Neutral Citation Number: [2007] IEHC 333

THE HIGH COURT

[2003 No. 11220 P]

BETWEEN

MICHELLE MYLES

PLAINTIFF

AND

ETHNA McQUILLAN AND THE NORTH EASTERN HEALTH BOARD

DEFENDANTS

Judgment of Mr. Justice John Quirke delivered the 11th day of October, 2007

The plaintiff is a young lady who is now 24 years old. She resides with her parents at No. 28 Chestnut Grove, Tallanstown, Co. Louth. She is the youngest of three children.

She seeks damages from the defendants for personal injuries, loss and damage which she claims that she has sustained by reason of negligence and breach of duty on the part of the defendants in the treatment and management of an inflammatory bowel disease from which she suffers and which is known as ulcerative colitis.

The first named defendant is sued in her capacity as the nominee of Our Lady of Lourdes Hospital in Drogheda, Co. Louth, (hereafter "Drogheda Hospital").

The second named defendant is the Health Service Executive which is the statutory body with responsibility for the provision of medical care and services within the State.

Relevant Facts

1. In the summer of 1997, the plaintiff consulted her general practitioner Dr. Eleanor Ward complaining of distressing abdominal and intestinal symptoms. On the 12th August, 1997, she was referred by Dr. Ward to Mr. Finbar Lennon who was then, a consultant surgeon at Drogheda Hospital.

On the 17th of September, 1997, she underwent a sigmoidoscopy at the hospital and was diagnosed with severe distal proctitis. Her condition was correctly treated by the application of suppositories containing steroids and a salazopyrin drug called Dipentum. She was reviewed in the hospital in December, 1997.

In January, 1998 she suffered severe abdominal pain, nausea, vomiting and the passage of bloody stools. She required admission to Drogheda Hospital where she came under the care of Dr.J.P.Long who was a consultant physician at the Hospital. Dr. Long recognised that the plaintiff was suffering from ulcerative colitis and treated her appropriately with variable levels of steroids and Dipentum between January, 1998 and August, 1998.

2. In August, 1998 she suffered an exacerbation of her condition. Dr. Long ascribed the exacerbation to infectious diarrhoea.

She continued to have significant symptoms throughout the autumn of 1998 and since she was suffering extreme embarrassment at school as a result of her condition, special arrangements were made to enable her to use the staff toilets and the bathroom in her grandmother's house. These arrangements were made because of the embarrassment which she invariably suffered when she used the ordinary school facilities. Her condition caused her to visit Dr. Long's clinic for treatment or assistance on nine occasions between January, 1998 and March, 1999.

Dr. Long wrote to the plaintiff's general practitioner Dr. Ward by letter dated the 17th November, 1998, in the following terms:

> "Michelle attended the clinic this morning with her mother. As you know, she has colitis. Really this is not all that severe. … She does become extremely anxious in school and is very embarrassed by the nature of her illness and tends not to use the toilets but uses her Granny's toilet who lives about 10 minutes from the school. On examination today she was well. I am concerned that most of Michelle's problems are related to her embarrassment about her condition rather than the condition itself. I have explained this to Michelle and her mother."

3. On the 25th July, 1999, she sustained a serious exacerbation of her disease and was admitted to Louth Hospital. The notes of the junior doctor who admitted her to hospital recorded that he did not perform a rectal examination but recommended that she should be "deferred to colonoscopy". The notes record a plan which suggested a colonoscopy the following morning and a recommendation that the plaintiff was "not for anti-motility agents or opiates". Treatment of the plaintiff by way of intravenous hydrocortisone was commenced.

On the 26th July, 1999, the plaintiff was discharged without having undergone a colonoscopy. She continued to have abdominal pain and was treated by Dr. Long by the prescription of a high dose of oral Prednisolone, (a steroidal drug), and Buscopan, which is an antispasmodic agent which slows motility and provides relief from stomach cramping.

She discontinued her schooling largely because of continuing embarrassment related to her condition and the difficulties which her condition caused her.

Her condition remitted until November, 1999 when she sustained a recurrence of diarrhoea. Thereafter, she felt that she was deteriorating and that her appearance had been adversely affected. She had lost weight and felt that her face had become swollen and had created a disfiguring contrast with her very thin body.

Her worsening symptoms caused her considerable concern and greatly alarmed her parents. Consequently, she attended with her mother at the clinic of her general practitioner Dr. Ward on the 20th December, 1999.

In evidence, Dr. Ward said that when she saw the plaintiff her immediate impression was that the plaintiff "looked unwell" and "had got very thin since I had seen her the last time…" Recording the plaintiff's weight at six and a half stone she immediately sent her to Drogheda Hospital for assessment advising the hospital that the plaintiff possibly needed admission to the hospital because of her condition.

When she attended the Casualty Unit of Drogheda Hospital on the same day the plaintiff was examined by a doctor, (probably Dr. Lobo, who was Dr. Long's Registrar). She was examined, prescribed medication and advised to return on the following day to keep a

review appointment made earlier with Dr. Long. A note of the visit made by Dr. Lobo referred to a "bed crisis" within the hospital on that day.

When she returned on the 21st December, the plaintiff was examined by Dr. Long who prescribed an increased level of steroidal medication (Prednisolone). He told her that she looked well and he sent her home. He advised her to return in two weeks for review. On the same day Dr. Long wrote to the plaintiff's general practitioner Dr. Ward advising the latter, *inter alia*, that the plaintiff's "..Crohn's seems to have become active recently … she was accompanied by her mother today and they are both very concerned about her illness. On examination she looks very well. Her abdomen is soft and she was not clinically dehydrated. Her Prednisolone has been increased to 40 mgs daily so I think she should continue with this and I have arranged to review her in two months."

4. In evidence the plaintiff described Christmas of 1999 as "the worst Christmas ever". Her symptoms were so severe that she was required to stay in bed in her room with the curtains closed during the entire Christmas period. She was unable to eat or to drink adequately and she was in constant severe pain. The smell of food made her nauseous and when her mother crushed tablets in order to assist her to take medication she "literally gagged" and her throat rejected the medication.

She remained in great pain discomfort and distress until the 30th December, when, in desperation, she attended her general practitioner Dr. Ward who advised her to go immediately to the Casualty Unit of Drogheda Hospital where she was admitted and remained until the11th January, 2000. A letter provided by Dr. Ward to the Hospital dated the 30th December, 1999, recommended admission and advised that the plaintiff was suffering from weight loss, severe abdominal pain, nausea and weakness. It also advised that her heart rate had been recorded at 130/min and that her abdomen was "tender".

5. On admission, the plaintiff's pulse rate was 120/min and her white cell and platelet counts were high. Clinical notes apparently made on the 3rd January, 2000 recorded the plaintiff's weight as "5 and a half stone". The medical staff at Drogheda hospital arranged for the plaintiff to see a social worker for "counselling" and she was given a high calorie energy drink.

Further clinical notes made on the 8th January, 2000, recorded the plaintiff as "crying + + --- says she has diarrhoea after eating…" Nursing notes made on the same day confirm the plaintiff's condition and complaints.

Although clinical and nursing notes recorded that she was seen by Dr. Long regularly there was no assessment of the plaintiff's colon by way of scanning, radiology or endoscopy during her confinement in the hospital. No surgical review of the plaintiff was conducted.

The plaintiff's recollection of the frequency of her bowel movements in the days immediately after her admission to Hospital was inconsistent with the clinical and nursing notes maintained by the Hospital. She was encouraged to maintain stool charts and did so.

She was recorded as having "a comfortable night. Settled and slept for short periods" on the night of the 10th January, 2000. She was seen by Dr. Long on the 11th January and discharged home with advice to see a Dietician.

The Discharge Summary provided by the Hospital to plaintiff's general practitioner, (to accommodate her ongoing treatment), recorded little other than the medications which had been prescribed for her and that she had been "seen by Dietician and a Social Worker re. her ulcerative colitis". It indicated that a further report on the plaintiff would be provided by the hospital. No report materialised.

6. On the 27th January, 2000, Dr. Long wrote to Dr. Ward advising that the plaintiff had been admitted to hospital after Christmas "because of an exacerbation of her Crohn's ...on discharge she is well and has gained almost 5 kg in weight…" The letter recorded that he had reduced the plaintiff's medication and would see her two weeks later. Crohn's disease is a disease similar to ulcerative colitis. The plaintiff was not suffering from Crohn's disease.

On the 1st February, 2000, Messrs. O' Flynn's pharmacy of Ardee, Co. Louth dispensed a number of Difene 50 mg capsules for the benefit of the plaintiff. The capsules were dispensed pursuant to a prescription issued by the practice of the plaintiff's general practitioner Dr. Ward. Difene is a non-steroidal anti-inflammatory agent which is usually prescribed in order to relieve pain. It is not consistent with general and approved medical practice to prescribe it for the treatment of ulcerative colitis because it is linked to ulceration of the colon.

The same pharmacy dispensed Prednisolone tablets for the benefit of the plaintiff on the same day pursuant to a prescription given by the same medical practice. The Prednisolone dispensed was 20 mg which corresponded with the level recommended by Dr. Long to the plaintiff on the 27th January, 2000.

The dispensing pharmacist, in evidence stated that in and around February, 2000 it was the practice in County Louth for patients to seek written drug prescriptions from their general practitioners for production at pharmacists. This practice developed because patients could recover the cost of drugs obtained pursuant to prescriptions from their general practitioners, (who were considered to be primary care-givers) but could not recover the costs of prescriptions written by hospital doctors.

