufficient materials, equipment and personnel to transfuse 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 tests and practices as would minimize the risk of, or prevent, the deceased experiencing fluid overload or other deleterious effect from same.

155. This was an admission by the first appellant that it had a non-delegable duty to the deceased to ensure the proper performance of the functions required to achieve the ends described in the admission whether those functions were performed by its servants or agents or third parties. This duty of care was not only with respect to those aspects of the deceased's care performed by its servants, as for instance the nursing care and laboratory services rendered to the deceased, but also extended to the actions of both Goetz and the second appellant.

156. The submission by the first appellant that the judge erred in concluding that there was a critical failure by its nursing staff when there was no evidence of any failure to follow any instructions given them by the clinicians in this circumstance has no validity. The question of whether instructions were given to the nurses or not by either Goetz or the second appellant was of no consequence given the wide scope of the first appellant's admitted duty of care. By the admission the first appellant took responsibility for the actions and non -actions of the doctors, including the failure to issue instructions, with

respect to the functions described by the admission, that is, the control of the post-operative bleeding and the management of transfusions of blood and blood products.

157. In this regard the case of **Wilsher v Essex Area Health Authority**[24] relied on by the appellants does not assist them. According to the appellants the decision in Wilsher established that the law did not recognize the concept of team negligence in medical negligence cases. Despite the use of the words "medical team" in the witness statements of the experts the instant case is not a case of team negligence but rather a case where the duty of care that each of the appellants had to the deceased was admitted to be the same. It is clear from the context of the words used in the witness statements that far from suggesting a position in law the phrase was merely a convenient method used by the experts in their witness statements to collectively describe Goetz, the second appellant and the nursing staff of the first appellant.

158. For these reasons, namely the lack of evidence as to the nature of the relationship between the first appellant and the doctors and the admitted duty of care, the case law limiting the first appellant's responsibility for independent contractors does not apply here. The judge's determination that the first appellant's duty of care was not limited to the provision of nursing care or hospital administration services and the second appellant's not limited to his duties of administering drugs cannot be faulted. Neither, in the light of the defence raised, can it be said that the judge failed to properly grasp or differentiate between the different duties of care owed by the appellants and Goetz. The appellants themselves made no such differentiation. While in some instances the functions of the appellants and Goetz were different the duty of care owed to the deceased was the same. Further the fact of the non-delegable duty of care to the deceased owed by the first appellant meant that it was also liable for breaches of that

[24] [1987] Q.B. 730

duty of care committed by Goetz and the second appellant with respect to the functions personally performed by them.

159. The appellants also submit that by an earlier decision made in these proceedings the judge determined that the appellants were not joint tortfeasors but rather concurrent tortfeasors and that his conclusions in this judgment runs contrary to that earlier determination. Noticeably the appellants do not submit that on the applicable law the judge could not have found the appellants' liability to be joint but rather that the judge impermissibly did a "volte-face" with respect to the status of the appellants. The judge himself briefly touches upon this issue when he says to suggest, as the appellants did, that there is an issue estoppel arising from the earlier ruling on a procedural matter without having considered the evidence is plainly disingenuous. Before us the appellants stop just shy of submitting that issue estoppel applies.

160. The short point here is that there was nothing to prevent the judge from determining on the evidence before him that the appellants were jointly liable for the death of the deceased even if he had come to a different conclusion in the earlier ruling. The earlier determination by the judge arose out of an application by the first appellant to strike out the respondent's claim or alternatively to bring third party proceedings against Goetz. It was not a final decision but an interlocutory decision made on the basis of the pleadings, the proposed evidence, including the witness statements filed on behalf of the appellants, and before the decision of the appellants not to lead any evidence. The factual basis upon which the application was based was not the same as the evidence that was before the judge at trial. In these circumstances it is difficult to identify a valid basis for the complaint.

161. It is convenient here to dispose of some other criticisms made by the first appellant of the judge that touch on the duty of care. The first is the submission that the judge was

wrong when he stated in the judgment that the first appellant persisted in its closing submissions to insist that there is no duty of care on it in relation to their nursing staff. I am satisfied that this was clearly a clerical mistake on the part of the judge. In the context of the paragraph it is clear that the word "except" was inadvertently omitted.

162. In addition the first appellant makes heavy weather of a claim that the judge had acknowledged pre-trial that the first appellants' duty concerned only nursing staff. It refers to the transcript of the hearing that it says supports this submission. It is clear that any statements to this effect by the judge were taken out of context. The transcript refers to a period before the commencement of the evidence when the first appellant was seeking to change its defence in order to limit its duty of care to the deceased to the provision of nursing care. This change was eventually not pursued by the first appellant.

163. An examination of the transcript reveals that there was no determination made by the judge that the liability of the first appellant was limited to the actions of its nursing staff. What occurred was simply a discussion between the judge and counsel for the first appellant on the nature of its case. After the discussion with the first appellant as to the nature of its case with regard to the nurses the judge then moved on to questioning the first appellant about its responsibility in the provision of blood. In the context of the whole interchange between the first appellant and the judge the statements made by the judge amounted to no more that an attempt to seek clarity on the nature of the first appellant's case in the context of its application to amend the defence which was subsequently withdrawn by it.

Standard to be applied to the first appellant's duty of care

164. Before us the first appellant submits that in coming to his conclusions the judge created a unique situation in that he found that the first appellant was guilty of clinical or

professional negligence based on the evidence of two non-peer experts. This submission deals with the relevant standards of care to be applied to the duty of care owed to the deceased by this appellant.

165. To establish a breach of the duty of care a claimant is required to prove that the actions or inactions of the defendant did not meet the standards held at the time and accepted as proper by responsible professionals in the field. The position, best put by McNair J. in the case of **Bolam v Friern Hospital Management Committee**[25] in the case of doctors**,** is that:

> "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art." ……"But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art."[26].
>
> **Bolam v Friern** was applied in this jurisdiction by Mendonca J.A in **Deonarine v Ramlal** [27]

166. Taken generally, in the case before us, the duties under consideration were with respect to the functions relevant to the control of the deceased's post-operative bleeding and the management of transfusions of blood and blood products to him. The first appellants' responsibility in this regard was wider than simply for the acts of its servants and/or

[25] [1957] 2 All ER 118
[26] page 121
[27] Civ. App No. 28 of 2003

agents and extended to the actions or non-actions of third parties, in this case, Goetz and the second appellant.

167. The case presented by the respondent against the first appellant related to two types of functions: with respect to its non-delegable duty to functions that ultimately were, or ought to have been, performed by Goetz and/or the second appellant personally or by way of instructions to the servants or agents of the first appellant and to functions performed by the servants and /or agents of the first appellant for whom the first appellant was vicariously liable. So for example, with respect to monitoring the deceased's vital signs, the evidence of the experts was that the relevant standard of care that applied to Goetz and the second appellant required instructions to be issued to the nursing staff. This would be separate and apart from any duty of the nursing staff in the performance of those functions. A failure to perform the first would give rise to the first appellant's non-delegable duty of care to the deceased while a failure in the performance of the second to its vicarious liability for the actions of its servants.

168. The first appellant submits that the judge found negligence on the part of the nursing staff when he had no grounds to do so not having any expert nursing evidence that could have set the appropriate standard for him. This, it submits, represents a fundamental misunderstanding of the nature of the case at hand and the role of the nurses.

169. The first appellant is not totally correct in this regard. Insofar as the issue was the first appellant's non-delegable duty this was not a case of the failure of nursing care. The case against the first appellant with respect to its non delegable duty is that it failed to ensure that Goetz and the second appellant acted properly in controlling the post-operative bleeding of the deceased and in the management of the transfusions of blood and blood products and that it failed to have readily available the appropriate blood and blood products to treat the deceased's excessive bleeding. It was to the performance of

these functions that the non- delegable duty of care admitted by the first appellant attached. The fields of anaesthetics and haematology were medical sciences that were pertinent to the function of controlling the deceased's post operative bleeding. This included a determination of the blood and blood products required to treat the risk of the deceased's post operative bleeding and the management of the transfusions of blood and blood products.

170. On trial here, with respect to the non-delegable duty of care, was not the practice of nursing or hospital administration but rather the practice to be followed in relation to containing post-surgical bleeding and administering blood transfusions in the particular circumstances that had arisen. This was the duty of care that the appellants accepted was owed to the deceased. It is to this duty of care that Dr. Jones-Lecointe, a consultant haematologist gave evidence of the haematological aspect of the standard of medical care that the deceased received at the hospital and Dr. Pitt-Miller, an anaesthetist by profession and a Retired Professor of Clinical Anaesthesia at the University of the West Indies, gave evidence on the clinical aspects of the standard of medical care that the deceased received at the hospital. These were the skills or the arts that were appropriate to the duty of care as admitted and the breaches alleged. In the circumstances the evidence from persons skilled either in the art of nursing, hospital administration or laboratory services were irrelevant to this aspect of the case.

171. The issue raised by the first appellant only arises if the judge found that there was a failure by the nursing staff to do something for which they were personally responsible or the first appellant vicariously responsible. For example, in accordance with the evidence of Dr. Pitt-Miller, properly monitoring the deceased. The question here would be whether in those circumstances there was a valid basis for the judge's finding of negligence where there was no evidence of the appropriate standard of care to be

applied to nurses in accordance with the Bolam test. This is more appropriately dealt with when treating with the judge's findings of breach.

The judge's conclusions on negligence and causation

172. With respect to his findings of negligence, after identifying the manner in which the appellants individually breached their duty of care, the judge concludes that both appellants "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."

173. According to the judge the appellants "were negligent in relation to pre-operative care by their 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 the condition. In relation to DIC: by the second Defendants failure to properly treat with that condition including administering the correct products and the failure to properly manage the deceased transfusions. These cumulatively resulted in Mr. Tesheria's death."

Negligence

174. The duty of care owed by the appellants to the deceased encompassed the duty to ensure that during and after the performance of the TURP (a) any bleeding of the deceased was so carefully monitored and/or properly contained and/or otherwise so managed as to protect the deceased from excessive bleeding; and that (b) such transfusions as may

have been necessary were carefully managed and carried out using such equipment test and practices as would minimize the risk of or prevent the deceased experiencing fluid overload or other deleterious effect from same. In order to establish negligence the respondent was required to show that the appellants breached their duty of care to the deceased in the manner alleged by her and that in this regard that the treatment accorded to the deceased by the appellants was not in accordance with a practice accepted as proper by a responsible body of medical practitioners skilled in that particular art.

