Michaelmas Term
[2022] UKPC 38
Privy Council Appeal No 0072 of 2018
and 0096 of 2018

JUDGMENT

Gulf View Medical Centre Ltd (Appellant) *v* Tesheira (The Executrix of the Estate of Russell Tesheira) (Respondent) (Trinidad and Tobago)

Roopchand (Appellant) v Tesheira (The Executrix of the Estate of Russell Tesheira) (Respondent) (Trinidad and Tobago)

From the Court of Appeal of the Republic of Trinidad and Tobago

before

LORD REED
LORD SALES
LORD HAMBLEN
LORD STEPHENS
LORD PENTLAND

JUDGMENT GIVEN ON
25 October 2022

Heard on 13 and 14 July 2022

Appellant (Gulf View Medical Centre)
Mary O'Rourke KC
David Boyle
Joseph Price
(Instructed by Duke Street Chambers (San Fernando))

Appellant (Crisen Jendra Roopchand)
Katherine Deal KC
(Instructed by Charles Russell Speechlys LLP (London))

Respondent
Douglas L Mendes SC
(Instructed by Signature Litigation LLP (London))

LORD STEPHENS AND LORD PENTLAND (with whom Lord Reed, Lord Sales and Lord Hamblen agree):

1. Introduction

1. The Board has before it two appeals from the Court of Appeal of the Republic of Trinidad and Tobago in proceedings for medical negligence brought against a private hospital ("the first appellant"), a consultant urological surgeon ("the surgeon"), and a consultant anaesthetist ("the second appellant"). The issues raised are essentially factual in nature and concern the application of well-established legal rules to the proven facts. On the critical factual issues, the courts below have made concurrent findings of fact. The appeals do not, contrary to the appellants' submissions, raise any question of wider principle. They turn instead on a correct understanding of the parties' written pleadings, certain aspects of the procedure followed in the High Court and the Court of Appeal, and the expert evidence led on behalf of the claimant, the substance of which went unchallenged at the trial.

2. The core facts

2. On 13 April 2004 the late Mr Russell Anthony Tesheira ("the deceased") was admitted to the first appellant's private hospital in Gulf View La Romaine, Trinidad, for a type of elective surgery known as a trans-urethral resection of the prostate ("TURP"). The procedure was to be carried out by the surgeon, Dr Lester Goetz, whom the deceased had previously consulted. The procedure is well-known to carry with it a high risk of post-operative bleeding. The deceased was a private patient of the surgeon, who frequently carried out surgery at the hospital. The second appellant, Dr Crisen Jendra Roopchand was the anaesthetist for the procedure. The hospital did not employ either the surgeon or the second appellant. Beyond that bare fact, the details of any contractual or other arrangements between the surgeon, the second appellant and the hospital were not explored in evidence and remain opaque.

3. The TURP having been completed by about 1.10pm on 13 April 2004, the deceased was taken from the operating theatre to a recovery room where nurses noted that his urine was heavily bloodstained. The bleeding could not be contained and at about 3.30pm the deceased was taken back to the operating theatre where the surgeon and the second appellant (latterly assisted by other doctors) attempted various medical and surgical procedures to try to stop the bleeding. After many hours the bleeding was eventually brought under control, but too late to save the deceased's life. He died on the operating table at 11.30pm while still under general anaesthetic. The cause of death was certified to be "irreversible shock with DIC

(disseminated intravascular coagulation)". At the time of his death, the deceased was 53 years of age.

3. Outline of the proceedings

4. In 2005 the deceased's widow and executrix, Mrs Karen Tesheira ("the respondent"), issued proceedings in the High Court of Trinidad and Tobago on behalf of her late husband's estate and his dependents against the first appellant, the surgeon and the second appellant. She alleged negligence by each of them in his care and treatment, resulting in his death. After prolonged exchanges and amendments of the pleadings, the filing of witness statements, and a plethora of interlocutory skirmishes, in 2012 the claim insofar as brought by the claimant against the surgeon, was settled on a confidential basis without any admission of liability.

5. Following the settlement between the respondent and the surgeon, the first appellant applied to have the respondent's claim against it struck out and alternatively to issue an ancillary claim against the surgeon for contribution to any damages that might be awarded. Kokaram J made interlocutory rulings by which he dismissed the strike out application and refused to allow an ancillary claim against the surgeon to be brought. An appeal against these rulings was in due course dismissed.

6. In 2014 the first appellant instructed new lawyers, as did the second appellant. Until that point those parties had been jointly represented. At the outset of the trial in November 2014 the first appellant sought to amend its defence, but withdrew the application. Thereafter the case proceeded based on the original joint defence for the first and second appellants.

7. The action against the first and second appellants went to trial before Kokaram J between November 2014 and February 2015 over several non-consecutive days. The respondent led expert evidence from two witnesses, in the fields of anaesthesia and haematology. At the end of the respondent's case both appellants made similar submissions of no case to answer and were put to their election by Kokaram J in accordance with established practice where such a submission has been made. This meant that the appellants had to decide whether to insist upon those submissions as, in effect, submissions after the close of the evidence or to call evidence themselves. The appellants elected to maintain their submissions. Accordingly, they led no evidence.

8. In a detailed and comprehensive judgment handed down in March 2015 Kokaram J found that negligence on the part of the two remaining defendants (the

present appellants) in their management of the risk of post-operative bleeding was established. He awarded substantial damages, which were to be paid after deduction of the ex gratia sum paid by the surgeon.

9. Kokaram J summarised his conclusions in paragraph 11 of his judgment as follows:

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

10. Both appellants appealed to the Court of Appeal, the first appellant filing more than 50 grounds of appeal. By a 109-page judgment issued in November 2017 the Court of Appeal reversed a number of findings (factual and of negligence) made by Kokaram J, but dismissed the appeals.

