Neutral Citation Number: [2010] IEHC 247

THE HIGH COURT

2009 219 SP

2009 40 SP

2008 446 SP

IN THE MATTER OF AN GARDA SÍOCHÁNA (COMPENSATION) ACTS 1941 AND 1945

BETWEEN

MICHAEL CAREY

RICHARD O'CONNOR

MARTIN O'SULLIVAN

PLAINTIFFS

AND

MINISTER FOR FINANCE

DEFENDANT

Judgment of Ms. Justice Mary Irvine, dated the 15th day of June, 2010

Introduction

0.1 These are three separate actions which were listed together for hearing. The plaintiffs have each brought claims under the Garda Síochána (Compensation) Acts 1941 – 1945 ("the Acts") seeking compensation for injuries maliciously inflicted on them in the course of their duties. I directed that these three cases be heard together because each of them concerns an alleged fear on the part of the plaintiff of contracting Hepatitis B (HBV), Hepatitis C (HCV) and/or Human Immunodeficiency Virus (HIV) infection and it was felt that it would be desirable for the Court to have the benefit of expert evidence in relation to the risks of contracting these diseases in an occupational setting such as An Garda Síochána. It was intended that these claims would serve as test cases to enable the Court to obtain a better understanding of these viruses, the true risk of their transmissibility and also to try to identify the principles to be applied when awarding compensation in what I will describe as "fear of disease" cases brought pursuant to the Acts. A more complete account of the reasons which informed the Court's thinking in directing the trial of these claims on oral evidence is to be found in the appendix to this judgment which records my observations to the relevant parties on 9th November, 2009. As can be seen from those observations, I was concerned that in a number of recent fear of disease cases that the advice given to the Gardaí by their general practitioners and/or the doctors at the hospitals which they attended post assault was at variance with the advice which had been given to this Court by specialists in the area of infectious diseases in other cases.

0.2 Having considered the evidence, I am satisfied that there are a number of factors contributing to the increasing prevalence of fear of disease claims being maintained under the Acts. They are as follows:

(i) a lack of up-to-date knowledge regarding the HIV and HCV viruses and their susceptibility to treatment;

(ii) an absence of a real understanding as to the circumstances in which blood testing and/or the imposition of restrictions on unprotected sexual relations are warranted following potential exposure; and

(iii) a grossly inflated view of the possible risk of transmission of these viruses.

Unfortunately, from the evidence, it seems that the lack of knowledge to which I have referred does not confine itself to members of the public, or as in these cases the members of An Garda Síochána ("members"), but also regrettably permeates the medical profession itself at many levels.

0.3 Prof. Samuel McConkey is a Consultant in Infectious Diseases and Tropical Medicine and General Medicine in Beaumont Hospital in Dublin; a Consultant in Our Lady of Lourdes Hospital in Drogheda and Head of the Department of Tropical Medicine in the College of Surgeons. He was retained by the defendant in the present proceedings on foot of the Court's direction. Dr. Gerard Sheehan is a Consultant Physician specialising in Infectious Diseases at the Mater Hospital and was retained on behalf of the plaintiffs to advise the Court in relation to the possibility of transmission in each of the three cases before the Court and also in relation to those categories of injuries set out by the Court in its directions of 9th November, 2009. I believe it will be easier for the reader to understand my conclusions in these cases if, prior to dealing with the facts of the individual cases and the legal issues arising therefrom, I set out a brief summary of the evidence of Prof. McConkey and Dr. Sheehan in relation to the three viruses of concern to the plaintiffs..

0.4 I will accordingly approach this judgment in the following manner:

(i) a summary of the general evidence given by Prof. McConkey and Dr. Sheehan, "the experts" in relation to HIV, HBV and HCV;

(ii) the evidence as to fact in each of the three cases;

(iii) the Plaintiff's submissions;

(iv) the Defendant's submissions;

(v) the role of the court when exercising its jurisdiction pursuant to Acts;

(vi) conclusions on legal issues;

(vii) conclusions as to fact in each of the cases; and

(viii) overall summary.

1. Summary of Evidence of Prof. McConkey and Dr. Sheehan

HIV
1.1 According to the experts, HIV was first described in 1981 and by 1983 it had become clear that it was transmitted through sexual activity and blood products. Later there were concerns that it might be transmitted through casual contact but by the late 1980's studies had established that intimate but non-sexual contact did not transmit HIV. Saliva and sputum were shown to be non-infectious and even deep kissing was established as being safe. HIV may be transmitted if an infected person's blood is inoculated into the flesh of another or onto a mucosal area such as the surface of the eye or the inside of the mouth. The most common form of transmission in an occupational setting is through needle stick injury (NSI) and this is encountered most frequently in the healthcare system.

1.2 The consequences for an individual contracting HIV, which in Ireland is predominantly an east coast phenomenon, have radically changed since 1996 due to the availability of powerful anti-retroviral therapies. Timely intervention with post-exposure prophylaxis (PEP) reduces transmission by more than 99%. PEP should be available to any Garda ("member") exposed to a risk of infection. Even without treatment, an infected individual taking anti-viral medication, will remain well for about 9 years. Thereafter, once they comply with their prescribed medication regimen once daily, infected patients are expected to live a relatively normal life. They can participate in physically demanding contact sports such as rugby. They should not suffer prejudice in matters of banking or borrowing, nor in matters of employment. Prof. McConkey described the life of a patient with HIV as being not dissimilar to that of a diabetic who requires daily medication. Once they take their medication they will remain well, but if they ignore medication the illness may prove fatal.

HBV
1.3 A vaccination exists against acquiring HBV and this is offered to all members. Each member carries a custom designed card to identify when they were last inoculated. Accordingly, if they are involved in an incident where they are potentially at risk of contracting HBV their status is immediately ascertainable by any medical practitioner who may then confidently advise as to whether or not it is necessary to check their titre levels. Depending on the result of these tests, a decision will then be made as to whether or not HBV immunoglobulin should be administered. Even without vaccination, 90-99% of those who contract the virus will clear it through their own immune response within 6 months.

HCV

1.4 HCV was initially known as Non A, Non B Hepatitis. It was defined as HCV in 1989. It is transmitted by blood and blood products, by mother to child transmission at birth and by sharing needles. About 20% of patients who contract HCV will clear their infections spontaneously. Of the remaining 80% of patients who experience chronic HCV, at 17 years post infection, only 2 % of this group will have developed a serious complication of the virus such as cirrhosis of the liver. However, most importantly in the context of the present proceedings, current treatments for acute HCV, as might arise, for example, if a member was to be stabbed with the syringe containing infected blood, are 98% effective.

1.5 Approximately 80% of all Intravenous ("IV") drug users have HCV as infected blood from one individual it is easily transmitted to another with whom they may be sharing needles.

How Are These Viruses Transmitted?
1.6 The first and most likely method of transmission for HIV and/or HCV is through percutaneous exposure. This involves the infectious substance, namely the blood of a contaminated individual, being inoculated through a break in the surface of another person's skin. Excluded from the type of break in the skin which might lead to transmission is what Prof. McConkey described as an injury caused by a "ruffle with the razor". It involves what he described as "visible holes with blood coming out". Percutaneous exposure most commonly occurs in the occupational setting through a needle stick injury ("NSI"). A cut to the skin caused by an implement, or a break in the skin caused by a human bite, may also permit infected blood from an assailant to infect their victim. It is vital to note that in the case of a bite that the saliva of an individual that is HIV/HCV positive does not transmit infection to an open wound. It is only where the saliva contains infected blood that even the remotest risk of transmission occurs and this is because HIV and HCV are blood borne viruses. In relation to bites Professor McConkey explained that the greater the amount of blood in the saliva and the greater the amount of internal tissue involved the greater the risk of infection. The type of bites referred to in case studies were bites involving "chunks of tissue".

1.7 The second method of exposure is by the transmission of infected blood, or other infected body fluid, onto or into mucous membranes such as the ocular surface or the inside of the mouth or nose. Regarding HIV, both the blood and genital secretions of an infected individual, male or female, may be infectious. However, with HCV, only blood is infectious.

Real Risk of Transmission from HIV/HCV
1.8 Dr. Sheehan advised the Court that the statistics which he relied upon when preparing his report and when giving evidence were from the pre-1996 era when almost all HIV patients had a high viral load. The level of an assailant's viral load is a critical factor in estimating the risk of transmission of HIV as the higher the viral load the greater the risk of transmission. However, the vast majority of individuals who are currently HIV positive have undetectable viral loads as a result of the fact that most of them are on antiretroviral treatment. Accordingly, the statistics relied upon overstate the real risk of transmission.

1.9 Dr. Sheehan advised the Court that knowledge of the index person's medical status is critical to the assessment of the risk of transmission. Sometimes, the HIV and/or HCV status of an assailant will be known. At other times, the precise HIV and/or HCV status of an assailant may be unknown but they may fall into a well defined risk group such as would be the case where an assailant is a known intravenous drug abuser. For these reasons, it is important to note Dr. Sheehan's evidence that the probability of an Irish person being HIV positive is in the order of 1:1,000 if they are not in an obvious well defined risk group such as those who use intravenous drugs. If an assailant is a drug abuser whose actual HIV status is unknown there is a 1:10 risk of them being HIV positive.

These statistics impact upon the risk of transmission of HIV to which I will now briefly refer.

1.10 Where an assailant is definitely HIV positive and an individual is subjected to an NSI, the risk of the victim contracting HIV is 1:300. Where an assailant is definitely HIV positive and there is real evidence that the blood of that individual has made contact with a mucus membrane of their victim, the risk of transmission of HIV is something between 1:3,000 and 1:30,000. Finally, where an assailant is definitely HIV positive and their blood makes contact with an open wound or with a laceration on their victim, the risk of transmission is, according to Dr. Sheehan "orders of magnitude less than for blood to a mucus membrane". However, the risk is not zero. The risk is between 1:10,000 and 1: 50,000. In this latter case, if the assailant is only known to be a drug user rather than somebody who is definitely HIV positive then the risk is between 1:100,000 and 1:500,000. For this same risk, if the assailant is an ordinary member of the public and not in a defined risk group, the risk to the victim is between 1:10,000,000 and 1:50,000,000. Bites, fall into this category insofar as the risk of transmission is concerned and then only if it can be established that there was blood in the saliva of the assailant at the time when the bite was inflicted.

1.11 Based upon all of the statistics available, Dr. Sheehan stated as follows in his report of 12th February, 2010, namely:-

> "The probability of an Irish individual being HIV positive is in the order of 1:1,000 or less, assuming they are not in an obvious well defined risk group. If the exposure is not needle stick injury, I usually estimate the risk of transmission as less than 1:1,000,000, which is zero for all practical purposes. In this case I discourage follow up bloods and any restriction on sexual life."

1.12 Dr. Sheehan also assisted the court in relation to the risk of transmission of HCV by each of the methods just discussed in respect of HIV. Because 80% of drug abusers are HCV positive, he stated that the risk of an individual contracting HCV by a NSI from an individual known to be an intravenous drug abuser was about 1:60 or where the assailant was known to be HCV positive the risk was in the region of 2% to 3%. For other types of transmission he stated that the statistical chances of contracting infection increased by two orders of magnitude beyond those which apply in relation to HIV transmission. However, he went on to state that this increased risk of the transmission of HCV was more than compensated for by the more benign nature of HCV compared to HIV, given that the majority of HCV cases will run a benign course even if undetected or untreated**.** He emphasised the fact that HCV can now be cured in a majority of cases with treatment in the first year being associated with exceptionally high cure rates.

1.13 Prof. McConkey tried to demonstrate why members should not fear infection from being bitten in the course of their duties. He advised that for a person to become infected with HIV from a bite, a series of low risk unfortunate events must happen:

> (i) the assailant must have circulating detectable HIV in their blood. This, Professor McConkey advised, would be highly unlikely as most drug users in Ireland are on treatment for HIV and if compliant will have undetectable viral loads and therefore are unlikely to be infectious;
>
> (ii) the bite must be one which actually breaks the skin of the victim thereby providing an access route for the infected blood;
>
> (iii) there must be blood in the saliva of the assailant and this must enter the open wound of the victim. The greater the amount of blood and the deeper the wound, the greater the chance of infection;
>
> (iv) the infective virus must come into contact with the appropriate cells; and
>
> (v) Post exposure prophylaxis (which is according to Prof. McConkey is 98% effective and according to Dr Sheehan more than 99% effective if administered in a timely manner) must fail.

1.14 Infected blood coming into contact with intact skin creates no risk. Dr. Sheehan told the Court that family members and healthcare workers look after patients with HIV all of the time and they are not deemed to be at risk. Small shaving cuts do not count. Saliva without blood does not transmit HIV and discordant couples i.e. where only one party is infected, may "deep kiss".

1.15 Because of the facts of the present cases some of the most comprehensible and meaningful evidence was that given to the court by Prof. McConkey when he referred to a study carried out in Amsterdam over a four year period commencing in 2000. In that study, 1,287 police officers were assessed as having been exposed to a transmission risk in respect of HIV and /or HCV, mostly through needle stick injuries and bites, yet none of them acquired infection. He also referred to a 2008 dissertation by Dr. David Poots regarding the known incidence of infection of Police Officers in England, Wales and Northern Ireland with HIV and/or HCV. Dr. Poots received responses from 64% of the relevant Occupational Health Physicians and found that there had been no recorded instance of HCV or HIV transmission. One case of occupationally acquired HBV was reported.

1.16 On a world wide basis, Prof. McConkey stated that there were only five reported cases of alleged HIV transmission through a human bite. He found only three of these cases convincing. In two of the three cases the assailant was in the later stages of AIDS and probably had a very high viral load. In all three cases a significant amount of blood had been present in the assailant's mouth.

1.17 As to the risk of contracting HCV from a bite, Prof. McConkey confirmed that blood is the main route of transmissions for HCV. The rate of transmission by way of NSI from an assailant known to be HCV positive is much greater than that for an assailant who is HIV positive, with the risk being 1.9%. Dr. Sheehan placed the risk as between 2% and 3%. These are the statistics where PEP is not given and this should be available to any member who requires it. PEP treatment is effective in 98% of cases. Prof. McConkey referred to one case in this jurisdiction where the High Court awarded damages on the basis that a member had contracted HCV from a bite to his ear. The bite in question was inflicted in 1985. The diagnosis was not made until 1994. As the members HCV status was unknown for all of the period up to the diagnosis, Professor McConkey stated that he was unconvinced that the bite was the probable cause of infection and felt that it was far more likely to have been contracted from a risk factor other than the bite.

1.18 Prof. McConkey found only two case reports in the medical literature of people who allegedly acquired HCV through a bite. The findings made in one of those cases he considered to be of doubtful validity. Further, he found no published case of any police officer or other security worker having acquired HCV from a bite or splash of blood to a mucous membrane.

1.19 It was clear from the evidence of Prof. McConkey and Dr. Sheehan that public understanding, and indeed the knowledge of those charged with the care of the victims of assault, has not kept a pace with the advances made by the medical profession in terms of its ability to ward off potential infection and treat it should it occur. Professor McConkey referred to the overall societal lack of knowledge as to how these viruses are transmitted. He stated that Irish people are not aware of what it really means to live with HIV infection in 2010. Worse still was the frequency with which patients presented to him with misinformation of a "staggering" nature

which in many instances had been given to them by doctors and/or nurses.

1.20 Prof. McConkey stated that it had to be accepted that not every general practitioner could be expected to be aware of the definite risk calculations for each patient potentially exposed to infection. However, he stated that there were simple cases, such as a splash of blood onto intact skin, which were clear cut and where the risk was essentially zero. He said that all doctors should be aware of this. He acknowledged that assessing the risk of infection in more complicated cases, such as where a surgeon may get a needle stick injury when operating on a HIV positive patient, is a more specialised task. He stated that experience for a general practitioner is driven by the frequency of the presenting event and he advised the Court that fights and assaults happen all of the time all over the country. If a general practitioner has victims of such assaults attending their medical practice it behoves them to be sufficiently knowledgeable to adequately advise them regarding the risks emanating therefrom and as to any precautions required.

1.21 In relation to Hepatitis C, Prof. McConkey stated:-

> "I think the key important message that many people probably aren't aware of I suspect in Hepatitis C is actually the 98% early cure rate. So people who are detected in an early stage after acute infection, as would be the case, for example in some of the unfortunate victims whether healthcare workers or Garda Síochána who are maybe maliciously or accidentally infected through blood exposure, in fact is that if Hepatitis C is treated at an early stage, the data out there in the medical literature suggests a 98% cure rate."

1.22 Prof. Collin Bradley, Professor of General Practice in University College Cork, also assisted the Court in relation to the manner in which general practitioners, over the last decade, would have been expected to deal with individuals seeking their advice in respect of events which they believed may have exposed them to a risk of developing an infectious disease such as HIV and/or HCV.

1.23 Prof. Bradley advised the Court that general practitioners treat blood borne viruses as a group and they do not normally differentiate between the various modes of transmission or the different rates of infectivity. They are principally concerned to establish the status of the source of potential infection, the nature of the contact between the source and the victim and the volume of the infectious fluid.

1.24 Prof. Bradley stated that a general practitioner should be in a position to roughly estimate the risk to the patient and should not carry out blood tests if the risk is sufficiently low. If testing is required, those tests carried out on the victim at three months are important as they allow the doctor to give the patient almost complete reassurance if they are negative. The test at six months was a belt braces measure. If testing is indicated then "safe sex" should be advised by the general practitioner. Initially, contact sports would have been seen as a potential method whereby people with possible blood borne viruses might transmit infection to third parties. However, this had changed in the last decade.

1.25 Medical knowledge regarding HIV and HCV has been stable now for approximately ten years. Doctors can keep themselves updated through ongoing professional development. Professor Bradley indicated that he would expect some general practitioners to have more knowledge than others regarding these viruses depending upon the location of their practice. However, he stated that the expectation would be that a general practitioner would seek advice should they find themselves in an area of uncertainty and/or unfamiliarity.

