**The Welsh Transplant Incident**

 *Remigius N. Nwabueze*

 School of Law, University of Southampton, Southampton, UK

 *R.N.Nwabueze@soton.ac.uk*

**Abstract**

Hughes and Stuart’s shocking and unexpected deaths from the transplant treatments they received at Cardiff’s University Hospital of Wales could, in Lord Denning’s terminology, be described as ‘a most extraordinary chapter of accidents’. As Hughes and Stuart’s transplant treatments were based on expanded criteria donor kidneys, their deaths underscore not only the perennial problem of organ shortage in England and Wales which necessitates the clinical use of ‘high risk’ organs; but also, their deaths invite a re-examination of some of the ethical and legal issues involved in transplantation with expanded criteria donor organs. Being incomparable in calamity and rarity, the Welsh transplant incident is bound to raise novel issues of first impression in negligence, issues that this essay attempts to identify and analyse.

**Keywords**

organ donation; high risk organs; infectious organs; negligence; transplantation

**1 Introduction**

In December 2013, Robert Stuart (67) and Darren Hughes (42) died in Cardiff’s University Hospital of Wales, just a few days after Mr Argiris Asderakis had accepted and transplanted into them kidneys donated by a 39-year-old alcoholic who died from meningitis. The donor kidneys had been rejected earlier by a transplant surgeon in another transplant hospital.[[1]](#footnote-1) However, with a view to organ donation after death, the donor had been treated with a course of antibiotic, leading Mr Asderakis to believe that the donor kidneys posed little or no significant risk of transmitting meningitis to the potential recipients.[[2]](#footnote-2) While meningitis tests were carried out on the deceased donor, he or she was not initially tested for the presence of halecephalobus parasitic worm because it is far from routine to test for such worms; it was only after the performance of a post-mortem examination on the deceased recipients that it was known for certain that they had been infected by parasitic worms transmitted through the donor kidneys. This was the first known case of human-to-human transmission of such worms. Because of the donor’s life-style and mode of death, the donor kidneys could quite appropriately be categorised as extended criteria or *high risk organs;*[[3]](#footnote-3) these terms are however used pejoratively. Before receiving one of these kidneys, Hughes had undergone two previous transplants and, consequently, had accumulated anti-bodies in his blood which meant that only 10% of available organs were suitable for him; this made it more difficult for him to receive a transplant treatment.[[4]](#footnote-4) Similarly, Stuart’s advanced age constricted the pool of organs that were appropriate for him.[[5]](#footnote-5) In the context of organ shortage, therefore, Hughes and Stuart were suitable patients to receive high risk organs, though they were also eligible to receive standard risk organs.

 Hughes and Stuart’s shocking and unexpected deaths after their transplant treatments might have been described by Lord Denning as ‘a most extraordinary chapter of accidents’.[[6]](#footnote-6) As a transplant incident of incomparable calamity and rarity it is bound to raise novel issues of first impression in the area of negligence (and product liability under the Consumer Protection Act 1987 which is not the focus of this essay).[[7]](#footnote-7) Although no suit is currently pending on the matter, this essay attempts to identify and analyse some of the difficult issues that might arise from potential claims in negligence in England and Wales, claims that the estates of the deceased recipients may wish to bring. Before the occurrence of the adverse transplant event above, Cronin and Douglas had usefully signposted the legal and ethical issues involved in the clinical use of extended criteria donor kidneys;[[8]](#footnote-8) the Welsh transplant incident has made their analysis more interesting, because it raises the same critical issues that were highlighted by Cronin and Douglas. This piece extends that analysis by focusing on the adverse transplant event in Wales, with relevant comparisons to Canada, Australia and the USA. I argue that, overall, the potential claimants in the Welsh transplant incident have little prospects of success against the defendants in claims based on negligence.

