SUPREME COURT OF QUEENSLAND

CITATION:	*Sochorova v Durairaj & Anor* [2020] QCA 158
PARTIES:	**TEREZIE SOCHOROVA** (appellant) **v** **DR RAMESH DURAIRAJ** (first respondent) **CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE** (second respondent)
FILE NO/S:	Appeal No 11923 of 2019 SC No 623 of 2018
DIVISION:	Court of Appeal
PROCEEDING:	General Civil Appeal
ORIGINATING COURT:	Supreme Court at Cairns – [2019] QSC 251 (Henry J)
DELIVERED ON:	28 July 2020
DELIVERED AT:	Brisbane
HEARING DATE:	Heard on the papers
JUDGES:	Sofronoff P and Boddice and Davis JJ
ORDERS:	**1. The application to adduce further evidence is refused.** **2. The appeal is dismissed.** **3. The appellant pay the respondents' costs of the appeal.**
CATCHWORDS:	TORTS – NEGLIGENCE – STANDARD OF CARE, SCOPE OF DUTY AND SUBSEQUENT BREACH – where the appellant suffered a stroke and, while in the Cairns Base Hospital receiving treatment, she suffered a further stroke – where the appellant claims damages against the operator of the hospital and the principal treating doctor – where the appellant submits that the further strokes were caused by the respondents administering thrombolysis – whether it was negligent of the respondents to administer the treatments – whether it was correct for the trial judge to conclude that the treatments administered to the appellant were appropriate TORTS – NEGLIGENCE – DAMAGE AND CAUSATION – CAUSATION – where the appellant suffered a stroke and, while in the Cairns Base Hospital receiving treatment, she suffered a further stroke – where the appellant claims damages against the operator of the hospital and the principal

treating doctor – where the appellant submits that the further strokes were caused by the respondents administering thrombolysis – whether the treatments caused the further strokes which damaged the right side of the appellant's brain and caused significant disabilities – whether it was correct for the trial judge to conclude that the treatments did not cause the appellant's additional strokes

Civil Liability Act 2003 (Qld), s 21
Evidence Act 1995 (NSW), s 79
Uniform Civil Procedure Rules 1999 (Qld), r 427, r 681

Abalos v Australian Postal Commission (1990) 171 CLR 167; [1990] HCA 47, cited
Clark v Ryan (1960) 103 CLR 486; [1960] HCA 42, cited
Devries v Australian National Railways Commission (1993) 177 CLR 472; [1993] HCA 78, cited
Fox v Percy (2003) 214 CLR 118; [2003] HCA 22, cited
Honeysett v The Queen (2014) 253 CLR 122; [2014] HCA 29, cited
Hull Pty Ltd v Thompson [2001] NSWCA 359, cited
Jones v Dunkel (1959) 101 CLR 298; [1959] HCA 8, cited
Jones v Hyde (1989) 63 ALJR 349; [1989] HCA 20, cited
Murphy v The Queen (1989) 167 CLR 94; [1989] HCA 28, cited
R v Bailey (1977) 66 Cr App R 31, cited
R v De Voss [1995] QCA 518, cited
R v Hall (1988) 36 A Crim R 368, cited
R v Matheson [1958] 2 All ER 87, cited
R v Morgan; Ex parte Attorney-General [1987] 2 Qd R 627, cited
R v Tumanako (1992) 64 A Crim R 149, cited
Taylor v The Queen (1978) 45 FLR 343, cited
Walton v The Queen [1978] AC 788; [1977] UKPC 16, cited
Warren v Coombes (1979) 142 CLR 531; [1979] HCA 9, cited

COUNSEL: J Moder (the brother and holder of power of attorney of the appellant) for the appellant
M Hickey for the first and second respondents

SOLICITORS: J Moder (the brother and holder of power of attorney of the appellant) for the appellant
Minter Ellison for the first and second respondents

[1] **SOFRONOFF P:** I agree with Davis J.

