Neutral Citation: [2014] IEHC 169

THE HIGH COURT

[2009 No. 3913 P.]

BETWEEN

GERRY FOLEY

PLAINTIFF

AND

BON SECOURS HEALTH SYSTEM LIMITED TRADING AS BON SECOURS HOSPITAL GALWAY AND JOHN NEE

DEFENDANTS

JUDGMENT of Ms. Justice Irvine delivered on the 1st day of April, 2014

Background

1. The plaintiff is a 65 year-old married man and father of three grown up children who lives with his wife Mary at Newcastle, Galway City. Prior to the events the subject matter of this claim he was employed as a court messenger in Galway City.

2. In these proceedings, the plaintiff claims damages in respect of personal injuries which he alleges he sustained due to the negligence of the defendants in relation to the care afforded to him at the Bon Secours Hospital, Galway, following upon the surgical repair of an incisional hernia on 20th August, 2007.

3. Initially the proceedings were maintained against the Bon Secours Hospital where the operation took place, Mr. Ali Zaki who carried out the surgery and Mr. John Nee who took over the plaintiff's care when Mr. Zaki went on holiday the day following his surgery. The proceedings were discontinued as against Mr. Zaki in January 2014.

The Liability issue

4. In general terms, the plaintiff maintains that had he received inappropriate care and monitoring in the days following his surgery. The major complaints of negligence advanced in the course of the hearing can be summarised as follows:-

(a) That the defendants failed to keep adequate clinical records in the post operative period;

(b) That Dr. Kah Hoong Chang, the Resident Medical Officer (hereinafter referred to as "RMO"), when he reviewed the plaintiff between 18.00 and 19.00 hours on Sunday 26th August, 2007, ought to have recognised a significant deterioration in his condition and should have managed him on the basis that the deterioration might have been due to a leak from the anastomosis that had been carried out the previous Monday.

(c) That Dr. Chang, at the time of that review, ought to have arranged for a chest x-ray to be taken, an investigation that would have definitively diagnosed the presence or absence of such a leak.

(d) That Dr. Chang, at the said review, ought to have arranged for immediate blood tests to be carried out.

(e) That Dr. Chang, at the time of the said review, ought to have advised Mr. Nee of his patient's deterioration.

(f) That the care afforded to the plaintiff by Mr. Nee fell short of an acceptable standard.

5. The plaintiff maintained that but for the defendant's negligence, the diagnosis of an anostomotic leak ought to have been made by about 20.00 hrs on Sunday, 26th August, 2007. Had that occurred the plaintiff would have been operated upon by way of laparotomy in the Bon Secours Hospital and this would have taken place at about by about 21:00 or 22:00 hours. However, due to the defendant's negligence, the diagnosis was not made until sometime after 07:30hrs the following morning. At that stage the plaintiff was so ill that he required ICU care and he was transferred to University College Hospital Galway (hereinafter referred to as "UCHG") where at approximately 14:00hrs he underwent what can only be described as life saving surgery to deal with peritonitis caused by an anastomotic leak. This surgery, which involved a laparotomy, small bowel resection and ileostomy was performed by Prof. Oliver McAnena, consultant surgeon.

6. It was maintained that had emergency surgery been commenceed by 22:00hrs on 26th August 2007, that the plaintiff would have avoided many of the complications which he subsequently had to endure. While he would always have required a laparotomy, bowel resection and ileostomy, due to the complications of the leak, he would probably only have required hospitalisation for about fourteen days as opposed to three months. He would also likely have avoided a tracheostomy, the development of a faecal fistula, renal failure and respiratory failure, the latter conditions being life threatening events. While the plaintiff would have had significant scarring, he would have avoided developing the great big defect which is now present in his abdominal wall.

7. The plaintiff also maintains that as a result of the injuries his working career was foreshortened. He also contends that he has needed additional assistance within the home over and above that which he would have required were it not for his injuries and that he will require ongoing care of this nature into the future by reason of the defendant's negligence.

8. Accordingly, the plaintiff maintains a claim for general damages for pain and suffering to date and into the future. He also maintains a claim for special damages which include past and future care as well as a sum to compensate him in respect of his early retirement from his employment which took effect on 1st July, 2009.

The Evidence

9. As to what occurred between the 20th and 27th August 2007, the court heard evidence from the plaintiff, his wife and two daughters. It also heard evidence from Mr. Brendan Harte, consultant anaesthetist and Prof. McAnena as to certain findings made in the course of the surgery carried out at UCHG on 27th August. In terms of expert testimony the plaintiff relied on the evidence of

Prof. M.R.B. Keighley, Colorectal surgeon. Finally, the court was assisted by the evidence of Dr. Gerard Brennan, the plaintiff's general practitioner and Ms. Anne Marie Regan, consultant psychologist, who gave their respective opinions as to his condition and prognosis post his surgical complications.

10. Dr. Chang, the RMO against whom, in reality, all of the specific allegations of negligence were made, gave evidence on his own behalf as to his dealings with the plaintiff over the relevant period. In terms of expert testimony, the defendants relied upon the evidence of Mr. Royston, General and Colorectal Surgeon. The court did not hear any evidence from Mr. Nee in circumstances where, at the conclusion of the plaintiff's evidence, the court granted a direction dismissing the plaintiff's claim against him.

11. Given that the focus of the allegations of negligence relate to the plaintiff's condition on 26th and 27th August, 2007, I have decided to set out in chronological order the relevant nursing and medical records covering this period. For ease of reference the reader should note that I have displayed the nursing records in ordinary type and the medical notes in italics.

26th August, 2007: 3am

? Received patient at 20:45

? Resting in bed watching TV

? Feeling well pleased re his post operative recovery

? IV antibiotics given, Nocte and as chartered. Nil required for pain – mobilised on corridor prior to settling.

? Felt he ate too much too soon this evening

? Settled, then slept for long spells when checked, PRN Nocte 26th August AM

? Received care of patient. Observations stable. Apyrexial.

? Patient for shower post IVAB's. Completed at 14:00hrs. Dressing intact to wound site.

26th August 11:00hrs

? IVAB's → POAB's post 14:00hrs dose

26th August

PM

? IVAB's as charted. Patient non-complaining. Encouraged with mobilisation. IV cannula removed.

18:00hrs

? Patient complaining of crampy pain – analgesia as charted.

? Observations stable. Temperature at 37! RMO asked to review patient

re: crampy pain and bloatedness. ? post op ileus. IV cannula resited by RMO. For IV fluids.

? For sips and meds only, remain NPO otherwise. Buscopan charted if required.

Entry of Dr. Chang

19:00

? asked to review re: crampy abdominal pain.

? day 6 post incisional hernia repair + small bowel resection.

? started crampy abdominal pain since 3pm today progressively getting worse. Intermittent associated with nausea. no vomiting. Small bowel motion two days ago. No dysuria/frequency + passing flatus. Was on sloppy diet yesterday. Back on full diet today.

? on examination: vitals stable comfortable now

12. Immediately beneath this note there is a diagram drawn by Dr. Chang which shows the plaintiff's abdomen and wound. The diagram includes a number of dots immediately beneath the wound. Beside this diagram the following notes are made:-

? dressing, clean, no oozing

? minimally distended, minimally tender supra pubic region, soft. No guarding/rebound. Bowel sounds sluggish.

? impression: post operative ileus. (most recent K+3.9)

? plan stop diet. IV fluids. MSU. Buscopan PRN.

Nocte – 26th/27th

? Patient slept for long periods. Cramps have eased.

