Neutral Citation [2017] IEHC 17

THE HIGH COURT

[2012 No. 7800 P.]

BETWEEN

LEO GREEN

PLAINTIFF

AND

EILISH HARDIMAN

DEFENDANT

JUDGMENT of Mr. Justice Cross delivered on the 20th day of January, 2017

1. Introduction

1.1 The plaintiff was born on 11th September, 1939, is a married man with four children. He is a retired sales manager with a company called Columbus Dixon and in his earlier life was an active rugby player and then referee and in more recent times before the indexed events was active and enthusiastic gardener and golf player. By the time this matter came to trial, it is true to say that his memory is probably not as good for dates as it would have been and he was not, at all times, a very accurate historian. There is no doubt, however, that he was a honest and truthful witness who though extremely angry at what occurred to him did in no way exaggerate his symptoms or deviate from the truth as he saw it.

2 History

2.1 In the period 2005 to 2007, the plaintiff was treated for elevated PSA levels giving rise to concerns about prostate problems which were out ruled and on 15th November, 2007, after a colonoscopy he was diagnosed with diverticular disease. A follow up CT scan confirmed that the plaintiff had a colovesical fistula which was causing problems with his colon and his bladder and treatment was recommended which entailed a repair by way of laparatomy which was undertaken by Prof. N., a widely respected expert surgeon in the defendant's hospital at Tallaght on 11th December, 2007.

2.2 During this surgery, an accidental tear was made in the plaintiff's small bowel.

2.3 Prof. N. subsequently identified this as a serosal tear, i.e. a superficial tear that did not go through the entirety of the bowel. Prof. N. believes that he physically palpated the small bowel and no evidence of escape of any gas or material was apparent and accordingly he concluded that the tear was superficial. Prof. K., the plaintiff's expert, is of opinion that what occurred in the operation was in fact a full tear of the small bowel which resulted in subsequent escape of matter into the plaintiff's body. Given the subsequent events and infections I find that the tear was in fact through the entirety of the bowel and not a serosal tear.

2.4 It is not submitted on behalf of the plaintiff that the fact of his tear in any way suggests negligence on the part of the defendant, as there is always a risk of some damage to the small bowel in the procedure because they can be adhesions in the area and tears to the bowel can and do occur without any fault on the part of the surgeon.

2.5 The surgery was performed and what Prof. N. understands to be an insignificant serosal tear was unrepaired and the plaintiff remained in Tallaght Hospital.

2.6 Shortly thereafter, the plaintiff's bloods indicated a raised white cell and there were elevated CRP figures and by 14th December, the plaintiff's abdomen became very distended and uncomfortable and the possibility of a leak was raised and on 14th December, a procedure akin to an x-ray of the colon was performed which showed that the colon repair was intact. No scan, however, was undertaken of the plaintiff's small bowel at that time and accordingly, as far as the defendant was concerned there was no explanation from the plaintiff's elevated white cell count or elevated CRP. The 14th December was a Friday and over the weekend, the plaintiff does not appear to be examined medically.

2.7 On 17th December, which was a Monday, the plaintiff was referred to a cardiologist as he was developing hypertension and his white cell count had risen and his CRP was continuing to be significantly elevated.

2.8 Eventually on 19th December, a second operation was performed by way of laparotomy with a significant incisional entry through the abdomen and a loop ileostomy was carried out providing a stoma through the abdomen whereby his bowel discharged through the stoma inserted into his abdomen onto which a bag was fitted.

2.9 The plaintiff's recollection was that he was advised by medical personnel that the second operation was required because, as he understood it, a suture of the bowel had come away and there was leakage.

2.10 After the procedure on 19th December, the plaintiff was admitted to the Intensive Care Unit for it seems 48 hours and at that stage he was critically ill and he was retained in the hospital until 28th December when he was discharged.

2.11 At home, his condition deteriorated and on 25th January, 2008, he was admitted to South Tipperary Hospital in Clonmel near where he lives and transferred to the defendant's hospital in Tallaght on 6th February and at this stage, the loop ileostomy was closed and the bag was removed and the plaintiff recuperated in Tallaght until 13th February when he was discharged.

2.12 On 27th March, 2008, the plaintiff was seen for follow up review by Prof. N. and at this stage, he was developing a ventral hernia and Prof. N. indicated to the plaintiff that this could be treated in approximately six months afterwards when he had got better.

2.13 The plaintiff is very angry that despite this arrangement, no further follow up was put in place by the defendants. It seems there was some mix up between the appointments desk and the plaintiff in that no follow up appointment was given.