[2] **BODDICE J:** The comprehensive summaries of evidence and relevant principles in the reasons for judgment of Davis J, which I gratefully adopt, allow me to shortly state my reasons for agreeing with the conclusions and orders of Davis J.

[3] A real review of the evidence and of the trial Judge's reasons for judgment supports a conclusion that the treatment administered to the appellant was appropriate. Further, that treatment did not cause the appellant's additional strokes.

[4] The findings of fact made by the trial Judge were consistent with the evidence accepted at trial. None of those findings of fact were wrong or contrary to the available inferences.

[5] The identified further evidence, for the reasons given by Davis J, has no prospect of altering that result.

[6] As no error of fact or law has been established, the appeal must be dismissed.

[7] I agree with the orders proposed by Davis J.

[8] **DAVIS J:** The appellant suffered a stroke on 29 July 2018 and, while in the Cairns Base Hospital receiving treatment, she suffered further strokes and was left significantly disabled. She sued the operator of the hospital, the Cairns & Hinterland Hospital and Health Service, and Dr Ramesh Durairaj, who was her principal treating doctor in the hospital.

[9] Henry J ordered that the issue of liability of the respondents to the appellant be tried as a separate issue to the quantification of any damages. After a trial in Cairns in September 2019, Henry J dismissed the appellant's claim.

[10] The appellant appealed against those orders and seeks leave to adduce further evidence. The parties have agreed that the appeal be determined on the papers without an oral hearing. Extensive written submissions have been received.

Non-contentious history

[11] The appellant was 84 years of age in July 2018. She was then in poor health having suffered a number of strokes.

[12] About 6.30 pm on 29 July 2018, the appellant's brother, Mr Joseph Moder, noticed that she was exhibiting physical signs of suffering a stroke. He took her to the hospital. She was admitted at 7.46 pm.

[13] Doctor Dermedgoglou is a medical registrar who examined the appellant soon after her admission. He diagnosed her as experiencing a stroke. Doctor Durairaj, the first respondent, was the hospital stroke specialist. He examined the appellant at about 8.30 pm.

[14] Various tests and investigations were undertaken and Dr Durairaj diagnosed the appellant as suffering from a severe stroke. He administered a treatment procedure called "thrombolysis". That procedure is designed to dissolve the blood clots which cause strokes. Later, prothrombinex was administered to the appellant. That is a drug which reverses anti-coagulant therapy and is designed to prevent bleeding.

[15] After the thrombolysis was administered, the appellant showed improvement but then declined. After the performance of the thrombolysis treatment but probably before the appellant was transfused with prothrombinex, she suffered further strokes and was left quite severely disabled. She now resides in a nursing home and requires significant care.

The trial

[16] Mr Moder, who has no legal qualifications, was permitted to represent the appellant at the trial.

[17] The case put by Mr Moder on the appellant's behalf did vary as the evidence progressed. Central to the appellant's case was that the treatment administered in the hospital caused the severe injuries ultimately suffered by the appellant. He argued:

1. It was negligent to administer the thrombolysis treatment.
2. It was negligent to administer the prothrombinex.
3. Either the thrombolysis or the prothrombinex caused the further strokes.
4. But for the treatments, the appellant would not have suffered the further strokes.[1]

[18] Further bases of liability were put, namely:

1. The respondents did not properly warn the appellant of the risk of the treatments being administered.
2. The appellant did not consent to the treatments.

[19] The appellant did not give evidence. It seems that she was capable of giving evidence but Mr Moder did not call her. Under the rules of evidence, it would have been possible for his Honour to have inferred that the reason why the appellant chose not to give evidence was that the evidence she might have given would have harmed her case,[2] but his Honour did not do that.[3]

[20] Mr Moder gave evidence of various things, including:

1. The appellant's health prior to 29 July 2018.
2. The events of 29 July 2018.
3. His understanding, obtained from his own research, mainly from materials obtained from the internet, as to the medical cause of the further strokes.