? Refused analgesia. IV fluids remain in progress and patient has sips only. Patient up to toilet, early Nocte and had PR bleed (approximately teaspoon bright blood loss). Patient stated he did not have bowel motion/wind plus may have exerted force. Patient believes he has haemorrhoids in the past. RMO Dr. Chang notified – to observe overnight plus discuss with Mr. Zaki/Nee in AM. Abdomen appears distended, soft, however patient feels size of abdomen normal.

? Complained of slight nausea – nil vomit. Patient refused anti-emetic. Wound dressing dry + intact. Nursed as per plan of care.

5:30am

? patient vomited 500mls in kidney dish and a large amount in toilet as well, green fluid

? complains of severe abdominal pain and said that while vomiting he felt something tear in the abdomen.

? RMO contacted. Patient reviewed zofran 4mg iv stat given at 6am with some effect.

? patient reluctant about nasogastric tube. Tramadol 100mgs IV given for pain with some effect.

? abdomen appears distended.

? observations within normal limits at this time.

13. To the immediate right of the last mentioned note and under the special instructions, the following directions appears:-

? For PFA-PO antibiotics discontinued

Monday 27-08-07 5:30am note of Dr. Chang.

? Asked to review re persistent vomiting. No PR flatus since last seen. On examination vitals stable.

14. Beneath this note there appears a drawing of the abdomen with an indication through the use of curved lines that the abdomen is distended. Immediately beside and beneath this note, the following matters are records, namely:-

? Distended abdomen. No bowel sounds. Soft. Plan: IV fluids, antiemetic. Patient reluctant to have nasogastric tube. PFA

6:45 Nursing note.

? patient vomited again + - 300mls. RMO contacted, to pass nasogastric tube. RMO rung to see patient.

15. A special instruction appears opposite this note which reads:

recommended IV antibiotics.

7:00 Nursing note.

? patient unwell. Abdomen distended. Hard. RMO rung to see patient.

27-08-2007 Retrospective note of Dr. Chang

7am

? persistent vomiting. Abdomen distended. Abdomen contents leaking through abdominal wound.

? 18 gage cannula right 20 gage cannula left.

? IV fluids Hartmans, urinary catheter, full blood count, FMAC, coagulation, group and cross match four units. IV antibiotics. Nasogastric tube. IV PPZ.

27-08-2007 Retrospective note of Mr. Nee

? unwell since during night. Abdominal pain. Vomiting. Wound draining ++ ? bowel content.

? seen by me on 26-08-NAD very well then. On diet. Bowel moving. Mobile. No pains and observations normal.

? Impression ? Wound to dehiscence

? ? fistula- anastomotic rupture.

? Plan continue NG drainage. IV fluids and antibiotics. Transfer to UCHG. I will arrange.

16. While the plaintiff pursued a claim for negligence in respect of the failure on the part of the defendants to keep appropriate clinical records for the period spanning 20th to 27th August, 2007, inclusive, I will not spend any time on this aspect of the claim. While it is blatantly clear that the clinical records maintained during the plaintiff's post operative period fell short of an acceptable standard, the plaintiff's expert witness Prof. Keighley, was satisfied that on the facts of the present case, given the extremely comprehensive nursing records, the plaintiff's outcome was not adversely affected by this default.

The Case Against Mr. Nee

17. At this early stage of the judgment, I also propose to deal very briefly with the negligence claim that was brought against Mr. Nee, referable to the care and attention which he allegedly provided for the plaintiff in the post-operative period and in respect of which claim I granted a direction at the close of the plaintiff's case.

18. This particular aspect of the plaintiff's claim was based principally upon his own assertion that Mr. Nee did no more than "put his head around the door" on a number of occasions, that he did not engage with him in any meaningful way and carried out next to no clinical examinations of his abdomen.

19. I have to say that the nursing notes spanning the period 20th to 27th August 2007, called into question the accuracy of the plaintiff's evidence in relation to the care he received from Mr. Nee. From these records, I am quite satisfied that Mr. Nee did much more than "put his head around the door", as the plaintiff had maintained. It is clear that he saw his patient twice on 22nd August, twice on 23rd August, once on 24th August, once on 25th August, and again on the morning of 27th August, when he arranged for his transfer to UCHG. Having regard to the information contained in the nursing records, I am satisfied that Mr. Nee was kept fully appraised of the plaintiff's condition by the nursing staff. Further, in circumstances where the notes record the specific directions given to the nursing staff following his review of the patient, it simply cannot be the case that Mr. Nee did not fully engage with the plaintiff and examine him as was appropriate. Those records demonstrate that on every occasion when he was contacted by the nursing staff, Mr. Nee came to review the patient and gave directions as to his care and management.

20. The exception to my view in this regard is what may have occurred on Sunday 26th August, 2007. The plaintiff's daughter, Ms. Jean Armer, told the court that she visited her father for about half an hour that day between 14.15 and 14.45 hours. During that period she remembered Mr. Nee coming to the door of her father's room and from that position making a polite inquiry as to his welfare. Ms. Armer told the court that on that occasion, Mr. Nee did not examine her father or have any detailed conversation with him regarding his progress.

21. I have to say I think Ms. Armer's evidence regarding Mr. Nee's fleeting visit to her father on Sunday, 26th August 2007, is likely to be a true account of what occurred. Mr Nee certainly did not see his patient that day with the presence of any member of the nursing staff, as there is no mention of such an attendance that day in the very comprehensive nursing records, as would be the normal practice had there been any such visit. Perhaps, it being a Sunday, having arrived when the plaintiff's family were present and armed with the knowledge that the plaintiff had been well the previous day, he decided nothing more than a salutation was required. However, even if this degree of care could have been considered as falling short of that expected of Mr. Nee, and I heard no evidence to that effect, I do not believe anything turned on it. From his daughter's evidence as to his condition at the time of that visit and from the nursing records, it appears that the plaintiff's condition had not deteriorated at that time and certainly he had made no complaints to any member of the medical or nursing staff. In such circumstances, I think it is highly probably that even if Mr. Nee had engaged in a more significant fashion with the plaintiff at the time of his visit, the plaintiff's outcome would have been no different to that which occurred.

22. Having regard to the aforementioned matters and in circumstances where no complaint was made regarding the care afforded by Mr. Nee after the plaintiff's deterioration in the late afternoon of Sunday, 26th August, 2007, I granted Mr. Nee a direction at the close of the plaintiff's case.

The Plaintiff's Medical Evidence

23. Regardless of pleadings and counsel's opening statement to the court, the plaintiff's expert evidence centred upon the plaintiff's condition as it was on Sunday, 26th August, 2007. Prof. Keighley focused on the standard of care to be expected of Dr. Chang, the RMO, in the light of the plaintiff's overall post operative recovery and the signs and symptoms he developed that day.

24. Prof. Keighley told the court, based upon the plaintiff's symptoms as recorded in the nursing records at 18.00 and Dr. Chang's note of 19:00 hrs on Sunday, 26th August, 2007, that it should have been clear that his condition had suddenly deteriorated. He had been well and improving over the previous two days and had reported no pain. Now he had intermittent crampy pain which he had reported as getting worse from three that afternoon. This pain was associated with nausea. The patient also complained of feeling bloated and sluggish bowel sounds were heard. His abdomen, on examination was minimally distended and tender.