 Notice that I have not delved into the practicalities of the potential litigation contemplated here, such as whether the potential claim(s) would be brought under the Law Reform (Miscellaneous Provisions) Act and/or Fatal Accidents Act, nor the impact of such a decision on the amount of damages recoverable which, in turn, would determine the chances of a solicitor taking the case on conditional fee agreement (CFA) or damages based agreement (DBA). In any event, rights of action under the above Acts are cumulative, and both forms of action could be brought by the executor or administrator of the deceased, one for the benefit of the estate under the Law Reform Act and the other for the benefit of the dependants under the Fatal Accidents Act.[[9]](#footnote-9)

**2.1 *Negligence***

The jurisprudence of England and Wales is yet to address the question of liability in negligence for the implantation of an infected solid organ into the body of a recipient. In such cases of first impression, the House of Lords had suggested that an analogical, incremental, approach to negligence is preferable to the sort of grand theoretical approach initiated in *Donoghue v Stevenson*.[[10]](#footnote-10) Thus, in *Caparo Industries Plc v Dickman*, Lord Bridge observed that attention should be paid to the ‘more traditional categorisation of distinct and recognisable situations as guides to the existence, the scope and the limits of the varied duties of care which the law imposes’.[[11]](#footnote-11) Similarly, in *Murphy v Brentwood District Council*, Lord Keith of Kinkel observed that as ‘regards the ingredients necessary to establish such a duty in novel situations, I consider that an incremental approach on the lines indicated by Brennan J. in the *Shire of Sutherland* case[[12]](#footnote-12) is to be preferred to the two-stage test’.[[13]](#footnote-13) One such established category in negligence, which is relevant to the Welsh transplant incident, concerns the liability of a defendant for the transfusion of infected blood or blood products into a recipient.[[14]](#footnote-14) The blood transfusion cases (analysed below) are analogically relevant because, like the Welsh transplant incident, they considered the question of whether or not a defendant should be liable for undiscoverable infection in transfused blood.

Of course, any negligence analysis, such as the one undertaken here, ought to fully consider the foundational elements of negligence, such as the existence of a duty of care, breach of duty/standard of care, causation and damages. In blood transfusion and transplant cases, however, a duty of care can be easily established because of the existence of a doctor-patient, or similar proximate, relationship between the parties.[[15]](#footnote-15)Similarly, causation is not problematical in the Welsh-transplant-type of cases because the autopsy report showed clearly that the recipients were killed by donor organ-derived parasitic worms;[[16]](#footnote-16) this evidence equally proves the element of damage. The decisive questions for the Welsh transplant incident, therefore, turn on the scope of duty and standard of care.[[17]](#footnote-17) Consequently, apart from the issue of space limitation, this piece does not provide a detailed analysis of the elements of duty, causation and damage; it focuses on the critical question of standard of care in relation to the Welsh transplant accident.

The standard of care inquiry should focus on the information available to the potential defendants in the Welsh transplant incident, particularly, what they knew or should have known at the relevant time regarding the infectivity of the donor kidneys. The analyst should also consider the general state of scientific knowledge and biomedical technology in relation to transplant procedures at the time of the incident; particularly, whether the parasitic worm infection could have been detected by the use of clinical and laboratory techniques prevailing at the time of the incident. Absent local cases on these issues, I analyse a few cases below from Canada, Australia and the USA; of course, these foreign cases are of persuasive authority only. This caution applies particularly to the cases from the USA because of the operation of ‘blood shield statutes’ in some states of the USA; ‘blood shield statutes’ exclude strict liability for blood transfusion by regarding it as the provision of a medical service rather than the sale of a product.[[18]](#footnote-18)

 In *Walker Estate* v*. York Finch General Hospital,*[[19]](#footnote-19) the three claimants contracted HIV from blood and blood products supplied by the defendant-Canadian Red Cross Society (CRCS).[[20]](#footnote-20) Two of the claimants died of AIDS in the course of the trial. Essentially, the claim was that the CRCS was negligent in the procedures it adopted to screen blood donors with HIV/AIDS. Thus, the main questions turned on the standard of care and causation since the CRCS was held to owe a duty of care to recipients of blood and blood products supplied by it. The standard of care analysis focused on what the CRCS did and should have done at the relevant time in light of competent blood donor screening procedures adopted by the voluntary blood bank sector at that time. The Supreme Court of Canada held that the March 1983 donor screening pamphlet of the American Red Cross Society (ARC) represented a model of competence upon which the actions of the CRCS would be judged;[[21]](#footnote-21) consequently, it held that the two donor screening pamphlets developed by the CRCS in April 1983 and May 1984 fell below the appropriate standard of care.[[22]](#footnote-22) Notice that these pamphlets underpinned the standard of care analysis in *Walker* because the relevant causes of action arose between 1983 and March 1985; at that time there was no clinical or diagnostic test for detecting the presence of HIV antibodies in the blood. ELISA test, currently used for that purpose, was not developed in Canada until May 1985. Thus, the Supreme Court of Canada held that the CRCS was liable to the claimants in negligence for its failure to observe the appropriate standard of care; also, it held that the claimants had proved the requirement of causation on the basis of the *material contribution* test.[[23]](#footnote-23)

