THE HIGH COURT

[2018 No. 4309 P.]

BETWEEN

RUTH MORRISSEY AND PAUL MORRISSEY

PLAINTIFFS

AND

HEALTH SERVICE EXECUTIVE,

QUEST DIAGNOSTIC INCORPORATED AND

MEDLAB PATHOLOGY LIMITED

DEFENDANTS

JUDGMENT of Mr. Justice Cross delivered on the 3rd day of May, 2019

1. The plaintiffs are husband and wife who have one child, Libby, aged seven and a half years. The plaintiffs' claim is for negligence and breach of duty against all three defendants and also they claim for breaches of Constitutional Rights and/or European Convention Rights arising out of the alleged failure of the defendants to correctly report upon two cervical smear tests. The first test was carried out by the second named defendant in August 2009 in the United States of America and the second test was carried out in August 2012 by the third named defendants in Ireland. The plaintiffs also claim exemplary damages.

2. Cervical cancer is a serious cancer affecting women, which if detected before it develops or indeed at the early stage of its development, can be easily and successful treated. However, if its detection is not until the cancer has significantly developed, the outlook is very poor.

3. As a result of the need to have early detection, the first named defendant, under the title of Cervical Check, organised free cervical tests for women of a certain age. Samples are taken by a patient's GP using a system known as Liquid Based Cytology which is a relatively new system and less invasive than taking a smear by scraping cells. These tests are regularly repeated depending on the age of the patient. In the first named plaintiff's case, the test were required to be regularly repeated every three years. The first named defendant originally used Irish laboratories but since 2008 when Cervical Check commenced its national screening policy, they contracted out the testing of the samples to various multinational firms, including those of the second named defendant, Quest Diagnostic Incorporated (Quest) and later, the third named defendants, Medlab Pathology Limited (Medlab). The contracts provide that the tests are to be carried out in accordance with the Bethesda System using the Cervical Check Quality Assurance Guidelines and the Guidelines to Smear Tests.

4. The reason the first named defendant contracted out the vast majority of its tests to the multinational firms was, I accept, that the Irish laboratories could not provide as fast a service as offered by the multinational firms. This "*contracting out*" did, however, result in opposition from the Irish laboratories who voiced concerns about difficulties in supervisions and failures of regulation in the amalgamation of allegedly looser American standards of testing with the Irish recall period for screens of three years as opposed to the American standard which used to require a recall every year. Also, Dr. G. who had previously been in charge of the screening laboratory in St. Luke's Hospital pointed out as of concern the fact that the United States laboratories had an apparently looser sensitivity than the Irish laboratories in that the laboratories in America reported only 1.4% tests as non-normal compared to 2.4% as reported in Irish laboratories.

5. The contract between the first named defendant and the second named defendant often involves testing in laboratories in the United States. The plaintiff's test in 2009, was undertaken by the second named defendant in one of their laboratories situated in Grand Rapids. This laboratory was not scheduled under the contract with the first named defendants and accordingly, was not subject to any realistic audit or inspection by the first named defendants. The reason for the second named defendant conducting some of its smear testing in laboratories not referred to under the contract was, according to the second named defendant, that they were under pressure as the number of Irish smears increased and at the same time they had a spare capacity in other non-scheduled laboratories. I am satisfied that conducting these tests outside scheduled laboratories by Quest was unknown to Cervical Check at the time of the plaintiff's tests and that the second named defendant were not authorised under their contract to utilise any non-scheduled laboratory. The test in 2012 was carried out by the third named defendant in one of its laboratory's situated in Co. Dublin.

6. Smear tests are not tests for cancer but to determine whether the cells tested are healthy or alarming. When cells are found not to be healthy the fear is that they have been contaminated by the HPV virus which in certain circumstances can lead (in the case of cells from the cervix) to cervical cancer. The HPV virus is present in most adults usually without any consequences. In the majority of cases, the virus is shed due to the normal immune response. A small number of women, however, will continue to harbour the virus of which there are 120 different types and two of these types, 16 and 18, are responsible for over 70% of cervical cancers. Should the body continue to carry high risk HPV after some two to three years, a premalignant Cervical Intraepithelial Neoplasia (CIN) will develop. The pre-cancer may be high grade or low grade. If the pre-cancer is low grade, it may regress but a significant number of high grade lesions will progress if not detected and treated and develop into an invasive cancer. The invasive cancers are typically either squamous cell tumours or glandular cell and tumours. I also accept the evidence of Prof. S. that CIN, or pre-cancer will normally progress to invasive cancer over a eight to twelve year period of time on average, approximately ten years.

7. I accept the evidence of Dr. McC, called by the plaintiff, that the tests are not diagnostic and reject any suggestion by Prof. P, the third named defendant's expert, in her report, that the purpose of the tests is to diagnose cancer. In her evidence, Prof. P. did clarify her report and accepted that the tests are not diagnostic. This is an important distinction as to the duty of the laboratories in relation to the analysis of the samples. The tests are screening tests. The results of the tests are graded by the screener using either the CIN terminology or the Bethesda system, both of which result in the same consequences for the patient. If the test finds that the cells are healthy, then the patient is referred for routine repeat examination. Where the laboratory finds the cells to be abnormal, then depending upon their condition, the patient is either sent for early repeat screening or else directly to the patient's doctor for colposcopy and, if necessary, other treatment. I accept also the evidence of all relevant experts that in the event of any ambiguity, the laboratory ought to report the cells as abnormal. Otherwise, the purpose of the screening system could not be achieved.

8. The grades to which a test should be marked, according to the Bethesda terminology are; unsatisfactory/inadequate sample, negative/NAD or ASCUS (borderline squamous cells), low grade SIL, high grade HSIL, squamous cell carcinoma, AGUS/AGUC (borderline abnormalities in glandular cells), glandular neoplasia or broken or damaged slides.

9. The borderline categories of ASCUS or AGUS do not themselves donate either cancer or pre-cancer but do represent a non-negative finding and require at least repeat smears or colposcopy.

10. Though the vast majority of cervical smear tests result in a negative result, the programme of cervical smear testing has resulted in the early diagnosis of cervical cancer in many thousands of women worldwide and has resulted in them availing of life saving treatment at an early stage. The cervical smear testing programme is in itself entirely admirable and is an important aspect of healthcare being provided by or under the auspices of the first named defendant for the public.

11. The present cervical check programme was launched by the first named defendant under the guise of "*Cervical Check*" in September 2008 as part of their national screening service and the purpose of the screening was stated by the first named defendants as being:-

> *"To carry or arrange to carry out an ongoing national cervical screening service for the early diagnosis and primary treatment of cervical cancer in women…*
>
> *The aim is to be achieved by the detection of changes in the cells of the cervix before they become cancerous."*

12. The test is made available through GPs and is free of charge. Once the test has been made, and the sample is taken and sent by the GP to Cervical Check, it is transferred by them to one of the laboratories. In the laboratories, the sample must be analysed in what is known as cervical cytology which is a microscopic examination of a single layer of cells scraped from the surface of the cervix.

13. In the laboratory, the procedure is that a slide is made from the sample, all samples are prepared using the Thin Prep Image System (TIS). The slide is examined by a screener who may be a technician or a degree scientist who first must assess the sample for its adequacy. The minimum number of cells on any slide for adequacy, counted as required by the Bethesda System is now fixed at 5,000. Previously, a much larger number of cells were required for the sample to be considered adequate but the figure of 5,000 as tested in accordance with the Thin Prep and the Bethesda system has been approved by peer review. If any abnormal cells are detected, irrespective of the adequacy of the sample, the slide must be classified as abnormal. Most samples will clearly be seen to be adequate on a quick overview but in the event of any doubt, the slide must be assessed for adequacy using the method prescribed by the Bethesda system. After any assessment for adequacy, the screener then looks at the slide methodically examining the cells to test for abnormality at various magnifications. The slide should be sent to a second screener to undertake a confirmatory review. The second named defendant, as a matter of policy, apparently had a full review of each slide to ascertain whether there are any areas of suspicion. The practice of the third named defendant is, as I understand, that if the first screener finds that the slide is negative and no issues arise, there is no manual rescreening but a machine is utilised to analyse the samples using the TIS system. If the first screen, highlighted any areas of suspicion then a full manual rescreening is made. If there are any areas of suspicion these are highlighted on the slide using a marker, then the slide is sent to a pathologist in the lab to report.

14. In the United States, the system for smears was that the laboratories reported results to the medical practitioners who decided upon a course of action but in Ireland and in the contracts entered into by the first named defendant, it was incumbent upon the laboratories when they recorded the results of the screening to also, in accordance with the HSE and Bethesda guidelines, record the appropriate treatment.

15. While the tests are of the greatest importance, it is clear and all sides in this case agree that they are not infallible. Given the nature of present testing, the tests may fail to locate abnormal cells in certain parts of the patient's body, as the sample may be only taken from certain parts of the cervix. In addition, the analysis is a study by human scientists and the existence of certain precancerous and cancerous or abnormal cells may not be ascertained in the analysis. Accordingly, there is room in the analysis for genuine and non-negligent divergence as to whether particular cells are negative or potentially alarming. To illustrate that fact, a further smear test was undertaken on Mrs. Morrissey in 2014, at a time when she had already developed cancer and when that cancer had been diagnosed, and this test was negative, and no one suggests that the reading was in any way negligent. Accordingly, at the time Mrs. Morrissey already had cancer, the smear was properly recorded as normal.

16. It is accepted by all sides that not every erroneous analysis will amount to negligence, though the extent of any errors that would not be negligent is not agreed. It is, however, agreed that audits of patients who went on to develop cervical cancer who had been previously screened negative, found that, at least, 44% (or 55% depending on whether samples labelled as "*inadequate*" are counted) were incorrectly read at first screening. Of course, this is not to say that 44% of screenings are incorrect, or anything like it. Where a person who has been screened went on to develop cancer before the next screening, given the relatively slow pace of development from HPV to CIN to invasive cancer, it is very likely that those persons would have had abnormal cells on a screening one, two or three years before. It is not surprising that in more in 40% of such cases, this abnormality would have been apparent on the slides. In order to ascertain whether there has been any negligence or breach of duty, each test would have to be assessed individually.

17. The HSE organises follow up tests on a periodic basis every three years for persons of the plaintiff's age. In the United State, the follow up period for rescreening was every year. As HPV vaccination came to be used in the United States, the follow up period for screening has been gradually extended to the first two and now, it is in some cases every three years. This extension of rescreening times in the United States had a result that the laboratories there had, in certain cases, overcapacity and, therefore, in particular, the second named defendant utilised laboratories, which otherwise would be underused but which were not specified in their contract with the first named defendant to screen Irish slides.

18. In the plaintiffs' case and in a number of other ones, where cancer was subsequently detected after a previous negative test, the laboratories performed an audit to examine the previous smears and their results. The main purpose of this audit is educational for the screeners and the laboratory to look into the quality of the testing and make any improvements. The majority of women who ultimately contract cervical cancer are persons who have never been screened. The next largest cohort are those who have been screened at least once and then missed the appropriate time for rescreening. It is noteworthy that notwithstanding the issue of retrospective bias, which will be discussed later, audits carried out by the second named defendant which would not have been conducted under a "*blind review*" only resulted in very few results being upgraded, notwithstanding the fact that the persons conducting the audits would have been aware that the patient had subsequently developed cancer. This is suggestive of a very high level of professionalism among the original screeners and the persons conducting audits who clearly approached the screening not in any way influenced by any retrospective bias.

The Plaintiffs
19. The first named plaintiff was born on 29th June, 1981 and the second named plaintiff was born on 1st October, 1978, they were married in 2008 and live in Co. Limerick. The first named plaintiff finished schooling in 1999 and did a diploma in Information Technology at Limerick Senior College and throughout her working career has been employed with UPS, a large multinational corporation. Since 2001 initially as a data analyst and subsequently as a customs solution supervisor, she has been again promoted to grade 14 and has been nominated by her employer for a European Protégé monitoring programme. She has been sponsored by her employer to take a BA through the University of Nottingham and has completed her first year with distinction. She expects further promotion. She is a highly intelligent and motivated person, well regarded by her employers and I accept the proposition that her promotion in the firm was highly likely.

20. The second named plaintiff is a warehouse manager who left school early. He has a history of colitis. The evidence of the second named plaintiff and indeed of Dr. Hillary, the psychiatrist, is that the first named plaintiff plays the leading role in the marriage. Mr. Morrissey referred to Mrs. Morrissey as being his best friend. They are clearly a devoted couple who have one child, Libby, who was born on 20th July, 2011. They had hoped to have more children which, of course, is now impossible.

The Plaintiff's Smear Tests
21. The first named plaintiff had an initial cervical smear in 2002 which was negative and nothing turns upon it.

22. In 2009, the first named plaintiff underwent a smear on 18th August, aged 28, carried out by her GP. The sample was sent to the second named defendants in the United States of America who are under a contract with the HSE through Cervical Check. The sample was analysed in a test laboratory in Grand Rapids. They reported first of all that the sample was adequate and the result was "*negative for intraepithelial lesion or malignancy*". The plaintiff was advised to have the standard recall three years later. This satisfactory result was communicated to the first named plaintiff by letter dated 1st September, 2009, from the HSE.

23. The next smear was taken, three years later, on 8th August, 2012, aged 31, as part of the same programme and then sent to the third named defendant's laboratory in Co. Dublin. Again, the report is that the sample was adequate for assessment, that the endocervical component was absent but there was no evidence of neoplasia, i.e. the no evidence of the presence of new abnormal growth tissues. She was again recommended for routine recall and was advised of this satisfactory result by a letter of 13th September, 2012.

The Diagnosis of Cancer in 2014
24. On 27th May, 2014, the first named plaintiff went to her GP complaining of postcoital bleeding and upon examination the GP discovered a lesion in her cervix and she was referred to Dr. S. who performed a biopsy and an MRI scan which disclosed the existence of cervical cancer. The MRI suggested a significant tumour on the cervix. The first named plaintiff was then referred to Dr. H. at the colposcopy clinic in Limerick and he performed a punch biopsy and not, as Mr. M.H. erroneously understood, what is known as a LLETZ procedure (Large Loop Excision of the Transformation Zone) which removes the cervical tissue for examination and treats the changes in the cervix. The biopsy led to a diagnosis of invasive squamous carcinoma of the cervix and the first named plaintiff was advised that surgery would be required and she was referred to Cork University Hospital under the care of Mr. M.H., the surgeon, who treated the first named plaintiff with apparent success and the cancer apparently disappeared.

25. The treatment Mr. M.H. undertook with the agreement of the plaintiff was that of Radical Trachelectomy which is a relatively new surgical procedure first carried out in 1991 and introduced to the United Kingdom in 1994 by Prof. S. which is less invasive than the traditional hysterectomy and which was specifically requested by the plaintiff in order to preserve her fertility. In order to qualify for a radical trachelectomy, each patient must be assessed to determine their suitability. The traditional procedure was a radical hysterectomy and radium/chemotherapy which would have resulted in rendering Mrs. Morrissey infertile.

26. Mrs. Morrissey's tumour as demonstrated by the images was believed to be less than 2cm. However, after the operation, the histology revealed that it was, in fact, greater than 2.5cm. Trachelectomy is not usually undertaken in tumours of greater than 2cm as there is a greater risk of relapse in larger tumours. However, no criticism is made of Mr. M.H. for his initial decision to undertake a trachelectomy or indeed, for the conduct of the operation he performed.

