Neutral Citation Number: [2011] IEHC 305

THE HIGH COURT

2007 4483 P

BETWEEN

MONICA CORRIGAN

PLAINTIFF

AND

HEALTH SERVICE EXECUTIVE

DEFENDANT

JUDGMENT of Ms. Justice Irvine delivered on the 22nd day of July, 2011

1. In the within proceedings, the plaintiff claims damages for negligence against the defendant arising from a fall that she sustained whilst a voluntary inpatient at the psychiatric unit of Roscommon County Hospital on 3rd December, 2005.

Background
2. The plaintiff was born in 1947. She is a married lady and the mother of four children who resides at Ballaghaderreen, County Roscommon. The plaintiff has a long history of psychiatric problems which appear to have commenced in and about the year 2000. She suffers from chronic depression and bipolar affective disorder. At times she suffers from paranoia, delusions, and hallucinations and may present in a manic and/or agitated state. She has been frequently hospitalised and has for all such periods has been under the care of Dr. Charles Byrne, Consultant Psychiatrist. To date, the plaintiff has had nineteen admissions in total. No admission has been for less than a couple of weeks and occasionally she has been admitted for periods in excess of three months. Regrettably, whilst the pattern of the plaintiff's illness has remained reasonably consistent, her admissions to hospital have increased over the years.

2005 Admission
3. The plaintiff was admitted as a voluntary patient to the psychiatric unit of Roscommon County Hospital on 15th November, 2005. She was in a manic state, was overactive and impulsive. By the end of November, 2005 her symptoms had somewhat dis-improved and at times she demonstrated symptoms of paranoia, aggression and delusion.

4. It is accepted by both parties that at approximately 11.00pm on 2nd November, 2005, the plaintiff advised the nursing staff that she had fallen in her room. She complained of soreness of the right shoulder. She was examined and was found to have no obvious signs of injury. She was restless and agitated and the doctor on call was notified. At the time of his arrival, the plaintiff was sleeping. He advised an X-ray of the shoulder.

5. At 7.00am on 3rd December, 2005, the plaintiff was found on the floor in her bedroom with no apparent injury. She got up by herself. She was agitated. She was reviewed by Dr. George who noted her to be "suspicious of people". He checked her blood pressure and vital signs. He directed urinalysis, an ECG and an increase in the plaintiff's fluid intake and advised that she should remain on her current medication. The plaintiff again complained of stumbling and falling on her way back from the smoking area in the early afternoon. She did not injure herself and had walked back to her bedroom unaided. She was again reviewed by Dr. George.

6. As to the fall the subject matter of the present claim which occurred on the 3rd December, 2005, the following appear to be the uncontested facts. Mr. Corrigan arrived to visit his wife and found her to be anxious and complaining of nausea and dizziness. Some minutes prior to the plaintiff's fall, they had walked down the hospital corridor together. They then sat down in room 2, the female observation ward, in which the plaintiff was staying. Mr. Corrigan described the plaintiff's mood as being about five out of ten, with ten being her at her worst. The plaintiff was sitting in a chair at the foot of her bed and Mr. Corrigan was sitting beside her at an angle about two feet away. After some minutes she told him she was going to go to the toilet. He was not alarmed by her announcement. She then got up suddenly and headed for the door. She had gone three to four steps, or some a very short distance, when she suddenly fell forwards without any warning striking her head on a gas cylinder which was on a trolley. She then landed heavily on her left shoulder. He was not able to prevent her fall.

7. The plaintiff was subsequently diagnosed with a severe fracture dislocation to the left shoulder. This required surgical intervention by Mr. Kenneth Kaar, Consultant Orthopaedic Surgeon, on 8th December, in Merlin Park Hospital in Galway. A hemi-arthroplasty was carried out following which the plaintiff was returned to Roscommon County Hospital on 12th December, 2005. Notwithstanding substantial physiotherapy, the plaintiff has not regained full function of her shoulder. She has very limited rotation, has reduced elevation. She experiences pain on activity and has a six inch scar at the operation site. It is common case that the Plaintiff finds it difficult to provide for her own personal care. She has problems dressing and carrying out a whole range of domestic activities which she formally managed without difficulty. These include hoovering, bed making, cooking and gardening. She finds lifting difficult. Her medical situation has been further complicated by a subsequent injury to her knee in May, 2009 when she fell off a treadmill in the course of a cardiac investigation.

