SUPREME COURT OF QUEENSLAND

CITATION:	*Sochorova v Durairaj & Anor* [2019] QSC 251
PARTIES:	**TEREZIE SOCHOROVA** (Plaintiff) **v** **DR RAMESH DURAIRAJ** (First Defendant) and **CAIRNS & HINTERLAND HOSPITAL AND HEALTH SERVICE** (Second Defendant)
FILE NO/S:	SC No 623 of 2018
DIVISION:	Trial
PROCEEDING:	Trial
ORIGINATING COURT:	Supreme Court at Cairns
DELIVERED EX TEMPORE ON:	26 September 2019
DELIVERED AT:	Cairns
HEARING DATES:	17, 18, 19, 25 and 26 September 2019
JUDGE:	Henry J
ORDERS:	**1. Claim dismissed.** **2. The plaintiff will pay the defendants' costs to be assessed on the standard basis if not agreed.**
CATCHWORDS:	TORTS – NEGLIGENCE – DAMAGE AND CAUSATION – CAUSATION – where the plaintiff claims damages for personal injury resulting from a severe stroke that left her permanently incapacitated, requiring full-time care – where the plaintiff alleges the stroke was caused by the defendants administering thrombolysis, a procedure utilised to treat the plaintiff for a prior stroke she had suffered on the day in question – where the plaintiff alleges the defendants breached their duty of care by proceeding with thrombolysis in circumstances where it was contraindicated, and by failing to warn the plaintiff of the risks associated with the procedure – where these allegations form the factual foundation of the plaintiff's case – whether the procedure was contraindicated – whether the risks of the procedure were adequately explained

	to the plaintiff – whether the element of causation has been made out
COUNSEL:	M T Hickey for the First and Second Defendants
SOLICITORS:	Mr J Moder (the brother and holder of Power of Attorney of the plaintiff) appeared in person for the Plaintiff Minter Ellison for the First and Second Defendants

HIS HONOUR: The plaintiff, Mrs Sochorova, who was represented by her brother Mr Joseph Moder, claims damages for personal injury resulting from a severe stroke. The stroke left her permanently disabled, requiring full-time care in a nursing home. She suffered the stroke, the so-called second stroke, after her admission to Cairns Hospital for an earlier stroke.

Mr Moder and his sister were reunited after many years of separation in the wake of World War II. They were committed to keeping each other company in the latter stage of their lives. He is clearly devoted to her and obviously aggrieved by her decline, just as she would be. Living in a nursing home in a permanently and severely incapacitated state is an awful way to live out one's twilight years.

It is difficult to avoid the impression that sad, emotionally stressful context has played some contributing role in the pursuit of someone to blame. It is a pursuit seemingly driven by suspicion and misunderstanding, and an apparently dogged unwillingness to accept by far the most obvious explanation for Mrs Sochorova's fate. That explanation is that an 84 year old lady in poor health, and with a history of strokes, suffered a stroke and, within five hours, despite competent emergency care, suffered a further and more severe stroke, with permanent disabling consequences.

Stripped bare, Mr Moder's argument assumes that because emergency care was administered between the first and second strokes it must follow that the emergency care caused the second stroke. It is an illogical assumption without evidentiary support, which also ignores the possibility, most obvious in the elderly, that, despite the best efforts of medical science, life-threatening malfunctions of the body may recur with increasing magnitude.

The question of liability was listed for determination as a separate question and heard over what has been a four-day trial. I deliver my reasons on the fifth day. The only witness for the plaintiff was Mr Moder. He called no medical expert. The challenge in proving a case of this kind without calling a doctor was explained at earlier mentions of this case. Three doctors were called by the defendants; two were treating physicians, the third, Dr Brown, is an expert neurologist who was engaged specifically for the purposes of providing an opinion in this case.

I record, for completeness, that Mrs Sochorova's incapacity would not have prevented her from giving evidence, though, it has to be said, not without considerable difficulty. This was drawn to my attention in closing submissions but I find no need to explore the potential inference arising from the failure to call her, given the state of the evidence, in any event.

The plaintiff alleges two failures in the exercise of the duty of care of the defendants. The first relates to the administration of a procedure called thrombolysis. Thrombolysis involves the administration of drugs into the bloodstream to dissolve blood clots. The plaintiff alleges

the circumstances indicated that thrombolysis ought not be administered. The second failure is an alleged failure to warn of the risks associated with thrombolysis. It is alleged if such a warning

had been given Mr Moder would have disallowed the procedure, thus avoiding the alleged causation of the subsequent second stroke.