11. The appellants were granted conditional leave to appeal to the Board in December 2017 and final leave in June 2018.

4. Paragraph 23 of the amended statement of claim

12. Before the Board, the parties were at odds as to the meaning of one passage in the pleadings, on the basis of which the case went to trial. The disputed averments were contained in paragraph 23 of the amended statement of claim (this is set out in para 56 below). In the joint defence both appellants admitted the contents of this paragraph without qualification. In her oral submissions before the Board, Ms O'Rourke KC for the first appellant said that the admission had been a mistake. The respondent maintained that this pleading amounted to the acceptance of a non-delegable duty of care owed by each of the appellants to the deceased. The appellants contended that no non-delegable duty was admitted.

5. Expert evidence at the trial

13. At the trial, the respondent led expert evidence from two witnesses: Dr Phyllis Pitt-Miller, a retired professor of clinical anaesthesia and intensive care at the University of the West Indies and Dr Altheia Jones-Lecointe, a consultant haematologist and head of the department of para-clinical sciences at the Faculty of Medical Sciences at the same University. As already explained, the testimonies of these two witnesses comprised the entirety of the medical evidence before the judge and was accepted by him. The experts spoke to the standards of care that ought to have been met by reasonably competent medical professionals in the specialist fields of anaesthetics and haematology.

14. The expert evidence given at the trial may be summarised as follows.

15. 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 DIC between about 4.30 and 10.00pm.

16. Dr Jones-Lecointe gave evidence that: (a) if the medical team had monitored the deceased properly after surgery he would not have developed hypovolemic shock; (b) if the 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 (c) if the DIC which the deceased

developed had been properly managed by the medical team through the administration of appropriate blood products (i.e. packed red cells, cryoprecipitate and/or fresh frozen plasma) and through regular PT (prothrombin time), PTT (partial thromboplastin time) and CBC (complete blood count) tests, the fluid overload which the deceased developed (and which was the proximate cause of his death) would not have occurred.

17. Dr Pitt-Miller dealt with the chain of events causing the deceased's death in the following way: prior to the TURP procedure the medical centre failed to identify or ignored indicators that the deceased might have had a bleeding tendency. After the procedure the deceased experienced post-operative bleeding and was allowed to bleed to such an extent that he developed hypovolemic shock, a condition in which as a result of 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 to which he succumbed.

18. Insofar as the deceased's pre-operative care was concerned, both experts were of the opinion that the relevant standard of care required, amongst other things, that prior to surgery at least two units of grouped and cross-matched red blood cells or packed red cells be readily available for use on the patient.

19. In any event, according to Dr Pitt-Miller, given the outside possibility of a peri-operative bleeding problem, as occurred in the present case, the first appellant ought at the very least to have taken steps to ensure that at the time of surgery fresh frozen plasma and cryoprecipitate were readily available at the hospital or could be obtained within half an hour of being required. Both experts testified that transfusion of these products, and at least according to Dr Pitt-Miller fresh whole blood, 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.

20. The experts' evidence of the relevant post-operative care dealt with the deceased's deteriorating medical condition. Both experts were of the opinion that in view of 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 his initial post-operative bleeding and the risk of fluid overload. The experts set out in detail the nature and extent of the monitoring which should have been carried out. The evidence of both experts was that had proper post-operative monitoring been done then steps would have been taken to arrest the deceased's bleeding and it was likely that he would not

have developed hypovolemic shock and would have made a successful recovery from the TURP procedure.

21. 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 said, was further increased by the risk of the deceased developing what was known as TURP syndrome. TURP syndrome occurs as a result of the absorption of large amounts of irrigant used during the TURP procedure and can result in fluid or circulatory overload. The syndrome is associated with congestive heart failure. Dr Pitt-Miller set out a number of basic steps which should have been taken to prevent and detect fluid overload.

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

23. 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 was a combination of packed red blood cells and plasma or whole blood and plasma. During the period between 3.30 and 4.30pm the deceased was transfused with ringers and haemaccel. These were not blood or blood products, but crystalloids and colloids. In Dr Pitt-Miller's opinion, the use of crystalloids and colloids was a poor substitute for blood since it takes three units of such fluids to replace each unit of blood lost, thereby creating a material risk of fluid overload.

24. 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 two units of whole blood or packed blood cells required to be available at the time of surgery were not in fact available at that time, or if they were available, that the failure to transfuse them constituted a serious error on the part of the medical team.

25. According to the expert witnesses, the results of the PT and PTT tests requested at 4.15pm and received at approximately 5.00pm were clear indicators that the deceased had developed DIC. The diagnosis of DIC ought to have been made at that time. The appropriate treatment for DIC was management by transfusions of red cell concentrates, fresh frozen plasma and cryoprecipitate, which would have served 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 three hours after the diagnosis of DIC ought to have been made.

26. In addition, Dr Pitt-Miller testified that the transfusion of O+ blood was a serious error and that such a transfusion may itself cause DIC and also result in the destruction of the patient's red blood cells. She stated that a transfusion of O+ blood into a patient with A+ blood was to be reserved for desperate emergencies and only where the patient's haemoglobin was so low as to be life threatening and where no A+ whole blood or packed red cells were available. According to Dr Pitt-Miller, at that time the deceased's haemoglobin level, although low, was acceptable and not life threatening.

27. Further, Dr Pitt-Miller stated that the transfusion of six units of whole blood without the transfusion of clotting agents over the period between 4.30pm and 7.45pm was contra-indicated because 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 his bleeding. Moreover, there was a significant risk of fluid overload in transfusing a large volume of fluid to a patient if the transfusion process was not monitored and managed in the manner she described.