25. Prof. Keighley told the court that the post operative risk of a leak following surgery involving an anastomosis is at its highest on days 5 and 6 following surgery. This was the most likely cause of the patient's symptoms. Because of the risk attendant upon a leak i.e. peritonitis and potential fatality, it was mandatory for the patient to be managed on the basis that they had developed such a leak until it was proven otherwise. Prof. Keighley told the court that it was most unlikely that the patient had developed an ileus, which is a condition used to describe a type of paralysis of a portion of the bowel, which Dr. Chang considered to be the likely cause of the plaintiff's symptoms.

26. Prof. Keighley stated that Dr. Chang ought to have arranged for the plaintiff to have an immediate chest and abdominal x-ray. which would have established the presence or absence of a leak.

27. Dr. Chang, according to Prof. Keighley, should also have arranged for a full set of blood tests to be carried out. The blood should have been taken by taxi to UCHG and the results would have been available within a half an hour. These results might have shown changes indicative of an anastomotic leak.

28. Prof. Keighley also stated that the patient's symptoms at 18:00 hrs on Sunday the 26th August, 2007, were such that he should have contacted Mr. Nee to advise him of his patient's deterioration. It was mandatory for him to either investigate the plaintiff himself and advise Mr. Nee of the results of those investigations or alternatively to contact Mr. Nee to advise him of the patient's condition and seek his advices, neither of which he did. It was not acceptable to do nothing more than advise that the patient take nil by mouth, direct that he receive IV fluids, chart an anti-emetic and await further developments.

29. If a chest x-ray had been directed by Dr. Chang following his examination of the patient between 18:00 and 19:00 hours, that x-ray, according to Prof. Keighley would have shown the presence of gas within the abdomen which would have been conclusive evidence of a leak. Once this result was communicated to Mr. Nee, he would have immediately come into the hospital and carried out an emergency laparotomy. This would have started by 21.00 or 22.00 hours on Sunday 26th August 2007.

30. Prof. Keighley told the court that 50% of leaks from an anastomosis do not happen acutely and that each patient's response is very variable. The first symptom will always be pain. He told the court that crampy or colicky pain is very unpleasant and can be severe and that in order for pain to be indicative of a leak, it does not have to be continuous. Indeed, he said crampy pain would be typical of a case where there is a small leak and the reaction in the gut is to produce symptoms of that nature. Prof. Keighley advised that pain which requires analgesia six days post operatively has to be taken seriously. He did not criticise Dr. Chang for not diagnosing an anastomotic leak at the time of his examination but said that it was unacceptable to fail to consider it as a possibility because it was the most likely cause for his symptoms and there were few other possibilities.

31. Prof. Keighley advised that Dr. Chang had no entitlement to take any comfort from the fact that the plaintiff's vital signs had been

reported as normal at the time of his examination shortly after 18:00hrs on Sunday, 26th August, 2007. Changes in vital signs are features of sepsis or peritonitis and this condition does not happen immediately there is a leak, but rather develops over a variable period of time. Likewise, the absence of rebound tenderness and guarding is no guarantee that a leak has not occurred as these are symptoms which arise when peritonitis is established.

32. It was Prof. Keighley's opinion that the nursing records for Sunday "Nocte", which recorded the patient as sleeping for long periods and the fact that his cramps had eased to the point that he refused analgesia, did not prove that the leak had not commenced at that point. The plaintiff's abdomen appeared to the nursing staff to be distended, even if the patient is noted as having stated that he felt this was not so. Further, while the plaintiff was not vomiting, he had become nauseous. In support of his conclusion that the crampy pain and bloatedness, recorded by the nursing staff at 18:00hrs on Sunday 26th August, 2007, were the first symptoms referable to an anastomonic leak, Prof.Keighley consistently emphasised that the most likely time for a leak to occur was about five days post surgery. It was most unlikely, he said, that the patient was demonstrating symptoms of an ileus as he had developed an ileus in the immediate post operative period, from which he had recovered four days later. On Sunday, 26th August, 2007, he had developed a new type of pain having been pain free for several days and Prof. Keighley felt this pain had to relate to the commencement of infection from a leak.

33. Prof. Keighley told the court that the fact that the plaintiff's observations as set out in the blood pressure and temperature, pulse and respiration chart were normal until 21:30hrs on 26th August, did not mean that the perforation had not started earlier that afternoon. It was his opinion that the leak when it commenced was probably very small and may have remained localised. He felt it was likely that the omentum had attached itself to the tissues at the site of the leak thereby hampering the escape of fluid into the abdominal cavity thus slowing down the infective process. This is why the plaintiff did not have the classical signs of peritonitis at 19:00hrs on the Sunday evening. Prof. Keighley also advised that the fact that his vital signs were recorded as normal at 21:30hrs that night establishes no more than that the leak had remained contained up to that point and that gross faecal peritonitis had not yet set in. However, gas would have readily leaked out and would have been visible on x-ray, had it been taken.

34. Prof. Keighley was of the view that the nursing and medical records established that the plaintiff had been experiencing symptoms referable to a leak by 15:00hrs on Sunday, 26th August 2007. The acute event that is described in the nursing and medical records as occurring at 05:30hrs on the following morning i.e. 27th August 2007, he said occurred as a consequence of ongoing infection in the peritoneum. He felt there was a gradual accumulation of faecal fluid in the abdomen due to the leak and that this had built up over night leading to the dehiscence of the abdominal wall and the sutures that were in the deep tissues. These sutures gave way as a result of infection and at the same time the leak, which had until that point been relatively contained, was acutely disturbed leading to a spread of the faecal fluid and to the rapid development of peritonitis.

35. Prof. Keighley advised the court that the plaintiff's nausea had been due to infection and that it was this which had caused him to vomit. The pressure from the vomit caused the disruption of the sutures which in turn caused the omentum, which had been holding the leak closed, to get displaced and allowed it to discharge rapidly into the abdomen and later through the wound.

36. Although not stated in his expert report, Prof. Keighley sought to support his opinion as to the time of the commencement of the leak by reference to a number of other findings in the medical records. Firstly, he relied upon the histopathology of the resected bowel material which was removed in the course of the laparotomy on 27th August, 2007, at UCHG. He referred to the size of the gaping hole in the anastomosis, which measured 2cm by 1.5cm. He said that a hole of that size does not happen quickly and its size suggested to him that the leak had probably started as far back as the early afternoon of Sunday, 26th August 2007.

37. Based upon a clinical note made by Mr. Harte, Consultant Anaesthetist, to the effect that 700cc of feculent fluid was found in the peritoneal cavity in the course of the laparotomy, Prof. Keighley told the court that this further supported his diagnosis that the leak had commenced by 15:00hrs on 26th August, 2007. He advised the court that over a 24 hour period, the small intestine normally generates something between 500 – 1000cc of fluid and if 700cc were removed in the course of the laparotomy, the leak must have commenced much earlier than contended for by the defendants.

38. He also relied on the degree of celulitis noted by Prof. McAnena in his operation record as indicating that the abdomen had been infected for longer than contended for by the defendants.

39. While principally called as a witness as to fact, Prof. McAnena, who carried out the laparotomy on the plaintiff at approximately 14:00hrs on Monday, 27th August, 2007, told the court that there was a lot of contamination in the abdominal cavity when it was opened up and it was this contamination that had caused the plaintiff's septicaemia. He felt that the overall picture was of a leak which had certainly happened at least 24 hours before he operated on the patient. The abdominal wall had feculent matter within it and was cellulitic apart from the presence of the 700ccsof feculent fluid. Prof. McAnena felt it was likely that when the leak had initially occurred it had been contained by the abdominal contents surrounding it such as the omentum or a small piece of bowel. He explained to the court how, somewhat like an abscess, material which leaks from the small intestine may be corralled in this way and can suddenly break free causing the patient to develop very significant sepsis.