Proof of one or the other of those foundations for liability would not, per se, lead to a finding on liability in the plaintiff's favour, for it would remain to consider whether the thrombolysis was causative of the second stroke. Nonetheless, it is clearly a prerequisite to the success of the plaintiff's case, as advanced, that it must be proved thrombolysis was contraindicated or the procedure was not properly explained and its risk warned of. For the reasons which follow, the plaintiff has failed to prove either of the factual foundations for her case on the balance of probabilities. Nor has she proved the thrombolysis caused the second stroke.

Ms Sochorova was 84 years old at the time of her admission to Cairns Base Hospital in the early evening of Sunday the 29th of July 2018. She was in poor health. Ms Sochorova already had a history of suffering strokes. Evidence was given of two previous admissions of her to Cairns Hospital for strokes, in 2013 and 2014 respectively. The first defendant, Dr Durairaj, an eminently well qualified stroke specialist, testified, quite credibly, that Ms Sochorova's medical history and condition, particularly her heart's abnormal rhythm, so-called atrial fibrillation, rendered her at exceedingly high risk of stroke.[1]

One of Ms Sochorova's various complaints described by Mr Moder in his testimony was that she had a heart condition for which she was prescribed anticoagulant drugs. Mr Moder described a history of those drugs apparently causing haematomas and external bleeding in the lower legs from time to time. He explained there were various changes of the medication, apparently in an attempt to manage those problems, which, by implication, derive from the consequence of the blood-thinning or anti-coagulating effect of the drugs.

Mr Moder testified that his sister recovered from the 2013 and 2014 strokes without the administration of any significant procedure during her admissions on those occasions. Mr Moder professes a belief that his sister would have recovered from the stroke which triggered her admission to Cairns Hospital in 2018 if the thrombolysis procedure had not been administered. Indeed, Mr Moder seems to believe that the anticoagulant drugs historically taken by Ms Sochorova had themselves been in some way causative of one or more of her earlier strokes. Such beliefs, however passionately they may be asserted, are lay opinions and not evidence of fact or expert evidence.

Mr Moder testified that in the lead-up to the 2018 admission to Cairns Hospital his sister had, for some time, been on rivaroxaban or apixaban.[2] Whichever it was, it still coincided with some apparent haematomas and lower leg bleeding, but apparently not to an extent which was as bad as that associated with some other anticoagulant medication Ms Sochorova had formerly been prescribed. Three days prior to Ms Sochorova's admission to hospital last year she ceased taking her

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1 T3-55 L23.

2 Compare T1-66 L33 and T1-73 L19.

anticoagulant medication. This was evidently done on the advice of a doctor in preparation for her undergoing a biopsy.

Mr Moder testified that three days later, on 29 July 2018, his sister was "feeling not the best", so they attended upon a general practitioner. She was, at that stage, experiencing some difficulty in walking and he had to help her walk. After the consultation he took her home and sat her up in the kitchen. It was approaching 6.30 pm. He noticed her speech was slowly disappearing, that she was slurring her words and her eyes were closing. He perceived another stroke was coming on and called the ambulance. While he was doing so she slid off a chair. He was unable to lift her back onto the chair again. Despite this, in Mr Moder's view there were no critical problems with her. He testified:

> "She was verbal. She was talking, and she was complaining that she had fell down, all that sort of thing. There was no sign of paralysis; nothing like that. It was very much the same as all the other strokes."

Mr Moder testified that the ambulance officers attended, loaded her onto a trolley and took her to the ambulance and on to hospital. She was admitted, it seems, at about 7.46 pm. Mr Moder followed by vehicle, joining her again in the emergency department at the hospital where he translated for her. Ms Sochorova's first language is Czech. She was not fluent in English but could speak some phrases.

Mr Moder noted at one point during Ms Sochorova's preliminary treatment that a cannula was put in her right hand but it swelled, so it was altered to her left. He described the swelling as unusual, extending as significant swelling between the wrist and elbow. Some days later he noticed an area of apparent black colouration in that part of her arm.