1.26 Having set out a brief summary of the general evidence in relation to the expert witnesses, I will now deal with the facts and evidence in each of the individual cases.

2. Facts and Evidence in each of the Subject Cases

Garda Carey

2.1 Garda Carey was born on 3rd August, 1978 and is currently attached to Portlaoise Garda Station. His claim relates to injuries sustained by him in the course of his employment on 30th December, 2005 when he was bitten on the ring finger of his right hand whilst endeavouring to arrest an individual who had been involved in an altercation. He claims that he sustained physical and psychological injuries as a result of this assault and seeks compensation under the Acts.

2.2 Garda Carey joined the force in 1999. Prior to the date of his assault, he had had no dealings with drug abusers and maintains that he had received no training in relation to the transmissibility of HIV or HCV. He was not aware of the existence of any leaflets on the topic at his garda station and believed that a bite or contact with an infected person's blood could cause infection. On the day of his assault, he had arrested two members of the travelling community. Both were in the back seat of the patrol car with him. One started spitting at him. He put up his hand to protect his face. Unfortunately, the prisoner then caught Garda Carey's finger in his mouth and bore down on it, breaking his skin.

2.3 Back at the station, Garda Carey noted blood on his face. He went to the toilet and washed his face and hands. He then went to the Accident and Emergency Department of Portlaoise Hospital. He knew that his HBV status was assured, having received vaccinations at the commencement of his service. He was advised that he was at risk of contracting HCV and/or HIV and that it was necessary for blood tests to be carried out. The treating doctor advised him of the importance of ascertaining his assailant's HCV/HIV status. Accordingly, the station orderly arranged for the assailant's bloods to be tested and this was done that evening. Garda Carey received a tetanus injection and his finger was dressed.

2.4 Garda Carey attended his General Practitioner, Dr. Booth on the morning of 30th December, 2005. He was prescribed an antibiotic in respect of the risk of bacterial infection to his finger. He was told that there was a risk that he might have contracted HIV or Hepatitis C. He was to return two weeks later on the 14th January, 2006 to discuss the results of his blood tests.

2.5 Shortly after his initial assault, Garda Carey became involved in a second incident on 18th January, 2006. On that occasion, Garda Carey was involved with five other colleagues in putting a prisoner, who was bleeding heavily and believed to be HIV positive, into his cell. His finger had not fully healed from his earlier bite and had a scab on it at the time. The finger was uncovered and he thought that it may have come into contact with the blood of the prisoner. As a result of this incident, the sergeant in charge decided that all gardaí involved should attend at Garda Headquarters for HIV and HCV screening and this took place over the following six month period. It was the advice of Dr. Collins, Chief Medical Officer, in relation to the second incident that blood tests were carried out as it was felt that the event posed a very slight risk of infection to those involved.

2.6 In the initial three week period after the first assault, Garda Carey had a number of sleepless nights caused by worry over the risk

of infection. Thereafter his worries in respect of that incident did not go away fully, although they abated somewhat when his assailant's test results were reported negative.

2.7 As a result of his testing in relation to the second assault Garda Carey said he became anxious that he might still be at risk of infection from the first assault if his assailant had contracted HIV or HCV shortly before he was tested. He came to understand that in such circumstances that infection might not show up in blood tests taken shortly thereafter. Accordingly, he continued to worry about potential infection from the first assault until the testing carried out in respect of the second incident was completed in July of 2006. Garda Carey told the Court that he viewed the second incident as minor in comparison to the assault of 20th December, 2005.

2.8 Mr. Seán O'Rourke, Consultant in Accident and Emergency medicine prepared a medico-legal report on behalf of Garda Carey following upon a consultation on 26th April, 2006, some four months after the assault. He did so from information gleaned from Garda Carey at interview and also from the Hospital's Accident and Emergency records.

2.9 Mr. O'Rourke stated that once it was established that Garda Carey's assailant's test results were negative that he was not at any risk thereafter of having contracted HCV or HIV. He later agreed that he could not have given an absolute guarantee in this regard as if the assailant had contracted HIV or HCV in the weeks immediately prior to his testing it was theoretically possible that he was infectious notwithstanding his negative test results. He stated that any patient undergoing testing for HIV/HCV could be significantly reassured at three months post assault if their test results were negative. Invariably infection, if it is to incur, will be detected within this timeframe. However, a follow up at six months is warranted to enable complete reassurance be given.

2.10 Dr. Booth, General Practitioner, gave evidence that Garda Carey attended him on the morning of 30th December, 2005. He redressed his finger and noted that his patient was somewhat upset when recounting the incident that had occurred. Dr. Booth advised him that he was at risk of contracting HIV and/or HCV and that he should not engage in unprotected sexual relations. Regrettably, he was not in a position to advise his patient as to the extent of that risk. He told Garda Carey that repeat blood testing would be required over a six month period and advised him to return to the surgery for review in two weeks.

2.11 Dr. Booth stated that Garda Carey did not come back for medical review as planned. He next received a request for a medical legal report from Garda Carey's solicitors in relation to the assault and he saw him for this purpose on 17th May, 2006, when he concluded that his patient had been anxious from time to time as a result of the assault. He was not advised that Garda Carey's assailant's test results had proved negative. Dr Booth told the Court that he was only made aware of the second assault when Garda Carey's solicitors wrote to him looking for a medical report in respect of that incident. Given that his patient had never attended in respect of that incident, he was not in a position to provide any such report.

2.12 Dr. Sheehan advised that once the assailant's blood tests were known to be negative, Garda Carey's risk of contracting HIV and/or HCV was zero. No further testing or restrictions on his sexual life were warranted. In relation to the second assault, he would have advocated testing due to the large volume of blood spilt even though the wound on Garda Carey's finger from the first assault was then healing. In relation to the window period during which an assailant might test negative for HIV and/or HCV by reason of very recent infection, he advised that any such concerns should be ignored unless it was an established fact that the assailant was an intravenous drug user. There was no suggestion in the present case that the assailant was an IV drug user or was a "high risk" individual. He was a member of the travelling community and as such would have had a 1% chance or less of being a drug user. Accordingly, before the assailant's HIV/HCV status was actually know, the perceived risk to Garda Carey of contracting infection would have been 1:100,000 to 1:500,000. Once the assailant's test results were available, the actual risk could be established to be zero.

2.13 Dr. Sheehan stated that it was difficult to disentangle the effects of the two assaults upon Garda Carey.

2.14 Prof. McConkey told the court that once Garda Carey's assailant's tests came back negative his only risk related to the possibility that the assailant was in the process of seroconverting at the time of testing i.e. developing the as yet undetectable virus. Having regard to the assailant's negative blood tests, but allowing for the risk that he might have been seroconverting, the risk of the assailant transmitting HCV in this scenario was 8:1,000,000 and a risk of transmitting HIV was 21:1,000,000,000. These risks, he advised, are so small that you do not test for them or advise people to take precautions. It was, in his view, correct to test Garda Carey's blood in the initial aftermath of the assault and he would not have faulted any doctor if they decided to administer PEP. To have advised Garda Carey not to have unprotected sex was initially reasonable but after the assailant's tests proved negative he should have been told to resume life as normal.

2.15 Prof. Bradley agreed on cross examination with a proposition put to him by Mr. O'Donnell, S.C. that even after his assailant's test result proved negative that a general practitioner might nonetheless continue to test the patient over the entirety of the six month period, a proposition with which the witness agreed.

2.16 Dr. Dennehy, Consultant Psychiatrist examined Garda Carey on 21st January, 2010, some five years after the incident. He concluded that Garda Carey had suffered from an adjustment reaction and/or an anxiety disorder, a condition which is a recognised psychiatric injury, as a result of the assault. Garda Carey's symptoms included loss of appetite and a concern that he was at risk of contracting HIV and/or HCV in the weeks following his assault. Whilst relieved at his assailant's negative test results some weeks after the assault, the subsequent assault, which involved large amounts of blood and consequential blood testing, caused him to worry about the risks associated with the first assault. At the end of testing following the second assault a weight was lifted off Garda Carey's shoulders.

2.17 On cross examination, Dr. Dennehy told the Court that he had neither consulted with Garda Carey's general practitioner nor seen his records. He did see the medical legal reports. He based his report upon his interview with Garda Carey. The relevance of the second incident was that in its aftermath Garda Carey had learned that a protracted process of blood testing was required to rule out all risks in relation to any assault and this knowledge generated intermittent anxiety. He was through the worst of his symptoms by the time he was involved in the second assault.

2.18 Dr. Dennehy advised that adjustment disorders may in certain cases be severe enough to warrant medication or supportive counselling and can interfere with a patient's ability to work. Ultimately, an adjustment disorder, if prolonged or severe may develop into a depressive disorder. None of these occurred here. For the purposes of diagnosing an adjustment disorder, the patient must have symptoms and in this case they were sleeplessness, interference with appetite and anxiety. It was his opinion that had Garda Carey been advised, after his assailant's test results came back negative, that he was risk free and had he not been involved in the second assault, that he would have made a full psychological recovery at that point.

Garda O'Connor

2.19 Garda O'Connor was born on 7th June, 1977. He is a married man and was, at the relevant time, attached to Killarney Garda Station. Garda O'Connor told the Court that he passed out of the Garda Training College in July, 2002 and was on probation at the time of the events complained of.

2.20 On 15th May, 2003, Garda O'Connor was spat at by a prisoner who was then in custody. At the time he was aware that his assailant was bleeding from his mouth and nose and that blood stained sputum had struck his face and neck. He had spoken to his assailant in relation to another criminal matter the week prior to his assault and was told by him that he was an intravenous drug user and that he was HCV and HBV positive. Garda O'Connor said he was uncertain as to his assailant's HIV status but knew that he was injecting heroin. He reported the incident to his superior, Sergeant Barrett, who told him to wash himself using sterile wipes. Garda O'Connor felt he should have been sent to the Accident and Emergency Department of Tralee General Hospital but decided it was best to say nothing and remain on duty – he said he didn't want to be seen to be "making a big deal out of nothing". The following night he was again on duty and at that stage he spoke to his own garda sergeant who advised that he should go to the hospital for advice the following day.

2.21 Garda O'Connor told the Court that he had shaved just before going on duty and was concerned that he might have nicked himself. This played on his mind after the assault.

2.22 Garda O'Connor attended the Accident and Emergency Department of Tralee General Hospital on the morning of 17th May, 2003. He said he was seen by an Australian doctor who he now believes to have been a Dr. Waring. Blood samples were taken and he believed that these were to enable testing in respect of possible HBV, HCV and/or HIV infection. He received HBV immunoglobulin and was told to come back to the Occupational Health Department the following Monday. He maintains that he was told that he was at risk of contracting an infectious disease and consequently advised to desist from participating in any contact sports to avoid potentially infecting fellow players. Having discussed the possibly of transmitting infection to his partner, Garda O'Connor said that he was advised that condoms were not 100% safe and that it was a matter for himself as to how he should deal with that risk. As a result, Garda O'Connor stated he felt the best course for him to adopt was to refrain from sexual activity with his then girlfriend, now wife, until his blood tests were completed.

2.23 Garda O'Connor stated that he telephoned the hospital the following Monday to be told that the Occupational Health Department was only available to staff members and that he should attend his General Practitioner. He could not explain the second set of hospital notes recording his apparent attendance and treatment at the hospital that day namely the 19th May, 2003.

2.24 Garda O'Connor attended his general practitioner's practice nurse for blood tests on 17th June, 2003. He also saw Dr. Nicholson, his General Practitioner on 1st October, 2003 and 17th November, 2003. He did not raise with her any concerns regarding the risk of transmitting infection to his girlfriend. He did, however, seek her advice as to whether or not he should participate in contact sports. She confirmed that he should not.

2.25 Garda O'Connor stated that he put his life on hold whilst awaiting his test results. He gave up his weekly soccer and rugby for seven months and thereafter never returned to participate as frequently as he had done prior to the assault. His relationship with his girlfriend was adversely affected due to his decision not to engage in sexual relations over the six month period of blood testing.

2.26 Dr. Nicholson told the Court that she had been the plaintiff's General Practitioner since he was a child. Tests for HIV and Hepatitis A, B and C had been carried out by her practice nurse on 17th June, 2003. She did not see Garda Carey personally until 1st October, 2003 at which stage she advised him to abstain from contact sports when he raised the issue with her. She stated she believed this would have been standard advice at the time. Dr Nicholson did not make any notes which recorded her patient as being anxious but she believes that he had communicated such anxiety to her. She reassured Garda O'Connor that the risk of HIV and/or HCV infection was low and stated that she was not surprised that Garda O'Connor had not raised with her the question of his sexual relationship with his girlfriend because of his reserved temperament.

2.27 Dr. Nicholson finally saw Garda O'Connor for the purposes of medical legal review on 19th July, 2004. On that occasion, he told her that he had postponed a mortgage application during the period of testing due to his uncertainty regarding his health status and that he was also anxious about the possibility of any recurrence of a like assault. He expressed himself aggrieved by the lack of protocols within the Garda Síochána to deal with the situation in which he had found himself. She did not see Garda O'Connor thereafter.

2.28 Mr. O'Rourke, Consultant in Accident and Emergency medicine, told the Court that he took up his appointment in Tralee General Hospital in October 2003. Dr. Waring had been in charge of the Accident and Emergency Department before his arrival. He was satisfied from the hospital records that a screen for HBV was carried out on Garda O'Connor. Blood was stored for any further testing as might be required by his GP. Contrary to Garda O'Connor's evidence, Mr O'Rourke was satisfied that he must have re-attended at the hospital on Monday 19th May, 2003. He referred to the hospital notes dated 19th May, 2003 noting that Garda O'Connor received Hepatitis B immunoglobulin that day. He noted that the records stated that there had been "no splash to the mucosal surfaces" and "no obvious skin break". Mr. O'Rourke was satisfied from the notes that nothing had been done on 17th May, 2003 and that the blood taken for HBV testing occurred on 19th of that month.

2.29 Mr. O'Rourke prepared two reports dated the 17th December, 2003 and the 23rd February, 2005, respectively. During the interview for the later medical report, Garda O'Connor advised Mr O'Rourke of a number of matters which he had not adverted to during his earlier visit. These included Garda O'Connor's reasons for not attending hospital in the immediate aftermath of the assault; his concerns regarding the absence of a clear protocol advising of the steps to be taken if potentially exposed to HIV and/or HCV; the lack of independent counselling; the difficulties he experienced in his intimate relationship; and the fact that a mortgage application had to be placed on hold pending the outcome of his blood tests.

2.30 Dr. David Walshe, Consultant Psychiatrist, reviewed Garda O'Connor for the purposes of the preparation of a medico legal report on 3rd February, 2010. He told the Court that Garda O'Connor had developed features of an anxiety disorder in the context of his traumatic assault. This condition lasted approximately six months until he was reassured from his final blood tests that he had not contracted any infectious disease. Thereafter he had some minor residual anxiety relating to certain work situations. He diagnosed Garda O'Connor as having experienced an adjustment disorder and that this condition was a recognised psychiatric illness.

2.31 Dr. Walshe explained that an adjustment disorder is a condition from which the patient is expected to achieve a good outcome. It does not normally involve symptoms of depression or panic. The normal pattern is for the victim to become nervous or anxious for a number of days after an acute event and for the symptoms to settle down thereafter. It varies from person to person. Some individuals can work through it whilst others cannot. Sometimes it requires medication but other times it does not. He felt that Garda O'Connor could probably be described as having experienced a mild or moderate adjustment reaction and that it was the perceived risk of infection that was responsible for this response. He stated that victims of an assault such as that experienced by Garda O'Connor would benefit from a clear protocol as to the steps to be taken in its aftermath and also from a clear explanation of any risks arising therefrom. This would allow the patient to remain in control and avoid unnecessary anxiety.

2.32 In relation to the advice which had been given to Garda O'Connor, Dr. Walshe stated that any patient advised to avoid contact sports and intimate sexual relations with their partner would be likely to perceive that they were at risk of infection and this would tend to heighten their response psychologically. He said that counselling was often of significant benefit to victims of traumatic events, but did not believe it was of value in every case.

2.33 Prof. McConkey told the Court that if there was no blood in the assailant's saliva that the risk of infection from HCV or HIV was zero or close to zero. He placed the risk at about three in one million. He contrasted this with the type of risks people accept in the course of their everyday lives. He referred to the number of people killed on Irish roads and the willingness of everyone using the roads to accept that type of risk. As a further example of the type of risks commonly accepted as part of everyday life, he told the Court that he and his family had lived in St Louis, in the U.S.A., a city where the homicides rate was approximately 300 per year, yet he and 300,000 other people where willing to accept that risk by continuing to live there.

2.34 Even if there was blood in the sputum the risk was still zero or unquantifiably low as for any risk of transmission to arise there must be both infected blood in the saliva and also a rupture to the skin. Garda O'Connor's skin was not ruptured. His view was that Garda O'Connor should have been reassured by his doctors and sent off without testing or the imposition of any restrictions upon him.

2.35 Based on the assumption that Garda O'Connor's evidence as to what happened at the hospital was accurate, Prof. McConkey told the Court that the advice received by Garda O'Connor was incorrect. On the basis of Garda O'Connor's instructions that he had been tested at the hospital for HIV and HCV he stated that such testing should not have been carried out and there was no need for any restrictions to be placed on his sexual or sporting life. Whilst sympathising with the pressures imposed on general practitioners, he stated that the advice given by Dr. Nicholson to the effect that he should not participate in contact sports was incorrect. He acknowledged that it was challenging for a general practitioner if dealing with an issue such as this for the first or second time to confidently advise that there was no risk, or even a miniscule risk of transmission, and it was understandable that a general practitioner might feel it better to err on the side of caution and advise a restriction on sexual life followed by further testing. However, he stated there were some simple cases, such as where blood splashed onto unbroken skin, where all doctors should know there is no risk of transmission. There were other much more complicated cases where it would be hard for a general practitioner to accurately assess the risk. He advised that unnecessary testing and the equally unnecessary imposition of restrictions on a patient's activities or intimate life may cause significant damage to the patient.