The Legal Basis for the Claim
8. Whilst widespread allegations of negligence and breach of duty were made in the personal injuries summons, the expert evidence on behalf of the plaintiff focused upon the failure on the part of the defendant to provide the plaintiff with what is referred to in the medical and nursing professions as one-to-one nursing care on a continuous basis from 1st December, 2005. She had, from time to time, been provided with one-to-one nursing care with the last such episode prior to her fall taking place on 1st December, 2005. On the plaintiff's behalf, it was maintained that the defendant's failure to continue that level of care and supervision over the ensuing days was to fall short of an acceptable standard of care having regard to the plaintiff's symptoms and history.

9. The plaintiff's relevant history was stated to include her history of a previous fall in 2003, when she fractured her right shoulder, reported unsteadiness and dizziness in the course of her 2005 admission and the fact that her condition in terms of agitation, paranoia and delusions had not improved and had actually dis-improved by the end of November, 2005 thus rendering her a risk to her

own safety and the safety of others. In particular, counsel for the plaintiff relied upon the fact that the plaintiff had fallen on a number of occasions between 1st December 2005 and the fall the subject matter of the present claim, had become verbally aggressive with members of the nursing staff, had threatened to break a window and a flower vase and had thrown off her wedding ring. In such circumstances, the plaintiff contended that one-to-one nursing care was mandated and that had it been put in place with effect from 1st December, 2005, the plaintiff would not have sustained the fall the subject matter of this claim. In the alternative, it was maintained that if by reason of her condition and response to one-to-one nursing care that type of intervention was not possible, then it was mandatory for the defendant to introduce two-to-one nursing care. If the plaintiff did not adequately respond to that type of nursing, she should have had what was described as open door nursing that being a scenario in which the patient is confined to their own room, the door is left open and a nurse remains outside the open door to safeguard their welfare.

10. In updated pleadings belatedly delivered, the plaintiff, in the further alternative, maintained that if it was not possible to manage the plaintiff using continuous nursing observation of the nature mentioned in the last preceeing paragraph, consideration should have been given to managing the plaintiff in seclusion as a last resort. This latter allegation was ultimately not supported by Dr. Mohan, the plaintiff's consultant psychiatrist, on the basis that if the purpose of additional nursing care was to prevent a patient from injuring themselves, to lock them in a room on their own, having of course first sought a change in their Voluntary patient status, would not ameliorate such a risk.

11. The defendant maintained that at no stage was it neglectful of the plaintiff's care. It submitted that an appropriate care plan had been put in place on the plaintiff's admission, taking all relevant factors into account. That plan was revisited on a daily basis by the medical and nursing staff and was reviewed once a week at a meeting of the appropriate multidisciplinary team. The care plan permitted nursing staff to introduce one-to-one nursing care if and when required and discontinue it when they considered it appropriate. The defendants contended that one-to-one care on a continuous basis was not required from 1st December, 2005, and that one-to-one care would actually have had an adverse effect on the plaintiff who was known to become excessively agitated and more manic if closely supervised. One-to-one nursing, on the defendant's evidence, would have increased the likelihood of the plaintiff lashing out and injuring herself and would have made her a greater risk to other patients and to the members of the nursing staff. The defendant maintained that a substantially increased level of observation was what was appropriate to best protect those interests and that this is what was implemented.

12. Finally, as to causation, the defendant contended that on the specific facts of this case that even if one-to-one nursing, or indeed any other form of continuous nursing care, had been provided, having regard to how that would have been deployed, the plaintiff would have fallen in any event.

The Plaintiff's Evidence

13. I do not intend to set out in any great detail the evidence of the parties. However, I will briefly refer to some aspects of the evidence introduced by both parties which are material to the findings of fact which I have made.

14. Mr. Corrigan gave evidence that his wife had fallen on several occasions in the course of an admission to the defendant's hospital in 2003. He stated that he believed she had had dizzy spells and falls throughout the period of her hospitalisation commencing 15th November, 2005 and that he had communicated his concerns about these to the nursing staff and to Dr. Byrne. He agreed that if medical or nursing staff interfaced too much with the plaintiff, that she would respond badly; that it was like walking on eggshells when she was at her most difficult and that she tended to lash out verbally and act aggressively in such circumstances. Mr. Corrigan agreed that the nursing staff had increased its level of observation of his wife because of her symptoms and that she was closely monitored in room 2. However, as far as he was concerned, this increased level of observation was insufficient and she should have had the benefit of one-to-one nursing care.