28. Dr Pitt-Miller stated that the medical records contained no evidence that there was any checking for fluid overload done clinically or by monitoring except that there was evidence that at 10.00pm two pulse oximeters were used to monitor the deceased. In particular, according to Dr Pitt-Miller's evidence, during this period the records did not reveal that any pulse oximetry or an ECG was done. Neither did the second appellant indicate if he auscultated the chest, checked for capillary refill or assessed peripheral vaso-constriction.

29. 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 stated 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 administered to the deceased in the space of 6½ hours itself suggested that the transfusions of those fluids were not properly monitored and managed.

30. Furthermore, the fact that the deceased received massive transfusions of fluid: three units of haemaccel, three litres of ringers, eleven units of whole blood, two units of fresh frozen plasma and three units of cryoprecipitate represented, in Dr

Pitt-Miller's 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 postmortem findings 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.

6. The judgment of Kokaram J

31. Kokaram J observed that the appellants had advanced a range of criticisms of the experts' credibility, for example on the ground that they had been unduly influenced by the lawyers who instructed them, that they had collaborated inappropriately, that their views were not truly independent, and that they did not understand the correct legal test for negligence. Having seen and heard the expert witnesses for himself, Kokaram J rejected all these criticisms. He was satisfied that the experts understood their duty was to assist the court. He found that the core of their evidence had not been challenged and remained "very much intact".

32. Kokaram J rejected the appellants' attempts to limit their responsibilities to their individual roles. In relation to the pleadings Kokaram J said this at paragraph 64:

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

33. In conclusion on the pleadings Kokaram J found the following at paragraph 123:

> "As discussed above there is no issue as to the existence of a duty of care. The pleaded duty was admitted by these Defendants and it included critically the monitoring of Mr Tesheira's blood loss, the containment of his blood loss, the management of the patient in post operative care to safely transfuse large quantities of blood products, and carefully manage same. There simply is no plea by Gulf View that its

duty or role was limited to support service or of providing accommodation, operating facilities or nursing care. …. The issues for determination at this trial have been properly identified in advance of this trial, …. The cross examination therefore of the experts to the effect that decisions were made by clinicians and not nursing staff are really irrelevant in that it does not advance the Defendants' case against the backdrop of its accepted duties of care."

34. Having identified what he understood to be the admitted scope of the appellants' duty of care, Kokaram J then proceeded to examine whether the evidence established that they had breached their duties and what the result of any breach was. He set out his conclusions in the following passages between paragraphs 125 and 128 of his judgment:

" Gulf View

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

Gulf View failed in my view:

(a) To make attempts to monitor and contain the post surgical bleeding as indicated earlier in this judgment. The lapse in time while Mr Tesheira was bleeding post operatively is basic carelessness. …. I am satisfied that but for this failure to monitor and contain the post surgical bleeding he would not have developed hypovolemic shock.

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

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

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

Dr Roopchand

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

127. Dr Roopchand:

(a) Failed to take any steps to arrest or control his bleeding post TURP. Mr Tesheira was bleeding continuously from 1:10p.m and bled heavily and excessively from 2:50p.m (at least as recorded by the reporting nurse) to 3:30pm. In a full 40 minutes of heavy bleeding nothing was done. … Dr Jones-Lecointe's evidence is quite clear that this failure to act was a serious breach to deliver the standard of care expected of him and exposed Mr Tesheira to an unnecessary risk. Dr Roopchand and Gulf View failed to carry out PT/PTT tests or make proper pre-assessment of the use of aspirin which relates directly to the management of blood loss.

(b) Failed to act quickly to transfuse the relevant blood products. The question that still remains unanswered by Dr Roopchand or Gulf View is where was the whole blood or plasma or packed red cells and plasma? …. It is more probable that the suitable products were simply not on site at Gulf View.

(c) Failed to ensure that prior to the TURP procedure there were adequate supplies of packed red cells or whole blood to treat hypovolemic shock or fresh frozen plasma and cryoprecipitate to treat DIC. …Again this is indicative that Gulf View was simply not ready for this and Dr Roopchand had failed to prepare adequately for the TURP.

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

(e) Failed to properly monitor and record Mr Tesheira's fluid output or ensure adequate proper or sufficient monitoring to monitor his status during the transfusion of

> blood and other fluids. There was a risk of fluid overload or TURP syndrome coming out of the TURP procedure. However it was double the risk when the 19 units of fluid and blood products cumulatively were transfused haphazardly. This according to the evidence of Dr Pitt-Miller would lead to fluid overload. There was according to both Dr Pitt-Miller and Dr Jones-Lecointe inadequate monitoring during these procedures. The experts repeatedly called for the temperature and pulse recordings and the use of an oximeter.
>
> 128. But for these failures or omissions and actions by Gulf View and Dr Roopchand, Mr Tesheira would not have gone into hypovolemic shock, he would not have developed DIC, he would not have developed TURP syndrome and died of irreversible shock and DIC."

7. The judgment of the Court of Appeal

35. In a carefully reasoned and comprehensive judgment, the Court of Appeal rejected most of the appellants' grounds of appeal.

36. The Court of Appeal held that on a proper interpretation of the pleadings, the appellants' defences did not distinguish between the duties of care they each owed to the deceased. Rather, when properly construed and understood, their defences were that they had each met the requisite standards of care. In short, the first appellant had admitted that it was subject to a duty to maintain adequate supplies of blood and properly to manage the transfusion of blood products. The second appellant too had accepted his duty to manage and monitor the blood products. The second appellant had participated in the two further operations performed on the deceased after he was taken back to the operating theatre. In such circumstances, his legal responsibility could not conceivably have ended after the TURP.