According to Mr Moder, by the time his sister was transferred to the hospital she looked basically normal. He asserted she was able to talk and that there was nothing unusual about her speech except that it was slurred. He also mentioned that she was "a bit dizzy from it all, or weak." His evidence was in contrast to the evidence of the treating physicians, whose evidence I regard as more expert and more reliable on this issue.

Dr Dermedgoglou, a medical registrar who attended upon Ms Sochorova soon after she was admitted, observed there was significant left-side weakness as well a sensory deficit. He enlarged upon that by explaining there was obvious drooping of the left side of her face. He also testified that there was "neglect", meaning she was unable to focus her attention towards one side of her body because of an apparent problem within the brain. He noted there was marked limb weakness in the arm and leg on the left side, where there was also a sensory deficit, in that Ms Sochorova did not sense a sharp touch or soft touch.

The evidence of Dr Durairaj, the hospital's stroke specialist, who was called in, arriving around 8.30 pm, was to similar effect. As he explained, the assessment revealed a National Institute of Health stroke score of 10, indicating this stroke was severe.

It appears Mr Moder either did not understand or has, in hindsight, played down the severity of his sister's condition when she was admitted.

Mr Moder gave evidence in a general sense of observing various medical personnel tending to his sister. As he put it, "They started to investigate and do tests, CT scans, blood tests". Mr Moder noticed that the stroke specialist, Dr Durairaj, arrived, he thought after about an hour. I favour Dr Durairaj's recollection that it was around 8.30 pm. Mr Moder acknowledged he had a conversation with Dr Durairaj, a topic to which I will later return. Mr Moder's recollection is that he left later in the evening at a stage when his sister was still in emergency, but was soon to go, at least so he thought, into an intensive care ward. That seemed to be a misunderstanding, for she was taken to the stroke ward.

He returned the next morning at which stage Ms Sochorova was in bed, conscious but not fully alert. Mr Moder testified it was only on about the third or fourth day, when Ms Sochorova was placed in a wheelchair, that he realised the full severity of the deficit she had suffered. He noticed she was completely collapsed on the left side, unable to bear her weight and that her left arm was seized up against her body. He also discovered her swallowing capacity was impaired. He noted what he described as: "a degree of cognitive damage. That is to say, she had trouble relating to anything that was on the left. It's like it didn't exist." In addition to being unable to sit, stand or walk, he noted she appeared to have hallucinations interspersed with apparently lucid conversation.

The sad upshot is that after being maintained in the hospital for about a month, on Mr Moder's account, she then went into full-time care at a Bupa Aged Care Home. She continues to require significant care, the only material progress having apparently been some slight improvement with her swallowing capacity.

In the aftermath, as a result of his consultations with hospital staff and subsequently his own research, Mr Moder came to allege that a thrombolysis procedure had been improperly administered upon his sister at the hospital. He blames the administration of that procedure for setting in train a course of events, including a subsequent procedure involving the infusion of prothrombinex, a drug administered to reverse anti-coagulant therapy and prevent bleeding. His case theory, as opened, is that the prothrombinex caused a second and major stroke, and that procedure was only made necessary, that is, it was caused by, the fact there had been an improperly administered thrombolysis procedure.

In his closing address, by which time the evidence had showed the second stroke likely occurred prior to the administration of prothrombinex, Mr Moder seemed to shift to alleging the thrombolysis was a more direct cause of the second stroke. The plaintiff's case, in effect, is that had thrombolysis not been administered, Ms Sochorova would have healed largely spontaneously, perhaps assisted by aspirin or other drugs which, according to Mr Moder, is what occurred in respect of her previous strokes which he believes were of similar magnitude to the stroke triggering

her admission on 29 July 2018. None of this theory is well supported by evidence of fact or by medical opinion.

As already explained, Mr Moder's observations of the full extent of his sister's deficits on her admission in July 2018 are inconsistent with the medical evidence on the topic. I accept the medical evidence that Ms Sochorova had actually suffered a severe ischaemic stroke. Ischaemia involves a decreased supply of oxygenated blood, and an ischaemic stroke is associated with deprivation of blood flow to an area of the brain. The immediate and understandable medical concern following Ms Sochorova's admission was to try and avoid further damage to the brain. The best known means of doing so was the administration of thrombolysis.