 In *PQ v Australian Red Cross Society*,[[24]](#footnote-24) which was a jury trial, the claimants brought an action in negligence because of their infection by HIV transmitted through the blood products they received from the defendant in the early 1980s. Specifically, the claimants alleged that the defendant had failed to take precautions that were necessary to exclude risky blood donors, such as sexually active homosexual and bisexual men and their partners. Although the case eventually turned on evidential matters, the claimants’ negligence claim required an examination of what the defendant knew or ought to have known at the relevant time about the risk of HIV infection through the transfusion of blood and blood products, as well as the defendant’s knowledge regarding the availability of the means of reducing or eliminating such risks.[[25]](#footnote-25) Thus, the issues centred on whether ‘the Red Cross fell short of the standard of reasonable care’;[[26]](#footnote-26) particularly, whether the financial resources of the Red Cross should be taken into account in determining the appropriate standard of care. In an interlocutory judgment, McGarvie J observed that the ‘standard of care is to be tested, not by reference to a reasonable person with the defendant’s actual resources of staff facilities and finance, but by reference to a reasonable person with adequate resources available to conduct the enterprise in which the Red Cross was engaged’.[[27]](#footnote-27) Similar issues have arisen outside the blood transfusion contexts, as illustrated by the Canadian Supreme Court’s decision in *Ter Neuzen v Korn*.[[28]](#footnote-28)

In *Ter Neuzen*, the claimant was infected by HIV as a result of an artificial insemination procedure (AI) administered on her by the defendant-doctor based on semen from a donor who was, unbeknownst to the doctor, HIV positive. The cause of action arose in January 1985, before the development of ELISA test for detecting HIV antibodies; at that time also, no connection was known to exist between HIV and AI. Expert evidence showed that the defendant’s AI practice, particularly the defendant’s semen-donor recruitment and screening procedures, met the standard of care prevailing across Canada at the relevant time. Surprisingly, the trial court held that the defendant was liable in negligence, but it failed to specify the reason for the alleged negligence; thus, the Court of Appeal and the Supreme Court of Canada had to speculate on the grounds for the alleged negligence. Accordingly, the Supreme Court of Canada held that the defendant’s negligence must have been based on the ground that his AI practice failed to reflect knowledge of the connection between HIV an AI, or that the defendant’s donor screening and follow-up procedures failed to meet the appropriate standard of care.[[29]](#footnote-29) Being a standard of care issue, the Supreme Court observed that it must be determined in the light of scientific/gynaecological knowledge existing in 1985. Thus, Sopinka J opined that ‘it was not possible for a jury acting judicially to have found that, in 1985, the respondent ought to have known of the risk’.[[30]](#footnote-30) Thus, the matter was sent back to the trial court for a new trial.

The principles above resonate with *Bolam*, [[31]](#footnote-31) where McNair J held that a professional person would not be liable in negligence if they complied with a competent body of professional opinion; however, the professional opinion must have a logical basis.[[32]](#footnote-32) It was not clear whether *Bolam* also applied to a doctor’s duty to warn of the risks associated with treatment. In *Sidaway*, the majority, in speeches that are not easy to reconcile, held that *Bolam’s* test applied to the giving of advice on risks associated with treatment.[[33]](#footnote-33) This aspect of *Sidaway* has now been overruled by the Supreme Court in *Montgomery*, holding that the value entailed by a patient’s right to self-determination, coupled with recent social and legal developments, meant that ‘the analysis of the law by the majority in *Sidaway* is unsatisfactory, in so far as it treated the doctor’s duty to advise her patient of the risks of proposed treatment as falling within the scope of the *Bolam* test’.[[34]](#footnote-34)

The standard of care analysis above raises four issues for the Welsh transplant incident. First, were the potential defendants presumptively negligent, on the basis of *res ipsa loquitur*, for the mere use of the high risk kidneys in that incident? Second, if the parasitic worms were not discoverable, could the potential defendants be accused of failing to meet the standard of care? Third, was dialysis therapy a better alternative treatment for the deceased recipients of the high risk kidneys? Fourth, were the deceased recipients warned of the risks associated with a transplant procedure based on high risk organs?