2.14 This was the last involvement of Prof. N. and was on 27th March, 2008.

2.15 The plaintiff's hernia developed and he was concerned about it, it was causing him difficulty in terms of movement and discomfort.

2.16 In particular the hernia affected his activities in gardening and playing golf which he was unable to continue to any real extent.

2.17 It should be stated that as a young man in his early 20s, the plaintiff developed an inguinal hernia which was treated by operation and a small scar in the pubic area resulted. This is not related to his present hernia. I have viewed his hernia and it bulges and stretches from the top of his stomach down towards his pubic area.

2.18 The hernia is reasonable faithfully represented in the photographs that were submitted though it is agreed that this has grown somewhat since then. It should be said that on his admission to the defendant's hospital initially, the plaintiff did have a small hernia above his umbilicus but it is not disputed in this case that the hernia which now presents itself was as a matter of probability caused by the wound infections from his leaking bowel and the procedures of the second operation.

2.19 In any event, the plaintiff who appears by this stage to have lost confidence in the defendant's hospital and also preferred local treatment was referred by his GP to Mr. M., Consultant in Tipperary Hospital who, in essence, advised against any further surgery for a number of reasons, to the effect, that the hernia would be difficult to repair and would involve the insertion of a mesh and the risk of further infection. The plaintiff accordingly did nothing about the problem and hoped that his condition would improve.

2.20 Mr. M. reported to the plaintiff's G.P. by letter dated the 14th January 2009 stating, *inter alia:-*

> *"As you know he has divarication of rectus abdominis muscle on his abdominal wall given the impression of a long standing midline hernia. This is a very common condition but does not particularly improve from surgery because of the geometric outline of where the rectus muscles now lie. Essentially they pull away from the midline and resuturing them back in really only facilitates a tear of these muscles and they get an even greater type herniation.*
>
> *Mr. Green's situation is compounded in that he has also actually developed a small incisional hernia component in the central part of his abdominal wall just below the umbilical area in keeping with a true incisional hernia at the site. However this would account for no more than 10% of the incisional herniation component …*
>
> *I have outlined to him that this is biomechemical problem rather than of an incisional hernia nature and that while his recent abdominal surgery was somewhat contributory to some of the protrusion of the abdominal wall, the main protruding component is due to divarication.*
>
> *I have outlined to them both that any surgical repair at first does not guarantee success and in general surgeons try to opt away from repairing divarication if at all possible, the reasons for this that the results are rather poor from a functional and cosmetic point of view. I have outlined to him that he would need large prosthetic mesh implanted onto his abdominal wall and there is no guarantee of success in this. I have also pointed out that he has already had an infection of his abdominal wall and implanting a prosthetic mesh runs risk of activating further infection developing a fasciitis which can result from dormant infection is his abdominal wall …"*

It should be pointed out that notwithstanding the views of Mr. M. in January 2009, the uncontested evidence in this case, which I accept, as to the causes and consequences of the plaintiff's hernia was that as given by the plaintiff's expert, Prof. K.

2.21 As stated above, however, the hernia disimproved through 2009 and into 2010, and in January 2011, having heard an advertisement on the radio for his present firm of solicitors, he attended therein to ascertain whether the treatment he was given was correct or otherwise.

2.22 The plaintiff's records in the file were requested from the defendant which arrived at their solicitors and the file was then sent to the plaintiff's expert, Prof. K. whose report arrived in May 2012.

2.23 It should be stated that the concern of the plaintiff and his solicitor at that stage, focused on the belief that the hernia developed as a result of a possibly negligently caused leak in his small bowel and not for the reasons as subsequently identified by Prof. K.

2.24 Prof. K's report which arrived in May 2012, was sent to the plaintiff who got emotional when he started to read it and did not and has not read it in full concluded that the defendants were in breach of duty in:-

> (a) Failing to test the apparent serosal tear in the small bowel so as to show what on the balance of probability was the case that this was not a serosal tear but a full tear which caused leakage of matter and infection to the plaintiff.
>
> In particular, under this heading, Prof. K. stated that the small bowel ought to have been delivered so that it could be palpated by hand so that gas could be squeezed through the injured segment and that then it would have been anticipated that there was a full thickness injury which required a full thickness repair which could and should have been carried out on 11th December, either by laparoscopy or by access through the already created midline laparotomy wound which would have minimised the risk of any hernia. Further, as there would not have been any time for any significant infection to have developed the prospect of a hernia would have been considerably reduced.
>
> (b) In failing to investigate the elevated CRP which are associated with infection on 14th December, 2007, when studies show that the original colon was sound, a CT scan or similar ought to have been carried out on 14th or 15th to determine the source of the contamination especially given the fact that there had been a recognised injury to the small bowel.
>
> (c) Which follows from (b) above, a failure to operate on 15th December at the latest and if the CT scan and other investigations had taken place on 14th that an operation could have taken place at the latest on 15th which caused a further four to five days delay increased the level of infection increased the prospect of a large scar and increased the likelihood of the hernia which developed taking place.