40. In cross-examination, Prof. McAnena advised the court that the edges of the skin at the site of the leak were found to be everted in the course of the surgery and this fact when taken together with the extent of the contamination and cellulitis found suggested that the leak did not commence within the previous 24 hours. He felt the leak could have been present for many days. Prof. McAnena stated that patients who have developed a leak might not look overtly sick nor have a change in their vital signs until such time as they become systemically septic. In the instant case, this may have happened when the omentum broke free from the site of the leek and the contaminated feculent fluid gone "all over the place".

41. Prof. McAnena was of the opinion that the consequences of the septic event had started to become apparent from the plaintiff's symptoms, which developed at about 15:00hrs on Sunday, 26th August 2007. This did not mean that the leak itself had commenced at that time and may have started much earlier. He confirmed that it was the presentation of a patient's symptoms that should set alarm bells ringing.

The Defendant's Evidence

42. Mr. Royston, who is a general surgeon with a special interest in colorectal surgery, told the court that he disagreed with Prof. Keighley and Prof. McAnena as to when the anastomotic leak had commenced. He did not agree that it was present at 15:00hrs on Sunday 26thAugust, 2007. From the nursing notes and medical records, he was satisfied that the plaintiff's symptoms, as recorded by the nursing staff at 18:00hrs and Dr. Chang at 7pm on that date, were of a sub-acute bowel obstruction. This, he explained, is a mechanical problem that develops when the bowel has a kink in it and causes crampy intermittent pain as the small bowel attempts to push material past the kink. Mr. Royston felt the sub-acute bowel obstruction was as a result of adhesions. While he accepted that the diagnosis of an ileus made by Dr. Chang was incorrect, he was satisfied that the plaintiff did not have signs or symptoms such

that he should have suspected that his patient had developed an anastomotic leak. He advised the court that leaks of this nature from the small intestine are very rare indeed.

43. Mr. Royston's evidence was that once a leak occurs in the small intestine, the patient develops very significant pain which is continuous. They develop a distended abdomen that becomes acutely sensitive and display symptoms of rebound tenderness and guarding. Mr Royston advised that once a leak occurs, the patient's vital signs change and you expect to see an immediate increase in the pulse and temperature and to notice a drop in blood pressure. These findings were not present at the time Dr. Chang examined the plaintiff shortly after 18:00 hours and he agreed with Dr. Chang that there was no indication such as would mandate the ordering of a chest x-ray or the carrying out of blood tests. Neither did Mr. Royston feel there was any justification for Prof. Keighley's assertion that Dr. Chang ought to have contacted Mr. Nee to inform him of the patient's symptoms.

44. As to when and how the leak occurred, Mr. Royston stated that the sub acute bowel obstruction led to the build up of bile in the small intestine. This is why the patient had colicky pain and was nauseous. When he vomited at 05:30hrs on the morning of Monday, 27th August, 2007, everything came apart. There was a simultaneous dehiscence of the deep layer structures in the abdomen and the opening of the anastomosis.

45. Mr. Royston was satisfied that the patient's symptoms as were presented to Dr. Chang shortly after 18:00hrs on Sunday, 26th August, 2007, were inconsistent with those of a patient with an anastomotic leak of a couple of hours duration. Likewise, the nursing note referable to the night of Sunday, 26th August, 2007, was, he maintained inconsistent with the leak having commenced several hours prior to Dr. Chang's examination of the patient at 18:00hrs. Mr. Royston was of the opinion that if this had occurred the patient would not have refused analgesia that evening, would not have been up to the toilet and would have had much more pain and abdominal tenderness than had been reported.

46. Mr. Royston disagreed with Prof. Keighley and Prof. McAnena that a leak from the small intestine can be corralled or plugged by the omentum which may be attached to the site of the leak and that it might take a significant period before the contaminated material, which had been isolated, would break free into the rest of the abdominal cavity. He said faecal fluid would come out of a small leak very readily and that even with an escape of a modest amount of fluid, the patient would have severe abdominal pain and a change in their vital signs.

47. Mr. Royston also disagreed with Prof. Keighley that the duration of an anastomotic leak could be estimated by reference to the size of the rupture identified in the course of a subsequent laparotomy such as occurred in the present case on 27th August, 2007.

48. As to the type of investigation that is appropriate in circumstances where an anastomotic leak is suspected, Mr. Royston agreed that a chest x-ray is used to detect such a leak. However, he was also of the opinion that had a chest x-ray been carried out on the evening of 26th August, 2007, that no gas would have appeared in the abdomen because in his opinion the leak had not commenced at that time.

49. Mr. Royston stated that even if a leak had developed by the evening of 26th August, 2007, he felt that blood tests carried out at 19:00hrs would not necessarily have identified the presence of infection and thereby the likely presence of a leak.

50. Mr. Royston told the court that it was not possible to estimate the duration of the leak from the intra-operative findings. You could not, he advised, rely upon the volume of the faecal fluid found in the abdomen or the description of the degree of cellulitis present to achieve this objective.

51. Mr. Royston felt that the changes which were identified in the plaintiff's symptoms and vital signs and which are noted at 05:40hrs the following morning were consistent with the leak having occurred at that time.

Dr. Chang's Evidence

52. Dr. Chang, against whom the principle allegations of negligence are made in these proceedings, told the court that he had obtained his medical degree in 2004 and completed his surgical training in June 2007. The following month he took up his position as resident medical officer in the Bon Secours Hospital in Cork. Dr. Chang stated that in the course of his surgical training and at house officer stage, he had experience of dealing with the medical complication of an anastomotic leak.

53. Dr. Chang advised the court that when he was called to review the plaintiff shortly after 18:00hrs on Sunday, 26th August, 2007, that he was not having as much pain as he had experienced earlier in the day. He examined the plaintiff, found his bowel sounds to be sluggish and he felt his patient had developed an ileus. He directed that the patient's diet be stopped, IV fluids be introduced and he prescribed buscopan, an antispasmodic. Dr. Chang said that the plaintiff did not look ill, that he had been mobilising during the day and was passing flatus. All of the signs were very reassuring. He had no clinical suspicion that the patient was suffering from a leak. He advised the court that colicky pain was not consistent with a leak as the pain from a leak would be persistent. Also, the patient would be expected to demonstrate much more by way of gastrointestinal symptoms such as nausea and vomiting. In the presence of a leak he would not expect the bowel to be functioning and there should be not flatus. He also stated that you would expect the patient to be tachycardic, to have sustained a drop in blood pressure and a rise in their temperature. He stated that if he had any concerns for the welfare of his patient, he would have called for a senior review by Mr. Nee.

54. Dr. Chang told the court that he reviewed the patient for a second time at 05:30hrs on the Monday morning (27th August, 2007). He noted that the patient had experienced no flatus since last seen. On examination he found the patient's abdomen more distended and he ordered plain film x-rays of the abdomen. He said the patient's vital signs were stable.

55. Dr. Chang could not recall much of what happened between 05:30 and 07:00 hrs on 27th August 2007, but told the court that he felt everything had moved very quickly. He remembered being up at the nurses station drawing antibiotics and also the putting up of certain cannulae. Dr. Chang told the court that there was a stark difference in the patient's vital signs from about 05:40hrs on the Monday morning. The patient's temperature had dropped to 35.6 which he described as hypothermia.