2.1.1 *Res Ipsa Loquitur*

As indicated above, the first step in the standard of care inquiry is to consider whether or not the *mere* acceptance and use of the high risk kidneys in the Welsh transplant incident gives rise to a rebuttable presumption of negligence against the potential defendants, on the basis of *res ipsa loquitur*. In the absence of direct evidence on a matter, the doctrine of res ipsa loquitur enables a court to make a rebuttable presumption or inference of negligence against a defendant from the peculiar circumstances of a case. Thus, *res ipsa loquitur* only establishes a prima facie case of negligence against the defendant.[[35]](#footnote-35) Having known that the donor kidneys belonged to the high risk category,[[36]](#footnote-36) Should Mr Asderakis have accepted them for transplantation?

As a body of professional opinion, the guidance issued by the NHS Blood and Transplant is relevant to the question above. The characterisation of an organ as *high risk* or *non-standard* might lead a reader to suppose that its quality is so bad that its mere use must amount to negligence, at least on the basis of res ipsa loquitur. However, the NHS Blood and Transplant has warned that such characterisations are infelicitous sobriquets for organs that fell below standard risks.[[37]](#footnote-37) Also, high risk organs are generally usable and their value is accentuated by organ scarcity. [[38]](#footnote-38) Therefore, the mere use of the high risk kidneys in the Welsh transplant incident is unlikely to give rise to a negligent liability on the basis of res ipsa loquitur.[[39]](#footnote-39)

2.1.1.1 *Discoverability*

The second issue for the standard of care analysis above concerns the *discoverability* of the parasitic worm infection in that incident. As seen from the cases above, much of this would depend on the professional knowledge of Mr Asderakis and the state of scientific and medical laboratory technology at the relevant time. Of relevance, again, is the guidance from the NHS Blood and Transport, which ensures that risks of infection transmission through donor organs are minimised: ‘the risk of an infection being passed on through transplanted organs, tissues and cells should be kept to a minimum, taking account of the balance of risk and benefit for the recipient.’[[40]](#footnote-40) A similar guidance was issued by the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO), prescribing detailed measures and procedures to ensure the elimination or minimisation of risks of infection transmission through donor organs.[[41]](#footnote-41) Comparable safety measures are required under Directive 2010/45/EU,[[42]](#footnote-42) transposed into domestic law in 2012.[[43]](#footnote-43)

To avoid liability, therefore, the potential defendants in the Welsh transplant incident must show that the parasitic worm infection could not be discovered despite their compliance with the quality and safety regulations above. *Roe* provides a good analogy;[[44]](#footnote-44) there, anaesthetic in glass ampoules were contaminated due to their immersion in a sterilising solution of phenol. The contamination occurred through invisible cracks in the ampoules. The claimants suffered paralysis when the contaminated anaesthetic was administered on them in a minor surgical procedure. At the time of the accident (1947), the risk was unknown, and was described for the first time in a medical text published in 1951. Denning LJ held that there could be no liability in negligence for such undiscoverable defects, and observed that ‘he (anaesthetist) did not know that there could be undetectable crack, but it was not negligent for him not to know it at that time. We must not look at the 1947 accident with 1954 spectacles’.[[45]](#footnote-45) Similarly, in *Perlmutter v Beth David Hospital*,[[46]](#footnote-46) the claimant was infected by hepatitis as a result of the contaminated blood transfused into him in the 1950s. At that time, there was no diagnostic test for detecting the presence of hepatitis in the blood. However, the action was brought under the sale of goods legislation in New York, probably because a negligence claim would have failed in the circumstances. Thus, much of the case turned on the question of whether the provision of blood amounted to a sale or service.[[47]](#footnote-47) Fuld J, however, observed *obiter* that ‘informed opinion is at hand that there is today neither a means of detecting the presence of the jaundice-producing agent in the donor’s blood nor a practical method of treating the blood to be used for transfusion so that the danger may be eliminated’.[[48]](#footnote-48) Fuld J implied that the non-discoverability status of the hepatitis would have guaranteed the failure of a negligence action in that case.