[21] No expert evidence was called by Mr Moder. Based on the knowledge he had gained through his research, he argued that because of recognised contraindications to the administration of thrombolysis to the appellant, thrombolysis should not have been administered. This caused a stroke and the necessity, in the opinion of the doctors, to infuse prothrombinex to stop bleeding and that caused the final, badly debilitating strokes.[4] In his closing address, Mr Moder submitted that it was the thrombolysis that caused the further strokes, perhaps independently of the transfusion of prothrombinex. This exchanged occurred:

> "MR MODER: Well, he referred - he simply referred to the ones in the protocol. He didn't refer to the prevailing other contra-indications. And there's quite a number of them. A lot of them don't necessarily are relevant to the plaintiffs case, but some of them are. And the ones that are have not been taken into account. Now, in that regard, it means that the medical team proceeded without fully

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1 Appeal Record Book ("ARB"), p 314-319; T 1-9 to T 1-14.
2 *Jones v Dunkel* (1959) 101 CLR 298.
3 *Sochorova v Durairaj & Anor* [2019] QSC 251, 2.
4 ARB, p 377; T 1-72 and following.

> complying with their requirements to address these contra-indications. In that case, they are not complying with their duty of care. Actually, the defendant's duty of care. Because the defendant's duty of care is to not to or do everything they can to prevent any injury to the patient.
>
> Now, that is a big hole in the whole process in the hospital and with the doctors: they did not follow the procedures as they should have. And that's the start and finish of it. Once the decision was made to implement the thrombolysis without taking into account all those things, the die was cast. All the other things that happened after that were simply a consequence of that first decision: the bleed and - what the - the prothrombinex - everything else after that was a consequence of that decision. And it is - - -
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> HIS HONOUR: As I understood your opening, you say it's the prothrombinex that actually was causative of the strokes - the second stroke. That's how you opened the case. Are you changing your case?
>
> MR MODER: Well, that's doubtful. We don't - we're not saying that the stroke was caused by either the - exclusively by bleeding or by clotting. That's very difficult to establish, even with all the experts. I mean, you're talking about being - the plaintiff being subjected to two conflicting drugs - medications. What that does to a person in terms of - I don't think even God could know."[5]

[22] The defendants called three doctors to give evidence: Dr Durairaj, Dr Dermedgoglou and Dr Brown. Dr Durairaj and Dr Dermedgoglou gave evidence of their observations, diagnoses and actions in treating the appellant. Doctor Brown was called as an expert on the treatment of stroke victims.

[23] Doctor Durairaj was called as a witness of the events in the hospital. He was not called as an expert and did not provide a report.[6] He gave evidence as to the clinical decisions which he made when treating the appellant and that evidence inevitably involved his expert opinion as to the condition being suffered by the appellant, how that progressed while she was in the hospital, what the appropriate treatment was, how that treatment was or was not effective, etc.

[24] Having heard and seen Dr Durairaj give evidence, his Honour accepted him as a reliable and honest witness. His Honour said:

> "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:
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> > '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

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5 ARB, p 688; T 4-13.

6 *Uniform Civil Procedure Rules* 1999, r 427.

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

[25] Both Doctors Brown and Durairaj gave evidence the effect of which was:

1. It was appropriate to administer thrombolysis.
2. Thrombolysis did not cause the further strokes.
3. The further strokes had occurred by the time the appellant was infused with prothrombinex.
4. The infusion of prothrombinex did not cause damage to the appellant.

[26] The alleged failure to warn the appellant of the possible ramifications of the medical treatment raises s 21 of the *Civil Liability Act* 2003 which provides:

> "**21 Proactive and reactive duty of doctor to warn of risk**
>
> (1) A doctor does not breach a duty owed to a patient to warn of risk, before the patient undergoes any medical treatment (or at the time of being given medical advice) that will involve a risk of personal injury to the patient, unless the doctor at that time fails to give or arrange to be given to the patient the following information about the risk—
>
> (a) information that a reasonable person in the patient's position would, in the circumstances, require to enable the person to make a reasonably informed decision about whether to undergo the treatment or follow the advice;
>
> (b) information that the doctor knows or ought reasonably to know the patient wants to be given before making the decision about whether to undergo the treatment or follow the advice.
>
> (2) In this section—
>
> ***patient***, when used in a context of giving or being given information, includes a person who has the responsibility for making a decision about the medical

> treatment to be undergone by a patient if the patient is under a legal disability.
>
> *Example—*
>
> the responsibility a parent has for an infant child"

[27] Mr Moder gave evidence that the risks were not explained and the appellant did not consent to the treatment. Doctors Durairaj and Dermedgoglou gave evidence that they explained the treatment to both the appellant and Mr Moder and obtained consent.