The Audits
27. In the meantime, unknown to the plaintiffs, the laboratories undertook audits or reviews of the 2009 and 2012 smears. The 2009 slide was reviewed on 11th September, 2014, by the senior staff pathologist of the second named defendant who reported that the original test was incorrect and under the heading the report of "*factors likely to lead to false negative results*", nothing was inserted.

28. The 2012 smear was also reviewed by the medical director of the third named defendant on 31st October, 2014, and this review also found that the original result was incorrect and under "*factors likely to lead to false negative results",* the laboratory listed the fact that the sample was "*scanty*". The 2012 slide was also audited by an independent reviewer in 2015, who also concluded that it had been inaccurately read and referred to the sample as "*scanty*".

29. At some date, at the latest in 2015, the results of the audits were communicated to Cervical Check by the laboratories. It seems that the audits of the two tests on Mrs. Morrissey were not co-related for some time, and that subsequently, a dispute arose between the second named defendant and Cervical Check in which the second named defendant disputed any release of the information in relation to the audits by the HSE and attempted to utilise the disputes resolution system as stipulated in the contracts in order to determine that issue. Both of these matters resulted in delay.

30. In any event, the results of the audits were made available by Cervical Check to the plaintiff's treating doctor in Cork, Mr. M.H., in June 2016. Mr. M.H. is a consultant working for the first named defendant.

31. The clinical notes of Mr. M.H. referred to the letter of 16th June and indicated this was to be discussed with the first named plaintiff on her next visit on 7th July, 2016. This was not done.

32. Unfortunately, neither the fact of audit or its results were disclosed to the plaintiffs until national publicity in relation to another patient occurred in mid-2018 and the plaintiff herself rang to make inquiries as to whether there had been misdiagnosis in her case. Subsequently, coincidently or otherwise, she was advised by Nurse T. to travel to Cork for a meeting with Mr. M.H. She was advised of the results at a meeting with Mr. M.H. He then apologised to the plaintiffs and indicated that he simply "*forgot*" to tell them.

Mrs. Morrissey's Follow Up Care
33. In the meantime, however, after the treatment in 2014, the plaintiff returned to Mr. M.H. on a regular basis in 2015 and 2016. She was examined with smears, colposcopy and a vaginal/pelvic examination on each occasion. There was some controversy on this point

but I find that she was so examined. No rectal examinations were performed. She was regularly reassured that the cancer had been successfully treated. However, in October 2017, the first named plaintiff had a significant pain on her right leg. She attended her GP in December 2018 and scans including MRIs were carried out on the plaintiff. On 16th February, 2018, Mrs. Morrissey went to the Galway Clinic for an MRI of her pelvis (a procedure which was not available in Limerick). This MRI revealed a 7x7.1cm pelvic side wall mass with bony invasion and enhancement or in the right acetabulum. The cancer had returned. A very serious diagnosis.

34. On 22nd February, 2018, a PET scan was carried out which disclosed a large necrotic mass invading the right iliac muscle and the scan also disclosed cancer in her left breast.

35. The left breast cancer was coincidental and the plaintiff originally in consultation with her breast surgeon decided on a double mastectomy but subsequently she had less invasive surgery as advised by another consultant in August 2019, but the results of this were not satisfactory and a double mastectomy was performed on 14th September, 2019 and the evidence is that the results of this procedure have been entirely satisfactory and any breast cancer has been cured and would not materially affect the plaintiff's life expectancy.

36. After the PET scan in February 2018, the plaintiff underwent intensive radiotherapy everyday over a period as well as chemotherapy once a week. The radiotherapy was not as invasive as the chemotherapy but resulted in pain and exhaustion.

37. The plaintiff has now completed her radiotherapy of her pelvic area and it is not possible for her to have any more radiotherapy in respect of her cervical cancer. She is still undergoing some radiotherapy in relation to her breast. The prognosis in relation to her cervical cancer is, at most, approximately two years.

The Case

38. The plaintiff's case is that had the 2009 smear been correctly reported, she would have been referred for further tests within three months or more probably immediate colposcopy which as a matter of probability would have disclosed a precancerous condition which would have resulted in a LLETZ procedure leading to the complete excision of the cancerous cells. This was described as a relatively simple procedure with a less than 5% chance of reoccurrence of pre-cancer development and less than 1% chance of invasive cancer developing. Accordingly, the case is that, the first named plaintiff would not have developed cancer in 2014 nor would have this reoccurred in 2017/18, there would have been no need for the radical treatment she is undergoing and the present ominous prognosis would not arise. She would have had a normal life with her family and her career.

39. The plaintiff further contends that the sample in 2012 was inadequate for testing and that either a second sample should have been taken from the liquid container or more likely the plaintiff returned for immediate retesting. However, the plaintiff also contends that even with its inadequate nature, the 2012 sample, if correctly analysed would have resulted in a non-negative reading. In either event, the plaintiff contends that had the 2012 smear been correctly reported, this would have resulted in either immediate rescreening or in a repeat smear at most six months thereafter which would have led, as a matter of probability to colposcopy which, as a matter of probability in 2012, would have disclosed a high grade lesion in early development and the treatment would have been the same as could have occurred in 2009, with the same benign results.

40. In consequent of these matters, the first named plaintiff claims that she has suffered injuries. She developed cancer, has undergone invasive treatments, the cancer has reoccurred, she has significant pain and interference with all normal aspects of her life including her marital life. She suffered psychologically. She has been deprived of the opportunity of completing her family, of seeing her seven year old daughter grow. She already requires care and is going to require care into the future and modifications for her house. She has a very limited life expectancy.

41. The plaintiffs also claim exemplary damages against the defendants.

42. The case commenced in July 2018 and was then adjourned to September 2018. In September, the plaintiffs applied for an adjournment to allow for a "*blind review*" to be carried out. This, in fact, was not carried out or no evidence was given of any blind review on behalf of the plaintiffs when the case resumed.

43. When the case was resumed on 29th January, 2019, the plaintiff alleged that had she been advised by the first named defendant of the audit results that as a matter of probability she would have in 2016 and 2017, insisted on a number of imaging scans which would have given her, as a matter of probability, an early alert that the cancer was returning and that this could have been treated much more satisfactorily and probably successfully at that earlier stage. She further alleged that it was negligent of the first named defendant not to require regular scans after the 2014 treatment had concluded. These later allegations of negligence arose initially from reports commissioned by experts retained by the second named defendant as part of the issue between the defendants. The reports were furnished to the plaintiff and subsequently the plaintiff's experts have endorsed those views. The second named defendant later withdrew these reports and did not lead any evidence against the first named defendant and did not in their submissions make any case for a contribution against the first named defendant.

44. On 29th January, I allowed the plaintiff to expand their case against the first named defendant on the above basis, in circumstances I will deal with later.

45. The second named plaintiff claims to have suffered injuries and has been diagnosed as suffering from depression as a result of the misdiagnosis of his wife and in particular, the failure of the defendants to tell his wife of the audit results. In addition, the second named plaintiff claims to have suffered a recurrence of his colitis as a result of stress and loss of consortium.

46. The plaintiffs also claim the costs of the first named plaintiff's care and loss of earnings that the plaintiff would have accrued throughout her normal lifetime and to the cost of the future care provisions of their daughter, Libby, into the future until she finishes third level education.

47. The plaintiffs claim these damages in negligence and breach of duty and for breach of Constitutional and/or European Convention Rights.

48. Each of the defendants deny liability and loss. The defendants deny causation, pleading that even if the plaintiff's slides were negligently read, that any alarming feature found in 2009 or 2012, is not related but coincidental to the ultimate cancer as diagnosed in 2014. The defendants contend that the plaintiff's cancer was on the balance of probabilities not developing in 2009 or 2012, or if it was developing that it was not likely to have been detected on re-screening or colposcopy. The first named defendant admits breach of duty limited to their failure to advise the first named plaintiff of the results of the audit but denies loss. The defendants also plead that the second named plaintiff is not entitled to any damages other than on the basis of the authorities in relation to nervous shock.

49. The first named defendant claims that even if there was negligence in relation to the reading of either of the slides that it has no liability. Further, they claim that if they have any liability in relation to the testing of the slides it is vicarious only and they claim an indemnity or contribution from the second and third named defendants in the event of any findings against the first named defendant. The second named defendant while denying the claim for an indemnity, itself claims an indemnity or contribution against the first named defendant on the basis that the first named defendant ought to have referred the plaintiff for regular screening after her cancer treatment in 2014 and the second named defendant claims that had this been done, her further cancer could have been detected and an early and treatable stage. The second named defendant led no evidence to support these allegations and indeed withdrew the reports of its two experts in this regard, Dr. L. and Dr. O.

50. The fact of any diagnosis of cancer is, of course, extraordinarily upsetting to a patient and their family. The fact that a previously treated cancer has returned is naturally even more traumatic. The fact that this returned cancer is inoperable and untreatable and that any patient, especially a young patient, has now only a very short life expectancy is naturally appalling. The further fact, if it be the case, that had tests carried out on the patient been reported accurately that this cancer and its return could have been prevented is even more distressing. The fact that audits of the previous tests carried out after the diagnosis of the cancer indicated that the screening in 2009 and 2012 were inaccurately reported must be almost unbearable. The fact that the patient was only told of the results of audits after she herself became suspicious as a result of intense publicity given to another case and specifically once she inquired herself as to whether indeed she was also the subject of erroneous reporting is undoubtedly tragic and reasonable grounds for fury and indeed has resulted in public outcry. However, not every tragedy, not every public outcry is inevitably suggestive of a breach of legal duty. Tragedies can and frequently do stem from inadvertence and the size and extent of the tragedy is not evidence of the level, or indeed the existence, of fault. Public outcry in these cases has tended to misstate the issues and not be of any assistance to those given so ominous a diagnosis. Each case must be examined in accordance with the evidence and the well known legal principles to establish whether in the erroneous reporting of the slides, there was negligence.

Issues
51. The issues in this case, as I identified during the trial, are as follows:-

(a) The standard of care.

(b) Were the defendants negligent or in breach of duty in relation to the August 2009 smear test?

(c) Were the defendants negligent or in breach of duty in relation to the August 2012 test?

(d) If the defendants were negligent in relation to the 2009 test and/or the 2012 test, what, if any, are the consequences of same?

(e) Have the plaintiffs a claim for breach of constitutional and/or European Convention Rights?

(f) Was the first named defendant negligent in failing to advise the first named plaintiff to undergo scans and imaging tests in addition to the treatment afforded to her after initial treatment in 2014 and/or did the first named plaintiff suffer any additional personal injuries due to her not being advised of the audit results until 2018?

(g) Is the first named plaintiff entitled to damages for the admitted breach of the first named defendant in failing to advise the plaintiff in relation to the results of the audit?

If liability is established against any of the defendants.

(h) Assess damages:-

(i) Is the second named plaintiff entitled to damages and, if so, on what basis?

(ii) Are the plaintiffs, or either of them, entitled to damages for future care and loss of earnings and other special damages which will arise after the death of the first named plaintiff and, if so, on what basis?

(iii) Are the plaintiffs entitled to exemplary damages?

(iv) The quantum of damages.

(i) The liability of the various defendants.

(A) The Standard of Care
52. A number of different though sometimes similar standards of care have been suggested in this case. The legal standard of care and also the factual standards and criteria to which the screener must adhere are different though interlinked issues. Both must be considered under this heading. The standard of care in medical negligence cases has been classically put in *Dunne (an infant) v. National Maternity Hospital* [1989] I.R. 91, by Finlay C.J. at p. 109, as being:-

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

provide any ground for leaving a question to the jury as to whether a person who has followed one course rather than the other has been negligent.

5. It is not for a jury (or for a judge) to decide which of two alternative courses of treatment is in their (or his) opinion preferable, but their (or his) function is merely to decide whether the course of treatment followed, on the evidence, complied with the careful conduct of a medical practitioner of like specialisation and skill to that professed by the defendant…."

53. *Dunne (an infant)* was following the earlier decision of *O'Donovan v. Cork County Council* [1967] I.R. 173, and also a similar test was found to apply to solicitors in the case of *Roche v. Peilow* [1985] I.R. 232.

54. Allowing for the fact that *Dunne* seemed to give particular deference to surgeons operating in hospitals, it remains the standard test in relation to professional negligence.

55. The next possible standard is contained in the contractual obligations of the laboratories. The laboratories have contracted with the HSE to conduct their tests in accordance with "*good laboratory practice*" which is defined as:-

"The exercise of that degree of skill, diligence, prudence and operating practice, which will be considered as good practice from a skilled and experienced laboratory of a similar scale and professional standing engaged in the provision of cervical cytology screening and related services."

56. I do not believe that in practice, the contractual obligations taken on by the laboratories fundamentally alter the standard of care required by *Dunne*, rather the contract specified this standard in reference to laboratories.

57. I was also referred to the **Guidelines for the review of GYN cytology samples in the context of litigation or potential litigation** issued by the American Society of Cytopathology and formulated by Prof. A. and others which stipulated that:-

"The standard of care should be that of the reasonable and prudent practitioner. Courts and experts should recognize that a false-negative result by itself is not sufficient proof of negligence. Rather, the courts should evaluate whether the overall Pap-test practices of the laboratory meet the standard of care and whether unbiased blinded rescreening consistently detects significant abnormalities not initially identified by the laboratory."

58. The Guidelines for the American Society of Cytopathology referred to the universally accepted truth that "*the findings of a false-negative sample is not necessarily evidence of practice below the standard of care".* However, the Guidelines also seek to impose an obligation in all cases for a "*blind review*" and suggest that in the absence of a "*blind review*" it is wrong to impute any negligence on a screener. In this regard, the Guidelines were criticised and rejected in the United States in the case of *Adams v. Laboratory Corp of America* 760F.3D1322(2014) 25FLA.L Weekly Fed. C197 and I accept the characterisation as submitted by counsel for the plaintiff that the guidelines were prepared by Prof. A. and other members of the American Society of Cytopathology in the light of litigation against members of the American Society of Cytopathology in order to attempt to limit litigation and provide a robust defence basis for screeners accused of negligence in the American Courts. I do not accept these guidelines as in any way setting a legal standard for the Court to operate.

59. It is, of course, as inappropriate for the American Society of Cytopathology to set the legal standard which courts should apply to their professional work as it would be for the Bar of Ireland to purport to define the limits of the liability of barristers in Tort.

60. A paragraph in the American Society of Cytopathology Guidelines states:-

"Atypical cells of undetermined significance represent an equivocal interpretive category with poor inter and intra-observer reproducibility. Therefore, most cases of ASCUS (atypical squamous cells of undetermined significance) and AGUS (atypical glandular cells of undetermined significance) do not represent consistently identifiable abnormalities and a reasonable basis for allegations of practice below a reasonable prudent practitioner standard of care."

If and insofar as this paragraph suggests that a finding of ASCUS or AGUS can generally be reported as normal without legal criticism it is entirely unacceptable and wrong. Yet, that is the apparent and genuinely held view of the American Society of Cytopathology, all of whose members must attest to follow these guidelines as drawn up by Prof. A. It certainly was the opinion of Dr. P. on behalf of the third named defendant who stated that even had blind reviewers consistently revealed a finding of ASCUS or AGUS that she would not deem it a breach of duty or negligence on the part of the original laboratory to find that slide as negative.

61. While there is much scope for legitimate difference between cytologists as to whether the slides suggest different types of abnormality, these differences should not give rise to any significant problems to the patient as if any abnormality is detected, the patient is to be referred either to colposcopy or a repeat review. What may give rise to much difficulty for a patient, however, is the distinction as to whether the slides are negative or abnormal. If the screener is going to be excused from legal liability in misreading any findings of ASCUS or AGUS cells, and whatever about their alleged ambiguity such cells represent the largest majority of abnormal cells found on screening, prejudged on an *a priori* basis by Guidelines of the American Society of Cytopathologists to which their members must subscribe, then the function of the courts would be entirely overruled by the determination of a professional body with a vested interest in the outcome.