56. In cross-examination, Dr. Chang stated that in his opinion, the breakdown of an anastomosis most commonly occurred between days 5 and 10 following surgery. He was certain that his note written at 19:00hrs on Sunday, 26th August, 2007, recorded that the patient was passing flatus at that time and that the entry regarding flatus did not relate to the patient's condition two days prior to the making of the note. He confirmed that had he suspected a leak, he would have contacted Mr. Nee and would have directed a CT scan be carried out. He did not believe that a chest x-ray or x-ray of the abdomen would have necessarily been diagnostic of the presence or absence of a leak because free gas was often found within the abdomen after surgery.

57. Dr. Chang was satisfied that he did not fall short of the standard of care which was to be expected of him in all of the

circumstances.

The Court's Conclusion
58. In a case with such conflict between the experts on almost every medical issue, the court was fortunate to have had the benefit of the entirely independent evidence of Prof. McAnena, a surgeon who enjoys qualifications at least equivalent to those of Prof. Keighley and Mr. Royston. He was able to assist the court on a number of relevant issues and was in a position to support his opinion based upon what he actually observed in the course of the surgery which he performed on the plaintiff at approximately 14.00hrs on Monday, 27th August, 2007.

59. Prof. McAnena's evidence gave little support to the position adopted by Mr. Royston on a number of important issues. To the contrary, he gave clear and unequivocal evidence supporting Prof. Keighley's view that the symptoms displayed by the plaintiff from 15:00hrs on 26th August, 2007, were secondary to an anastomotic leak. He was absolutely certain that the leak had been in existence for at least 24 hours when he operated upon the plaintiff and it could, in his view, have been present for as long as 72 hours. Prof. McAnena told the court that he had reached this conclusion based on the degree of cellulitis and the volume of faecal fluid he observed in the abdomen during the laparotomy as well as from the plaintiff's overall condition, which was close to death.

60. Prof. McAnena also supported Prof. Keighley's evidence on two other disputed issues. He agreed that leaks from anastomosis are very variable and that in many instances the initial leak may be corralled and restrained from spilling into the peritoneal cavity if the omentum or a loop of bowel attaches itself to the area of the leak. Many leaks he said evolved in this manner, an opinion not shared by Mr. Royston.

61. Prof. McAnena also made it very clear that the vital signs of patients who develop an anastomotic leak may remain normal for a significant period after the commencement of the leak. He was at pains to explain that the change in a patient's vital signs will only occur when sepsis is established and depending on the nature of the leak this may not occur for a considerable period of time.

Findings of Fact
62. Before moving to consider the issues of negligence, I feel it is convenient at this point in the judgment to set out a number of findings of fact which I am happy to make based on the overall evidence.

63. I am quite satisfied as a matter of fact that the plaintiff developed an anastomotic leak sometime before 15:00hrs on Sunday, 26th August, 2007. I do so based on the evidence of Prof. Keighley and Prof. McAnena. It did not commence at 05.30hrs on the morning of Monday, 27th August, 2007, as contended for by the defendants. Further, I accept the evidence tendered on behalf of the plaintiff that all of the patient's symptoms of pain, bloating, nausea, abdominal distension, tenderness and vomiting noted between 18:00hrs on 26th August, 2007 and 07.00hrs on 27th August, 2007, were attributable to that leak.

64. I am also satisfied, that when the patient vomited, a large amount of green liquid at 05.30hrs on the morning of 27th August, 2007, that this was, as advised by Prof. Keighley, a response to the continued deterioration in the plaintiff's condition due to the leak. I accept Prof. Keighley's evidence that the expulsive force of that vomit caused the deep layer of sutures in the abdomen to dehisce and that as they did so the omentum was pulled off the site of the leak causing the faecal material, which had previously been restrained, to run free into the peritoneal cavity.

65. It follows that I reject Mr. Royston's view that the patient's symptoms up to 05:30hrs on 27th August, 2007, were as a result of a build up of bile in the small intestine secondary to a sub acute obstruction. I reject his evidence that the patient vomited at 05.30hrs on 27th August, 2007, as a result of nausea generated by any such obstruction and his evidence that there then was a simultaneous dehiscence of the sutures in the abdomen and an immediate opening of a previously non-existent anastomotic leak. I accept Prof. Keighley's evidence and that of Prof. McAnena that the patient could never have deteriorated to the condition which he was in by 14:00hrs on Monday 27th August, 2007, if this is how and when the leak occurred. In particular I find it inconceivable, in the light of Prof. McAnena's evidence, that I could conclude that the leak started at 05.30hrs on 27th August, 2007, and that by 05.40hrs, ten minutes later, he had, as recorded, developed hypothermia, a change in vital signs, which according to Prof. Keighley and Prof. McAnena, occurs as part of the body's response to the secondary condition of sepsis. Sepsis could not have set in within ten minutes of the commencement of the leak and the body could not, on the evidence which I accept, have responded with such a dramatic change in temperature over a ten minute period.

66. In coming to the aforementioned conclusions, I accept the evidence of Prof. Keighley as to the manner in which pain may present as a result of an anastomotic leak, particularly where the leak is not acute, as occurred in this case. I accept his evidence that it does not have to present as severe and continuous. As is apparent from my earlier conclusions I also accept his evidence as to the time the leak commenced and his evidence and that of Mr. McAnena that a leak does cause an immediate change in the patient's vital signs and the point at which such change does take place will depend upon when septicaemia, the secondary event, occurs. I also reject the defendant's evidence that the night-time nursing note for 26th August 2007, is inconsistent with the leak having commenced earlier that day. At the time that note was written, the patient had received analgesia at 18:00hrs but his abdomen, according to the nursing staff, remained distended and he continued to remain nauseous even though he was taking "sips" only. The fact that he was able to go up to the toilet in the early evening was not, according to Prof. Keighley, any way inconsistent with the presence of an anastomotic leak.

Breach of Duty
67. The fact that an anastomotic leak was present for several hours when Dr. Chang examined the patient shortly after 18:00hrs on Sunday, 26th August, 2007, does not mean that Dr. Chang was necessarily guilty of any negligence or breach of duty to his patient Mr. Foley. The onus is on the plaintiff to establish negligence having regard to the standard of care as advised by Finlay C.J. in *Dunne v. National Maternity Hospital* [1989] IR 91, [1989] ILRM 735.

68. While the court was entitled to use the benefit of hindsight to assist in reaching its conclusions as to when, as a matter of probability, the plaintiff's anastomotic leak commenced, it is not permitted to use such an approach when considering the allegations of negligence levelled at Dr. Chang in respect of his management of the patient when called to review him shortly after 18:00hrs on 26th August, 2007. It must confine itself to a consideration of the facts as might reasonably have been known to Dr. Chang at that time. It is important to exclude a consideration of facts which have since been established such as the fact that an anastomotic leak had been present for several hours by the time he examined the patient at 18:00hrs and that the plaintiff was close to death when operated upon by Prof. McAnena about 14:00hrs the following day.

69. Having considered all of the evidence in the proceedings, I prefer the evidence of Prof. Keighley to that of Mr. Royston as to the standard of care to be expected of Dr. Chang on the evening of Sunday, 26th August, 2007. I accept Prof. Keighley's evidence that from the patients history over the period up to and including the time at which Dr. Chang wrote his note at 19:00hrs on 26th August,

2007, that his failure to consider the possibility that the plaintiff had developed an anastomotic leak and to manage his care as if he had such a leak until otherwise proven, was to fall short of the standard of care expected of him. It follows that his failure to investigate the plaintiff for a potential anastomotic leak by directing that the patient have an urgent chest x-ray shortly after 18.00hrs on Sunday, 26th August, 2007, was to fall below an acceptable standard.