2.36 Prof. Bradley advised that he considered any advice given to Garda O'Connor to refrain from sexual intercourse to have been "over the top". Condoms he said are perfectly safe where there is a risk of transmission of infection. Abstinence might, however, be a patient's choice. The testing of Garda O'Connor's blood was appropriate in the circumstances and he described the risk of infection as moderate. If testing had been carried out at twelve weeks, it should have been possible to strongly reassure Garda O'Connor that he was not at risk of infection. As to any advice received by Garda O'Connor to refrain from contact sports, he was of the opinion that such advice was excessive. However, he conceded that in the early phase of knowledge of these infections that contact sport would have been perceived to pose a risk for individuals with possible blood borne infection.

2.37 Dr. Sheehan told the Court that he had patients who were HIV positive and who, notwithstanding the presence of a high viral load, were not restricted from participation in games such as rugby. He advised that there are lots of people playing contact sports who have sexual risk factors for HIV and HCV. These risks are dealt with through the system of what is called universal precautions which requires that anyone who starts to bleed must leave the field of play.

2.38 Dr. Sheehan advised that the objective risk for Garda O'Connor was zero for both HIV and HCV. He would test a patient who was assaulted in circumstances such as had occurred to Garda O'Connor but only if the patient was one of those exceptional people whose anxiety could not be removed without adopting such a course. He disagreed with Prof. Bradley's description of the risk to Garda O'Connor as being "moderate" and also with Prof. Bradley's advice that it was appropriate to test Garda O'Connor against the risk of HIV or HCV. He was also sceptical about the value of counselling in the context of the existence of a miniscule to zero risk. What patients needed was complete reassurance.

2.39 Dr. Sheehan was at pains to explain that sexual precautions could only be justified in relation to needle stick injuries where the assailant was from a group known to be HIV positive. Similarly, in respect of exposure of blood to a mucus membrane, once again sexual precautions were only required if the assailant was known or highly likely to be HIV positive. For risks that are less than those, precautions are not required. He reminded the Court that HCV is not transmitted in the course of sexual intimacy.

Garda O'Sullivan

2.40 Garda O'Sullivan joined An Garda Síochána in 1983. In 1994 he was transferred to the Drugs Unit in Limerick. He has received numerous commendations in the course of his career. Garda O'Sullivan told the Court that drugs, including heroin, became prevalent in Limerick in the late 1990s. Accordingly, he believed that many drug dealers and drug users in Limerick in 1994 were HIV and/or HCV positive.

2.41 Garda O'Sullivan was assaulted whilst effecting an arrest in the course of his duties on the 3rd May, 2000. According to Garda O'Sullivan, his assailant was like a rabid dog and was drooling saliva from his mouth when he bit into his upper thigh. As soon as the prisoner was placed in a cell, Garda O'Sullivan went to the bathroom to check his thigh. He believes his skin was broken by the assailant's eye teeth. He washed the area with soap and water. Because he felt at risk of infection, Garda O'Sullivan later asked the prisoner if he would submit to blood testing. He refused.

2.42 Garda O'Sullivan then went to the Accident and Emergency Department of the Midwest Regional Hospital in Limerick. There he stated the wound to his thigh was cleansed and dressed. He received a tetanus injection and was advised that he was at risk of having contracted an infectious disease whilst being reassured that this was unlikely. He was advised of the need for follow up blood testing in the hospital or with his G.P.

2.43 Garda O'Sullivan attended his General Practitioner, Dr. Hannon the following morning. Dr. Hannon checked the dressing on his

thigh and took blood for HCV and HIV testing. He advised Garda O'Sullivan that he was at risk of contracting HIV and/or Hepatitis A, B and/or C. He was advised to refrain from unprotected sex with his wife until such time as infection could be ruled out, namely for a period of six months.

2.44 Garda O'Sullivan told the Court that he had some sleepless nights after his assault and that he had woken up sweating on a number of occasions. He stated that he was anxious, irritable and not pleasant to live with. Even after his final blood tests were clear at six months, he was still not quite back to normal having been advised by his GP that there was still a remote risk of him developing infection. Garda O'Sullivan was also concerned about a story circulating in Limerick that one of his colleagues had contracted HIV from a bite. His worries, he said, affected his work and he lost some confidence.

2.45 Garda O'Sullivan was not off work as a result of his assault. He continued in the Drugs Unit until 2003 at which stage he was transferred to another unit. In 2005, he opted for community policing, allegedly influenced by the traumatic effects of the events of 3rd May, 2000. He did not seek a transfer earlier because he was hoping for promotion which he successfully obtained in March 2003.

2.46 Dr. Hannon advised the Court that he saw Garda O'Sullivan on 4th May, 2000 when he inspected the wound and put in place a plan of management for his patient. This included advice as to the tests required, the risk of transmission, the precautions required and reassurance. Dr. Hannon believed that the bite to Garda O'Sullivan's thigh rendered him at risk of infection from HCV and/or HIV and he advised him of that fact. He said he knew quite a lot about HIV but little enough about HCV. He next saw Garda O'Sullivan on 19th June, 2000 when the results of the initial blood tests were available. He saw him again on 23rd June, 2000 at the request of his solicitor for the purposes of preparing the first of a number of medical legal reports. Thereafter, Garda O'Sullivan attended for further blood tests in November 2000. Dr. Hannon had no notes recording that Garda O'Sullivan had any ongoing concerns between June and November 2000, but stated that he believed he provided him with ongoing support over that period. He described Garda O'Sullivan as being apprehensive and initially fearful. He was not depressed at any time and neither did he report the occurrence of any nightmares or flashbacks.

2.47 Dr. Hannon told the Court that he repeated Garda O'Sullivan's blood tests for HIV and HCV in February 2002 and again in 2008. He said that he did this whilst carrying out blood tests routinely required by Garda O'Sullivan in respect of an unrelated liver condition. He believed that by doing these additional tests that Garda O'Sullivan would be further reassured.

2.48 Prof. Bradley advised the Court that given that there was a break in Garda O'Sullivan's skin it was appropriate for Dr. Hannon to test him for HIV and HCV and to advise that safe sex precautions be taken. He stated that it was important for a general practitioner in such circumstances to advise that whilst the risk was not zero, that the testing was really only precautionary and not because there was a realistic risk of infection. Testing beyond the period when infection might occur was counterproductive and tended to feed a patient's anxiety.

2.49 Prof. McConkey advised the Court that as there was no blood in the assailant's mouth at the time he bit Garda O'Sullivan, that his risk of contracting HCV was zero or close to zero. For there to be any risk of HCV infection there had to be both infected blood in the saliva and a break in the victim's skin. In relation to potential HIV infection, he refused to quantify the risk as it was an absolute requirement for infection that the sputum would contain the assailant's blood. He advised the Court that there was no justification for any blood testing being carried out on Garda O'Sullivan and that the assault did not warrant any restrictions being placed on his intimate life. He should have been reassured and discharged.

2.50 Dr. Sheehan told the Court that at the time he prepared his report he did not understand that Garda O'Sullivan's skin had been breached and hence he had advised that testing was not warranted. If there was a break in the skin, even though there was no blood in the assailant's sputum, he believed that testing was justifiable. However, even with a breach of the skin there was a zero risk of HIV transmission and only a miniscule risk of HCV transmission. Garda O'Sullivan's personal life should not have been restricted in any way even if testing was to be carried out. Dr. Sheehan noted that he had been told by Garda O'Sullivan that he had had protected sex for a period of 14 – 16 months after the assault. HCV is not sexually transmitted and medical practitioners do not advise discordant couples i.e. couples where only one party is HCV positive, to refrain from having unprotected sexual intercourse. He stated that Garda O'Sullivan's reaction to his assault was understandable and proportionate to the medical assessment he had been given.

2.51 Dr. Sheehan was concerned that Garda O'Sullivan did not receive the most important treatment he required, namely protection against potential bacterial infection from a human bite. He told the Court that people risk losing parts of their body through amputation as a result of necrotizing soft tissue infection left untreated. Antibiotics should have been prescribed.

2.52 Dr. Sheehan stated that Garda O'Sullivan's blood should have been blood tested at three months as well as six months because at three months, very strong reassurance can be given to the victim regarding their status as invariably infection, if it is to present, will emerge within the first three months. Testing, as occurred twice in the present case beyond the initial six month period was illogical and medically inexplicable. Testing so long after an assault would be likely to generate anxiety in the patient.

2.53 Dr. Mary McInerney, Consultant Psychiatrist, assessed Garda O'Sullivan for the first time, on the 4th February, 2010, almost 10 years after the assault. This she did for medico-legal purposes. She provided a report to the Court dated the 11th February, 2010. Dr. McInerney told the Court that she diagnosed Garda O'Sullivan as having developed an acute stress reaction post his assault which was characterised by irritability, worry, anxiety, loss of confidence, emotional withdrawal, depressed mood, change in eating and sleeping patterns. This lasted for 48 hours. Thereafter, Garda O'Sullivan experienced an adjustment disorder, the symptoms of which were intrusive thoughts, flashbacks, difficulties concentrating, working below par and feeling as if he was on "red alert".

2.54 Dr. McInerney advised the court of a number of physiological problems reported by garda O'Sullivan relating to the assault including aches and pains, fatigue, muscle tension, indigestion and occasionally elevated blood pressure. She was satisfied from her interview with Garda O'Sullivan that most of his psychological problems had resolved within the first seven months. In her report she ascribed a number of physical problems experienced by Garda O'Sullivan over the period 2002 to 2004 to his assault. She was satisfied that when seen by her on 4th February, 2010 that Garda O'Sullivan had made a full recovery.

2.55 Dr. McInerney advised the Court that an acute stress reaction followed by an adjustment disorder was a recognised type of psychiatric illness. Finally, she also stated that Dr. Devitt, Consultant Psychiatrist, who had evaluated Garda O'Sullivan on behalf of the defendant, had reached a similar diagnosis.

3. The Submissions of the Parties

3.1 Detailed oral and written submissions were received by the Court on behalf of each of the plaintiffs in these proceedings. As there

is a significant overlap in the legal submissions made, it is not necessary, to do otherwise than to set out briefly a summary of those submissions. Insofar as the submissions specifically relate to any individual member, I will refer to the same where appropriate.

The Plaintiff's Submissions

3.2 It was submitted on behalf of the plaintiffs that an application for compensation under the Acts is effectively a two stage process. The first stage is controlled by the Minister for Justice ("the Minister") to whom the injured member applies for compensation. The Minister, then, exercising the powers conferred on him under s. 6 of the Garda Síochána (Compensation) Act 1951 ("the Act of 1951") is mandated to authorise the applicant to apply to the High Court for compensation once (*inter alia*) he is satisfied that the injuries complained of are not minor in nature. This stage of the process involves the Minister seeking and considering the medical advice furnished to him. It was submitted that once the Minister authorised the issue of High Court proceedings that he had determined that the injury to the member concerned was non-minor, was maliciously inflicted and caused by the relevant assault. Accordingly, he had made a determination in respect of liability and causation which was conclusive and binding on the Court. The possibility of the Court determining liability or causation had accordingly been circumvented by statute. In this regard the plaintiffs relied upon *McGee v. Minister for Finance* [1996] 3 I.R. 235.

3.3 The second stage of the process, according to the plaintiffs, is controlled by the Court whose sole function it is to determine the damages to be awarded to the plaintiff. It was submitted that the Court was bound by the Minister's decision that the injury sustained by the member was non-minor and accordingly, the Court could not of its own motion dismiss the proceedings on the grounds that the injuries were not compensatable under the Acts. It was also submitted that the court, in measuring the damages to be awarded, must approach the issue of compensation based upon the Minister's conclusion that the injuries were not of a minor character.

3.4 The plaintiffs were agreed that the test for the recoverability of compensation under the Acts is not the test of reasonable foreseeability as applies in negligence actions, a test which only permits recovery in respect of injuries which are the natural and probable consequences of the negligent act. The test for recoverability is to be found by adopting a purposive approach to the interpretation of the statute itself. It was submitted that s. 10(2) of the Act of 1941 made it clear that the Oireachtas intended to create a robust scheme of compensation for members of An Garda Síochána once the injuries sustained were captured by the Act. The plaintiffs rejected the respondent's submission that the court should only compensate the plaintiffs for injuries "directly caused" by the malicious acts of third parties given that the words "directly caused" do not appear in the Act. The court should not rewrite the legislation.

3.5 The plaintiffs submitted that when looking at the issue of recoverability, the Court should be guided by the relevant case law in respect of assault, battery and the infliction of emotional harm as none of the present cases related to unintentional wrongs. By way of example, in respect of Garda O'Connor's claim, it was submitted that the spitting of material known to contain an infectious virus (HCV) at him, demonstrated a clear intention on the part of his assailant to inflict emotional suffering on him. Reliance was placed upon the decision of Wright J. in *Wilkinson v. Downton* [1897] 2 Q.B. 57, a case in which the defendant, intending it as a joke, falsely told the claimant that her husband had been seriously injured in an accident as a result of which she suffered significant psychological reaction and where the trial judge determined that she had a good cause of action for the intentional infliction of emotional distress.

3.6 In response to the issue raised by the Court when it directed these cases to be heard on oral evidence as to whether or not a finding by the Court that part or all of the plaintiff's injuries were caused by incorrect medical advice subsequent to the malicious act would affect causation, the plaintiffs made the following submissions.

3.7 It was firstly submitted that causation and liability are determined by the Minister under the Act. Accordingly, the respondent has no right to argue, nor the Court the jurisdiction to embark upon a consideration of any causation issue.

3.8 Apart from the Court's lack of jurisdiction to determine causation it was submitted that the respondent never formally contested nor even put the plaintiffs on notice that causation would be raised as an issue in any of the three cases. Consequently, even if the court has jurisdiction, it would be wrong for the court, following the conclusion of what was essentially uncontested evidence, to determine that issue against the plaintiffs.

3.9 If the Court has jurisdiction to deal with causation, the plaintiffs urged the court to take guidance from what is commonly known as the "but for" rule regularly used by the court for guidance in negligence actions at common law and which is described by McMahon and Binchy, *The Law of Torts,* 3rd Ed., (Dublin, 2000) at para. 2.10 in the following manner:-

> "An act is a cause of an event if the event would not have occurred without ('but for') the act in question. If the event or effect would have occurred without the act in question, then the act cannot be deemed to be a cause."

3.10 It was submitted that the nature of the medical advice was not sufficient to break the chain of causation.

3.11 If the Court has jurisdiction to engage upon the issue of causation and decides to consider whether any of the medical advice in these cases might constitute a *novus actus interveniens*, the Court should, as these cases were the result of deliberate rather than negligent behaviour, by analogy apply the principles which emerge from the jurisprudence on intentional torts. This, it was submitted, required the plaintiffs to be compensated for all of the sequelae that flow from the relevant malicious event unless it can manifestly be shown not to flow therefrom. Once the intervening act is not grossly negligent or reckless then the plaintiff must be compensated for all of their injuries. Accordingly, even if any of the plaintiffs received medical advice in these proceedings which was incorrect or which may have exacerbated the initial injury, proof of these facts would not break the chain of causation so as to deny the plaintiffs a right to recover in respect of the totality of their injuries.

3.12 On behalf of each of the plaintiffs it was urged that there was no *novus actus interveniens* such that could relieve the defendant of liability to pay compensation in these cases. Once again they relied upon the discussion of this concept by McMahon and Binchy in the *Law of Torts* at para. 2.28 where the authors examined the circumstances in which an intervening act would have the effect of relieving the original perpetrator of an award of damages:-

> "…two factors feature in the judge's approach: first, whether, and to what extent the intervening act was foreseeable by the original actor, and second, what was the mental attitude of the subsequent intervener – was he careless, negligent, grossly negligent, reckless or did he intend to do damage?"

3.13 The plaintiffs submitted that the more likely the intervening act, in this case the medical treatment and advice, the less likely it was to break the chain of causation. They relied upon a series of observations made in Hodgson in *The Law of Intervening Causation* (Hampshire, 2008) wherein consideration was given to the effect of adverse medical intervention in the aftermath of a negligently

inflicted injury. The authors concluded that it was the generally accepted view of most common law jurisdictions that any negligent medical treatment which resulted in the aggravation of an initial injury should not be regarded as a *novus actus interveniens* such as to relieve the original defendant of liability because the original injury should be regarded in any event as one which carried some risk that consequential medical treatment might be negligently administered.

3.14 The plaintiff relied upon the decision in *Forbes v. Merseyside fire and Civil Defence Authority* [2002] EWCA Civ 1067 where the Court of Appeal held that a *bona fide* medical error of judgment was not sufficient to sever the causal chain.

3.15 The plaintiff went on to submit that "he who does the first wrong is answerable for all the consequential damage" – a reference to the finding in *Roswell v. Prior* (1701) 88 ER 1570, a decision cited with approval by Nares J. in *Scott v. Shepherd* (1773) 2 WB1 892 where the plaintiff's injury was adjudged to be the "natural and probable consequence" of the defendant's act as the doctors in those cases were not what could be described as "free agents".

3.16 From the aforementioned submissions it is clear that the plaintiffs maintain that even if the Court has jurisdiction to embark upon an inquiry as to whether the medical advice and treatment afforded to each of these plaintiffs was appropriate, that unless the it comes to the conclusion that such advice was grossly negligent or reckless that it would not break the chain of causation.

3.17 It was not open to the Court to look at what were described as "satellite issues" such as the appropriateness or otherwise of medical advice given following upon an assault such that the Court would be entitled to diminish the plaintiff's damages by attributing some of the injuries to other causal events.