15. Mr. Corrigan stated that his wife was anxious and distressed when he arrived on 3rd December, to see her. She had tried to poke him but did not strike him. He gave an account of the plaintiff's fall which is in accordance with that set out earlier in this judgment and stated that at the time of her fall that the nurses were in the nurse's station. They came in immediately on hearing his wife call out. He believed that the fall in question occurred at about 8pm as it was his habit to visit his wife in the evening time rather than the afternoon.

16. The plaintiff's daughter, Lorraine Corrigan, told the court that she visited her mother frequently. She described her mother as being like a "feather in the wind". She had no coordination, was dribbling from the mouth and had Parkinsonian symptoms. She said that her mother had had lots of falls and that she complained to her regularly about being dizzy. She stated that she had expressed her concerns regarding her mother's falls and her dizziness to the nursing staff and she too believed that she should have had one-to-one nursing care in November and December, 2005.

17. Dr. Mohan, Consultant Psychiatrist and Lecturer in Psychiatry in Trinity College, told the court that the one-to-one nursing care which was introduced for a period on 1st December, 2005, should have been continued and that it was negligent on the part of the defendant to discontinue it. He stated that one-to-one nursing care had three objectives, namely, observation, supervision and support. It had a particular therapeutic value and was proactive insofar as it allowed for interaction with the patient. This was different to general nursing and to any increased level of observation that may have been carried out by members of the nursing staff from the nurses station or, indeed, from some little distance away. It was possible to make one-to-one nursing un-intrusive if the presence of a nurse made the patient agitated. In those circumstances, the relevant nurse might remain at arm's length, or perhaps somewhat distant from the patient, thus minimising any aggravating stimulus to the patient whilst allowing for ongoing proactive intervention.

18. Whilst one-to-one nursing could not, Dr. Mohan, explained, eliminate all risk it permitted the nurse concerned to identify risks and to manage the patient within the resources available. The risks in the present case arose from the unsteadiness of the plaintiff's gait, her unsettled and disturbed demeanour and the fact that she might pose a danger to herself and to others. Dr. Mohan was of the opinion that as of 1st December, the plaintiff was acutely disturbed. Her behaviour had not responded to medication, she was a danger to herself and to others and the one-to-one nursing which was introduced briefly on that date should only have been removed if there had been a sustained response to the change in her medication. Dr. Mohan stated that if one-to-one nursing did not work, the next step was to try two-to-one nursing, and if that was unsuccessful the patient should have been nursed in their her own room with the nursing staff remaining outside the open door.

19. As to how one-to-one nursing would have impacted upon the events immediately surrounding the plaintiff's fall, Dr. Mohan agreed that the special nurse would have sat some distance away from Mr. and Mrs. Corrigan to allow them privacy in the course of that visit. He stated that the nurse might have advised Mrs. Corrigan not to get up too quickly, being aware that she previously had difficulties with blood pressure variation. Dr. Mohan agreed that one-to-one nursing could never eliminate the risk of a patient falling but it certainly lowered the probability of such an occurrence.

The Defendant's Evidence

20. Dr. Byrne, Consultant Psychiatrist, told the court that he had been in charge of the plaintiff's care since May, 2000. In 2003, in the course of her third admission, she had fallen and had fractured her right shoulder due to an adverse response to a particular drug. The Plaintiff had no problems with unsteadiness once that drug was withdrawn and she did not fall again until 2nd December, 2005. She was very sensitive to antipsychotic medication. It had to be introduced very slowly to avoid the onset of Parkinsonian symptoms. However, he said that even in the presence of Parkinsonian symptoms, the plaintiff was not prone to falling.

21. Dr. Byrne advised that the patient had unstable blood pressure during the first three days of her stay commencing 15th November, 2005. This accounted for her initial dizziness. The plaintiff's blood pressure was brought fully under control over that period and she had no further episodes of dizziness. Neither did she fall prior to 11.00pm on 2nd December, 2005. Until that time she was going around the hospital freely and was fully mobile. These facts he said were borne out by the nursing records.

