THE HIGH COURT

[2012 No. 2336 P.]

BETWEEN

EUGENE MCCORMACK

PLAINTIFF

AND

MARCUS TIMLIN, MATER PRIVATE HOSPITAL

AND MATER PRIVATE HEALTHCARE

DEFENDANTS

JUDGMENT of Mr. Justice Cross delivered on the 18th day of January, 2019

1. The plaintiff was born on 18th September, 1959 and claims damages as against the first named defendant as a result of complications following surgery on 10th March, 2010. The plaintiff also, in these proceedings, brought an action against the hospital in relation to a specific incident post-surgery (which will be referred to later) and in respect of the plaintiff's claim against the second and third named defendant, the same was prior to the commencement of this case settled and the proceedings against these defendants were struck out with an order for the plaintiff's costs.

2. As stated by the defendants in their submissions, this is a complex case both in terms of liability and causation. The court is faced with two radically different interpretations of the events by the plaintiff's and defendants' expert witnesses. However, notwithstanding the complex nature of this case due to the efficiency of the legal advisors for both the plaintiff and the defendants, the case was fully heard and the issues ventilated over a period of only twelve days and I also had the benefit of learned submissions delivered in writing by counsel both of the plaintiff and the defendants. These submissions were of great assistance.

3. The plaintiff left school at the age of fifteen and he commenced work as a butcher, having been an apprentice for some four years, he then went to Australia, married and returned to Ireland at the age of 26. He commenced the business as a butcher in Mullingar and was very successful. He opened another shop in Longford in 1988 and went on to build an abattoir and diversified into a "*farm shop*" which consisted of selling food stuffs and including meat. He had up to twelve people working for him.

4. Following the acquisition of new accountants, who advised that he should engage in "*tax planning*", he bought a number of *section 23* properties and went into building and developing properties at the commencement of the century. He also built properties in Mullingar and Multyfarnham.

5. The plaintiff was also very interested in outdoor pursuit and loved horse riding and hunting.

6. The plaintiff has three children now all adult. The plaintiff's wife worked as a teacher and subsequently as a school principal. After the indexed incident, the plaintiff's wife gave up her job as a principal which she loved and became a fulltime carer of the plaintiff.

7. The plaintiff had a significant past medical history. In 1995, he underwent a vasectomy in Clane Hospital and subsequently due to pain an orchiectomy was carried out in St. James Hospital and pain in his inguinal area continued for some three years thereafter. The plaintiff's first complaints of back pain were in 1998 and in 1999, he also complained of lack of sleep and some depressive symptoms. The back pain at this stage does not seem to be significant but in the years 2004 to 2005, the back pain seems to have returned and he was prescribed diazepam. In May 2006, he had a CT scan which showed a large disc bulge impinging on his nerve and the back pain radiated down his right legs.

8. The plaintiff came under the care of Dr. D'S, Consultant Orthopaedic Surgeon, who recommended nerve block injections and epidurals which were performed in March 2007 and in April 2007, the plaintiff's first operation, a discectomy at L5/S1 was performed by Mr. D'S and subsequently in May 2007, there was a revision of this discectomy, the plaintiff's second operation on his back.

9. The plaintiff lived what might poetically be described as a "*hard riding country man's*" lifestyle but he was functioning well at this stage and his businesses were thriving. Notwithstanding the operation and the revision, however, the back pain returned and he was referred by Mr. D'S to Mr. O'N for a second opinion and in October 2008, a left sided L5/S1 decompression and micro discectomy was performed. This was the plaintiff's third operation on his back and it gave some relief but back pain recurred and in February 2009, the plaintiff was referred to an MRI and subsequently was referred to the first named defendant in April 2009 with his back problems as bad as ever. In April 2009, the plaintiff described chronic low back pain with pain in his buttocks, legs which required medication. He had difficulty in working at this stage. He described himself to his doctors as being "*incapacitated*" but I accept the plaintiff's evidence that, in fact, he was working though with limitations.