175. The appellants submit that the judge failed to link the breaches found by him to the allegations made against them by the respondent. The appellants are correct in this regard. In his reasoning in support of his findings the judge does not specifically refer to any of the particulars of negligence alleged by the respondent. In addition, in the majority of instances, the judge fails to link his conclusions on breaches of duty on the part of the appellants with the standard of care identified by the experts as attaching to such duty. Where he does so the judge seems at times to have misread or misunderstood the expert evidence. Further he fails to connect his findings to any duty of care owed by the appellants. This is particularly egregious with respect to the first appellant's non-delegable duty of care.

176. In this regard therefore the judge fell into error. In arriving at his findings of negligence the judge seems to have simply arrived at conclusions of fact based on his assessment of the evidence and concludes negligence. These failures by the judge of themselves however are not indicative of the success of these appeals. The question for our determination is whether these and any other failures by the judge led him into error when he concluded negligence on the part of the appellants.

177. Essentially the appellants submit that there is no evidential basis to support the judge's findings on both the breaches and causation. In examining this submission it must however be born in mind that no contrary evidence, factual or by way of expert opinion,

has been placed before the judge by the appellants and that the judge accepted the evidence placed before him by the respondent. The requirement that we be satisfied that the judge has gone plainly wrong requires us to consider whether it was permissible for the judge to make the findings of fact that he did in the face of the evidence as a whole.[28]

178. To the extent that there may be valid challenges to the judge's conclusions on the evidence insofar as these challenges are to the inferences drawn by the judge from the primary facts as found by him, as a Court of Appeal, we are in as good a position as the judge to examine the evidence and evaluate and arrive at the proper inferences to be drawn from these primary facts.[29]

179. In these circumstances, I propose to examine the findings of the judge, place them in the context of the allegations of negligence made in the case and the evidence accepted by him, and, if unsupportable or untenable, consider whether there is other evidence not specifically referred to by the judge or other inferences that can be drawn from these primary facts and whether this other evidence or inferences support the findings of negligence made by the judge against either or both of the appellants. If they do then it will be difficult if not impossible to conclude that the judge was plainly wrong.

The judge's findings of negligence against the first appellant

180. In treating with the breaches the judge seems not to have specifically identified the breaches relating to this appellant's non-delegable duty of care or its vicarious liability for the acts of its servants and agents. In those circumstances, and given that the judge came to separate findings of negligence on the part of the appellants, it may also be necessary to consider whether the first appellant was also liable for any of the breaches

[28] Beacon Insurance Co. Ltd. v Maharaj Bookstore per Lord Hodge at para 12
[29] Benmax v Austin Motor Co. Ltd. [1955] 1 All E.R. 326 at 329

found by the judge to have been committed by the second appellant. If those breaches were the subject of complaint by the respondent against the first appellant then in accordance with its non-delegable duty of care to the deceased those findings ought properly to have also resulted in a corresponding finding of negligence against the first appellant. In these circumstances it may be necessary to consider whether this is an apt case in which to apply section 39 of the Supreme Court of Judicature Act Chap 4:01.

(i) the first appellant failed to make attempts to monitor and contain the deceased's post surgical bleeding

181. The particulars of negligence allege that the first appellant failed:

> "whether properly or at all, to measure and/or monitor and/or make any assessment of and/or have any regard to and/or make any attempt to contain the bleeding experienced by the deceased during the period 1.10 pm to 3.10 pm on the day in question."

182. The judge found that the first appellant failed to make attempts to monitor and contain the post surgical bleeding of the deceased. According to the judge:

> "The lapse of time while Mr. Tesheira was bleeding post operatively is basic carelessness. Even if one is to accept that Mr. Tesheira was bleeding heavily at 2.50 pm 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 3.30pm 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."

183. The judge here fell into multiple errors. First of all this was not the period identified by the respondent as giving cause for the complaint. The complaint dealt specifically with the period of time when the deceased was under the care of the nursing staff and prior to the second appellant attending on the deceased. The complaint was not with respect to the lapse of time but rather addressed the failure by the nursing staff to take certain actions. The judge's conclusions therefore did not specifically relate to the pleaded breach.

184. Nor did his conclusion accord with the evidence before him. The judge misunderstood the evidence of Dr. Jones- Lecointe. The conclusions of Dr. Jones-Lecointe referred to by the judge was based on assumptions by her that the deceased was bleeding heavily for a period of approximately two hours, that there was a failure to inform Goetz or the second appellant of that fact and that thereafter, even after Goetz was informed, the deceased continued to bleed for a further 20 minutes before developing hypovolemic shock.

185. These were the factors, together with the further delay of approximately one hour between the deceased showing signs of early hypovolemic shock and the transfusion of his first unit of blood, that Dr. Jones-Lecointe felt constituted the serious failure to provide the standard of medical care reasonably to be expected and created the unacceptable and unnecessary risk of harm to the deceased. Her evidence, and her conclusions, were therefore not limited to the period of time specified by the particulars of negligence.

186. Despite referring to it the judge failed to identify the relevant standard of care that had been breached. The relevant standard of care identified by the experts treated not with the length of time but rather the need for proper monitoring of the deceased. More

importantly the judge failed to recognize that there was evidence of monitoring of the deceased by the nursing staff as evidenced by the fact that at all material times the deceased was attached to monitors and that there had been some recordings of his vital signs, temperature and fluid intake. There was also evidence of attempts to contain the deceased's bleeding by the manual irrigation done by the nursing staff at 3.10 pm.

187. The judge's conclusion that the first appellant failed to make attempts to monitor and contain the post surgical bleeding was therefore wrong and contrary to the evidence. In the circumstances the judge fell into error in this regard.

188. The question here is whether there was sufficient evidence before the judge for us to conclude that the first appellant failed: "whether properly or at all, to measure and/or monitor and/or make any assessment of and/or have any regard to and/or make any attempt to contain the bleeding experienced by the deceased" during the period of time under review.

189. The answer is no. This allegation related to this appellant's vicarious liability with respect to the nursing staff. There was evidence of monitoring by the nursing staff. The burden of proof would have been on the respondent to establish that this was not done in accordance with a standard of care applicable to nursing staff, that is, in accordance with a practice adopted by reasonably competent nursing practitioners. She has not done so.

190. Further while there was some evidence of a failure by the nursing staff to estimate the quantity of the blood loss of the deceased not only is there no evidence of the relevant standard of care to be adopted by the nursing staff but Dr. Jones-Lecointe in cross-examination admits that to do this would be impossible given the additional absorption of fluids at the site of the resection.

191. In these circumstances there was no evidence that the first appellant, in accordance with the relevant standard of care, failed whether properly or at all to measure and/or monitor and/or make any assessment of and/or have any regard to and/or make any attempt to contain the bleeding experienced by the deceased during the period 1.10 pm to 3.10 pm on the day in question. Insofar as he found that the first appellant was negligent in this regard therefore the judge was wrong.

(ii) the first appellant (a) failed to maintain appropriate supplies of blood and blood products and clotting agents sufficient to meet the risk of bleeding and (b) failed to have the appropriate products readily available in half an hour.

192. The judge deals with these findings separately. They relate however to the same allegation of negligence. By its particulars of negligence the respondent alleges that the first appellant failed to maintain appropriate supplies of whole blood, blood platelets, fresh frozen plasma, cryoprecipitate and other clotting agents at the hospital sufficient to meet the risk of the deceased experiencing excessive bleeding during and/or after the TURP procedure.

193. On the evidence no distinction is made between blood and whole blood. They are used interchangeably to mean blood that contains all its elements that is blood cells and plasma. With respect to his finding that the first appellant failed to maintain appropriate supplies of blood and blood products and clotting agents sufficient to meet the risk of bleeding the judge was of the opinion that "the undisputed evidence of Dr. Jones-Lecointe is that the preferred fluid to prevent bleeding and to increase the chance of haematosis[30] is fresh whole blood. But this was not administered until 8 pm that night."

194. With respect to his finding that the failure to have the appropriate products readily available within a half an hour exposed the deceased to the unnecessary risk of

[30] cessation of bleeding

hypovolemic shock which developed into DIC and later fluid overload the judge was of the view that: "But for the receipt of timely transfusions of the correct blood that is packed red cells within half an hour or cryoprecipitate and fresh frozen plasma the deceased would not have developed hypovolemic shock or that it would have progressed to DIC or it would have progressed further to fluid overload".

195. The judge confused and misread the evidence on the transfusions required to treat, first, the deceased's excessive bleeding that led to his going into hypovolemic shock and, then, the deceased's DIC, and the evidence of the standard of care that applied to each type of transfusion. In doing so the judge fell into error. He also here seems to have misread the evidence with respect to the deceased's fluid overload but it is not necessary to treat with that at this stage.

196. The particulars of negligence here dealt with the first appellant's duty to maintain appropriate supplies of whole blood and the specified blood products including fresh frozen plasma and cryoprecipitate. This was a function covered by this appellant's non-delegable duty to the deceased. The judge ought first to have considered whether the relevant practices described by the experts required that the first appellant maintain these supplies and, in particular, whether the requirement that the first appellant have fresh whole blood, fresh frozen plasma and cryoprecipitate readily available or available within half an hour of being required fell within the ambit of the respondent's complaint.

197. To meet the risk of excessive bleeding presented by the TURP procedure, according to the experts, the standard medical practice was that the first appellant was required to have two sets of blood and blood products readily available: (a) at least two units of blood or packed red cells that had been grouped and cross-matched to the deceased's blood; and (b) supplies of fresh whole blood and blood products such as fresh frozen plasma and cryoprecipitate.

198. With respect to the 2 units of blood or packed red cells the evidence was that this ought to have been available at the hospital at the time of the TURP. This was the blood required to treat the deceased's initial excessive bleeding and prevent him going into hypovolemic shock. With respect to the blood and blood products required to treat the deceased's DIC, that is, the fresh whole blood, fresh frozen plasma and cryoprecipitate the standard medical practice was that these products be sourced and made available within half an hour of being required.

199. With respect to the blood necessary to treat the deceased's initial excessive bleeding there was therefore evidence from which the judge could have come to the conclusion that the first appellant was required to maintain appropriate supplies. There was no similar evidence with respect to the fresh whole blood and blood products required to treat the deceased's DIC. Insofar as the judge came to the conclusion that the first appellant was required to maintain supplies of fresh whole blood therefore he was wrong. The first appellant was not required to maintain supplies of fresh whole blood, fresh frozen plasma or cryoprecipitate at the hospital but merely to have it available within half an hour of being required.

200. The first appellant submits that the judge failed to take into consideration that there was evidence of blood tags that confirmed that there were at least 2 units of grouped and cross- matched blood available. While there is evidence in the medical records that suggests that on 13th April there were at least two units of this blood available for use on that date there is no evidence to show when this blood became available or more precisely to show that they were available at the time the deceased began to bleed excessively and went into hypovolemic shock, that is, prior to 3.30pm. In the circumstances on the evidence before him the judge cannot be faulted for ignoring the evidence of the blood tags and the laboratory reports.