62. It should be remembered that the vast majority of non-negative reporting of slides in the screening or involved reports of either ASCUS or AGUS. Accepting difficulties in defining what is or is not ASCUS or AGUS, this must not lead us to the conclusion as advocated by the American Society of Cytopathology or its witnesses, to the effect, that in most cases, the mis-description of what are actually AGUS or ASCUS cases is not negligent. Each case falls to be examined on its merits and remembering the words of Dr. Scally in his scoping report of the importance of ASCUS, I cannot accept the American guidelines as setting a factual no more than a legal standard.

63. The purpose of screening is, as previously stated, not to diagnose, that is done by the pathologist and the medical doctors, but to warn of the existence of future potential harm. The pathologist's professional body in America, also produced a serious of guidelines in relation to liability but they were produced after the *Adams v. Laboratory Corporation of America* case and are similar to but somewhat less strident than the Society of Cytopathology Guidelines.

64. In her second report dated 12th September, 2018, Prof. P., on behalf of the third named defendant, formulates the question of standards in a slightly different way: the question to answer when reviewing PAP tests in the setting of litigation is "*was the*

interpretation of the PAP test a reasonable interpretation and would the average competent trained reviewer make the same interpretation under the similar screening conditions". I believe that this second setting of the standard advanced by Prof. P. is of itself little different from the contractual obligation of the laboratories to the HSE and just as the contractual obligation of "*good laboratory practice*", it can be given a similar meaning as the standard as set by the Supreme Court in *Dunne v. National Maternity Hospital*.

65. Counsel for the plaintiff relies upon additional standards which are gleaned from the leading case of *Penney Palmer & Canon v. East Kent Health Authority* Lloyds Law Reports 2001, page 41.

66. The case of Penney Palmer & Canon v. East Kent Health Authority is of the greatest importance. I fully accept the law to be correct as stated by Woolfe M.R. in that case. In Penney Palmer, the Court of Appeal per Lord Woolfe M.R. expressly approved of the legal test for the standard of care in scanning cases as that stated in *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 583, which is together with *Bolitho v. City and Hackney Health Authority* [1988] A.C. 232, the English equivalent of *Dunne v. National Maternity Hospital*. Insofar as the lower court held that the *Bolam* test did not apply in the case of cytology, the Court of Appeal disagreed but held that notwithstanding that fact the decision of the lower court was correct.

67. Indeed, Woolfe M.R. went on to quote with approval from the judgment of the original court:-

> *"The standard which I have to apply is that of a reasonably competent screener exercising reasonable care at the time when the screening took place. I must ignore any advances in screening practice which have occurred since the relevant events. I must also put out of my mind when considering the extent of the screener's duty of care the fact that all three (claimants) subsequently developed carcinoma.*
>
> *Equally importantly I must bear constantly in mind that in cases where an exercise of judgment is called for, the fact that with the benefit of hindsight that judgment was exercised wrongly is not itself proof of negligence."*

I agree with these observations which are an important reminder to a court but do not themselves define the legal standard to be applied.

68. That, however, is not the end of the matter. As Woolfe M.R. stated in *Penney Palmer*:-

> *"…the Bolam test has no application what the judge is required to do is make findings of fact. This is so even where those findings of fact are the subject of conflicting expert evidence. Thus, in this case there were three questions which the judge had to answer:-*
>
> > *(i) What was to be seen in the slides?*
> >
> > *(ii) At the relevant time could a screener exercising reasonable care failed to see what was on the slide?*
> >
> > *(iii) Could a reasonably competent screener aware of what a screener exercising reasonable care will observe on the slide treat the slide as negative?"*

69. Therefore, before applying the *Dunne* principles, the starting point must be what was on the slides. This ultimately is a question of fact which must be determined on the balance of probability by weighing the merits of competing expert opinions. However, *Penney Palmer* does go further than the three questions above referred to and the case endorsed the opinions of all the experts in that case that if there was any doubt in the mind of a screener as to whether the slide was normal, he or she should not classify it as negative. A slide should not be classified as negative unless the screeners had "*absolute confidence*" that it was so.

70. Dr. McK gave evidence that the need for absolute confidence is the practical obligation of screeners when they analyse slides and in this he was supported by Ms. T. and their evidence was not disputed. The "*absolute confidence*" test was also accepted by the second named defendant's expert, Prof. A., although it must be said with some initial scepticism. The "*absolute confidence*" test was accepted by the second named defendant in their submissions. Prof. P., in her evidence, on behalf of the third named defendant also accepted the need for "*absolute confidence*" though she did appear somewhat unfamiliar with the wording. Mr. F., the expert on behalf of the second named defendant when asked on the "absolute confidence" test said very fairly that one had to be "*confident*" and said in cross examination that he was unhappy as a scientist with the words "*absolute confidence*" though he accepted that it may have some meaning for lawyers. It should be noted that Mr. F. also when referring to ASCUS/AGUS said that one had to be "*confident*" to call a slide in this category. I believe it is fair to categorise the American experts called for the defendants as not being entirely happy with the "*absolute confidence"* test preferring instead to rely upon the skill and judgment of the cytotechnologist in relation to their opinion as to what was on the slide.

71. I hold that "*absolute confidence*" is the screeners practical duty in relation to their analysis of what is on the slide and indeed the adequacy of the sample, and the legal issue is whether or not they have carried out that duty in accordance with the *Dunne* principles. These extra tests set out in *Penney Palmer* are combinations of factual and legal matters, but I accept that a screening programme especially one such as in Ireland which does not have annual retesting, is inherently deficient if screeners ascribe as normal, results in which they are in any doubt. Accordingly, to ascribe as normal, a slide which the screener has any doubt of that fact even if he legitimately believes it to be normal on the balance of probabilities, is to fall below the *Dunne* standards required of that screener. Whether the screeners were right not to have any doubt is a matter to be assessed at law in accordance with the *Dunne* principles.

72. In other words, if there is any room for doubt that the slide was normal and the screener ascribes a normal result to the slide then the screener is in breach of the *Dunne* principles as he has been guilty of such failure that no professional scanner of equally specialist or general status and skill would have been guilty of if acting with ordinary care. A screening programme cannot operate safely if screeners are left to judge the slides and whether they are safe merely on the balance of probabilities. The dangers of false positives, referred to by some the American experts, and any distress that that might cause are far outweighed in the balance by the dangers of false negatives. Indeed, if the patient is advised that the reason for rescreening or indeed colposcopy is a doubt as to normalcy, any adverse effects of a false positive should be minimal. It should be noted that the fear of false positives together with a fear of not properly "*balancing*" the need of costs with safety seemed to be to the fore in the minds of a number of the defendant's experts. If the screeners must "*balance*" these requirements when reporting, as stated by a number of the defendant's experts, there is a clear danger that the screener will not apply the standard of "*absolute confidence*".

73. Just as there is room for difference between two competent screeners as to how a slide should be graded and just as there is

some though significantly less room for competent screeners to disagree as to whether a slide should be reported as normal or of concern, where slides are subject to audit, the audit findings must be also treated with some caution. In this regard, I accept the observations in the Public Health Guidance on applying Duty of Candour and Disclosing Audit Results V1.0 September 2016, p. 16:-

> *"No matter how closely the review tries to reproduce the original screening conditions, the conditions of a review are different – the fact that a review includes records of a patient known to have serious condition, such as cancer, will heighten vigilance and increase reports of abnormality.*
>
> *Finding discrepancies on review does not imply that the same findings should have been made under routine conditions.*
>
> *Hindsight has a significant impact on the interpretation of images.*
>
> *In a number of screening programmes such as foetal anomaly ultrasound, cervical and breast screening, the result is based on interpretation of appearances on a scan, slide or mammogram in circumstances where the boundary between normality and abnormality is not firmly drawn – this may result in debate between experts as to the appropriate classification of the sample or interpretation of the image."*

74. Therefore, to summarise, the legal standard to be applied on the issue of the liability of the defendants is the *Dunne* test. Questions of fact, however, are for my decision on the balance of probabilities. The questions of fact include what was to be seen on the individual slides. Accordingly, as in *Penney Palmer*, the correct approach is to determine:-

> (i) what was to be seen on each slide;
>
> (ii) whether a reasonably competent screener at the relevant time could have failed to see what was on the slide; and
>
> (iii) whether a reasonably competent screener in the light of what he or she should have observed, could have treated the slide as negative.
>
> Questions (ii) and (iii) above and any issues as to adequacy are to be decided in the light of the "*absolute confidence*" test and thereafter, the test for negligence is as stated in Dunne.

(B) Were the Defendants Negligent or in Breach of Duty in relation to the August 2009 Smear Test

75. In analysing the issue of the slides, both in relation to the 2009 and 2012 slides, one must at a starting point must always keep in mind the issue of retrospective bias. This was accepted by all the witnesses who were asked of it, was adopted by Woolfe M.R. in the *Penney Palmer* case, it is specified in the English "*Public Health Guidance on Applying Duty of Candour and Disclosing Audit Results*", it was averted to by Dr. Gabriel Scally in his scoping inquiry and frankly does not require the assistance of a learned Prof. of Psychology to advise me on that fact.

76. The object of audits and examinations by experts is to reproduce as closely as possible the original screening conditions. The findings on an audit which is designed for the education of screeners have to be treated with caution. It is, however, also the case that there are potential hazards in any method of evaluation after the fact. Whereas the advocates of a blind review indicated that this was the best way to reproduce the original testing element, it clearly is not the only way and blind reviews have their own potential hazards as outlined in his evidence by Dr. McM. Any reviewer knows that litigation is likely. Also, it may well be, as was the case in the second named defendant's slide, that a circle exists on a particular area which was highlighted by the original screener for one purpose or another, I believe the best conclusion from all the evidence is that any retrospective analysis of the slides must be treated with caution, that there are certain merits to a blind review though such a review is by no means compulsory and any eminent cytologists such as Dr. D.R. in the *Adams v. Laboratory Corporation of America* case and Dr. McK. and Ms. T. in this case did not conduct blind reviews and came to their conclusions based upon their professionalism and their analysis of the particular slide. Indeed, Mr. F. analysed the slide on behalf of the second named defendant without himself conducting a blind review and gave evidence as to his opinion.

77. On the other hand, I am asked on behalf of the plaintiff to treat the very concept of a "*blind review*" as something sinister given its origins from Dr. A. on behalf of the members of the American Society of Cytopathology. While I reject the idea that *a "blind review"* is the only valid method of analysis of a slide or that any non-blind review analysis is somehow invalid and while I recognise the reasons Dr. A. and the American Society adopted the guidelines, evidence of blind reviews cannot be excluded just because of the origin of this process. Because one disagrees with or rejects propositions, it does not follow that findings of conspiracy theories can validly be made. A court must be weary of hindsight bias in any review and must assess the professional opinion of any expert whether conducting a blind review or otherwise and then come to a judgment.

(a) What was to be seen in the slide?

78. The original report found the slide as negative or NAD. The internal audit carried out by the defendant's laboratory in 2014, found the slide as borderline nuclear abnormalities (glandular) or AGUS or AGC. The review by Ms. T. of the slides in September 2018, found that features of atypical repair/malignant cells are present. The review by Dr. McK. in October 2018, determined the slide as AGC. Mr. F. who gave evidence on behalf of the second named defendant principally in relation to the blind review stated that six of the eight reviewers found the slide to be negative and two in the AGUS/AGC category and that he himself, in a non-blind review would have reported the slide as normal or negative.

79. The issue of what was or was not to be seen on the slide is more objective than how the slide is to be interpreted. I accept the evidence of Ms. T. and of Dr. McM. and the conclusions of those who conducted the audit that the particulars of sensitivity in the slide were common ones and that on the 2009 slide, there were, at the time, cells in the AGUS/AGC category. Dr. McK. gave evidence that the slides contained abnormal cells in that there was a variation and intensity of staining throughout the nuclei's, variation in size and shape of nuclei, irregularities in the nuclear membrane, bi-nucleation, enlarged nucleoli, discohesive cells with distinctive architecture known as feathering, overlapping nuclei and mitotic features.

80. I do not hold that there was any major difference between Dr. McK's first and second report. His first report was based on his views of the slide. His second report was based upon the photographs taken by Ms. T. of the slides which served as an aid to the court expounding on what was Dr. McK's view of the slide. With this in mind he helpfully annotated one of the photographs to demonstrate the areas of concern.

81. I have had the benefit of the photographs taken by Mr. T. and in particular her photograph No. 8 in dealing with the 2009 slide. The cells in Ms. T's photograph No. 8 which was then annotated by Dr. McK. show cells with a very enlarged nucleus and a variation in nuclear size and shape and nucleoli which were enlarged and variable from cell to cell and also a cell with an irregular nuclear membrane. All of these matters were present on the slide. Mr. F. on behalf of the first named defendant states that these cells could be classified as reactive and normal and indicated that there could be "*other reasons*" for what was seen other than those suggestive of AGUS or AGC. I will deal with that observation subsequently when I consider what a reasonable screener could or should have observed. On the factual basis of what was on the slide, I have no doubt that the cells on the slide were AGUS/AGC, as identified by Dr. McK.

(b) Could a reasonably competent screener at the relevant times have failed to see what was on the slide?
82. The second named defendant's defence is mainly grounded upon the unreliability of non-blind review and also of the "*grey area*" as described by Mr. F. of the ACSCUS/AGUS categorisation and the degree of hindsight bias on the part of, in particular, Ms. T. and Dr. McK.

83. The independence of the first named defendant's witnesses was called into question and put in issue by the plaintiffs. A number of the experts called by the second and third named defendants did not include in their reports the declarations as to independence as required by the Irish Statutory Instrument. However, they all swore to their independence and I fully accept that all of the witnesses called on behalf of all of the parties, gave their evidence in an honest manner expressing their genuinely held beliefs.

84. This is not the end of that issue as Prof. A., in particular, was criticised given the fact that he was responsible for drafting the Guidelines of the American Society of Cytopathology which I accept were drafted, in effect, to attempt to limit litigation against cytopathologists in America and, therefore, on a self-serving basis. I accept that his evidence and also the evidence of a number of other American expert was affected by the *a priori*, though genuine, belief in the Guidelines of the American Society to which as members they had attested, that most cases of ASCUS or AGUS "*do not represents consistently identifiable abnormalities and a reasonable basis for allegations of a practice below a reasonable prudent practitioner's standard of care".* The same guidelines also stated that slides should be reviewed and evaluated as to whether "*unbiased blinded rescreening consistently detects significant abnormalities not initially identified by the laboratory*". I fear that this a priori view did indeed colour Prof. A's evidence. Clearly, however, that is not the end of the issue and I must determine whether a reasonably competent screener at the relevant time could have failed to see what was on the slide.

85. Furthermore, Prof. A. stated that where a cytologist sees only a few cells of concern, he is going to be cautious about relying upon them and will want to see more cells before he can interpret them. That view is not easily compatible with the "*absolute confidence*" test which Prof. A. accepted and which the second named defendant endorsed.