Dr Durairaj explained Ms Sochorova would have had a clot which likely developed in her heart because of her atrial fibrillation and travelled to and lodged in the brain, blocking a blood vessel. He explained there remained a risk another clot would do likewise. Moreover, as he explained, the existing blockage in the brain would gradually result in the death of the part of the brain near the blockage. That process would be slowed to some extent by blood finding its way via collateral blood vessels, but that temporary remedy of the body may collapse. And, in any event, that would not prevent the area of damage near the blockage from eventually worsening. The doctor explained that thrombolysis was a procedure calculated to dissolve the clot, mitigating further damage, and, hopefully, also dissolving any clot in the heart thus avoiding the risk of further stroke.

Dr Durairaj is highly qualified and experienced. He is plainly well accomplished as a stroke specialist here in Australia, though he began his specialist training and initial practice in the field in the United Kingdom. Of that era he said:

> "I started as a … stroke physician in a University Hospital Aintree … in Liverpool – it's a tertiary centre for stroke. And I worked there till 2015. The last three years I was the Clinical Director of Stroke … As the Clinical Director, apart from clinical duties, I had to manage other consultants, manage the department and try and make sure the effective and safe care of our patients is delivered. Because it was a tertiary hospital, I was covering six other hospitals' stroke care as well. And I also had additional responsibilities. I was a Research Director of the hospital for stroke. As a result, I was heavily engaged in research. I did a lot of clinical trials, many of them that has, as a primary investigator, many of them have shaped the way stroke is being managed now. Particularly IST-3 is one primarily I would like to mention where I was one of the primary investigators which established that thrombolysis above the age of 80 years was safe. And that was published in Lancet in 2012."[3]

He went on to explain that that particular research in which he had been engaged, involved a meta-analysis that has actually been quoted in the expert report of Dr

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[3] T3-49 L47 – T3-50 L17.

Brown. The probability is that Dr Durairaj is as expert in this field as Dr Brown, perhaps more so.

Dr Durairaj appraised, after what I find was proper and professional inquiry, that it was safe to administer thrombolysis to Ms Sochorova. That included consultation with Mr Moder and Ms Sochorova to which I will return. It also included a CT scan taken at around 8.27 pm, which showed pre-existing ischaemic changes consistent with the occurrence of a past stroke or strokes. The real significance of that scan in the present context is that it revealed no bleeding. Such bleeding would have been a contra-indicator to the administration of thrombolysis. Blood testing also carried on Ms Sochorova, including testing of her clotting parameters, did not reveal any particular abnormality or suggest an increased risk of bleeding.

The administration of thrombolysis commenced with the administration of a thrombolytic agent called alteplase by a weight-adjusted bolus at 9.24 pm with subsequent infusions of alteplase occurring in the ensuing hour. The procedure was thus commenced just under three hours after the onset of symptoms. On the completion of the infusion constituting the thrombolysis procedure, Ms Sochorova was transferred to the acute stroke unit at the hospital and frequently monitored. There was an initial improvement of her symptoms noted, but in the half hour or so leading to midnight it was noticed she was deteriorating clinically. A CT scan was urgently performed at 4 past midnight. It only showed a small region of asymptomatic bleeding in the high medial left parietal lobe within the left sensory strip.

However, it was apparent from Ms Sochorova's clinically observed deterioration that she had suffered a second stroke. I accept the evidence of Dr Durairaj and Dr Brown that the second stroke coincided with Ms Sochorova's deterioration between about 11.30 and midnight. A follow-up CT scan about 14 and a-half hours later at 2.31 pm on 1 August 2018 showed new ischaemic changes in the region of the right internal capsule. This does not mean stroke was not occurring in those regions back as at the time I have referred to, around the midnight hour, for it was explained in evidence that it does take time for damage of this kind to show up in, or be revealed by, CT scans.

An MRI brain scan on 10 August 2018 revealed numerous scattered infarcts, that is, tissue death caused by inadequate oxygenated blood supply. These infarcts were scattered through Ms Sochorova's right MCA territory, consistent with strokes, and they included the region of the right internal capsule earlier referred to.

Dr Brown opined the small region of bleeding which Ms Sochorova developed following administration of intravenous thrombolysis in her left mesial parietal region did not cause her deterioration overnight on 29 and 30 July 2018. That is because the site of the small bleed does not anatomically co-relate with the location of her symptoms of a left-sided weakness and neglect. This is a point of importance, because the bleed to the left of the brain might have resulted from the thrombolysis but it is not on the side of the brain where the injury causing damage happened. It is the multiple regions of stroke detected to her right middle cerebral artery territory, as

revealed by the MRI brain scan of 10 August, that accounted for her physical deficits, which were left-sided. Damage on one side of the brain is reflected in deficit to the opposite side of the body.