37. The admitted terms of paragraph 23 of the amended statement of claim constituted a clear acceptance by the first appellant that it owed non-delegable duties 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 employees, agents, or third parties. The duty of care was not limited to those aspects of the deceased's care performed by its employees, such as nursing care and laboratory services. The duty extended to the acts and omissions of the surgeon and the second appellant.

38. Similarly, the second appellant's duty was not limited to his duties arising from the administration of anaesthetic drugs.

39. The trial judge had, however, failed to link the breaches of duty found by him to the allegations made by the respondent against the appellants or to the standard of care identified by the experts. In light of these failings, the Court of Appeal proceeded to examine the judge's findings, place them in the context of the allegations of negligence and the evidence accepted by the judge, and to the extent that the findings were misconceived, consider whether there was other evidence or inferences that could be drawn to support the findings of negligence. If there was such other evidence or inferences that could be properly drawn, it could not be said that the judge had been plainly wrong.

40. Applying this approach, the Court of Appeal then proceeded to carry out a meticulously detailed examination of the expert evidence and the judge's approach towards such evidence. It is not necessary to set out the details of this exercise here. Suffice to say that the Court of Appeal concluded that 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 his initial bleeding after the TURP;
>
> (c) transfused Group O+ blood into him; and
>
> (d) failed properly to monitor and record his fluid output and properly or sufficiently to monitor his status during the transfusion of blood or other fluids.

41. In respect of the second appellant, the Court of Appeal held that he 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 properly to 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.

42. With regard to the issue of causation, the Court of Appeal concluded that the evidence showed that this was a case of death as a result of fluid overload caused by poor management of the deceased's excessive bleeding. The proximate cause of death was not excessive bleeding, but rather the manner in which the appellants had sought to treat the deceased's excessive bleeding. The Court of Appeal encapsulated its findings on causation as follows:

> "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's 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."

8. The grounds of appeal before the Board

43. The main challenges to the reasoning and decisions of the lower courts are set out in outline in the paragraphs that follow.

44. Ground one - whether a non-delegable duty was admitted on the pleadings. Both appellants submitted that properly construed, the pleadings did not contain any admitted non-delegable duty on their part.

45. Ground two - whether either of the appellants were under a non-delegable duty at common law. This ground of appeal does not arise if a non-delegable duty has been admitted on the pleadings.

46. Ground three - issue estoppel. Having refused the first appellant permission to bring contribution proceedings against the surgeon at an interlocutory stage on the basis that he was a concurrent and not a joint tortfeasor, both appellants submit that an issue estoppel arose such that it was not open to the judge at the stage of the trial

to hold that on the evidence before him the appellants were jointly liable for the deceased's death.

47. Ground four - the assessment of the expert witnesses. The appellants contend that because of several "significant problems" the evidence of Dr Pitt-Miller and Dr Jones-Lecointe ought to have been rejected by Kokaram J or alternatively no weight ought to have been attached to their evidence.

48. Ground five – breach of duty. The appellants submit that Kokaram J ought to have acceded to the application that there was no case to answer because the claimant had failed to lead sufficient evidence to establish her case against the appellants.

49. Ground six – duty of care on the second appellant. The second appellant submits that the lower courts had failed properly to address the duty of care incumbent on him. He asserts that he had no role to play in containing, managing or arresting the bleeding from which he suggests the deceased died.

50. Ground seven – causation. The appellants submit that there was, in any event, no proper basis on which it could be held that any act or omission on their part materially contributed to the deceased's death.

9. The Board's consideration of the grounds of appeal

Ground one – whether a non-delegable duty was admitted on the pleadings

51. A non-delegable duty of care can arise under statute (see *Armes v Nottinghamshire County Council* [2018] AC 355 at para 38) or at common law (see *Woodland v Swimming Teachers Association and others* [2014] AC 537) or alternatively by admission on the pleadings. The issue under this ground of appeal is whether there was an admission on the pleadings of a non-delegable duty of care resting on both appellants.

52. Lord Reed in *Armes v Nottinghamshire County Council* at para 31 stated that "[the] expression 'non-delegable duties of care' is commonly used to refer to duties not merely to take personal care in performing a given function but to ensure that care is taken." He continued by observing that such duties "are described as non-delegable because they cannot be discharged merely by the exercise of reasonable care in the selection of a third party to whom the function in question is delegated."

53. The first appellant submits that there was no admission of a non-delegable duty on the pleadings. Rather, it seeks to establish that the scope of its duty of care was limited to hospital administration and vicarious liability for any tortious conduct of its employees such as the nursing staff, but excluding the surgeon and the second appellant who were not employees.

54. The second appellant also submits that there was no admission of a non-delegable duty on the pleadings. Rather, he seeks to establish that the scope of his duty of care was limited to his role in administering the anaesthetic during the operation. He also submits that he was not liable for any tortious conduct of either the first appellant or of the surgeon.

55. Both appellants accept that paragraph 23 of the amended statement of claim ("paragraph 23") filed on 15 January 2008 was admitted without any qualification in their joint amended defence filed on 26 February 2008. So, if paragraph 23 does contain an allegation of a non-delegable duty of care resting on both appellants, then because of this admission on their pleadings, both appellants would be under such a duty to protect the health of the deceased. This ground of appeal therefore turns on the proper interpretation of paragraph 23.