7. Between the 11th January and the 29th April, the plaintiff in evidence stated that she felt she did not have a life. She became reclusive because of her condition and spent most of her time lying on the couch in her home. She refused to see her friends and had no social life. During this time the plaintiff's mother enquired from Dr. Long if surgery was a potential option in order to reduce the plaintiff's discomfort. The plaintiff's mother said that Dr. Long replied that many patients suffering from ulcerative colitis had symptoms worse than those of the plaintiff.

By letter dated the 17th February, Dr. Long advised Dr. Ward that the plaintiff's "Crohn's continue to settle… and I have asked her to reduce her Prednisolone to 15 mgs daily…"

By letter dated the 2nd March, 2000, Dr. Long's Registrar Dr. O'Brien advised Dr. Ward that the plaintiff's "Crohn's seems to have settled… she is putting up weight. She looks a little cushingoid at the moment. She is on Prednisolone 15 mg and I reduced it down to 10 mg for the next two weeks…"

By letter dated the 16th March, 2000, Dr. Long advised Dr. Ward that the plaintiff was "doing reasonably well. Her bowels had become a little more frequent…I left her Prednisolone 10 mg daily…".

By letter dated the 30th March, Dr. Long advised Dr. Ward that the plaintiff "Crohn's is settling but still hasn't settled entirely... She should continue to stay on Prednisolone 10 mg daily…" As has been indicated earlier the plaintiff was not suffering from Crohn's disease.

On the 29th April, 2000, the plaintiff attended Dr. Ward who advised her to attend the hospital and provided her with a letter recommending admission. The letter advised the hospital that the plaintiff "… has been unwell during the week. Severe abdominal pain, nausea and vomiting. She has Crohn's disease for which she attends Dr. Long. He advised an increase in her steroids during the week and she was prescribed antiemetics during the week with no relief also."

She was admitted to the Hospital but was not seen by a consultant. The clinical notes of her admission record, *inter alia*, her condition and that she had been feeling unwell for one week with lower abdominal pain, vomiting and nausea.

It was noted by the junior doctor who admitted her that, during the period immediately prior to her admission she had been treated with Prednisolone 30 mg together with Predfoam enemas. It follows that between the 30th March, 2000, and the 29th April, 2000, her condition had deteriorated and her symptoms were so severe that Dr. Long had felt it necessary to prescribe an increased level of Prednisolone, (from 10mg to 30 mg), for her together with Predfoam enemas. It is probable that this change in treatment resulted from advice given by Dr. Long to Dr. Ward by telephone.

On admission to hospital the plaintiff was treated with intravenous fluids including hydrocortisone 100 mg, (intravenously four times each day), and Dipentum 500 mg, (orally twice each day). Among the recommendations made by the junior doctor who admitted her to the hospital was that she should be provided with a "surgical review". She was not surgically reviewed whilst she was in hospital on this occasion or at any other time during the management of her condition by Dr Long.

A radiological report of an x-ray taken on the 2nd May, 2005, provided that "P.F.A. a paucity of gas in the large and small bowel. No dilated bowels of thickened bowel loops identified. No evidence of pneumoperitoneum".

Hospital records of tests undertaken after the plaintiff's admission to hospital on the 29th April, 2000, showed a significantly high platelet count and an increased haemoglobin count. On admission her blood pressure was recorded as 123/102 and her pulse rate was 140/min.

8. On the 2nd May, 2000, she was discharged home. She was seen by Dr. Long immediately before her discharge. She was not seen by any other consultant during her confinement in hospital. The Discharge Summary provided by the Hospital to plaintiff's general practitioner, (to accommodate her ongoing treatment), recorded her complaint on admission as "abdominal pain, vomiting for one week".

The "Medications on Discharge" recorded within the Summary were(1) "Dipentumt 500 mgs, (2) Prednisolone 40 mgs and (3), Difene 75 mg."

9. Shortly after returning home the plaintiff received written notification from the hospital that she had developed a urinary tract infection. The note included a written prescription of antibiotic medication. The prescribed antibiotic, (called Augmentin), was administered by the plaintiff's mother who crushed the tablets in milk for the plaintiff, who was unable to swallow without vomiting. The plaintiff's pain gradually increased in intensity and reached an unbearable level. Between the 5th and 8th of May, she was unable to sleep and was too weak to go to her bathroom unaided. It became necessary for her to keep her mobile telephone beneath her pillow so that she could call her mother for assistance.

10. At approximately 11.30 p.m. on the evening of the 8th May, 2000, the plaintiff's pain level and symptoms became so intense that her mother, deliberately armed with; (a) notes of her daughter's medical history treatment in the hospital and (b) her current medication prescriptions, telephoned the hospital for assistance.

Her call was transferred, at her request, to the hospital's Casualty Department. She spoke on the telephone to a person who introduced herself as a "Sister in Charge". She immediately provided this person with a history of the plaintiff's condition, treatment and medications and advised her that the plaintiff had been admitted to the hospital with severe symptoms on the 29th April, 2000, and discharged on the 2nd May, (less than a week earlier). She described the severity of the plaintiff's symptoms and her extreme pain and she asked for advice and assistance.

The person who had described herself as a "Sister in Charge" advised the plaintiff's mother; (a) to give the plaintiff two Paracetamol tablets and (b) to telephone the plaintiff's general practitioner the following morning in order to arrange for a "home visit" to the plaintiff by the general practitioner.

The telephone call from the plaintiff's mother to the hospital lasted approximately three minutes. Immediately after its conclusion the plaintiff's mother administered two Paracetamol tablets to the plaintiff crushed in milk. The tablets were ineffective and the plaintiff and her family had little, if any sleep for the remainder of the night.

11. Early the following morning the plaintiff's mother telephoned the plaintiff's general practitioner and was promised a "home visit" from Dr. O'Neill, (deputising for Dr. Ward who was not available).

At approximately 10 a.m. the plaintiff's mother assisted the plaintiff into the bathroom. Shortly afterwards the plaintiff suffered an extreme and acute attack involving a sudden explosive spasm and vomiting and the evacuation of black substances from her body in a manner which was quite terrifying.

Responding to the plaintiff's screams the plaintiff's mother helped her back into bed and telephoned Dr. O'Neill for urgent assistance. When Dr. O'Neill arrived he recognised that the plaintiff was in immediate danger of death, administered emergency treatment and called an ambulance.

The ambulance arrived expeditiously and the plaintiff was brought to Dundalk Hospital where she was immediately admitted under the care of Ms. Ursula Mulcahy who was the Consultant Surgeon within that hospital. X-rays of the plaintiff taken immediately upon her admission to Dundalk Hospital disclosed that the plaintiff had developed a generalised peritonitis, a condition so dangerous that Ms. Mulcahy decided that immediate surgery was required. She embarked upon it at 3p.m.

Upon opening the plaintiff's abdomen Ms. Mulcahy found "free faecal fluid swimming throughout the whole abdomen …" It was necessary to perform a total colectomy, (removal of most of the large bowel), leaving the plaintiff with an ileostomy. The plaintiff required a number of emergency procedures for a variety of different life threatening conditions which developed and required surgical and other treatments during the days and weeks immediately after her emergency admission to hospital on the 9th May.

When asked her view as to when the peritonitis might have occurred Dr. Mulcahy replied "I would reckon somewhere in the region of

24 hours, but I just don't know".

When asked whether it might have developed "near the start of the 24 hours" She replied "I would say it was probably nearer the start … there are all sorts of ifs buts and maybes. Certainly it wasn't a question of perforating and then being rushed straight to theatre. It looked as though the perforation had been going for some time. If you are trying to pin me down to a precise time … I am afraid I couldn't …" She continued "the sooner you get a perforation operated on, the better the outlook and the less adhesions you are likely to get afterwards. … they couldn't do a pouch because of the adhesions and I don't think anybody could give you a definite answer but there probably would have been fewer adhesions if she had been operated on earlier".

When asked whether the perforation occurred at the time when the plaintiff experienced a sensation of an "explosion" and a "popping sensation" she said "it could be yes".

12. The plaintiff's post-operative care was complicated by the ongoing peritonitis, severe wound infection (with an element of necrotizing fasciitis), intestinal fistulation, pneumonia, and severe malnutrition. She suffered psychological symptoms and Ms. Mulcahy was worried about her mental condition over a significant period of time. In consequence she was seen by a Consultant Psychiatrist Dr. Lyster on the 28th June, 2000.

Three months later, still hospitalised and requiring ongoing surgical and other treatment, she was transferred to Beaumont Hospital under the care of Mr. Brian Lane, a Consultant Surgeon with a special interest in colorectal surgery. Her multiple abdominal abscesses and intestinal fistulas were treated using vacuum drainage. Subsequently she developed pulmonary emboli and was placed on intravenous anticoagulation and Warfarin which is an oral anticoagulant. She developed a splenic infarct. She required continuous parental nutrition and the insertion of central venous catheters to allow for intravenous nutrition. She developed a tension hydrothorax which is a complication of the parental nutrition. She contracted MRSA.

On the16th November, 2000, Mr. Lane performed a laparotomy on the plaintiff. He excised a fistula and performed an endoanal anastomosis on the small bowel. She required a chest drain. The plaintiff was allowed home one week before Christmas 2000. However, her nightmare was far from over.