70. I am further satisfied that having regard to the patient's deterioration over the previous three hour period that Dr. Chang was obliged to contact Mr. Nee so as to advise him of the patient's changed condition and to seek his further advices.

71. In coming to my aforementioned conclusions, I accept Prof. Keighley's evidence that when Dr. Chang was called to review the patient shortly after 18:00hrs, he ought to have been concerned at the patient's deterioration. He had been well and without complaint the previous day and had, earlier in the week, recovered from a post operative ileus. He had been eating well and was mobilising. In contradistinction, the patient now had a new type of pain which was described by him as crampy and which Prof. Keighley reminded the court can be very painful indeed. This pain was accompanied by nausea and by the time Dr. Chang saw the patient this had been getting worse over a three hour period.

72. I also accept Prof. Keighley's evidence that for Dr. Chang to have made an incorrect diagnosis of a post operative ileus was not negligent per se. However, I accept his evidence that, having regard to the patients post operative history and progress as recorded in the nursing records, the most likely cause for the plaintiff's symptoms at that time was a leak and that it was unacceptable for Dr. Chang to fail to consider a leak within his differential diagnosis. The fact that Dr. Chang in his own evidence did not consider the patient's symptoms as possibly referable to a leak was to fall short of the standard to be expected of him

73. I also accept Prof. Keighley's evidence that, because a patient who sustains a leak will go on to develop peritonitis, a potentially fatal condition, once a leak is considered to be even a remote possibility, the patient must be managed as if they have a leak until the contrary is established and that to this end the patient must have an immediate chest x-ray which will be definitive one way or the other as to the existence or absence of a leak. Accordingly Dr. Chang's failure to direct an x-ray at the time of his examination of the patient shortly after 18:00hrs on the evening of 26th August, 2007, was, I believe, to fall short of an acceptable standard of care. Even if he considered the patient's symptoms to be more indicative of an ileus, he ought nonetheless have considered the possibility of a leak and directed the appropriate investigations.

74. I accept Prof. Keighley's evidence that having regard to the plaintiff's significantly altered condition and his own findings, that Dr. Chang's response which was to direct that a drip be sited, that the patient should take nil by mouth and remain under observation was to fall short of the standard to be expected of him.

75. I am satisfied from Prof. Keighley's evidence that Dr. Chang was not entitled to exclude from his consideration the possibility of a leak because the patient's pain was not continuous, there was no guarding rebound and his vital signs remained normal. I accept that these changes occur when the patient has developed peritonitis and that investigation cannot be postponed to await such signs and symptoms.

76. In coming to the aforementioned conclusions, I have factored into my consideration, the evidence of Prof. Keighley which I accept, to the effect that approximately 50% of anastomotic leaks occur in a gradual way and because such leaks, in their early phase may be corralled and curtailed, the symptoms and signs of the leak may evolve more slowly than happens with an acute leak. This being so, I accept Prof. Keighley's evidence that the signs and symptoms so clearly noted in the nursing records and in Dr. Chang's own note ought to have led him to direct that a chest x-ray be taken to rule out the possibility of a leak and to have made contact with Mr. Nee to advise him as to the patient's deterioration.

77. I am satisfied from the evidence of Prof. Keighley that had an x-ray been carried out following Dr. Chang's examination of the patient shortly after 18:00hrs on 26th August, 2007, that gas would have been seen in the abdomen, particularly as we now know that the leak had commenced at that time. Again, I reject Mr. Royston's evidence that had an x-ray been carried out at that time, it would not have shown the presence of gas in the abdomen as his evidence was based on his opinion that a leak had not occurred at that time and his opinion that if there had been a leak the patient would have had changes in his vital signs, an opinion which I cannot accept for reasons earlier stated. It was not contested that if gas had appeared in the aforementioned x-ray that a laparotomy would have likely been performed later that evening by Mr. Nee.

78. Given that Prof. Keighley accepted in the course of his evidence that blood tests, had they been carried out shortly after 18:00hrs on 26th August, 2007, might not have shown changes indicative of a leak, it is not necessary for me to decide whether Dr. Chang was negligent for his failure to direct that blood tests be carried out following his examination of the patient shortly after 18:00hrs on the evening of Sunday, 26th August, 2007.

79. While the court did not hear evidence from Mr. Nee, probably due to the fact that a direction was granted in respect of the case made against him, I am nonetheless satisfied as a matter of probability that had he been informed of his patient's changed condition in or about 19:00hrs on Sunday, 26th August, 2007, that he would either have come directly to the hospital himself to review the patient or would have directed that an urgent x-ray be carried out and have immediately come to the hospital on receipt of the results of such x-ray.

80. As it happens, from the nursing notes it seems probable that that Mr. Nee was only contacted regarding the patient's deterioration at about 07:00hrs on Monday, 27th August, 2007, at which time Dr. Chang was called by the nursing staff to review the patient for the third time that morning. Mr. Nee subsequently arrived and reviewed the plaintiff at 07:40hrs and because of his condition arranged for his immediate transfer to UCHG. Having regard to Mr. Nee's swift response to the emergency once advised of the patient's deterioration, I am satisfied that had he been called the previous evening, either due to the patients deterioration or the results of an x-ray showing gas in the abdomen, he would, in either scenario have been in the hospital by 20:00hrs and would have commenced a laparotomy by about 21:00hrs or 22:00hrs.

81. I have therefore concluded that Dr. Chang's negligence led to the plaintiff's surgery being postponed by about 17 hours, a delay which had a very significant adverse effect in terms of his outcome.

82. In circumstances where I have concluded that Dr. Chang was negligent in his failure to direct a chest x-ray between 18:00 and 19:00 hours on 26th August, 2007, and for not calling Mr. Nee to advise him of his patient's deterioration, it is not necessary for the purposes of these proceedings to consider Dr. Chang's further engagement with the plaintiff. However, for the purpose of completeness I think it maybe worthwhile for me to state that I do not feel that Dr. Chang had any real appreciation of the significance of his patient's deterioration until 07.00hrs on the morning of 27th August, 2007.

83. The nursing notes at 05:30hrs on Monday, 27th August, 2007, record that the patient had felt his abdomen tear as he vomited 500mls of bile into a kidney dish. To the nursing staff his abdomen also looked distended. They contacted Dr. Chang and he came to review the patient, as is confirmed in his own note. That note draws out in pretty clear detail the increased distension in the plaintiff's abdomen when compared to his findings at 18:00hrs the previous evening. He also noted that the patient at that stage had persistent vomiting and had passed no flatus since last seen, both worrying signs. Rather surprisingly Dr. Chang's note makes no mention of the fact that the patient had felt something tear in his abdomen as he vomited, notwithstanding the fact that this seemed to be the event that triggered the call to him to review the patient and is the moment when, as agreed by both parties the internal abdominal sutures ripped apart.

84. It is also perhaps surprising that Dr. Chang's note written at 05.30hrs on Monday the 27th August 2007, records that the patient's vital signs were stable. Yet ten minutes after he wrote his note the TPR chart records the plaintiff's temperature as 35.5, a finding consistent with the patient being hypothermic. This leads me to believe that when Dr. Chang examined the patient he must have relied on the plaintiff's vital signs as recorded at 04.00hrs, an hour and a half earlier, when the patient's temperature was recorded as 36.5.

