Neutral Citation Number: [2014] IEHC 87

THE HIGH COURT

[2013 No. 183CA]

BETWEEN

LAURENCE FLYNN

PLAINTIFF

AND

BONS SECOURS HEALTH SYSTEMS LTD.

DEFENDANT

JUDGMENT of Mr. Justice Hogan delivered on the 14th day of February, 2014

1. This is an appeal by the plaintiff against a decision of the Circuit Court (His Honour Judge Ó Donnabháin) on the 30th July 2013 whereby he directed that the plaintiff's medical negligence proceedings against the defendant hospital be permanently stayed. A similar order was made in *Flynn v. Blackrock Clinic Ltd.* (Circuit Court, 2012, 00919) and in *Flynn v. Mater Private Hospital* (2012, 01301). This judgment also covers the appeal in these cases (2013 CA 184 and 2013 CA 183 respectively).

2. These appeals present a difficult issue against an unusual factual background. The issue is this: should the plaintiff's actions for medical negligence against all three hospitals be stayed permanently in circumstances where the plaintiff is unable to produce a medical report of his own, even though at least one of the defendants is in possession of a report which, to some degree, supports some of the plaintiff's factual contentions?

3. As it happens, I have already set out that background in quite separate judicial review proceedings involving the present plaintiff, *Flynn v. Medical Council* [2012] IEHC 477. Although those proceedings were entirely separate to the present proceedings, that judgment should really be read in conjunction with those earlier proceedings, not least given that I propose to reproduce and, where appropriate, adapt some of that summary for the purposes of the present case.

The background to the present proceedings

4. The plaintiff, Mr. Flynn, maintains that in his late teenage years he suffered a mishap when in 1987 he pressed the back of his palate with his finger and in the course of this accident broke and moved his left pterygoid hamulus bone. This is a hook like narrow bone around which the tendon of muscles of the soft palate glide at the very back of the palate of the mouth. As we shall see, the injury in question is exceedingly rare and not very often encountered, even by specialists.

5. As a result of this mishap Mr. Flynn contended that he suffered considerable pain and had difficulties in swallowing. In some respect it seems that this complaint was not received very sympathetically by the medical personnel he consulted in the years that followed. Thus, as late as November 1995 a Professor of Dentistry dismissed the suggestion that a bone on the left side of the mouth was broken, saying that:

> "Multiple investigations have failed to find any reason for this pain and the only people who felt that they could help him in the past have been psychiatrists, although he dismisses them and says they did not help at all."

6. The contemporary psychiatric notes from the period are in a similar vein. Most of the comments were to the effect that the applicant was suffering from a delusion to the effect that there was a pathology "in his face which is either not there at all or [is] only minimal."

7. Yet Professor Gordon Russell of the Department of Dental Surgery at UCC noted in a letter of 16th September 1994 that:

> "At examination today for the first time I have found a tiny firm/bony swelling or nodule at the distal end of the hard palate well to the left of the mid-line of the tuberosity [protruding bone]. This nodule coincides with the centre of the painful symptoms which are now said to occur to a lesser extent on the right side of the neck."

8. A CT scan was performed on the applicant in September 1994 at Cork Regional Hospital.The radiologist in question, Dr. Ryder observed that:

> "The only feature for comment is that the tergoid plate anteriorally on the right side is somewhat larger than on the left side. This is not pathological and would represent normal anatomical variation. However, it may be more susceptible to local trauma."

9. Mr. Flynn was not entirely happy with these investigations and in June 2006 he had another CT scan done at another private hospital. The consultant radiologist in question concluded that the "diagnostic quality" of the scan was excellent and that he did not see any abnormality in the study. He further added:

> "I note that Mr. Flynn has had two previous CT scans, both reported as normal with reference to slight asymmetry of the pterygoid bone with normal limits on the study dated 26th September 1994. There does not appear to be any discrepancy between the reports of those studies and the recent CT [scan]."

10. Another consultant radiologist reviewed the files and concluded in January 2008 that:

> "Axial and coronal reconstruction show both the right and left pterygoid bones to be intact. I see no evidence of any deformity or fracture currently. No appreciable change since 2004."

11. Another radiologist, Dr. C, also reviewed these images and concluded that the "pterygoid plates appear within normal limits." In

view of Mr. Flynn's concerns about a possible misdiagnosis, the images were also reviewed by a Dr. D, a consultant radiologist, a Dr. D., who also agreed that there was no evidence of a pterygoid plate fracture or erosion.