10. The first named defendant advised that the plaintiff was a candidate for revision, decompression at L5/S1 and posterior fusion in order to reduce back pain. The plaintiff agrees that he was given an 80% chance that symptoms would improve with a 20% chance that they would either stay the same or dis-improve.

11. On 15th May, 2009, the first named defendant performed his first surgery on the plaintiff's back which was, in fact, the plaintiff's fourth operation on his back. Subsequent to this operation, the plaintiff did improve and he went for painkilling injections but later in 2009, he became depressed and stressed and his physical pain returned.

12. In February 2010, the first named defendant reviewed the plaintiff and indicated his leg symptoms were doing well after the fusion of L5/S1 but that he had ongoing back pain and there was no fusion of L4/L5 identified due to loosening of screws and further surgery was proposed.

13. On 11th March, 2010, revision, decompression and posterior lumber interbody fusion of the L4/L5 was performed by Mr. Timlin. It is the consequences of this, Mr. Timlin's second and the plaintiff's fifth surgeries, that the complaint is made in relation to the plaintiff's care between 11th March, 2010 and 19th March, 2010. The plaintiff alleges that he developed a Cauda Equina Syndrome (CES) which was not addressed until 19th March, and that as a consequence of the failure to address it in time, he has suffered significant personal injuries.

14. The cauda equina nerves spray out from the bottom of the spine leading into the lower limbs and if pressure is brought to bear on the cauda equina, a patient can develop CES which can, if it completely develops result in total loss of function of the lower limbs or if the CES does not completely develop, it can still cause significant injury and incapacity.

15. The issues in this case are whether after 11th March, 2010, surgery, the plaintiff developed CES which was not appropriately treated by the defendants and if so whether the defendants' conduct was negligent and if so, what if any damages resulted.

The Law
16. I accept that my function in this case is to first make findings of fact on the evidence and secondly, applying the legal principles decide whether on those facts negligence ought to be inferred.

17. The law in relation to liability in medical negligence is set out in the judgment of the Supreme Court in *Dunne v. National Maternity Hospital* [1989] I.R. 91 as follows:-

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

18. As is submitted by the defendant, the *Dunne* case establishes that there is not one single "*right way*" in medical practice. It is not, however, the law that just because one expert says that the action of a professional defendant in a medical negligence action is acceptable or right that it follows that the plaintiff has failed in his case. Were that the position, no plaintiff in any contested case could succeed.

19. The function of a judge in relation to the conflict of expert testimony was set out by Finlay C.J. in *Best v. Welcome Foundation Limited* [1993] 3 I.R. 421, when he stated:-

> *"I am satisfied that it is not possible either for a judge of trial or for an appellate court to take upon itself the role of a determining scientific authority resolving disputes between distinguished scientists in any particular line of technical expertise. The function which a court can and must perform in the trial of a case in order to achieve a just result is to apply common sense and a careful understanding of the logic and likelihood of events to conflicting opinions and conflicting theories concerning a matter of this kind."*
>
> That is the function I must perform.

The Plaintiff's Post Operation History
20. I accept the plaintiff's evidence that after the surgery on 11th March, 2010, he felt very unwell. He communicated this to his wife who also communicated this to the first named defendant. While considerable reliance has been placed by the defendants upon nursing notes, I have come to the conclusion that the nursing notes are, to say the least, very anodyne and do not give, as sometimes nursing notes do, any impression of the real distress the plaintiff was suffering.

21. The purpose of nursing notes is not to record forensic analysis of what occurred but to advise or record the salient medical complaints and treatments. I accept Mr. Timlin's evidence when he said that he did not rely upon the nursing notes but rather relied upon his discussion with the nurses on the ground as well in his own examinations of the plaintiff.

22. In any event, in his distress on the day after surgery in an attempt to call nursing assistance, the plaintiff accidentally pulled out a catheter which had been inserted. This was, of course, excruciatingly painful. It seems that the plaintiff's distress was not appropriately identified in the hospital for apparently the plaintiff was scolded for the removal of the catheter as if it were some intentional act on his part.