85. While again irrelevant to the liability issue, Dr Chang's instructions after the examination at 05.30hrs that Monday morning were confined to advising that the patient continue with the IV fluids and the anti emetic medication earlier prescribed. He clearly felt it advisable to pass a naso- gastric tube but due to the patient's reluctance this did not happen, according to the nursing notes, until 06:45hrs at which time the nursing staff had contacted Dr Chang for the second time that morning regarding the plaintiff's ongoing symptoms. Further, while it appears from the notes that Dr Chang at the time of his 05.30hrs examination directed an x-ray be taken, it does not appear that this was to be done urgently as the patient had not been taken for x-ray by the time his condition deteriorated further at 06.45 hours. Further, notwithstanding the patient's condition at 05.30hrs it does not appear that even at this stage that Dr. Chang felt he should involve Mr. Nee.

86. It is difficult to work out with any certainty Dr. Chang's involvement with the patient after he wrote his note at 5.30 hours. In his evidence he said he could not remember much about the period but that everything moved very quickly. He said he remembered being up at the nurses station drawing antibiotics and then putting up an IV cannula, but from the nursing note a somewhat different picture emerges, not that it is of any relevance to the liability issue.

87. The nursing and medical records are inconsistent with any urgency or significant concern on the part of Dr. Chang after his visit to the patient at 05.30hrs on Monday, 27th August, 2007. If Dr. Chang had been managing an emergency from 05.30hrs or 05.40hrs, as he suggested in evidence, it would not have been necessary for the nurses to have recorded, as they did, that Dr. Chang was called yet again to review the patient at 06.45hrs due to persistent vomiting. Further, it also seems unlikely that Dr. Chang came to review the patient after that call at 06.45hrs, as he made no note to this effect in the records and any such review is not recorded in the nursing records. He appears to have advised, by some method which is not clear, that the naso-gastric tube should be passed.

88. The nursing notes record that fifteen minutes later at 07:00hrs, Dr. Chang was called for the third time that morning to review the patient and I think it was only at this time that he appreciated that anything serious might be occurring. I do not believe Dr. Chang even suspected there might be a possibility that his patient had an anastomotic leak as late as06.45hrs on Monday, 27th August 2007.

89. Anyway, as already stated, the only matters to be considered when determining whether there was negligence on the part of Dr. Chang are the facts up to and including the time he reviewed the patient at 18:00hrs on Sunday, 26th August, 2007, at which stage I am satisfied that he fell short of providing the requisite standard of care. Had he not failed in this regard the plaintiff would have been operated approximately 17 hours earlier than ultimately transpired and would have been saved much of the pain and suffering which he has had to endure ever since.

General Damages

90. In trying to assess the general damages to which the plaintiff is entitled, I have considered not only his own evidence but that of his wife, Mary and his two daughters. In addition, I have taken into account the evidence of Prof. Keighley; Dr. Brennan, the plaintiff's General Practitioner; and that of Dr. Anne Marie Regan, Consultant Psychologist.

91. From the evidence, it is clear that the plaintiff had what can only be described as a horrific period of four months following his admission to UCHG for the emergency laparotomy. In the course of that laparotomy, the area of perforated bowel was removed and an ileostomy performed. At the time that operation was performed, the plaintiff was close to death as was apparent from Prof. McAnena's evidence.

92. In the aftermath of his surgery in UCHG, the plaintiff was taken to the Intensive Care Unit where he remained intubated and ventilated. He was in receipt of intravenous antibiotics. The plaintiff later went into acute renal failure and required dialysis until 31st August. He also had to be fed intravenously. A tracheostomy was performed on 12th September, 2007, to assist with ventilation. The plaintiff's wound had to be debrided on 13th September, 2007, and a split skin graft carried out on 28th September 2007. It was October 2007 before he was self ventilating. The plaintiff's wound had healed by 5th November, 2007, at which stage he was discharged from ICU and he was allowed home on 30th November, 2007.

93. During the aforementioned period, the plaintiff also developed two conditions which, on the medical evidence, cannot be ascribed to the defendant's negligence. The first of these was a transient ischemic attack which occurred in November 2007, and the second an entrapment of ulnar nerve which subsequently required surgery to release it the following February.

94. Prof. Keighley's evidence in relation to the plaintiff's condition when in UCHG was relatively uncontested. He made it clear that had the plaintiff had surgery in the Bon Secours Hospital by 21:00hrs or 22:00hrs on 27th August, 2007, that he would have avoided the life threatening situation which evolved thereafter and he would not have developed neutropoenia, a condition that occurs when the bone marrow is not functioning. He would also have avoided the need for ventilatory support, which he required for the better part of a week. In addition, it was Prof. Keighley's evidence that the plaintiff would not have experienced renal failure and would not have needed dialysis. If surgery had been carried out earlier, he would not have developed dehiscence of the abdominal wound and neither would he have developed a faecal fistula. If this had not developed, he would not have required intravenous feeding for about a month. He would also have avoided the tracheostomy. Prof. Keighley advised that while the plaintiff would probably have developed another hernia, he would have avoided the development of an abdominal defect of the size that now appears in his abdominal wall. He advised that regardless of any negligence on the part of the defendants, the plaintiff would in any event have been left with very significant scarring but of a lesser magnitude than presently exists.

95. When considering the general damages to be awarded in respect of pain and suffering to date, I must of course take into account

the fact that, even absent the defendant's negligence, the plaintiff would have had to cope with the consequences of two serious operations. First the hernia repair of 20th August 2007, in the course of which an anastomosis had to be carried out, and secondly the laparotomy to repair the serious complication of the anostomatic leak. This later operation, regardless of the delay in its performance, would have had significant consequences for the plaintiff even if it had been carried out in more benign circumstances given that the surgery involved an ileostomy and the creation of a stoma. The plaintiff, according to Prof. Keighley, would have required at least two weeks of hospitalisation as a result of this surgery and of course he would have experienced a considerable period of pain and discomfort.

96. When assessing the amount of damages to which the plaintiff is entitled the court must also take account of the fact that the plaintiff has, since January 2008, experienced quite a number of medical complications or what are described as co morbidities, unrelated to the defendant's negligence. These problems alone, regardless of any disabilities caused by the defendant's negligence, would have had a major impact on his physical and mental health as well as on his overall quality of life.

97 The plaintiff first experienced cardiac symptoms in November 2007, when still in UCHG. He suffered a transient ischemic attack in the course of which he had impaired vision for a short period of time. The next complication arose in February 2008, when the plaintiff required surgery for the release of his ulnar nerve. Then, in April 2008, while driving in traffic his vision became impaired as a result of a CVA (stroke). He was hospitalised for ten days and spent many weeks at home during which period his vision, according to his wife, was impaired to the point that he was bumping into furniture. As a consequence, he was unable to drive until July 2008, and he was only certified fit to return to work, in June 2008. In his own evidence, he told the court it took him four to six months to get over this event.

98. In addition to the physical and psychological consequences of his CVA, the plaintiff has continued to experience the adverse consequences of obesity. He suffers from fatigue, shortness of breath, limited mobility and respiratory impairment. He uses an inhaler intermittently following exertion. In October 2009, he developed respiratory symptoms that went on for many months and these problems led to sleep studies being carried out. These studies diagnosed sleep apnoea and since June 2010, the plaintiff has been using a sleep apnoea machine. Nonetheless he continues to suffer from exhaustion. The plaintiff also suffers from colitis and psoriasis.

99. The plaintiff's overall health took a further turn for the worse in early 2012, when he was investigated for pain and stiffness in his hips. X-rays revealed the presence of arthritis in both hips, a condition that required pain killing and anti inflammatory medication as well as physiotherapy.