2.25 The pleadings were then commenced by personal injury summons dated 7th August, 2012.

2.26 A full defence was filed by the defendants on 18th November, 2014, putting virtually all matters in issue and in particular pleading the statute of limitations.

2.27 A reply to the defence was delivered on 17th May, 2006, submitting that the provision of the Statute of Limitations (Amendment) Act 1991, applied and also pleading that the defendant is estopped from relying upon the statute of limitations by their conduct. The latter plea has been withdrawn subsequently.

3 Consequences
3.1 The plaintiff alleges that as a result of the defendant's negligence, first of all the plaintiff required a second operation on 19th December, 2007, which was a repair of the full thickness defect in the small intestine and the insertion of a stoma on the right side of his abdomen and an ileostomy bag being fitted. He was critically ill at that stage and required two to three days in intensive care. He also had a prolonged stay in hospital as a result of what occurred in the wound infection.

3.2 When the plaintiff returned home, his wounds were treated for some three weeks by a district nurse and his dressings changed. He had while at home at the beginning of 2008, a significant excessive discharge from the stoma into his bag which led him to loose a considerable amount of weight. He was described as anorexic and dehydrated and was then admitted to South Tipperary Hospital on 25th January, 2008, and transferred to Tallaght where he had a third operation and the bag was removed. He is left with the pronounced abdominal hernia which though Prof. K. would be more optimistic as to its chance of success than Mr. M., Prof. K. does not suggest that the plaintiff is unreasonable in his decision that he will not have further treatment.

3.3 Whereas the defendants did not call their expert, Prof. H., his reports were submitted by agreement and Prof. H. stated:-

> *"Following his two operations with peritonitis at the second operation, it is not surprising that there was a significant surgical site infection post operatively as described by the plaintiff.*
>
> *It is my opinion that as a result of this infection, the two surgical procedures within the abdominal cavity that the plaintiff was at high risk of developing an incisional hernia (in the region of 10 – 20%)."*

3.4 I accept the evidence of Prof. K. that had the tear been discovered at the time of the first operation on 11th that no further scar would have occurred. Had the problem of the tear been discovered on 14th, it is likely that a laparoscopy repair would have been carried out resulting in no extra scar and further had the infection not been allowed to continue up to 19th with a continuous escape of material from the small intestine, the likelihood is that no significant herniation would have occurred. In the event of a laparoscopy, there would have been no need for the stoma and the bag that had to be inserted after the laparotomy on 19th. Indeed, I note that a laparoscopy repair was considered on 19th but would have been more likely to have been carried out on 14th/15th and accordingly, the plaintiff's present condition is, as a matter of probability, as a result of the indexed events.

3.5 The plaintiff was left from 11th to 19th with infected matter leaking from his small bowel which caused infection as was demonstrated by raised temperature and other signs which were recorded. When the plaintiff was operated for the second time on 19th, the infection caused the herniation on the site of the incision.

3.6 Given Prof. H's report, there is no dispute in the expert evidence as to Prof. K's conclusion which, of course, differs from Prof. N's view that the small intestine was not damaged in the initial operation and that no significant infection was evidenced from the charts and also differs from the diagnosis of Dr. M. in 2009. Dr. M., of course, was not in a position to know of the eight days of leakage as concluded by Prof. K.

4 Negligence and Breach of Duty
(A) The failure to discover the fact of the full tear by physical palpitation

4.1 Prof. K. originally believed that the defendants were negligent in their failure to carry out a palpitation of the small intestine and that such a palpitation would, in all likelihood, would have discovered the fact that a full tear had occurred.

4.2 Whereas Prof. N. does not accept that a full tear was made on 11th, he has no real explanation for the full tear that was ultimately discovered and for the infection that was caused. This infection commenced almost immediately after the initial operation and I believe and accept that a full tear of the small intestine occurred during the operation on 11th.