201. The first appellant submits that, given that there was nothing recorded in the notes or otherwise as to the lack of products, there was no basis for the judge to assume that there was a lack of arrangements in this regard based only on the times of the transfusions. I do not agree. The conclusion that the first appellant did not have the required 2 units of blood or the packed red blood cells in storage was open to the judge to draw on the evidence even without recourse to the **Wizniewski** principles. The evidence from the nurses' notes was that at 3.30 pm the deceased was taken to the operating theatre and blood was requested for transfusion. There was nothing in the medical records to account for the failure to transfuse the blood requested within the half an hour as required by the relevant standard of care.

202. In the circumstances there were only two inferences open to the judge to draw from the failure to transfuse the 2 units of blood by 4 pm and the transfusion instead of non-blood products: that the grouped and crossed matched blood was not available or that someone had made a serious mistake. This accorded with the opinions of the experts. Had the blood been available then the logical inference would be that that would have been used to transfuse the deceased rather than the non-blood products. The judge, as he was entitled to do, inferred that the blood, which the standard medical practice required the hospital to have in storage, was not available. If the blood was available there would have been no need to transfuse with non-blood products which were themselves contra indicated according to the experts.

203. With respect to this allegation of negligence therefore in his conclusion and his assessment of the evidence the judge got it partially wrong. There was no evidence from which the judge could have come to the conclusion that the failure by the first appellant to have available for use fresh whole blood before 8pm or to have fresh frozen plasma or cryoprecipitate available within half an hour was a breach of the first appellant's duty of care to maintain these products as alleged by the respondent.

204. There was evidence however from which he could have come to the conclusion that the first appellant failed to maintain appropriate supplies of whole blood and that this failure breached the relevant standard of care described by the experts. This was with respect to the blood appropriate to treat the deceased's initial excessive bleeding and the early signs of hypovolemic shock.

(iii) that the first appellant committed a cardinal sin by pumping O + blood into the deceased.

205. The judge found that the appropriate products were not available. According to the judge this was not only carelessness but simply dangerous and it was very likely that this was a direct causative link to the deceased's fluid overload as O+ blood had no recuperative value for the deceased in his condition of DIC and resulted in the destruction of the red blood cells in his blood.

206. According to the judge:

> "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 was suitably explained by Dr. Pitt- Miller. These steps were not followed. The level of testing was inadequate and incapable of assisting those treating the deceased as to the clotting ability of his blood."

207. The judge lumped together his findings on two breaches: transfusions of O+ blood and the inadequacy of the testing. In the context of these two aspects of the deceased's treatment however his references to the standard of care required by the normal competent specialist as explained by Dr. Pitt-Miller makes no sense. In her evidence Dr. Pitt-Miller references two sets of steps which standard medical practice required be

adopted: the monitoring by the nursing staff immediately after the procedure and the steps required to be followed to prevent and detect fluid overload during the transfusion of large amounts of fluid.

208. It is this latter evidence that identified the basic steps to be taken by the specialists Goetz and the second appellant. Rather that two aspects of the deceased's treatment the judge here therefore seems to be dealing with three: transfusions of O+ blood; the level of testing and controlling the deceased's fluid balance.

(a) Transfusions of O+ blood

209. The respondent alleges that the first appellant was negligent in transfusing O+ whole blood into the deceased and/ or permitting and instructing same to be transfused into the deceased. The judge seems to base the first appellant's liability on the unavailability of the appropriate products. There was however no evidence from which the judge could have drawn this conclusion. Nor was it an inference that the judge needed to make since the allegation merely dealt with the fact of the transfusion and not the reason for the transfusion.

210. Indeed if an inference was to be drawn the only reasonable inference that could be drawn from the transfusion of the O+ blood was that the persons responsible for the transfusions were unaware of the dangers of such transfusions and were of the opinion that O+ blood could be used in these circumstances. This is consistent with the appellants' pleaded position that at all material times Group O universal blood was available which could be readily transfused into any person with another blood group including the deceased who was A+.

211. While there was no evidence that the first appellant was directly responsible for transfusing O+ blood into the deceased or instructing that it be done the conclusion by the judge that the first appellant breached its duty of care to the deceased by transfusing O+ blood into him cannot be faulted. The transfusion of O+ blood into the deceased was

a breach of the first appellant's non-delegable duty of care to ensure that such transfusions that were carried out were carefully managed and carried out using practices that would minimize the risk of the deceased experiencing fluid overload or other deleterious effect from such transfusions. In the circumstances the judge's finding that the first appellant was negligent in transfusing O+ blood into the deceased was correct.

(b) inadequate testing

212. The judge seems to deal with this by way of an afterthought. He refers to no evidence nor does he give any reasons for his conclusion. The only relevant allegation of negligence against this appellant is the allegation that it failed 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 the surgery.

213. No PT or PTT tests were done prior to the TURP procedure. The evidence of both experts is that standard medical practice required that such tests be conducted just prior to the TURP procedure being performed. According to Dr. Pitt-Miller these tests should have been carried out to ensure that the deceased's low platelet count, as shown by the January blood test, did not indicate or was not accompanied by blood clotting problems.

214. Dr. Jones-Lecointe was of the opinion that in a small hospital without an on-site blood bank or where the emergency supplies of blood products are not predictable, in the event of bleeding and particularly where the operation itself carries the risk of bleeding, PT and PTT tests ought routinely to be done prior to the operation. To fail to do so would involve a high risk of severe and uncontrolled bleeding. The TURP procedure carried a risk of heavy bleeding. The hospital was a small hospital with no on-site blood bank. In her cross-examination Dr. Jones-Lecointe describes a situation in Trinidad and Tobago where emergency supplies of blood products are not predictable. PT and PTT tests ought therefore to have been done just prior to the procedure.

215. The hospital staff could only have performed the tests had they been ordered by either of the doctors. The failure to conduct these tests just prior to the procedure was therefore an aspect of the first appellant's non-delegable duty to ensure that during and after the TURP procedure any bleeding of the deceased was carefully monitored, contained and/or otherwise so managed to protect the deceased from excessive bleeding. There was evidence accepted by the judge that showed negligence on the part of the first appellant in failing to ensure that PT and PTT tests were conducted on the deceased immediately prior to the performance of the TURP.

(c) fluid overload

216. Despite not specifically referring to this as a breach by the first appellant it is obvious that by his reference to basic steps required to be followed by the normal competent specialist exercising the skill in undertaking that task the judge could only be referring to the steps required to detect and prevent fluid overload as identified by Dr. Pitt-Miller. These were the only steps identified by Dr. Pitt-Miller that the specialist doctors were themselves required to follow.

217. The relevant allegation of negligence states that the first appellant was negligent in failing "to monitor and/or record the deceased's fluid output and to monitor and 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 by CBC monitoring, use of a central venous pressure line auscultation of the chest, testing of arterial blood gasses, chest x-rays or by any other means.

218. This was an aspect of the first appellant's non-delegable duty to the deceased. The judge considered and found that the second appellant had breached a similar allegation made against him by the respondent. In the circumstances it seems more appropriate to consider this when treating with the judge's findings of liability against the second appellant.

(iv) the first appellant failed to make a proper pre-assessment of the deceased's use of aspirin

219. In dealing with the breaches of the second appellant the judge also concludes that the first appellant failed to make a proper pre-assessment of the use of aspirin. Again this relates to the first appellant's non-delegable duty of care to the deceased to ensure that during or after the performance of the TURP 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. The respondent however makes no allegation of negligence against this appellant in this regard in these circumstances the judge erred in arriving at this conclusion of negligence against the first appellant.

The judge's findings of negligence against the second appellant:

(i) failed to take any steps to arrest or control the deceased's bleeding post TURP

220. The judge here is treating with the period 1.10pm -3.30pm. According to the judge the deceased was bleeding continuously from 1.10 and heavily and excessively from 2.50 to 3.30. He says that for a full 40 minutes of heavy bleeding nothing was done. He says: "When Dr. Jones Lecointe pointed out from her experience how quickly a cross-match of blood can be done, CBC tests conducted, Mr. Tesheria'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 expected standard of care and exposed the deceased to an unnecessary risk." He then adds: "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 blood loss."

221. The judge here seems to have made three findings of breach on the part of the second appellant: his failure to: (a) to take steps to arrest or control the deceased's post TURP bleeding; (b) carry out PT/PTT tests and (c) make a proper pre-assessment of the deceased's use of aspirin. Save that by linking them to the first appellant he seems to suggest that the last two conclusions are related to the first appellant's non-delegable duty of care the judge provides no rationale for these two conclusions. In arriving at these conclusions of negligence against the second appellant the judge makes no reference to the allegations made by the respondent and fails to identify the appropriate standards of care to be applied.

(a) steps to arrest the deceased's bleeding post TURP

222. The judge's concern seems to be with the failure of the second appellant to assess the deceased's condition during the period between 1.30 and 3.30 pm and take steps to arrest or control this bleeding. The judge fails to appreciate however that the second appellant was only informed of the deceased's heavy bleeding at 3.10 pm and in those circumstances if there was a failure by the second appellant to take steps to arrest the deceased's bleeding it was over a period of 20 and not 40 minutes.

223. Insofar as the judge refers to the evidence of Dr. Jones-Lecointe there was evidence from her that the failure of Goetz, the second appellant and the nursing staff to take any substantive action for a further 20 minutes after the second appellant was informed of the deceased's bleeding constituted a serious failure to deliver the standard of medical care which is to be expected of them and created an unacceptable and unnecessary risk of harm to the deceased.

224. While Dr. Jones-Lecointe does not in her evidence identify the standard of medical care that she says has not been delivered the judge obviously considered her evidence on the time it ought to take to cross-match the blood and conduct CBC tests relevant. This in itself however could not be evidence of any wrong doing on the part of the second

appellant. His responsibility with regard to those functions could only be to assessing the situation, ascertaining that there was a need for blood and ordering that this blood be prepared for transfusion.

225. The only reference made by the judge to anything that could be considered to be a failure on the part of the second appellant was his statement that the deceased's condition could have been assessed a long time before he went into hypovolemic shock. If the evidence supported this, insofar as the second appellant was concerned, this would clearly be a breach of his admitted duty to ensure that 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.