86. The plaintiffs further criticise the independence of Prof. A. as an expert on the basis of the reasonably close identification of Prof. A. with the second named defendant. The plaintiffs highlighted joint papers he has undertaken with employees of the second named defendant and also joint ventures undertaken by Prof. A's university and the second named defendant. I am not of the view that any such involvement had any real effect on Prof. A's evidence. However, I have been and am critical of the involvement with the American Society Guidelines and the effect they have on the independence of a number of witnesses. This is not to say, however, that the evidence of Prof. A. and the other American witnesses should be disregarded, rather it must be treated with some caution.

87. Mr. F. on behalf of the second named defendant stated that in his view the slide was normal. His observation, of course, was not "*blind*" but was on his evaluation of Mrs. Morrissey's slide after his screeners had undertaken their blind review. I note also, Mr. F's reluctance to ascribe to an "*absolute*" confidence standard which candour I acknowledge and commend.

88. I believe, however, Mr. F's opinion was probably based upon his utilisation of his professional skill and judgment to come to a conclusion on the balance of probabilities as to what was or was not on the slide. Mr. F. referred to the high degree of inter-observer variability in respect of the ASCUS and AGUS categories. He also stated that these categories are not used at all in the United States for proficiency audits or examinations of cytoscreeners. I fear that this opinion, which is similar to the description by Ms. S. on behalf of the third named defendant of ASCUS/AGUS cells as being a "*waste basket*" category together with the Guidelines of the American Society of Cytopathology have all influenced the opinions of the American experts when they dismiss as non-negligent any misreading as ASCUS/AGUS cells. The fact that the categorisation of ASCUS/AGUS is sometimes difficult to define is no reason to excuse from legal liability all, or most, who fail to properly categorise what are the most common non-normal cells. If the screener believes, even subconsciously, that ASCUS/AGUS cells need not be examined with the same scrutiny and subject to the same absolute confidence, then errors are more likely to occur.

89. I believe that the evidence of the American experts must be treated with caution as being, at least, subconsciously affected by the Guidelines of the American Society of Cytopathology and its view on ASCUS/AGUS cells. I find that the evidence of Dr. McK. is not tainted by any such predetermined bias, though, in Dr. McK's case like the evidence of all reviewers we must be cautious as to any hindsight bias.

90. The duty of the screeners was to adopt the absolute confidence test and having viewed the photograph No. 8 in its original form and as annotated, I accept Ms. T. and Dr. McK's evidence in relation to the irregularities to be seen on the 2009 slide which were annotated by him at photograph No. 8. Allowing for any retrospective bias, I believe that a reasonably competent screener at the relevant time should not have failed to see what was on the slide. The cells on the slide as evidence in particular by Dr. McK. had clear peculiarities which showed themselves as being other than normal. This ought to have be seen by a competent screener.

(c) Whether a reasonably competent screener in the light of what he or she should have observed, could have treated the slide as negative.
91. This issue is similar to but not identical to the previous one.

92. The second named defendant chose not to call as evidence either by video link or in person, the original two screeners of the slide in 2009, one of whom is still employed by the second named defendant and the other is known. In the absence of the screeners, I was left in a vacuum as to what they did or did not see or how they did or did not appraise the slide. The second named defendant also did not call to give evidence, the person who conducted the internal audit of the slide and I was, therefore, left without his evidence as to the basis he concluded that the slide contained AGUS/AGC cells. This was not satisfactory.

93. Accepting the absolute confidence tests, however, even on the basis of Mr. F's evidence e.g. "*that there could have been other reasons for what we are seeing here*", the absolute confidence test has not been met. As I stated above, I believe that the American screeners were utilising their professional skill and judgment and recording what they believed as a matter of probability was the case but that they ought not to have treated the slide as negative given the abnormalities as identified by Dr. McK.

94. Accordingly, I hold and decide that the defendants were negligent and in breach of duty in relation to the reading of the August 2009 smear test.

(C) Were the Defendants Negligent or in Breach of Duty in relation to the August 2012 Tests
95. There are significant issues in relation to the adequacy of the sample and what should or should not have resulted therefrom in relation to the 2012 sample. However, it is accepted that even if the number of cells on a slide were deemed inadequate that the slide should still be viewed to ascertain whether any of the cells were abnormal. Accordingly, I shall first address the three questions as to what was to be seen in the slides before, if necessary, dealing with the question of the adequacy of the sample.

(a) What as to be seen in the slide?
96. The original report recorded a negative finding. The internal audit carried out by Dr. C. in October 2014 determined that the slide was in the ASCUS or the AGUS category. The external audit by Dr. McG. carried out by the third named defendant in May 2015, determined that the slide was in the ASCUS category. The initial reviewed carried out by Ms. T. in July 2018, concluded that the slide should have been categorised as AGC and her subsequent review on the slides in September 2018, concluded that the applicant slide should be categorised as AGH, a higher categorisation in the borderline group and Mr. McK. in October 2018, also characterised the slide as AGC. Prof. P. on behalf of the first named defendant indicated that no abnormal cells were identified and blind reviews carried out by Ms. C.S. supported a negative finding.

97. The nature of the blind review carried out by the third named defendant was subject of much controversy in that for some reason which was not explained, the third named defendant married the plaintiff's slide for the purposes of the blind review with the patient's details of another woman who was post-menopausal and with a different history and no explanation was forthcoming as to why this was the case. On balance, I do not find that the plaintiffs have established any sinister motive for this irregularity.

98. The third named defendant did not call either of the screeners of the slide who were both based in Co. Dublin to give evidence as to what they found. This is, of course, entirely a matter for the third named defendant but from the court's point of view was unsatisfactory. Also, the third named defendant failed to call either the person who conducted the internal audit or the external audit of the slide, to give evidence as to why they found the slide to be abnormal. This was also highly unsatisfactory.

99. Ms. S. described the ASCUS/AGUS category as being a "*waste basket*". The categories certainly describe "*indeterminate*" cells which are abnormal if not cancerous or pre-cancerous. As we have seen there is an obligation for the screener in cases of ASCUS/AGUS to have the patient rescreened within a short number of months. As I remarked earlier, I fear that such descriptions as given by Dr. S. result from the Guidelines of the American Society's view that atypical cells can, in effect, be ignored when discussing liability, a proposition specifically endorsed by Prof. P.

100. Prof. P., as previously stated, having given her evidence as the necessity for blind review confirmed that as far as she was concerned even had there been a blind review and the reviewers had consistently reported ASCUS/AGUS that she would not have held the laboratory negligent as she supported the Guidelines of the American Society referred to above. These Guidelines suggested that any misreading of ASCUS/AGUS cells should generally not be classed as negligent. I believe that Prof. P's evidence accordingly, must be treated with caution though I fully accept her belief in what she has said, I fear that she did from time to time depart into the realm of an advocate rather than an expert.

101. Returning to what was on the slide, Ms. T. in her initial report indicated that she would make a preliminary diagnosis of AGC based upon her analysis of three areas on the slide. Her second report was more detailed, I do not accept the characterisation that her second report was fundamentally different from the first, it clearly was however the result of further time and she maintained her view that the sample contains abnormal cells displaying features of atypical glandular cells or AGH which is a higher characterisation in the borderline category than AGUS and would require a reference to colposcopy.

102. Dr. McK., however, in his analysis indicated that he would have found only one of the three areas of the slide identified by Ms. T. as being abnormal, to be so. Dr. McK. found this one area to contain AGC or AGUS cells. He found two of the areas described as abnormal by Ms. T. to be normal, one of which contained endometrial cells. Dr. McK. is, of course, to be congratulated as to his candour and his professionalism as an expert in not accepting the characterisation of three areas of abnormality as found by Ms. T. His evidence also, of course, indicates the difficulties of any retrospective analysis. In relation to the 2012 slide and whether it was normal or abnormal, I should, I believe, only consider the one area of abnormality as found by Dr. McK. and ignore the other two areas as found by Ms. T.

103. Dr. McK. went through this one area on the slide identifying its features which suggested AGUS. He found features of hyperchromatism and a certain irregularity of nuclear shape and gave evidence that some of the criteria within the group of cells were sufficient to show that the sample was not negative and not normal. Dr. McK. also gave evidence that the cells on the edge of the group had some nuclear enlargement that it would be sufficient to be considered abnormal. In relation to the centre of the cluster, he said that there was uncertainty as to the nature of the cells due to the inability to see the central part of the group of cells and that applying the absolute certainty test means that the sample could not be classified as negative. I accept the careful and professional evidence of Dr. McK. that on the slide in 2012, there were, in fact, AGC cells to be seen on the slide. This is confirmed by the retrospective audits conducted on the slide.

(b) At the relevant time, could a screener exercising reasonable care have failed to see what was on the slide?
104. The one area of criticism identified by Dr. McK. was described by Prof. P. as being equivalent to attempting to spot one pine tree in a forest of oaks from a height. Notwithstanding my reservations in relation to Prof. P's evidence which criticisms I have referred to above and will refer to again below, I believe that her characterisation of the one area in dispute in this case was reasonable. A screener is, of course, expected to identify the one pine tree in an oak forest but where the pine tree has characteristics similar to that of the oak forest, questions of liability do arise.

105. The slide was clearly "*scanty*". The offending cells are in one particular area only. I accept that in this case, the suspicious cells are clubbed together and they also bear the characteristics of normal cells. I came to the conclusion that the abnormalities present in the 2012 slide were significantly different from those in the 2009. In 2012, there was one area of abnormality as identified by Dr. McK. in which there were a number of cells clumped together. I am aware that I am forming my judgment on the basis of examining photographs rather than the slide itself but I came to the conclusion that the area of concern to Dr. McK. was not easily distinguishable from the two other areas which Ms. T. thought abnormal but Dr. McK. considered to have been properly assessed as normal.

106. Given the similarities of the abnormal cluster of cells with other cells that are properly classified as normal, I cannot accept on the balance of probabilities, that in 2012, a screener exercising reasonable care should be faulted for failing to see what was on the

slide.

(c) Could a reasonably competent screener aware of what a screener exercising reasonable care would observe on the slide, treat the slide as negative?
107. A reasonably competent screener must have "*absolute confidence*" to describe a slide as negative. However, given the similarities between the cells in question and normal cells, I am not satisfied that the plaintiffs have established on the balance of probability that a reasonably competent screener could not have treated this slide as negative and accordingly, the failure to determine that this slide contained abnormal cells was not negligent.

108. Therefore, I find that though the 2012 slide contained abnormal and non-negative cells, the nature of these cells was such that the failure to record them as abnormal was not a breach of duty of care.

Adequacy
109. That, of course, is not the end of the issue in relation to the 2012 slide as the issue of the adequacy of the sample has to be considered. As stated above, under the Bethesda system, a minimum of five thousand cells must be on counted a slide for it to be found to be adequate and if the tester finds less than that amount, he or she must return the slide and arrange for a repeat smear in one to three months. Most slides are obviously adequate and their adequacy can be attested as such by the screener by a brief visual examination and without any formal analysis.

110. In this case, Ms. T. in her report did not refer to the slide as being inadequate, though in her evidence she indicated that it was inadequate but that as she had found abnormalities, this is what she reported. Dr. McK. found the slide unsatisfactory for assessment and the internal and external audits conducted by the third named defendant which both found abnormal cells gave as a reason for the false positive that the slide was "*very scanty*". Prof. P. indicated that, after an analysis that she found the slide inadequate for sampling but indicated that a cytopathologist or screener more used to regular screening might well reasonably have determined without any analysis that there were sufficient cells on the slide and she would not fault a finding that the slide was adequate.

111. Dr. McK. and Prof. P. both tested the slide for adequacy utilising the method of testing prescribed under the Bethesda system and, therefore, under the laboratories' contractual obligations namely viewing the slide on an axis twelve to six or nine to three and magnifying random points on that axis to count the number of cells on the magnified slide and multiply therefrom to ascertain whether the minimum number of cells was present on the slide.

112. Where the screener cannot have absolute confidence as to adequacy from a quick visual inspection then the Bethesda method is the appropriate method of adequacy testing, utilising the Thin Prep Method. Most screeners will have fixed microscopes which can only therefore measure the slide on a thorough basis using the twelve to six or nine to three axis. Utilising any other access would in all probability leave gaps between areas analysed and would, accordingly, not be satisfactory.

113. It was suggested to Dr. McK. that a study had been undertaken in Vincent's Hospital, Dublin which found more than five thousand cells but it transpired that this study was purposively looking for cells and counting only where cells were found and then the study multiplied the areas where cells were found to achieve a purported total, rather than sampling on a random basis in order to achieve an average as required by the Bethesda System. I find this was not a valid approach. A similar observation can be made in relation to a second search conducted by Prof. P. designed to purposefully search out areas on the slide on which there were cells and to count these. This also subsequently found more than five thousand cells. Prof. P. was also specifically looking for areas in which there were cells rather than conducting a random sample. Initially, of course, Prof. P. had conducted a random search which found the slide to be inadequate for sampling.

114. I accept that Ms. S. in her adequacy review, apparently conducted in accordance with the Bethesda system, found that there was sufficient cells on the slide. In other words, it is possible that a random review carried out in accordance with the Bethesda system would have found sufficient number of cells but on the balance of probabilities, I believe any such random review would have been unlikely to have found the slide to be adequate.

115. Prof. P., on her own initiative it seems, requested Dr. M. a pathologist with a fellowship in cytopathology to subject the slide to a computer analysis using what he described as a Qupad system and this apparently determined that there were, in fact, over 35,500 cells on the slide.

116. When this evidence was put to Mr. McK., he responded that the five thousand cells sufficient for adequacy must be five thousand cells counted and analysed in accordance with the Bethesda system as this number, as assessed by this method, had been subjected to peer review and had been reduced considerably from what had previously been regarded as adequate that accordingly, the fact that a computer had discovered that there were actually over 35,000 cells on the slide, was irrelevant.

117. The plaintiffs further say that the finding by Dr. M. of over 35,000 cells due to his computer analysis is indeed irrelevant as pursuant to the contract, the slide ought to have been assessed utilising the method prescribed in the Bethesda system and that as a matter of probability, an assessment using this method, would have revealed that the slide was inadequate and accordingly, the plaintiff ought to have been referred for repeat smear between one and three months.

118. I accept the evidence of Prof. P. that in most cases, a quick visual glance can be made by the screener of the slide and that no formal test need be made. The original scanners of the slide did not give evidence as to what they saw or did not see or how they tested the slide for adequacy if at all. The third named defendant called two cyto-screeners by video link from the United States of America. These screeners participated in the blind reviews on behalf of Ms. S. Neither of these persons conducted a formal adequacy test, deeming such a test to be unnecessary though both did conduct a formal adequacy test on another slide in the blind review which they both deemed to be inadequate. I should note that one of these screeners, methods of conducting a formal adequacy test does not appear to be in accordance with the requirements of the Bethesda system and Thin Prep.

119. It is clear that the 2012 slide is significantly different from a visual examination from all the other slides I have witnessed. It clearly appears to have significantly less cells on it. The question arises as to whether a screener could have absolute confidence that the slide was adequate without undergoing a full test.

120. I note that Prof. P. felt the need to conduct an examination pursuant to the Bethesda system herself and that she found the slide to be inadequate. I must reject the suggestion of Prof. P. that the reason she subjected the slide to a formal test is that she is less experienced than the screeners and that had she been more experienced she could have passed the slide as adequate and that the failure to conduct a proper analysis cannot be faulted.

121. I fear that in relation to her evidence as to adequacy, Prof. P. clearly adopted the role as an advocate rather than an expert. She first deemed the slide to be inadequate using the prescribed method of testing. She then opined that the screener, who we did not hear from, was not negligent in failing to conduct an adequacy overview. Next, Prof. P. herself conducted a adequacy assessment of the slides purposefully to find areas where there were cells to show how it would have been possible to have found five thousand cells in a review and finally, of her own motion, it seems, she engaged Dr. M. to conduct a computer analysis which established there were over 35,500 cells. Prof. P. was clearly not willing to confine her evidence to what she found and indeed what her "*blind reviewers*" found but set out, as an advocate, to attempt to undermine the plaintiff's case.