23. To move forward in time for a moment, on a subsequent examination in 2011, it was discovered that a piece of catheter had been left in situ in the plaintiff's bladder. This problem was then dealt with in St. Vincent's Hospital in 2011. In the meantime, the plaintiff had clearly suffered great discomfort and pain as a result. It is as a result of the second and third named defendant's failure to notice this remaining piece of catheter that proceedings were initiated against them and subsequently settled.

24. To return to the plaintiff's immediate post-operative history, on 16th March, 2010, an MRI scan was performed by the first named defendant in conjunction with Prof. E., due to worsening symptoms and a concern that the plaintiff might be developing a CES. The defendant and Prof. E. were reassured by their interpretation of the scan and subsequently in consultation with a colleague Mr. A.P. conservative treatment was advised. However, on 19th March, 2010, Mr. Timlin performed his third surgery on the plaintiff with washout and dural repair as post 16th March, the plaintiff's signs and symptoms continued to develop.

25. The plaintiff's case is that the MRI scan ought to have been carried out earlier than 16th March given the plaintiff's post operative symptoms and complaints and that the operation on 19th March, ought to have taken place days earlier and that as a consequence, the plaintiff was developing a CES.

26. It is alleged that due to the failure of the first named defendant to intervene earlier that the plaintiff is left with neurological injury including a drop foot, neuropathic pain, bladder sequelae, loss of sexual function and a significant psychiatric injury, which included two attempts at suicide. These suicidal attempts were serious and one was avoided only because of the prompt intervention of one of the plaintiff's sons. They indicate a significant psychiatric disorder post operation. The issue in the case is whether these injuries were caused or contributed to by the negligence or breach of duty of the first named defendant.

The Plaintiff's Developments Post Surgery of 19th March

27. After the surgery on 19th March, the plaintiff was discharged home, he was reviewed by the first named defendant in May 2010, complaining bitterly of chronic neuropathic pain in his right leg down to his calf, an MRI scan was performed which revealed that the L4/L5 interbody cage inserted in March had backed out and was itself compressing the plaintiff's nerves and a fourth operation was performed by Mr. Timlin (the plaintiff's seventh back operation) which involved the revision and decompression of the L4/L5 and removal of the interspinous cage and placement of local bone graft.

28. The plaintiff was then discharged pain free but the pain reoccurred and the plaintiff became very depressed and attempted suicide in July 2010. At this stage, the plaintiff was under severe pressure from his banks and had to rearrange his debts and sell his properties. He believed that had he been in the whole of his health, he would have been able to deal with these matters better and save his business but this was not to be the case. By this stage, the plaintiff was unable to work.

29. As previously stated in 2011, it was discovered that a piece of catheter had been allowed to remain in his bladder. This was then dealt with. However, he continued to experience bladder problems and in September 2014, a cystoscopy was performed. The cystoscopy was reported as normal but his bladder problems continued and persist. In December 2014, a second serious suicide attempt was made by the plaintiff. His urodynamics were reported as being normal in 2015. A spinal cord stimulator was inserted in April 2016, which gave some relief, however, that has worn off and the plaintiff has been advised to lead an active life as possible but the attempts to improve or reset the spinal cord stimulator have not been successful. The plaintiff has had the advantage in recent times of counselling which he says have been of great assistance and of help to him in relation to his psychiatric injury. Otherwise, I believe the plaintiff's condition is permanent.

30. The plaintiff's evidence was that notwithstanding significant pre-event problems with his back, he was able, before the indexed surgery, to walk into the hospital unaided and that he has been essentially crippled thereafter.

The Plaintiff's Case

31. The plaintiff's case is that post the operation of 11th March 2010, he was suffering from ongoing compression of caudal nerves which was caused by a space occupying fluid collection/haematoma extending from the soft tissues and muscles into the spinal canal at L4/L5 which compressed the caudal nerves and that he manifested symptoms that were "*red flag*" signs of impending CES, a condition which if allowed to progress without urgent surgical removal could result in the total loss of bladder control, bowel function, sexual function and lower limb paralysis.