22. Dr. Byrne stated that it was a guiding principle of psychiatric care that patients should be cared for in the least restrictive environment possible. Care of a patient as sick as the plaintiff was a challenge for all concerned and a patient, such as the plaintiff, when manic should be permitted to move around their environment freely, if at all possible, as they cannot bear to be confined. At the time of her fall the plaintiff needed the least intrusive level of care which was consistent with her safety and the safety of others. This approach had worked with the plaintiff in the past. In general, Dr. Byrne stated that the plaintiff responded well to the nursing staff, but when manic and paranoid, she became hostile and demonstrated antipathy to the nursing staff At times, she would become both verbally and physically abusive to them and he referred to approximately five entries in the nursing notes demonstrating the plaintiff's hostility to staff when in that condition. One such example he stated occurred in the aftermath of the plaintiff's fall on the night of 3rd December, 2005, when two nurses were with the plaintiff in her room. He referred to the nursing note at 22.00hours which stated "Monica was being assisted into bed, became hostile towards nursing staff and resentful of help, attempted to push staff nurse Jenny Keogh and slipped to the floor in the process". It was Dr. Byrne's opinion that to have provided the patient with continuous one-to-one nursing from 1st December, 2005, would have been counterproductive and would have made her worse. Manic patients hated intervention and she also had delusional feelings regarding the staff. He advised the court that the relevant Guidelines indicate that intrusion worsens mania and makes the patient more agitated and distressed.

23. Having regard to the plaintiff's condition from 1st to 3rd December, 2005, Dr. Byrne believed that the appropriate level of care had been afforded to the plaintiff. She was closely observed in a bed that was underneath the window of the nurses' station which was always staffed. Throughout the unit, the nursing staff maintained an increased level of observation of the plaintiff because of her presenting symptoms but only introduced one-to-one nursing care if they felt it was essential.

24. Dr. Byrne told the court that he reviewed all in-patients twice a week and that one day each week the multidisciplinary team would formulate the care plan for the patient, consider their ongoing treatment, drugs, nursing issues and progress. The team decided that because of the plaintiff's symptoms and her varied presentation, that her care would be nurse led rather than doctor driven. If the patient became manic, nurses could institute one-to-one nursing which could remain in place until the episode passed. Mostly, this was required to stop the plaintiff annoying other patients. The staff had found that restriction or even the physical presence of a nurse beside the plaintiff when in such a condition made her worse and was prone to cause her to hit out.

25. Even if the plaintiff had been under one-to-one nursing supervision on 3rd December, 2005, the nurse concerned would not, in Dr. Byrne's opinion, have been able to prevent her fall. The nurse would not have been immediately beside the patient as she got up. Even if she had been beside the patient, the plaintiff was sixteen stone and it would not have been possible for a nurse to prevent such a fall. He pointed to the fact that the plaintiff had fallen twice on the same evening after the fall the subject matter of these proceedings. On both occasions, she had fallen when in the presence of two members of the nursing staff and they had not been in a position to save her.

26. On cross-examination, Dr. Byrne accepted that the patient was very disturbed on 1st December, 2005. He refuted the assertion that nothing had been done for the patient. He asserted that the plaintiff was assessed on an ongoing basis by himself and Dr. George. Following her first fall at 11pm on 2nd September, 2005, the plaintiff was seen by Dr. George. He checked her blood pressure, ordered a number of tests and directed that she be given additional fluids. The management plan was that the plaintiff's medication would be increased slowly because of her sensitivity to anti-psychotic medication and whilst waiting for that to take effect the nursing staff would monitor the patient very closely. The plaintiff was not to be placed on continuous one-to-one nursing as it was felt this would have been counterproductive. The plan included, however, the right of the nursing and medical staff to introduce short term therapeutic intervention if it was considered to be in the patient's best interests or if the interests of others.

27. Nurse Jenny Keogh told the court that she started working with the plaintiff in 2003. The patient was nursed in special observation room 2. The nurse's desk was about 4ft from the plaintiff's bed, albeit in the next room. That desk was manned 99% of the time. The nursing staff sometimes introduced one-to-one nursing to prevent the plaintiff upsetting other patients. If manic, nurses had to stay at a distance as she would often hit out and push them away. When going to the bathroom in that state she would not always accept help and could only be monitored at a distance. Following the plaintiff's fall on the 3rd December 2005, she provided her with a period of one-to-one care in the course of which she gave her tea and toast, took her to the bathroom and tried to help her with her sling. The plaintiff was however resentful of her assistance and hit out at her. In doing so she fell onto the floor and it took three members of staff, to lift her up.