226. The evidence is that at 3.10 pm Goetz was summoned and the second appellant came. The nurses' notes suggest that the second appellant observed that the deceased's blood was still heavily blood stained and reported back to Goetz. While this is clearly conjecture on the part of the nurses it was an inference that it was open to the judge to make. The second appellant was in a position to observe first hand the deceased's excessive bleeding. For a further 20 minutes, while the deceased continued to bleed heavily nothing was done to contain or arrest that bleeding. In particular the second appellant did not during that time request blood for transfusion. Blood for transfusion was only requested at or around 3.30 pm.

227. The statement of Dr. Jones-Lecointe that the failure to take any step for a further 20 minute period constituted a failure to deliver the standard of care expected of the second appellant and created an unacceptable and unnecessary risk of harm to the deceased begs the question what was the standard of care expected of this appellant.

228. The experts refer to two standards of care that can be applied to the treatment accorded to the deceased during this period of time: the monitoring and recording of the deceased's vital signs, oxygen saturation level and pulse wave form and the assessment

or measurement of the blood loss and the availability to the patient of the cross-matched blood in storage at the hospital within half an hour of the transfusion request. With respect to the monitoring and the assessment of blood loss by the nursing staff the purpose of this was clear. It was to inform Goetz and/or the second appellant should the results of the monitoring be above or below the specified levels. According to Dr. Pitt-Miller the nursing staff was to inform Goetz and/ or the second appellant immediately so that immediate action could be taken by Goetz and/or the second appellant to arrest or control the deceased's bleeding. The relevant standard of care therefore required immediate action on the part of Goetz and/or the second appellant to arrest or control the deceased's bleeding.

229. The blood that the first appellant was required to have at the hospital at the time of the TURP procedure met the criteria of blood required to treat the deceased's initial heavy bleeding and his hypovolemic shock. The evidence was that this blood had not been required for use during the TURP procedure and so ought to have been available for use to treat the deceased's excessive bleeding. This blood was required to be grouped and cross-matched before transfusion. The judge's reference to the time it ought to have taken to cross- match the blood was clearly a reference to this.

230. In doing nothing between 3.10 and 3.30 and, in particular, in not arranging for blood, which ought to have been stored at the hospital, to be available for transfusion immediately or at least within half an hour the second appellant breached the duty of care owed by him to the deceased to ensure that any bleeding of the deceased was contained so as to protect him from excessive bleeding.

231. The only allegations of negligence that treat with the judge's concern are the allegations that the second appellant failed to act quickly enough in transfusing the relevant blood and blood products into the deceased and that he failed to take any or any adequate steps to prevent the deceased from succumbing to excessive bleeding. The failure by the

second appellant to take any action during that 20 minute period clearly falls within the first of these allegations but the judge deals with this aspect of this appellant's negligence later in his judgment.

232. While there is evidence that in the period considered by the judge the second appellant did not take any steps to prevent the deceased succumbing to excessive bleeding during the 20 minutes under review the second allegation is much wider and involves a consideration of the second appellant's actions not embarked upon by the judge. The evidence however is that after the discovery that the deceased was bleeding heavily the first step to taken to prevent the deceased from succumbing to excessive bleeding, in accordance with the standard of care identified by the experts, was the transfusion of two units of blood at 4.30pm and 5.00pm. It is clear that this step was not sufficient to arrest or control the deceased's bleeding since the results of the PT and PTT tests requested at 4.00-4.15 and received at 4.45-5.00pm showed that the deceased had already succumbed to excessive bleeding and had developed DIC. While the judge was not strictly correct when he determined that the second appellant was negligent in failing to take any steps to arrest or control the deceased's bleeding post TURP there was evidence to support such a finding that the second appellant failed to take any or any adequate steps to prevent the deceased from succumbing to excessive bleeding.

(b) to carry out PT and PTT tests or (c) make a proper pre- assessment of the use of aspirin

233. There is no allegation of negligence against the second appellant that he failed to carry out PT and PTT tests or make a proper pre-assessment of the use of aspirin. If, however, either of these (a) were steps which could have the effect of arresting or controlling the deceased's bleeding or (b) comprised a failure 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 then these failures would

accord with allegations of negligence made by the respondent against the second appellant. It is clear from the evidence of the experts that the conduct of these tests, insofar as there was a need to instruct that they be done fell within the function of the second appellant.

234. In determining that the second appellant failed to carry out PT and PTT tests the judge was wrong. While not conducted prior to the procedure 2 PT and PTT tests were done after the deceased was returned to the operating theatre. These tests, if done prior to the procedure being performed, would have provided information on the clotting ability of the deceased's blood. This information was vital in assessing the risk of the deceased succumbing to excessive bleeding. The tests would have identified the deceased's susceptibility to excessive bleeding. In the circumstances the failure of the second appellant to ensure that PT and PTT tests were conducted prior to the TURP procedure comprised a failure on his part to take a step to prevent the deceased from succumbing to excessive bleeding and amounted to negligence.

235. Dr. Pitt-Miller's evidence is that the risk of fluid overload of the deceased was increased by the failure to regularly do CBC and PT and PTT tests of the deceased's blood. This, according to Dr. Pitt-Miller, would have determined the effect of the transfusions of copious amounts of whole blood and the fresh frozen plasma and cryoprecipitate on the deceased's bleeding condition. She was of the opinion that the level of testing actually done would not have enabled a proper assessment of the effect of the transfusions on the deceased. By not carrying out additional PT and PTT tests during the period of the transfusions the second appellant was therefore in breach of his duty to ensure that the transfusions were carried out using tests and practices that would minimize the risk of or prevent the deceased experiencing fluid overload.

236. Insofar as it related to an allegation of negligence this was relevant to the allegation that the second appellant failed to properly manage and/or monitor the transfusion of blood, blood products and other fluids to the deceased after the completion of the TURP procedure. This failure therefore also amounts to negligence on his part. In the circumstances while the judge was wrong in his determination that the second appellant failed to carry out PT and PTT tests there was evidence that the second appellant was negligent in (a) failing to carry out PT and PTT tests prior to the TURP procedure and that this amounted to a failure to take a step to prevent the deceased from succumbing to excessive bleeding and (b) failing take additional PT and PTT tests during the period of transfusion and that this amounted to a failure to properly manage and monitor the transfusions of blood and blood products after the completion of the TURP procedure.

237. There is no evidence of the deceased being asked prior to the procedure whether he was taking aspirin. While the presence of aspirin would not have caused the deceased's excessive bleeding by causing additional bleeding complications it would have hindered the appellant's ability to prevent the deceased from succumbing to excessive bleeding. A pre-surgery assessment of whether the deceased was taking aspirin was therefore a step that ought to have been taken to prevent the deceased succumbing to excessive bleeding. In failing to do so the second appellant was negligent. The judge therefore was correct when he determined that the second appellant was negligent in failing to make a proper pre-assessment of the use of aspirin by the deceased.

(ii) failed to act quickly to transfuse the relevant blood products

238. This finding mirrors the respondent's allegation that the second appellant did not act quickly enough in transfusing the relevant blood and blood products into the deceased. The judge deals only with the transfusions required to treat the initial bleeding and the deceased's hypovolemic shock. According to the judge instead of being transfused with

the acceptable products, whole blood or plasma or packed red cells and plasma, "at 4.30 an hour after he developed hypovolemic shock he was being transfused with crystalloids and colloids." He concludes that it is more probable that the suitable products were simply not on site at the hospital.

239. Insofar as the judge concludes that this was the responsibility of the second appellant he was correct. The evidence of Dr. Pitt-Miller is clear. The anaesthetist's role in a situation of unusual heavy bleeding would include organizing fluids and getting blood and to "resuscitate the patient: ensure that the patient's blood pressure, pulse and other vital functions are functioning, so that the surgeon can in fact stop the bleeding." This also fell within the ambit of the first appellant's non-delegable duty to ensure that any bleeding of the deceased was properly contained and managed so as to protect him from excessive bleeding but no such allegation was made against the first appellant by the respondent.

240. The judge misstates the evidence with respect to these transfusions. Crystalloids and colloids were transfused into the deceased prior to 4.30 not at 4.30. The conclusions by the experts were made on that basis. The judge's assumption that more likely than not the suitable products were not on site was irrelevant to the allegation. The allegation does not deal with the presence of the blood on site but rather with the time when the blood or the relevant blood products were in fact transfused into the deceased.

241. The treatment for the deceased's initial heavy bleeding and subsequent hypovolemic shock was grouped cross-matched blood or packed red cells and not, strictly speaking, blood products. It is clear however from his reference to whole blood earlier that the judge was also considering the second appellant's failure to transfuse blood in addition to blood products. With that in mind insofar as the judge found that the second appellant was negligent in failing to act quickly in transfusing the relevant blood that could have treated the deceased hypovolemic shock he was correct. On the evidence the

blood required to treat the deceased's initial heavy bleeding and ultimately his hypovolemic shock was not transfused within the half an hour required by the standard of care. The failure to transfuse this blood in time resulted in further bleeding by the deceased. This was therefore a breach of the second appellant's duty to ensure that any bleeding of the deceased was properly contained and managed so as to protect the deceased from excessive bleeding and constituted negligence on his part.

242. Where the judge fell into error is that he seems not to have considered the time lapse in transfusing the relevant blood and blood products for the treatment of the deceased's DIC. The evidence is that a diagnosis of DIC ought to have been made by 4.45-5pm when the results of the first PT and PTT tests were received. These products, according to the evidence of Dr. Pitt-Miller, should have been available for transfusion into the deceased within half an hour of the diagnosis. Instead the first transfusion of any product suitable to treat the deceased's DIC was not done until 7.45 pm.

243. It is clear therefore that the time taken to transfuse both the blood used to treat the deceased's hypovolemic shock and the blood and blood products necessary for the treatment of the deceased's DIC was too long and did not accord with the relevant standard of care. In this regard the second appellant was also negligent. The judge was therefore correct in his conclusion that the second appellant was negligent in failing to act quickly to transfuse the relevant blood and blood products to the deceased.

(iii) failed to ensure that prior to the TURP there were adequate supplies of packed red cells or whole blood to treat hypovolemic shock or fresh frozen plasma and cryoprecipitate to treat DIC

244. The relevant allegation of negligence here is that the second appellant failed to 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 hospital. In accordance with the evidence of Dr. Pitt-Miller this was the second appellant's responsibility.

245. The judge draws two conclusions on the availability of the necessary blood and blood products. With respect to the treatment for the deceased's hypovolemic shock he concludes that, based on the doubts of both experts and the fact that a request for blood was made at 3.30 pm, it was more probable than not that the products necessary to treat hypovolemic shock were not there "as it took unusually long in Dr. Jones-Lecointe's view for the first transfusion at 4.30 pm." In this regard the judge cannot be faulted. As we have seen when treating with the findings of negligence against the first appellant there was evidence from which he could have come to this conclusion.