The judgment

[28] His Honour accepted the expert evidence of Dr Brown, supported by Dr Durairaj, that the treatment was appropriate.[7]

[29] The evidence of Dr Brown supported the evidence of Dr Durairaj that the thrombolysis did not cause the further strokes.[8]

[30] His Honour found the further strokes had occurred before the transfusion of the prothrombinex and therefore concluded that the prothrombinex did not cause the further strokes.[9]

[31] His Honour then concluded that if the appellant had not proved a causal connection between the treatment and her injuries, then even if a lack of consent to the treatment was established, that would not visit liability upon the respondents.[10]

[32] In any event, his Honour preferred the evidence of Doctors Durairaj and Dermedgoglou to the evidence of Mr Moder and found that the treatment had been explained and the appellant had consented to the treatments.[11]

[33] Based on those findings, his Honour dismissed the claim.[12]

The appeal

[34] The appellant seeks orders as follows:

> "1. the appellant was caused a major ischaemic stroke by the post-thrombolysis infusion of a prothrombinex blood clotting agent at the Cairns Base Hospital on 29 July 2018.
>
> 2. The respondents are liable for the personal injuries caused the appellant by the post-thrombolysis infusion of a prothrombinex blood clotting agent at the Cairns Base Hospital on 29 July 2018.
>
> 3. The respondent pay all costs of the proceedings."

[35] In her outline of argument, she raises various arguments against factual findings made at the trial.

[36] There is no submission that his Honour made any error of law. The appeal is against factual findings which were based on uncontradicted expert evidence.

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7 *Sochorova v Durairaj & Anor* [2019] QSC 251 at 10.
8 At 7-8.
9 At 8.
10 At 8.
11 At 12.
12 At 13.

[37] An expert may give opinion evidence as an exception to the general rule that opinion evidence is not admissible. An expert's evidence is admissible where there is a field of specialised knowledge, the expert witness is an expert in the field and the opinion is based on the expertise.[13]

[38] A corollary to the requirement that the opinion must be based on specialised knowledge is the principle that if the evidence is within the common knowledge of persons, the evidence ought to be excluded as evidence which is not expert opinion.[14]

[39] It necessarily follows that if there is evidence of an expert, which is by definition about matters beyond the common knowledge of persons not trained in the relevant field, there must be some rational basis for a tribunal of fact to reject it.[15]

[40] Here, Doctors Brown and Durairaj were well qualified. They had access to good primary evidence upon which to form their opinions. Various investigations of the appellant's condition were undertaken, including brain scans. No expert contradicted the opinions of Doctors Brown and Durairaj.

[41] The learned primary Judge had the opportunity to assess the doctors giving evidence and being cross-examined and he accepted their evidence. A court of appeal conducting an appeal by way of rehearing must consider the evidence itself and draw its own inferences[16] but must also recognise the advantage enjoyed by the trial Judge in seeing and hearing the witnesses.[17]

[42] There are various factual errors said by the appellant to have been made by the primary Judge.

There were contraindications to administering thrombolysis

[43] Mr Moder submitted that there were contraindications for the administration of thrombolysis but the contraindications were neither assessed nor acted upon by the doctors at the hospital.

[44] The hospital had developed a protocol for the use of thrombolysis. Both Doctors Durairaj and Dermedgoglou were familiar with the protocol.[18] A copy of the protocol is used to record information as to the examination and treatment of a stroke victim. The form relating to the appellant was before his Honour.[19] Doctor Durairaj explained that he had looked at the blood tests and CT scan before recommending thrombolysis. He also gave evidence that he worked through the

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13 *Clark v Ryan* (1960) 103 CLR 486.