122. The "*absolute confidence*" test must also apply in the case of the adequacy of the slide and in the event of any doubt by a screener, it ought to have been subjected to a test for adequacy. I observed the photographs at the side and heard the evidence of Dr. McM. and I find that the failure to test the slide for adequacy in accordance with the Bethesda system was negligent and a breach of duty. No competent screener could have had absolute confidence without a formal test that the slide was adequate.

123. I accept that it would have been possible to test that slide in accordance with the Bethesda system and to have discovered sufficient cells and this was apparently done by Ms. S. It should be pointed out, however, that the nature of the adequacy test carried out by Ms. S. was not clear and was not referred to in any report, though for the purposes of this decision, I will accept that she did, in fact, conduct a test in accordance with the Bethesda System. However, notwithstanding what Ms. S. happened to find, I believe that it is unlikely that if the slide were subjected to such a test that an adequate finding would have been made. Prof. P. first tested the slide appropriately as did Dr. McK. and also apparently Ms. T. and probably the persons who conducted the audit, whom we have not heard from and who found the slide "*scanty*". Accordingly, I believe that no screener of equal specialist or general status would have, if acting with ordinary care, failed to subject the slide to an appropriate test as to adequacy.

124. It is again unfortunate that the two persons who tested the slide in the third named defendant's laboratory in Co. Dublin were not made available by the third named defendant to give evidence as to what they did or did not do or whether they considered an adequacy test or whether indeed that they carried one out. One must have to presume that they did not.

125. I also find, as a matter of probability, that had a test been carried out by the screeners in accordance with the Thin Prep and Bethesda System, as outlined above, that it would have resulted in the slide being deemed to be inadequate.

126. Accordingly, the fact that an alternative system of measuring cells by computer subsequently discovered that there are over 35,500 cells on the slide is irrelevant. There has been no study conducted, subjected to peer review or otherwise, to demonstrate that such a computer analysis is suitable or indeed what number of cells found by the computer must be on the slide in order to determine that the slide is adequate. In the case of any doubt as to adequacy, the slide must be treated only under the Thin Prep and Bethesda System. The third named defendant rejects this proposition. It is, of course, possible to conduct an adequacy test using other methods. However, I find that the third named defendant was obliged under the terms of its agreement with Cervical Check to utilise the Thin Prep method as described by Dr. McK. The breach of duty and negligence of the third named defendant is their failure to conduct an adequacy review which are a no competent screener would have failed to do. Therefore, the third named defendant is in breach of the *Dunne* principles. The adequacy review that the third named defendant were obliged to conduct and would have conducted was the Thin Prep method.

127. Had the test been conducted under the Bethesda System, using the Thin Prep method, in accordance with the guidelines required by the first named defendant and their contract with the third named defendant, as a matter of probability, this slide would have been reported as inadequate and the plaintiff would have been required to be retested between one and three months.

128. Therefore, the defendants were negligent or in breach of duty, as defined by the *Dunne* principles in failing to have the slide properly tested for adequacy.

(D) What are the consequences, if any, for the plaintiffs of the said negligence?
129. The plaintiff was diagnosed with invasive cancer in 2014.

130. As a matter of probability, HPV infection was present in the plaintiff for ten years and upwards before that time.

131. The scan of August 2009, ought to have been reported as abnormal. The issue of whether the cells were squamous cells or glandular cells and, therefore, were in accordance with the Bethesda Terminology to be listed as ASCUS or AGUS is not of any consequence to the issues in this case as, if the slides had been indicated as being in either category, the plaintiff would, at least, have been advised to a repeat smear in six months time. At best, she would have been referred for immediate colposcopy. In either event, I accept the evidence that had she been screened again six months afterwards, it is likely that these findings would have been abnormal.

132. It is contended on behalf of the defendants that it is possible that the findings on a rescreening would have been normal, that is so. On the balance of probabilities, however, that is unlikely and should, therefore, be discounted.

133. Evidence was given by Prof. A. on behalf of the second named defendant that screening is less effective in the case of younger women. What is defined for these purposes as "*younger women*" was an age between 25 and possibly 35. On this categorisation, and only on this categorisation, Mrs. Morrissey was either borderline or was not in the category of a "*younger woman*" even on the date of the first relevant test in 2009.

134. In any event, many reasons for the difficulty in screening for younger women were given by the defendants. One of these was provided, as a default explanation in studies by epidemiologists and by statisticians and suggested that cervical cancer in younger women developed more rapidly than in the case of older women and accordingly, that the average of ten years for the development was less in the case of younger women. The defendants then built upon this opinion to suggest that the cancer that was found in 2014, might not have been present in 2009 or 2012. This proposition was not accepted by the clinician, Prof. S., and indeed there was no evidence in Mrs. Morrissey's case that her cancer developed more rapidly than the average. When it was examined, Mrs. Morrissey's cancer did not bear the characteristics of a rapidly developing cancer and the fact of its reoccurrence after eighteen months or so, did not suggest it to have been particularly rapid in its recurrence either. In this regard, I accept the evidence of Prof. S., who is a clinician. The cancer which recurred apparently arose from nodes left in situ unnoticed by Mr. M.H. where he had performed his trachelectomy in 2014 (and there is no criticism of this fact) and the cancer developed and became invasive but was not particularly rapid in its development. Indeed, at its best, the theory that cervical cancer may develop more rapidly in younger women is merely a hypothesis advanced in the statistical and epidemiological studies to explain the fact that cervical cancer are more difficult to detect in younger women.

135. Without specific evidence that Mrs. Morrissey's cancer was rapidly developing. The defendants advance what was, in effect, a circular argument: i.e. Mrs. Morrissey's cancer was not detected in 2009 or 2012, therefore the cancer was not there in 2009 or 2012 and, therefore, it must have been a rapidly developing cancer. In the circumstances, I have decided that the abnormal cells were present to be found on the slides in 2009 and 2012, and this circular argument must fail.

136. I believe that the suggestion that Mrs. Morrissey's cancer developed rapidly and accordingly, was not present in a pre-cancerous form in 2009, or indeed in 2012, is not supported by any factual evidence. It should be pointed out also that in Prof. A's joint paper with four other learned authors employed by the second named defendant, which advocated the effectiveness of combining screening with HPV vaccination, and not just proceeding on the HPV vaccination route alone, Prof. A. made no concession or did not even suggest that screening was ineffective, or indeed less effective, in the case of younger women.

137. In the circumstances, I accept the evidence from Prof. S. that as a result of the pre-cancer being detected after the subsequent rescreening and colposcopy, it would have resulted in the LLETZ procedure which would have led to a complete excision of the cancerous cells with as was stated, less than 5% chance of recurrence of precancerous development and less than 1% chance of invasive cancer developing. Accordingly, had there not been negligence in the reporting of the 2009 smear, the serious consequences for the plaintiffs and the plaintiff's damages as claimed in these proceedings would not have arisen.

138. The plaintiff developed squamous cancer. She did not develop glandular cancer. The abnormalities shown on the slides were glandular and not squamous. The plaintiff contends that glandular abnormalities can co-exist with squamous abnormalities and that the ultimate development of squamous cancer is, therefore, quite possible. The defendants dispute that this is likely. On this point, I accept the evidence of Prof. W. that the same carcinogenic stimulus is affecting the stem cells of the cervix that can differentiate along either squamous or glandular lines and that it is highly likely where one sees glandular pre-cancer that there is an associated squamous pre-cancer.

139. The plaintiffs' case does not depend on the identity of the cells which ought to have been detected as abnormal in 2009, developing into the cancer that was diagnosed in 2014. Rather, the plaintiffs' case which I accept, is that had the slide been correctly interpreted in 2009, she would have been rescreened and, as a matter of probability, been referred to colposcopy and as a matter of probability, the colposcopy would have revealed, in its precancerous stage, the squamous cells which ultimately took hold.

140. In relation to the 2012 smear by Medlab, my conclusions are the same. Had the sample in 2012 been tested in accordance with the Bethesda System and Thin Prep, the sample would have been deemed as inadequate and had it been deemed as inadequate, the plaintiff would have had a repeat smear between one to three months. On the balance of probabilities, the repeat smear would have resulted in colposcopy. It follows that the issue that the plaintiff developed squamous cancer and the cells which Dr. McK. described as abnormal were glandular cells in the AGUS category is not relevant. My analysis in relation to the 2009 slide applies, but more importantly in relation to the 2012 slide, the third named defendant is not being criticised in relation to the analysis of the cells in the slide but due to their failure to have the slide adequately tested and found to be inadequate.

141. I find that in those circumstances, the cancer which in 2012 was certainly developing would have been identified and the same procedure undertaken as could have happened in 2009 with the same benign results. Accordingly, the entirety of the plaintiffs' claims for injuries and loss are also caused by reason of the negligent misreading of the 2012 smear in failing to find that the sample was inadequate as defined by their contractual obligations and failing to ensure that Mrs. Morrissey was retested.

(E) Have the plaintiffs a claim for breach of Constitutional and/or European Convention Rights?

142. Under s. 3(2) of the European Convention on Human Rights Act 2003, the courts may award damages for contravention of a s. 3(1) right by an organ of the State. The HSE is clearly an "*organ of the State*" being a body "*…which is established by law…*". The damages available to an injured party are similar to that available to Irish Courts when assessing damages at common law – see *Pullen v. Dublin City Council* [2009] IEHC 452, per Irvine J. i.e. that a successful claimant should, as far as possible, be placed in the same position as if his Convention Rights had not been infringed. The plaintiffs contend that Articles 6, 8 and 13 are of the Convention are engaged.

143. Damages may also be awarded for breach of constitutional rights against the State – see *Green v. Minister for Agriculture* [1990] 2 I.R. 17 per Murphy J. However, damages in this regard are normally against the State for breach of constitutional duty or possibly for breach of fundamental rights. Though the HSE is an emanation of the State for certain purposes including a possible claim under the European Convention on Human Rights Act 2003, the State is not a party in this case.

144. The plaintiffs claim that had they been advised of the audits and the misreading of the slides, they could have issued proceedings earlier. I do not accept that submission. Initially when Mrs. Morrissey ought to have been informed of the results of the audits, she was well and not ill. It is possible but not, I think, likely that in those circumstances she would have considered litigation. Mrs. Morrissey's diagnosis of the return of the cancer was not made until February 2018. I do not believe that any material differences arise between the initiation of proceedings in February 2018 and July 2018.

145. A further and fundamental difficulty, however, for the plaintiffs in maintaining a claim of damages for breach of constitutional rights and/or European Convention Rights is that the rights complained of are fundamentally the tort and breach of duty rights that the plaintiff complain of in the main body of the proceedings and for which they are entitled to be compensated. In *W. v. Ireland (No. 2)* [1997] 2 I.R. 141, Costello J. held that a discrete action for damages for breach of constitutional rights only exists in situations in which damages are not otherwise provided for. I do not find that any of the European Convention Rights have been engaged other than possibly those rights which are covered by the tort and further, the actions complained of and found against the defendants do not amount to any or to any other breach. Accordingly, I do not have to specifically address this claim in any other detail.

(F) Was the first named defendant negligent in failing to advise the first named plaintiff to undergo scans and imaging tests in addition to the treatment afforded to her after the initial treatment in 2014 and did the first named plaintiff suffer any additional personal injuries due to her not being advised of the Audit results until 2018?

146. It should be noted that these allegations did not form part of the plaintiffs' initial pleadings against the first named defendant and were not referred to in the opening of the case on behalf of the plaintiff or in the original evidence given by the first named plaintiff in July 2018. Nor, were these allegations referred to in the initial reports by the plaintiffs' experts. Apparently, on 9th January, 2019, the second named defendant furnished the plaintiff with a number of reports including a report from Dr. P.L. and Dr. O. and these reports alleged that there had been a failure on behalf of the first named defendant in relation to the follow up of the plaintiff after she underwent her radical trachelectomy in 2014, and Dr. P.L. and Dr. O. apparently opined that the first named plaintiff ought to have been subject to regular imaging by CT scans and/or MRI scans. This criticism of the first named defendant arose from the issues between the defendants. However, the second named defendant withdrew Dr. P.L. and Dr. O's reports and made no allegations or submissions against the first named defendant. I would not, therefore, have referred to the opinions of Dr. P.L. or Dr. O., other

than the fact that the first named defendant's submissions refer to these expert views and quote from them. Accordingly, I will consider the quoted reports as in the submissions of the first named defendant in relation to the medical negligence issue against the first named defendant. On receipt of these reports, the plaintiff then had the matter investigated and Prof. S., who had previously reported on other aspects of the case, furnished a further opinion supporting the criticisms of the follow up care of Mrs. Morrissey in relation to the issue of imaging. In this, Prof. S. was supported by the evidence and report of Prof. J.

147. On the reopening of the case on 29th January, counsel for the plaintiff applied to have this additional medical negligence aspect of the case included in the plaintiffs' claim and also that the plaintiff be allowed to give evidence of a separate but related matter that had she been aware in 2014, that her original slides had been incorrectly read, that she herself would have insisted upon regular scanning. This argument was also not mentioned in her original evidence.

148. At the original opening of the case in July, counsel for the plaintiffs agreed that the plaintiff did not suffer any additional personal injuries as a result of not being informed of the results of the audits.

149. Counsel for the first named defendant understandably objected to this enlargement of the plaintiffs' claim on the basis it would constitute a major widening of the issues in the case.

150. Having heard the submissions of counsel on both sides, I satisfied myself that the first named defendant would have a reasonable opportunity to investigate and report in relation of these new allegations of which the first named defendant had notice since the previous September from the second named defendant. Counsel for the first named defendant fairly stated that on receipt of the second named defendant's reports, some preliminary inquiries as to these allegations had been undertaken. I also satisfied myself that given the time available in the case, the first named defendant would not suffer any prejudice. I allowed the case to proceed as now pleaded, as to whether the first named defendant was negligent in relation to the follow up care of Mrs. Morrissey in their failure to have regular imaging undertaken and also whether the plaintiff suffered injury due to her not being informed of the results of the audit and, therefore, not insisting upon regular imaging.

151. I did not allow the medical negligence to proceed on any wider basis, e.g. that the first named defendant had failed to conduct appropriate examinations on the plaintiff and in particular, had not carried out any rectal examination or any appropriate physical examinations. Indeed, I was not asked on 29th January, to allow the medical negligence issue to proceed on any basis other than the imaging issue. The matter did come somewhat of an issue in March 2019, when Prof. J. gave evidence and was critical in particular, the lack of a rectal examination as part of the follow up. I determined that the issue of medical negligence against the first named defendant was on the basis of the imaging and no more, however, evidence was led from both sides on the issue of the general adequacy of follow up care. I determined that this evidence is relevant only to the issue of the credibility of witnesses. I believe that to allow the medical negligence issue against the first named defendant to further expand would have been unfair notwithstanding the fact that as it subsequently transpired the witnesses from the first named defendant dealt with the issue of rectal examinations and general follow up care in their evidence.

152. The second named defendant subsequently withdrew the reports of Dr. P.L. and Dr. O. and did not lead any evidence on this aspect of the case. The plaintiffs relied upon Prof. S. and Prof. J. and on the recalled evidence of Mrs. Morrissey to support this aspect of her case.