32. The plaintiff contends that it is the emerging or incomplete CES that cause the plaintiff's present symptoms or a significant number of them which would not have been present had the first named defendant acted promptly. Whereas the case initially was somewhat wider, the case before the court was that the plaintiff had given and exhibited sufficient signs that ought to have alerted the first named defendant to perform the MRI prior to 16th March and that surgery ought to have been performed on 16th or 17th March and that had it been done so, the plaintiff's present symptoms would not have occurred or, at least, these symptoms would have been significantly less severe. As early as the day after the operation the physiotherapy notes record problems in both buttocks. This is a significant neurological sign suggestive of at least possible nerve compression.

33. The plaintiff was in significant distress post operation. This is not recorded in the notes, but I accept the evidence of the plaintiff and of his wife to this effect. Mr. Timlin agrees that he did see the plaintiff's wife but seems to regard the complaints made as natural post a serious operation and were not alarming.

34. The plaintiff's experts stated the plaintiff showed signs of possible urinary misfunction by 12th March, which required him to be catheterised. One litre of urine was drained. Because of ongoing urinary difficulties after the catheter was accidentally pulled out, a scan was performed on 14th March which established, what I accept to be an abnormally large volume of urine retained after the bladder had been emptied twice. I accept that though the notes describe him as "*passing urine freely*" that the plaintiff was also retaining a sufficient volume of urine to be of concern.

35. On 14th March, Dr. O. reviewed the urinary complaints of difficulty and of frequency. The cause of this retention was not established. The plaintiff contends that retention of urine is a "*red flag*" sign for impending CES and the nursing records relied upon by the defendants, to the effect, that the plaintiff was "*passing urine freely*" did not, according to the plaintiff's experts, mean he was properly discharging as the tests show that he was retaining more than ten times the normal value of urine after voiding. The physiotherapy notes of 15th March, indicate that the plaintiff was complaining of numbness in both buttocks, suggest of saddle anaesthesia. The plaintiff gave evidence and I accept that he did make similar complaints to the nurses. These complaints were not unfortunately recorded. The nursing notes, however, do record "*right leg numbness*" persisting.

36. The physiotherapy notes indicated that as early as on 11th March, the day after the operation, that the plaintiff had numbness in both buttocks. Furthermore, as previously stated, on 15th March, the physiotherapy notes stated that the plaintiff was "*still numb in buttocks*" and queried caudal compression. These notes also record on 16th March record clearly that the numbness was in "*both buttocks*". The plaintiff does not dispute that the physiotherapy notes were not, unfortunately, brought to the attention of Mr. Timlin. The plaintiff submits, however, that Mr. Timlin ought to have been aware from his own examinations as well as the difficulties in passing urine and the neurological complaints given orally by the plaintiff that he was indeed developing a CES.

37. Mr. Timlin regularly examined the plaintiff and on 16th March, recorded some weakness in his right foot and there was a new symptom of buttock/perianal numbness though his anal tone was normal. As a result of this development, he directed an MRI scan be performed. The plaintiff contends that this scan should have been performed earlier.

38. Mr. Timlin was at this stage concerned in relation to the developing neurological signs which and he queried whether there was "*neuropraxia*" or as a differential diagnosis a "*caudal pressure*" and the purpose of the MRI scan was, in effect, to out rule the differential diagnosis of caudal pressure made because of the progressing nature of the plaintiff's symptoms.

39. There is a major dispute as to what the MRI scan revealed. The plaintiff contends that Mr. Timlin's analysis in conjunction with Prof. E. of the MRI scan was taken without proper consideration of the history of the plaintiff's complaints and events and the signs of a developing neurological deficit which prompted his decision to seek the MRI scan. The plaintiff contends indeed that the MRI ought to have been ordered on 14th rather than 16th because of the urinary symptoms but that in any event, it was definitely required on 15th. The plaintiff contends that the MRI scan if properly read showed a compressive lesion attributable to a collection of CSF and blood which resulted in the dura containing the nerve roots to be squashed to one side creating a "*rugby ball*" type shape as opposed to the circle which would be usual and that correlation between the plaintiff's symptoms and the finding of the MRI mandated immediate surgery.