14 *Honeysett v The Queen* (2014) 253 CLR 122 at 131, [23], which considered the statutory formulation of the rule in s 79(1) of the *Evidence Act* 1995 (NSW). See also *Murphy v The Queen* (1989) 167 CLR 94 at 111-113, 120-122, 125-127 and 129-131.

15 This has arisen in criminal cases, see *R v Matheson* [1958] 2 All ER 87; *R v Hall* (1988) 36 A Crim R 368; *R v Morgan; Ex parte Attorney-General* [1987] 2 Qd R 627; *R v Tumanako* (1992) 64 A Crim R 149; *R v De Voss* [1995] QCA 518; *R v Bailey* (1977) 66 Cr App R 31; *Walton v The Queen* [1978] AC 788. Cross-examination may justify the rejection, see *Hull Pty Ltd v Thompson* [2001] NSWCA 359 at [21], *Taylor v The Queen* (1978) 45 FLR 343.

16 *Warren v Coombes* (1979) 142 CLR 531 at 551.

17 *Jones v Hyde* (1989) 63 ALJR 349 at 351-352, *Abalos v Australian Postal Commission* (1990) 171 CLR 167 at 179, *Devries v Australian National Railways Commission* (1993) 177 CLR 472 at 479 and 480-483 and *Fox v Percy* (2003) 214 CLR 118 at 126-129, [25]-[30].

18 ARB, p 469; T 2-66; and ARB, p 550 and following from T 3-57.

19 ARB, pp 226-231; Exhibit 1.

protocol[20] including turning his mind to contraindications such as the appellant's age and alleged bleeding issues.[21] He assessed the appellant as appropriate for thrombolysis.[22] That decision was supported by the expert evidence of Dr Brown.[23]

[45] His Honour found:

> "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."

[46] It was, in my view, open to the learned primary Judge to accept the evidence of the two doctors. The evidence was cogent, not contradicted by any other evidence, and his Honour did not err by accepting it.

The respondents failed to warn the appellant of risks and obtain consent

[47] Mr Moder gave evidence that there was no explanation of risk nor the giving of consent to the procedures. There were undoubtedly conversations between Mr Moder and the appellant on the one hand and the doctors on the other. Mr Moder, under cross-examination, said he could not recall all of the conversations.[24] Doctors Durairaj and Dermedgoglou both gave evidence that they explained the procedures and the risks and obtained consent.[25] The appellant sought to cast doubt on this evidence by reference to two documents. Firstly, the protocol did not record the giving of advice and obtaining consent and secondly, it was suggested that a note made by Dr Dermedgoglou was not made contemporaneously but was made after the event.

[48] The protocol is a proforma document which is to be completed during the treatment of the patient. Various steps that must be taken are specified and then there is a column where the doctor will tick "yes" or "no" depending upon whether the step was completed.

[49] The form contains the following:

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

[50] Neither are ticked either "yes" or "no".

[51] There is a note which appears twice in the progress notes. The note is:

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20 ARB, p 559; T 3-66.
21 ARB, p 556; T 3-63.
22 ARB, p 560; T 3-67.
23 ARB, pp 248-250; Exhibit 33.
24 ARB, p 435; T 2-32 and ARB, pp 439-440; T 2-36 to T 2-37.
25 ARB, pp 474-476; T 2-71 to T 2-73 and ARB, pp 562-563; T 3-69 to T 3-70.

> "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 administration of thrombolysis may cause clot lysis and reduce disability related to this acute stroke"[26]

[52] Mr Moder submitted that this raised suspicion as to the making of the note. The two entries are about an hour and a half apart.

[53] Doctor Dermedgoglou explained in his evidence[27] that while the first note is made under the name of a nurse, Charlotte Beard, it was in fact made by him. She had not logged off on the computer and he made the entry. At a later time, he remade the entry.