13. When she returned home she was so debilitated that her father had to carry her upstairs at night. Her recovery was lengthy, painful and distressing. She suffered severe breathing problems consequent upon the insertion of chest drains. She required treatment for a variety of different complaints including urinary incontinence, gallstones and rectal symptoms, (including bleeding and acute proctitis). Most of her hair had fallen out and its restoration took some time. She required physiotherapy to improve her mobility.

In June and July of 2002, two attempts were made by Mr Lane to form an ileal pouch for the plaintiff in order to allow for the ileostomy to be reversed. This was not possible because of the severity of the scarring in the lower abdomen and pelvis. Dense adhesions and extensive bleeding were among the factors which caused the surgery to be abandoned on both occasions.

The plaintiff will require surgery for the removal of her rectal stump at some future date, (surgery described in evidence by Mr. Deasy the Consultant Surgeon who will probably perform it as "daunting"). It will be necessary because of an increasing risk of rectal cancer over the passage of time.

The extensive surgery which the plaintiff has undergone has resulted in equally extensive and disfiguring scarring which causes the plaintiff great embarrassment and makes her feel physically unattractive. Her ileostomy causes leaking difficulty and embarrassment. She does not anticipate that she will ever enjoy a satisfactory personal or sexual relationship by reason of her physical and psychological condition. Whilst she is physically capable of childbearing, pregnancy would carry significant risks for her. Professor John Bonnar who is a Consultant Obstetrician and Gynaecologist stated in evidence that she has "… a poor prognosis for childbearing". She has undergone bone density testing and has been diagnosed with osteopenia which places her at risk of developing osteoporosis.

14. Mr. Joseph Deasy who is a Consultant Surgeon with a special interest in General and Colorectal Surgery stated in evidence that the plaintiff came under his care in Beaumont Hospital in 2006. She is still under his care and it is his opinion that during the next ten years it will be necessary to attempt to surgically remove her rectal stump. This will be required because of an increasing risk of the development of rectal cancer. This surgery carries a 10% risk of adhesions and that risk can double or treble or even quadruple for persons who have had peritonitis.

He was of the opinion that "the time of the perforation" was approximately 10.30 a.m. on the morning of the 9th May, when the plaintiff felt what she described as "an explosion" or "popping sensation" followed by vomiting and the release of black liquid material from her body.

He said that if the plaintiff had been brought to the Casualty Department of the hospital on the night of the 8th May, 2000, or the early morning of the 9th May, 2000, she would probably have been admitted. Thereafter the distension of her abdomen would have been apparent. That, in turn, would have warranted "urgent investigation and x-ray".

He said that when a perforation occurs "the sooner you get in there the better. Results show that when a patient has a perforated colon for longer than 24 hours and usually longer than 18 hours, the complication is a lot worse, the mortality is a lot higher and than if you intervene in the first six hours".

15. Dr. Fred Bereen who is a Consultant Psychiatrist stated in evidence that she suffers from post-traumatic stress disorder as a result of the trauma associated with the rupture of her colon. He said that notwithstanding therapeutic intervention her symptoms remain and have been exacerbated by further negative information regarding her overall health. Dr. Paul Scully who is a Consultant Psychiatrist stated that the post-traumatic stress disorder from which she suffers is consistent with major trauma of the kind endured by the plaintiff. She receives ongoing treatment for this condition by way of psychotherapy and pharmacotherapy administered by her general practitioner.

16. In evidence the plaintiff stated that it had been her intention to complete her Leaving Certificate examination and to then pursue a career in computer skills. Because the embarrassment associated with her colitis caused her to leave school prematurely she was unable to complete her Leaving Certificate.

She commenced a computer course (ECDL) in April, 2003 and completed it successfully. She has since successfully completed a Diploma in Information and Communication Technology. In March, 2004 she obtained a specialist certificate from the FAS-on line Microsoft Office.

The plaintiff was unable to sustain full time employment because she continued to suffer symptoms consequent upon her peritonitis. Between July, 2004 and January, 2005 she obtained part-time employment as an assistant tutor (ECDL) for two hours each week. Subsequently, she secured additional work as a tutor and was able to work between four and six hours every week.

Between May, 2005 and August, 2006 she secured full-time employment as a legal secretary with a firm of solicitors but was subsequently forced to reduce her working hours from 40 to 20 hours each week because of her symptoms. Ms. Brenda Keenan who is a vocational rehabilitation consultant, in evidence, was of the opinion that the plaintiff was "at best confined to minimal part time employment only" by reason of her present medical condition.

The Plaintiff's Claim
In summary, it is claimed on behalf of the plaintiff that the defendants were negligent in the management and treatment of her colitis because:

(a) They failed to adopt appropriate and proper investigative measures in order to establish the extent and severity of her colitis;

(b) They continued to treat and manage her colitis by the prescription of Prednisolone and Dipentum for an unacceptable length of time after the treatment had become ineffective and the plaintiff had become steroid dependent;

(c) They failed to communicate and consult with the plaintiff and her family during the management and treatment of the plaintiff's colitis and permitted the quality of her life to deteriorate to a degree that required her to discontinue her education and suffer inappropriate and unnecessary distress, embarrassment, humiliation and upset;

(d) They failed to have the plaintiff surgically reviewed and to consult with the plaintiff and her family in order to discuss and consider the possibility of treatment by way of elective surgery when treatment by medication was proving ineffective and her condition was deteriorating;

(e) They failed to investigate and treat her condition and her symptoms by way of colonoscopy and otherwise between the 20th December, 1999 and the 11th January, 2000, causing her unnecessary and extreme pain distress and other severe and debilitating symptoms at that time;

(f) They failed to adequately investigate treat and manage the plaintiff's colitis by providing her with the services of an appropriately qualified consultant physician or surgeon between the 29th April, 2000 and the 2nd May, 2000 while she was a patient in the hospital;

(g) They permitted her to be discharged from hospital on the 2nd May, 2000, when it was unsafe and inappropriate to do so and without advising her or her family that it was necessary for her to report any deterioration in her colitis to the hospital immediately should that occur;

(h) They prescribed inappropriate medication for the plaintiff while she was in hospital in April and May 2000, and recommending that she should continue to take that medication after her discharge from hospital when it was unsafe and dangerous for her to do so;

(i) They provided the plaintiff's mother with inappropriate and improper advice on the night of the 8th May, 2000, when the plaintiff's mother telephoned the hospital in distress seeking assistance and advice in relation to the plaintiff's deteriorating condition.

It is claimed on behalf of the plaintiff that the management and treatment of the plaintiff outlined above, comprised a clear departure from general and approved medical practice appropriate for the proper care and management of a patient suffering from ulcerative colitis at the material time.

Expert Medical Evidence
1. Dr. Graham Neale who is an experienced Consultant Physician and Gastroenterologist testified at length during these proceedings. He was critical of the manner in which the plaintiff's ulcerative colitis was managed by Dr. Long and by the hospital.

He described a failure in communication between Dr. Long and the plaintiff and her family. He acknowledged that colitis is a very unpleasant disease for which there is no known cure. He said that, notwithstanding its ill effects, the proper management and treatment of the disease does not require a patient to endure the type of constant distress, embarrassment, humiliation and sheer misery endured by the plaintiff on several occasions between July, 1999 and May, 2000. She was between 15 and 17 years old at that time.

He said that the failure by Dr. Long and the hospital staff to properly investigate and treat the very severe symptoms from which the plaintiff was suffering on the 20th December, 1999 and during the days immediately thereafter was inappropriate and represented a departure from proper and approved methods of investigating and treating ulcerative colitis at that time. In January, 2000 when it was clear that treatment by steroids had been ineffective, the plaintiff should have been surgically reviewed and thereafter, consulted with a view to discussing and considering the possibility of undergoing elective surgery by way of treatment of her colitis.

It was his opinion that the failure by the hospital to have the plaintiff properly investigated and treated by an appropriately qualified consultant physician or surgeon shortly after her admission to hospital on the 29th April, 2000 and before her discharge from hospital on the 2nd May, 2000, was inexplicable and represented a clear breach of appropriate standards and approved practice for the management and treatment of colitis at the material time.

He described her treatment in hospital as " … a very abnormal state of affairs" and said that the plaintiff should not have been discharged from the hospital on the 2nd May, 2000 and certainly not without advice to report any deterioration in her condition to the hospital immediately and to return for further investigation and treatment in that event.

He said that the cause of the perforation was "mutli-factorial" and that mismanagement was "a very significant component in the end result …" The prescription of Buscopan was inappropriate because it was an anti-motility agent and masked significant symptoms. The prescription of Difene was inappropriate because it is a drug with an acknowledged link to ulceration of the bowel. Its prescription for the plaintiff was a "significant contributory cause" associated with the perforation of the plaintiff's colon. He said "Difene is known to exacerbate the colitic process (which may end up with distension of the caecum) … (which) …can rupture because of that so it is

part of the chain of events …"

By prescribing these drugs the defendants, from time to time and on particular occasions, departed from general and approved medical practice in the management of the plaintiff's colitis.

Dr. Neale was unwilling to give an authoritative opinion on the time at which the perforation occurred. He said that this would be "best explored by considering the findings of Ms. Mulcahy at operation. I don't think I should comment on that because I don't operate on patients with perforations."

Pressed in cross-examination as to when the perforation occurred he said "my view is that it occurred about 24 hours before the operation at the time when Ms. Myles developed this crescendo pain during the afternoon and evening of the day before she was admitted to hospital".