56. Paragraph 23 stated:

> "23. Further, the Defendants were under a duty in performing the TURP procedure on the deceased, to *ensure* that during and after the performance of the procedure (a) any bleeding of the deceased was carefully monitored and/or properly contained and/or otherwise so managed as to protect the deceased from excessive bleeding; (b) there were sufficient materials, equipment, and personnel as to facilitate the safe transfusion of large quantities of blood and blood products to the deceased; and (c) such transfusions as may have been necessary were carefully managed and carried out using such equipment, tests and practices as would minimise the risk of, or prevent, the deceased experiencing fluid overload or other deleterious effects from same" (emphasis added)

57. The Board makes a few preliminary observations as to the duty alleged in paragraph 23. First, it is a duty in respect of both the period "during" and the period "after the performance of the procedure." It is not limited to a duty "in performing the TURP procedure." Second, it is a duty in respect of matters such as (a) blood loss;

(b) transfusions; and (c) fluid overload. Third, the duty extends to persons performing different roles and functions in the period during and after the performance of the TURP. So, insofar as paragraph 23 discloses a duty in respect of the first appellant, it is not restricted to the role or functions to be performed by the first appellant's nursing staff but extends to include all those other persons who performed any role in respect of the deceased's (a) blood loss, (b) transfusions, and (c) fluid overload. Fourth, it does not disclose an absolute duty as demonstrated by the references in paragraph 23 to "carefully" monitoring and "properly" containing the bleeding; and "carefully" managing transfusions and carrying out tests and practices "as would minimise the risk of" fluid overload. For the duty alleged to be breached fault must still be established.

58. Both appellants invited the Board to read the whole of the amended statement of claim in order to determine how paragraph 23 should properly be interpreted. It was said that paragraphs 3 - 5 of the amended statement of claim made clear that separate and distinct roles were alleged in respect of the first appellant, the surgeon, and the second appellant; and that in paragraphs 6 - 7 separate and distinct duties were alleged to attach to each of them in respect of those roles. In this way it was suggested that an interpretation of paragraph 23 as imposing a non-delegable duty on all of them was inconsistent with those earlier paragraphs in the amended statement of claim. The Board is prepared to accept without deciding that in those earlier paragraphs of the amended statement of claim distinct roles together with individual duties were alleged in respect of the first and second appellants. However, in any event, the Board considers that there is no inconsistency. The respective duties are not mutually exclusive so that it is possible for both a specific duty of care and a non-delegable duty of care to co-exist.

59. It was submitted on behalf of the second appellant that it was highly unusual for an anaesthetist to admit responsibility for parts of the treatment of the deceased which he did not undertake. On this basis it was submitted that any interpretation of paragraph 23 as establishing that a non-delegable duty lay on an anaesthetist should be rejected as being absurd because such an admission would make him liable for the tortious acts of both the first appellant as the hospital authority and of the surgeon. The Board accepts that it would be unusual for an anaesthetist to admit a non-delegable duty under which he would be liable for the tortious conduct of the hospital authority and the surgeon but does not consider that such an admission would lead to absurdity in circumstances where (as here) the first and second appellants were running a joint defence. There can be sound practical reasons for an admission of the same duty of care resting on both appellants as such an admission would enable them to present a unified defence jointly concentrating on whether there was any breach of that duty.

60. Mr Mendes SC in his carefully reasoned written and oral submissions on behalf of the respondent, whilst accepting that the words “non-delegable duty” did not appear in paragraph 23 of the amended statement of claim, argued that as paragraph 23 alleged a duty to “ensure” that reasonable care was taken this was a way of alleging a non-delegable duty of care.

61. The Board considers that the use of the word “ensure” in paragraph 23 of the amended statement of claim was a way of alleging a non-delegable duty of care in the context that this was not an absolute duty but still required fault to be established on the part of those caring for the deceased. Several judgments delivered prior to the date upon which the amended statement of claim and the amended defence were filed articulated a non-delegable duty as a “duty to ensure.” In *The Commonwealth v Introvigne* (1982) 150 CLR 258 Mason J in the High Court of Australia at paras 26, 30, 31, 32 articulated a non-delegable duty using the word “ensure” as did Murphy J at paras 3 and 5. In *Kondis v State Transport Authority* (1984) 154 CLR 672, at para 32 Mason J referred to a non-delegable duty as “a duty to ensure that reasonable care and skill is taken for the safety of the persons to whom the duty is owed ….” In *State of New South Wales v Lepore* [2003] HCA 4(2003) 212 CLR 511, at para 25 Gleeson CJ also used the word ensure in the context of a non-delegable duty. In addition to those judgments the fifth edition of The Law of Torts by John G. Fleming published in 1977 refers at page 362 to “a non-delegable, personal duty to ensure ….”

62. After the date of filing of the amended statement of claim there are also examples of a non-delegable duty of care being articulated as a “duty to ensure.” See for instance *Armes v Nottinghamshire County Council* at para 31 as quoted at para 52 above; *Woodland v Swimming Teachers Association* at para 26. In the Australian case of *Fitzgerald v Hill* [2008] QCA 283 McMurdo P in the Supreme Court of Queensland also articulated non-delegable duties using the word “ensure.” She stated at para 66:

> “The non-delegable duty of care is a special duty to *ensure* that reasonable care is taken for the safety of those to whom it is owed. It is not vicarious; it is a personal duty, breach of which requires fault. It is an onerous duty in that if a defendant owing the duty to a claimant does not take reasonable care to avoid a foreseeable risk of injury which eventuates causing damage to a claimant, then liability cannot be avoided by the defendant engaging another to carry out the defendant’s responsibilities” (emphasis added).

63. The Board's conclusion that paragraph 23 alleged a non-delegable duty of care is also supported by consideration of the amended defence. If the first appellant had not admitted a non-delegable duty, then the Board would expect it to deny responsibility for the acts or omissions of the surgeon or of the second appellant in its defence. However, parts of the amended defence demonstrate that the first appellant did not deny that it was under a duty in respect of matters which would be the responsibility of the surgeon or of the second appellant but rather it was asserting that it had met the relevant standard. In other words, the first appellant asserted in its defence that those to whom a duty had been delegated or for whom it was vicariously liable were not negligent.