4.3 Prof. N., however, states that he always teaches his pupils and as a matter of practice that he would have examined small intestine physically and palpated it as Prof. K. suggested he should.

4.4 While, of course, Prof. N. does not have any actual memory of the particular operation so far back, he believes that physical palpitation was his universal practice and his belief that he actually physically palpated the small intestine on this occasion is strengthened by the fact that the hospital notes indicate that there was no request for the instruments that would have been necessary to examine the small intestine without palpitation. I accept that Prof. N. did, indeed, palpate the small intestine at the time of the operation.

4.5 Unfortunately, this tactile palpitation by Prof. N. did not reveal, as was the fact, that there was a full tear at the time.

4.6 Prof. K. was firstly of the view that a tactile palpitation did not occur because it is not recorded in the notes but I accept the evidence of Prof. N. that the palpitation did take place.

4.7 Prof. K. believes that had such a palpitation been properly carried out, the fact of the full tear would have been ascertained.

4.8 The issue before me on this first allegation of negligence by Prof. K. is whether the failure to detect the fact of a full tear (which I have found to exist) by his palpitation (which I accept he performed) was negligence and breach of duty on the part of Prof. N.

4.9 I do not believe that the state of the evidence is such that I can comfortably conclude that defendants were negligent in terms of *Dunne v. National Maternity Hospital* in the failure of Prof. N. to detect the fact of the full tear by his palpitation.

4.10 In answer to one of my questions to the effect that if a palpitation test were done and a full tear was missed, whether it was something that Prof. K. could understand, he replied *"yes these things happen".* Accordingly, I believe that the plaintiff has not established, on the balance of probabilities negligence in relation to the first ground complained of by Prof. K.

(B&C) The failure to study by CT scan or otherwise the small bowel on 14th and to operate on 14th/15th

4.11 Prof. N. in his evidence defended his practice and in particular denied there was any real evidence of infection by 14th and felt

that he was reassured there was no tear at the site of the original operation by his study on 14th and that it was only later that the plaintiff's symptoms developed more significantly. I do not accept that evidence. I accept the evidence of Prof. K. that as of 14th, there was sufficient and significant evidence of infection in the plaintiff's signs of raised temperature, raised CPR and raised white cell count, and that when it was discovered that there was no tear at the site of the original operation, the small bowel ought to have been examined by CT scan or similar to establish the next most likely source of infection.

4.12 Prof. N. is, as accepted by Prof. K., an eminent expert surgeon but he was giving evidence not as an expert but as a lay witness, in essence, defending what he had done.

4.13 It is significant that while the defendant's expert did not give evidence, his report as submitted agreed that the failure to provide a CT scan on 14th cannot be defended. This was also the testimony of the only expert who gave evidence, Prof. K. and I accept his evidence and I accept accordingly that the defendants were negligent in their failure on 14th to carry out a CT scan or other imaging of the plaintiff's small bowel given the level of infection and I conclude as a matter of probability that had they done so, they would have discovered the leak and they would have performed an operation on 14th or 15th to deal with the growing infection. It follows that their failure to do so on 14th or 15th is also negligent and accordingly, I accept the uncontested evidence that the defendants were negligent.

4.14 The consequences of that negligence have been referred to above.

5 The Statute of Limitations
5.1 The defendant relies on the provisions of the Statute of Limitations, as amended. It is, of course, incumbent upon the defendant to establish this defence. Under the provisions of s. 7 of the Civil Liability and Courts Act 2004, the relevant period is two years from the date of commencement. Clearly, the proceedings which were commenced by personal injury summons of 7th August, 2012, in respect of the indexed errors in December 2007, are well in excess of that two year period.

5.2 The plaintiff in response pleads the provisions of s. 2 of the Statute of Limitations (Amendment) Act 1991, which insofar as they are relevant provides:-

> *"(1) For the purposes of any provision of this Act whereby the time within which an action in respect of an injury may be brought depends on a person's date of knowledge… are references to the date on which he first had knowledge of the following facts:*
>
> > *(a) that the person alleged to have been injured had been injured,*
> >
> > *(b) that the injury in question was significant,*
> >
> > *(c) that the injury was attributable in whole or in part to the act or omission which is alleged to constitute negligence, nuisance or breach of duty…*
>
> *and knowledge that any acts or omissions did or did not, as a matter of law, involve negligence, nuisance or breach of duty is irrelevant…."*

Once it has been confirmed that the three year limitation period has elapsed, the onus is upon the plaintiff to establish that the provisions of s. 2(1) of the 1991 Act are applicable.