He was strongly of the opinion that when the plaintiff's mother telephoned the hospital for assistance on the evening of the 8th May, 2000, "medical help should have been forthcoming … she should have been taken immediately to the hospital or somebody should have gone out to see her and they would have admitted her to hospital immediately".

He described the advice given to the plaintiff's mother by the nurse or "Sister in Charge" of the Casualty Department in the hospital as "totally unacceptable" He said that the plaintiff should have been admitted to hospital and immediately x-rayed. That would have resulted in emergency surgery and would have prevented many of the infections and complications which the plaintiff was caused to endure.

In summary, it was his opinion that the management of the plaintiff's ulcerative colitis fell short of general and approved medical practice in a number of respects and on a number of occasions between August, 1997 (when her condition first manifested itself), and May, 2000(when her colon ruptured).

2. Professor Alexander Williams who is an experienced surgeon and a Professor of Gastro-Intestinal Surgery said that the investigative measures undertaken by Dr. Long were inadequate and inappropriate. He said that she should have been investigated by way of colonoscopy at an early stage in the management of her colitis. This was necessary in order to establish the full extent of her condition and its progression. During her several admissions to hospital arising out of exacerbations of her colitis, this type of investigation was never undertaken.

He said that elective surgery should have been performed before the plaintiff's colon perforated. He did not accept that the perforation was "an unexpected sudden complication". He said "I think that it should have been recognised before this happened, before the perforation occurred."

Surgery without perforation would have comprised a total colectomy leaving the rectal stump. This would have been an uncomplicated operation and there would have been no thrombosis and no septic complications. Whilst the plaintiff would have had adhesions, they would not have been severe and would not have affected her changes of pregnancy. He said "there would not have been organisms in the peritoneal cavity. She would have made a rapid recovery from that operation … that would have been a very straightforward operation without the serious risk of complication but once you have peritonitis it is an entirely different picture."

Two further operations would have been required to complete an ileal anal anastomosis which would have provided normal continuity of gastrointestinal tract with no stoma.

Because the plaintiff suffered so many post operative complications and infections consequent upon her peritonitis there is now only a slight possibility that surgery could be successful and it is very likely that she will remain with a permanent ileostomy.

He said that the plaintiff's mother should have been deeply involved in the consultation relative to the treatment of the plaintiff's condition and in particular to the consideration of surgery.

It was his opinion that the phone call made by the plaintiff's mother to the hospital on the 8th May, was of considerable significance because it indicated that "her mother was worried to death about Michelle's condition on the 8th and still she was not admitted. I think it is possible had she been operated on the 8th she would still have had a perforation but it would not have been anything like as bad as it was. She would not have had the same septic complications and organ failure that she got".

He said that Buscopan and Difene should not have been prescribed for the plaintiff.

Cross-examined by Mr. McGrath S.C. on behalf of the defendants, Professor Alexander Williams agreed that the perforation could have occurred within 28 and 48 hours prior to the surgery performed by Ms. Mulcahy on the 9th May.

In summary, it was his opinion that the treatment provide by Dr. Long and by the hospital to the plaintiff fell short of general and approved medical practice in a number of respects and on a number of occasions between August, 1997 and May, 2000.

3. Dr. Long, in evidence, acknowledged that at the time when the plaintiff was discharged from Drogheda Hospital on the 11th January, 2000, she been the subject of active treatment for ulcerative colitis for some 28 months and had been under his personal care and management for approximately 24 months.

For the first 23 months of her condition she had been intermittently treated by the prescription of corticosteroids which had been partly successful. She had required admission to hospital in July, 1999 consequent upon a moderate exacerbation of her condition.

After her discharge from Drogheda Hospital in July, 1999 she was treated with corticosteroids on a continuous basis for more than five months without remission of her condition. She was then admitted again to Drogheda Hospital on the 30th December, 1999, suffering from a severe exacerbation of her condition. Dr. Long agreed that at the time of her admission on the 30th December, 1999, the plaintiff had become "steroid resistant" (i.e. her ulcerative colitis was not responding to treatment by steroids).

He described his letter to Dr. Ward dated the 21st December, 1999, as a "critically poor letter there are certainly two mistakes and probably a third". He agreed that the plaintiff " … clearly was not very well" and described the letter as " … not the letter I am most proud about … there is clearly an error about Crohn's and two months instead of two weeks. ….and that is a fact I cannot change that..it is there in black and white."

He said that, although the evidence justifying continued treatment by steroids was weak and diminishing the only other options available by way of treatment were; (a) treatment by immuno-modulatory drugs or (b) surgery.

He stated that he had taken the view that treatment by immuno-modulatory drugs was undesirable since those drugs were unproven at the time and were believed to carry a risk of cancer. He therefore considered that the only real alternative treatment available to the plaintiff was surgery, (a colectomy and the construction of a pouch). This would require artificial accommodation for bowel evacuation on a temporary basis and thereafter by means of the pouch. This surgery had obvious ongoing social and other problems and difficulties associated with it.

He said (and it is acknowledged by all of the expert witnesses who testified), that the plaintiff's condition, as a matter of near certainty, would have required that type of surgery at some point in her life. It was desirable to postpone surgery for young patients for as long as was reasonably possible because of the social and other problems resulting from the surgery. Accordingly, he believed he should postpone the plaintiff's surgery having regard to the plaintiff's youth and disposition at the relevant time.

He said that he made a clinical decision to make a "final attempt" to treat the plaintiff by the administration of steroids. That decision was not recorded in any document or notes maintained by Dr. Long or by the Drogheda Hospital.

On each occasion when the plaintiff was discharged from hospital after treatment for exacerbations of her ulcerative colitis, a document called a "Discharge Summary" was provided by the hospital to her general practitioner, (in order to accommodate her ongoing treatment). It recorded her complaints on admission, her treatment in hospital and the medication recommended and prescribed for her.

The Discharge Summaries in respect of each of the plaintiff's admissions to Drogheda Hospital were identical stereotyped one-paged documents which made provision only for the insertion of cryptic information in handwriting beside a small number of questions. Dr. Long described these documents as "…a generic Discharge Summary which every specialty uses". He explained that it applied to the entire hospital and to the disciplines of "general surgery, orthopaedics and gynaecology".

The Discharge Summary in respect of the plaintiff's admission and treatment in the hospital between the 30th December, 1999, and the 11th January, 2000, recorded only the dates of her admission and discharge, the identity of her consultant (Dr. Long) and her "Complaint ", (identified as "U.C." (Ulcerative Colitis)- exacerbation diarrhoea weight loss abdominal U. C) Her "Investigations/Treatments" were recorded as "- seen by Dietician and a Social Worker re her ulcerative colitis". The medications which she had been prescribed were then listed.

The document was signed by a junior doctor on the date of discharge. A box on the document beside the words "A further report will follow…" was ticked in the affirmative. No report was submitted to the general practitioner. Dr. Long agreed that "…the G.P. needed a lot of information about that. Getting a Discharge Summary like that would not seem satisfactory…" He said that he submitted no further report because of an agreement with general practitioners within the area which discouraged the submission of additional information from consultants to general practitioners.

He said that before the introduction of this document by the hospital, "We used to dictate a discharge summary…" Referring to the documents completed in respect of the plaintiff he said"...these were introduced following discussion with the G.P.'s because they felt they were getting too much information and what they wanted to know was how long the patient was in, under whose care they were, their presented complaint, the diagnoses, investigations and operations and their meds (sic) and discharge and what follow-up arrangements."

He continued "I agree this is unsatisfactory in terms of the amount of information but this was by agreement with the G.P.'s in the area."

When asked when by Mr. Bradley whether or not the arrangement "seems to leave the G.P. in the dark" he replied "well it may well do but we did this because this was what they wanted. They said this was the information they needed."

He acknowledged that he should have consulted the hospital notes which recorded the plaintiff's admission to hospital on the 29th April, 2000, and her treatment in the hospital thereafter. He agreed that if he had adopted appropriate medical practice at that time and consulted the hospital notes and the Discharge Summary he would have discovered that Difene had been wrongly prescribed for the plaintiff and he would have countermanded that prescription

He wrote to the plaintiff's general practitioner by letters dated the 27th January, 2000, the 17th February, 2000, the 2nd March, 2000 and the 30th March, 2000.

In each letter he referred to the plaintiff's condition as "Crohn's". He advised that her condition was improving and that he had reduced the level of steroids required for her treatment. A number of hospital documents and notes referred to the plaintiff's condition as "Crohn's" or "Crohn's disease".

It was acknowledged by Dr. Long that the plaintiff never suffered from Crohn's disease and that the constant references to that disease associated with the plaintiff were misleading and could in particular circumstances, have had serious implications for the plaintiff's health.

4. Professor Dermot Kelleher, who is a physician and a Consultant Gastroenterologist attached to St. James' Hospital and a Professor of Clinical Medicine in Trinity College Dublin testified on behalf of the defendants. It was his opinion that, in general, the treatment provided for the plaintiff was "entirely standard treatment for acute exacerbation of ulcerative colitis" and was accordingly, appropriate in the circumstances.

He said the events which resulted in the perforation of the plaintiff's colon and her consequent admission to hospital on the 9th May, 2000, occurred subsequent to her discharge from hospital on the 2nd May, 2000. He said that those events could not reasonably have been predicted because the abdominal x-rays taken during her confinement in hospital did not disclose evidence of toxic dilatation.