40. The plaintiffs experts analysis of the MRI scan is in hot contention from the defendant and his experts and the defendants' evidence will be discussed later. The MRI report stated:-

> *"at the site of the posterior decompression there is extensive inflammatory change with a well circumscribed walled off fluid collection which has signal characteristics of CSF thought to represent a CSF leak. There is no evidence of a haematoma on this study. In the axial plain, there is some central clumping of nerve roots but no discrete focal nerve root compression".*

41. Mr. Timlin said that he did not base his conclusions on the written report but that he based his analysis on his own survey of the multiple films taken in the MRI and his discussion with Prof. E., the Radiologist, as well as a second opinion he took from Mr. A.P., a fellow surgeon in relation to management.

42. Conservative management and steroids were stipulated by Mr. Timlin. The plaintiff was kept under observation on 17th March and he was in great distress showing no interest in the Cheltenham racing festival or the Gold Cup race as would certainly be his norm.

43. On 18th March, however, as the plaintiff's symptoms were continuing and indeed further progressing, Mr. Timlin put the plaintiff for operation on 19th.

44. On 19th, Mr. Timlin operated for revision and decompression and washout and dural repair. This was Mr. Timlin's third and the plaintiff's sixth operation on his back. Mr. Timlin's operation notes state:-

> *"An organised haematoma and fluid haematoma was noted deep in the thoracolumbar fascia. This was under pressure and is the most likely cause of his urinary dysfunction and right leg weakness…"*

45. The plaintiff argues that this note of Mr. Timlin is confirmatory of the fact that the plaintiff did indeed have an organised haematoma (blood clot) and a fluid haematoma (CSF) which was under pressure and was the most likely cause of his dysfunction.

46. It should be noted that subsequently Mr. Timlin resiled from his opinion as stated in the operation notes that the haematoma was the most likely cause of his dysfunction and right leg weakness. However, the plaintiff's experts contend that this operation established that the plaintiff's caudal nerves were indeed under pressure contrary to what Mr. Timlin had concluded after the MRI on 16th March and they further contend that there was no new event between 16th and 19th March, to suggest that the organised haematoma and fluid haematoma identified were not present on 16th March and that Mr. Timlin's conclusion on 19th that compression was the cause of the plaintiff's urinary dysfunction and right leg weakness which was correct which proves the differential diagnosis of "*caudal compression*" and that other diagnosis of neuropraxia was incorrect.

47. CES is a progressive condition, if unchecked it can have devastating consequences and the plaintiff's contention is that were it not for the breach of duty of the defendant in his failure to have an earlier MRI scan, his misinterpretation of the MRI scan and his failure to act upon the symptoms of the plaintiff that the plaintiff is now in a significantly more disabled condition that would otherwise have been the case.

48. The plaintiff does not dispute that he had multiple back surgeries which would have left scarring in place which could cause pain and that he was given absolutely no guarantees of a good result. However, the contention on behalf of the plaintiff is that he is now in a significantly worse position physically and psychologically than would otherwise have been the case and that he has suffered significant financial loss as well as his personal injuries. He developed CES in which the nerves were allowed to press and cause permanent damage. As the plaintiff stated himself, he walked into hospital before the operations unaided but emerged as a "*cripple*".

The Defendant's Case

49. As stated above, this is a highly complex and contentious case. The defendants submit that the plaintiff did not and does not have any CES that the defendants' experts are to be preferred on this point to the experts of the plaintiff and in particular the plaintiff's ongoing symptoms are not related to the indexed actions or failure to act of the defendant. His urinary problems are not as a result of any nerve compression given the urodynamic studies and that prior to the indexed operation, the plaintiff had significant back problems as well as associated leg pain and also some psychological problems.

50. The defendant accepts that the plaintiff experienced a number of post operative symptoms between the indexed surgery and 19th March, 2010, when he was returned to theatre but it is contended that the plaintiff was merely displaying common signs of a patient who was in a post operative recovery from a major spinal surgery having had, at least, four spinal surgeries previously. It was submitted that as a matter of fact that the centre and right sided motor deficit displayed by the plaintiff and his urinary complaints were not as a result of compression of the cauda equina nerves. This had been considered a possibility by Mr. Timlin he concluded or as Prof. B. stated that the plaintiff was in fact displaying normal signs of neuropraxia following surgery and that his bladder retention was relatable to his post operative status and age.