153. The plaintiffs' case is that had the regular images been undertaken that either the return of the cancer would have been detected sufficiently early to allow a cure or in any event to prolong a painless existence for the first named plaintiff.

154. Notwithstanding the late notification of the matter, this issue is now a live one and must be assessed according to its merits. Prof. S. on behalf of the plaintiff who was a pioneer in the Radical Trachelectomy procedure which was undertaken by Mr. M.H. on the plaintiff in 2014, was initially critical of Mr. M.H. personally for not carrying out MRI or CT scans after the radical trachelectomy on a regular, perhaps every six months, basis. It is clear that Prof. S. has great respect for Mr. M.H. and believe that he carried out the initial trachelectomy expertly but he based his criticism on the fact that this procedure is a relatively new one having first been carried out in 1991, and first carried out in the UK in 1994 and that as part of being permitted to utilise a procedure, the ethical committees at St. Bartholomew's Hospital and the Royal Marsden Hospital, London, provided a stringent selection and follow up criteria including imaging. Prof. S. and Prof. J. stated that follow up imaging was a routine and regular matter in the United Kingdom hospitals and was particularly required in Mrs. Morrissey's case given what they described as the high risk of recurrence given the size of the tumour in 2014. They also gave their opinion that the failure to have regular imaging was in the case of Mrs. Morrissey a breach of duty of care.

155. Subsequently, Prof. S. seemed to resile from a personal criticism of Mr. M.H. and instead indicated that the responsibility would have been in the multidisciplinary team (MDT) who should have insisted upon this regular follow up which Prof. S. and Prof. J. insisted were the normal required follow up procedures in the cases of trachelectomies.

156. On behalf of the first named defendant, Prof. D.B. gave expert evidence in relation to follow up after radical trachelectomy and in his report stated:-

> *"The goal of any post treatment surveillance programme is to identify early detection of recurrent disease so that it can be appropriately treated. There are no international recommendations or guidelines for post operative surveillance in women who have undergone a radical trachelectomy. It is generally considered appropriate to perform a colposcopy, smear test and pelvic examination at regular intervals in an attempt to identify central recurrences as outline above… There are no international guidelines that suggest post treatment radiological surveillance should be undertaken in women after radical hysterectomy or trachelectomy…"*

157. Prof. B. also stated that imagining is not routinely recommended for surveillance but may be indicated in patients with symptoms or findings that are suspicious for recurrence. In Mrs. Morrissey's case, he stated that there were no such symptoms or findings and the size of Mrs. Morrissey's tumour was not such a reason.

158. Prof. A. also gave evidence for the first named defendant on this point and in his evidence, he did not accept that the fact that the plaintiff's initial tumour was found on histology to be over 2cm, should result in her follow up care being any different from the normal. Prof. A. accepted that some recent guidelines, in the United States of America in 2019, did refer to follow up imagining but the American Guidelines in 2013, did not do so and his view was that the proper practice was not to have follow up imagining unless the patient was symptomatic. A reason given by him and Prof. B. for not having follow up imaging was that same were generally ineffective for detecting a recurrence.

159. Insofar as it goes to credibility, I accept the evidence of Mr. M.H. that he regularly does perform thorough follow up examinations involving smear testing, colposcopies and pelvic and vaginal examinations and that he did so in Mrs. Morrissey's case. Mrs. Morrissey gave evidence that on one occasion this did not occur, but I believe she is mistaken and as a matter of probability that it did. Insofar as the failure to conduct a rectal examination is part of the case, and it can only relate to credibility, there is no doubt but that Mr. M.H. did not conduct any such examinations and whereas again there is some evidence, which indeed Prof. B. brought to the attention of the court that rectal examinations are recommended in some learned articles, I accept the evidence of Prof. B. and of Prof. A. that the preponderance of the opinions is that rectal examinations are not routinely required and indeed, that they probably would not have detected the tumour in Mrs. Morrissey's case had they been conducted. I am not deciding the issue of the lack of rectal examinations from the point of view of a medical negligence action but on the basis of the credibility of witnesses and of their evidence.

160. The independence of Prof. B. as an expert was called into question by counsel on behalf of the plaintiff due to a letter that he co-wrote to The Irish Times after the cervical smear controversy was given great publicity in June 2018, advocating cervical screening and making the point that "*cancer screening is performed across community of healthy asymptomatic individuals and was designed to reduce deaths from cancer in the overall population. It differs from a diagnostic test targeted at an area of abnormality in an individual patient. Sadly false negatives are an inevitable part of even the best screening programmes, regardless of the disease they target or the country they are based in". The letter also made the point that "automatic financial compensation for future false negative cases 'could lead to all screening programmes being abandoned*." The arguments referred to in the said letter, are first of all not central to Prof. B's evidence which was not dealing with the smears but rather with the medical negligence allegations against the HSE and indeed, the letter to the newspaper was saying little other than what I believe all sides in this case accept. I do not believe that the independence of Prof. B. was in any way affected by his ardent belief in the contents of that letter and Prof. B. was most careful in bringing papers to the attention of the court that appeared to run somewhat counter to his opinion. I find Prof. B. to be a most fair and careful expert witness.

161. I believe that the practices of Prof. S. and Prof. J. in advocating follow up scans, probably resulted from Prof. S's pioneering work in the field of trachelectomy and the ethical guidelines that were required of him in the 1990s when the procedure was first utilised. I accept that the normal standard and the usual practice of clinicians in Ireland, the United Kingdom or the United States of America is not to require follow up of imaging. Whereas some papers do suggest that imaging should be part of the follow up programme, I accept the evidence of Prof. B. and of Prof. A. that the preponderance of the opinion is that screening is not usually indicated, unless they are clinical signs of concern. I do not accept the contention by the plaintiffs' experts that the mere fact that the initial tumour was over 2cm is such a sign.

162. Therefore, there is no general requirement for post trachelectomy screening and there was no specific requirement for post trachelectomy screening in the case of the plaintiff.

163. Accordingly, I accept the evidence of the defendant's witnesses in this regard and the plaintiff must fail on the first ground of the *Dunne v. National Maternity Hospital* test. Even insofar as the plaintiff is alleging breach of duty on the basis of the third ground in the *Dunne* case, the evidence of Prof. S. and of Prof. J. does not establish that the practice had inherent defects which ought to be obvious to a person giving the matter due consideration. The arguments against regular scanning as to its ineffectiveness and to its lack of necessity except in particular cases where there are clinical signs, are cogent.

164. Accordingly, the plaintiffs should fail in the allegation of negligence against the first named defendant in relation to the care of the first named plaintiff after her treatment in 2014.

165. In relation to the second aspect under this heading, that had she been aware of the misreading of the original slides that the first named plaintiff would have insisted herself on regular CT/MRI imaging, this, of course, raises a different issue.

166. The plaintiff in her original evidence given in July 2018, did say that she asked about imaging on a few occasions but did not make any case against the first named defendant that had she known of the results of the audit that she would have insisted on screening. When the matter was resumed in January 2019, I allowed the plaintiff to give further evidence and to made the case that had she been advised at the time of the diagnosis of her cancer and her treatment in 2014, that her slide had been inaccurately read, she would have insisted upon regular screening.

167. I accept that had the plaintiff insisted upon screening, the first defendant would have supplied it, if only to reassure Mrs. Morrissey. I also accept that the plaintiff is entirely sincere in her present belief that had she known about the misreading of the slides in 2009 and 2012, as discovered by the audits that she would have insisted upon her regularly screened after her treatment.

168. The issue in this case is then if Mr. M.H. had advised the plaintiff on her visit on 7th July, 2016, that the audits revealed that the slides had been misread would the plaintiff have insisted upon regular scanning so as to effect a cure or, at least, a relief of symptoms and a reasonable extension of life.

169. Though Mrs. Morrissey was very clear in her evidence in January 2019, that she would have insisted on regular rescreening, I believe that that evidence is based on hindsight and upon Mrs. Morrissey's anger at not being informed of the audits. Had she been told in July 2016, or later, that the audits of her 2009 and 2012 smears indicated that they had been incorrectly read, she would have been given this information at a time that she believed that the 2014 procedures had resulted in a cure and I am not satisfied on the balance of probabilities that she would, in fact, have made any such insistence. There is, of course, nothing that connects the misreading of a test in 2009 or 2012, with the likelihood that the cancer which has been treated will return.

170. Had Mrs. Morrissey raised concerns having been told of the misreadings, she would have been rightly assured that the appropriate treatments and monitoring were being undertaking.

171. The point that needs to be made is that Prof. J. said that the opportunity for detection of the recurring tumour would only have arisen by February 2016, due to the previously small size of the tumour, and the opportunity for a cure ended around July 2016, and certainly by the winter of 2016 that window for a cure would have been closed. After that period, on the balance of probabilities, the best that could have been hoped for would have been a longer prognosis. However, given my findings on the issue of fact, it is not necessary for me to come to a view as to whether imaging being insisted upon, it would have detected the cancer in sufficient time to alter the outcome.

172. Accordingly, the plaintiff must also fail in the separate but related allegation that had she been advised of the misreading that she would have insisted on regular screening and that she has suffered personal injuries thereby.

173. It follows from the foregoing that the plaintiffs did not suffer any additional personal injuries due to the failure to advise the plaintiffs of the results of the audits on the slides.

(G) Is the first named plaintiff entitled to damages for the admitted breach of the first named defendant in failing to advise the plaintiff in relation to the results of the audit?
This issue will be analysed separately from the issue of exemplary damages.

174. The first named defendant has from the initiation of these proceedings properly admitted that it through its servants or agents was in breach of their duty of care to the plaintiff in failing to advise her of the results of the audit.

175. This not a minor or necessarily inevitable admission as a case could possibly have been made by the first named defendant that the obligations of treating doctors/health carers in relation to disclosure are different in questions of audit tests than in issues such as the diagnosis of injuries or their prognosis. Mr. M.H. said that when the results of audits relating to misdiagnosis commenced to appear, his original view was that the audits were educational and that screening always carried a high risk of false positives or false negatives and accordingly, he did not at the start believe that patients should be told. However, as the audit results continued to appear on his desk, he changed his mind and commenced telling the patients. This changes of mind occurred before the results of Mrs. Morrissey's audits were communicated to him in July 2016, unfortunately Mrs. Morrissey's case, notwithstanding Mr. M.H's belief by July 2016, that a patient ought to be informed of the results of audits, Mr. M.H. simply "*forgot*" and the letter remained on Mrs. Morrissey's file.

176. Mr. J.G. from the first named defendant was called as a witness by the plaintiff essentially dealing with the issue of exemplary damages, which will be considered under a different heading. He gave evidence of why the issue of screening might be a "*grey area*" in that it was not specifically referred to under the HSE's open disclosure policy and in particular, why the issue of audits and their disclosure might be different.

177. Mr. J.G. also stated that there was some delay in notifying the plaintiff of the result of the audit because the first defendant apparently did not coordinate the audit results from the two tests on the plaintiff. After that, however, the first named defendant was also delayed in furnished the results of the audit to Mr. M.H. due to the contention by the second named defendant that the plaintiff should not be advised of the results of the audit and the attempt by the second named defendant to invoke the disputes resolution system in their contract.

178. Notwithstanding any such difference between the defendants, the first named defendant wrote to their agent, Mr. M.H., the surgeon, with the results of the audits in 2016, and the note on Mrs. Morrissey's medical file was that the result were to be discussed with the plaintiff on her next visit in July 2016. However, Mrs. Morrissey was never advised of the audit results and Mr. M.H's explanation was that he simply "*forgot*". I accept that explanation. I also accept that it is difficult for Mrs. Morrissey to agree that human error was the reason that she was not advised of the results of the audit in 2016 and I accept that the plaintiffs are by now convinced and I accept correctly, that were it not for the fact of the nondisclosure of audit results becoming a matter of public controversy in relation to another case that Mrs. Morrissey herself may never have been told.

179. The first named defendant accepts and admits, however, that they were in breach of duty in relation to the failure to advise the plaintiff of the results of the audit. The issue to be determined is whether the first named plaintiff is entitled to damages in respect of that admitted breach.

180. I have previously discussed the issue of the alleged negligence of the defendant in failing to provide regular scanning after 2014 and also the related issue as to whether had the plaintiffs known of the audit that she, herself, would have insisted on regular scanning's and I have concluded that the evidence does not support these propositions.

181. It follows from my conclusion, the fact that Mrs. Morrissey was not advised as to the misreading of the original slides has not affected the plaintiff's treatment. Once it was discovered that she had developed cancer, in 2014, the cancer was appropriately treated with apparent success. The audits were carried out by the defendants after Mrs. Morrissey was treated for cancer in 2014. Her treatment was undertaken by Mr. M.H. before the audit results were available and was not, in any way, affected by the audits or by the fact that the plaintiffs were not informed of their results. Therefore, the fact that the audits disclosed that the slides had been misread, or indeed the fact that I have found that these misreadings were a breach of duty has had no effect upon the first named plaintiff's treatment or, indeed, the outcome

182. There is, no doubt, that Mrs. Morrissey is upset and angry about the issue of the audits. Indeed, those words "*upset*" and "*angry*" do not do justice to the plaintiff's feelings.

183. For a good cause of action, the law requires not damage (or "*damnum*"), but a legal wrong or "*injuria*". In this case, it is clear and it has been admitted that the first named defendant is in breach of a legal duty and that, therefore, an "*injuria*" has been done to the plaintiff. The issue is whether in addition to the "*injuria*" she has as a result suffered "*damnum*" to result in damages for personal injury.

184. The evidence of Prof. H., the plaintiffs' psychiatrist, is that the first named plaintiff's annoyance, upset and distress do not amount to a physical or psychiatric injury as required by law. An injury to be compensated in general damages, must be a disease or recognise a physical or mental injury. The first named plaintiff's anger, upset and distress as she described and as Prof. H. described, do not amount to a "*damnum*" as is required by law in order to be compensatable in general damages.

185. The state of the law is that where there is "*injuria sine damno*", i.e. a legal wrong without loss or damage as recognised by law that only nominal damages can be awarded. It is, however, Right and Just to separately record a finding of damages, even if only nominal damages against the first named defendant, under this heading. The quantum of the nominal damages under this heading will be considered later.

(H) Assess Damages
I will deal with two of the subheadings of this issue together.

(i) Is the second named plaintiff entitled to damages, and if so on what basis?

(ii) Are the plaintiffs, or either of them entitled to damages for future care and loss of earnings and other special damages which will arise after the death of the first named plaintiff and, if so, on what basis?
186. The second named plaintiff is clearly entitled to damages for Loss of Consortium. Since the decision of the Supreme Court in

McKinley v. Minister for Defence [1992] 2 I.R. 333, this action is equally available to a wife as well as a husband. An action for damages for loss of consortium, may now be maintained whether there is partial or total loss of consortium. The second named plaintiff is entitled to both general damages for loss of the society of the first named defendant but also to special damages arising from that loss.

187. In Spaight v. Dundon [1961] I.R. 201, at p. 215, the Supreme Court held that:-

> *"There is no doubt that the husband can recover for the medical and surgical expenses which he has been put to by the injury to his wife and for extra domestic expenses in which he has been involved… These are pecuniary losses easily ascertained where already incurred and capable of fair estimation for the future. In addition he is entitled to damages for the total deprivation of his wife's company, even if such deprivation is for a limited period or periods. Such damages should not be too generous…"*

It is clear that in cases where the husband will suffer, as in this case, the future loss of his wife's salary, that loss of income can and should also be included, as well as general damages, under this heading.