5.3 The interpretation of the similar though not identical English Statute of Limitations was analysed in the English Court of Appeal in the case of *Spargo v. North Essex Health Authority* [1977] 8 Med L.R. 125, by Brooke L.J. and he referred to a number of English authorities from which he drew the following principles:-

> *"(1) The knowledge required to satisfy s. 14(1)(b) is a broad knowledge of the essence of the causally relevant act or omission to which the injury is attributable;*
>
> *(2) 'Attributable' in this context means 'capable of being attributed to', in the sense of being a real possibility;*
>
> *(3) A plaintiff has the requisite knowledge when she knows enough to make it reasonable for her to begin to investigate whether or not she has a case against the defendant. Another way of putting this is to say that she will have such knowledge if she so firmly believes that her condition is capable of being attributed to an act or omission which she can identify (in broad terms) that she goes to a solicitor to seek advice about making a claim for compensation;*
>
> *(4) On the other hand she will not have the requisite knowledge if she thinks she knows the acts or omissions she should investigate but in fact is barking up the wrong tree: or if her knowledge of what the defendant did or did not do is so vague or general that she cannot fairly be expected to know what she should investigate; or if her state of mind is such that she thinks her condition is capable of being attributed to the act or omission alleged to constitute negligence, but she is not sure about this, and would need to check with an expert before she could be properly said to know that it was."*

5.4 The Spargo judgment has been cited with approval in various Irish decisions, and in particular by Geoghegan J. in *Gough v. Neary* [2003] 3 I.R. 92, though as Geoghegan J. stated the summary of the case law by Brooke L.J. was helpful, the application for the four principles is by no means easy *"certainly there is no merit in my view in casting them as stone…".*

5.5 In *Gough v. Neary*, it was held by Geoghegan J. for the majority of the Supreme Court, that in order for the statute to run, a plaintiff must know enough facts such that he would capable of, at least, upon further elaboration establishing a cause of action even if the plaintiff had no idea that those facts of which he or she did have knowledge did, in fact, constitute a cause of action, as that particular knowledge is irrelevant under the Act.

5.6 In *Halford v. Brookes* [1991] 1 W.L.R. 428 at p. 433, Donaldson M.R. stated:-

> *"The word (knowledge) has to be construed in the context of the purpose of the section, which is to determine a period of time within which a plaintiff can be required to start any proceedings. In this context 'knowledge' clearly does not mean 'know for certain and beyond possibility of contradiction'. It does, however, mean 'know with sufficient confidence*

to justify embarking on the preliminaries to the issue of a writ, such as submitting a claim to the proposed defendant, taking legal and other advice, and collecting evidence'. Suspicion, particularly if it is vague and unsupported, will indeed not be enough, but reasonable belief will normally suffice."

5.7 Dunne J. in *Naessens v. Jermyn* [2010] IEHC 102, having established that the plaintiff suffered a significant injury in her operation in February 2002, which was more invasive than would have been necessary had the operation been carried out earlier held that the question to be considered was when the plaintiff had sufficient knowledge of the facts that the injury was attributable in whole or in part to the acts or part of the Acts or omissions alleged to constitute negligence and quoted a section from Healy *Medical Malpractice Law:-*

> *"… It is therefore more usually the case that before the plaintiff begets a reasonable suspicion as to a right of action against the defendant, he must first have formed a reasonable suspicion, or been advised accordingly, that his present physical condition potentially constitutes a compensable injury or that the treatment he received was neither therapeutic nor carefully preformed. …"*

5.8 Dunne J. went on to state:-

> *"I accept that s. 2(1)(c) of the Act does not require a triggering event to start the statute running. What is clear from the case law is that the statute begins to run when a plaintiff has knowledge of attribution i.e. that the injury was caused by the act or omission involved and knowledge that there was a connection between the injury and the matters alleged to have caused the injury as described in the case of Fortune v. McLoughlin by McCracken J. …In other words, the plaintiff has to be able to make that connection."*

5.9 In my decision in *Farrell v. Ryan* [2015] IEHC 275, I decided that it was only at the stage when the plaintiff had obtained hospital notes that could have been said to have the knowledge *"to justify embarking on the preliminary to issue a writ"* and suggested that up to that time, her position was similar to the plaintiff in subpara. (4) of the judgment of *Spargo* i.e.:-