[54] His Honour made detailed findings about this evidence:

> "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:
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> > '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.
>
> 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:
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> > '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

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26 ARB, pp 232-233; Exhibit 2; ARB, p 270; Exhibit 8.

27 ARB, pp 518-526; T 3-25 to T 33.

- 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."[28]

[55] The findings are supported by the evidence and his Honour's assessment of the witnesses. The explanation for the apparent discrepancies in the protocol form and the progress notes is logical and credible. It is logical to accept Dr Durairaj's evidence of conversations at the hospital over Mr Moder's evidence when Mr Moder accepted that he could not recall all conversations. No error is identified in his Honour's findings on this issue.

Bleeding was caused by the thrombolysis

[56] Mr Moder submits that bleeding in the appellant's brain was caused by the thrombolysis and that in turn caused the further strokes.

[57] After the thrombolysis was administered, the appellant did suffer a bleed in the left mesial parietal region of her brain. It was the right side of her brain where the appellant suffered the stroke which permanently disabled her. Mr Moder submits that:

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28 *Sochorova v Durairaj & Anor* [2019] QSC 251 at 10-12.

> "1) Bleeding the brain is least likely to occur in the absence of thrombolysis.
>
> 2) Bleeding in the brain is most likely to occur during a thrombolysis infusion because thrombolysis carries a risk of causing just such bleeds."

[58] The evidence does not support that submission. Doctor Brown, in her report:

> "The small region of bleeding that Ms Sochorova developed following administration of intravenous thrombolysis in her left mesial parietal region did not cause her deterioration overnight on 29-30 July 2018 as the site of the small blood does not anatomically correlate with her symptoms of left sided weakness and neglect. This small region of blood appeared to be clinically asymptomatic and it was the multiple regions of ischaemic stroke that she suffered, predominantly throughout her right middle cerebral artery territory, as shown on her MRI brain scan on 10/8/2018 that accounted for her physical deficits. These multiple embolic strokes were likely due to her underlying cardiac condition in addition to her other numerous vascular risk factors (age > 60, hypertension, dyslipidaemia, smoking history, temporary cessation of anti-coagulation, known vascular disease including prior strokes, TIA and peripheral vascular disease)."[29]

And:

> "Despite optimal therapy with intravenous thrombolysis, her stroke symptoms progressed; this can be seen over the first 24 hours post stroke as the patient's collateral circulation is unable to continue to perfuse the 'at risk' region of ischaemic penumbra and the symptoms worsen as the brain's collateral blood supply fails. In addition in this lady's case given her MRI brain scan on 10/8/2018 showed that she suffered a shower of multiple ischaemic strokes within her right middle cerebral artery territory, it may well have been that the thrombolysis was initially successful and unfortunately she had a shower of embolic strokes following thrombolysis resulting in further stroke. At the time of her deterioration, no further intervention was possible given the small region of bleeding she had sustained in her left mesial parietal area and she had been treated with thrombolysis only a few hours earlier."[30]

[59] Doctor Brown was cross-examined on this topic and maintained her opinions.[31]

[60] Doctor Durairaj gave evidence which supported the opinions of Dr Brown.[32]

[61] His Honour found:

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29 Exhibit 7; ARB, pp 248-252.
30 ARB, p 253.
31 ARB, pp 655-656; T 4-80 to T 4-81.
32 ARB, pp 567-568; T 3-74 to T 3-75; ARB, pp 590-591; T 4-15 to T 4-16 and ARB, pp 593-594; T 4-18 to T 4-19.

> "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."[33]

[62] Given the absence of expert evidence to the contrary, such findings were all but inevitable. The findings are well supported by the evidence and there is no basis for appellate interference.

The infusion of prothrombinex caused the further strokes[34]

[63] Mr Moder submits that the infusion of prothrombinex was an inappropriate treatment and secondly that the further strokes occurred effectively contemporaneously with the administration of the treatment so the inference is that

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33 *Sochorova v Durairaj & Anor* [2019] QSC 251 at 7-8.