246. With respect to the treatment for the deceased's DIC the judge concludes that the first appellant "was simply not ready for this and Dr. Roopchand had failed to prepare adequately for the TURP". He bases this conclusion on the fact that when the deceased developed DIC based on the tests issued at 4.20 pm he was only administered with the recommended products to treat the condition at 7.45 pm. In this regard the judge was partly wrong. The tests which confirmed the deceased's DIC were the PT and PTT tests. The results issued at 4.20 pm were the CBC results. According to the medical records and the admissions the results of the first PT and PTT tests were received between 5.15 and 5.30 pm.

247. The standard medical practice required that the blood and blood products necessary to treat the deceased's DIC be available to the deceased within half an hour of been required, that is, within half an hour of the results of the first PT and PTT tests becoming available. Despite this the request for the blood and blood products was not made until 5 pm. The blood and blood products were not received by the hospital until 7.30pm and not made available to the deceased until 7.45pm.

248. The allegation of negligence however only complains of the failure to ensure that the relevant blood and blood products were at the hospital immediately prior to the performance of the TURP. In accordance with the evidence of the experts this could only therefore have related to the blood needed to treat the deceased's initial heavy bleeding. In the circumstances the judge was correct in concluding that the failure of the second appellant to have available at the hospital the 2 units of blood required to be transfused into the deceased in the event of excessive bleeding amounted to negligence but incorrect when he suggests that the failure of the appellants to have readily available the supplies necessary to treat the deceased's DIC accorded with an allegation of negligence made by the respondent. The judge's conclusion that the second appellant was negligent in failing to ensure that prior to the TURP procedure there were adequate supplies of packed red cells or whole blood to treat the deceased's hypovolemic shock was therefore correct.

(iv) failed to manage properly the transfusion of blood and administered excessive amounts of blood and blood products.

249. The judge draws these two conclusions from the records of the second appellant which he says showed that from 4.30 pm at almost half an hour intervals the deceased was being transfused with the wrong blood. Further, speaking of the deceased, the judge states: "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 was administered 3 units of O positive. This according to Dr. Pitt-Miller completely destroyed his A red blood cells."

250. The judge's focus seems to be mainly on the transfusions of the wrong type of blood or blood products. Here the judge's failure to have regard to the particulars of negligence

led him into error. In the particulars of negligence while there was a specific allegation that referred to transfusions of the wrong type of blood it was only with respect to O+ blood. This allegation was that the second appellant transfused group O+ whole blood into the deceased and/or permitted and/or instructed the same to be transfused into the deceased.

251. Insofar as the judge found that instead of being transfused with the right type of blood the deceased was administered 3 units of O+ blood it was more relevant to this allegation of negligence than to the failure to properly manage the transfusion of blood or administer excessive amounts of blood and blood products. In accepting that the deceased was administered with O+ blood instead of A+ blood and that this was the responsibility of the second appellant the judge ought to have made a specific finding in this regard.

252. The judge's reference to the evidence of Dr. Pitt- Miller was not completely accurate. Dr. Pitt-Miller's evidence was not that such a transfusion completely destroys the deceased's A red cells but that a transfusion of O+ blood into the deceased may result in the destruction of the deceased's red blood cells by antibodies present in the O+ blood. As we have seen earlier the standard medical practice, identified by Dr. Pitt-Miller, was that such a transfusion should only be done where the situation was life threatening and only in circumstances where the patient's haemoglobin level was so low as to pose a danger to the patient's life and where there is no A + blood or packed blood cells available. She was of the view that the CBC test results received at 4.20pm showed that this was not the case. According to her what should have been done in the event that there was no A+ blood available was not to transfuse O+ blood into the deceased but rather wait for A+ blood to become available while repeating the CBC tests to monitor the deceased's haemoglobin level.

253. In the circumstances although not the subject of a specific finding by the judge there was evidence before the judge, accepted by him, to support a finding that the second appellant was negligent in transfusing or permitting O+ blood to be transferred into the deceased.

254. The particulars of negligence relevant to the judge's conclusions that the second appellant failed to manage properly the transfusion of blood and administered excessive amounts of blood and blood products were: (a) administering and/or transfusing excessive amounts of blood and blood products to the deceased after/ during the TURP procedure and (b) 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.

255. The first allegation simply concerns the action of transfusing too much fluid into the deceased while the second deals with the failure to manage or monitor the transfusions in accordance with the steps identified by Dr. Pitt-Miller. The transfusion of blood and blood products was a responsibility of the second appellant in accordance with his function of stabilizing the deceased and obtaining blood. This also accords with the admitted duty of the appellant to ensure that transfusions were carried out using such practices as would minimize the risk of or prevent the deceased experiencing fluid overload.

(a) administering excessive amounts of blood

256. Between the period 3.30 to 10.00pm the deceased was transfused with 3 units of haemaccel; 3 litres of ringers, 11 units of whole blood 2 units of fresh frozen plasma and 3 units of cryoprecipitate. According to Dr. Pitt- Miller this represented a massive transfusion amounting to more than twice the average volume of blood in the human body.

257. While the evidence of the experts state that the transfusions were excessive the experts do not specifically say what is the standard medical practice to be followed with respect to the amount of fluid to be transfused. Rather the evidence is simply that standard medical practice required Goetz and/or second appellant to have been monitoring the deceased in the manner described by Dr. Pitt-Miller while he was being transfused with these massive amounts of fluid to ensure that he did not succumb to fluid overload as a result of the transfusions.

258. Despite the failure of the experts to specifically treat with this aspect of the case the fact is that according to the experts the fluid transfusions were excessive and were the proximate cause of the deceased's death. They both conclude that had the transfusions been monitored, managed or controlled the likelihood was that the results would have been different. According to Dr. Pitt-Miller:

> "if the transfusion of the massive amount of fluid received by the Deceased after the completion of the April 2004 TURP procedure was not carefully monitored, managed and controlled there was a serious risk of the Deceased developing fluid overload cardiac failure. The massive volume of fluids that was administered to the Deceased in the space of 6.5 hours in of itself suggests that the transfusion of those fluids was not properly monitored and managed.

259. It follows from the evidence of the experts that if the deceased's fluid intake had been properly monitored in accordance with the required standard he would not have been transfused with such massive amounts of fluid. Both experts were of the opinion that the deceased succumbed to fluid overload as a result of the massive amount of fluid that was transfused into him. Dr. Pitt-Miller's evidence was that the amount of fluid transfused was excessive.

260. Despite the fact that there was no specific evidence from the experts as to the standard of care to be applied in determining when fluid being transfusing to a patient is excessive it was open to the judge to conclude negligence on the part of the second appellant. This was not a scientific or technical matter. By applying some common sense it was an inference that could have been properly drawn from the evidence. In the context of the negligence of the second appellant therefore there is sufficient evidence from the experts to conclude that in administering and transfusing massive amounts of fluid the second appellant breached the standard of care accepted as proper by the experts. In the circumstances there was sufficient evidence upon which the judge could have determined that the second appellant was negligent in administering and/or transfusing excessive amounts of blood and blood products to the deceased after/ during the TURP procedure. In arriving at this conclusion the judge was therefore correct.

(b) manage properly the transfusion of blood.

261. Standard medical practice required that certain basic steps to prevent and detect fluid overload during and after the TURP procedure, and in particular when being transfused with large amounts of liquid as treatment for his hypovolemic shock and DIC, ought to have been taken by Goetz and the second appellant. These steps were identified by Dr. Pitt-Miller. According to Dr. Pitt-Miller these steps were particularly necessary given the fact of the possibility of TURP syndrome, the large amounts of fluids which were required to be administered to him post operatively and the fact that the deceased had been diagnosed with "early coronary disease". Except for using 2 pulse oximeters at 10.00 pm that night these steps were not taken.

262. The evidence of Dr. Pitt-Miller establishes a failure by Goetz and the second appellant to manage and/or monitor the transfusions of blood and blood products to the deceased after the completion of the TURP procedure in accordance with standard medical practice. It is clear from the evidence of the experts that these transfusions had the effect

of destabilizing the deceased. In the circumstances therefore the failure by him to properly manage and monitor these transfusions amounted to negligence on his part. In this regard therefore the judge was correct when he determined that the second appellant was negligent in failing to manage properly the transfusion of blood to the deceased.

(v) failed to properly monitor and record the deceased's fluid output or ensure adequate proper of sufficient monitoring to monitor his status during the transfusion of blood and other fluids

263. According to the judge:

> "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 transferred 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 recording and the use of the oximeter."

264. The relevant allegation here by the respondent is that the second appellant failed 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 by CBC monitoring, use of a central venous pressure line, auscultation of the chest, testing of arterial blood gasses, chest x-rays or by any other means. In this regard this allegation is similar to and treats with the same evidence as the allegation treating with the failure to properly manage the transfusions of blood and blood products dealt with earlier. The relevant evidence here was the evidence of Dr. Pitt-Miller with respect to the steps to be followed in monitoring the transfusions.

265. Insofar as the judge found that the transfusion of 19 units of fluid and blood products doubled the risk of fluid overload or TURP syndrome and that the blood products were transfused haphazardly he misrepresented the evidence. There was no evidence from any of the experts that the transfusions were done haphazardly. The evidence was simply that the transfusions were not monitored in accordance with standard medical practice.

266. While there was evidence of at least 19 units of fluid and blood products being transfused into the deceased and that increased the risk of fluid overload there was no evidence that this doubled the risk of fluid overload or TURP syndrome. In addition the judge wrongly seems to suggest that fluid overload and TURP syndrome was one and the same. The evidence of Dr. Pitt-Miller is that they were two different things. TURP syndrome occurred as a result of the absorption of large amounts of irrigant used during the TURP procedure. According to Dr. Pitt-Miller the risk of the deceased developing fluid overload was further increased by the risk of his developing TURP syndrome.

267. There was evidence before the judge as to the relevant standard of care: that of Dr. Pitt-Miller referred to earlier. While the judge was correct in concluding that both experts were of the view that there was inadequate monitoring during the transfusions there was no evidence that both experts repeatedly called for the temperature and pulse recordings and use of an oximeter.

268. At the end of the day however the judge was correct when he concluded that the second appellant was negligent in this regard. The evidence of Dr. Pitt-Miller was that no monitoring or recording of the transfusions were done in accordance with the standard medical practice in this regard. The evidence of Dr. Pitt- Miller was that during the period there should have been monitoring using a central venous pressure line as well as auscultation of the chest, testing of arterial blood gases and chest x-rays. None of these

were done. Further she says that regular CBC tests ought to have been done to prevent the further increase of the risk of fluid overload.