It was his opinion that the social embarrassment associated with ulcerative colitis was of considerable significance and should be taken into account in the management and treatment of the condition.

He said that Difene is a drug which is "best avoided in inflammatory bowel diseas, and only used with caution. It is not particularly

effective for abdominal pain and it is not the best agent to use in the circumstances".

He said it would have been preferable if the plaintiff had been seen by a consultant whilst she was in hospital between the 29th April and the 2nd May, 2000. A consultant would probably have prevented the prescription of Difene for the plaintiff. It was not appropriate to prescribe that drug for her.

He said that the advice given to the plaintiff's mother on the evening of the 8th May, 2000, by a nurse or "Sister-in Charge" within the Casualty Department of the hospital was "an inappropriate response … if somebody with colitis phones up they should be put on to a doctor, I would say to discuss the case and certainly not be told to take two Paracetamol".

He said that the sooner surgery is performed after a perforation the better the end result will be for the patient. It was his opinion that the perforation of the plaintiff's colon occurred "the day before admission, based on the fact of severe pain at that time".

5. Mr. Paul Durdey who is a surgeon and who has been appointed to the United Bristol Healthcare Trust as a Consultant in Gastrointestinal Surgery with a special interest and expertise in the treatment and management of inflammatory bowel disease also testified on behalf of the defendants.

In summary, it was his opinion that the management and treatment of the plaintiff whilst she was under the care of Dr. Long was, in general, consistent with general and approved medical practice in 2000 and was appropriate and reasonable in the circumstances.

Asked for his "considered opinion" as to the timing of the occurrence of the perforation he said "on the evidence I have available, I would say it occurred when Ms. Myles felt the popping sensation in her abdomen." This occurred at approximately 10 a.m. on the morning of the 9th May when the plaintiff felt a sensation which she called "an explosion" and "popping sensation" followed by a feeling of well-being and relief.

He says "that would be indicative, in my experience, of the perforation having occurred at that time. Patients who have perforation of the intra-abdominal organ can normally time it to the second it happens. The most common situation is where patients perforate a peptic ulcer and they describe as though they have been punched in the stomach or kicked in the stomach. It is the same with any perforation that you have and particularly in a toxic megacolon, you have a very inflamed, tender, distended bowel and when it goes pop it actually relieves itself. So a patient often feels remarkably better for a period of some hours afterwards, after the perforation has occurred, because the colon is deflated and has taken the pressure off, but then of course the faecal material leaking into the abdominal cavity causes the onset of bacterial peritonitis."

He agreed that if the plaintiff had been admitted to the hospital immediately after her mother's telephone call to the hospital on the night of the 8th May, 2000, the perforation probably would not have occurred. He said that if the perforation had, in fact, occurred before the plaintiff went into hospital, then on the balance of probabilities the complications from which she suffered would have occurred in any event.

6. Dr. Luke O'Donnell who is a Consultant Physician and Gastroenterologist attached to the Mayo General Hospital also testified on behalf of the defendants.

In summary, it was his opinion that the care provided by Dr. Long to the plaintiff in respect of her condition was of a high standard and commensurate with general and approved medical practice in 2000. He said that the plaintiff received appropriate therapy during the several acute exacerbations of her colitis and during her admissions to hospital whilst under the care of Dr. Long. He said there was no evidence of an imminent risk of a perforation of the plaintiff's colon at the time when she was discharged from hospital by Dr. Long on the 2nd May, 2000.

It was his opinion that "the moment of the perforation" was the moment when the plaintiff suffered "excruciating pain" on the morning of the 9th May and felt a sensation "like an explosion …" and "felt something pop inside me and …I said … 'something is after popping'…and all this black stuff and blood started coming out … and … I started throwing up all this black stuff and blood as well." He said that when a perforation occurs "it is just like the dam bursts and is instantaneous".

Although he agreed that Difene should not be prescribed because "there is a risk that it can exacerbate colitis", it was his opinion that the chance that Difene had made the plaintiff's colitis worse between the 2nd of May and the 9th of May was "slim" because Difene had been prescribed and ingested by the plaintiff for more than a month after February, 2000 without causing exacerbation of her colitis.

He agreed that if the plaintiff's mother telephoned the Casualty Department of the hospital on the evening of the 8th May and explained her history, condition and symptoms to the person who answered her call then she should have been advised either to contact her general practitioner or to come to the hospital immediately if there was a doctor to see her.

The Law

The principles which apply to claims for damages for injury, loss or damage allegedly sustained by reason of negligence by professional persons in the conduct and discharge of their professional duties and obligations have been identified by the Supreme Court in *Dunne v. National Maternity Hospital* [1989] I.R. 91 where Finlay C.J stated at p.109 that:-

> "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.

6. If there is an issue of fact, the determination of which is necessary for the decision as to whether a particular medical practice is or is not general and approved within the meaning of these principles, that issue must in a trial held with a jury be left to the determination of the jury. In order to make these general principles readily applicable to the facts of this case, with which I will later be dealing, it is necessary to state further conclusions not expressly referred to in the cases above mentioned. These are:

(a) "General and approved practice" need not be universal but must be approved of and adhered to by a substantial number of reputable practitioners holding the relevant specialist or general qualifications.

(b) Though treatment only is referred to in some of these statements of principle, they must apply in identical fashion to questions of diagnosis.

(c) In an action against a hospital, where allegations are made of negligence against the medical administrators on the basis of a claim that practices and procedures laid down by them for the carrying out of treatment or diagnosis by medical or nursing staff were defective, their conduct is to be tested in accordance with the legal principles which would apply if they had personally carried out such treatment or diagnosis in accordance with such practice or procedure.

In order fully to understand these principles and their application to any particular set of facts, it is, I believe, helpful to set out certain broad parameters which would appear to underline their establishment. The development of medical science and the supreme importance of that development to humanity makes it particularly undesirable and inconsistent with the common good that doctors should be obliged to carry out their professional duties under frequent threat of unsustainable legal claims. The complete dependence of patients on the skill and care of their medical attendants and the gravity from their point of view of a failure in such care, makes it undesirable and unjustifiable to accept as a matter of law a lax or permissive standard of care for the purpose of assessing what is and is not medical negligence. In developing the legal principles outlined and in applying them to the facts of each individual case, the courts must constantly seek to give equal regard to both of these considerations."

Issues
The issues for determination in this case can be summarised as follows:

1. Did Dr. Long, or the hospital, or both, fail to manage and treat the plaintiff's colitis with the care and skill required of a medical practitioner (or hospital), of equal status and specialist skills?

2 If Dr. Long, (or the hospital), or both were guilty of negligence or the breach of a duty owed to the plaintiff, did that negligence or breach of duty cause injury, loss or damage to the plaintiff?

3. If so, what was the extent of the injury, loss or damage sustained by the plaintiff and;

4. If the plaintiff has suffered injury, loss or damage by reason of negligence on the part of Dr. Long or the hospital then how much by way of damages is she entitled to recover from Dr. Long or the hospital, (or both)?

Findings
1. The expert witnesses who testified agreed that investigation by colonoscopy should have been undertaken at an early stage in the management of the plaintiff's colitis. However, Dr. Long correctly diagnosed the plaintiff's ulcerative colitis and it was not established in evidence that a colonoscopy would have provided Dr. Long or the hospital with more relevant or important information than what was, in fact, discovered by clinical examination.

It has not been established on behalf of the plaintiff that any other investigative measure adopted by Dr. Long would have provided him with significant medical information relevant to the plaintiff's condition or alerted the defendants to the risks of an impending perforation of the plaintiff's colon.

The plaintiff's condition was recorded in clinical and hospital notes and documents as "Crohn's" and "Crohn's disease". It was acknowledged in evidence by Dr. Long that the plaintiff never suffered from Crohn's disease and that the constant references to that disease which appeared in correspondence and in the hospital notes and documents were mistaken and could, in other circumstances, have had serious implications for the plaintiff's health.

However, it was established on the evidence that Crohn's disease is similar to ulcerative colitis and that Dr. Long was at all times aware of the fact that the plaintiff was suffering from ulcerative colitis and not from Crohn's disease. Accordingly, whilst the constant misdescription of the plaintiff's medical condition was careless, potentially dangerous, and therefore negligent, it did not cause or contribute to the perforation of the plaintiff's colon in May of 2000.

It has not, therefore, been established on the evidence and on the balance of probability that Dr. Long or the hospital failed to adopt any appropriate or proper investigative measure which would have; (a) helped to establish the extent and severity of the plaintiff's colitis and (b) consequently reduced or eliminated the risk of a perforation of her colon.

There was a consensus amongst the expert medical witnesses that the initial management and treatment of the plaintiff's colitis by

the prescription of Prednisolone and Dipentum was correct and appropriate and in accordance with proper medical practice at the material time. They were also in agreement that by January, 2000 it had become clear that the plaintiff had become steroid-dependent and that her continued treatment by the prescription of Prednisolone and Dipentum was questionable.

In evidence, Dr. Long said that, in January, 2000 he had decided to make "one last attempt" to manage and treat the plaintiff's colitis by the combined prescription of corticosteroids and Dipentum. He said that it was his intention to discuss with the plaintiff the possibility of treatment by elective surgery if his "last attempt" was unsuccessful. That decision, although unrecorded, was a clinical decision made by an appropriately qualified consultant physician and cannot be categorised as a decision that no consultant physician of like status, specialisation and skill would have followed taking the ordinary care required from such a consultant physician.