12. Mr. Flynn was still dissatisfied. He commenced a personal injuries action against the hospital in question, Mater Private Hospital, but as part of an agreement to discontinue the proceedings, the hospital agreed to commission a report from Professor Nigel Hoggard, a specialist from the Academic Unit of Radiology at the University of Sheffield. He reviewed the images from 1994 and concluded:

> "There appears to be asymmetry between the left and right pterygoid hamuluses. This is a bony projection arising from the medial pterygoid plate which extends down toward the roof of the mouth posterior to the hard palate. Without continiguous images at higher resolution (normally we would undertake much higher resolution imaging today) it is difficult to be certain but there would appear to be a possible fracture through the hamulus on the left.
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> Interpretation
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> The appearances support the contention that the pterygoid hamuluses are asymmetrical and hamulus related pain is a recognised pain syndrome. *However, this is not common and most general radiologists would, in my opinion, be unaware of this*. I am the radiology lead for an atypical facial pain service and for head and neck imaging in my centre which is a large teaching hospital and also incorporates a leading teaching dental hospital where there is an interest in atypical facial pain. During my time in this post I have never been asked to specifically comment on the pterygoid hamulus on a CT scan." (emphasis supplied)

13. In a covering letter, Professor Hoggard added that while the earlier imaging was not optimal, he nonetheless concurred "with Mr. Flynn's interpretation of his imaging; the pterygoid hamuluses do look asymmetrical and in this context trauma is entirely feasible." I should, perhaps, pause here to note that this letter can only be regarded as an important vindication of Mr. Flynn's position. Contrary to what he had been told by a succession of medical practitioners and consultants since 1994, a recognised expert now more or less admitted that Mr. Flynn's interpretation of the CT scan was probably correct and that the most likely explanation was that he had, in fact, suffered a fracture of the left hamulus.

14. The importance of this report for Mr. Flynn should not, I think, be overstated. After all, a succession of medical practitioners had rejected his contentions and, moreover, some had thought that he was suffering from a psychiatric condition. In many respects, Mr. Flynn was doubly unlucky. He was unlucky in the first instance to have (probably) fractured his left hamulus in a freak incident, but he was secondly unlucky in that this condition is so rare that even the specialist radiologists whom he consulted were unaware of it.

15. In the end, the proceedings against the Mater Private Hospital were not discontinued, but were ultimately transferred to the Circuit Court, sitting in Cork along with the two other related cases which were to be heard at venue. The claim of negligence in all three cases is essentially related to the issue of diagnosis.

16. In June 2010 Judge Ó Donnabháin had adjourned generally the claim against the Bon Secours Health Systems Ltd. on condition that all of the other cases against the other defendants were heard in the same. Following the transfer to the Cork Circuit Court of the two other cases involving the Blackrock Clinic and the Mater Private, Judge Ó Donnabháin made an order on 30th July, 2013 "permanently staying" all three sets of proceedings. The plaintiff now appeals these orders to this court.

17. The question of what medical evidence the plaintiff proposed to lead at the trial was scheduled as a preliminary issue before Judge Ó Donnabháin. The plaintiff indicated that he was not in a position to lead any such evidence. This, in some respects, is not a great surprise. The plaintiff is unemployed and he is wholly dependent on disability benefit. He is not professionally represented and he informed me at the hearing of this appeal that his efforts to secure the attendance of Professor Hoggard as an expert witness on his behalf were unavailing.

18. It would appear that Judge Ó Donnabháin took the view that as the plaintiff was not in a position to lead any appropriate medical expert it was appropriate to grant a permanent stay on these proceedings.

19. In *Cooke v. Cronin* [1999] IESC 54 the Supreme Court held that it was an abuse of process to pursue an action in medical negligence in circumstances where there were no reasonable grounds for so doing. In her judgment Denham J. approved the following passage from the judgment of Barr J. in *Reidy v. The National Maternity Hospital*, High Court, 31st July, 1997, where he stated:

> "It is irresponsible and an abuse of the process of the court to launch a professional negligence against institutions such as hospitals and professional personnel without first ascertaining that there are reasonable grounds for so doing. Initiation and prosecution of an action in negligence on behalf of the plaintiff against the hospital necessarily required appropriate expert advice to support it."

20. She added:

> "While bearing in mind the important right of access to the Courts, I am satisfied that these statements of law are correct. To issue proceedings alleging professional negligence puts an individual in a situation where for professional or practice reasons to have the case proceed in open Court may be perceived and feared by that professional as being detrimental to his professional reputation and practice. This fear should not be utilized by unprofessional conduct."

21. Denham J. also acknowledged, however, that:

> "There may be difficulties in obtaining professional evidence; for example, a siege mentality may be encountered, which is inappropriate professional behaviour. The need for evidence should be met by appropriate professionals who are willing to give evidence of standards of care, whether the witness be from this jurisdiction or elsewhere."