269. According to Dr. Pitt-Miller it was the responsibility of both Goetz and the second appellant to take these steps. Insofar as these steps were necessary to stabilize the deceased it was the second appellant's specific responsibility. The judge was therefore correct when he concluded that second appellant was negligent in failing to monitor and record the deceased's fluid output or ensure adequate proper or sufficient monitoring to monitor his status during the transfusion of blood and other fluids. In these circumstances this being a facet of the first appellant's non-delegable duty of care to the deceased and being an allegation made against the first appellant by the respondent the first appellant was also negligent in this regard.

270. With respect to the first appellant therefore the judge was correct when he concluded that this appellant was negligent in that it:

(a) failed to maintain appropriate supplies of blood sufficient to meet the risk of the deceased's initial bleeding after the TURP; and

(b) transfused Group O+ blood into the deceased;

271. With respect to the second appellant the judge was correct when he concluded that second appellant was negligent in that he:

(i) failed to make a proper pre-assessment of the use of aspirin;

(ii) failed to act quickly enough in transfusing the relevant blood and blood products into the deceased;

(iii) failed to ensure that prior to the TURP procedure there were adequate supplies of packed red cells or whole blood to treat the deceased's hypovolemic shock;

(iv) failed to manage and/or monitor the transfusions of blood and blood

products to the deceased after the completion of the TURP procedure in accordance with standard medical practice.

(vii) administered excessive amounts of blood and blood products and

(viii) failed to properly monitor and record the deceased's fluid output or to ensure adequate proper or sufficient monitoring to monitor his status during the transfusions of blood and other fluids.

272. Insofar as it is relevant to this case **section 39 of the Supreme Court of Judicature Act Chap 4:01** provides:

"(1) On the hearing of an appeal from any order of the High Court in any civil cause or matter, the Court of Appeal shall have the power to—

(a) confirm, vary, amend, or set aside the order or make any such order as the Court from whose order the appeal is brought might have made, or to make any order which ought to have been made, and to make such further or other order as the nature of the case may require;

(b) draw inferences of fact;

(c)…….;

(2) The powers of the Court of Appeal under this section may be exercised notwithstanding that no notice of appeal or respondent's notice has been given in respect of any particular part of the decision of the High Court by any particular party to the proceedings in Court, or that any ground for allowing the appeal or for affirming or varying the decision of that Court is not specified in such a notice; and the Court of Appeal may make any order, on such terms as the Court of Appeal thinks just, to ensure the determination on the merits of the real question in controversy between the parties."

273. In particular section 39(2) allows a Court of Appeal in the appropriate case to exercise the powers granted it by subsection (1) to ensure a determination on the merits of the real question in controversy between the parties notwithstanding the absence of a respondent's notice in this regard.

274. The wide discretion given the Court by s. 39 is however restricted in its application to the circumstances in which the court whose judgment is being reviewed has acted. In the case of **Hannays v Baldeosingh**[31] the Court of Appeal applied the section to grant an order which the trial court could not have granted on the application before it. The Privy Council determined that the section could only be applied in the context of what was the actual application before the judge at the time. According to **Lord Jauncey of Tullichettle:**

> "Thus one must look at the application before that court and consider what order that court could competently have made thereupon. The reference to 'such further or other order' once again must refer to orders consequential upon any order which could or ought to have been made upon the application." [32]

275. No specific finding was made by the judge on the first appellant's negligence in (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; and (b) accordance with its non delegable duty to the deceased in failing to properly monitor and record the deceased's fluid output and properly or sufficiently monitoring the deceased's status during the transfusion of blood or other fluids.

276. In addition with respect to the second appellant the judge made no specific finding that (a) he failed to take any or any adequate steps to prevent the deceased from succumbing

[31] (1989) 41 WIR 388
[32] at page 407

to excessive bleeding. This failure included the failure to conduct PT and PTT tests immediately prior to the TURP procedure.

277. There has been no respondent's notice in this regard. This is however an appropriate case in which to apply section 39(2) of the Supreme Court of Judicature Act. These were findings that were open to the judge to make: they were available to the judge on the evidence accepted by him and accord with the particulars of negligence pleaded by the respondent. In the circumstances these additional findings of negligence ensure the determination on the merits of a real question in controversy between the parties.

278. Accordingly on the evidence before the judge and applying **section 39 of the Supreme Court of Judicature Act** the first appellant was negligent in that it:

(a) failed 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 the surgery;

(b) failed to maintain appropriate supplies of blood sufficient to meet the risk of the deceased's initial bleeding after the TURP;

(c) transfused Group O+ blood into the deceased; and

(d) failed to properly monitor and record the deceased's fluid output and properly or sufficiently monitoring the deceased's status during the transfusion of blood or other fluids.

279. In similar manner the second appellant was negligent in that he:

(a) failed to take any or any adequate steps to prevent the deceased from succumbing to excessive bleeding including failing to carry out PT and PTT tests and make a proper pre-assessment of the use of aspirin;

(b) failed to act quickly enough in transfusing the relevant blood and blood products into the deceased;

(c) failed to ensure that prior to the TURP procedure there were adequate supplies of packed red cells or whole blood to treat the deceased's hypovolemic shock;

(d) transfused O+ blood into the deceased;

(e) failed to manage and/or monitor the transfusions of blood and blood products to the deceased after the completion of the TURP procedure;

(f) administered excessive amounts of blood and blood products and

(g) failed to properly monitor and record the deceased's fluid output or to

i. ensure adequate proper or sufficient monitoring to monitor his status

ii. during the transfusions of blood and other fluids.

Causation

280. The burden of proof is on the respondent to show that, on a balance of probabilities, the negligence of the appellants caused the deceased's death. The judge was satisfied that but for the failures or omissions and actions by the appellants the deceased would not have died. He concluded that the negligence of the appellants cumulatively resulted in the deceased's death.

281. Insofar as the deceased's cause of death was concerned the judge's findings were inconsistent. At times he attributes the deceased's cause of death to irreversible shock and DIC and at other times to fluid overload caused by the appellants' mismanagement of the deceased's DIC. Insofar as the judge suggests that the cause of death was irreversible shock and DIC this does not accord with the evidence. Although this was an opinion voiced by Goetz it was not a conclusion shared by the pathologist or the

experts. In the autopsy report the pathologist simply refers to Goetz's opinion as part of the deceased's clinical history.

282. The death certificate of the deceased identifies the cause of death as: "status post prostate surgery with acute myocardial infarction congestive heart failure coagulopathy". This accords with the findings under heading 'Autopsy Report' in the pathologist's report. According to Dr. Pitt-Miller these findings strongly indicate that the deceased experienced fluid overload as a result of the fluids administered to him after the TURP procedure and such fluid overload was the direct cause of his death. Dr. Jones-Lecointe concurs with the opinion that the proximate cause of the deceased's death was fluid overload.

283. Contrary to the submissions of the appellants therefore this was not a case of death by excessive bleeding rather this was a case of death as a result of fluid overload caused by poor management of the deceased's excessive bleeding. The second appellant sets great store by the fact that under cross-examination by him Dr. Pitt-Miller accepted the suggestion that if they had all the blood and blood products available at the hospital on that day and Goetz failed in his duty to stop the bleeding the patient would have died. This "admission" is of no moment on the facts of this case. The fact is that on the evidence, according to Goetz, the bleeding had been abated before the deceased died. But more importantly on the facts of this case the proximate cause of death was not excessive bleeding but rather as a result of the manner in which the appellants sought to treat the deceased's excessive bleeding.

284. The judge found that the second appellant failed to make a proper pre-assessment of the use of aspirin. Prior to the performance of the TURP procedure the deceased was not asked whether he was taking aspirin. There is however no definite evidence that the deceased was taking aspirin at the time of the procedure. The evidence in this regard is contradictory and the judge makes no definitive finding in this regard. In the absence

of such a finding it is impossible to conclude that the failure to ask the deceased whether he was taking aspirin contributed to his death.

285. The appellants accept that there was a foreseeable risk to the deceased of excessive bleeding after the TURP procedure. Further the appellants were aware of the deceased's cardiac impairment. They had already postponed the procedure as a result of a poor ECG result. Further by the letter from the cardiologist, contained in the medical records, the appellants were advised that the deceased suffered from early coronary disease with a 40 to 50 % stenosis in the right coronary artery and that he had an athlete's heart. The fact that the deceased had been assessed as having athlete's heart meant that it would have been more difficult to assess the extent of his bleeding and the effect of any excessive bleeding on his vital organs and, in particular, his heart. The conduct of PT and PTT tests to better assess the risk to the deceased posed by heavy bleeding was therefore even more essential in this case.

286. The fact that the letter also advised that he was "fit for general anaesthesia without special precaution. He may be considered a standard risk" is of no consequence. The reference to the deceased being a standard risk clearly refers to the risks involved in undergoing general anaesthesia. There is no dispute that the deceased recovered from the anaesthesia administered during the TURP procedure. In any event the appellants admit that they had a duty to ensure that any bleeding of the deceased was properly managed and contained.

287. The failure to conduct PT and PTT tests was a major contribution to the death of the deceased. Had the appellants properly assessed the risk to the deceased by engaging in this pre- TURP risk assessment the likelihood is that either the operation would not have been done at the time or, aware of the increased risk of bleeding presented by the results of these tests, greater precautions would have been taken by them to treat with the known risk. In particular the appellants would have ensured that the blood and blood

products necessary to treat the deceased's excessive bleeding and hypovolemic shock and, in the extreme case, DIC would have been readily available in accordance with the standards of care identified by the experts.

288. According to Dr. Jones-Lecointe had Goetz and the appellants properly prepared for a surgical procedure known to carry a risk of bleeding so as to allow the timely transfusion of appropriate blood products if required the progression of hypovolemic shock and the development of DIC in the deceased would have been prevented. This was the transfusion of the blood which standard medical practice required be available in the event of excessive bleeding by the deceased during and after the TURP procedure. This blood was not used during the TURP procedure and ought to have been available for use on the deceased to prevent his going into and/or to treat his hypovolemic shock. The timely transfusion of this blood could have prevented the deceased's progression into hypovolemic shock and from hypovolemic shock into DIC. The fact that at that time colloids and crystalloids were transfused into the deceased instead not only did not assist in treating the deceased's hypovolemic shock but also contributed to the appellants' inability to control the deceased fluid's balance.

289. While there is no evidence of a failure to properly monitor the deceased's initial bleeding there is evidence of negligence by the second appellant taking no action for 20 minutes after being advised of the deceased's heavy bleeding. This failure resulted in the deceased's excessive bleeding being left untreated for an additional 20 minutes. Although it is clear that time was of the essence and that this itself was a breach of the second appellant's duty of care to the deceased there is no evidence however that this 20 minutes lapse on the part of the second appellant would have itself made any difference to the deceased going into hypovolemic shock.