Dr Brown opines the second stroke, or what she called a shower of strokes, was likely due to Ms Sochorova's underlying cardiac condition, in addition to her other numerous vascular risk features. In short, the site of the small bleed was clinically asymptomatic and cannot explain the physical deficits which onset before midnight on 29 July.

The upshot of Dr Brown's and Dr Duriraj's opinions, which I accept, is that the progression of Ms Sochorova's serious deficits resulted from her stroke symptoms progressing despite, not because of, the administration of thrombolysis. Dr Brown posits, and I find, that the thrombolysis was likely initially successful but, subsequent to its completion, there ensued a second stroke. The prothrombinex was not commenced until 1 am, by which time the second stroke had occurred. It is not to blame either.

Dr Brown's uncontradicted opinion is well supported by the known evidence and uncontradicted by other expert evidence. The foundations for it have been adequately proved. It is, of course, conceivable that the asymptomatic bleed in the left mesial parietal region was a result of the administration of thrombolysis. But the difficulty for the plaintiff's case is that her ensuing deterioration could not be connected with that and had to be a consequence of the second stroke, effectively multiple strokes, that ensued in the area of the right middle cerebral artery territory. There is no evidence that the thrombolysis procedure or, indeed, the administration of prothrombinex caused those strokes.

That conclusion dispenses with the prospect of any causal connection between the administration of thrombolysis and Ms Sochorova's subsequent stroke or strokes. In other words, even if thrombolysis was contraindicated the fact that the procedure was undertaken was not causative, directly or indirectly, of the injury the subject of the present claim. Further to that fatal difficulty for this component of the plaintiff's case, the plaintiff has also failed to establish, on the balance of probabilities, that thrombolysis was, in any event, contraindicated.

Mr Moder obviously has read widely on the internet about contraindications for thrombolysis. He attempted to tender a very wide variety of documents he had downloaded from the internet. I need not reiterate my reasons for rejecting most of them. It is illustrative of the maxim, "A little knowledge is a dangerous thing", that in respect of one document, which I did admit as an exhibit, expressing hesitation as to whether it would apply to a clinical case of this kind, it later emerged that, indeed, it did not apply to a case of this kind and, rather, related to someone having a heart attack.

It is apparent from Mr Moder's opening of the plaintiff's case and, indeed, his arguments in support of his tendering of those various internet documents, that he

asserts the existence of the following relevant contraindications, namely that thrombolysis is contraindicated for:

(1) patients over 80 years of age,
(2) patients with susceptibility to bleeding, particularly in the form of allergy to anticoagulants,
(3) patients who have experienced mild self-healing strokes in the past and,
(4) patients who have experienced previous strokes.[4]

The second defendant's own acute ischaemic stroke thrombolysis protocol, exhibit 1, contains a list of inclusion criteria as follows:

> "Clinical diagnosis of acute ischaemic stroke causing a measurable neurological deficit (must be more than minimal);
>
> Aged 18 years or more (use with caution if over 80 years);
>
> Onset of ischaemic stroke within 4.5 hours of initiating treatment;
>
> Non-contrast brain CT excludes haemorrhage."

It is clear on the evidence that Ms Sochorova satisfied each of those criteria. It is noteworthy, of course, that she was over 80 years old and the inclusion criteria calls for the use of caution if the patient is over 80 years old. It does not follow the defendants were precluded from administering thrombolysis by reason of Ms Sochorova's age. Rather, the fact of her age called for additional caution in deciding whether to administer the procedure. It is apparent from the evidence that Dr Durairaj was well aware of Ms Sochorova's age and the need for caution and deciding, in light of it, whether to administer the procedure.

He explained at length that old age was once regarded as a contraindication but no more, for further testing has established that the procedure can be safely administered to persons over 80.

The acute ischaemic stroke thrombolysis protocol also lists various items as part of an exclusion criteria. It includes the following:

> "Any intracranial surgery, serious head trauma or previous stroke within three months; …
>
> History of bleeding disorder;
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> Any other condition that would constitute a bleeding hazard; …
>
> If presenting at >3 hours, caution if both previous stroke AND diabetes; …

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[4] Compare paragraph 10.1 of the amended statement of claim and the opening at T1-10 to 11.