51. The defendant submits that the evidence from the nursing notes did not indicate any significant or serious development of any symptoms that might be neurological in the initial days post operative.

52. In relation to the MRI scan on 16th March, the defendant and Prof. E. and Mr. A.P. all gave evidence of a discussion of the images produced during the scan and that the course of action adopted was, the agreed consensus. The defendants contend that the MRI scan represented merely a CSF leak which was not in any way threatening and would not result in any pressure. Accordingly, the decision to observe the plaintiff and provide him with steroids was a reasonable one.

53. Prof. E. disputed the opinion of the plaintiff's expert, Prof. M. that there was pressure on the thecal sac demonstrated in the MRI or that the nerve roots were compressed. Rather, he said that the thecal sac had contracted away from the vertebral body creating a space between the thecal sac and the vertebral body due to the high levels of scarring and inflammation given the number of

operations undergone by the plaintiff. Prof. E. stated *"the hallmark feature of chronic inflammation arach noiditis is the shirking of the thecal sac and the clumping of nerve roots"*.

54. The defendants accept that the plaintiff did display a number of post operative symptoms. They were not the consequence of pressure on the cauda equina nerve rather they were the usual symptoms following a complex spinal surgery as a result of his scarring and were the result of neuropraxia (or inflammation of the nerves) following surgery. This swelling was the cause of his right leg motor deficit and the numbness in the days after the surgery.

55. The defendants further rely upon the fact that given the plaintiff's ongoing complaints after 19th March, 2010, Mr. Timlin performed a fourth surgery (the plaintiff's seventh) on 20th May, 2010, involving revision and decompression and removal of the interspinous cage and placement of local bone graft, in order to ease the plaintiff's discomfort. This had some positive effect indicating that the plaintiff's problems were contributed to by reason of the fact that the cage was not effective. The cage, which had been placed over the surgery was compressing on his nerves. The defendant also contends that the main cause of the plaintiff's urinary problems was due to the piece of the catheter left in situ or certainly not related to the indexed events.

Findings of Fact

56. Having reviewed the expert evidence and the submissions of the parties, I have come to the conclusion that after the index surgery on 10th March, 2010, the plaintiff was indeed suffering from a developing CES resulting in pressure on his nerves. My main reason for coming to this conclusion is the opinion formed at or immediately after the revision operation on 19th March by Mr. Timlin himself in which he found both an organised and a fluid haematoma and which he gave as his opinion for the most likely cause for his urinary dysfunction and right leg weakness. As previously stated Mr. Timlin did resile from this opinion and indeed stated that the organised haematoma was of very small size. I reject the opinion of the defendant's expert that Mr. Timlin was not able to give any opinion as to the cause of the plaintiff's problem at the time of the operation. Certainly, that opinion of Mr. Timlin is only his opinion and best analysis but it is an analysis made at the time when there was no question of litigation, and while the patient was on the operating table or immediately thereafter. It is, of course, impossible to be certain as to the cause of the plaintiff's symptoms but Mr. Timlin accepted at the time that this was the most likely cause and I agree with that conclusion.

57. I also base my conclusion that the plaintiff was developing a CES on the fact that the plaintiff's symptoms still persist notwithstanding the removal of the cage and the placement of local bone graft. This did produce some levitation of symptoms but the symptoms have persisted. Furthermore, though the piece of catheter in the plaintiff's bladder was ultimately removed in September 2014, and though the plaintiff's urodynamics were normal in 2015, the plaintiff's problems with urine have persisted. These factors, I find, all point to pressure on the plaintiff's nerves as a result of the developing CES.

58. I also accept that had the revision operation on 19th been performed earlier on 16th or 17th or possibly even 18th, the plaintiff's developing CES would have been dealt with at an earlier stage and without, at least, a considerable amount of the resulting symptoms.