3.18 It was submitted on the plaintiff's behalf that the evidence of the experts in infectious diseases called in relation to the risk of transmission of those infections should not have any bearing on the plaintiffs rights to compensation. Their evidence should not be used by the Court to find fault against their less specialised colleagues. It had not, in any event, been established by the defendant that the advice given by the plaintiff's medical advisers was objectively incorrect. Further, the doctors concerned were not challenged in this regard. It was submitted that the advice given and treatment undertaken was established in evidence to have been that which would have been considered standard practice for non-specialist doctors at the relevant time. Allied to this submission, counsel for Garda O'Connor submitted that even if it could be established objectively that he received incorrect advice regarding the need for blood tests that there should be no assumption that even if he had received objectively correct advice that he would nonetheless not have received testing as a patient who required special reassurance, something that Dr. Sheehan stated occurred from time to time. In any event, whatever advice or treatment was given, even if it was incorrect or unnecessary and caused damage, the same could not be considered to be grossly negligent or reckless such as to be consider a *novus actus interveniens.*

3.19 The plaintiffs submitted that it was not open to the Court in the context of the framework of the legislation to embark upon an enquiry as to the appropriateness or otherwise of the medical care afforded to the claimants. The medical practitioners were not parties to the proceedings and had no method of having their interests represented. It was submitted that the Court cannot in proceedings of this nature make any finding that a doctor's advice was incorrect. Neither is it open to the Court to find negligence or culpability or professional misconduct on the part of any such doctor. To make any of these decisions in such a fashion would amount to a breach of natural justice, fair procedures and potentially could amount to a breach of Article 6 of the European Convention on Human Rights.

3.20 On behalf of Garda O'Connor it was submitted that the advice received by him had not been established to have been objectively incorrect. In fact, it was established that the advice corresponded with the state of knowledge for a non-specialist at the time. Prof. Bradley did not criticise the advice given by the general practitioner in the case i.e. to abstain from sports. Further, the infectious diseases consultants agreed that it would be appropriate, if a patient needed reassurance, to test them for HIV and/or HCV. The advice that condoms can fail was objectively correct. Accordingly, any such medical intervention or advice could be considered to be to a *novus actus interveniens* breaking the chain of causation.

3.21 It was further submitted on behalf of Garda O'Connor that he had not failed to mitigate his losses in failing to avail of "peer support" as that service was not confidential and his decision not to participate was one which was reasonable.

3.22 Counsel for Garda O'Sullivan submitted that Dr. Sheehan had agreed that Dr. Hannon's decision to test Garda O'Sullivan for HIV/HCV was not irrational or unreasonable as Dr. Hannon said he could not have been sure that there wasn't blood in the saliva of the assailant. Accordingly, Dr. Hannon's decision to test was not irrational or unreasonable.

3.23 On behalf of Garda Carey it was submitted that the treatment and advice received by him at the Accident and Emergency Department of the Midwest Regional Hospital in Limerick was entirely appropriate as was the advice and treatment afforded by Dr. Booth, his General Practitioner. Accordingly, there was no issue as to causation on the evidence. On his behalf it was submitted that his initial injuries were aggravated by the advice he received at the Garda Medical Centre when attending there in relation to the subsequent assault, and that he should be compensated for all of the anxiety so caused.

4. The Respondent's Submissions

4.1 The respondent submitted that the first function of the court when dealing with a compensation claim was to satisfy itself that the Act applied to the injuries complained of. Mr. Boyle S.C., submitted that notwithstanding the Minister's authorisation, the court had an independent function and was entitled to consider *de novo* whether the applicant's claim qualified for compensation. He submitted that the assessment of compensation was a matter entirely for the court and that it was not constrained either by the Minister's authorisation or any concession made regarding malice. Counsel submitted that the court could award no compensation if it was satisfied, for example, that no personal injuries had been sustained.

4.2 The respondent argued that, whilst the Act does not expressly import the legal principles from the law of negligence, where there are gaps in the Act as to how a matter ought to be approached, the court would be justified in applying the principles of the law of negligence by analogy.

4.3 The respondent submitted that the issue of causation was a matter to be determined by the court notwithstanding the Minister's authorisation and that the appropriate test under the statutory scheme must be whether the personal injuries were or were not directly caused by the malicious act. Given that the defendant is not a wrongdoer in these cases, it was for the applicant to demonstrate that any indirect consequences of an assault were covered by the Act of 1941. Where pain and suffering could be attributable to both the direct consequences of the malicious act and to some other cause, the court should apportion the injuries to each cause and only award compensation in respect of that pain and suffering which was demonstrated to flow from the malicious act. In this regard, counsel relied upon the decisions in *Gavin v. Criminal Injuries Compensation Tribunal* [1997] I.R. 132 and *R. v. Criminal Injuries Compensation Tribunal, ex parte Ince* [1973] 1 WLR 1334 as authority for the court's right to adjust the damages to

take into account indirect consequences of the malicious act. Accordingly counsel submitted that if the Court determined that some element of the distress of any plaintiff was due to any incorrect medical advice that such distress should not attract compensation.

4.4 It was argued on behalf of the respondent that where personal injuries were solely caused by some intervening factor, such as incorrect medical advice, by analogy with the doctrine of *novus actus interveniens*, no compensation should be awarded under the scheme.

4.5 The defendant urged the Court to accept that the purpose of the statutory scheme was not to compensate a plaintiff for injury which was attributable to a doctor's lack of knowledge. In support of this argument, reference was made to Garda O'Sullivan's evidence that he had been led to believe by Dr. Hannon that he was still at risk of contracting HIV/HCV notwithstanding the fact that his blood tests at six months proved negative. He was subsequently tested on two occasions over the following seven years when there was no risk of infection, a fact generally well known to all doctors. He accordingly submitted that if the doctor gave such advice, a matter which Dr. Hannon denied, and if it was the cause of ongoing anxiety, the same was wholly unconnected with the malicious act and it represented a break in the chain of causation.

4.6 The defendant submitted that the psychological injuries in the present cases were minor but it was possible to imagine circumstances where incorrect medical advice concerning a persistent risk of infection could trigger a much more serious psychological injury which impact in a much greater way on an applicant's personal life. Psychological injury, it was urged, is normally parasitic upon physical injury and the Court should be cautious when awarding compensation for psychological injury where there is little or no physical injury. In particular, in assessing compensation for psychological injury, the court should place significant reliance upon any contemporaneous medical evidence such as medical notes and records rather than psychiatric evidence procured long after the relevant events and procured solely for the purposes of the claim for compensation.

4.7 It was submitted that aggravation, exacerbation or prolongation of anxiety or stress by objectively incorrect medical treatment or advice is not covered by the statutory scheme and ought not to be compensated. The onus was on the plaintiffs to demonstrate that all of their psychological symptoms were caused by the malicious event. If symptoms are partially attributable to the incident and partially to incorrect advice, the Court should apportion between the causes and only award compensation for the former.

4.8 As regards the approach of the Accident and Emergency Departments to fear of infection cases, as such departments deal regularly with situations of needle-stick injuries and other injuries involving the risk of infection, they should be judged by the standard of the specialist in infectious diseases rather than that of the general practitioner.

4.9 Finally, counsel for the respondent submitted that it was a fundamental principle of law that a claimant should have to mitigate their loss. Reference was made to the failure on the part of Garda O'Connor to avail of the peer counselling offered to him in the aftermath of his assault and it was submitted that any such failure must be reflected in any award of compensation..

Court's Conclusions on the Issues of Law Raised by the Parties

4.10 Role of the Minister
4.11 Having considered carefully the submissions of the parties, I reject the plaintiff's submissions as to the alleged limitation on the court's powers when determining a claim for compensation authorised by the Minister.

4.12 The statutory process commences with an application being made by a member for compensation pursuant to s. 5 of the Act of 1941. The Minister, having received the application, which is prepared in a standard form, may under s. 5(e) and (f) require the applicant to furnish additional information or require verification of the application. Thereafter, s. 6(b) makes it clear that the Minister has three options namely:

> (i) if the injuries are of a minor character sustained in the course of ordinary duties he must refuse the application;
>
> (ii) if satisfied that the injuries are of a minor character but were sustained in the course of duties involving special risk and that a sum of £100 would be adequate compensation he may pay the applicant a sum not exceeding £100; and
>
> (iii) in any other case, he must authorise the applicant to apply to the High Court in accordance with the Act for compensation.

4.13 In each of the three cases before this Court the Minister exercised the third of those options as per s. 6(1)(b)(iii) of the Act. In authorising the issue of proceedings under that section, the only decision made by the Minister was that these claims did not fall within the categories of cases set out in s. 6(1)(b)(i) and (ii) and that he considered the injuries in each case were not "of a minor character". However, there is nothing in the Act to state or from which it can be inferred that the court's role in assessing damages is in any way circumscribed by that opinion.

4.14 Insofar as liability is concerned, I reject the plaintiffs' submissions that the Oireachtas, by the enactment of the Act, has ousted the court's jurisdiction in relation to this issue. Section 6(1)(b)(iii) does not provide that the Minister, when he authorises an application to the High Court, has determined that the injuries complained of were sustained by the member in the course of his duties. Unlike s.6 (1)(b)(i) and (ii), s. 6(1)(b)(iii) does not require the Minister to be satisfied that the injuries were sustained by the applicant in the course of his duties. To my mind, the Minister's role under s. 6 is, as was succinctly described by Carney J. in *McGee v. Minister for Finance* [1997] 1 I.L.R.M. 301, "to filter out trivial or minor claims".

Role of the Court
4.15 Following the Minister's authorisation, the member will apply to the High Court for compensation under s. 7 of the Act. He does so by special summons and grounding affidavit. Section 7(2)(c) provides that all of the evidence at the hearing of the application shall be given *viva voce*, save insofar as the court directs otherwise. The role of the judge when hearing the application for compensation is set out at s. 8(2) of the Act which provides as follows:-

> "Where the judge hearing an application to the High Court for compensation under this Act in respect of personal injuries not causing death is satisfied –
>
> (a) that this Act applies to the said injuries, and
>
> (b) that the applicant is the person on whom the said injuries were inflicted, and

(c) that the applicant is duly authorised by the Minister to make the application,

the judge shall award to the applicant compensation under this Act in respect of the said injuries and shall fix the amount of such compensation in accordance with this Act and shall order that the compensation so awarded and fixed shall be paid to the applicant by the Minister for Finance."

4.16 From the aforementioned section it is clear that the High Court judge hearing the application must satisfy himself/herself that the Act applies to the injuries. Accordingly, the judge must refer back to the provisions of s. 2(1)(c) of the Act. That section provides as follows:-

"(1) This Act applies

(c) to personal injuries (not causing death) maliciously inflicted after the date of the passing of this Act on a member of the Garda Síochána –

(i) in the performance of his duties as such member while actually on duty, or

(ii) while exercising powers or otherwise acting in his general capacity as a policeman when off duty or on leave or otherwise not actually on duty, or

(iii) while on duty or off duty or on leave or at any other time because of anything previously done (whether before or after the passing of this Act) by him as a member of the Garda Síochána or merely because of his being a member of the Garda Síochána…"

4.17 It is clear to me from this section that the onus is on the applicant in every case where authorisation is issued, to satisfy the court, unless it is conceded by the respondent, that the injuries were maliciously inflicted and that they were inflicted on the member in the course of his duties. Accordingly, I believe that the plaintiff's submission that the court cannot involve itself in determining issues of liability or causation is misplaced. In an appropriate case it is open to the court to dismiss a claim on the grounds that the injuries were not maliciously inflicted or were not sustained by the member in the course of his duties. It is not an irregular occurrence that the respondent will contest malice or will dispute that the injuries sustained fall within the provisions of s. 2(1)(c)(iii) of the Act. One such example is to be found in the case of *Harrington .v. Minister for Finance* [1946] 1 I.R. 320. In that case the widow and children of a member of An Garda Síochána who died from injuries maliciously inflicted upon him by another member whilst on duty sued the Minister for Finance for compensation under the Act. The evidence suggested that Garda Harrington was shot whilst on duty by his colleague who then proceeded to commit suicide. The Court dismissed the claim on the grounds that the plaintiff, whilst she had proved that the injuries causing the death occurred whilst her late husband was on duty, had not been in a position to prove, as was crucial to the liability of the respondent, that the injuries had been maliciously inflicted upon him in the performance of his duties.

4.18 There are other provisions in the Act which appear to lend some support to my view that the court is entitled to engage with the issues of liability and causation. Firstly**,** s. 7(h), which provides that in the event of an application being unsuccessful the costs will be paid by the Minister for Finance, seems to be consistent with the court enjoying the jurisdiction to dismiss a claim on the grounds of liability or causation. Secondly, the fact that the court has, under s. 9 of the Act, been given the power to state a case to the Supreme Court for its opinion on any question of law arising on the hearing of such an application, does not fit comfortably with the plaintiff's submission that the sole function of the court is to assess damages once the Minister has authorised the institution of the proceedings.

4.19 I am accordingly satisfied that the statutory scheme provided for by the Act is one which permits the respondent to argue, and the court to determine, in an appropriate case, albeit subject to the appropriate procedures being adopted, whether or not the injuries sustained by a member are compensatable as a matter of law.

Approach to Compensation

4.20 The approach to be taken by the court in assessing damages in a garda compensation claim is clearly set out in the Act. There is nothing in the legislation to support the assertion made on behalf of one of the plaintiffs that the court must, in assessing damages, accept the Ministers opinion that the relevant injuries concerned were "non-minor" in nature. The words "non-minor" are only of relevance to the role of the Minister when exercising his functions under s. 6(1)(b)(i) and (ii) of the Act.

4.21 Once the claim is authorised by the Minister, the approach to be adopted by the court is that provided for in ss. 8 – 10 inclusive. Those sections make no reference to the words "non-minor". It makes sense that the court should be unfettered in its right to assess the damages to be awarded to any plaintiff given that the statute has provided at s. 7(1)(c) that all of the evidence at the hearing is to be given *viva voce* save as the court may otherwise direct. Thus, unlike the position of the Minister, the defendant and the court are afforded an opportunity to test the evidence and assess the witness.

4.22 For these reasons, I have concluded that the court is at large as to the damages it may award. However, I accept the plaintiffs submissions that where liability and causation are established the court must award compensation irrespective of how modest it concludes the member's injuries are. In this regard, I agree with the decision of Carney J. in *McGee v. Minister for Finance* [1997] 1 I.L.R.M. 301 both as to the effect of s. 6(3), a section which provides that the Minister's decision authorising the maintenance of the proceedings is final and conclusive, and as to the significance of the use of the word "shall" in s. 8(2) of the Act. In that case, a claim for compensation under the Act, the defendant belatedly came to the view that the injuries sustained by the plaintiff should be considered to be minor in character. Accordingly, the trial judge was asked to dismiss the claim and to either set aside or disregard the certificate of authorisation granted by the Minister. The learned trial judge concluded that he was precluded from setting aside the authorisation on the grounds that the Minister's decision under s. 6(3) is stated in the Act to be final and conclusive and also by reason of the fact that the Minister who granted the authorisation was not a party to the claim. He went on to assess compensation in the sum of £300 having satisfied himself that authorisation should not have been granted as in his view the injury was trivial and/or minor in nature.

4.23 The aforementioned judgment is good authority for the proposition that once the Minister authorises an applicant to maintain proceedings for compensation that the High Court judge, even if of the view that the injuries are minor, must proceed to award compensation under the Act once satisfied that the Act applies to those injuries.

4.24 As to the matters to be taken into account in the assessment of damages, s.10 of the Act provides clear guidelines for the court. This section directs the court's attention to the issues of pain and suffering, the expected costs of future medical and surgical

care, the potential effect of the injuries on future earnings and consequential pension adjustments. There is nothing in the Act or in the provisions of s.10 which suggest that the court should not approach compensation in the same manner as it would approach the issue of damages in a personal injuries claim at common law. In this regard, I agree with the judgment of Walsh J. in *O'Looney v. Minister for Public Service* [1986] I.R. 543, a case in which the court was asked to consider, in the context of a garda compensation claim, whether or not a special pension paid to the applicant on his discharge from the force as a result of his injury should be deducted from the claim for economic loss. In concluding that the pension should be so deducted, he had cause to consider the scheme for compensation provided for in the Act. I agree with the *obiter* sentiments he expressed at p. 546 where he stated as follows:-

> "During the course of the submissions to this Court some reference was made to the possible difference between compensation and damages. In my view such distinction is not relevant in the present case. The whole function of the Act is to provide compensation by way of damages for the personal injuries suffered and for the economic consequences of these personal injuries. When one examines the structure of the Acts and compares the provisions made in respect of fatal cases and cases not resulting in death, it is quite clear that the intention of the Oireachtas was to put the members of the Garda Síochána in virtually the same position as persons who bring actions for death or personal injury caused by negligence."

4.25 Having regard to the provisions of s.10 of the Act and the decision in *O' Looney*, I see no reason to depart in any significant way from the approach that would be adopted by the court if assessing these claims for damages at common law and there is nothing in the Act which would encourage me to conclude that a claimant under the Act should receive a greater amount for his injuries than his counterpart maintaining an action for negligence at common law.

4.26 Because of the prevalence of "fear of disease" applications under the Act, I believe that it is appropriate to set out clearly for those concerned with claims of this nature how I believe the court should approach the assessment of compensation in such cases given that the greater part of the injuries so sustained are psychological in nature. Some helpful guidance is to be found in the *Guidelines for the Assessment of General Damages and Personal Injuries Cases* (4th Ed., Blackstone Press, London, 1998) which points to the factors which should form the basis for the court's quantification of damages in cases involving psychiatric injury.

4.27 Having heard the evidence of the plaintiffs and of the medical practitioners in the present proceedings, I have concluded that the following matters, *inter alia,* should be taken into account in considering the compensation to be awarded in any case where a member of An Garda Síochána claims compensation for a fear of having contracted HIV and/or HCV as a result of an assault, namely:-

> (i) the severity of the assault;
>
> (ii) whether any general or specialised medical treatment was warranted and if so the nature and extent of same;
>
> (iii) the injured members' ability to cope with life and work following their assault, including any time they may have spent out of work;
>
> (iv) the effects, if any, of the injury on the members' personal relationship with his/her family and friends;
>
> (v) any restrictions imposed upon the member as a result of their injury including any restrictions on their sexual relationship with their partner;
>
> (vi) the prognosis for the member and any future vulnerability that they may have a result of their assault; and
>
> (vii) the extent to which the injured party has mitigated their loss.