188. Under this heading, Mr. Morrissey is entitled to damages in respect of the future care that he and his daughter will require after the death of the first named plaintiff as well as compensation for his losses resulting from the loss of earnings of his wife throughout her career, together with general damages for loss of consortium. The defendants submit that *Coppinger v. Waterford County Council* [1998] 4 I.R. 243, is authority for the proposition that damages for loss of consortium are only recoverable during the injured spouse's life. That is not so. Geoghegan J. in *Coppinger* was deciding the issue of general damages for loss of consortium, not the issue of future pecuniary losses. Furthermore, Geoghegan J's view on this point was clearly obiter. I do not accept that a spouse is not entitled to damages under the heading of loss of consortium for future loss as a result of loss of society. The fact that such damages are in certain circumstances available under Part 4 of the Civil Liability Act is not relevant to this discussion.

189. A judge should, in deciding a case, should only decide the minimum amount necessary for him/her to reach a conclusion. I am, however, aware that there are other cases involving claims by women whose slides were allegedly incorrectly read, it is probable that in some of these cases, the plaintiff does not have a spouse but does have dependent children. A question in those cases would arise as to whether in the absence of a spouses, losses such as future care of a child or loss of earnings or other items of special damage would be recoverable.

190. As the defendants have submitted, these cases are not Fatal Claims, cases taken under Part 4 of the Civil Liability Act 1961, which gives a statutory entitlement for named dependents including children to have their losses included in the fatal claim.

191. In *Veronica Mahon v. Gerard J. Burke & Anor* [1991] 2 I.R. 495, Lavan J. held that in a case where a deceased who had brought an action for negligence claiming damages for personal injuries against the defendant which was settled by compromise before his death, that after his death, the plaintiff, a statutory dependent, was not entitled to maintain an action under Part 4 of the Civil Liability Act for funeral expenses, mental distress and loss of consortium, as to hold otherwise would be to subject a defendant to more than one case arising from one cause of action. Accepting the decision in *Mahon*, it is important that it not be extended into the realms of unfairness. To exclude the children dependents of an injured party such as the plaintiff who had not a spouse, unlike Mrs. Morrissey, from claims for compensation for financial loss into the future just because their mother had vindicated her rights during her lifetime to claim damages for the wrong she suffered would clearly be grossly unfair and is not what the Civil Liability Act 1961 requires. To require such an injured party to make a choice either to vindicate her own rights in a personal action claiming damages for personal injury and, therefore, depriving her dependents of any claim for dependency or in the alternative, to forego her personal claim so that her dependants could achieve compensation for their losses, is clearly grossly unfair.

192. However, since the *Mahon* decision above, the children of a person who has been wrongly injured and whose life has been foreshortened as a result of the negligence of a defendant are not entitled to process separate claims under Part 4 of the Civil Liability Act if their mother has previously brought her own claim for injuries. I am conscious of the fact that no such issue arises in the instant case, given the claim for loss of consortium on the part of Mr. Morrissey. It would be wrong of me not to state that this problem, which could give rise to gross injustice in the case of a women with dependence who had no spouse, can be solved by resort to the principle of "*lost years*" as discussed by Dr. White in his *Irish Law of Damages*, Vol. 1 4.9. *McMahon & Binchy* (4th Ed.) para. 44.144 states the "*better opinion*" is that a plaintiff whose working life expectancy has been cut short may be compensated for earnings and other losses of the resulting from her "*lost years*". This view was favoured by Walsh J. in the Supreme Court decision of *Doherty v. Bowaters Irish Wallboard Mills Limited* [1968] I.R. 277 at page 285.

193. I am aware that the principle of "*lost years*" has been criticised on a number of grounds including a "*flood gates*" argument. Without deciding on any general application of the principle of "*lost years*", I hold that this principle must have application in cases where otherwise the great injustice I have referred to above, would occur. If, as is the case, a plaintiff can in certain circumstances be compensated for the loss of earnings due to their "*lost years*", it is Right and Just that they are also entitled to compensation in respect of the damages caused by the lost years of their inability to care for their children.

194. Clearly, of course, where these damages are being awarded in an action under another heading e.g. to a second plaintiff, the spouse of the injured party under the heading of loss of consortium, they cannot be doubly recoverable. If I am incorrect in my decision that the second named plaintiff is entitled to damages for these future losses under the heading of loss of consortium, and if the defendants are correct in citing *Coppinger*, to that effect, then I would find that the same damages would be recoverable by the first named plaintiff under the heading of "*lost years*". I believe, however, it is much more logical to include these items under Mr. Morrissey's losses. It is Mr. Morrissey who is going to have to provide in the future for the care of Libby. It is Mr. Morrissey who is going to have to endure the loss of income of Mrs. Morrissey. It is Mr. Morrissey who is going to have to seek to provide out of his own pocket services which Mrs. Morrissey would otherwise do so.

195. The next issue in relation to the second named plaintiff is whether, in addition to his general and special damages for loss of consortium, he is entitled to damages in respect of his personal injury, namely the undoubted psychiatric injury he has been diagnosed with by Prof. H. as well as the return of his colitis. The defendants contend that the second named plaintiff is not entitled to these personal injury damages on the basis that the primary injury was to Ruth Morrissey and that a causation nexus does not exist between any negligence of the defendants and Paul Morrissey's illness.

196. In *Mullally v. Bus Éireann* [1992] ILRM 722, the plaintiff's husband and children were involved in a serious bus accident of which the plaintiff learnt when he was away on a visit to another town and she telephoned a hospital and was told that one of her sons was "*very bad*" and she phoned another hospital to be informed that her husband was dying and that a second son was there as well. As a result, the plaintiff developed PTSD which is a recognisable psychiatric injury, Denham J. analysing the situation stated:-

> *"It appears to me that the causal link is there. That the illness was reasonably foreseeable. The facts of this case clearly establish, a horrific situation for the plaintiff from the time of learning of the accident, through her journey to the hospital, to the appalling sights at the hospital, the terrifying sights of her sons Paul and Francis, and the fact of her apparently dying husband. All these events were caused by the accident caused by the defendants. It would be unjust, and contrary to the fundamental doctrine of negligence, not to find that there is a legal nexus between the actions of the defendants causing the accident, and the resultant aftermath of the accident in the scenes in the hospitals … The duty of care of the defendants extends as to injuries which are reasonably foreseeable…"*

197. The real issue on this aspect of the case, therefore, is whether the defendants owed to Mr. Paul Morrissey a duty of care and are his injuries reasonably foreseeable. In *Kelly v. Hennessy* [1996] 1 ILRM 321, Hamilton C.J. identified five requirements for a successful claim for nervous shock: (i) the plaintiff must establish that he has suffered a recognisable psychiatric illness; (ii) the illness must have been shock-induced; (iii) the nervous shock must have been caused by the defendant's act or omission; (iv) the nervous shock must have been "*by reason of actual or apprehended physical injury to the plaintiff or a person other than the plaintiff";* and finally; (v) the plaintiff must show that *"the defendant owed him or her a duty of care not to cause him or her a reasonably foreseeable injury in the form of nervous shock*". It is the last of the five requirements that is open to debate.

198. I believe that approaching this case on the basis of the duty of care issue is more satisfactory than an analysis as is sometimes engaged in courts in England as to distinctions between "*primary*" and "*secondary*" victims. The neighbour principle established by Lord Akins in *Donohue v. Stephenson* [1932] A.C. 562, is the principal basis for establishing a duty of care. However, since the decision of the Supreme Court in *Glencar Explorations plc v. Mayo County Council (No. 2)* [2002] 1 I.R. 84, a court must consider three or four (and whether it be, there are three or four, is not of any great significance) preliminary conditions in cases where the issue of whether a duty of care is owed arises, i.e. is there reasonable foreseeability, is there proximity of relationship, are there any countervailing public policy considerations and, finally, the justice and reasonableness of imposing a duty of care. Whereas, *Glencar* and other related cases dealt with the issue of economic loss, where the existence of a duty of care has been denied, I believe that Mr. Morrissey's claim for personal injuries must also be subject to this analysis. The fact that Mr. Morrissey suffered a physical injury (the return of his colitis symptoms) which was brought on by stress as well as psychological injuries is not of importance.

199. Mr. Morrissey has a recognised physical and psychiatric injury. His injuries started when he was advised in Galway of the return of the cancer. Clearly, there is a close proximity of relationship between him and his wife, especially so given the nature of the disease being suffered by Mrs. Morrissey. In relation to issues of countervailing policy, insofar as Mr. Morrissey's claim is for physical injury caused by reason of his wife's misdiagnosis, issues of countervailing policy do arise in that every spouse or close family member of a victim of medical malpractice is not *per se* entitled to compensation for psychological or physical stress related injury. To so hold would be to broaden considerably and unacceptably the number of plaintiffs who could claim damages in respect of a legal wrong done to their family members. Accordingly, Mr. Morrissey's claim for damages for personal injuries arising from the misdiagnosis of cancer should fail on public policy alone. I make this point even assuming it was established that a duty of care exists.

200. However, Mr. Morrissey's claim is also that his physical and psychiatric injuries have been considerably exasperated by the breach of duty of the defendants in their failure to notify himself and his wife of the results of the audit. In this regard, the quantity of potential plaintiffs is clearly very small and is a limited claim which would not be of general application so issues of countervailing policy may not arise.

201. The overriding issue in the case of Mr. Morrissey's claim for damages for his personal injuries is that of the duty of care and, in particular, whether Mr. Morrissey's injuries insofar as they relate to the issue of the nondisclosure of the audits are reasonably foreseeable.

202. I do not believe that a reasonable person in 2009, 2012 or 2016 could reasonably have concluded that if they negligently misread the slides or failed to tell Mrs. Morrissey of the results of the audits that her husband would be so affected that he would suffer a recognisable physical and mental injury. Accordingly, I have come to the conclusion with some reluctance that Mr. Morrissey is not entitled to maintain a claim for his personal injuries apart from naturally the issues that are compensatable under the heading of general damages for loss of consortium. I have come to this conclusion bearing in mind also the fact that I have found that the breach of duty of the first named defendant in relation to the failure to advise the plaintiffs of the result of the audit was caused because in his own words, Mr. M.H. "*forgot*".

(iii) Are the plaintiffs entitled to exemplary damages?

203. The principal object of General Damages the law of torts is to restore the plaintiff to the position that he or she occupied before the wrong was committed, principally through compensation in monetary form. The plaintiff in this case claims, in addition, exemplary damages. Exemplary damages are a vindication of the plaintiff by the punishment of the defendant. Dr. White in *Irish Law on Damages*, Vol. 1.2.03, states:-

> *"The justifications for awards in the nature of exemplary damages are twofold. First vindication of the plaintiff by punishment of the defendant. Secondly, deterrence of the defendant and others from repetition of similar misconduct. As regards vindication, it may be, and usually is, a great satisfaction to the victim of a tort that he may bring a wrongdoer before a court in order that he may be branded as being in the wrong collectively by society through the medium of the courts. Feelings of grievance, and even a desire for revenge, may be assuaged in this way whereas otherwise such feelings may fester, leading to undesirable tensions and hostility in the community, and perhaps occasionally explode resulting in recourse by the plaintiff to extra judicial methods of securing such satisfaction. Where the plaintiff has been a victim of egregious misconduct the law must, if the victim is to be vindicated, deal with the defendant in a manner significantly different from that in which it deals with an ordinary wrongdoer. The defendant must be punished and must be seen to be punished. An injured person's feeling of impotence, being a victim, in the power of a bullying aggressor or of a perpetrator who is reckless i.e. consciously indifferent to the welfare of the plaintiff or the security of his property, are not to be underestimated and are of an entirely different order to the feelings of grievance experienced by a plaintiff who has been injured in different circumstances amounting to a tort. The only appropriate response of the law in this context is to mulct the defendant in an award in the nature of exemplary damages…"*

204. The House of Lords in *Rookes v. Barnard* [1964] A.C. 1129 restricted the categories of law in which exemplary damages may be awarded in England:-

> (a) where there had been "*oppressive, arbitrary or unconstitutional action by*
>
> *the servants of the government*";

(b) where the defendant's conduct has been calculated by him to make a profit for himself which may well exceed the compensation payable to the plaintiff; and

(c) where exemplary damages are expressly authorised by statute.

This case also distinguishes between aggravated and exemplary damages whereas previously the terms had been used almost interchangeably.

205. In Ireland, whereas the restrictions specified in *Rookes v. Barnard* have not been specifically rejected, there are a number of cases in which the restrictions have been rejected in obiter remarks (see McCarthy J. in *McIntyre v. Lewis* [1991] 1 I.R. 121 and Murray C.J. in *Shortt v. Commissioner of An Garda Síochána* [2007] 4 I.R. 587. In any event, in this case, I believe that the HSE could be properly described as "*servants of government*". So the issue of the restrictions in *Rookes v. Barnard* is not of relevance to the claims against the first named defendant for exemplary damages and insofar as the plaintiff's might have a claim against the other defendants for exemplary damages, I will follow the reasoning of McCarthy J. in *McIntyre v. Lewis* (above).

206. *Rookes v. Barnard* also drew a sharp distinction between exemplary or punitive damages and aggravated damages. This distinction is also to be found in Finlay C.J's judgment in *Conway v. Irish National Teacher's Organisation* [1991] 2 I.R. 305, where he defined exemplary damages as:-

> *"…damages arising from the nature of the wrong committed and/or the manner of its commission which are intended to mark the court's particular disapproval of the defendant's conduct in all the circumstances of the case and its decision that it should publicly be seen to have punished the defendant for such conduct by awarding such damages, quite apart from its obligation where it may exist in the same case to compensate the plaintiff for his damage."*

207. Aggravated damages, as distinct from exemplary are additional compensation due to the conduct on the part of the defendant in the case and consequent distress and suffering for the plaintiff. Whether the plaintiff could formulate a claim for aggravated damages in these proceedings is disputed as only exemplary damages were pleaded. However, I will not decide this case on any pleading points. In relation to aggravated damages resulting from the conduct of the first named defendant's defence clearly this cannot arise given the early admission by the first named defendant of breach of duty and in relation to the audits. In relation to the other criticisms of the conduct of the first named defendant's defence, I do not find that this conduct was sufficient to justify a claim for aggravated damages. The first named defendant was entitled to deny any liability until a ruling from this Court was given on the issue. However, it would have achieved the same results had the first named defendant merely put in issue any misreading of the slides and claimed that if any of the slides were misread that they are entitled to an indemnity.

208. The second and third named defendants, of course, denied liability and chose not to call the persons who originally carried out the screening or the persons who carried out the audits on the slides but given the nature of their expert reports, I hold that they were reasonably entitled to deny liability and have the matter decided by a court. Accordingly, even assuming a claim for aggravated damages is open to the plaintiffs on the pleadings, the same does not arise in these proceedings.

209. The claim, as pleaded, however, is for exemplary damages. Exemplary damages are specifically recognised as a distinct head of damages under the Civil Liability Act 1961, and the issue I have to determine under this heading is whether the defendants by reason of their conduct of the governance of the screening system and of the tests and by their failure to reveal the findings of the audits to the plaintiff until, in effect, they were forced to do so by the inquiries of the plaintiffs and the public outcry in other case were guilty of such egregious conduct that they ought to be punished.

210. I have no doubt that for many observers the preliminary justifications for the award of exemplary damages as so eloquently outlined by Dr. White in the passage I have quoted from *Irish Law on Damages* would clearly be met. However, it must be said that the function of the law is not to place anyone in the modern equivalent of stocks so that they can be pelted by rotten vegetables for the entertainment of the public just because the public are enraged, even if understandably enraged. It is only as Dr. White indicated if the conduct of the defendant could be described as egregious that exemplary damages could be awarded.