Evidence of active bleeding or acute trauma (e.g. fracture)."

There is no evidence of Ms Sochorova experiencing a previous stroke within three months prior to the stroke occasioning her admission. The procedure was administered within three hours, so considerations about presentation at greater than the three-hour mark were not to the point. There was no evidence of active bleeding or acute trauma, a topic to which I will return.

Far from there being any other condition that would constitute a bleeding hazard, it is apparent that the anti-clotting drug she had been taking she had ceased taking three days earlier. I highlight this because it appears Mr Moder perceives the fact that his sister used to haemorrhage easily, and occasionally bleed from her legs as a result of the medication she had been on, itself constitutes what is meant in the protocol as being a history of bleeding disorder, or a condition that would constitute a bleeding hazard. However, as was explained by Dr Durairaj, such exclusion criteria relate to an actual disorder of the body likely to cause bleeding as distinct from the body's reaction to a drug which, in any event, Ms Sochorova had ceased taking. The uncontradicted medical evidence is that the residual effects of that drug would have passed well prior to her admission to hospital.

Dr Durairaj also explained the fact Ms Sochorova had some bruising to her back, and had the adverse reaction to the cannula insertion, were not indicators of a disorder or condition of the kind meant by the protocol. That subsequent to the events of 29 into 30 July, Mr Moder noticed other bruising, is an aspect unconnected with Ms Sochorova's state, and the presence or absence of contraindications at the time the thrombolysis was administered. I accept Dr Durairaj's evidence, which is well supported by the expert evidence of Dr Brown, that thrombolysis was not contraindicated by any of the exclusion criteria.

It is difficult to avoid the conclusion that Mr Moder, a lay person, who has endeavoured to self-educate himself about thrombolysis and its contraindications, has tended to see what he wants to see in order to prove his hypothesis, unaided by the absence of medical expertise. There was, of course, the medical expertise proffered by the defendants but Mr Moder was evidently not disposed to accept the evidence of experts in preference to what he could learn from the internet.

I turn to the other foundation for liability: the alleged failure to warn and give consent. As to the former see s 21 *Civil Liability Act* 2013. As to the topic of absence of consent, I will not dwell on the point that it would be pertinent to an action in trespass or battery rather than an action of the present kind. I do not need to do so, because, in any event, my factual findings exclude it as an issue of concern. Indeed, I only turn to this foundation for liability as an academic exercise, because my finding that the administration of thrombolysis played no causal role in Mrs Sochorova's personal injury the subject of this suit makes it irrelevant, for the purpose of this action, whether or not the alleged failure to warn or procure consent occurred.

It did not bode well for the proof of this foundation that, in Mr Moder's evidence, he acknowledged having been spoken to by Dr Durairaj at a time which, even on Mr Moder's account, was before the commencement of the thrombolysis. His own apparent recollection of the conversation is that Dr Durairaj was very keen to know when the stroke commenced, such information being important to them because they were trying to alleviate the symptoms of the stroke.

According to Mr Moder, nothing at all was said about any kind of thrombolysis or anti-clotting agents being injected. The adamance of that assertion seemed less compelling in hindsight when, in cross-examination, a variety of matters were put to Mr Moder about the substance of the conversation and he was then unable to recall one way or the other whether they had been said. While Mr Moder ultimately denied that proposed treatment and risks were discussed with him and his sister, I was left with the distinct impression by the time the cross-examination gradually arrived at that point[5] that there were likely many things that had been said in the course of the conversation that Mr Moder could not recall.

Illustrating my point, when being pressed about his recollection of particular things being said during this conversation, Mr Moder at one stage testified:

> "If I don't know, I don't know. It was, as I said – it was a busy time. Lots of things were going on, and you're asking me, "Did he specifically ask you this? Did he specifically ask you that?". All I can remember was the emphasis on time of the stroke and that they're trying to alleviate her problems."[6]

I highlight this as no criticism of Mr Moder. He was in a stressful situation. The difficulty is that Dr Durairaj and Dr Dermedgoglou have provided evidence that the nature and risks of the thrombolysis procedure were explained to Mr Moder and his sister, and they consented to the procedure. Their evidence was credible and I accept it as reliable.