> *"She may have thought that she knew the acts or omissions that she should investigate but it was quite possible that she was barking up the wrong tree. She may have been aware by that stage, in 2010, that the procedure carried on her was indeed a symphysiotomy but she was not armed with any information that could have justified her issuing proceedings against the defendants or going to a solicitor to instruct that solicitor to issue proceedings, until the furnishing of the records…"*

5.10 However, Peart J. in the judgment of the Court of Appeal in the *Farrell* case dealing with the issue of Statute of Limitation, held that my reasoning was incorrect and he analysed whether the information which the appellant had by February 2010, when she heard a report of a television programme and which made her want to obtain her medical reports from the hospital was sufficient to *"mark the point at which the statute started to run"* (as per McGuinness J. in *Cunningham v. Neary*) or whether that point was not reached until she actually received the medical reports in August 2011, and Peart J. concluded:-

> *"It is incorrect as a general proposition that a plaintiff may wait until she receives her medical records before time starts to run against her under the statute. That would give a plaintiff control over when time starts to run, as it would be dependent on how long the plaintiff chooses to wait before seeking her records. If a plaintiff has had an operation or some procedure carried out, and thereafter has suffered adverse sequelae in the nature of a personal injury reasonably attributable to what was done, she does not need to wait for her hospital records or other records to arrive before she can be taken to know that she has a cause of action….*
>
> *In my view the trial judge was incorrect to conclude that she needed to know more than* [having heard a report of a television programme in February 2010] *that before time started to run under the statute, and in particular that she needed her medical records before she could be said to have enough knowledge to justify the commencement of proceedings. In my view that was the wrong test. She did not need to know at that point that she had a good case. It was sufficient if she had enough knowledge to connect her injuries to the procedure which she knew had been carried out on her in 1963, and as she admitted herself in her evidence, she knew on 10th February, 2010, that the symphysiotomy she underwent was unnecessary. I believe that the evidence is clear that she had that knowledge as of 18th February, 2010. Medical records would no doubt elaborate upon the knowledge that she had, but were not a prerequisite to time commencing to run."*

5.11 In *Fortune (a person of unsound mind not so found) v. McLoughlin* [2004] I.R. 526, McCracken J. for the majority of the Supreme Court analysed, as Dunne J. did *in Naessens*, the importance of the word *"attributable"* as contained in s. 2(1) of the 1991 Act and he held that the word was not satisfied by the plaintiff's knowledge of the factual situation. The knowledge must be one of attribution that there was connection between the injury and the matters alleged to have caused the injury at p. 534:-

> *"I cannot accept the defendant's contention that the word 'attributable' in s. 2(1)(c) of the Act of 1991 is satisfied by the plaintiff's knowledge of the factual situation. The knowledge referred to in that subparagraph is knowledge of attribution, in other words knowledge that there was a connection between the injury and the matters now alleged to have caused the injury. This is a connection which the plaintiff did not make in this case. If a plaintiff is to have knowledge within the meaning of s. 2(1)(c) of the Act of 1991, she must have knowledge at least of a connection between the injury and the matters now complained of to put her on some inquiry as to whether the injury had been caused by the matters complained of. At what stage she is put on inquiry must be a matter to be determined in each case, but in the present case the plaintiff quite clearly did not make the connection at all, as even when she was alerted to the fact that there might have been negligence, her reaction was to attribute her injuries to the actions of the National Maternity Hospital rather than of the defendant. It should be emphasised that the plaintiff's knowledge of these matters is largely a question of fact. The trial judge in this case heard and placed reliance on, not only the expert evidence, but also the evidence of the plaintiff herself…."*

5.12 In this case, the plaintiff knew reasonably shortly after the indexed procedure that he had developed a hernia. The plaintiff was advised by Prof. N. that this could be treated some six months later. The plaintiff was angry that due to some mix up, no follow up appointment with Prof. N. was given to him and he went to a consultant in Tipperary Hospital, Mr. M., who, in the absence of knowledge of the eight days of infection, attributed the cause of the hernia to a combination of a pre-existing hernia and a small contribution by the operational incision and advised against further surgery. The plaintiff hoped the condition would improve. The condition did not improve and in January 2011, having heard an advertisement for his present solicitor on the radio, he sought advice. His solicitor promptly sought the medical records and engaged Prof. K., who reported in May 2012.

5.13 In other words, I accept that the plaintiff was aware that he had suffered an injury in the procedure. He went to Mr. M. in January 2009, and Mr. M. not alone advised essentially against any operation to "cure" the hernia but also his view as to the cause of the hernia was in the main longstanding and only related to the indexed procedure to a small degree such as, I believe, any operation might produce.