In the Welsh transplant incident, similarly, the parasitic worm infection was the first of its kind,[[49]](#footnote-49) and was only discovered after death through a post-mortem procedure.[[50]](#footnote-50) Also, the coronial inquiry on the matter observed that ‘no case of infection by the worm had ever been successfully diagnosed and treated’;[[51]](#footnote-51) and, obviously, meningitis tests performed on the donor prior to transplantation did not include a test for the parasitic worms because such a test is not routine.[[52]](#footnote-52)As the parasitic worm infection was undiscoverable, the conclusion, based on the current facts, must be that liability in negligence does not arise on this issue.[[53]](#footnote-53)

2. IV Availability of Alternative Treatments

The third issue for the standard of care analysis above concerns the availability of reasonable alternative treatments for the deceased recipients. The relevance of this issue was most poignantly captured in Norrie’s observation that ‘if a patient’s kidney failure would possibly have been susceptible to drug treatment, but a doctor recommends and carries out a renal transplantation, then the patient may have a good ground of action if the operation leaves him worse off than he would have been had the drug treatment been provided’.[[54]](#footnote-54) In *Montgomery*, the Supreme Court equally underscored the duty to provide a patient with information relating to alternative treatments, prompting Lady Hale to observe that ‘it is not possible to consider a particular medical procedure in isolation from its alternatives’.[[55]](#footnote-55) To avoid liability, therefore, the potential defendants in the Welsh transplant incident would need to prove that the recipients’ transplantation with high risk kidneys was better than the alternative treatment of dialysis.

There is documented evidence that transplantation with a high risk organ is clearly superior to dialysis therapy; [[56]](#footnote-56) so the legal burden above should be easily discharged by the potential defendants. In the press report of the Welsh transplant incident, however, there was a suggestion that the recipients would have been better off on dialysis. For instance, Mr Stuart’s widow was quoted as saying that ‘he’d only gone onto dialysis six months earlier and he’d been coping with it so well’;[[57]](#footnote-57) and that ‘Jim (Mr Stuart) was very optimistic about the operation… it would have meant he didn’t have to be on dialysis. He was very fit and healthy…and had coped brilliantly with dialysis’.[[58]](#footnote-58) Thus, she implied that dialysis was a preferable treatment option for Stuart. Since Mrs Stuart is neither a nephrologist nor a transplant surgeon, her comments on the issue bear little weight, more so as those comments are inconsistent with the well-documented evidence of the relative superiority of transplantation with high risk organs in comparison to dialysis therapy. Much less is known about Hughes; however, for the same reasons above, it is unlikely that dialysis was a better treatment option for him than transplant with a high risk kidney.

**3 Consent**

The fourth issue for the standard of care analysis above concerns the questions of consent to transplant treatment and the duty to warn of risks associated with that treatment. In *Montgomery*, a unanimous Supreme Court held that a patient is *entitled* to information relating to the material risks associated with their treatment, and that the materiality of the risk should be determined objectively based on a prudent or reasonable patient’s test, or on the basis of whether the doctor knew or should have known that the patient would consider the risk significant.[[59]](#footnote-59) In the context of the Welsh transplant incident, therefore, the recipients were not only entitled to information relating to the risks generally associated with a transplant procedure (including risks pertaining to the surgery, possibility of graft failure, infection transmission and immunosuppression), but also, they were entitled to be informed of the high risk status of the kidneys and the added risks to the procedure, if any, that would arise from the non-standard status of the kidneys.[[60]](#footnote-60) Thus, a relevant guidance states that a doctor must ensure that ‘where a high risk organ is being considered, the potential recipient is aware of this and has given informed consent’.[[61]](#footnote-61) As the facts of the Welsh transplant incident are still undeveloped, it is difficult to say whether or not appropriate warning or relevant information on the status of the kidneys and potential risks of the procedure was given to the deceased recipients. In the media account of the incident, for instance, it was not clear whether or not Mr Asderakis obtained the full informed consent of the recipients.[[62]](#footnote-62) Thus, it suffices to say that the potential defendants would be liable in negligence unless they complied with the consent principles above.