290. The failure of the second appellant to take steps adequate steps to prevent the deceased's from succumbing to excessive bleeding was however a major factor in the death of the deceased. According to both experts had the bleeding been treated properly the deceased would not have succumbed to excessive bleeding which ultimately caused him to go into hypovolemic shock and then DIC.

291. The transfusions of O+ blood into the deceased increased the chances of the deceased succumbing to DIC. These transfusions themselves could have been a material contributor to the DIC suffered by the deceased and the situation in which the appellants were required to make further transfusions. As well these transfusions increased the amount of fluid being poured into the deceased. This failure therefore also contributed to the death of the deceased. In the circumstances it is likely that these transfusions themselves contributed to the deceased developing DIC or at the very least did not assist with the treatment of DIC and contributed to his fluid overload.

292. Given the situation that developed as a result of the negligence of the appellants further transfusions were required to treat the deceased's DIC. In order to treat the DIC more blood and blood products were transfused into the deceased. These products, representing more than twice the average volume of blood in the human body, were transfused into the deceased in a relatively short space of time without the monitoring required by the standard practice. According to Dr. Pitt-Miller while a fit person could deal with such transfusions up to a point compensation for fluid overload for persons with cardiac impairment is difficult and if left unaddressed or unchecked fluid overload may lead to heart failure. Her evidence is that the findings of pathologist strongly indicate that the deceased experienced fluid overload as a result of the fluids administered to him and that such fluid overload was the direct cause of his death. The transfusions of this amount of fluid without proper monitoring resulted in the deceased experiencing fluid overload and was the proximate cause of the deceased's death.

293. In the circumstances while the judge may have at times misstated the cause of death I cannot say that in determining that the negligence of the appellants cumulatively resulted in the deceased's death the judge was plainly wrong. The negligence of the appellants in failing to carry out PT and PTT tests just prior to the performance of the TURP procedure increased the risk of the deceased succumbing to excessive bleeding after the TURP procedure. The absence of the test meant that the appellants were unable to properly assess the already existing risk of heavy bleeding and either postpone the procedure or properly prepare for it by ensuring that the blood and blood products needed to treat the bleeding were readily available.

294. By failing to have the appropriate blood available for transfusion into the deceased within a half an hour of being requested at 3.30pm and transfusing O+ blood into the deceased when his blood group was A+ the deceased heavy bleeding was allowed to progress into hypovolemic shock and then DIC. In the course of treating the DIC, the failure of the appellants to properly monitor the deceased's status during the transfusions of blood and blood products led to excessive fluids being transfused into the deceased and caused his death as a result of fluid overload. Had the appellants treated the deceased's excessive bleeding properly and in a timely manner the deceased would not have succumbed to the excessive bleeding to such an extent as to require such massive transfusions of blood and blood products which resulted in his fluid overload and ultimately his death. Insofar as the judge determined that but for the negligence of the appellants the deceased would not have died therefore it cannot be said that the judge was plainly wrong. On the evidence before him there was sufficient evidence for him to conclude that on a balance of probabilities the death of the deceased was caused by the negligence of the appellants.

DAMAGES

295. Before dealing with the findings of the judge on the quantum of damages it is appropriate to put to rest submissions of the first appellant with respect to the failure by the judge to apportion the damages awarded between the appellants and between the appellants and Goetz. This, and other similar submissions of this appellant, are based on the erroneous conclusion that the judge determined that the liability of these parties was concurrent and not joint. As we have seen there was no such finding by the judge in this appeal.

296. The effect of the decision under review was that the liability of the appellants to the deceased was joint. Each by their own admission owed to the deceased the same duty of care and by way of similar breaches caused the death of the deceased. The judge found that the appellants were joint tortfeasors and jointly and severally liable for the death of the deceased.

297. This finding meant that each appellant, irrespective of the degree of his blame in relation to the other joint tortfeasors, is liable to the respondent for the whole of the damage which the tort has caused him: see the statements of Salmon LJ in **Wah Tat Bank Ltd. v Chan Cheng King**[33]. In that case the court determined that the plaintiff was in the circumstances entitled to judgment against each of the joint tortfeasors for the whole of the damage suffered but could not recover in the aggregate more than the sum at which that damage is assessed. In these circumstances there was no question of the judge apportioning the damages awarded.

298. The respondent, as she was entitled to do, chose to pursue her claim against the appellants and not Goetz. The fact that the respondent accepted an ex gratia payment from Goetz makes no difference. In **Bryanston Finance Ltd and others v De vire** [34] dealing with a similar situation Lord Denning, agreeing with the Privy Council decision in **Wah Tat Bank Ltd**, stated:

[33] [1976] A.C. 507
[34] [1975]Q.B. 703

"In the present case, the question that arises is this: suppose that the plaintiff settles with one of the wrongdoers before judgment by accepting a sum in settlement: or suppose that by consent an order is made by which the plaintiff accepts an agreed sum from the one tortfeasor and discontinues against him, but goes on against the other. I believe this to be a new point. It should be solved in the same way as the payment into court was solved. If the plaintiff gets judgment against the remaining tortfeasor for a sum which is *more* than the sum already recovered (by the settlement or the consent order), he is entitled to enforce it for the excess over which he has already recovered. But, if he gets judgment for *less* than he has already recovered, then he recovers nothing against the remaining tortfeasor and should pay the costs. I do not think that it should depend on whether the sum was paid under a covenant not to sue, or a release, such as were discussed in *Duck v. Mayeu* [1892] 2 Q.B. 511 and *Cutler v. McPhail* [1962] 2 Q.B. 292. That is an arid and technical distinction without any merits. It is a trap into which the unwary fall but which the clever avoid. It should be discarded now that we have statutory provision for contribution between joint wrongdoers. The right solution nowadays is for any sum paid by the one wrongdoer under the settlement to be taken into account when assessing damages against the other wrongdoer. If the plaintiff recovers more, he gets the extra. If he recovers less, he loses and has to pay the costs. And as between the joint wrongdoers themselves, there can be contribution according to what is just and equitable: see section 6 (1) (*c*) and (2) of the Act of 1935."

The statutory provision referred to in both cases was in similar terms to section 26 of the Supreme Court of Judicature Act Chap 4:01.

299. The judge took exactly this position. He determined that the agreement with Goetz did not preclude him from assessing the damage to the deceased but deducted the sum

payable by Goetz from the amount ordered to be paid by the appellants and representing the whole of the deceased's damage.

300. In treating with the quantum of damages and considering the appropriateness of the award of damages in this case it is important to note that an appellate court will only interfere with an award where it is satisfied that the trial judge erred in principle or made an award so inordinately low or unwarrantably high that it cannot be permitted to stand: **Flint v Lovell**[35] as adopted in this jurisdiction in **Calix v Attorney General of Trinidad and Tobago**[36]

301. The judge awarded damages in the total sum of $18,034,772.33. On the claim pursuant to the **Supreme Court of Judicature Act Ch. 4:01** ("the estate claim") the judge calculated damages in the sum of $16,131,058.82. This comprised the sum of $20,000.00 for the loss of expectation of life and the sum of $16,111,058.82 representing the deceased's loss of earnings during the lost years.

302. On the claim pursuant to the **Compensation for Injuries Act Ch.8:05** ("the dependency action") the judge valued the dependency at $18,034,772.33. This claim was eventually pursued with respect to two dependants only: the respondent and their daughter who was, at the time of the deceased's death, 17 years and a student. She was, according to the judge, expected to have qualified as a medical doctor in 2013. The judge accepted that these were the only two dependants.

303. Evidence on the deceased's income was given by two witnesses. These witnesses, employed by the deceased's last employer, gave evidence of the deceased's actual earnings for the period 1994 to 2003 and the earnings of the successor to his job ("his successor") during the period 2005 to 2010. The earnings comprised a basic salary and various allowances and other benefits that had increased over the years. The judge

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35 [1935] 1 KB 354 at 360

36 [2013] UKPC 15 at paragraph 28.

accepted the evidence of the deceased's earnings produced by these witnesses and their evidence that, had he lived, the deceased would have been entitled to receive the same level of earnings as those received by his successor.

304. In arriving at the awards the judge adopted the multiplier and multiplicand approach. The appellants do not challenge this approach. In arriving at a multipler of 5 in both claims the judge considered other comparable cases. He found that a multiplier of 5 was appropriate given that the deceased was 53 at the time of his death and would have continued to work and earn an income until his retirement at age 60. According to the judge the deceased had no life threatening medical conditions and, in accordance with the evidence of the respondent, an active sports life. While he noted that there was evidence of the deceased's employer's financial collapse in early 2009 he was of the opinion that given the deceased's earning potential he would have found suitable employment elsewhere. In any event he recognized that a multiplier of 5 would involve a consideration of a period prior to the collapse of the company.

305. Consistent with the evidence from the deceased's employers the judge arrived at separate yearly multiplicands using the actual income earned by the deceased and his successor. Using the base figures provided by the witnesses he calculated the deceased's annual earnings for each year as follows:

2004:$5,488,756.41; 2005: $10,600,919.15; 2006: $11,633.096.47; 2007: $10,475,425.06 and 2008: $ 904,196.78.[37]

306. In the estate action in arriving at the deceased's loss of income for the lost years the judge made a 25% deduction for tax and a 15% deduction from the annual figures to reflect what he described as the inherent uncertainties attached to the generation of sales and some of the other bonuses that the deceased would have received. He then made a 33% deduction representing the deceased's living expenses. Using these figures he

[37] This amounted to the sum of $39,102,366.70 over the 5 year period or an average of $7, 820,473.34 a year.

arrived at a value of loss of earnings for the lost years in the sum of $16, 111,058.82 to which he added the sum of $20,000.00 representing the deceased's loss of expectation of life.

307. With respect to the dependency claim from the deceased's net earnings, that is, the sums that he found would have been earned by the deceased minus 25% for tax and 15% for uncertainties. The judge then deducted a further 25% representing monies that the deceased would have spent on himself and arrived at a dependency valued at 75% of the deceased's earnings. In coming to the determination that 75% was appropriate the judge applied the methodology employed in the case of **Harris v Empress Motors Ltd.**[38]

308. Using these deductions the judge calculated the multiplicand to be: 2004: $1, 963,251.91; 2005: $5,068,564.47; 2006: $5,562,074.26; 2007: $5.008,562.61 and 2008: $432,319.08. The judge therefore arrived at a total figure of $18,034,772.33 representing the value of the dependency. To prevent a duplication of the awards the judge then awarded the sum of $18,034,772.33 as follows: $ 16,131,058.82 to the estate and the remainder of the dependency claim, that is the sum awarded over and above the sum of $ 16, 131 058.82 awarded under the estate claim, 2/3s to the respondent in the sum of $1,269,142.34 and 1/3 to the daughter in the sum of $634,571.17. There has been no appeal from this aspect of the judge's order.