4.28 The existence of an obligation on any claimant to mitigate their loss seems to follow as a logical consequence of agreeing with the views of Walsh J. in *O'Looney* that the assessment of compensation in garda compensation claims should be approached in much the same way as the court would approach the issue of damages at common law. Accordingly**,** in the context of any claim brought by a member claiming a fear of infection from HIV and or HCV, the court should have regard to any evidence adduced by the respondent to suggest that such member has failed to mitigate their loss. By way of example, the court might be asked to consider the extent to which the fears expressed by a claimant may materially conflict with any instruction or advice furnished to them regarding these viruses either in the course of their training or thereafter. A claimant should not be rewarded for holding to a position of ignorance in the face of clear and unequivocal instruction or advice to the contrary. As McNulty J. put it, delivering the judgment of the Appellate Court of Illinois in *Majca v. Beekil* 682 NE 2d 253 at 255:-

> "Where hysterical fear of disease is sufficiently widespread, and popular knowledge concerning its etiology is limited, a plaintiff may foreseeably experience severe emotional distress without medically verifiable evidence of a substantially increased risk of contracting the disease. Most courts have held that recovery for fear of disease should not extend to such foreseeable fears, because, as commentators have noted, such broad recovery rewards ignorance about the disease and its causes."

4.29 This paragraph from *Majca* was quoted with approval by the Supreme Court in the leading Irish case on compensating fear of disease, *Fletcher v Commissioners of Public Works* [2003] 2 I.R. 465. Common sense would suggest that those who receive advice regarding these viruses in the course of their training or subsequent thereto should be expected, not only to maintain their knowledge of such information, but also to have regard to it in the event of their being exposed to any risk of infection.

4.30 In relation to mitigation of loss, I have concluded that the Court should also take into account any failure on the part of a claimant to seek to obtain the results of blood tests to which their assailant may have agreed or their failure to transmit those results to their treating doctors for the purpose of obtaining further advice as to their significance. The results of such tests, which Dr. Sheehan stated should be available within two days, are the most critical piece of information required by any medical practitioner faced with advising a patient exposed to a risk of contracting HIV or HCV. If negative, the test results enable complete reassurance to be given to the victim and ought to bring a halt to any further testing or restrictions on their lifestyle. From the evidence it is clear that there is a significant onus upon the garda authorities to ensure that all assailants are asked, and if necessary repeatedly asked to agree to blood testing, and that they thereafter follow up those tests so as to make sure the results available to their members. This fact however does not, in my view, relieve any member from their obligation to take all steps necessary to obtain those results and to make them known to all concerned with their care. Indeed, a failure to do so may even cast doubt upon the validity of any claim for compensation based upon an alleged fear of infection from that source.

4.31 As regards to the courts approach to the assessment of damages, I briefly want to mention an assertion that appears to be almost universally made by claimants in cases of the present nature, namely, that prior to their assault they enjoyed the benefit of unprotected sexual relations with their partner or spouse but that post assault, for the period of their testing, they were obliged to have what has been described as safe sex. Clearly, any such claim must be approached with understanding and sympathy. However, the court ought, in my view, take a measured, and perhaps even conservative approach, to awarding damages in respect of such loss. The extent of this interference with unrestricted intimacy, I believe, should be viewed against the backdrop that, for a whole range of reasons, both within and outside of marriage, a wide sector of the sexually active population will find it acceptable to have protected sexual intercourse for significant periods of their lives. Further, for those who claim that prior to their assault they enjoyed unprotected sexual intimacy, a claim in itself which can never be contested, the relatively modest restriction required should be viewed in the context of their continued ability to enjoy significant sexual intimacy curtailed only by the need to use a condom during penetrative sex.

4.32 Finally, I agree with the defendants' observations that, as psychiatric injury is normally parasitic on a co-existing physical injury, it is easier for a court in a case where there is a significant physical injury to satisfy itself as to the existence and severity of a coexisting psychiatric injury than to make the same judgment in a case where there is insignificant physical injury. The caution urged by the defendants is appropriate in circumstances where the existence of a right to compensation has occasionally been shown to have corrupted the narrative or the telling of the evidence by a claimant to the court or to their medical advisors. That is not to state that this has happened in the present cases. However, any clinician or court can be misled where the injury concerned cannot be objectively tested. H.G. Kennedy, in his article entitled "*Limits of Psychiatric Evidence in Civil Courts and Tribunals: Science and Sensibility*" (2004) 10(1) MLJI 16 made the following pertinent observations at p. 17:-

> "…any clinician, and therefore any psychiatrist in the role of expert witness, can be wrong and can be deceived. In clinical practice, the psychiatrist's normal means of ensuring against being misled is never to rely only on the account of one person. Multiple primary sources of information, independent of the individual assessed, are essential."

4.33 Consequently, medical practitioners advising the court should, wherever possible, try to avoid relying solely on the account of the claimant and should have regard to any other primary sources of information available to them when coming to their conclusions. For example, a medical report prepared by a consultant psychiatrist who did not treat a claimant in respect of their injuries and who did not have any contact with their general practitioner prior to its preparation, is evidence to which the court can attach little weight, particularly if, as occurred in the case of Garda O'Sullivan, that report relies on the existence of a number of medical conditions not previously mentioned in the course of earlier medical review by their general practitioner.

Causation and *Novus Actus Interveniens*

4.34 The issue of causation in these cases has arisen for consideration principally because of concerns expressed by me at the time when I directed that these cases should be heard on oral evidence. I indicated that I would be grateful for the assistance of the parties as to the approach the Court should adopt if it were to conclude that, in any given case, it was incorrect or negligent medical advice that caused the plaintiffs injuries or substantially aggravated what would otherwise have been a less significant injury.

4.35 As the Court's findings of fact are relevant to the causation argument, it is important for me to record that having heard the evidence of Prof. McConkey, Dr. Sheehan and Prof. Bradley, I am satisfied that none of the doctors concerned in these proceedings were careless or negligent in the treatment or advice they afforded to their patients and that at all times they acted in what they considered to be their patient's best interests. Whilst judged by the state of knowledge of consultants in infectious diseases, some of their decisions might be said to be have been incorrect. However, by and large, the Court was told that their actions were broadly in keeping with what would have been recognised as standard practice for general practitioners and non-consultant hospital doctors at the relevant times. That is not to say that a different approach in a number of instances might not have significantly reduced the anxiety suffered by the plaintiffs and that there are not lessons to be learned from the informative and discursive evidence given by the experts. However, it cannot be said that any of their medical advice in these cases contributed, in the legal sense, to any of the injuries complained of by the plaintiffs.

4.36 I agree with the plaintiffs' submission that the Court should take a purposive approach to the interpretation of s. 2 of the Act of 1941. The scheme provided for is one principally designed to award compensation and there is nothing in the Act from which it can be inferred that the Court should, save in the exceptional circumstances hereinafter referred to, conduct its proceedings so as to inquire into the extent to which some portion of a claimants injuries may be ascribed to the acts or omissions of those who treated them as a consequence of their respective assaults so as to reduce the damages in respect of their overall injuries.

4.37 Section 2 of the Act requires the Court to compensate a claimant who has suffered "personal injuries maliciously inflicted" upon them. It is these words which require interpretation when considering the issue of causation. Having regard to the aforementioned wording I have concluded that the causation test that ought to be applied by the Court is whether or not the assailant's malicious conduct was the substantial cause of the injuries complained of. In interpreting the section in this manner I have been influenced not only by the language of the section itself and by the overall provisions of the act but also by the decision of the Court of Appeal in *R. v. Criminal Injuries Compensation Board, ex parte ince* [1973] 1 W.L.R. 1334 and the decision of Caroll J. in *Gavin v. Criminal Injuries Compensation Tribunal* (1997) 1 I.R. 132, to which I will later refer. I have also taken some guidance from the various causation tests commonly considered by the courts when dealing with claims for damages for negligence at common law.

4.38 To interpret the section in the manner proposed is to adopt an approach not dissimilar to one of the causation tests referred to by the plaintiffs in their submissions, namely that advanced in *Prosser and Keeton on the Law of Torts* (5^{th} Ed., London, 1971). That test is one which in a claim for damages at common law, requires the court to decide whether a defendant's conduct was a material element and a substantial factor in bringing about the injury complained of. If it was, then it can be stated in a factual sense that the defendant caused the plaintiff's injury. If such a test was to be applied to the facts of these cases the plaintiffs would comfortably establish causation. It is also of some relevance to note that even if the Court were to take guidance in the manner urged by the plaintiffs by testing the facts of each of these cases against the "but for" rule which commonly is used to determine causation in actions for negligence at common law, the plaintiffs would also establish causation.

4.39 In rejecting the causation test proposed by the defendant, namely that any claimant is obliged to prove that the entirety of their injuries were "directly caused" by the malicious actions of a third party, I have had regard to the precise wording of s. 2 where the words "directly caused" are not used. It seems to me that if it had been the intention of the Oireachtas to place such an onerous obligation upon a claimant, the legislation would have so stated. However, even if I were to conclude that there was such an onus on the plaintiffs to establish that their injuries were "directly caused" by the malicious actions of a third party, the plaintiffs would in any event establish causation. In this regard, the decisions relied upon by the defendant namely *Gavin v. Criminal Injuries Compensation Tribunal* and *R. v. Criminal Injuries Compensation Board* are of assistance.

4.40 In *R. v. Criminal Injuries Compensation Board*, the widow of a police officer who was killed when he drove through a red light on his way to the scene of a robbery brought a claim for compensation under the Criminal Injuries Compensation Scheme 1964. That scheme at, para. 5, provided for compensation where a police constable either sustained injuries or was killed. The scheme provided that the death had to be "directly attributable" to an attempt to effect an arrest. The Board initially rejected the claim on the basis that the constable's death was not, as required, "directly attributable" to his attempt to prevent an offence. However, the Court of Appeal, ultimately concluded that the words "directly attributable" were not equivalent to the words "solely attributable". It concluded that so long as the constable's response to the emergency call to attend the scene of the robbery was a "substantial" cause of his death, then his widow should recover in full.

4.41 The judgment of Denning J. is of assistance not only to the causation test proposed by the defendant but also to the issue of whether or not any of the medical treatment afforded the plaintiffs in the present cases might be deemed to constitute something akin to a *novus actus interveniens* at common law sufficient to discharge the defendant from liability. Denning J. at p. 1341 of his judgment stated as follows:-

> "In my opinion "directly attributable" does not mean "solely attributable." It means directly attributable, in whole or in part, to the state of affairs as P.C. Ince assumed them to be. If the death of P.C. Ince was directly attributable to his answering the call for help, it does not cease to be so attributable because he was negligent or foolish in crossing the lights. In such case there were two causes: (i) the call for help; (ii) his negligence, or foolishness. His widow can rely on the first, even though the second exists. Just as in pension cases, so in these compensation cases, "even if the intervening cause is the negligence or wrongful act of the injured person or a third party," the injury may still be attributable to the original event and give rise to a claim for compensation. It only ceases to be so when the intervening event is so powerful a cause as to reduce the original event to a piece of the history: see *Minister of Pensions v. Chennell* [1947] K.B. 250, 255."

4.42 The decision of Megaw L.J. is of further assistance in relation to the issue of causations. In his decision at p. 1344, he stated as follows:-

> "First, there is the question of the meaning of the phrase "directly attributable to". In my judgment, personal injury is directly attributable to any of the matters (crime of violence, arrest of an offender, attempted prevention of an offence, or any of the other matters set out in paragraph 5 of the Scheme), if such matter is, on the basis of all the relevant facts, a substantial cause of personal injury. It does not need to be the sole cause. By the word "substantial" I mean that the relationship between the particular cause and the personal injury is such that a reasonable person, applying his common sense, would fairly and seriously regard it as being a cause."

4.43 The decision in *R. v. Criminal Injuries Compensation Board* was relied upon by Carroll J. in *Gavin,* a case in which she was asked to grant an order of *certiorari* to quash a decision of the Criminal Injuries Compensation Tribunal in relation to the scheme which provided for the making of an *ex gratia* payment of compensation to a victim of crime. The scheme provided that the injury had to be shown to be "directly attributable to a crime of violence".

4.44 To consider the relevance of the judgment in *Gavin* to these proceedings it is necessary to record some of the basic facts and, they are as follows. The applicant made a claim for compensation under the Scheme for Compensation for Personal Injuries Criminally Inflicted ("the scheme") as a result of injures he sustained when he tried to prevent thieves from stealing his car. In the course of the incident he was carried on the bonnet of the car before being thrown off onto the ground thus sustaining his injuries. After he had lodged his claim for compensation the applicant was subjected to five separate threatening events as part of an ongoing campaign of intimidation by those charged with the thefts.

4.45 The Tribunal refused an application by the applicant to reopen his initial claim and proceeded to award him a modest sum in respect of the injuries sustained in the initial crime. It permitted him nonetheless to lodge a further claim in respect of the later events which he duly did. That claim was substantial as his life had unravelled in the face of the campaign of intimidation waged against him. He had developed post traumatic stress disorder and become dependant on alcohol. He had lost his job and had little prospect of future employment. His claim for loss of earnings alone amounted to £500,000.

4.46 The Tribunal, having stated that it accepted his evidence concerning his financial loss and that his injuries were attributable to the aforementioned intimidation, awarded him a sum of £100,000 to cover all aspects of his claim. This was upheld by a three man tribunal on appeal. Thereafter, the applicant, being unhappy with his award, wrote to the Minister questioning how much of the award was for pain and suffering and how much was for special damage. The Minister was advised by the Tribunal Secretary that the award was one which was inclusive of general and special damages, an explanation which proved unsatisfactory to the applicant who thereafter commenced proceedings claiming, *inter alia*, orders of *certiorari* and *mandamus*.

4.47 In the replying affidavit filed in those proceedings the Tribunal Secretary in seeking to explain the decision of the Tribunal stated that the Tribunal had not been satisfied that the entirety of the applicants personal injuries and consequential loss and damage were directly attributable to the five incidents of intimidation complained of. They had concluded that some of his injuries had been caused or contributed to by different factors including the original theft, the resulting court case, the fact that the thieves escaped custody and were at large and further that they were not satisfied that his inability to find suitable employment was directly attributable solely to threats the subject matter of the claim.

4.48 In her judgment, Carroll J. was forced to consider, amongst a number of other significant legal issues, the meaning of the words "directly attributable" as provided for in the scheme. She concluded that the words "directly attributable" were not the same as the words "solely attributable". She pointed to the fact that in the scheme there was no provision to say that the loss and damage had to be solely attributable to the crime and she followed the decision in *R. v. the Criminal Injuries Compensation Board* just referred to. She concluded that once the applicant's injuries were directly attributable in whole or in part to the events complained of that he was entitled to compensation without reduction, save only that if the Tribunal concluded that the original crime for which he had already received compensation was the *causa causans* for part of his injuries, then that portion attributable to the earlier injury could be deducted.

4.49 The aforementioned decisions have convinced me that even if I were to adopt the defendant's interpretation of s. 2 of the Act, and the plaintiffs had to prove that their injuries were directly caused by the malicious act, I would only have to be satisfied, which I am, that the plaintiffs injuries were in whole or in part caused by the malicious act to award them full compensation under the Act. Accordingly, the fact that the plaintiff's injuries may have been partially caused by incorrect medical advice subsequent to the respective assaults cannot diminish their entitlement to compensation unless the defendant can establish that such intervention amounts to something equivalent to a *novus actus interveniens* at common law such that I could no longer conclude that the

malicious act complained of in each case was a substantial cause of the injury sustained.

4.50 Notwithstanding the fact that proceedings under the Act are brought by way of special summons, it would be open to the defendant in an appropriate case to seek to avoid liability by attempting to establish that a claimant's injuries were more properly attributable to a supervening or subsequent event of such magnitude that the court should determine the injuries could no longer be substantially ascribed to the malicious act.

4.51 I agree with the plaintiffs that, if dealing with such an issue, the court might take guidance from case law dealing with the concept of *novus actus interveniens,* a concept which is regularly considered by the court in the context of negligence actions at common law.

4.52 I have been referred at length to a significant number of decisions demonstrating the operation of the doctrine of *novus actus interveniens* in this jurisdiction, namely *Cunningham v. McGrath Brothers* [1964] I.R. 209, *Crowley v. AIB & O'Flynn* [1987] 1 I.R. 282 and more recently the judgment of Fennelly J. in *Breslin v. Corcoran & MIBI* [2003] 2 I.R. 205. Whilst these decisions are helpful, they all essentially focus upon the concepts of foreseeability, proximity and remoteness, all of which are somewhat alien to a statutory scheme such as that provided for in the Act. However, they do give helpful guidance as to the very significant burden faced by a party who seeks to discharge their own liability in reliance upon a *novus actus interveniens*. In this regard, in *Crowley* it was decided that the more outrageous the conduct of the intervener, the more likely it was to breach the chain of causation. The case law also demonstrates that actions that might be considered to be careless or reckless will not, in an action for negligence, breach the causation chain whilst actions which may be viewed as grossly negligent or outrageous may and that the court should have regard to the extent to which the intervening act relied upon by the defendant may be viewed as a foreseeable consequence of the initial wrong. If it can be said that the intervening act was a foreseeable consequence of the initial wrong, that fact should influence the court to conclude that the defendant should remain liable for it.

4.53 Applying the aforementioned guidance to the evidence in the present cases, it can firstly be stated that even if some of the medical advice and/or treatment given by the plaintiffs' respective doctors could be stated to have been incorrect by the standards of the experts in infectious diseases at the relevant time, it simply cannot be stated to have been either careless or reckless, never mind negligent or outrageous, such that in an action at common law, the chain of causation would be broken.

4.54 Secondly, it is practically inevitable that the malicious acts which form the basis for claims for compensation under the Act will result in the victim requiring medical treatment. Any such treatment brings with it the possibility that it may actually aggravate or exacerbate the initial injury and as such can realistically be viewed as a foreseeable consequence of the assault. Accordingly, in applying by way of analogy the jurisprudence of the courts as it relates to the issue of *novus actus interveniens* in negligence cases, it could only be in extraordinary circumstances that any action on the part of a treating doctor could relieve the defendant of liability under the Act.