28. Nurse Keogh confirmed that if a patient who was receiving one-to-one nursing had a visit from their husband or wife the nurse would move a good distance away to afford them some privacy. It was her opinion that even if one-to-one nursing had been provided on 3rd December, that this would not have stopped the plaintiff falling. Unless two people were linking the plaintiff at the time she started to fall such a fall could not be been prevented and it was her opinion that the plaintiff would not have tolerated intervention of that nature in her manic state.

29. Mr. Larry Kelly, a nurse in the acute unit in Roscommon County Hospital, told the court that he had an excellent relationship with the plaintiff and her family. He came on duty on the morning of 3rd December. Shortly before her fall he had seen the plaintiff with her husband on the corridor and they seemed to be getting on okay. Then he heard a commotion and went into room 2 to find the plaintiff had fallen. She had a bump over her eye. Dr. George then arrived to carry out a medical review. Later, at about 5.50pm, he wanted to take the plaintiff's vital signs. At that stage the plaintiff decided to get up and he and another nurse shadowed her out into the corridor. The plaintiff would not allow Irene, the other nurse, to link her and she suddenly plummeted to the ground. They were not able to react in time to stop the fall even though they were beside her. On cross-examination, Mr. Byrne stated that the plaintiff was being very closely monitored on and off for most of the day on 3rd December, 2003, even though this may not be noted in the records.

30. Dr. John Ryan, Consultant Psychiatrist, stated that the plaintiff's condition during December, 2005 was manic and that she was

also aggressive, hostile, uncooperative and overactive. She was disturbed, irritable, had delusionary ideation and was resistant to instruction. She was verbally and occasionally physically aggressive to staff. In his opinion, one-to-one nursing was not indicated. To have introduced one-to-one nursing on a continuous basis, as contended for by Dr. Mohan, would have provoked an escalation in her behaviour as a patient in her condition would be intimidated and irritated by the intrusion of any close physical presence. It was his professional opinion that the care provided by the defendant over the relevant period was in accordance with approved practice. Dr. Ryan was further of the view that even if one-to-one nursing had been introduced by the defendant over the relevant period that this would not have prevented the fall which the plaintiff sustained on 3rd December, 2005.

The Law

31. There have been many judgments in recent years in which the courts in this jurisdiction have reviewed the test to be applied in medical negligence litigation. I see no need to go further than to state that the law in this regard remains as first encapsulated by Finlay C.J. in his decision in Dunne v. The National Maternity Hospital [1989] I.R. 91 at 109 where he stated as follows:-

> "1. The true test for establishing negligence in diagnosis or treatment on the part of a medical practitioner is whether he has been proved to be guilty of such failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care.
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> 2. If the allegation of negligence against a medical practitioner is based on proof that he deviated from a general and approved practice, that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualifications.
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> 3. If a medical practitioner charged with negligence defends his conduct by establishing that he followed a practice which was general, and which was approved of by his colleagues of similar specialisation and skill, he cannot escape liability if in reply the plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.
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> 4. An honest difference of opinion between doctors as to which is the better of two ways of treating a patient does not provide any ground for leaving a question to the jury as to whether a person who has followed one course rather than the other has been negligent.
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> 5. It is not for a jury (or for a judge) to decide which of two alternative courses of treatment is in their (or his) opinion preferable, but their (or his) function is merely to decide whether the course of treatment followed, on the evidence, complied with the careful conduct of a medical practitioner of like specialisation and skill to that professed by the defendant.
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> 6. If there is an issue of fact, the determination of which is necessary for the decision as to whether a particular medical practice is or is not general and approved within the meaning of these principles, that issue must in a trial held with a jury be left to the determination of the jury."

Findings of Fact

32. Having stated the legal position, I now propose to set out very briefly a number of findings of fact which are material to my ultimate conclusions in respect of both liability and causation.