The plaintiff has, therefore, failed to establish that Dr. Long was negligent or in breach of a duty owed to the plaintiff by continuing to treat and manage her colitis by the prescription of Prednisolone and Dipentum between January, 2000 and the 29th April, 2000.

It has been established on the evidence that the management and treatment of the plaintiff's colitis by, (and on behalf of), Dr. Long on the 20th and 21st December, 1999, fell short of the standard of care required of a medical practitioner of Dr. Long's status and specialist skills.

I am satisfied on the evidence that when the plaintiff attended the hospital on the 20th December, 1999, she was extremely ill and required immediate admission to hospital and treatment for the very severe pain, distress, discomfort and debilitating symptoms from which she was suffering. That fact had been recognised by the plaintiff's general practitioner, Dr. Ward, who was very concerned by her condition and distress. She provided the plaintiff with a letter recommending admission to hospital.

On successive days, (20th and 21st December, 1999), the plaintiff was examined in the hospital, (by Dr. Lobo and by Dr. Long respectively). Contrary to appropriate, proper and approved medical practice she was not admitted to hospital on either occasion but was simply prescribed an increased level of steroidal medication and advised to return home.

In consequence, she suffered severe pain, distress and symptoms causing her acute misery for approximately nine days, during which her condition deteriorated dangerously.

Whilst the ulcerative colitis from which the plaintiff suffered was likely to have caused her distressing and unpleasant symptoms from time to time, it is undeniable on the evidence that the failure by Dr. Long and by Dr. Lobo to adequately and properly manage the plaintiff's colitis at that time and to provide her with appropriate care, attention and treatment caused the plaintiff unnecessary and untold additional hardship, pain, discomfort and misery which resulted directly from negligence and breach of duty on the part of Dr. Long and the hospital.

I accept the unchallenged evidence of Dr. Andrew Neale that the proper management and treatment of ulcerative colitis in a 15 year old child requires constant communication and consultation with the child and with her family during the management and treatment of the disease. I accept also the unchallenged evidence of Dr. Dermot Kelleher that social embarrassment associated with ulcerative colitis is of considerable significance and should be taken carefully into account in the management and treatment of the condition.

Dr. Long stated in evidence that he was well intentioned towards the plaintiff and her family and was under the impression that he was communicating adequately with the plaintiff. However, on the evidence there was a serious failure in communication and consultation between Dr. Long and the plaintiff and between Dr Long and the plaintiff's family in relation to the management and treatment of the plaintiff's colitis.

I am satisfied that this failure of communication and consultation was grave and significant and can be categorised as a failure which should not be expected of a consultant physician of Dr. Long's status and specialist skills. I accept the evidence of Dr. Neale that communication and consultation with the plaintiff and her family was essential to the management and treatment of the plaintiff's colitis. I accept also his evidence that common sense dictates the importance of such consultation and communication and the overriding requirement that the pain, distress, embarrassment, humiliation and misery of a child with ulcerative colitis should be reduced to the lowest possible level.

I am satisfied on the evidence that Dr. Long and the hospital repeatedly failed in their obligation to communicate and consult with the plaintiff and her family during the management and treatment of the plaintiff's colitis and that in doing so they were guilty of negligence and breach of the duty of care owed by them to the plaintiff. This negligence and breach of duty caused a severe deterioration in the quality of the plaintiff's life and lifestyle and caused her to discontinue her education and to suffer extremely inappropriate and unnecessary distress, embarrassment, humiliation, upset and misery.

More importantly, it was established on the evidence that the level of communication between the defendants and the plaintiff and her parents should have been sufficient to encourage the plaintiff and her parents to report significant changes in the nature and level of the plaintiff's symptoms to the defendants without delay. On the evidence, the plaintiff and her parents were made to feel uncomfortable about such reporting and were, accordingly, discouraged from doing so. This had significant consequences for the plaintiff.

It was established in evidence that Dr. Long was not on duty in the hospital during the three-day period between the 29th April and the1st May, 2000, which was a Bank Holiday weekend. It was, however, acknowledged by Dr. Long and by the other expert medical witnesses that it was necessary in the interests of the proper and appropriate management and treatment of the plaintiff's disease and the very severe symptoms from which she was suffering that she should be investigated by a physician at consultant level. This was not done at any time whilst the plaintiff was in hospital, (until her discharge by Dr. Long on the 2nd May, 2000).

It was also candidly acknowledged by Dr. Long and by the expert medical witnesses who testified in these proceedings that this failure comprised a serious departure from the medical standards required for the proper treatment of patients with colitis. I am satisfied on the evidence that it was the responsibility of the hospital to take reasonable steps to ensure that appropriately qualified medical practitioners are available to treat patients who are admitted to the hospital in emergency circumstances of the kind that gave rise to the plaintiff's admission on the 29th April. The hospital failed to do so.

I am, accordingly, satisfied on the evidence that by failing to provide the plaintiff with the services of an appropriately qualified consultant physician or surgeon whilst she was a patient in the hospital between the 29th April, 2000 and 2nd May, 2000, the hospital failed to manage and treat the plaintiff's colitis with the level of care and skill commensurate with the hospital's resources, status and responsibilities.

Dr. Long was negligent and in breach of his duty to the plaintiff by failing to consult the hospital documentation and to adequately monitor the medication which had been prescribed for the plaintiff and in particular to note that Difene which had been prescribed for the plaintiff and to cancel or otherwise discontinue its prescription. The hospital departed from general and approved medical practice in the management of the plaintiff's colitis by causing or permitting the prescription of Difene for the plaintiff while she was in hospital between the 29th April and 2nd May, 2000 and after her discharge from the hospital on the 2nd May, 2000.

Difene was prescribed as a form of treatment for the plaintiff's colitis during February, 2000. It has not been established on the evidence as a matter of probability that it was necessarily Dr. Long who prescribed Difene on behalf of the plaintiff. It might have been a junior doctor within the hospital, or the plaintiff's general practitioner.

It has, however, been established on the evidence that Difene should not have been prescribed as a form of treatment for the plaintiff's colitis because it is a drug which is linked to ulceration of the colon and is therefore quite inappropriate by way of medication for a person suffering from ulcerative colitis.

Accordingly, by prescribing Difene for the treatment of the plaintiff during her admission to hospital on the 29th April, 2000, the hospital, through its medical staff, departed significantly from appropriate and approved medical practice for the management and treatment of ulcerative colitis and was, accordingly, negligent and in breach of its duty to the plaintiff.

However, whilst it has been established on the evidence that Difene is an inappropriate form of medication for the treatment of colitis and is a potential contributory factor in the development of colon perforation, it has not been established on the balance of probabilities that the Difene prescribed as treatment for the plaintiff's colitis in April and May, 2000 directly caused the perforation of her colon less than a week later.

The evidence has also established that the appropriate management of the plaintiff's colitis on the 2nd May, 2000, required that she should have been advised, on discharge from the hospital, to immediately contact the hospital in order to seek admission if her condition deteriorated in the days following her discharge. Tests had disclosed that, whilst in hospital, her platelet levels and white blood cell count were excessively high. She had continued to require medication to control severe pain throughout her confinement in hospital and was discharged on the 2nd May. Dr. Long failed in his obligation to give that advice to the plaintiff and to members of the plaintiff's family. No other consultant examined the plaintiff whilst she was in the hospital on that occasion.

It has been clearly established in evidence that the plaintiff's mother was given wholly inappropriate and improper advice at approximately 11.30 p.m. on the night of the 8th May, 2000, when she telephoned the hospital in distress and desperation, seeking assistance and advice in relation to the plaintiff's deteriorating condition.

I accept, without qualification, the evidence of the plaintiff's mother and of the plaintiff herself in relation to the telephone call made by the plaintiff's mother to the hospital on the night of the 8th May, 2000. The evidence adduced in these proceedings has consistently and repeatedly disclosed the proximity of the relationship between the plaintiff and her mother and the constant and meticulous care, support and attention provided for the plaintiff by her mother. The evidence adduced disclosed an increasing level of concern and worry by the plaintiff's mother in respect of her daughter's deteriorating condition and a failure by Dr. Long and the hospital to address that concern and worry.

The decision, by the plaintiff's mother, to telephone the hospital at approximately 11.30 p.m. on the night of the 8th May, 2000, was understandable having regard to the plaintiff's deteriorating condition and symptoms. It was a decision consistent with an increasing level of worry, concern and indeed, desperation on the part of the plaintiff and her mother.

Evidence was adduced on behalf of the hospital by three nurses who were employed in the hospital in April and May of 2000. The evidence adduced comprised the production of hospital records indicating that the three nurses who testified were on duty in the casualty department of the hospital on the night of the 8th May, 2000.

Unsurprisingly, none of the nurses recalled a telephone call made by the plaintiff's mother to the hospital on the night of the 8th May, 2000.

Each of the nurses stated that it would be wholly improper and inappropriate for a nurse on duty in the hospital at the time in question to have given advice to the plaintiff's mother of the kind which she said she received. Each nurse said that, in the circumstances outlined by the plaintiff's mother, an appropriately trained and qualified nurse should have advised that the plaintiff should be brought to the hospital for admission or to her general practitioner urgently and immediately.

Each nurse agreed that advice of the kind received by the plaintiff's mother, if offered, would have been contrary to the proper and appropriate nursing and medical practice at the material time. Each agreed that if they had received the telephone call described by the plaintiff's mother, they would definitely have advised the plaintiff either to come to the hospital for immediate admission and treatment or to immediately take the plaintiff to her general practitioner for urgent attention and treatment.