4.55 In this regard, the plaintiffs have relied upon, what I consider to be a most helpful extract from Hodgson on *The Law of Intervening Causation* where at Chapter 12, p. 169, the author deals with intervening causes that can emerge from medical interventions:-

> "Hospitals and health carers are often involved in situations where the patient presents with injuries which are attributable to the defendant's negligent conduct... However, as a result of the negligence of the hospital and/or health carer, some further damage is sustained by the plaintiff. In such a case, provided the plaintiff acts reasonably in seeking and accepting medical treatment and the original injury is exacerbated by negligence in the administration of the medical treatment, it is the generally accepted view of most common law jurisdictions… that the negligent medical treatment will not be regarded as a *novus actus interveniens* relieving the original defendant of liability for the aggravated injuries, because the original injury may be regarded as carrying some risk that the medical treatment might be negligently administered. In those cases, where negligent medical treatment is deemed to be a recognisable risk for which an accident victim might hold the original defendant responsible, the plaintiff will be permitted to recover from the original defendant… full damages both for the accident related injuries as well as for the aggravated injuries attributable to the medical negligence… On the other hand, where the injured plaintiff receives inexcusably bad or grossly negligent medical treatment or advice, such treatment will break the causal chain and the negligent health carer will be solely responsible for any exacerbation of the plaintiff's injuries."

4.56 In looking at the present cases it is clear that each of the plaintiffs was maliciously assaulted. They all acted reasonably in seeking and accepting the medical advice given to them. Their injuries were substantially caused by those assaults even if those injuries may have been exacerbated by medical advice which was less than reassuring and somewhat less than optimum in a number of instances. However, the medical advice and treatment was in no sense negligent and has not been demonstrated, as would be required, to amount to intervention so powerful in terms of its significance and effect so as to reduce the initial assault to "a piece of history" such that I could validly conclude that the substance of the injuries sustained by the plaintiffs were not to be attributed to the malicious act in each case. In light of my interpretation of s.2 of the Act and the strength of the type of *novus actus* required to break the chain of causation in any claim for compensation under the Act, I am satisfied that the defendant is liable for the wrongs perpetrated against the plaintiffs and that no legal blame can be laid at the door of the doctors in these cases. The issue of apportionment of damages contended for by the plaintiffs does therefore not arise.

4.57 Having regard to my aforementioned conclusions, it is not necessary for me to consider whether or not the Court should, as urged by counsel for the plaintiffs, be guided by the legal principles which apply at common law when a court is considering the issue of *novus actus interveniens* in claims based upon intentional torts. These claims are treated differently from those where injuries are negligently inflicted. That law provides that if a person intends to cause damage to another person he cannot, in a subsequent action for damages be heard to say that whilst he intended to inflict an injury that its consequences were not foreseeable. The principle underlying this approach seems to be one destined to ensure that the wrongdoer must never be allowed escape the consequences of an intentional act no matter how unforeseeable. Given that the defendant in the present case is not a wrongdoer, I am not at all satisfied that the plaintiff's submissions based upon the principles which apply to intentional torts are of any significance to claims brought under the Act. However, having regard to my other findings, it is not necessary for me to decide this issue.

4.58 For all of the aforementioned reasons, I have concluded that having regard to the precise wording of the Act that a claimant will establish causation if they prove that their injuries are substantially the result of the malicious assault the subject matter of the claim and that unless there is a supervening or subsequent event which is, to quote Denning J. in *R. v. Criminal Injuries Compensation Board* "so powerful a cause as to reduce the original event to a piece of history" that the court should compensate the claimant for the entirety of his injuries which post date the assault. In coming to that conclusion, the court may take guidance from the common law in relation to *novus actus interveniens* and look to the extent to which that event might be considered to be so outrageous or

grossly negligent such that it could be considered to relieve the defendant of his responsibility.

4.59 It is nonetheless clear from the Act that the damages to be awarded by the court in any claim for compensation must be confined to those injuries substantially caused by the malicious act, the subject matter of the claim. The court cannot compensate a claimant under the Act for any injury caused, for example, by another assault not the subject matter of a compensation claim. Neither can it award damages in respect of all of the injury complained of where there is clear evidence that a significant portion of the pain and suffering relates to another unrelated event such as perhaps an earlier accident or may be ascribed to a medical condition that predated the malicious event. To conclude otherwise would be award compensation beyond that which would be recoverable in a claim for damages at common law and this would be inconsistent with the views expressed by Walsh J in *O'Looney* when he stated that a claimant under the Act should find himself in virtually the same position as the plaintiff maintaining a claim for damages at common law. Further, as Carroll J. made clear in *Gavin,* if the *causa causans* of the injury or some part of it lies elsewhere such as in another assault or accident the court must adjust the compensation to reflect that fact. Clearly, there are no circumstances in which double collection can be permitted to occur. Neither should a claimant under the act receive damages substantially different from those he would recover if maintaining a claim for damages in respect of the same injuries at common law.

4.60 Finally, in relation to causation, I accept the plaintiff's submission that it would be highly unsatisfactory for a defendant to be entitled to raise an issue of causation and/or a defence in reliance upon *novus actus interveniens* for the first time in the course of any hearing. The facts which might support such a defence are likely to be apparent from the medical reports which are universally exhibited in the grounding affidavit to these claims or, if not, may emerge in the course of the examination of the plaintiff by the Chief Medical Officer. Accordingly, unless such issue arises by way of surprise from the evidence in the course of the hearing, any defence of this nature is one which should be raised by the defendant on affidavit as would be the normal approach by a defendant in proceedings brought by way of special summons. The proper procedure thereafter is for one of the parties to apply to the court for directions pursuant to the provisions of O. 38, r. 8 of the Rules of the Superior Courts. That order provides a mechanism whereby any such issue can be litigated between the parties. The court, when making its order directing the time and mode of trial may also make such ancillary orders as it deems fit, including where appropriate an order for discovery.

5. Findings of Fact in each Case and the Consequences Thereof

Findings of Fact

Garda Carey

5.1 Approaching the issue of damages in the manner detailed earlier in this judgment it is clear that Garda Carey must be compensated for the physical injuries maliciously inflicted upon him on 30th December, 2005 and also for the psychiatric injury arising from that assault, namely the anxiety disorder described by Dr. Dennehy.

5.2 In assessing damages, I have taken into account the fact that Garda Carey sustained a bite to one of his fingers, which was dressed and healed without complication in ten days leaving two very small permanent scars which are of no cosmetic significance. He also received a tetanus injection, was prescribed a course of antibiotics to combat bacterial infection from the bite and had baseline blood tests carried out on account of possible infection from HIV and/or HCV.

5.3 As a result of medical advice that he was at risk of contracting HCV and/or HIV Garda Carey expected to undergo routine blood testing over a period of six months. Thankfully, his assailant's test results were reported negative in the first week of January 2006 and these results were made known to him shortly thereafter. However, he had a number of sleepless nights whilst awaiting those results.

5.4 I am satisfied as a matter of fact that the reason Garda Carey did not return for review as planned to his general practitioner on 13th January, 2006, was because he had received his assailant's negative blood test results and believed himself no longer to be at risk of contracting infection. Hence, were it not for the second assault, his physical and psychological injury in respect of the assault of 30th December, 2005, would then have been at an end.

5.5 In approaching the issue of damages, I have considered and then discounted as irrelevant to that issue, the evidence of Prof. Bradley that, even though Garda Carey's assailant's test results were negative, the so called "window period" would have justified the continued testing of Garda Carey for the whole of the six month period post the assault. In this regard, Prof. Bradley's evidence on this issue was very significantly at variance with the evidence of Dr. Sheehan, the plaintiff's own witness, who said that the window period should be ignored unless the assailant, which he was not in the present case, fell into a high risk category. Further, Dr. Booth was not canvassed as to whether or not, if his patient had returned for further review, he would have continued to test him in respect of HIV or HCV. In any event, such supposition is irrelevant as the fact of the matter is that Garda Carey did not return for review after he received his assailant's negative blood test results and Dr. Booth accordingly never had to make any decision on the matter. Accordingly, the subsequent blood testing carried out on Garda Carey and/or any restrictions advised in respect of his personal relationship post the 18th January flow from the second assault rather than the assault the subject matter of this claim.

5.6 I have been urged by counsel to compensate Garda Carey for the anxiety disorder which Dr. Dennehy stated continued to affect him until such time as his final blood tests in relation to the second assault in July, 2001 were reported negative. This submission is based upon the evidence of the various medical practitioners who found it difficult to segregate Garda Carey's psychological response to the separate assaults and also on the basis of Garda Carey's evidence that the information gained by him in the course of his testing at Garda Headquarters made him concerned about the extent to which he could validly rely upon the negative test results of his assailant obtained in early January 2001.

5.7 Having considered the evidence, I have concluded that the vast preponderance of the anxiety suffered by Garda Carey post the second assault must be attributed to that assault and not to the assault the subject matter of this claim. I cannot accept the plaintiff's evidence that he viewed the second assault and its effects on him as being minor in comparison to the assault the subject of this claim. The assailant in the assault the subject of this claim was proved to be HIV/HCV negative within a week of the assault and this fact was communicated to Garda Carey shortly thereafter. Further, he did not return to Dr. Booth for any further advice or treatment, as had been planned, after he was made aware of these results. By way of contrast the second assault involved a very significant blood spillage, the assailant was HIV positive and all involved were taken to Garda Headquarters in Dublin where they underwent six months of testing and for the same period were advised to restrain from unprotected sexual relations.

5.8 As a matter of law, I have concluded that it would be wrong for me to compensate Garda Carey in the present proceedings in relation to the entirety of his anxiety symptoms referable to both assaults even if there is an overlap in psychological symptomology. From a causation perspective, the two assaults are unrelated events. Each potentially gave rise to a separate right to claim

compensation under the Act. No claim was made in respect of the latter assault. Given that I am satisfied that some of the injuries now complained of relate to the second malicious assault, I am not entitled as a matter of law to compensate Garda Carey for the consequences of that assault in the course of these proceedings.

5.9 Taking into account the fact that Garda Carey was only out of work for two days, that he made only one visit to his general practitioner in relation to this assault, that he had only one blood test in relation thereto, that his intimate relationship was only interfered with for a very short period of time, that all blood testing and restrictions placed on his private life post 18th January, 2006 were attributable to the second assault, that all subsequent attendances upon medical practitioners were solely for the purposes of medical legal review, that he required no specialist medical care and did not have to forego any of the normal amenities of life. All of this, when combined with an excellent prognosis has led me to conclude that Garda Carey sustained what I consider to have been a minor injury in the context of this statutory scheme and that his injuries justify the modest award of a sum €6,000.

Garda O'Sullivan

5.10 There is no disputing the fact that Garda O'Sullivan received a significant bite to his thigh which was maliciously inflicted upon him in the course of his duties on 3rd May, 2000. As it is a matter of small import in the context of this judgment, I have concluded, not without some reservation, that the bite inflicted upon Garda O'Sullivan did in fact breach his skin. I have reached this finding notwithstanding:-

(i) that the notes from the Accident and Emergency Department of the hospital state to the contrary;

(ii) that the special endorsement of claim on the special summons states to the contrary;

(iii) that the report of Mr. Coleman O'Leary states to the contrary;

(iv) the fact that the plaintiff does not depose to these facts in his grounding affidavit;

(v) Prof. McConkey's evidence that the skin could not have been broken having regard to the Accident and Emergency record which stated:-

"was wearing jeans

no hole in jeans

bruising right anterior thigh

no break in the skin

for tetanus toxoid

bruise cleaned

antiseptic and betadine tulle applied"; and

(vi) Prof. McConkey's evidence that the administration of a tetanus injection and the application of a betadine dressing was not decisive evidence that there was a breach to the skin.

5.11 In relation to the plaintiff's physical injuries, there is no contest. Garda O'Sullivan sustained a bite and a bruise which resolved without complication. The difficulty arises in relation to the extent of any consequential psychological injuries occasioned to Garda O'Sullivan and in relation to the compensation which should rightfully be awarded.

5.12 I accept that Garda O'Sullivan was concerned about the possibility of infection from HCV and/or HIV, that he had a number of sleepless nights in the aftermath of the assault and that he woke up sweating on a number of occasions. His fears were validated by the medical practitioners charged with his care, namely the doctor in the Accident and Emergency Department and his general practitioner, Dr. Hannon, both of whom advised that routine blood tests were required and that he should take precautions to protect against potential transmission to his wife.

5.13 I accept that Garda O'Sullivan complied with the precautions advised by Dr. Hannon and that he continued to experience anxiety until the results of his blood tests carried out in early November, 2000 were available. I do not believe that the level of that anxiety was disabling or particularly significant in circumstances where he attended his general practitioner on more than one occasion over that period in relation to other matters and yet Dr. Hannon's notes of those attendances do not make any reference to any ongoing concerns regarding HCV and/or potential HIV infection.

5.14 I also accept Garda O'Sullivan's evidence that notwithstanding the negative results of his blood tests which were reported to him in November, 2000 that he continued to worry about infection for some time. This seems to be borne out by Dr. Hannon's note of 14th February, 2002 which refers to his patient's use of condoms since the bite and the fact that he required significant reassurance.

5.15 I cannot attach significant weight to the evidence given by Dr. Mary McInerney, Consultant Psychiatrist, who prepared a comprehensive report having interviewed the plaintiff for the first time almost ten years after his assault. This is no reflection on Dr. McInerney's professional competence. I must discount her evidence substantially for a number of reasons. Firstly, in coming to her conclusions, Dr. McInerney has relied upon an account given to her by Garda O'Sullivan of his symptoms which are significantly at variance from those symptoms described by him to other medical practitioners. In particular, she referred to an alteration in his eating pattern, flashbacks, difficulties concentrating and his feeling of being "on red alert". She factored into her conclusions what she stated were a number of physiological effects of this stress upon Garda O'Sullivan including aches and pains, fatigue, muscle tension, indigestion and elevated blood pressure. None of these symptoms appeared in the medical reports of Dr. Hannon, his General Practitioner or that of Mr. Coleman O'Leary, Accident and Emergency Consultant. They were not referred to by Garda O'Sullivan in his affidavit and are not recorded in his medical records. Further, neither Garda O'Sullivan himself nor any of the medical witnesses gave evidence in relation to any of these matters in the course of the proceedings. Indeed, Dr. Mary McInerney's evidence demonstrates the difficulties identified by the court earlier in this judgment when describing the difficulty faced by a court when trying to assess the weight to be attached to evidence proffered by a medical expert who did not treat the claimant, who did not assess them against the backdrop of a general practitioner's referral letter, who had no access to the patient's medical history or records and where the

existence of the injury and/or their determination as to its severity is entirely dependant on the narrative of the patient, the fear of infection being entirely psychological in nature.

5.16 I have accordingly concluded that Garda O'Sullivan suffered an acute stress reaction for a number of days. Thereafter he suffered anxiety as a result of his assault and this continued, albeit on a diminishing basis, until approximately February 2002. Garda O'Sullivan's anxiety disorder did not involve any nightmares or flashbacks and neither did he experience or report any depression. He had no need for any psychological support or counselling and, otherwise than for blood testing, did not receive any treatment or medication from any medical adviser. He was able to continue his intimate relationship with his wife save that he had to use condoms during sexual intercourse. His injuries, physical and/or psychological, did not otherwise interfere with any other aspect of his life albeit that the assault may have rendered him more vigilant when dealing with the public or prisoners in the course of his duties.

5.17 I cannot conclude, as I have been urged to do, that the assault the subject matter of this claim had a significant impact on Garda O'Sullivan's career. He was not out of work as a result of his assault. Thereafter, the evidence established that he remained in the Drugs Unit for a period of two years. I believe that he would have sought a much earlier transfer if it was the case that this assault was impacting on his ability to carry out his duties to any material extent. As was clear from the evidence, not only did Garda O'Sullivan remain in the Drugs Unit but he was promoted in 2003 and thereafter did not seek a transfer to community policing until 2005.

5.18 In all of the circumstances, I think the appropriate award for general damages in the present case is a sum of €15,000.

5.19 Whilst not particularly significant to my overall decision, I believe that it is relevant in the context of the reasons underlying these test cases for me to record that, contrary to Dr. Hannon's recollection, I have concluded that the blood tests which he carried out in respect of HIV/HCV on 14th February, 2002 and 24th November, 2008 were not carried out as part of any other routine blood tests in respect of Garda O'Sullivan's liver condition. Garda O'Sullivan attended his general practitioner on both of the aforementioned occasions for the purposes of medical legal review only and as a result medical reports were prepared for his solicitors by Dr. Hannon on 26th February, 2002 and 2nd December, 2008, each of which refer to the aforementioned blood tests. I believe that this finding is borne out by Dr. Hannon's medical records and medical reports and also the haematology records from Limerick Hospital. In relation to the blood test of the 14th February, 2002, the same was referred to by Dr. Hannon in his medical report of 26th February, 2002 in the following manner:-

> "Today I took the opportunity to carry out repeat blood investigations on Detective O'Sullivan.
>
> Fortunately his HIV test remains negative. In addition his Hepatitis A, B and C tests are also negative.
>
> Prognosis:
>
> This man has undergone considerable psychological upset as outlined above. Fortunately his blood HIV and Hepatitis tests remain negative which is very consoling and reassuring for him.
>
> Hopefully he will now be able to relax more and come to terms with the injury."

This extract from Dr. Hannon's report suggests to me that the blood tests carried out on the date of that examination were not carried out in the course of routine testing of Garda O'Sullivan's blood for an unrelated liver matter and further suggest to me that Dr. Hannon remained under the mistaken belief that Garda O'Sullivan was still at some risk, 18 months post assault, of developing infection. This finding is consistent with Garda O'Sullivan's evidence that he was led to believe he was still at slight risk even though his blood tests six months after the assault were clear.