 Overall, therefore, the estates of the deceased recipients in the Welsh transplant incident might not be able to prove a claim in negligence against the potential defendants; however, a window of opportunity exists to prove such a claim, in the sense that the recipients’ estates might prove that the deceased recipients were not fully informed about the high risk status of the kidneys and the added risks entailed by their use.

**4 Conclusion**

The problem of organ shortage has brought about a significant increase in the clinical use of high risk organs. Clinical evidence shows that such organs achieve satisfactory long term outcomes, and are superior to the alternative of dialysis therapy or remaining on the waiting list without a transplant. However, high risk organs produce outcomes that are inferior to standard criteria donor organs and, as the Welsh transplant incident shows, transplantation with high risk organs could raise significant legal liability issues. Any litigation, if at all, that eventuates from the Welsh transplant incident would be a case of first impression; surely, it would raise difficult issues in the area of negligence. By analogy to cases on blood transfusion and tissue transplants in other jurisdictions, a potential claim in negligence over the Welsh transplant incident would primarily involve issues relating to the standard of care; particularly, whether the mere use of the high risk kidneys gives rise to a presumption of negligence under the doctrine of res ipsa loquitur; whether the non-discoverability of the parasitic worms amounts to a failure of the standard of care; whether dialysis therapy was a better alternative treatment than transplantation with the high risk kidneys; and whether the potential defendants complied with the requirements of informed consent. Overall, the prospects of a successful claim in negligence are slight. Considering the remedial difficulties above, it might be that the best route for compensation is to develop a ‘no-fault’ compensatory system. The different types of ‘no-fault’ system of compensation applicable in Sweden, Finland and New Zealand (of which the latter is the most comprehensive) attest to its variability in coverage, nature and reach;[[63]](#footnote-63) however, space does not permit further discussion of this point.

 Generally, the Welsh transplant incident draws attention to some of the dangers or risks that are inherent in a transplant procedure. Although organ transplantation is a high technology and high skill based medical procedure, in which the health personnel evince extreme care, competence and attention, yet adverse transplant events sometimes occur; this is dramatized by the incident in Wales. The Welsh transplant incident is, therefore, a clarion call for greater vigilance on the part of everybody involved in the transplantation process. Particularly, the Welsh transplant incident underscores the need to give full and effective information on all aspects of a transplant process to a potential recipient. In part, this means that where the use of a high risk organ is contemplated, the potential recipient must be informed of the specific nature or status of the organ, the risks and benefits of transplant treatment with that organ compared to dialysis, and the unavoidable risk of infection transmission through unknown viruses; the potential recipient’s consent to transplant treatment with such an organ must be obtained.

1. \* Professor Margaret Brazier kindly read and commented on the initial draft of this article, and the article would have been poorer without her assistance, for which I am grateful. I am also grateful for the helpful comments of the journal’s reviewers.