It is not possible for this Court to establish; (a) whether the hospital's records for the night of 8th May, 2000 are accurate, (b) if the nurses who testified in these proceedings were the only persons who could have answered the telephone in the casualty department of the hospital on the night of the 8th May, 2000, or (c) if one of the nurses who testified did in fact answer the telephone and give the plaintiff's mother advice on the 8th May, 2000.

It is, however, possible for this Court to be satisfied on the evidence and on the balance of probabilities that the plaintiff's mother did in fact telephone the hospital and did in fact provide the person to whom she spoke with details of the plaintiff's medical history and her alarmingly deteriorating condition and symptoms. This Court is so satisfied.

It is also possible for this Court to be satisfied on the evidence and on the balance of probabilities that, if the plaintiff's mother was advised by the hospital on the night in question to bring her daughter to the hospital for immediate admission or to take her daughter to her general practitioner for immediate treatment, the plaintiff's mother would unquestionably have taken that advice and followed the course suggested.

I am satisfied on the evidence and on the balance of probabilities that the plaintiff's mother; (a) did in fact telephone the hospital when she said she did, (b) was not advised to bring the plaintiff for immediate admission to hospital or to take the plaintiff to her general practitioner, and (c) took the advice which she was given on the telephone which was to give her daughter two Paracetamol tablets and to contact her general practitioner on the following morning.

It follows from the evidence of every medical witness who testified in these proceedings that the person who answered the telephone in the casualty department of the hospital on the night of the 8th May, 2000 departed radically from general and approved medical practice; (a) in giving the advice which was given to the plaintiff's mother and (b), in failing to advise the plaintiff's mother; (i) to bring the plaintiff immediately to the casualty department of the hospital for admission or, (ii) to bring the plaintiff to a properly qualified medical practitioner without delay for immediate investigation and treatment.

It follows further that the failure by the hospital and its staff to provide the plaintiff and her mother with proper and appropriate medical advice on the night of the 8th May, 2000, comprised clear and serious negligence by the hospital and a breach by the hospital of its duty to provide proper advice, care, management and treatment to the plaintiff in respect of her ulcerative colitis.

Causation
I have found that Dr. Long and the hospital failed, on a number of occasions and in a number of respects, to manage and treat the plaintiff's colitis with the care and skill required of a medical practitioner and a hospital of the status and specialist skills enjoyed by Dr. Long and by the hospital.

On some of those occasions the plaintiff was subjected to greater levels of distress, humiliation, degradation, discomfort and misery than would have been the case if her colitis had been managed and treated by the application of general and approved management and treatment methods. They were incidents of negligence and breach of duty which had discrete and temporary consequences for the plaintiff.

However the most important question for determination by this Court is whether negligence and breach of duty on the part of Dr. Long or the hospital, or both, caused or contributed to the perforation of the plaintiff's colon and the dreadful consequences which that event had for the plaintiff's health and welfare.

Although there was considerable discussion within these proceedings relative to the prescription of Difene and Buscopan for the plaintiff in the management and treatment of the plaintiff's colitis and it was established in evidence, that Difene should not have been prescribed for the plaintiff because of its link with ulceration of the colon, it was not established on the balance of probabilities that the prescription of Difene either in February, 2000 or during and after her admission to hospital on the 29th April, 2000 directly caused the perforation of the plaintiff's colon approximately a week later.

Similarly, whilst Dr. Neale disapproved of the prescription of Buscopan because it masked potentially significant symptoms associated with ulcerative colitis it was not established in evidence that the prescription of Buscopan was centrally relevant to the perforation of the plaintiff's colon in May, 2000.

Although an x-ray of the plaintiff's colon undertaken after the plaintiff's admission to hospital on the 29th April, 2000, disclosed no evidence of a megacolon, the evidence has established that the prediction of the onset of peritonitis is known to be difficult and that a patient, such as the plaintiff, who is suffering from ulcerative colitis and has had a history of the exacerbation of that condition, must be monitored carefully and consistently in order to reduce the risk of a colon perforation. For that reason they must be warned to report deterioration in their condition or an increase in the level of pain or other symptoms so that they can be investigated expeditiously.

I have found that Dr Long and the hospital were negligent because, when discharging the plaintiff from hospital on the 2nd May, 2000, they did not advise her to immediately contact the hospital to seek admission in the event of an exacerbation of her colitis.

I am satisfied that if that warning had been administered to the plaintiff or to her mother then, as a matter of probability, the plaintiff or her mother would have contacted the hospital at or before the time when her pain level reached what was described by Dr. Neale as "this crescendo of pain during the afternoon and evening of the day before she was admitted to hospital".

Central to the issue of causation in this case is the time at which the plaintiff's colon perforated.

Dr. Neale was unwilling to give an authoritative opinion in relation to the time of perforation. When pressed by Mr. McGrath S.C., he said that he thought that it might have occurred "about 24 hours before the operation at the time when Ms. Myles suffered this crescendo of pain during the afternoon and evening of the day before she was admitted to hospital".

Professor Alexander Williams was of the opinion that the perforation could have occurred within 28 or 48 hours prior to the surgery performed by Ms. Mulcahy on the 9th May.

Professor Dermot Kelleher was of the opinion that the perforation occurred "the day before admission, based on the fact of severe pain at the time".

Mr. Paul Durdey believed that the perforation occurred "when Ms. Myles felt the popping sensation in her abdomen" at approximately 10.00 a.m. on the morning of the 9th May. He gave detailed reasons why he had reached that conclusion.

Dr. Luke O'Donnell was also of the opinion that the "moment of the perforation" was at 10.00 a.m. on the morning of the 9th May, when the plaintiff felt a sensation "like an explosion" and "felt something pop inside me …".

Mr. Joseph Deasy also believed that the "time of the perforation" was approximately 10.30 a.m. on the morning when the plaintiff felt what she described as "an explosion" or "popping sensation" followed by vomiting and the release of black liquid material from her body.

Ms. Ursula Mulcahy thought that the peritonitis might have occurred "somewhere in the region of 24 hours" before surgery. She said that it "…wasn't a question of perforating and then being rushed straight to theatre. It looked as though the perforation had been going for some time. If you were trying to pin me down to a precise time … I'm afraid I couldn't …"

When asked whether the perforation occurred when the plaintiff experienced the sensation of an "explosion" and the "popping" sensation, she replied "It could be, yes".

I accept without qualification her evidence that "The sooner you get a perforation operated on, the better the outlook and the less adhesions you are likely to get afterwards …they couldn't do a pouch because of the adhesions and I don't think anybody could give you a definite answer but there probably would have been fewer adhesions if she had been operated on earlier".

It is undeniable that at approximately 10.00 a.m. on the morning of the 9th May, 2000, the plaintiff underwent a sudden acute medical event. Dr O'Neill was immediately summoned. He found that her condition was so grave that she was close to death.

It is also undeniable that if the plaintiff had been admitted to the hospital on the night of the 8th May, 2000, (as she should have been), and investigated and treated appropriately, the sudden acute event which occurred at 10 a.m. on the morning of the 9th May, 2000, would not have occurred.

I am satisfied on the evidence of Ms. Mulcahy, Mr. Deasy, Mr. Paul Durdey, and Dr. Luke O'Donnell that, whilst the process of perforation may have commenced during the afternoon or evening of the 8th May, 2000, it is probable that the plaintiff developed a toxic megacolon which perforated or "burst" at approximately 10.00 a.m. on the morning of the 9th May, 2000.

The process resulting in perforation caused a gradual deterioration in her condition and increase in the level and severity of her symptoms. The "precise moment of perforation" was probably the moment at approximately 10.00 a.m. on the morning of the 9th May, when the plaintiff felt the "explosion" and a "popping sensation" which had such immediate, unpleasant and grave consequences for her. In either event, if the plaintiff and her immediate family had been advised, (as they should have been), to immediately contact the hospital if her condition deteriorated, it is probable that her mother would have done so at the commencement of the process which resulted in perforation.

It was alleged on behalf of the plaintiff that Mr. Long should not have discharged the plaintiff from hospital on the 2nd May, 2000, because of her condition and symptoms.

There was a difference of medical opinion on this issue. And accordingly, it has not been established on behalf of the plaintiff that Dr. Long was negligent or in breach of duty by discharging the plaintiff from the hospital when he did so.

However the evidence adduced in this case has established that, having regards to; (i) her medical history, (ii) her white cell and platelet levels and (iii) her ongoing symptoms, both she and her family should have been advised to contact the hospital in order to seek admission if her condition deteriorated in the days following her discharge. Had she done so then, it is probable that the plaintiff would have been admitted to hospital and properly investigated more than 24 hours before she was in fact admitted to hospital. It follows that if general and approved medical practice had been followed in the management and treatment of the plaintiff's colitis then she would have been admitted to the hospital at least 24 hours before she was in fact admitted and surgery would have been undertaken at least 24 hours before it was in fact undertaken.

It is possible that some perforation or leakage might have occurred before her admission and before surgery could be undertaken and I am conscious of the evidence of Ms. Mulcahy which established that even the commencement of a perforation which results in the leakage of a faecal material is likely to cause permanent damage. However, as I have already indicated I accept without qualification Ms. Mulcahy's evidence that "the sooner you get a perforation operated on, the better the outlook and the less adhesions you are likely to get afterwards.... they couldn't do a pouch because of the adhesions and I don't think anybody could give you a definite answer but there probably would have been fewer adhesions if she had been operated on earlier."