22. *Cooke* must, however, be viewed in its context. The plaintiff had clearly suffered intense vaginal discomfort following the delivery of her first child. She contended that following the suturing which was necessary following the cut in the episiotomy during the course of the delivery, four nylon stitches had been sewn too tightly and as a result fell out leaving the outer aspect of the episiotomy cut to heal by secondary intention and thus allegedly causing a tenderness, discomfort and a lack of elasticity in the vagina.

23. The defendants accepted that had the stitches been stitched too tightly that this would have amounted to negligence but they nevertheless denied that this had occurred and that the vaginal discomfort which she had suffered was not caused in this fashion.

The plaintiff's only medical evidence was a general practitioner who had been introduced to her for the first time a few days before the trial. In this Court, Quirke J. dismissed the action as against the first defendant and the second defendant was released by consent. Here it is important to state that the second defendant had had nothing, as such, to do with the plaintiff's ante-natal care, a point which was emphatically stressed by Lynch J.:

> "Whatever about suing the hospital there never was any conceivable basis for suing the second defendant personally. He had nothing to do with the plaintiff's ante-natal care, nor with her confinement or delivery or episiotomy, nor with the stitching. The first time he saw the plaintiff was five days after the birth when he was asked by Dr Pauline Morris to examine the plaintiff after the first stitch had fallen out. He was dismissed from the case by consent at the latter stages of the High Court trial and nevertheless the notice of appeal was directed to both defendants. The joinder of the second defendant as a personal defendant was at all times wholly unwarranted and his apparent inclusion as a respondent to the appeal was deplorable and is in no way excused or even explained by the apology that his inclusion as a respondent to the appeal was due to an oversight in drafting the notice of appeal.
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> In all cases of alleged negligence on the part of a qualified professional person in carrying out his professional duties there should be some credible evidence to support the plaintiff's case before such an action is commenced."

24. It is clear from *Cooke* that it is inappropriate to commence (or, for that matter, to continue) medical negligence proceedings against a medical professional without an appropriate basis for so doing because of the reputational and other implications of such proceedings for the professional involved. Is that the situation in the present case?

25. First, it must be noted that the proceedings here are not against the medical professionals as such, but are rather as against the three hospitals. This is not necessarily dispositive, because in such proceedings the reputations of the medical professionals concerned are also in practice at stake. It is nonetheless a consideration.

26. Second, it cannot be said that there is no appropriate basis for continuing these proceedings. Unlike the second defendant in *Cooke*, the hospitals concerned all treated the plaintiff and, furthermore, it is clear from Professor Hoggard's report that the plaintiff's basic complaint is, at least to some degree, well founded. It is true that Professor Hoggard also formed the view that this diagnostic failure was a result of the exceedingly rare nature of the condition. It is also true that I held in *Flynn v. Medical Council* that the Council was entitled to conclude on the basis of this particular evidence (and, specifically, these conclusions of Professor Hoggard) that the medical consultants who treated Mr. Flynn could not have been guilty of poor professional performance within the meaning of s. 57(1) of the Medical Practitioners Act 2007, precisely because of the exceptionally rare character of the injury.

27. Yet this does not necessarily mean that the plaintiff could not possibly establish negligence within the meaning of the test articulated by Finlay C.J. in *Dunne v. National Maternity Hospital* [1989] IR 91, even if this would be something of an uphill struggle. It is, for example, possible that the plaintiff will be able to show that even if the consultants in question followed a general practice, that practice nonetheless has, in the words of Finlay C.J. in *Dunne*, "inherent defects which ought to be obvious to any person giving the matter due consideration."

28. Third, while the leaned Circuit Court Judge referred to the fact that he was imposing a "permanent" stay, this really must be adjudged to be in the nature of a dismissal of the action, since by reason of the nature of such a stay the plaintiff cannot either now or in the future advance his proceedings. To my mind an order of this kind would be premature. It is true that the defendants are entitled to a timely disposition of the present proceedings. But this must be balanced against the plaintiff's right of access to the courts. Account must in particular be taken of the plaintiff's limited personal and professional resources and the obvious difficulties which confront him in securing such specialist evidence.

Conclusions

29. In these circumstances I will allow the appeal in part, but only upon certain terms. I think it clear that the plaintiff has an appropriate basis for suing the three defendant hospitals, so that the first limb of the *Cooke* test is satisfied. The plaintiff must, however, be given a fair opportunity to satisfy the second limb of that test by leading evidence from a medical expert. It will be a matter for the plaintiff to obtain a report from such an expert and to have that expert give direct evidence on his behalf. That opportunity cannot, however, be open-ended, since the defendants are also entitled to have the matter determined within a reasonable time.

30. If, therefore, the plaintiff wishes to proceed with these proceedings, I will accordingly require him to obtain such a report within twelve months of today's date and to supply a copy of same to the defendant's solicitors. In the event that such a report is not supplied, then the defendants will be entitled to apply by motion to the Circuit Court sitting at Cork to have the action dismissed.