309. The first appellant submits that the judge erred in failing:

(i) to properly assess the evidence of the respondent's witnesses, Margaret Chow and Carolyn John, as to their credibility and reliability given the striking similarities in their witness statements;

(ii) to properly address the circumstances in which their statements came to be drafted with the assistance of the respondent's attorneys and the

[38] [1984] 1 WLR 212.

inexplicable similarities in their evidence which was incapable of explanation;

(iii) to consider the appropriate multiplier and multiplicand and

(iv) to properly consider and apply the submissions on quantum by the appellants.

310. No further submissions are made by the first appellant on the quantum of damages. In particular there are no submissions by this appellant as to how the judge went wrong in considering what was the appropriate multiplier or multiplicand or the manner in which or which of their submissions on quantum were not considered or applied by the judge.

311. Apart from challenging the judge's findings with respect to the appropriate multiplier and multiplicand in its notice of appeal the second appellant makes no written submissions on the judge's findings on quantum. In his oral submissions before us the second appellant seeks to rely on his submissions filed before the trial judge and advances one additional submission. According to the second appellant the judge seemed to simply pluck a figure from the air for expenses and not consider the evidence or more specifically the lack of evidence in this regard. The result of this is that apart from broad and general criticisms of the judge, the challenge to the judge's finding on credibility and the one submission made orally by the second appellant we have had no assistance from the appellants as to where the judge went wrong.

Credibility

312. As with the experts the appellants challenged the credibility and reliability of the two witnesses Carolyn John and Margaret Chow on the basis of the similarities in their witness statements. While the witness statements of both witnesses are in similar terms under cross-examination they both explained the circumstances under which their witness statements came to be prepared. According to their evidence the witness statement of Margaret Chow was prepared in the event that Carolyn John was

unavailable. The information contained in the witness statements was sent to the Attorneys by them; were drafted by the Attorneys and approved and completed by the witnesses themselves. The judge accepted their evidence. Ultimately it was a matter for him as to what weight he put on their evidence.

313. At the end of the day after observing the witnesses in the witness-box and hearing their cross-examination the judge, as he was entitled to do, found them credible and accepted their evidence. In any event the relevance of their evidence was simply to present to the court and give evidence of a schedule prepared by John setting out the salary, allowances and bonuses received by the deceased during the period 1994 to 2003 and the salary allowances and bonuses that the deceased's successor received during the period 2005 to 2010. There was no cross-examination of either witness on the contents of the schedule.

Multiplier and Multiplicand

314. Before the trial judge the appellants submitted that given the deceased's age, his health uncertainties and the financial crisis suffered by his employer the appropriate multiplier ought to be 4. It is clear that in arriving at a multiplier of 5 the judge took all these matters into consideration albeit, unlike the appellants, he was of the opinion that the deceased was relatively healthy. There was evidence upon which the judge could have arrived at this conclusion. His opinion accorded with the findings of the pathologist in the autopsy report when he recorded the deceased as a young male, the advice of the cardiologist that he had an athlete's heart, was fit for general anesthesia and was to be considered a standard risk and the evidence of the respondent under cross-examination.

315. Given the age of the deceased and the retirement age of 60 a multiplier of 5 seems a little high but the establishment of the appropriate multiplier is not an exact science. Given the manner in which a multiplier is ascertained there is in reality not much difference between multiplier of 4 and one of 5. In fact a recalculation of the figures

accepted by the judge on the basis of a multiplier of 4 does not make such a difference in the award to make it so unwarrantably high that it cannot be permitted to stand. In these circumstances the mere fact that the multiplier is on the high side is not sufficient to disturb the award.

316. Adopting a multiplier of 5 meant that the period under consideration was 2004 to 2008. In those circumstances the financial crisis of the employer in 2009 would have made no difference. In any event the judge had evidence of the actual earnings of his successor. Similarly the submission by the appellants that the multiplier should have been apportioned into a pretrial multiplier of 3 and a post trial multiplier of 1 did not arise since by the time the matter came to trial the 5 years had already passed. While the judge did not specifically consider the length of the dependencies it is clear that the dependency of both the wife and the daughter would have been longer than the deceased's working years. The appellants have not been able to persuade me that the judge was wrong in arriving at a multiplier of 5 for both claims.

317. With respect to the multiplicand the appellants submitted to the judge that he should assess the deceased's earnings at an average of $50,000.00 a month. They submit that this figure is reasonable given (a) the uncertainty of a number of the items which formed a part of the deceased's earnings such as his allowances and conditional bonuses; (b) the discrepancy of $459,310.32 between the sum of $3.8 million which they say was received by the respondent as a 2003 bonus due to the deceased and the sum of $3,340,689.58 listed in the schedule for the same bonus; and (c) the lack of supporting documents.

318. According to the judge to pluck a figure of $50,000.00 as an estimate of the deceased's earnings was a gross undervalue. Before us the appellants provided no justification for their choice of the sum of $50,000.00 as an appropriate sum to represent the deceased's monthly income. It certainly does not even closely approximate to the deceased's basic

monthly salary over the years. According to the evidence his basic monthly salary over the years ranged from $91,800 in 1994 to $290,210.00 in 2003 and that of his successor from $428, 222.00 in 2004 to $594,384.00 in 2008. The fact that given the nature of the allowances and the conditional bonuses there may have been some fluctuation from year to year was of no moment since the judge took into consideration the amounts actually received by his successor. In any event the judge made a further 15% discount on these amounts for these and other uncertainties.

319. Similarly the fact that there was a discrepancy between the amount of bonus actually received on the deceased's behalf and the sum recorded in the schedule ought to have been of no consequence to the appellants since in arriving at the multiplicand the judge actually used the lower figure recorded in the schedule. The fact that there were no supporting documents provided by the witnesses to quantum, although a relevant consideration, was not fatal. The evidence of the witnesses was that the schedule was prepared from information and data obtained from various records including computerized records held by the employer over a period of 17 years. There was no challenge to the contents of the schedule by the appellants. The judge, as was open to him, accepted the evidence. It therefore cannot be said that, in arriving at his basic figures in support of the multiplicand used by him, the judge was plainly wrong. His findings were based on the evidence before him.

320. In arriving at a multiplicand under both the estate and the dependency claims the judge was required to make an appropriate deduction for the deceased's living expenses. In the dependency claim the sum that had to be deducted was the amount of the deceased's earnings spent exclusively on himself. In the estate claim consideration also had to be given to the joint expenses for his spouse and children. In both claims the judge adopted the available surplus approach in that he arrived at a decision of what the

deceased would have spent on himself and deducted this from the net earnings of the deceased.

321. In determining what was the deceased's living expenses rather than apply an itemized list of the deceased's expenses the judge applied a percentage of the earnings of the deceased. In doing so he followed the approach recommended by the Court of Appeal in England in **Harris v Empress Motors Ltd**[39] and acknowledged as applying in this jurisdiction in **Presidential Insurance Company Limited v Zimmer and another**[40]**.**

322**.** In **Harris** it was determined that there was no longer the need for tedious calculations. According to O'Connor LJ:

> "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 upon its own facts"

323. In the **Presidential Insurance case,** while accepting the conventional percentage approach adopted in Harris, Mendonca JA determined that it was relevant to bear in mind that the 25% deduction arrived at in Harris was in relation to a dependency claim where the deduction under the Act was with respect to the amount the deceased spent exclusively on himself with no deduction for expenditure made for the joint benefit of the deceased's spouse and children. Where the claim was for the benefit of the estate it was also necessary to take into consideration monies that were expended for the joint benefit of the deceased and others and a pro-rata deduction be made. With respect to claims for the benefit of the estate therefore our Court of Appeal has accepted that the

[39] [1984] 1 WLR 212
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deduction for the deceased's living expenses would usually be greater than the dependency claims.

324. In dealing with the dependency claim in **Harris** O'Connor LJ suggested that the conventional figure to be used for the victim's living expenses where there was a spouse and family was 25 %. In the instant case the judge was of the opinion that a 25% deduction was reasonable. In doing so he adopted the conventional figure suggested by O'Connor LJ. The only possible reference to evidence which in this case would tend to make the conventional figure inappropriate was the second appellant's submission before the judge that the respondent herself was a wage earner and that fact should be taken into consideration in reducing the dependency. Such a conclusion does not however accord with the evidence. The respondent's evidence was that apart from certain of her personal items and monies spent on her son the practice in the family was that she saved her money and the deceased met all the family expenses. In the circumstances the finding by the judge that 75% of the deceased's income should be used to determine the value of the dependency had a sound basis in law and was not unreasonable on the evidence.

325. With respect to the estate claim the judge made a greater deduction representing the deceased's living expenses. Here he deducted 33 % of the deceased's earnings. According to the judge in dealing with the deceased "whose life is settled and fairly predictable, an older married man earning a high income, he is likely to have a large surplus.....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 judge therefore concluded that the appropriate deduction should be no more than one third.

326. This conclusion is supported by the evidence of the respondent. Indeed the deceased's monthly expenses identified by her, even including all of the joint expenses, amount to

far less than the sum of $1,829,585.47 a year or $152,465. 45 a month that approximates to 1/3 of his annual income for 2004. Even if reasonable sums are added to that to represent the travel, car insurance entertainment and car maintenance, which according to the respondent was paid by his employer. His expenses could not have amounted 1/3 of his annual income. The use by the judge of a 33% of the deceased's income as representing his living expenses was based on the correct principles in law and on the evidence before him was not unreasonable. Indeed on the evidence the deduction of 1/3 of the deceased's income could be considered excessive.

327. In the circumstances even bearing in mind the injunction by Lord Wilberforce in **Pickett British Rail Engineering Ltd**.[41] that "damages during the lost years should be assessed justly and with moderation", given the evidence in this case, it cannot be said that in coming to his determination on damages the judge erred in principle or made an award so inordinately low or unwarrantably high that it cannot be permitted to stand.

328. Accordingly the decisions of the judge that the appellants were negligent in the care and treatment of the deceased; that this negligence resulted in the death of the deceased and assessing the deceased's damages in the sum of $18, 034,772.33 were conclusions open to the judge to draw from the evidence presented to him. The appellants have demonstrated no basis upon which we should interfere with these conclusions. In the circumstances the appeals are dismissed.

J. Jones
Justice of Appeal

[41] [1980]A.C. 136