100. Since late 2008, the plaintiff has been treated by his general practitioner for depression. He has continued to take Cipramil, an antidepressant, since that time. It is difficult to know, regardless of the evidence tendered to the court by Dr. Brennan the plaintiff's general practitioner and Ms. Anne Marie Regan, Consultant Psychiatrist, who assessed the plaintiff for medical legal purposes, just how much of his depression is attributable to the consequences of the injuries caused by the defendant's negligence. From a physical perspective, with the exception of the increased scarring and the fault in the abdominal wall, both of which are permanent, the plaintiff made a pretty remarkable recovery physical recovery from his acute medical complications within about six months of his surgery. I readily accept of course that when the plaintiff was initially discharged from hospital, he had a period of significant dependence when he was only in a position to mobilise with the aid of a Zimmer frame and then later a stick. The plaintiff told the court that approximately eight to ten months post surgery, he was in a position to join friends for a couple of pints several evenings a week.

101. Much of the plaintiff's depression appears to be tied up with the fact that he retired from work on 1st July 2009. He feels deeply the loss of his employment, which had given him a sense of purpose and confidence in his ability to provide for his family. Now, without his job, his sense of self worth and confidence has, according to Dr. Brennan and Ms. Regan, been eroded. He feels deeply dependant on his wife and family and hates being on his own. The plaintiff told the court that he wants his wife to be with him all of the time. Ms. Regan told the court that she felt the plaintiff demonstrated symptoms of post traumatic stress with depressive features; including decreased libido and that he appeared to be preoccupied with his physical symptoms. Given the ongoing nature of his physical symptoms, she felt it would be difficult for him to make a full recovery.

102. Because the plaintiff seeks to ascribe much of his ongoing psychiatric complaints to the fact that he no longer enjoys gainful employment it is necessary for me to consider the extent to which the injuries sustained by reason of the defendants negligence may have caused or contributed to his early retirement. The question I must ask myself is whether the plaintiff, but for the defendant's negligence, would have retired early in July 2009. In this regard it is relevant to note that following a long period of recuperation during which he suffered no reduction in income the plaintiff had managed to return to work in August 2008. By September 2008, he was working 3 days a week albeit it on relatively light duties. In October, he was working a 4 day week and by November a five day week.

103. It is clear from the medical records and the oral evidence of his general practitioner, Dr. Brennan that at the time he decided to retire in July 2009, the plaintiff was in generally poor health. Up until that point he remained in employment and could have continued were it not for his own decision to retire. He was doing clerical work at that time and told the court that he would have liked to have tried to go back to full outdoor duties thus signalling to me that he had made a fairly good physical recover at that time.

104. I am satisfied that the plaintiff's decision to retire was stimulated, not by the injuries consequential on the defendant's negligence, but rather by reason of the stroke which he suffered in frightening circumstances in April 2009. In fact, this is what he said in reply to counsel at question 317 on day 2 in the course of his own evidence.

105. In April 2009, the plaintiff, reported to Dr. Brennan, following his CVA earlier that month that he was feeling exhausted, was having problems driving, was worried about his stomach and was depressed. Dr. Brennan advised him to retire on health grounds, which he did. While the plaintiff maintained in the course of his evidence that his employers never accepted that he had retired on health grounds, I am satisfied that his overall health was the de facto reason for his retirement, a decision perhaps reinforced by the some degree of paranoia on his part that his colleagues did not want him back in his job.

106. Because of the plaintiff's co morbidities to which I have already and the consequences of his stroke, I am satisfied that regardless of any negligence on the part of the defendants, he would not have withstood the demands of his former job and would, in any event, have retired in July 2009.

107. I do not intend to recite all of the difficulties that the plaintiff is likely to have in the future as a result of the defendant's negligence. However, the following are perhaps the most significant in the context of considering his entitlement to damages for pain and suffering into the future. Firstly, he has a significant amount of additional scarring and a grossly disfiguring abdominal defect which runs the entire width of his abdomen. The plaintiff has been advised that he could do with wearing some type of support to

give him more comfort and protection for this area of his body. However, he finds the wearing of any type of corset or elastic support extremely uncomfortable.

108. The plaintiff's wound has broken down on a number of occasions since his surgery and it is anticipated that he will continue to experience further breakdowns of the very fine layer of skin which overlies the abdominal fault intermittently into the future. I also understand the plaintiff's concern as to the risk of injuring his abdomen having regard to the lack of protective flesh overlying this fault. In this regard, I note that he no longer plays snooker for fear of injuring his abdomen on contact with the table.

109. I am not prepared to ascribe the plaintiff's lack of mobility to the defendant's negligence. The plaintiff got back to work following his hospitalisation and worked for several months prior to his stroke in 2009. Indeed, he complained to the court that he was being confined to light duties at a time when he felt he was in a position to go back to outdoor work at least on a trial basis. Hence, I cannot see how he can blame his current lack of mobility on the defendant's negligence. Further, he can still drive and it is not readily clear to me why he cannot fully look after himself in a relatively normal fashion. Neither do I see any reason why he cannot cook meals for himself or cater to all of his own hygiene needs.

110. While I have heard a lot of evidence to the effect that the plaintiff lacks confidence in social situations and that the wants his wife present with him all of the time, again, I am not prepared to ascribe this need to the defendant's negligence. As already stated, he managed to return to work for several months prior to retiring and he told the court that he was back socialising to the extent that he was out drinking four pints with his friends a couple of times a week.

111. While the plaintiff required significant support from his wife and daughters following his discharge from hospital in November 2007, I feel he made a relatively rapid recovery from the physical injuries which arise from the defendant's negligence. I, of course, must take into account that he lost some five stone when in hospital and was very weak as a result when he sought to mobilise again in early 2008. However, I am quite satisfied that a significant amount of the plaintiff's lack of confidence and his desire to have his wife or somebody else with him all of the time is a natural consequence of all of his other medical problems and that those injuries which may be ascribed to the defendant's negligence is only one contributing factor to this problem. In this regard, it is to be noted that the plaintiff's wife continued to work full time until she took early retirement in 2011.

112. Perhaps, having been through all the plaintiff had to endure from August to December 2007, it is understandable that he may genuinely believe that all of his subsequent medical complications and life's tribulations are as a result of the defendant's negligence but that is a conclusion which I do not believe is supported by the evidence. For example, I cannot ascribe the plaintiff's inability to get out of bed in the morning and his requirement to go to bed at 7 pm every evening to the consequences of the injuries caused by the defendant's negligence. Further, while I do accept that the plaintiff has been left with some psychological sequelae and depression as a result of the defendant's negligence, I am absolutely satisfied that the greater portion of these difficulties arise by virtue of a lack of confidence stemming from his co-morbidities and the loss of employment which again I believe was unrelated to the defendant's negligence.

113. In all of the foregoing circumstances, I am not disposed to making any award in respect of loss of earnings. Neither do I feel it appropriate to make anything other than a relatively modest award to compensate those responsible for the plaintiff's care in that period of time which predates his return to the workforce. I think it is impossible to contend that a man who was capable of working full time, even if only on light duties and was capable of socialising to the extent already referred to in this judgment, can maintain any claim for future care and seek to visit it upon the defendant's negligence in this claim. Any care which the plaintiff needs should be ascribed to his comorbidities and the psychological consequences attributable to his early retirement.

114. In all of the foregoing circumstances, I will award a sum of damages of €200,000 in respect of pain and suffering to date and a sum of €100,000 in respect of pain and suffering into the future. I will allow an additional sum of 10,000 euro in respect of past care.