59. While the plaintiff's present symptoms are complex and result from a number of different sources, I also accept as a fact that had the intervention occurred earlier, the plaintiff would not have developed the post operative CES, neuropathic pain in both lower limbs, right sided foot drop and some of the bladder pain and urinary dysfunction he complains of, mechanical back pain due to his facet joint dysfunction, sexual dysfunction and a considerable amount of his significant depression including his two attempts at suicide.

60. I further accept that as no event occurred between the MRI on 16th and the operation on 19th that the developing CES was there to be interpreted on the films.

61. The issue in relation to liability in this case is whether on these findings of fact, the plaintiff has established on the balance of probabilities that the defendant was negligent.

Liability

62. The plaintiff's first complaint is that the MRI scan was not carried out until 16th and ought to have been carried out a number of days previously. I do not believe that the plaintiff's experts gave evidence to this effect and in reality this argument was not pressed by the plaintiff and should be rejected.

63. The second allegation is that the defendant ought to have noticed the signs of the developing CES in the MRI scan taken on 16th March, especially in view of the plaintiff's neurological complaints.

64. Mr. Timlin embarked upon the MRI study essentially to investigate the possibility of a developing CES. This was his fear. Having taken the MRI films, Mr. Timlin examined same and then discussed the films with the radiologist who was responsible for taking them, Prof. E., and also discussed the case and what he should do with his orthopaedic colleague Mr. A.P. The consensus of this discussion was that the films did not demonstrate any haematoma which might put pressure upon the cauda equina nerves. Prof. E. gave expert evidence, to this effect, and whilst his independence might be somewhat in question, his opinion was endorsed by the independent expert, Prof. B.

65. The plaintiff contends that I should examine the evidence in relation to the MRI in conjunction with the plaintiff's developing symptoms. This I do. I also approach my conclusions in relation to the liability in relation to the MRI scan from my previous conclusion that the developing CES would have been present on 16th and that, therefore, the factual interpretations of the MRI scans given by Prof. M. on behalf of the plaintiff were correct.

66. That is not, of course, the end of the analysis. The plaintiff must establish pursuant to *Dunne v. National Maternity Hospital* (above) that the diagnosis by Mr. Timlin in relation to the findings of the MRI was of such failure that no medical practitioner of equal specialist or general status and skill would be guilty of, if acting with ordinary care. The plaintiff has failed to establish liability in relation to the MRI scan.

67. The defendant must be judged, in relation to the MRI scan, and on all matters, on the basis of his knowledge at the time. The interpretation of signs and shadows on films is a difficult science and clearly from the evidence in this case, the MRI scan is still open to different interpretations. I have found as a fact that the plaintiff developed CES and indeed, that that CES was developing on 16th and accordingly, as stated by the plaintiff's experts, the signs in the MRI pointed to that fact. However, on 16th Mr. Timlin examined the MRI films, discussed the same with Prof. E. and also with a colleague Mr. A.P. I accept the submissions on behalf of the defendants that this was, in fact, a *"gold standard"* approach and Mr. T. took reassurance from the slides, this reassurance was confirmed by Prof. E. and together with Mr. A.P. conservative management was proposed.

68. Mr. Timlin cannot be faulted for his interpretation of the MRI scan and the course of action he took following from his opinion. The developing CES and its signs on the scan was a marginal thing and its existence was, at that time, and indeed still is, open to significant expert debate. Having discussed the matter with Prof. E., the radiological expert and with his colleague, Mr. A.P, I accept the submissions of the defendants that at that stage, Mr. Timlin was operating a gold standard and his actions cannot be faulted or described as negligent notwithstanding my findings of fact.

69. In relation to the MRI scan the defendant has established in accordance with the third *Dunne* principle that his conduct was as a matter of fact approved by his colleagues are of similar speciality and skill and the plaintiff has not established any inherent defect in this conduct.

70. The issue in relation to the delay to operate until 19th is more complex. Mr. Timlin decided on operation on 18th because of developing neurological symptoms in the plaintiff's second lower limb.

71. I accept as a fact that had this operation been carried out earlier that the plaintiff's present symptoms would not have developed as they had.