 *BBC News*, ‘Kidney deaths: Prof rejected infected transplant organs’ 3 December 2014, hhtp://www.bbc.co.uk/news/uk-wales-south-east-wales-30292148?, accessed on 5 December 2014. [↑](#footnote-ref-1)
2. *BBC News*, ‘Kidney deaths inquest: Patients told donor had meningitis’ 3 December 2014, <http://www.bbc.co.uk/news/uk-wales-south-east-wales-30319600>?, accessed on 5 December 2014. [↑](#footnote-ref-2)
3. NHS Blood and Transplant and British Transplantation Society*, Guidelines for Consent for Solid Organ Transplantation in Adults* (London: NHSBT and BTS, 2011) p.5.2 (Guidelines Consent). [↑](#footnote-ref-3)
4. *BBC News*, ‘Kidney transplant surgeon apologies after patients died’ 19 November 2014, <http://www.bbc.co.uk/news/uk-wales-south-east-wales-30104691>?, accessed on 5 December 2014. [↑](#footnote-ref-4)
5. E. Jackson, *Medical Law* (Oxford: Oxford University Press, 2013) p.583. [↑](#footnote-ref-5)
6. *Roe* v. *Minister of Health* [1954] 2 Q.B. 86. [↑](#footnote-ref-6)
7. J. Herring, *Medical Law and Ethics,* 6th ed. (Oxford: Oxford University Press, 2016) p.463-4. [↑](#footnote-ref-7)
8. A.J. Cronin and J.F. Douglas, ‘Non-Standard Kidneys for Transplants: Clinical Margins, Medical Morality, and the Law’, 21 *Medical Law Review* (2013) 448-473. [↑](#footnote-ref-8)
9. W.V.H. Rogers, *Winfield & Jolowicz on Tort,* 18th ed. (London: Sweet and Maxwell, 2010) pp.1079-1096. [↑](#footnote-ref-9)
10. *Donoghue* v. *Stevenson* [1932] A.C. 562. [↑](#footnote-ref-10)
11. *Caparo Industries Plc* v. *Dickman* [1990] 2 A.C. 605, 618. [↑](#footnote-ref-11)
12. *Council of the Shire of Sutherland* v. *Heyman* [1985] 157 C.L.R 424, 481. [↑](#footnote-ref-12)
13. *Murphy* v. *Brentwood District Council* [1991] 1 A.C. 398, 461. [↑](#footnote-ref-13)
14. A. Farrell, *The Politics of Blood: Ethics, Innovation and the Regulation of Risk* (Cambridge: Cambridge University Press, 2012). *The Penrose Inquiry: Final Report* (OGL, 2015). [↑](#footnote-ref-14)
15. *Re HIV haemophiliac Litigation* [1990] 41 B.M.L.R. 171. [↑](#footnote-ref-15)
16. K. Stern, ‘Strict Liability and the Supply of Donated Gametes’, 2 *Medical Law Review* (1994) 261, 269-270. [↑](#footnote-ref-16)
17. *Re Creutzfeldt-Jacob Disease Litigation* [2000] 54 B.M.L.R. 8. [↑](#footnote-ref-17)
18. F. Shu-Acquaye & L. Innet, ‘Human Blood and Its Transfusion: The Twist and Turns of Legal Thinking’, 9 *Quinnipiac Health L. J.* (2005-2006) 33. [↑](#footnote-ref-18)
19. *Walker Estate* v. *York Finch General Hospital* [2001] 1 S.C.R. 647. [↑](#footnote-ref-19)
20. CRCS was the only defendant in the case. [↑](#footnote-ref-20)
21. *Walker, supra* note 19, p. 681. [↑](#footnote-ref-21)
22. Unlike the American pamphlet, the CRCS pamphlets failed to ask potential blood donors disease-centred questions; nor identified donors in high risk categories. [↑](#footnote-ref-22)
23. *Walker, supra* note 19, p. 680. [↑](#footnote-ref-23)
24. *PQ* v*. Australian Red Cross Society* [1992] 1 V.R. 19. [↑](#footnote-ref-24)
25. *Ibid.*, 36-37. [↑](#footnote-ref-25)
26. *Ibid*., 30. [↑](#footnote-ref-26)
27. *Ibid*., 33. [↑](#footnote-ref-27)
28. *Ter Neuzen* v. *Korn* [1995] 3 S.C.R. 674. [↑](#footnote-ref-28)
29. *Ibid*., 688, 692. [↑](#footnote-ref-29)
30. *Ibid.*, 694. [↑](#footnote-ref-30)
31. *Bolam* v. *Friern Hospital Management Committee* [1957] 1 W.L.R. 582, 587. [↑](#footnote-ref-31)
32. *Bolitho* v. *City & Hackney Health Authority* [1998] A.C. 232, 242. [↑](#footnote-ref-32)
33. *Sidaway* v. *Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] A.C. 871. [↑](#footnote-ref-33)
34. *Montgomery* v. *Lanarkshire Health Board* [2015] UKSC 11, at para. 86. [↑](#footnote-ref-34)
35. Rogers, supra note 9, pp.299-304. [↑](#footnote-ref-35)
36. *Kidney apologies supra* note 4. [↑](#footnote-ref-36)
37. *Guidelines Consent supra* note 3, p.5.2. [↑](#footnote-ref-37)
38. *Guidelines Consent supra* note 3, p.4.1; Advisory Committee on the Safety of Blood, Tissue and Organs, *Guidance on the Microbiological Safety of Human Organs, Tissues and Cells Used in Transplantation* (2011), at p.10.1. (*Guidance on Microbiological*). [↑](#footnote-ref-38)
39. Cronin and Douglas*, supra* note 8, p.463. [↑](#footnote-ref-39)
40. *Guidance on Microbiological, supra* note 38, p.1.6. [↑](#footnote-ref-40)
41. *Ibid*. [↑](#footnote-ref-41)
42. Directive 2010/45/EU of the European Parliament and of the Council of 7 July 2010 (On standards of quality and safety of human organs intended for transplantation). [↑](#footnote-ref-42)
43. Human Tissue: The Quality and Safety of Organs Intended for Transplantation Regulations 2012 (2012 No.