34 This is really the issue of the written submissions made by Mr Moder under both the heading "As to infusion of prothrombinex clotting agent" and "As to causation of second stroke".

they were caused by the prothrombinex. Neither submission is supported by the evidence. Administration of prothrombinex is a standard treatment to stop bleeding.[35] It is a clotting agent which counterbalances the blood thinning effect of the thrombolysis. One side effect is that it can cause heart attacks and clotting.[36] However, Dr Durairaj gave this evidence:

> "And what were the results?---The Prothrombinex is used to limit the bleeding. And - and - and the stroke patients go through their stroke journey, and get discharged.
>
> So the ones that you gave Prothrombinex to had no problems with that?---No.
>
> All right. What - what are the possible effects of Prothrombinex?---Prothrombinex is suppose to reverse the clotting deficiency that the thrombolysis has achieved. That by make sure that the bleeding doesn't get any worse, and so limit the size of the bleed in the brain. When it comes to bleeding in the brain, the size of the bleed has a direct correlation into - to the damage caused to the patient. So when we give them medicine it limits the bleeding, and so the clinical deterioration is prevented.
>
> It's a clotting agent, right?---Yeah.
>
> Okay. It's quite logical that it limits the bleeding. The question I need to ask you is, what are the side-effects - what can happen with this?---It can cause venous artery; a thrombosis is less than one percent of patients.
>
> Yes. But - thrombosis meaning - meaning, what? Can she get a stroke from it; heart attack, whatever?---She can-well, patients can get stroke from it in in a extraordinary situation. But we need to remember that with Ms Sochorova, the symptoms of - lets say, the weakness - happened before the clotting factor was given. And so there is no correlation between the Prothrombinex and the stroke itself. The Prothrombinex was given after the weakness developed: not before.
>
> And lets be clear on this. When did you find out that she had the second stroke?---Right. Let me just run through the chronology for you. She - Ms Sochorova got - had a thrombolysis clot around 9.30 - 9.25, I think-and the treatment would have finished by 10.30. She made good clinical recovery from it. By 11.30 she developed a new left-sided weakness, which is a worsening of the same symptom she came in with. So that weakness never changed after that. She had a stroke by 11.30. By 11.45 she had a scan, which showed a-symptomatic insignificant bleeding, which we wanted to limit, and we have the medicine - the Prothrombinex - well after midnight.
>
> That's right. So is the - so the Prothrombinex was after midnight?---After midnight.

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35 Doctor Dermedgoglou's evidence, ARB, p 528; T 3-35 and Dr Durairaj ARB, p 583; T 4-8.

36 ARB, pp 530-531; T 3-38 to T 3-39.

> And when did you discover that she had the second stroke?---By 11.30.
>
> From what - from what?---From a clinical examination.
>
> Clinical examination. And what was that examination?---The dense left-sided weakness with neglect.
>
> So you had no evidence of x-ray's, MRI scans, anything like that- CT scans: it's just an assessment according to a condition, that she had had the second stroke, but you can't tell - you can't say, exactly, when that happened. There was a - an MRI scan on the 10th - - -
>
> HIS HONOUR: Could I just - could I just check something. The questioning has been assuming that you regard there having - it as having been a second stroke. That may be our lay terminology.
>
> Is it accurate to describe it in that way?—It is an accurate - accurate description, and a stroke happened by 11.30. And it is purely based on clinical examination. And I say, the post, earlier on, when she did have a scan, and an ischemic stroke doesn't show in a scan in the first 24 to 48 hours. And that's why the scan looked normal. An MRI is a much more sensitive test. And when she had it there, later on, it demonstrated the full extent of the stroke that happened at 11.30 that night. What is important to note, here, is her clinical condition - the neurological changes that happened - didn't change after 11.30. She didn't have any new problems after 11.30 pm that night, for the rest of her tenure in the hospital. This means that the stroke happened, and reached its maximum point of intensity; at 11.30 that night. The fact that the scan was done on 10th, I'm sure the stroke - is only showing the stroke that happened on that night."[37]

[64] His Honour found that the prothrombinex was administered after the stroke which inflicted the significant damage upon the appellant and therefore found that the injury was not caused by that treatment.[38]

[65] His Honour's findings are supported by cogent evidence which is, in reality, not contradicted. It was clearly open on the evidence for his Honour to make that finding. No error is demonstrated.