72. It is, as I had previously indicated, unfortunate that the report from the physiotherapy department was not circulated as indeed on 11th March, the physiotherapist was reporting numbness in both buttocks. This complaint was also made to the nurses but the nursing notes were, I am afraid, anodyne as I have previously stated. I have little doubt that had Mr. Timlin been made aware of the physiotherapist's report and the potentially alarming findings that his concerns that the plaintiff might be developing a CES would have been considerably heightened and he would have acted sooner.

73. As late as 15th, the nursing note referred to only right leg numbness and the plaintiff's case is that Mr. Timlin ought to have taken into account the plaintiff's subjective symptoms complaints as well the objective nature of his urinary problems as being "*red flags*" suggestive of a CES problem. In determining liability, I must not look at the matter from hindsight but what Mr. Timlin found on his examinations and from discussions with the nursing staff. There is absolutely no evidence that Mr. Timlin was given any more alarming picture by the nursing staff than what was stated in the nursing notes. I also accept that Mr. Timlin was not advised in relation to the findings of the physiotherapist.

74. On Mr. Timlin's own examinations, he found on 11th March, that the plaintiff was "well" that there was no neurological defect and again on 13th March, he found him well and ordered films in relation to his urinary retention. The experts differ to whether these retention problems were "*red flags*" or likely complications of surgery but it is clear that Mr. Timlin kept these problems in his mind as by 16th March, when he recorded severe weakness in his right foot and a change in neurological signs, he ordered the MRI scan.

75. After the MRI scan, Mr. Timlin directed conservative treatment and steroids and on 17th March, he recorded that the neurological examination was stable.

76. On 18th March, there was a deterioration of neurological signs and Mr. Timlin marked the plaintiff for surgery which performed on 19th.

77. Having considered the evidence notwithstanding my findings of fact, I cannot conclude that the decision of Mr. Timlin not to operate until 18th March and the operation being carried out as soon as possible on 19th March, was negligent.

78. I have been invited by the defendants that in the event of my being unable to decide between the experts I should conclude that the plaintiff having failed to satisfy me that there was negligence that the case should be dismissed. However, I do not think that the case should be left in that vacuum. On the evidence I have heard, I am not left in a position of doubt but rather I must conclude that there was no negligence on the part of Mr. Timlin.

79. Mr. Timlin was aware of the possibility of CES. He was alert to the possible dangers in relation to the urine retention although, initially at least, he out ruled these factors as being likely complications of surgery. He was monitoring the plaintiff for ongoing neurological developments and until 16th, he was reassured. On 16th, he was further reassured by his interpretation and the interpretation of Prof. E. of the films. The situation, based on his examinations, did not further deteriorate until 18th. In the circumstances, I do not believe that the defendant can be faulted for his decisions.

80. Had there been a communication to Mr. Timlin of the findings by the physiotherapist of neurological signs in both buttocks as early as 11th March and had he delayed surgery until 19th, then my determination would have been different.

81. I note that the plaintiff when he accidentally removed the catheter was initially criticised by some of the staff and may have been regarded as a difficult patient but it is unfortunate to say the least that his complaints and concerns were not fully noted and, I accept were not passed on to Mr. Timlin.

82. Mr. Timlin must be judged on what he did and did not do based upon his examinations and the reports he received. His examinations of the plaintiff did not result in the complaints that the plaintiff had been making to others. Probably the plaintiff was minimising his distress when being examined by Mr. Timlin. In any event, there were many possible interpretations of the signs and symptoms exhibited by the plaintiff, one of which was the developing CES and Mr. Timlin was aware of this possibility but given the many other possible causes, the defendant cannot be faulted at law for what he did or did not do, and in particular he cannot be faulted for continuing with conservative management until 19th March.

83. Accordingly, in relation to the decision not to operate until the 19th I find that Mr. Timlin acted in accordance with a reasonable and approved practice and the plaintiff has not demonstrated that that practice had any inherent defects.

84. In those circumstances, therefore, the plaintiff must fail in his case against the defendant and the proceedings must be dismissed.