> (i) I accept that the plaintiff's fall in 2003, which led to the fracture of her right shoulder, was, as stated by Dr. Byrne, due to a particular drug and that once it was removed from her drug regime that she had no further falls until the evening of 2nd December, 2005. His evidence is fully supported by the very thorough nursing records which make no mention of any falls over that period. Insofar as Mr. Corrigan and Ms. Corrigan gave evidence that the plaintiff fell on a regular basis, I believe that the falls to which they referred can only have been those that either predated her injury in 2003 or those which occurred on 2nd and 3rd December, 2005.
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> (ii) I find as a fact that the plaintiff was dizzy and unsteady on her feet on the first three days of her admission in November 2005. I accept Dr. Byrne's evidence that this brief period of unsteadiness related to her fluctuating blood pressure. This was brought under control and the plaintiff did not have any further periods of unsteadiness prior to the evening of 2nd December, 2005. This appears to be validated by the nursing notes which record her as moving around the hospital freely without supervision. She was able to go to the dining room for meals, to attend to her own personal hygiene and to walk outside and enjoy the company of other patients who, unlike herself were smokers. Accordingly, I cannot accept Mr. Corrigan's evidence or that of his daughter that the plaintiff was dizzy during all of the period of her hospitalisation in November and December, 2005 and that they complained of this fact to the nursing staff. I think it is highly likely that, because of the passage of time, their recollection may not be as reliable as the contemporaneous nursing records and that the events that they were recalling were confined to the periods where such symptoms are in fact noted in the records. In this regard, it is worth stating that Dr. Ryan was of the opinion that the nursing notes were as good as he had ever seen in his 40 year career in psychiatric medicine.
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> (iii)I am satisfied that the plaintiff's fall, contrary to Mr Corrigan's evidence, occurred shortly before 4pm on 3rd December. All of the nursing and medical records are consistent with this finding. Further, Dr. Byrne gave oral evidence that he was telephoned by Dr. George about the plaintiff's fall at 4pm and this is again noted in the medical records. I also accept the evidence of Nurse Larry Kelly that the fall happened in the later afternoon and that the X-ray carried out after the fall had been reported upon by 7.15pm before he went off-duty.
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> (iv)I accept as a matter of fact that when agitated, manic and paranoid, the plaintiff's condition was aggravated by nursing intervention and that her behaviour became more abusive and aggressive towards medical and nursing staff. Again, this appears to be corroborated by the nursing records. On 27th November, 2005, it was recorded that the plaintiff was "very abusive towards staff when they intervene". On 28th November it was recorded "she is irritable and argumentative when corrected". On 29th November the plaintiff was noted to be "irritable when corrected by staff to comply with treatment here" and on 1st December as being "paranoid about members of the staff". On the same night she was noted as being "verbally abusive towards nursing staff", that she had "hit out at female staff on one occasion and threw a cup of water at female staff also". She is further recorded as having "attempted to

push staff out of way". On 2nd December she was recorded as believing that "one member of staff had a curse on her, when she hears his voice she feels dizzy and that's why she falls".

(v) I am satisfied that in the days prior to her fall on 3rd December, 2005, that the nursing staff increased its level of observation over the plaintiff and that the extent and nature of the nursing care she required was kept under constant review. I am also satisfied that each of the plaintiff's falls, commencing on 2nd December at 11pm, were formally reported; that she was assessed by the medical staff after each such fall and that a multiplicity of interventions were directed by the medical staff with a view to improving her condition and establishing the cause of the falls.

(vi)As a matter of fact, I have concluded that one-to-one nursing care was effective principally when used as a method of curtailing the plaintiff's interaction with other patients when she was at her most disruptive as is, for example, demonstrated by the nursing note made on 27th November, 2005. There it is stated that "she was nursed one on one principally to stop her disturbing other patients".

(vii)I am further satisfied as a matter of fact that one-to-one nursing did not serve as a method of improving the plaintiff's own safety. This is borne out by the two falls that the plaintiff had on the night of 3rd December, 2005, when on both occasions she was attended by two members of the nursing staff but yet managed to fall.

(viii)Finally, I have concluded that that the plaintiff's condition when an inpatient in the defendant's hospital in July, 2006 was not comparable to her condition at the time of her fall, the subject matter of these proceedings. In July, 2006 she was suffering from both cardiac instability and a respiratory infection. In addition, she then had the history of having fallen in December, 2005 and having broken her shoulder. According, the level and nature of the nursing care afforded to her in July, 2006 is not material to the liability issue in these proceedings.