The application to adduce further evidence

[66] The appellant seeks to adduce three new pieces of evidence.

Further progress notes

[67] These document bruises which were noticed on the appellant while she was in hospital after suffering the further strokes. While the notes were not in evidence at the trial, the bruising was an issue considered by the witnesses.[39] The notes add nothing and I would not admit them into evidence on the appeal.

Physiotherapist's opinion

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37 ARB, p 583-584; T 4-8 to T 4-9.

38 *Sochorova v Durairaj & Anor* [2019] QSC 251, 5 and 7-8.

39 For example, Dr Durairaj, ARB, p 605-618; T 4-30 to T 4-43.

[68] After suffering the debilitating strokes, the appellant has received physiotherapy. The physiotherapist has identified right-sided weakness in the appellant. Right-sided weakness potentially correlates to left-sided brain injury. That is significant, the appellant says, because there was a small area of bleeding to the left side to her brain following the thrombolysis treatment.

[69] Even if this evidence was admitted, there is no evidence that the right-sided weakness observed by the physiotherapist was caused by the bleeding. Even if that was proved, it does not follow that the respondents are liable for the consequences of the damage. Given his Honour's finding that the administration of the treatment was appropriate, the respondents have not acted negligently.

[70] It follows that the admission of the physiotherapist's evidence will not alter the result of the appeal so I would refuse to admit the evidence.

Handwriting samples

[71] The appellant seeks to tender samples of her handwriting to show a deterioration in the use of her right arm. This evidence is sought to be tendered for the same reasons as the appellant seeks to tender evidence of the physiotherapist. For the reasons I would not admit the physiotherapist's evidence, I would also not admit the evidence of the handwriting samples.

Conclusions

[72] There were two issues in this case. Firstly, whether it was negligent of the respondents to administer the treatments and secondly, whether the treatments caused the further strokes that damaged the right side of the appellant's brain and caused left-sided disabilities. The appellant had to prove that the treatments ought not to have been given *and* that the treatments caused the further strokes.

[73] His Honour pressed Mr Moder to show him the evidence which proved that the treatment caused the appellant's left-sided disabilities. Mr Moder responded:

> "She came in the hospital, they gave her a particular procedure, and then she had the stroke."[40]

And later:

> "because it happened in hospital after these procedures."[41]

And later still:

> "No. I can't - I can't demonstrate that it's daylight out there - prove it. There are some things that are just obviously true. You can't - you can't go to a hospital and get some sort of treatment then die from it if the hospital hasn't done - followed the proper procedure. You have to then say, 'Well, something is wrong. They haven't done the right thing.'"[42]

[74] As Mr Moder's final address proceeded, this exchange occurred:

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40 ARB, p 689; T 4-114.
41 ARB, p 689; T 4-114.
42 ARB, p 690; T 4-115.

> "HIS HONOUR: Could another way it be seen, Mr Moder, that you've got an elderly sister who had a series of strokes, she went in with one on this occasion against a terrible background of ill health, and, despite the hospital's best attempts, she had a further catastrophic stroke while she was in hospital? Could that not be the most obvious way of seeing all of this?
>
> MR MODER: No. No. No."[43]

[75] The scenario put by his Honour to Mr Moder was the one overwhelmingly supported by the evidence.

[76] His Honour's findings were all supported by evidence which his Honour was entitled to accept. After reviewing the evidence I draw the same conclusions as did his Honour. There is nothing suggestive of error. The appeal should be dismissed.

[77] There is no reason why costs should not follow the event.[44]

Orders

[78] I would order:

1. The application to adduce further evidence is refused.
2. The appeal is dismissed.
3. The appellant pay the respondents' costs of the appeal.

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43 ARB, p 691; T 4-116.

44 *Uniform Civil Procedure Rules* 1999, r 681.