64. This point can be illustrated by reference to the allegation in particular (m) of the particulars of negligence that, as a hospital authority, the first appellant 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 was not to deny that it had any responsibility for the transfusion of blood on the basis that this was performed by the second appellant, for whose activities it was not liable, but rather it asserted that blood group O was available and could be readily transfused into any person with another blood group including the deceased whose blood group was A+. The pleaded case of the first appellant, as the hospital authority, was not to deny responsibility for the transfusion carried out by the second appellant, but rather to maintain that transfusing blood group O was the proper action to take in the circumstances.

65. The Board also considers that the interpretation of paragraph 23 as alleging a non-delegable duty of care is supported by documents filed after the dates upon which the amended statement of claim and the amended defence were filed.

66. First, on 1 April 2009, prior to the trial commencing on 28 November 2014, the first and second appellants filed a document dated 31 March 2009 entitled "Unagreed Statement of Facts filed on behalf of the First and Third named Defendants" which at para 19 accepted that:

> "At all material times the First Second and Third Defendants were under a duty in performing the TURP procedure to ensure that during and after the performance of the procedure 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, that there were sufficient materials, equipment and personnel to facilitate the safe transfusion of large quantities of blood and blood products to the

> deceased and that such transfusions as may have been necessary were carefully managed and carried out using such equipment, tests and practises as would minimise the risk of or prevent the deceased from experiencing fluid overload or other deleterious effects from same."

This document again admitted the non-delegable duty that rested on the first and second appellants.

67. Second, in a further document filed and dated 28 April 2014 the respondent identified the issues for determination at the trial. As stated by Kokaram J, at para 76 of his judgment, these issues "were discussed at a pre-trial review" and the High Court "determined that these issues conveniently set out all the issues arising from the pleaded case which require investigation." The Board notes, as did Kokaram J, that no issue as to the duty owed by the first and second appellants to the deceased was raised. The Board considers that the appropriate explanation is that there was no issue as to the duty owed because a non-delegable duty had been admitted.

68. Third, on 19 November 2014 the first appellant filed an application to amend its defence. On 28 November 2014, the first day of the trial, Kokaram J commenced hearing the application, but it was withdrawn. The significance of this is that in the proposed amended defence the first appellant for the first time denied that it was "in any way vicariously liable and/or otherwise liable" for the acts or omissions of the surgeon or the second appellant. Furthermore, rather than admitting para 23 of the amended statement of claim the first appellant denied that paragraph and proposed to make a positive case that:

> "the [first appellant] was not retained by the deceased to carry out the TURP procedure, which was solely within the control and discretion of [the surgeon] and/or [the second appellant] pursuant to their private contract with the deceased as his private medical practitioners for this express purpose. Accordingly, neither the [first appellant] nor its servants or agents could or did not have any authority over whether the TURP procedure was carried out or not and had no authority to prevent the contract between [the surgeon, the second appellant] and the deceased being performed, where [the surgeon and the second appellant] were satisfied that it should be" (sic).

69. Fourth, the respondent's understanding of the pleadings is clear from her written closing submissions at trial. At para 5 of that document filed on 13 February 2015 it is stated that:

> "The following matters pleaded in the [respondent's] Amended Statement of Claim are … admitted in the Amended Defence"

Amongst the following matters at para 5(xi) was:

> "Both defendants were under a duty to ensure that during and after the performance of the procedure:
>
> (a) Any bleeding of the deceased was carefully monitored, properly contained, and managed so as to protect the deceased from excessive bleeding;
>
> (b) There were sufficient materials, equipment, and personnel as to facilitate the safe transfusion of large quantities of blood and blood products to the deceased; and
>
> (c) Such transfusions as may have been necessary were carefully managed and carried out using such equipment, tests and practices as would minimise the risk of, or prevent, the deceased experiencing fluid overload or other deleterious effects from same."

70. For all the above reasons, the Board considers that this ground of appeal is not made out.

Ground two – whether either of the appellants were under a non-delegable duty at common law

71. In the light of the foregoing, it is not necessary to determine whether either of the appellants were under a non-delegable duty at common law, as that duty has been admitted on the pleadings.

Ground three – issue estoppel

72. Both appellants rely on the earlier interlocutory ruling of Kokaram J that the appellants were concurrent rather than joint tortfeasors as establishing an issue estoppel such that it was no longer open to Kokaram J to find that the appellants were joint tortfeasors under a non-delegable duty of care. The Board considers that this ground of appeal is not made out for two main reasons.

73. First, it appears that this issue was not raised in the Court of Appeal. Paragraph 159 of the Court of Appeal's judgment records that "the appellants stop just shy of submitting that issue estoppel applies." On this basis, the matter is not suitable for consideration on appeal to the Board as it was not raised below.

74. Second, the first appellant asserts that it acted to its detriment by failing to call evidence at the trial to support the earlier ruling that the appellants were concurrent tortfeasors. However, not only was there nothing to prevent the first appellant from calling any evidence, but in any event the first appellant has failed to identify the evidence it would have called. Accordingly, the suggestion that the first appellant was induced to act to its detriment based on the earlier interlocutory ruling is rejected.

Ground four – The trial judge's assessment of the expert witnesses

75. The appellants contend that because of several "significant problems" the evidence of Dr Pitt-Miller and Dr Jones-Lecointe ought to have been rejected by Kokaram J, or alternatively no weight ought to have been attached to their evidence.

76. Dr Pitt-Miller and Dr Jones-Lecointe who both gave evidence at the trial had each first prepared their medical reports and then in conjunction with the respondent's legal representatives they had each prepared witness statements which expanded upon and explained their conclusions as set out in their respective reports. Their medical reports were annexed to their witness statements which were then filed in court.