5.20 I have no doubt that Dr. Hannon, in carrying out the additional testing to which I have just referred, had his patient's best interests at heart and that he felt that by carrying out these ongoing tests, including those carried out by him in 2008, he was giving his patient additional reassurance. However, Prof. McConkey, Dr. Sheehan and Prof. Bradley, all agreed that ongoing medical testing for HIV/HCV outside the initial six month period is counterproductive. Prof. Bradley referred to the phenomenon of somatization, which describes how patient's anxieties can actually be fed by a doctor constantly carrying out what are believed to be reassuring tests. There is simply no risk of any patient developing HIV or HCV six months beyond an assault. At that stage, according to Prof. Bradley, the patients worry gauge needs to be reset at zero. Dr. Sheehan described the need for a line to be drawn in the sand after six months whilst also advising the court that as early as three months post assault, very significant reassurance can be given to the patient that they will not go on to develop infection. Again, in Garda O'Sullivan's case, he was not tested at three months as was established in evidence to have been standard practice as far back as the year 2000 and accordingly did not get the type of reassurance that he might otherwise have received had that step been taken.

Garda O'Connor

5.21 Having considered all of the evidence in relation to Garda O'Connor, it is clear that the assault perpetrated upon him on 15th May, 2003 occurred when his assailant spat at him causing blood strewn mucus to strike the side of his face and neck. That spit amounts to an assault and in circumstances where it has not been contested by the respondent that it was the likely intention of his assailant to cause the plaintiff to fear infection from HIV and/or HCV, I believe that I must approach his claim on that basis.

5.22 At the core of Garda O'Connor's claim are his complaints that he suffered from significant anxiety for the six month period of testing during which period he both abstained from sexual relations with his partner and from participation in contact sports, on advice given to him at Tralee General Hospital. I intend to deal with this claim in some detail. He further maintains that he deferred a mortgage application thus placing his life further on hold whilst awaiting the outcome of his final blood tests.

5.23 In this case, I have had to make a number of findings of fact which impact upon the compensation to which Garda O'Connor is entitled. These findings arise from the fact that I found Garda O'Connor's evidence, at times, to be at variance with the documentary evidence in the case, possibly as a result of the significant passage of time that has elapsed since his assault.

5.24 Garda O'Connor stated that he did not attend hospital on 19th May, 2003 as a result of a phone call he made to the hospital that morning. However, I am satisfied that he did attend the hospital on that date. In coming to this finding of fact, I have firstly noted that at para. 5 of his affidavit sworn on 8th April, 2009, he stated that he did attend the hospital on that date. Secondly, Mr. O'Rourke, Consultant in Accident and Emergency medicine, having regard to the extensive note in the hospital records dated 19th May, 2003, was satisfied that he must have attended the hospital on that date. Finally, the records from the blood transfusion

department of the hospital clearly state that the blood tested for HBV was taken from the patient on 19th May, 2003.

5.25 I am also satisfied that, contrary to Garda O'Connor's belief, he was not tested for HIV or HCV at the hospital on either 17th or 19th May, 2003. In coming to this finding of fact, I have taken into account Mr. O'Rourke's evidence that whilst a blood specimen was taken at the hospital, the same was retained for any further testing as might be required by Garda O'Connor's general practitioner. This evidence was consistent with the hospital records for 19th May, 2003 which state that the patient was advised to contact his department doctor for HCV and/or HIV screening and also with the records from the blood transfusion department which solely relate to HBV screening. Finally, the fact that HCV and/or HIV screening was not carried out seems consistent with the noted history of the assault in the records indicating that there was no splash onto a mucosal surface and no obvious skin break, the presence of which might otherwise have warranted HIV and/or HCV screening.

5.26 Garda O'Connor claims that he was advised at the Accident and Emergency Department of Tralee General Hospital that he was at risk of contracting Hepatitis C and/or HIV as a result of his assault. He further maintains that in the course of a discussion regarding these risks, he was informed that condoms had been shown not to be 100% safe when used for contraceptive purposes. He stated that as a result of this information he formed the view that, given that a condom might fail, he would be placing his partner at risk if he continued to have sexual intercourse with her. Accordingly, he decided to abstain from sexual intercourse for the six month period post his assault. He maintains that at the same time he was advised not to engage in contact sports to avoid the possibility of transmitting infection to other players.

5.27 Notwithstanding the fact that Garda O'Connor was not challenged by the defendant as to the advice he maintained he received at Tralee General Hospital, I am not satisfied from the evidence, on the balance of probabilities, that the Accident and Emergency doctor advised him not to participate in sport or that he received any information which could be deemed to amount to medical advice that protected sex might nonetheless leave open the possibility of him transmitting HIV or HCV to his partner.

5.28 In coming to these conclusions, I have firstly taken into account Garda O'Connor's affidavit. At para. 5, Garda O'Connor deals with his attendances at Tralee A&E Department and makes no mention of any such advice in the course of that paragraph. He goes on at para. 6 to state that he was advised by **his** doctor not to engage in sports. In the context of the entirety of his affidavit, I read this averment as relating to the advice given to him by Dr. Nicholson which is referred to by her in her letter of 2nd October, 2003 directed to Garda O'Connor's solicitors. There is no mention in Garda O'Connor's affidavit of having received this advice at the hospital. Secondly, the giving of such draconian advice seems highly improbable in circumstances where a contemporaneous decision appears to have been made, unlike what occurred in the other two cases, not to test Garda O'Connor for HIV or HCV notwithstanding the fact that blood was drawn for HBV testing. Further, of even more significance is the hospital record which sets out an account of the assault and details all of the factors relevant to determining the existence of any potential risk of the patient contracting HCV and HIV and all of which are negative. The note is as follows:-

> "Blood splash from prisoner 4/7
>
> 2/7 blood over body (arms)
>
> No splash to mucosal surfaces
>
> No obvious skin break over the body
>
> Concerned re: Hepatitis B, C status
>
> ? HIV screening
>
> Levels awaited on prisoners blood samples in about 3/52
>
> Discussed with Dr. Waring? Advice taken from occupational health
>
> Advise HB screening (for antibody levels and triage)
>
> Patient should contact his department doctor for Hep C and HIV screen"

5.29 As is clear from the note, the hospital had been advised that the sputum had not come into contact with any mucosal surface and there had been no obvious break in Garda O'Connor's skin. Given these findings and the decision of the hospital not to test for HCV or HIV, I believe it unlikely that Garda O'Connor would have been advised against participating in contact sports and/or that there was any risk to him from having protected sexual relations with his partner.

5.30 Material to my decision on this issue is also the fact that Garda O'Connor attended Mr. Seán O'Rourke, Consultant in Accident and Emergency medicine and his own general practitioner, Dr. Nicholson, for the purposes of having medical legal reports prepared to support the present claim. Those reports were prepared after consultation with Garda O'Connor and none of them make any mention of the fact that Garda O'Connor received the type of advice at the A&E Department of Tralee General Hospital for which he now contends.

5.31 Finally, in concluding that Garda O'Connor did not receive any advice to the effect that protected sexual intercourse would nonetheless leave open the possibility of transmitting infection from HIV/HCV to his partner, I believe that I should take into account all of the evidence in this case to the effect that where there is a real risk of transmission of infection it is the standard practice of medical practitioners to advise their patients to pursue protected sex. I, therefore, conclude it is highly unlikely, particularly having regard to the fact that advice was taken from the Occupational Health Department at Tralee General Hospital, that any advice could have been given to this patient suggesting that such precautions might prove inadequate.

5.32 For all of the aforementioned reasons, I reject Garda O'Connor's evidence as to the advice he stated he was given at Tralee General Hospital albeit that I accept, having heard Dr. Nicholson, that some five months post his assault, almost at the end of the period of testing, that she advised Garda O'Connor to abstain from contact sports.

5.33 Even had I been satisfied that Garda O'Connor was advised at the Accident and Emergency Department that condoms could fail, it is clear that he was not advised against pursuing sexual intercourse using condoms. If, as a result of a statement by a doctor that

condoms had been known to fail, a patient such as Garda O'Connor decided to refrain from sexual intimacy, that is an election the patient is entitled to make but one which cannot sound in damages. In this regard, I accept the evidence given by Prof. McConkey, which was of course based on his acceptance that the conversation contended for took place, that the decision taken by Garda O'Connor to refrain from sexual intercourse rather than accept the risk that a condom might fail was unreasonable.

5.34 Life, as advised by Prof. McConkey, involves people taking risks all of the time. Everyone is entitled to organise their life so as to rule out as many remote risks as they like. Even if those restrictions are implemented as a result of an injury they are not automatically entitled to be compensated for their consequences. For example, anyone who drives a car accepts the small possibility that they may be injured in a crash. If this happens they may decide never to drive again or indeed never to go beyond the perimeter of their home so as to rule out the remote risk that they may someday once again be injured by a car. This is a choice they are entitled to make. But if they bring proceedings against the offending motorist they will not be compensated for the self-imposed restriction unless they can establish the existence of perhaps a post traumatic stress disorder or phobia of such magnitude that the restriction can no longer be viewed as an election. Hence, even if he was told that condoms fail and I was to decide that abstinence was a reasonable election for him to make, both of which I reject, given that it is standard worldwide accepted medical practice for doctors to advise patients to engage in safe sex where there is a risk of infection, this election should not sound in damages.

5.35 In coming to my conclusion that any decision as may have been made by Garda O'Connor not to engage in sexual relations with his partner for a period of six months was unreasonable and should not be compensated, I have taken into account, in addition to Prof. McConkey's evidence, the plaintiff's reliance upon the potential occurrence of two extraordinarily unlikely events as the basis for his decision to abstain from sexual intercourse with his partner. First, the highly unlikely risk that a condom might burst and secondly, the even more unlikely risk of his having contracted a virus from his assailant as a result of a spit onto unbroken skin. I do not believe it is tenable to argue that a choice made on such a basis can sound in damages against the defendant.

5.36 Garda O'Connor claims compensation for an adjustment disorder which, through the evidence of Dr. David Walshe, Consultant Psychiatrist, he maintains he developed as a result of the assault. He also claims compensation for the frustration and annoyance which he states he experienced as a result of the garda authorities having no protocol in place to deal with events such as those which occurred on 15th May, 2003.

5.37 Having considered the evidence, I have concluded that the anxiety experienced by Garda O'Connor was not as significant as that contended for on his behalf. Garda O'Connor told Mr. O'Rourke in December, 2003 that the reason there was a two day delay in him attending the hospital after his assault was because of his work commitments. However, the evidence established that he was not on duty on 16th May, 2003 until 10p.m. Accordingly, he had ample opportunity to attend the hospital if he was as anxious as he now maintains he was regarding his condition, particularly in the light of his assertion that he was annoyed that he had not been referred to the hospital by Sergeant Barrett the previous evening.

5.38 In coming to my conclusion regarding the level of Garda O'Connor's anxiety, I have also taken into account that the first blood test for HIV/HCV did not take place until 17th June, 2003 over a month after his assault. Further, on that date he did not ask to see Dr Nicholson to seek her advice or any reassurance. The blood test was carried out by the practice nurse. The first time he saw Dr. Nicholson was on 1st October, 2003 some five months after the assault. Further, Dr. Nicholson in her letter to Garda O'Connor's solicitors sent the day after her examination of the claimant, namely 2nd October, 2003 makes no mention of any symptomology and refers solely to the advice given by her to Garda O'Connor not to participate in contact sports until his testing was completed.

5.39 Mr. Seán O'Rourke, Consultant in Accident and Emergency medicine having assessed Garda O'Connor on 17th December, 2003 prepared a medical report on the same date which makes no mention of any concerns regarding the transmission of HIV or HCV and neither do his clinical notes made on that date.

5.40 Garda O'Connor's assailant was tested for HIV following this assault. The hospital records of 19th May, 2003 make it clear that he was told that those tests would be available within three weeks yet he never sought to obtain the results. Those test results, as is apparent from Dr. O'Rourke's note of 17th December, 2003 were reported as HIV negative. I find it hard to understand that if Garda O'Connor was so concerned about the risk of transmission of HIV that he did not follow up these test results and thereafter seek medical advice as to their significance. Those test results were of real significance in the context of his alleged decision not to engage in sexual intercourse with his partner given that HCV is not sexually transmitted. Given that his assailant was HCV positive but HIV negative he might well have received advice that there was no need for him to restrict his sexual activity in any way. In this regard, had I been disposed to compensate Garda O'Sullivan for his decision to abstain from sexual intercourse with his partner, which I am not, I would have reduced any sum awarded in respect of this aspect of his claim due to what I consider to have been Garda O'Connor's failure to mitigate his loss in failing to ascertain his assailant's HIV status when he knew he had been tested for this virus.

5.41 There is one final matter to which I feel I must refer in relation to my findings on this issue and that is Garda O'Connor's evidence that his anxiety was heightened because he had shaved immediately before coming on duty on the night of his assault and that this fact had prayed on his mind as potentially exposing him to a risk of contracting infection. This concern is not noted in the hospital medical records, it was not mentioned in his grounding affidavit, it was not conveyed to Mr. O'Rourke, it was not mentioned to Dr. Nicholson and appears to have been raised for the first time when he discussed events with Dr. Sheehan for the purposes of obtaining his advices as per his medical report of 12th February, 2010.

5.42 To conclude, as a result of Garda O'Connor's assault, he attended at Tralee General Hospital on 17th and 19th May, 2003. He had HBV testing at the hospital and somewhat delayed HIV and HCV testing carried out at his general practitioner's practice. He saw his general practitioner on two occasions in the course of which blood tests were carried out. He suffered from a degree of anxiety for a period of six months. Thereafter, all further medical review by Dr. Nicholson, Mr. Coleman O'Leary and Dr. David Walshe was for medical legal purposes. Garda O'Connor did not require any treatment or medication of any nature. He did not miss any period out of work. He had no physical injuries. He was advised by Dr. Nicholson to avoid contact sports five months after his assault and consequently lost enjoyment from this activity as a result of medical advice for a brief period of time. If he did not return to active sport after his final blood tests were available, that cannot be ascribed to his assault. Accordingly, any ongoing abstinence from sporting activity cannot be included when awarding compensation.

5.43 Having regard to my findings of fact, I believe that I must discount to a significant extent the report of Dr. David Walshe which was based upon the accuracy of the facts reported to him. However, I must proceed to award damages having regard to my conclusions in relation to the legal issues earlier addressed in this judgment. In doing so I reject the defendants submission that Garda O'Connor failed to mitigate his losses in declining peer support counselling, a system which whilst laudable in general, does not provide

the type of assured confidentiality required for individuals who may fear infection from HIV and/or HCV. In all of the circumstances, I have concluded that Garda O'Connor, as a result of the assault perpetrated upon him, sustained what I consider was a minor injury in the context of the statutory scheme for compensation. I think an appropriate award for general damages, taking into account any postponement by Garda O'Connor of his plans to obtain a mortgage, a claim which I have to say I found somewhat unconvincing in that it arose for the first time in what I would describe as the second round of medical legal reports, is a sum of €7,000.

6. Summary on Legal Issues

6.1 The present claims were brought under a scheme established to compensate members of An Garda Síochána for (*inter alia*) injuries maliciously inflicted upon them in the course of their employment. Each plaintiff was maliciously assaulted. Garda O'Connor was spat upon and Garda O'Sullivan and Garda Carey were both bitten by their respective assailants. Each developed a recognisable psychiatric condition due to a fear that they might contract HCV and/or HIV.

6.2 The Court has concluded that it has jurisdiction under the Acts to determine issues of liability and causation. Its role is not confined to assessing damages. In the present cases, the liability of the defendant to compensate the plaintiffs was established under s. 2 of the Act insofar as each of them proved that they were injured in the course of carrying out their duties as members of An Garda Síochána and malice was conceded by the defendant. The Court considered the issue of causation in each case and has resolved that issue in favour of each of the plaintiffs thus entitling them to compensation. All medical treatment, testing or advice as was received by these plaintiffs was received as a consequence of maliciously inflicted injuries. This being so, even if any incorrect medical advice or treatment was given to the plaintiffs and their injuries were thereby exacerbated, the Court must compensate them for all of their injuries sustained as a result of their respective assaults unless satisfied that the medical treatment and advice so received was inexcusably bad or grossly negligent, in which case the chain of causation would be broken. None of the medical advice or treatment given to these plaintiffs by their respective medical advisers can be so categorised.

6.3 As to the Court's jurisdiction when assessing compensation, the Court has concluded that, subject to the specific provisions of s. 10 of the Act, it should follow the approach normally adopted by a court assessing a claim for damages for personal injuries at common law. The Court has, however, concluded that there are certain factors, and these are set out earlier in this judgment, that should guide its approach when assessing compensation in claims based upon a fear of infection from viruses such as HIV and HCV as these claims invariably involve psychiatric rather than physical injury and thus pose a greater challenge to the court in terms of assessing not only their validity but their severity.

6.4 When assessing compensation in respect of any injuries captured by the Act, the court, if satisfied as to causation, is mandated to make an award even if it is of the view that the injuries sustained were minor in nature and as such ought not to have passed the statutory threshold which guides the Minister when exercising his power to authorise an application to the High Court under s. 6(1)(b)(iii) of the Act. Further, when awarding compensation, the court is not circumscribed as to the amount of damages it may award and is at large to award whatever sum it deems appropriate, be it minimal or substantial.

General Conclusions

6.5 The evidence given by the infectious diseases consultants, Prof. McConkey and Dr. Sheehan, has been described in the written submissions delivered by one of the parties as being "broad, discursive, intellectually illuminating and generous". I agree with this description of their evidence. Because these experts were reluctant, when giving evidence, to find fault with their less specialised colleagues, I have been urged not to use their evidence to make adverse findings in relation to the medical advice and treatment afforded to the plaintiffs by their respective treating doctors. It has also been submitted that to do so would amount to a breach of natural justice and fair procedures and might also be in contravention of the European Convention on Human Rights.