It is probable that if the plaintiff suffered some permanent damage and adhesions resulting from early leakage, the damage and the resultant adhesions would have been reduced to a minimum and it is probable that septic complications would have been reduced considerably, if not eliminated and she would not have suffered thrombosis.

It is probable also that, in that event, it would have been possible for the plaintiff to undergo two further operations to complete an ileal anal anastomosis. This would have provided her with normal continuity of gastrointestinal tract with no stoma.

It has been established on the evidence that even if the plaintiff's colitis had been managed and treated properly and appropriately and in accordance with general and approved medical practice, the quality of her life would nonetheless have been significantly reduced because of the nature of ulcerative colitis.

However, because her disease was not properly managed and treated she suffered distress, humiliation, degradation, pain and discomfort on a number of discrete occasions and finally she suffered a near catastrophic perforation of her colon. These events were caused by negligence and breach of duty on the part of Dr. Long and on the part of the hospital.

Mr. McGrath S.C. requested that, in the event of findings of negligence, I should apportion degrees of fault as between Dr. Long and the hospital. No reliable scientific evidence is available which would enable me to measure levels of fault in the manner requested.

I am satisfied that failure in communication and consultation between Dr. Long and the plaintiff and her family was attributable to Dr. Long's negligence.

Similarly I am satisfied that the pain, distress and other symptoms from which the plaintiff suffered between the 20th December and the 31st December, can be attributed to Dr. Long's negligence.

I am also satisfied that the failure to advise the plaintiff and her family on the 2nd May, 2000, that the hospital should be contacted immediately in the event of a deterioration in the plaintiff's condition and symptoms can be attributed to Dr. Long's negligence. That failure was of significance in relation to the perforation of the plaintiff's colon.

However, I am satisfied on the evidence and on the balance of probabilities that the most serious breach of duty which has been established in these proceedings has been the failure by the hospital to give proper and appropriate advice to the plaintiff's mother when she telephoned the hospital at 11.30 p.m. on the night of the 8th May, 2000, seeking urgent assistance for her daughter.

Insofar as I can apportion fault, I would attribute 35% to Dr. Long in respect of the incidents to which I have already referred to and in respect of his failure to administer an adequate warning to the plaintiff and her family on the 2nd May, 2000. I would apportion 65% of fault to the hospital for the reasons for which I have outlined.

As I have indicated the apportionment which I have made has not been based upon any particular scientifically reliable evidence. In short it is rudimentary in nature and the best that I can do in the circumstances.

Damages
As I have already indicated, the nature of the ulcerative colitis from which the plaintiff suffers decreed that the quality of her life would have been significantly diminished by reason of the disease from which she suffers.

However by reason of the negligence and breach of duty of Dr. Long and the hospital she has additionally suffered; (a) serious and unnecessary distress, embarrassment, humiliation, upset and degradation which caused her to discontinue her education, (b) excessive and severe pain, distress and other unpleasant symptoms which caused her condition to deteriorate dangerously between the 20th December and the 30th December, 1999, and (c) a toxic megacolon which perforated or "burst" at approximately 10 a.m. on the morning of the 9th May, 2000.

The development and perforation of the toxic megacolon had appalling consequences for the plaintiff. These have been fully outlined earlier. If her colitis had been properly and adequately managed and treated she would have been admitted to hospital at least 24 hours before she was in fact admitted and the toxic megacolon would not have perforated. Surgery would have been performed before the perforation and would have been far less extensive than what was required to be performed by Ms Mulcahy. The majority of the complications, infections, intestinal fistulae, chronic adhesions and other dreadful consequences which the plaintiff suffered would have been avoided.

It is also unlikely that she would have developed and suffered from such a large number of related conditions including pulmonary emboli, MRSA, rectal symptoms, breathing problems, urinary incontinence and the other complaints and conditions described earlier.

She would probably not have had to endure two separate surgical attempts to form an ileal pouch and two surgical failures. She would probably not have to live the remainder of her life relying upon a permanent ileostomy.

She would not have had to suffer extremely disfiguring scarring which causes her such embarrassment. She would probably not have had to face the prospect of a life without a satisfactory personal or sexual relationship and a poor prognosis for childbearing.

She would not have suffered from post-traumatic stress disorder and require ongoing treatment by way of psychotherapy and pharmacotherapy.

She would probably have completed her Leaving Certificate and have pursued a career in computer skills enabling to her to obtain full time employment at her chosen occupational career.

It is difficult to assess the level of general damages which should be awarded to the plaintiff to compensate her for what she has endured during the past seven years by reason of the negligence and the breach of duty of the defendants. She was seventeen years old or thereabouts when most of these events occurred. Her life had already been blighted by a serious and distressing disease. She faced the prospect of surgery at an early date comprising a total colectomy leaving the rectal stump. She would have required two further operations to complete an ileal anal anastomosis to provide her with normal continuity of gastrointestinal tract with no stoma.

However her disease could have been managed and treated effectively on an ongoing basis and she could have lead a more or less normal life, married and have borne children if she had so wished. She now faces further "daunting" surgery for the removal of her rectal stump and the many disadvantages which have already been outlined in detail.

The plaintiff is entitled to damages to compensate her for the events which caused her such distress in 1999 and resulted in her discontinuing her education.

She is also entitled to damages to compensate her for the pain, discomfort and other unpleasant symptoms which she suffered between the 20th December, 1999 and the 30th December, 1999.

She is entitled to damages to compensate her for the increased pain, distress, surgery, infection, disease, psychological damage and constant admissions to hospital which has characterised her life for most of the period of seven years which has elapsed since the events of May, 2000.

Even if her disease had been properly and appropriately managed and treated, the plaintiff's colitis would have comprised a very serious and ongoing blemish upon her life and would have significantly diminished the quality of her life. For that reason the additional injuries which she has now suffered can be categorised as catastrophic.

In *Sinnott v. Quinnsworth Limited* [1984] I.L.R.M. 523 the Supreme Court (O'Higgins C.J.), reduced a jury award of IR£800,000 for general damages to IR£150,000. The plaintiff was a young man who had suffered injuries in a road traffic accident which left him paraplegic.

O'Higgins C.J. observed, (at pp 531to 532), that "In my view, unless there are particular circumstances which suggest otherwise, general damages, in a case of this nature, should not exceed a sum in the region of £150,000. I express that view, having regard to contemporary standards and money values and I am conscious that there may be changes and alterations in the future, as there have been in the past."

Contemporary standards may well require to be reconsidered in the light of the recent decision of the Supreme Court (Hardiman J.) in *Shortt v.Commissioner of An Garda Siochana* [2007] I.E.S.C. 9. However, no evidence of contemporary standards was adduced in these proceedings and no detailed argument on that issue was advanced on behalf of either party.

The appropriate "cap" on the level of general damages for very serious or "catastrophic" injuries has been reconsidered on a number of occasions since 1986

In *Kealy v. Minister for Health* [1999] 2 I.R. 456, the High Court (Morris P.) awarded general damages of IR£250,000 to a 44 year old lady who suffered from Hepatitis because she had been injected with a contaminated vaccine. Her condition had caused her very significant symptoms including the substantial risk of a liver transplant. She had a 15% to 20% prospect of cirrhosis developing in the transplant. Morris. P. observed (at p.458 of his judgment) that the "cap" on general damages imposed by the Supreme Court in *Sinnott* had "only limited relevance to an award of this type."

In assessing general damages for very serious or catastrophic injuries, the courts have been careful to take into account a number of factors including; (a) the fact that the catastrophic nature of the injuries may be such that no award of damages will be adequate to compensate the injured plaintiff, (b) that in awarding general damages the court should attempt to take a detached and objective approach and consider the full award on a "global" basis, taking into account any additional awards of damages to the plaintiff including sums to compensate for past and future care, past and future loss of earnings and other special damages and (c) that there should be no punitive element in the award of general damages, (punitive or exemplary damages may be sought separately in the

limited number of special cases).

Taking those factors into account and applying the principles identified by the Supreme Court in *Sinnott v. Quinnsworth Limited* (supra) and other more recent authorities, and applying contemporary standards as best I can, I would assess at €125,000 the general damages which the plaintiff is entitled to recover from the defendants for what she has suffered between 1999 and the date of trial.

Applying the same principles and factors in respect of the general damages which the plaintiff is entitled to recover from the defendants to compensate her for the ongoing pain, suffering, distress, surgery, and psychological injury which she will suffer for the remainder of her life I would assess the damages to which she is entitled at €175,000.

In respect of loss of earnings from September, 2003 (when the plaintiffs would have expected to commence full time employment), to the date of trial, I am satisfied on the evidence and on the balance of probabilities that the difference between what she has earned during that period and what she might reasonably have expected to earn had she not endured what she has had to endure is of the order of €25,000 and I will award her that sum.

In respect of loss of earnings into the future I have, in line with the principles identified by the courts in that regard, been assisted by the actuarial evidence adduced in the case as a guide and not as a precise calculation of the plaintiff's loss of earnings in the future. I am satisfied on the evidence that she is likely to sustain a loss in the region of €100 per week from now until she reaches the age of 65 years. Accordingly I will award her the sum of €150,000 to compensate her for that loss. For future medical expenses I will award her the sum of €27,700.

The plaintiff is, therefore, entitled to judgment in the amount of €502,700.