77. The matters which were said by the appellants to be "significant problems" were raised at the trial before Kokaram J. They included that: (a) the experts had been approached directly by the respondent rather than through her legal representatives; (b) neither expert had reviewed the deceased's pre-2004 medical records; (c) the experts had sent their reports to other experts for comment before they were finalised; (d) each expert in preparing witness statements, which were

supplementary to their medical reports, had done so in conjunction with the respondent's legal representatives; and (e) neither expert had any knowledge of the test in relation to medical negligence set out in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582; [1957] 2 All ER 118 ("*the Bolam test*") or of the qualification to that test set out in *Bolitho v City and Hackney Health Authority* [1998] AC 232; [1997] 4 All ER 771 at the time of writing their reports.

78. Kokaram J had the benefit of seeing both experts give evidence in court. He accepted, at para 105, that both experts "sought to provide independent assistance to the court by way of an objective unbiased opinion" and that they held "no brief" for the respondent with whom they had "no personal relationship." Kokaram J observed, at para 109, that Dr Pitt-Miller's qualifications were never in question and that she came across as "a forthright and straightforward person" who was "quite independent-minded, careful in her thinking process and in drawing conclusions." Kokaram J considered, at paras 116-117, that Dr Jones-Lecointe was an experienced professional with a vast expertise in her field of haematology who recognized her duty of impartiality and who "demonstrated her capability of giving … reliable and sound medical evidence."

79. In relation to the criticism that the experts had prepared their witness statements in conjunction with the respondent's legal representatives Kokaram J 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 the experts being assisted by an attorney in the preparation of their witness statements.

80. Kokaram J stated that it was for him to determine what weight was to be attached to the experts' reports. In determining the weight, he took into consideration the objections made by the appellants and weighed them against what he described as the cogency and relevance of the reports. He accepted their evidence.

81. The Court of Appeal considered at paragraph 74 that there was no merit in the appellants' challenge to the acceptance by Kokaram J of the evidence of the experts.

82. The Board having considered each of the matters which are said to amount to significant problems with the evidence of the experts considers that there is no merit in this ground of appeal. In relation to the criticism that at the time of writing their respective reports the experts were not familiar with the *Bolam* test, the Board observes that the experts are medical experts who are not and do not have to be legal experts. Rather, their role is to give evidence as to appropriate medical practice.

In relation to all the other criticisms, they are matters going to weight which were taken into account and properly assessed by the trial judge.

83. This can be illustrated by reference to the criticism that the experts' statements were prepared in collaboration with the respondent's lawyers. Kokaram J was alive to the risk that the opinions expressed by the experts in their written statements were either not their opinions or alternatively that their opinions had been coloured by their discussions with the respondent's lawyers. However, at trial the substance of the experts' opinions was not challenged - there being no suggestion that any particular conclusion or part of the opinion had been tainted or inappropriately influenced by the respondent's lawyers. Furthermore, Kokaram J had the opportunity to assess the experts as they were challenged by rigorous cross examination that their evidence was tainted. He was entitled to and did reject that challenge as "unfounded".

84. The Board considers that this ground of appeal is not made out.

Ground 5 – breach of duty

85. The appellants submit that Kokaram J ought to have acceded to their application that there was no case to answer because the respondent had failed to show sufficient evidence to establish her case against the appellants.

86. The *Bolam* test states that a practitioner is not negligent if he acted in accordance with a practice accepted as proper by a responsible body of medical opinion "merely because there is a body of opinion which would take a contrary view". Kokaram J in considering whether there was sufficient evidence of a breach of a non-delegable duty of care resting on the appellants correctly directed himself in accordance with that test, as did the Court of Appeal in its judgment.

87. The Board considers that there is no merit in this ground of appeal for two fundamental reasons.

88. First, there was sufficient evidence to support the findings of negligence set out at paras 40 and 41 above.

89. For instance, Kokaram J found that the first appellant was negligent in that it transfused Group O+ blood into the deceased. Paragraph 33 of Dr Pitt-Miller's witness statement contained the following:

> " … the transfusion of O positive Whole Blood to the Deceased who had A positive blood, was a serious error on the part of the Medical Centre as such a transfusion may: (a) itself cause DIC; and (b) result in the destruction of the Deceased's red blood cells by antibodies present in the O positive whole blood transfused to the Deceased. Such a transfusion is reserved for desperate emergencies where the patient's haemoglobin level is so low as to be life threatening and where there is no A positive whole blood/packed red cells available. However according to the CBC test results issued at 4:20pm on the 13th April 2010 the Deceased's haemoglobin level although low, was acceptable, and certainly was not life threatening. There are no other CBC test results amongst the Deceased's Records which showed his haemoglobin level to be so low as to be life threatening. In those circumstances there was no justification for taking the extreme and dangerous step of transfusing him with O positive whole blood. If there was no A positive blood product available then the Medical Team should have waited until same became available while repeating the CBC test to ensure the Deceased's haemoglobin did not dip to dangerously low levels."

This evidence which remained unchallenged was accepted by Kokaram J. Based on Dr Pitt-Miller's evidence transfusing O+ blood was a "serious error" amounting to an "extreme and dangerous step." In short there was obvious evidence of this breach of the duty of care.

90. A further illustration is by reference to the finding that the first appellant was negligent in that it failed properly to monitor and record the deceased's fluid output and properly or sufficiently to monitor his status during the transfusions of blood or other fluids. The unchallenged evidence of Dr Pitt-Miller is contained in paragraphs 34 – 38 of her witness statement. She stated that:

> "34. During the period 3:30pm. to 10:00pm. (6.5 hours) the Deceased received by way of transfusions 3 units of haemaccel, 3 litres of Lactated Ringers, 11 units of whole blood, 2 units of FFP, and 3 units of Cryoprecipitate…. This represents a massive transfusion amounting to more than twice the average volume of fluid in the human body.