5.14 Mr. Foley, of counsel, on behalf of the defendant in his forceful submission urges that following the decision in the Court of Appeal in Ryan that it is not necessary that the plaintiff should be in a possession of the medical reports or records, and that as is clearly stated in the statute, knowledge that the particular acts did or did not constitute negligence is irrelevant.

5.15 Counsel on behalf of the defendants referring to the authorities cited above, said that the plaintiff was or ought to have been aware from an early stage that something serious had occurred and as suggested by Dunne J. in *Naessens v. Jermyn*, that he had sufficient knowledge to justify embarking on the preliminaries to the issue of a writ. Further, before 7th August, 2010 (two years prior to the issuing of proceedings), the plaintiff was aware that he had a hernia. He knew that he had suffered a perforation of his small bowel and that the pathway of care that was intended or expected on his admission in December 2007, had "gone drastically away from expectation". It is further submitted, that as is clear from the plaintiff's particulars that after seeing Mr. M. in January 2009, the plaintiff specifically accepted that he doubted that the outcome of this operation was acceptable. The hernia was causing him a great deal of discomfort and difficulty and he was unable to pursue his activities of gardening and the like. Counsel specifically referred me to the matters pleaded in the plaintiff's replies to particulars as to his concerns about the quality of his care arose when his "hernia became difficult".

5.16 Counsel on behalf of the plaintiff submits that the case, as pleaded against the defendant is on the three grounds I have referred to at para. 2.23 above. When the plaintiff went to his solicitor, he had a general concern about the quality of his care but that concern is not sufficient for the date of knowledge to be attributable to the actions or omissions which are alleged to constitute the negligence, as is required by the 1991 Act. The plaintiff's concern at that stage was that his hernia had been caused by Prof. N. in the second operation and that the defendants had not, in effect, cured him.

5.17 In this belief, it was submitted that, the plaintiff and his solicitors at the time were, in effect, "barking up the wrong tree" as per para. 4 of the principles in Spargo (above). It was only when Prof. K. reported, having examined the plaintiff's notes that the allegations of negligence made against the defendant could be formulated. Had the plaintiff taken the preliminary steps to issue a writ prior to receiving Prof. K's report then he would have embarked upon a cause of action which would not have succeeded.

6 Determination on Issue of the Statute of Limitations

6.1 The interpretation of s. 2 of the 1991 Act ought to be simple but is extremely difficult in practice. Every case will turn on its own facts and the principles of the authorities offer guidance to the decision maker but probably no more. The starting point must be the Act itself and for the purposes of this case, the relevant subsection is s. 2(1)(c):-

> *"that the injury was attributable in whole or in part to the act or omission which is alleged to constitute negligence, nuisance or breach of duty."*

6.2 I accept that the word "attributable" cannot be airbrushed out of the equation and is central to my conclusion. The plaintiff was before August 2010, upset about his treatment and the result thereof. His first port of call was the referral to the gastrointestinal surgeon in South Tipperary General Hospital, Mr. M., who, as we have seen, not alone advised him as to the difficulties of further surgery but his report is not supportive of any action claiming significant personal injuries as a result of the indexed procedure. Mr. M. was presumably advised of the two operations but would not have had the notes or information that there had been some eight days of infection from the small bowel prior to the second procedure and could not conclude that the hernia was as a result of this infection.

6.3 In *Farrell v. Ryan*, Peart J. held that *"it is incorrect as a general proposition that a plaintiff may wait until she receives her medical records before time starts to run against her…".* In the *Farrell* case, Peart J. indicated that the plaintiff, after hearing about a television programme on symphysiotomies in February 2010, was aware that she underwent what she believed to be an unnecessary symphysiotomy. In the *Farrell v. Ryan* case, that knowledge was sufficient to allow the statute to commence to run against the plaintiff.

6.4 The fact that as a general proposition, a plaintiff cannot insist that the Statute does not run until he or she obtains medical records does not, of course, mean that Medical Record may, in some cases, be essential for knowledge and attribution under the Statute.