Conclusions

33. The plaintiff is a lady who is obviously greatly loved and respected by her family. That is a respect shared by the medical and nursing staff at the defendant's hospital where she has been treated intermittently, but regrettably for very substantial periods, since her first admission in 2000. It is clear from the evidence that the plaintiff is extremely engaging and charming when she is well but when unwell, she is, to put it kindly, very uncooperative and disruptive. Whilst of no relevance to the liability issue, it is perhaps appropriate to note that all of the defendant's witnesses remarked upon the fact that in the aftermath of a period of agitation and/or paranoia that the plaintiff is always incredibly contrite and apologetic for any disturbance that she may have caused.

Liability

34. I know that the plaintiff and her family are genuine in their belief that she should have had the benefit of one-to-one nursing care in the run up to 3rd December, 2005 and that if it had been provided she would not have sustained her injury. However, I am not satisfied that the plaintiff has discharged the weighty burden of proof demanded of a plaintiff in proceedings of this nature. Dr. Mohan has not convinced me that the defendant's failure to provide the plaintiff with continuous one-to-one nursing care from 1st December, 2005, or to consider as an alternative, two-to-one nursing care or nursing the plaintiff in her room with an open door, amounts to "such a failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care". Having regard to the evidence of Dr. Ryan and Dr. Byrne, I am satisfied that there is a substantial body of medical opinion that would, having regard to the plaintiff's history, support the defendant's management of her care over the period, 1st – 3rd December, 2005, inclusive.

35. It was not disputed that it is now a fundamental and guiding principle that all persons with mental health problems should be managed in the least restrictive environment possible consistent with their safety and the safety of others. Neither was it contested that the relevant psychiatric guidelines indicate that intrusion worsens mania and makes a patient in such a state more agitated and distressed. Further, all three psychiatrists agreed that during the relevant period, the plaintiff appeared to feel threatened and was paranoid when engaged by members of the nursing staff; that she was irrational, hostile and responded aggressively to physical intervention or efforts to confine her, and that these features created what Dr. Mohan described as an extremely challenging situation for those charged with her care.

36. It is undoubtedly the case that as of 1st December, 2005, the plaintiff's condition was such that those responsible for her care were mandated to consider the risk she posed to herself and to others and to consider her potential need for the introduction of some level of additional nursing care. However, that decision and indeed all subsequent decisions regarding the level and nature of the care which she required had to be made taking into account her likely response to any measures introduced to achieve this objective.

37. Having considered the evidence, I am satisfied that Dr. Mohan's evidence on the liability issue is significantly undermined by the facts of the case. He maintained that continuous one-to-one nursing care, which he described as a type of therapeutic security, ought to have been provided principally to reduce the risk that the plaintiff might injure herself, another patient or a member of the staff. Firstly, there is no evidence from which I could conclude as a probability that the introduction of one-to-one nursing care, two-to-one nursing care or indeed open door nursing care, would have reduced the plaintiff's risk of causing injury to herself. In this regard, she fell twice when in the presence of two members of the nursing staff on the evening of 3rd December, 2005. Further, the latter of those falls appears to have been directly stimulated by efforts on the part of Nurse Keogh to assist the Plaintiff whilst providing her with one-to-one nursing care. In addition, Dr. Mohan accepted that, because the plaintiff responded badly to the close physical presence of nursing staff, any nurse assigned to one-to-one duties, would have to stay a short distance from the patient. This would have hugely undermined the effectiveness of one-to-one nursing care as a method of reducing the plaintiff's risk of sustaining an injury brought about by a sudden fall.

38. Secondly, as to Dr. Mohan's evidence that one-to-one nursing care was necessary to reduce the risk of the plaintiff injuring members of staff, that opinion is in the teeth of the oral evidence and the medical and nursing records. As already alluded to in my findings of fact, the plaintiff was continually argumentative and abusive to staff throughout all of the relevant period. She struck out physically at nursing staff on a number of occasions when they came within reach. In addition, she was also paranoid and suspicious of not only the nursing staff but of the medical staff. By way of example, Dr Byrne recorded in the medical chart on the night of her fall that the plaintiff "remains very disturbed and manic. Paranoid towards staff. Believed I was going to break into the room when she was asleep". I accept Dr Byrne's evidence that whilst the plaintiff was in this condition the close proximity of nursing staff would have increased the risk of injury to members of the staff.

39. As to the likelihood of one-to-one nursing care reducing the risk to third parties, the evidence was that when the plaintiff was

deemed to be a risk or a nuisance to other patients that one-to-one nursing care was deployed.