35. There is a significant risk of causing fluid overload … when transfusing a large volume of fluid to a patient if the transfusion process is not carefully monitored and managed. Fluid overload in this context refers to a condition where there is too much fluid in the blood, that is to say more than the heart can effectively cope with, as a result of the infusion of too much fluid or the infusion of fluid too fast. A fit person can usually deal with excessive fluid administration up to a point. However, compensation for fluid overload is difficult or impossible for those patients with cardiac impairment. If left unaddressed and/ or unchecked, fluid overload may lead to heart failure.

36. Given the fact that the deceased had 'early coronary disease' with a 40 to 50% stenosis in the right coronary artery, there was a significant risk of him developing fluid overload in the event that the post-operative transfusion of fluid was not monitored and managed carefully. The risk of [the deceased] developing fluid overload was further increased by the risk of him developing what is commonly known as 'TURP syndrome'. There is a 2% incidence of this syndrome which is associated with congestive heart failure, pulmonary oedema, hypotension, and acute hyponatraemia as its main manifestations. It results from the absorption of large amounts of irrigant used during the TURP procedure resulting in amongst other things fluid … overload.

37. Given the risk of the deceased developing fluid overload as a result of TURP syndrome, the large amount of fluids which were required to be administered to the deceased post-operatively, and the fact that the deceased had been diagnosed with 'early coronary disease', [the surgeon and/or the second appellant] ought to have taken certain basic steps to prevent and detect fluid overload in the deceased both peri-operatively and post-operatively, and in particular, during the period the deceased was being transfused with large volumes of fluids as treatment for shock. These steps include:-

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

(ii) the insertion of a central venous pressure line - this is a device used amongst other things to determine whether there is too much or too little fluid in the body;

(iii) intra-arterial line to monitor accurately changes in blood pressure and indirectly cardiac output and to provide for the monitoring of blood gasses. Blood gasses show the efficiency of oxygenation and the acid/base of the circulating blood;

(iv) the use of a pulse oximeter to measure oxygen levels in the deceased blood – a reduction in oxygen levels in the blood is a symptom of fluid overload;

(v) monitoring of the deceased for jugular venous distention – an indication of fluid overload;

(vi) auscultation of the chest (i.e. listening to lungs) for crepitations (i.e. crackling, rattling or clicking noises) another indication possible fluid overload;

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

(viii) arterial blood gas tests;

(ix) Chest x-rays

38. There is nothing in the deceased records that indicate that any of these steps were taken by the [first appellant] save that it is recorded in [the second appellant's] notes that at 10:00pm that 2 pulse oximeters were used to monitor the patient"

Again, the uncontradicted evidence of Dr Pitt-Miller provided ample evidence of this breach of the duty of care.

91. Second, in accordance with the Board's normal practice, it is not appropriate, save in exceptional circumstances, to go behind the concurrent findings of fact of the

two lower courts. For that practice of the Board see, *Devi v Roy* [1946] AC 508; *Central Bank of Ecuador v Conticorp SA* [2016] 1 BCLC 26, para 4; *Juman v Attorney General of Trinidad and Tobago* [2017] 2 LRC 610, para 15; *Al Sadik v Investcorp Bank BSC* [2018] UKPC 15 at paras 43– 44.

92. In this case, there are several instances where the appellants seek to challenge concurrent findings of fact by the courts below. For instance, at para 127(e) of his judgment Kokaram J found that there was a failure to monitor and record the deceased's fluid output and a failure to undertake monitoring of his status during the transfusion of blood and other fluids. The Court of Appeal made a similar finding of fact at paras 216-218. There are no grounds for the Board to go behind such concurrent findings.

93. The Board considers that this ground of appeal is not made out.

Ground six - duty of care on the second appellant

94. This ground of appeal does not arise for determination in light of the Board's conclusion as to Ground one.

Ground seven - causation

95. The appellants submit that there was no proper basis on which it could be held that any act or omission on their part materially contributed to the deceased's death. The Board disagrees.

96. There was evidence that the breach of duty in relation to fluid overload was the direct cause of the deceased's death. At para 39 of her witness statement Dr Pitt-Miller referred to the post-mortem report of Dr Daisley which found that the deceased had a one litre right and a 600 ml left pleural effusion together with ankle oedema. Furthermore, there was also congestion of the liver, lungs and spleen together with biventricular dilation. Dr Pitt-Miller stated that these post-mortem findings "strongly indicate that the deceased experienced fluid overload as a result of the fluids administered to him after the April 2004 TURP procedure." She was of the opinion that:

> "such fluid overload was the direct cause of his death."

This was the uncontradicted expert evidence of Dr Pitt-Miller at the trial. Dr Jones-Lecointe was also of the opinion that fluid overload was the proximate cause of the deceased's death.

97. Kokaram J found at para 3 of his judgment, that fluid overload was the last aspect of a trilogy of causative matters which led to the deceased's death. In a footnote to para 30 of his judgment, he accepted that the deceased "succumbed" to fluid overload and at para 61 he cites with apparent approval para 39 of Dr Pitt-Miller's report which concludes that "fluid overload was the direct cause of [the deceased's] death."

98. The Court of Appeal, at para 283 of its judgment, made a concurrent finding of fact that the cause of the deceased's death was fluid overload and concluded at para 294 that:

> "On the evidence before [the judge] 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."

99. There are no grounds for the Board to go behind such concurrent findings as to the cause of the deceased's death.

10. Conclusion

100. The appeals are dismissed.