6.5 In *Fortune v. McLoughlin*, McCracken J. stated:-

> *"However, the question is not whether the plaintiff knew the physical facts of her injuries, but whether she knew that the injury was attributable in whole or in part to the act or omission which is alleged to constitute the negligence, which basically was the failure of the defendant to monitor her properly during the latter part of her pregnancy. The trial judge held that the plaintiff herself did not make the connection between her injuries and the actions or omissions of the defendant. It is quite clear from the evidence that the proceedings were ultimately issued as a result of advice from a general practitioner in September, 1999 and even at that stage, she believed that any relevant blame would lie on the National Maternity Hospital. At this stage she sought advice from her solicitor who obtained her medical records from the hospital. It was only when the relevant records were obtained and advice was received by her from an independent medical expert based on those records that the facts now relied upon by the plaintiff in relation to her treatment by the defendant came to light."*

6.6 I find that it was only when the plaintiff, in this case, received the medical records that the basis of the case and the attribution of the plaintiff's injuries to the failures on 14th and 15th could be known. The plaintiff's general suspicions as to having suffered an injury and that that injury was caused by some actions of the defendant were, as it transpired ill founded.

6.7 The plaintiff has, subject to the Statute, established liability on the failure of the defendants to examine the plaintiff's small bowel by way of a CT scan or similar on 14th and their failure to operate on 14th or 15th.

6.8 Prof. K. has given evidence which I have accepted that as a consequence of these matters, the plaintiff's injuries have occurred.

6.9 The plaintiff's initial concerns as to any faults whatsoever on the part of the defendants for any significant injury must have been assuaged by Mr. M's report in 2009. Prof. N. still does not accept that in the first operation he entirely ruptured the small bowel or

that there was any significant evidence of infection by 14th. Prof. K. on examination of the notes concluded that the hernia was caused by the initial undetected and untreated rupture which caused leakage and infection and which resulted in the hernia after the substantial incision which was required by the second operation on 19th.

6.10 The plaintiff in this case is in a significantly different position than the plaintiff in *Farrell v. Ryan*, in that Mrs. Farrell was aware from the reports of a television programme that she had suffered an injury caused by what she believed to be an unnecessary symphysiotomy. The plaintiff in this case was not and could not have been aware that he has suffered an injury due to the failure of the defendant to examine by way of CT scan or similar his small intestine on 14th and to operate on 14th or 15th. This knowledge and this attribution could only and did only arise on the receipt of the report of Prof. K. or, arguably, when the plaintiff received the hospital records. Either date, of course, is within the statute.

6.11 The requirement for the records in this case prior to the requisite knowledge and attribution is not because of any nuance in particulars of negligence or because of any minor refinements in the case, the records were required in order to attribute the injuries of the plaintiff to the failure of the defendants to investigate on 14th and to operate on 14th or 15th. Dr. M. did not have the records and did not attribute the hernia to these facts.

6.12 To conclude otherwise would, in my view, be to ignore the fourth paragraph of the judgment of *Spargo ("barking up the wrong tree")* and to ignore the decision of Dunne J. in Naessens, it would be to ignore the decision of McCracken J. in *Fortune v. McLoughlin* and would be to specifically ignore the provisions of s. 2(1)(c) of the Statute of Limitations (Amendment) Act 1991.

6.13 I find accordingly that the plaintiff's action against the defendant is not barred by virtue of the Statute of Limitations.

7 Damages
7.1 The special damages in this case have been agreed in the sum of €1,403.

7.2 The general damages in this case consist of the plaintiff's hernia which I have viewed. This is the major heading of damages of the plaintiff together with its consequences. In addition, the plaintiff complains of the effects of the untreated infection between 14th and 19th and the necessity for a second substantial operation on 19th which may not have been required had prompt intervention occurred. In addition, the second operation on 19th resulted in a stoma and bag being supplied. This was naturally distressing for the plaintiff and the bag required a third operation in order for it to be removed. Had a laparoscopy been performed on 14th/15th, there would as a matter of probability not have been a requirement for the stoma or the bag. Clearly, the latter matters are of significantly less importance than the fact of the hernia itself which is, by far, the main aspect of the plaintiff's damages.

7.3 As the Court of Appeal has held in a number of cases, proceedings involving small injuries should result in low damages, moderate injuries in moderate damages and serious injuries result in serious damages.

7.4 Damages of scarring are not covered by the PIAB Book of Quantum and given the nature of the scaring, the age of the plaintiff and the resulting effects of the hernia, I would assess the plaintiff's damages as being a significant and higher than moderate but not, of course, in any way catastrophic.

7.5 Being fair to both the plaintiff and the defendant, as I am obliged to be I assess the general damages as follows:-

General damages for pain and suffering to date €60,000

General damages for pain and suffering to the future €35,000

The total of general and special damages is €96,403 which I believe to be fair and reasonable in all the circumstances.