 1501) [↑](#footnote-ref-43)
44. *Roe, supra* note 6. [↑](#footnote-ref-44)
45. *Ibid*., 84. [↑](#footnote-ref-45)
46. *Perlmutter* v. *Beth David Hospital*, 300 N.Y. 100 (C.A.N.Y 1954). [↑](#footnote-ref-46)
47. Held that it was a *service*, but a *sale* in *Carter v Inter-Faith Hospital of Queens*, 304 N.Y.S. 2d 97 (1969). [↑](#footnote-ref-47)
48. *Perlmutter, supra* note 46, p.106. [↑](#footnote-ref-48)
49. BBC News, *Kidney apologies, supra* note 4. [↑](#footnote-ref-49)
50. *BBC News*, ‘Kidney deaths: No criticism over transplant deaths’ 4 December 2014, <http://www.bbc.co.uk/news/uk-wales-south-east-wales-30323602>?, accessed on 5 December 2014. (No Criticism). [↑](#footnote-ref-50)
51. *Prof rejected organs, supra* note 1. [↑](#footnote-ref-51)
52. *BBC News*, ‘Patients given kidneys rejected “unfit” by other hospitals’ 18 November 2014, <http://www.bbc.co.uk/news/uk-wales-30086735>?, accessed on 5 December 2014. (Patients Given Rejected Kidneys). [↑](#footnote-ref-52)
53. Non-discoverability of a known defect may not defeat a product liability claim. [↑](#footnote-ref-53)
54. K.C. Norrie, ‘Human Tissue Transplants: Legal Liability in Different Jurisdictions’, 34 *I.C.L.Q.* (1985) 442, 444. [↑](#footnote-ref-54)
55. *Montgomery, supra* note 34, para. 109. [↑](#footnote-ref-55)
56. A. Rana et al., ‘Survival benefits of solid-organ transplant in the United States’, 150 *JAMA Surg* (2015) 252; P.S. Rao and A. Ojo, ‘The alphabet soup of kidney transplantation; SCD, DCD, ECD – Fundamentals for the practicing nephrologist’, 4 *Clin J Am Soc Nephrol* (2009) 1828; A.O. Ojo et al., ‘Survival in recipients of marginal cadaveric donor kidneys compared with other recipients and wait-listed transplant candidates’, 12 *J Am Soc Nephrol* (2001) 589; R.M. Merion et al., ‘Mortality risk for expanded donor kidney recipients compared with wait-listed dialysis patients’, 13 *J Am Soc Nephrol* (2002) 47A. [↑](#footnote-ref-56)
57. *BBC News*, ‘Families’ grief at men’s “infected” Cardiff kidney ops’, 17 November 2014, <http://www.bbc.co.uk/news/uk-wales-30081265>?, accessed on 5 December 2014. (Families’ Grief). [↑](#footnote-ref-57)
58. *Ibid*. [↑](#footnote-ref-58)
59. *Montgomery, supra* note 34, para. 87. [↑](#footnote-ref-59)
60. *Guidelines Consent, supra* note 3, para.5:2. [↑](#footnote-ref-60)
61. NHS Blood and Transplant and British Transplantation Society, *Responsibilities of Clinicians for the Acceptance of Organs from Deceased Donors* (London: NHS BT and BTS, 2014), para. 2:6. [↑](#footnote-ref-61)
62. *Prof rejected organs, supra* note 1. [↑](#footnote-ref-62)
63. Rogers*, supra* note 9, pp.48-53. [↑](#footnote-ref-63)