It is true there are some aspects of the medical records which are not helpful to the defendants' position on this topic. For example, the second page of the Acute Ischaemic Stroke Thrombolysis Protocol contains a number of entries, including:

> "Discuss benefits and risks with patient and/or family.
>
> Obtain verbal consent and document in patient record."

Against those propositions there is space for the time of those events to be noted and initialled. However, those entries, along, indeed, with all of the entries in that particular part of the document, have not been completed. It is obvious from the state of the document that there are actually a number of other sections that have not been completed either.

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5 See T2-32 to 43.
6 T2-43 LL10-14.

It does not follow from that fact that the relevant events did not occur. I readily accept that, while in an ideal world such documents should be completed in full, and such completion would avoid giving oxygen to suspicion, it can happen in busy circumstances that the priority given to the actual performance of tasks exceeds the priority given to the task of recording every last one of them. That said, the process of obtaining verbal consent and documenting it in the patient record is a process going beyond the mere notation of a time or initial in the protocol document. The reference to the patient record is, on the evidence, a reference to progress notes maintained, in the present day and age, on computer.

Dr Dermedgoglou recorded a progress note which was electronically signed at 10.57 pm on the night of 29 July 2018. That progress note records various aspects of the investigation and treatment of Ms Sochorova, and, relevantly, includes the following:

> "Risks and benefits explained at bedside by Dr Durairaj to Terezie and her brother, who is next of kin
>
> - Explained the risk of haemorrhage as main complication
> - Explained that the administration of thrombolysis may cause clot lysis and reduce disability related to this acute stroke."

(See exhibit 2 and exhibit 8, exhibit 8 being the more complete record.)

Mr Moder seized in cross-examination on the fact that, in these progress notes, there appeared to be an identical entry to that referred to above, attributable to a registered nurse called Charlotte Beard. That note was not electronically signed off on. Dr Dermedgoglou explained that was because he had actually made the note in the computer at a time when, unbeknownst to him, the relevant field had been opened by Ms Beard. Not realising that, he did not log out of that field and create his own, at least until some time later, when he realised the error. It is apparent from the progress notes that this must have been at 9.51 pm, the so-called "service date/time". The corresponding time recorded in the field pertaining to Charlotte Beard was 9.16 pm. The progress notes made by Dr Dermedgoglou in his correct field were electronically signed off at 10.57 pm. This is materially before it was discovered that there was a deterioration in Ms Sochorova's condition, subsequent to the administration of thrombolysis.

In light of that chronology, and in light of my own impression of the doctor's evidence, I am quite satisfied that the progress note quoted by me is not some after the event concoction and, rather, reflects the truth of what occurred. I appreciate that note does not expressly record the fact consent was given, but it is, after all, a summary.

Quite apart from my acceptance of the testimony of Dr Durairaj and Dr Dermedgoglou that the risks and benefits of the procedure were explained and that consent was given, I note the inherent implausibility of Dr Durairaj having had a conversation with Mr Moder and Ms Sochorova prior to the administration of thrombolysis but not discussing the procedure with them.

Furthermore, it is inherently implausible that such a discussion would not have involved explanation of the procedure and its risks and would not have culminated in consent being given. It is very obvious Mr Moder had a determinative influence as to his sister's care at that time. It is simply inconceivable he would have refused the treatment recommended by the medical professionals. Emblematic of the kind of thinking he would have engaged in is this answer given to questioning about his acquiescence to other medications administered to her in the past which caused problems for her:

> "I couldn't go against the doctors. I mean, when you are – you have a problem and you go to the doctors and the doctors prescribe something you do it."[7]

I accept Dr Durairaj and Dr Dermedgoglou's evidence on this issue, and I reject the plaintiff's allegation that thrombolysis was administered without consent and without warning associated with it. The reality, about which Mr Moder should feel no guilt, is that he did his best by his sister in agreeing to a procedure which this case has now shown was not, in any event, the cause of her presently sad state.

It follows, in light of all of these reasons, that neither of the critical foundations for the plaintiff's case, or the element of causation have been proved, and the claim must fail.

The claim should be dismissed. My order is:

(1) Claim dismissed.

I will hear the parties as to costs.

(Argument and reasons as to costs ensued)

I further order:

(2) The plaintiff will pay the defendants' costs to be assessed on the standard basis if not agreed.

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[7] T2-35 LL24-27.