40. This is not a case in which the defendant simply ignored or failed to consider the risks emanating from the plaintiff's condition in the course of her hospitalisation commencing 15th November, 2005. The defendant assessed the plaintiff and drew up a plan for her care. That plan was reviewed on an ongoing basis by the nursing staff, the medical staff and the multidisciplinary team. It allowed for the introduction of one-to-one nursing care when medical or nursing staff felt it necessary and this was implemented on many occasions. However because of the plaintiff's adverse response to any therapeutic intervention which involved close interaction with the nursing staff, continuous one-to-one nursing care was not deemed an appropriate method of protecting the plaintiff from causing an injury to herself or to the nursing staff. Instead, the defendant responded to the Plaintiff's ongoing symptomology by continuing to monitor and assess her condition from a medical and nursing perspective, by placing her under an increased level of observation and by introducing short periods of one to one therapeutic intervention when it was deemed necessary and appropriate.

41. Finally, on the liability issue, having considered the evidence of Dr. Ryan and Dr. Byrne, I reject Dr. Mohan's evidence that if the plaintiff was not tolerating one-to-one or two-to-one nursing care, that open door nursing should have been considered. Firstly, his evidence did not go so far as to suggest that the failure of the defendant to introduce this type of care for the plaintiff was to fall short of the appropriate standard. Further, Dr. Mohan did not contest the Defendant's evidence that when in a manic state any efforts to curtail the plaintiff's movements tended to escalate her symptoms. Accordingly, the Plaintiff cannot establish liability on this basis. This type of care would probably have exacerbated the plaintiff's symptoms and put her at an even greater risk of causing injury to herself. Also, in such a scenario the nursing staff would have remained at some distance from the Plaintiff outside her bedroom door. Accordingly, as a matter of fact it seems most unlikely that this type of care would, if introduced, have reduced the risk of the Plaintiff falling. Thus, any claim made on this ground must also fail.

Causation

42. Even if I were to accept Dr. Mohan's evidence on the liability issue in my view the plaintiff's case must in any event fail on causation. All three consultant psychiatrists were agreed that any patient who was having a visit from their spouse would be afforded a degree of privacy, even if they were receiving one-to-one nursing care. The relevant nurse would retreat some distance away to allow for a private exchange to occur between the couple. Thus, even if the plaintiff had been receiving one-to-one nursing care on the afternoon of 3rd December, that nursing care would not, on the balance of probabilities have prevented the fall that occurred.

43. Dr Mohan's evidence that had a nurse been present she might have advised the Plaintiff to get up more slowly and that this advice might have prevented the fall is not a sufficient basis from which the court could make a causation finding in the plaintiff's favour. Firstly, this scenario presupposes that the plaintiff would have announced her intention to get up in sufficient time to allow for the possibility that the relevant nurse would have intervened before she moved. It then presupposes that the nurse would actually have intervened and advised the patient to get up slowly. It also assumes that the plaintiff's fall occurred because she got up too quickly in the presence of blood pressure irregularities. This was not established to be the reason why the plaintiff fell. His scenario also presumes that, having announced that she was intending to go to the toilet, the plaintiff would then have complied fully with the nurse's advice to move slowly, notwithstanding the fact that the evidence clearly established that when manic and paranoid she was resistant to any such advice or intervention by the nursing staff. Lastly his scenario assumes the plaintiff would then not have fallen.

44. The facts as established are that plaintiff got up quickly and fell for no apparent reason. Her husband, who was only two to three feet away, did not predict a fall and he was not able to save her. She had been in moderately good form in the minutes prior to the fall and her husband was not alarmed by her announcement that she was heading to the toilet. It would be fanciful to conclude, having regard to the speed at which she fell, the location of the fall, her antipathy to the nursing staff, the likely position of any member of the nursing staff who might have been in attendance, her weight of over 16 stone and the fact that she fell twice later the same evening when accompanied by two nursing staff, that either one-to-one nursing care or two-to-one nursing care could have prevented the fall the subject matter of this claim.

45. For all of the aforementioned reasons, I accept the defendant's evidence that the standard of care provided to the plaintiff over the relevant period and in particular over the period, 1st – 3rd December, 2005, was appropriate and did not fall below the appropriate standard. Even if I am wrong in coming to this conclusion the Plaintiff's case, having regard to the evidence must in any event fail on the grounds of causation.