6.6 I do not accept that it is not open to a court, in the course of proceedings between two parties, to make a finding that a third party did something incorrectly. This happens all of the time in litigation. What I do accept is that it is not open to me in the course of this judgment, because of the manner in which the present proceedings have been litigated, to conclude that the medical treatment or advice given by any of the treating doctors was negligent or amounted to professional misconduct. Indeed, having heard the evidence, I am entirely satisfied that none of the medical treatment or advice falls to be criticised in this way. At all stages each of the doctors to whom I have referred had their patient's welfare to the forefront of their minds. Also, having heard the evidence of Prof. Bradley, it must be accepted that even where the advice given by any of the treating doctors was criticised by Prof. McConkey or Dr. Sheehan, perhaps with one exception, that the very same advice has been established to have been common practice for other medical practitioners of equivalent expertise at the relevant time. However, to ignore the evidence of Prof. McConkey and Dr. Sheehan and in particular their criticisms would, to my mind, defeat the principal purpose behind the setting up of these test cases for oral hearing.

6.7 The evidence of Prof. McConkey and Dr. Sheehan has demonstrated that the state of knowledge of general practitioners and other non-specialist doctors, regarding the true nature of HCV and HIV; how those viruses are transmitted; the true risk of infection therefrom; when testing and the imposition of restrictions on sexual relations are warranted, was, over the past decade, and still may be significantly removed from the knowledge held by their specialist colleagues.

6.8 In the present cases, the experts referred to instances where testing for HIV and/or HCV post assault was unnecessarily carried out. They referred to blood testing carried out twice on one plaintiff more than six months after the relevant assault at a time when it could be stated with absolute certainty that infection could not occur and to the fact that testing in such circumstances was adverse to patient welfare. They also referred to the imposition of restrictions on unprotected sexual relations which were unwarranted thus causing unnecessary anxiety and worry to the patient. In one case a patient was advised to refrain from participation in contact sports, advice which whilst common practice amongst general practitioners at the time was unnecessary having regard to the knowledge then available as to how these viruses are transmitted. In two cases the standard practice of testing at three months was not carried out. Accordingly, the type of reassurance that could and should have been afforded to the patient at that stage was not forthcoming. In one case the potential risk of HCV/HIV infection seemed to cloud the medical picture to the point that the patient did not receive the antibiotic cover he required to protect him against a significant risk of bacterial infection from a human bite.

6.9 Prof. McConkey and Dr. Sheehan sympathised with the difficulties faced by general practitioners and junior hospital doctors when faced with any medical problem for the first time and then often in a pressurised environment. They referred to the challenge faced by general practitioners in terms of trying to keep up to date with continuing advances in medical science. However, both were satisfied that in cases of the present nature, the answer to these difficulties did not lie in routinely giving the patient what is generally perceived to be the cautious and conservative advice that they should have ongoing blood testing over a period of six months and for the same period to advise them to refrain from unprotected sexual relations with their partners.

6.10 What has clearly been established in the present cases is that the testing of patients for HIV and/or HCV and the imposition of restrictions on their intimate lives cannot be considered to be medically neutral treatment. Such an approach conveys to the patient the doctors' belief that they are at risk. Consequently, doctors should not be testing patients when there is a negligible or zero risk of infection – such as a splash of blood onto intact skin or cases involving saliva only.

6.11 In cases where there is a risk of infection both experts felt that the use of medical terminology such as mild, moderate or severe, to describe that risk was unhelpful and did not provide adequate reassurance to the patient. The risk to the patient is often miniscule and it needs to be normalised for the patient. Patients should, where appropriate, be advised that their risk of infection is significantly less than a whole range of risks which they accept as a normal part of everyday life. Prof. McConkey felt it was helpful to compare the risk to those risks which as citizens we run everyday of our lives, such as when we go out and drive our car, and then to explain to the patient that the risk of being killed driving is very much greater than the risk of contracting HIV or HCV after an assault. Dr. Sheehan in his medical report, in normalising the risk of infection in one instance, described the risk of infection as being about as unlikely as the patient being struck by an asteroid.

6.12 From my hearing of cases similar to those of these plaintiffs over the last number of years, I have concluded that there is a lack of knowledge amongst the members of An Garda Síochána about these viruses in general. They do not seem to understand how these viruses are transmitted notwithstanding the education programme available in Templemore and the detailed material set out in the garda code. The protocol in relation to Information and Procedures on Infectious Diseases 2003, circulated to each officer, inspector and station in the country, was described by Dr. Sheehan as an excellent document. He felt, however, that the difficulty was in trying to insure that the content of such documentation is adequately communicated to the member. Notwithstanding all of the training referred to by Dr. Collins in the course of his evidence, I have been driven to conclude that in 2010, members appearing before this court continue to demonstrate, for whatever reason, a significantly inflated view as to their potential risk of contracting HIV and/or HCV in a wide variety of circumstances.

6.13 I hope that the evidence in the present cases will serve to educate, as it has done me, those interested as to the risk posed by HIV and HCV infection in an occupational setting. It is highly desirable that present and future members of An Garda Síochána are educated to understand the true nature of these formerly fatal viruses, their amenability to treatment and/or prophylaxis, how they are transmitted and the true risk of infection dependent upon the circumstances in which that risk arises. Also, it is vital that they come to understand that for anyone unfortunate enough to actually contract HCV in an acute setting that current treatment is successful in 98% of cases. Even for those chronically infected, the evidence suggests that 17 years post infection that only 2% of that group will have developed a serious complication of that virus such as cirrhosis of the liver. Further, members at risk of contracting HIV in an acute setting have post exposure prophylaxis available to them. This reduces the transmission risk by more that 99%. Even if this is unsuccessful, daily medication will now allow a person who contracts HIV to live a relatively full and normal life.

6.14 I have no doubt that those members who may fear they are at risk of infection from HIV and/or HCV in the course of their duties will be comforted to know that Prof. McConkey, in his search through worldwide medical literature, could only find three cases where it was convincingly demonstrated that HIV had been transmitted by a bite and that he could only find two cases, both of which he found to be unconvincing, reporting the transmission of HCV by a similar route.

6.15 Further confidence might be instilled in members of An Garda Síochána if advised of the fact that not one member from a group of 1,300 police officers exposed to a risk of transmission of HIV and HCV in Amsterdam in the four year period commencing 2000, went on to contract either virus. In addition, a recent survey carried out by Dr. David Putts, into the incidence of infection in the police forces of England, Northern Ireland and Wales revealed no case of reported infection with either HIV or HCV.

6.16 I would hope that the garda authorities, perhaps through Dr. Collins, in association with Prof. McConkey, Dr. Sheehan or perhaps Dr. Bergin to whom he referred in evidence, will continue and renew their efforts to make sure that trainees and current members of An Garda Síochána receive up to date information regarding these viruses. Whilst it is not a matter within the Court's remit, I will nonetheless, having heard such an extensive amount of evidence in these cases, briefly proffer one potential idea that might be worth further consideration by the relevant authorities.

6.17 Even if members can be educated to the point that they will not harbour unnecessary fears regarding potential infection from HIV and/or HCV, much of that work may be undone if they later receive medical advice at A&E Departments which is not reassuring or which subjects them to unnecessary testing and/or restrictions being imposed on their private lives. In this regard, I note that the 2003 protocol requires members exposed to a risk of infection to attend a limited number of designated specialist hospitals. However, this protocol is not always complied with at local level notwithstanding the impressive efforts made by Dr. Collins to ensure that members attend only designated hospitals. In particular, in the course of the evidence, the Court was furnished with copies of excellent posters printed and forwarded to every garda station in the country designed to ensure that members did not attend non-designated hospitals. Accordingly, I sympathise with Dr. Collins's feelings of frustration at the fact that advice from Garda Headquarters is not always complied with or implemented at local level and that occasionally victims of assault may end up attending non-designated hospitals. Perhaps this is an area that warrants renewed attention.

6.18 Even if members receive appropriate education regarding HIV and HCV and are routinely referred to a designated specialist hospital post assault, there is still the risk that a general practitioner may subsequently, through lack of knowledge, catapult their patient into a state of significant and unnecessary anxiety. In this regard, one would hope that general practitioners would subscribe to Prof. Bradley's expectation of them, not only in respect of ongoing professional development, but his evidence that they should seek advice from their more specialist colleagues if they realise that they are giving advice to a patient in an area of uncertainty or unfamiliarity.

6.19 Perhaps some thought might be given to the possibility of a brief advisory pamphlet being prepared by the garda authorities in conjunction with one of the experts in infectious diseases. Such a document could set out very briefly the nature of these viruses, how they are transmitted, when testing and the imposition of restrictions are warranted and their susceptibility to treatment and prophylaxis. Perhaps the pamphlet might also include some statistical information regarding the risk of infection in a range of sample cases. These leaflets could be made available and their contents thoroughly explained to gardaí in the course of their original training and/or any further professional development programme. Thereafter, those pamphlets could be made available in every garda station so that in the event of any assault causing a member to fear infection, they could refer to these pamphlets for reassurance and bring them with them to the relevant hospital and/or to their general practitioner where they might be of further assistance. In making this suggestion, I would want to make it perfectly clear that I accept there may be many good medical and/or legal or indeed, other perfectly good reasons for not considering or implementing such a proposal and any failure on the part of the garda authorities to pursue such considerations should not accordingly be considered a target for potential criticism in any future litigation.

6.20 If accurate information and adequate reassurance can be provided to members of An Garda Síochána as to the true nature of

these infectious diseases, the Minister should not be faced with applications from members seeking leave to maintain claims for compensation based on a fear of contracting HIV and/or HCV. Even where blood testing may be justified in any case, if that testing is accompanied by proper reassurance and an accurate assessment of the true risk of infection, even allowing for the likely modulation of a members private life over a six month period, their injuries should at best be minor in nature and as such insufficient to warrant the Minister granting authorisation for leave to apply for compensation before the High Court.

6.21 My final comment in relation to these proceedings is directed not to the parties themselves but to those members of the legal profession who are involved, on a regular basis, in advising members in relation to potential claims under the Act. Over the past three years I have noted the very early involvement of solicitors in claims of the present nature. This is understandable as the Act requires that any claim should be made within three months of the date of the injury the subject matter of the intended claim. However, in relation to any potential claim based upon an alleged fear of infection from HIV or HCV, my fear is that the health and welfare of the members may become compromised in the pursuit of the evidence necessary to maintain their clients claim for compensation. Members are often sent for a series of examinations by doctors and specialists alike and it has been my experience that these, what would I describe as medical legal consultations, do little to assuage the fears of the members and seem if anything to serve to reinforce their concerns regarding potential infection at a time when what they desperately need, according to the experts, is an accurate assessment of any real risk of infection from a suitably qualified person and appropriate reassurance as to their true medical status. It must nonetheless be stated that no solicitor can be criticised for pursuing their client's legitimate interests.

6.22 The solicitors to whom I refer are, in the context of what has emerged in these proceedings, uniquely well placed to ensure that the very positive evidence of the experts and the findings in the present cases are made known to their clients even if the consequences of doing so may be adverse to their own interests. By doing so they can provide valuable additional support to the other professionals more intimately and better qualified to protect the psychological welfare of a group who perform such a vital role in our society.

6.23 I would hope that this judgment, if allied to some change in approach by those charged with the care of members of An Garda Síochána who may be exposed to a risk of infection from HIV and /or HCV, may herald not only an early end to what appears to me to be a significant amount of unwarranted and avoidable anxiety for those unfortunate enough to be assaulted in the course of their duties but also an end to the monetary consequences of such claims on the finances of the State.

Appendix

"One of my functions over the last two years has been to hear and determine the claims that come to the High Court under the Garda Síochána Compensation Acts 1941-45.

As you all know, claims only come to this Court where the Minister for Justice Equality and law reform has certified that the injuries claimed are serious. No member of An Garda Síochána who is injured in the course of their duty has an automatic right to compensation and all compensation paid under the Act, as per its long title, comes from public monies.

To succeed in a claim an applicant must prove that the injury the subject matter of the claim was maliciously inflicted and that it was a serious injury. Alternatively, if the injury was not of itself serious the applicant must demonstrate that it was sustained in circumstances involving special risk thus justifying compensation.

Over the years the High Court has dealt with a wide variety of claims under this legislation. At their most serious and distressing have been those claims arising from fatalities to members of An Garda Síochána. At the other end of the spectrum have been cases of much less significant but nonetheless compensatable injuries, such as fractures to a member's finger.

Whilst HCV and HIV are viruses which have been prevalent in Ireland for a number of decades, and knowledge as to their transmissibility is widely available, there has been a significant growth in the number of cases coming before this Court in recent times concerning these viruses. In the vast preponderance of these cases it is not the assault itself that forms the basis for the compensation claimed. Rather, the claims tend to focus upon an injury deriving from a fear on the part of the garda concerned that, as a result of an assault, they may be at risk of contracting HCV or HIV. In many such cases the garda member will give evidence to the court that such fear has caused him or her significant psychological problems, including at times Post Traumatic Stress Disorder, Depression, and/or Anxiety. In almost every such case the court is told that these fears, at a minimum, have adversely affected their intimate personal relationships and family life.

The cases to which I have just referred, involving an alleged fear of contracting HIV and/or HCV, loosely fall into one of the following categories:

1. an assault or altercation which causes the assailant to bleed and where in the course of such assault the garda member also sustains a laceration or some open wound;

2. an assault or altercation in the course of which the assailant starts to bleed but where the garda does not sustain a laceration or break in the surface of his skin but where the blood of the assailant may make contact with members clothing, body, face or eye;

3. an assault or altercation in the course of which the assailant may spit on or bite a garda member who may sustain a laceration or puncture wound to the skin in the course of the assault; and

4. an assault or altercation in the course of which sputum may be propelled by an assailant onto a garda's clothing, body, face or come into contact with his or her eye but in circumstances where the garda member's skin has not been perforated or lacerated;

In any of the scenarios I have just mentioned the HIV and/or HCV status of the assailant may be unknown at the outset but is very often known within a number of weeks.

The court must ensure that its approach to these cases is consistent and transparent and that it conducts these claims in a manner which does justice to both the injured party and the party who is to pay for that injury. This has not been an easy task to date as the evidence heard from specialists in the area of infectious diseases in one or two recent cases

regarding the risk of transmission of these viruses and the precautions to be taken arising from an assault, has in some cases been with the advice which the court has seen furnished to members of an garda Síochána by other medical practitioners, and in particular general practitioners.

This being so, and having regard to the ever increasing amount of these claims, I must ensure as a matter of priority that the Court is furnished with all of the necessary medical evidence so that it can readily determine in each case what precisely is the **real** risk of transmission of HCV and/or HIV. As I have already stated, most cases will fall into one of the four categories referred to above.

It is also vital for the court and indeed all of those concerned with the welfare of the members of an garda Síochána, be they the garda training college, the members of the force themselves or their doctors or superiors, to know the nature of the advice that should be given to those assaulted in terms of the risk of infection and also as to any precautions that should be taken by a garda assaulted in any of the scenarios that I have just mentioned.

To this end I have decided to designate three of the cases in today's list to be dealt with as test cases to be heard together: The cases will act as a vehicle for the court obtaining the information I have already referred to and hopefully the hearings may also serve to further enlighten many of those who may be affected by an assault in the future as to the potential repercussions to their health arising therefrom.

Cases are those of Michael Carey No 2

Richard O'Connor No 6

Martin O'Sullivan No 10

In the course of these three test cases

1. I would like to hear expert evidence as to the risk of transmissibility of HCV /HIV in each of the three test cases and any precautions warranted as a result thereof... In addition the expert/experts concerned must be in a position to advise the Court on the risk of transmission and any precautions warranted as a result of assaults of the nature described in the four scenarios earlier referred to insofar as those risks are not covered by the three test cases.

2. The Court also wants to hear evidence regarding the statistical occurrence of the transmission of these infections in an occupational setting and particularly in an garda siochana over the past 20 years.

3. I would further like to hear evidence from a witness from the Royal College of General Practitioners in Ireland as to what advice should be given by G.P.'s to patients in each of the four scenarios referred to earlier.

In this regard, it has to be stated that the Court has heard medical evidence from infectious diseases experts in some cases that would suggest that the advice given to gardaí both in respect of the risk of infection and the precautions to be taken following assault has been otherwise than in accordance with the risk generated by the incident complained of.

On a Practical Level

In relation to the test cases the Court can give all parties and their solicitor's reassurance that the Court will certify for senior counsel at the conclusion of the litigation.

Because of the nature of the cases it is essential that all documents that may impinge on the evidence be available to the witnesses who are to give evidence. For this reason, I will make an order in each of the test cases that the applicant make discovery of all general practitioners notes, consultants notes, hospital records and all test results. The discovery is to be made within ten days. If necessary I will make orders for third party discovery but this should not be required if there is cooperation between the parties.

I will fix a date for hearing of the test cases to commence Tuesday the 12th January, next. The cases will be heard together rather than sequentially.

I propose to adjourn all cases listed between now and the start of January which concern the risk of transmission of HIV and /or HCV I will put them all in for mention on Monday 8th February, 2010.

Hopefully I will be in a position to give judgment by the end of January, 2010 in the test cases. I would accordingly hope to reschedule all hearings of these HIV/HCV cases as and from the start of March, 2010. By then all parties will have had the opportunity to consider anything that may arise from my judgment.

It would be my intention that the parties to any such future litigation would be able, if they wish, to rely on the transcripts of the evidence in the test cases by referring to the relevant section in a brief supplemental affidavit thus putting their opposition on notice of such evidence.

Legal Submissions

The final matter that I would like to hear legal submissions on is the test to be applied by the Court in respect of the injuries sustained. Is it the negligence test of reasonable foreseeability or some other test? If, for example, the Court were to conclude that a garda's response to an assault was not foreseeable having regard to the risk or indeed lack of risk of transmission, where does that leave the Court legally, particularly having regard to the minister's certification? Or if the Court were to determine that the garda's injury was not as a result of the assault but rather consisted of a fear generated by either erroneous medical advice or advice that was not foreseeable, once again, is the Court obliged to compensate the garda for this injury?"