211. Exemplary damages are only payable in the event of what could be described as an egregious or a deliberate or wilful act, such as an assault by a "*wealthy man in a dominant position*" with a most humiliating effect upon a plaintiff as in *McDonald v. Galvin* (McWilliam J., High Court, 23rd February, 1976) or false imprisonment by members of An Garda Síochána (*Dillon v. Dunne Stores (George's Street) Limited* (Unreported, Supreme Court, 20th December, 1968)) etc. In the plaintiffs' case, the breach of duty of the first named defendant (other than their liability for the conduct of the second and third named defendants) is as I have so found that a busy surgeon "*forgot*" to advise the plaintiffs of the audit. Further examples of the conduct of the first named defendant that the plaintiffs rely upon are the nature of the "*contracting out*" of the tests to foreign companies and the alleged mismatch of American lower standards with the Irish recall of three years rather than one year and the alleged fact that no proper account was taken of this mismatch in the contracts with the laboratories. When dealing with the issue of any claim for exemplary damages as against the first named defendant, I do not find that the liability as admitted or that any of the other matters raised by the plaintiff represented egregious conduct. The HSE, through Cervical Check, contracted with reputable international laboratories who could and did, in fact, conduct the smear tests in a more timely manner than the previous Irish laboratories. Efficiency of reporting is of vital importance in a smear check programme.

212. As regards, the second named defendant, the plaintiffs rely upon the fact that the second named defendant analysed the samples in the plaintiff's case in a laboratory that was not specified to in the contract between the first named and second named defendant and it is unclear how or why this was done. I accept that the fact that Mrs. Morrissey's slide was analysed by the second named defendant in a laboratory that was not specified in the contract and was not known to the first defendant meant that any systems of audit or governance put in place by the first defendants were ineffective, to say the least.

213. I regard the conduct of the second named defendant in relation to their contract with the HSE and Cervical Check as being, to say the least, cavalier. However, I do not believe that there is any evidence that the second named defendant utilised the laboratory not listed in the schedule to the contract for the purposes of avoiding or evading scrutiny by Cervical Check. The second named defendant's laboratories were not compliant with ISO standards which was a requirement under the contract with the HSE. They were, however, compliant with American standards which were different though largely similar to the ISO. Cervical Check seemed to accept this difference and in their latest contract with the laboratories, they have specifically indicated that while the laboratories will attempt to comply with ISO standards that their present compliance is sufficient for the purpose of the contract. I do not believe that anything turns in relation to this case on any differences between ISO compliance and the compliance that the laboratories had with American standards.

214. As I indicated, perhaps with too much colour, during the course of the trial the central issue in the case, is whether the slides were negligently read. The issue is not whether they were read in the most modern and up to date laboratory subject to the most rigorous monitoring by the HSE or whether the slides were read by a Transition Year school student in his hut in the bottom of a garden. Of course, if the evidence showed that the HSE allowed the slides to be read by the equivalent of a student in the hut in the bottom of a garden, or if the second named defendant had purposefully outsourced the reading of the slides to a substandard laboratory, in order to avoid scrutiny, that would be grounds for exemplary damages. Though the reason for the second named defendant utilising laboratories not specified in the contract were not communicated to Cervical Check, and neither was the approval of Cervical Check sought for these other laboratories including the laboratory in Grand Rapids which tested the plaintiff's slide in 2009, I do not believe that I can speculate that there was anything malicious or egregious in that fact, nor in the fact that the first named defendant did not, until this trial, discover where the slides had been read.

215. Neither, do I find that the claim for exemplary damages against the other defendants due to the delay in informing the plaintiff of the audit results, is well founded. The second named defendant was clearly responsible for some of the delay in transmitting the reports to the first named defendant and for a time vigorously opposed the first named defendant's intention to inform the plaintiffs of the audit and indeed, notwithstanding the fact which is likely to be the case, that this opposition by these defendants was self-serving, the fact is that the main reason the audits were not reported to the plaintiffs is that reporting was delegated by the first named defendant, to Mr. M.H. in 2016, and unfortunately, Mr. M.H. "forgot". The opinion of the other defendants that the results of the audit should not be disclosed has been rightly rejected by the HSE. Though erroneous, this view was not without, at least, an arguable basis at the time. The issue of nondisclosure of audit results especially when the audit results did not affect the treatment of a patient is not necessarily the same as nondisclosure of a patient's illness or disease.

216. The actions of the third named defendant in relation to the utilisation of another patient's name and details and inserting those on the slide of the plaintiff in relation to the blind review was not explained and was somewhat bizarre but I have not found this to be in any way sinister.

217. Accordingly, I do not find that the actions of the other defendants are grounds to hold that they should be punished or that their self-serving conduct was necessarily egregious. Therefore, the plaintiffs are not entitled to succeed in their claims for exemplary damages.

(iv) The Quantum of Damages
I will assess damages for each of the plaintiffs under separate headings and differentiate between the actual losses of each plaintiff.

(a) Special damages for the first named plaintiff
218. In assessing special damages, I adopt the formula utilised this Court and by the Court of Appeal in *Russell v. HSE* [2014] IEHC 590, that the proper method to test claims for special damages is to analyse whether the plaintiff's claims are reasonable rather than attempting a paternalistic view of balancing the reasonableness of the competing claims from the plaintiff and the defendant. It is only if the plaintiff's claims are unreasonable that the defendant's suggestions should be considered.

219. Certain items of the first named plaintiff's special damages have been agreed between the parties. The parties have agreed that the occupational therapy costings have been agreed at €55,000 and the claim for home adaptation has been agreed at €70,000. In addition, there has been agreement in relation to miscellaneous items of special damages amounting to €12,508. The next aspect of the plaintiff's claim for special damages is her loss of earnings. As previously stated, the plaintiff was employed as a customer solutions supervisor with UPS. I accept that she was scheduled to be promoted to customer solution manager in 2018, giving an annual salary of €50,103.48 and that as a matter of likelihood she would have been promoted to customer solutions manager in around 2025, earning a salary of €59,925.55 gross at today's levels. Beyond that, I believe to be speculation.

220. I think it is fair to allow Mrs. Morrissey the sum of her loss of earnings for the remainder of her life based on a salary of approximately €50,000 and allowing for her living and expenses including the cost of caring for Libby, a sum of €50,000, under this heading is reasonable.

221. In relation to the cost of assistance and care for the plaintiff for the rest of her life, and particularly for her end of life care, I believe that the costings as set out by Ms. N.R. are probably excessive in relation to the length of time such end of life care will be required. I do not believe that the plaintiff will require the care for the length of period as suggested by Ms. N.R. However, the figures set out by the defendants' expert, Ms. P. insufficiently take into account the reality of the plaintiff's loss.

222. An issue does arise in relation to the costings. Ms. N.R's costings are on the basis of payment to persons who are in a regular position in relation to their taxation, whereas the defendants' costings are it seems, at least, partly based upon payments of cash to neighbours/friends. Just as a plaintiff claiming damages for loss of earnings cannot expect to be compensated in respect of undeclared income lost so a defendant cannot expect a court to countenance payment on a "*cash*" basis even if such a basis is frequently utilised for the engagement of such services.

223. This is not an exact science and involves some necessary speculation. Being fair to both the parties, I will assess the care of the plaintiff for the rest of her life in the sum of €60,000 assuming a two year life expectancy. I assess, therefore, the special damages to the plaintiff for her life in the sum of €247,508. The balance of the losses will fall to be considered under losses for the second named plaintiff.

(b) General damages for the first named plaintiff
224. Had the slides been properly analysed in 2009 or had the slide in 2012 been deemed inadequate and the plaintiff been reviewed within one to three months, then as I have found as a matter of probability, the plaintiff would have been re-tested and as a matter of probability, her slides would have been abnormal and she would have been sent to colposcopy and would have been, as a matter of high probability, successfully treated using the non-invasive LLETZ procedure and she would never have contracted cancer in 2014. She would have been spared the pain and distress of what followed and in particular, the cancer would not, as a matter of probability have recurred. She would not have been subjected to the radium or chemotherapy treatment. She would not have suffered all her pain and distress that she has undergone so far. She would not have been left in the knowledge that she has only, at most, two years to live, her career would not have been interpreted. Her martial relations would not have ended with her husband. She would have, as a matter of likelihood, had at least one further addition to her family. She would have been spared the prospect and the knowledge that her daughter and her husband will have to go through life without her care and guidance and in particular, she will not live to see her daughter make her way through life and probably start her own family and of most and more importance, her life would not have been so tragically cut off.

225. The purpose of general damages is, of course, to attempt to place a plaintiff in the position she would have been had the insult

to her not occurred. It is extraordinary that some analysis referring to the "*recalibration*" of damages should approach the issue without significant, or any, reference to the person, general damages serve in the first place. Indeed, general damages are "*assessed*" they are not "*calibrated*" so they cannot be "*recalibrated*". The Court of Appeal in *Shannon v. O'Sullivan & Ors* [2016] 1 I.R. 313, made clear that there is no question of "*recalibration*" in any of their decisions.

226. No two persons with the same or similar injuries suffer to the same degree. The assessment of damages can never be based upon any pseudoscientific exercise in "*box ticking*". Such an exercise, though perhaps superficially attractive is entirely subjective and dependent upon which "*boxes*" the box ticker creates in order for them to be ticked. The reasonable objective of consistency in awards can never trump fairness for individuals who must be individually assessed. In this regard, to ensure fairness, it seems a judge can never be replaced by a formula or by a computer, however, intelligent.

227. The first issue that arises in relation to general damages for the first named plaintiff is whether these general damages are to be limited in accordance with "*the cap"* on general damages first referred to by the Supreme Court in *Sinnott v. Quinnsworth* [1984] ILRM 523, leading on from the earlier decision of the Supreme Court in *Reddy v. Bates* [1983] 1 I.R. 141.

228. The cap on general damages was most recently fixed by Quirke J. in *Yun v. MIBI* [2009] IEHC 318, at €500,000 which sum he reduced because of the then economic recession to €450,000. I have discussed the issue of the cap on general damages in a number of decisions including in *Woods v. Tyrell* [2016] 355. More recently, there has been an excellent review of the law by Barton J. in the important case of *B.D. v. Minister for Health and Children* [2017 No. 1 C.T.] (judgment delivered 19th January, 2019). I entirely agree with the analysis of Barton J.

229. General damages are awarded so that an injured party can utilise the money to purchase goods or services, serious or frivolous, to compensate for what he or she has lost. A plaintiff might want to buy a new car, engage in foreign travel or indeed, purchase a new or better house. Persons with catastrophic injuries will usually have less freedom to utilise their general damages to compensate for their loss which is the central reason given in *Sinnott* (above) to justify the "*cap*".

230. In Reddy v. Bates, the Supreme Court referred to a fact that the plaintiff "*has been awarded what is considered to be sufficient damages to cover all her prospective losses, to provide for all her bodily needs, and to enable her to live in comparative comfort (having due regard to her disabilities)"*, and stated that this fact "*should be reflected in the amount of general damages to be awarded".*

231. Having quoted from the above passages in *Reddy v. Bates*, the Supreme Court in Sinnott stated that:-

> *"In a case such as this, regard must be had to the fact that every single penny of monetary loss or expense which the Plaintiff has been put to in the past or will be put to in the future has been provided for and will be paid to him in capital sums calculated on an actuarial basis. These sums will cover all his loss of earnings, past and future, all hospital and other expenses in relation to the past and the future and the cost of the special care which his dependence requires, and will require, for the rest of his life. …"*

232. In the instant case, the first issue I must decide is whether this cap should apply. Clearly, if the cap does not apply, the injury suffered to the plaintiff is indeed at the most extreme. She does not, of course, have an ongoing disability at the moment equivalent to a tetraplegic or someone with significant brain damage which injuries would be expected to last for a considerable number of years. However, unlike plaintiffs with significant brain damage, possibly caused at birth, the plaintiff has a full knowledge of her situation. Mrs. Morrissey's life has been ruined and she will be aware of that fact for the rest of her life. Mrs. Morrissey has suffered a life sentence of which she is fully aware which is expected to take effect within two years and for which there is no reasonable prospect of a reprieve. The fact that her injuries were caused by negligent inadvertence and not by any intentional act or even moral culpability, as I have so found, is relevant only to my decision in relation to exemplary damages. She has suffered a catastrophic injury no less than that of a tetraplegic or someone with brain damage. If the "*cap*" does not apply, then I would have no hesitation in awarding general damages at a rate higher than €500,000.

233. I am providing the first named plaintiff in special damages with what I believe to be all her reasonable losses to date and for the rest of her life for the next two years. Though she herself is not being compensated but rather her husband is, in respect of the losses of her future income after her death and the costs of the future care of her daughter, Libby, I have come to the conclusion that the cap on general damages should, following the principles in Sinnott, be applied in this case and accordingly, she is entitled to the sum of €500,000 for general damages. Any less would be an insult.

(c) Special damages for the second named plaintiff

234. I have already rejected the proposition that the second named plaintiff is only entitled to damage for loss of consortium for his losses while Mrs. Morrissey is still alive. If I am incorrect in that conclusion, then Mrs. Morrissey would be entitled to the same amount under the principle of "*lost years*". The second named plaintiff is entitled to his losses in respect of the loss he has suffered due to the plaintiff's future earnings, and the extra cost of care for Libby until she reaches the age of approximately 23.

235. As previously stated, I believe that Mrs. Morrissey would have gone on to be promoted but the status of customer solutions manager at a salary of €59,922.55 in 2025. I believe that such a promotion is reasonable, it is quite clear that Mrs. Morrissey was a highly value employee of UPS but further promotion argued on behalf of the plaintiff is a matter of more speculation and I will not allow for it. The actuaries have calculated the loss of earnings figures as a whole where I have differentiated between losses to the first named plaintiff and the second named plaintiff.

236. When calculating loss of earnings to the second named plaintiff, one must, as the actuaries have, subtract from the figures the expenses that Mrs. Morrissey would have expended had she lived and which would not have been available for either Mr. Morrissey or Libby. Clearly the loss under this heading is Mr. Morrissey's loss.

237. One must treat the actuaries figures as guides merely and allow for the fact that I have already compensated in respect of the next two years of the plaintiff's earnings. The defendant's valuations are based upon the plaintiff's income as it was in 2017 and do not allow for the increases which I think are reasonable. Therefore, the plaintiff's actuary's approach is to be preferred in this regard.

238. The plaintiff's actuary has given alternative figures of either €773,519 or €1,167,960. The higher figure assumes that the bonus of 3% is permanently added to the salary each year. I do not think that that is valid and will use the lower figure as a guide from which I must deduct, not alone the loss of earnings to Mrs. Morrissey for the next two years but also a sum for *Reddy v. Bates*, such deduction must be made as though Mrs. Morrissey is an enthusiastic and highly regarded employee, it is likely that had she survived and, for example, gone on to have a second and possibly a third child, that she would have been out of work for a period. I believe

that a sum of €600,000 is reasonable under this heading.

239. In addition, the plaintiff's claim to loss of State pension, company car, private benefit, share options. The defendants have not calculated the company car and share options but have allowed a sum for loss of occupational pension. The plaintiff's actuary allows a figure of €200,000 for these figures. However, there is a level of uncertainty about some of these matters and I think being fair to the parties, a sum of €150,000 should be allowed.

240. In relation to the cost of future child care for Libby until she 23 and domestic assistance for Mr. Morrissey for his life after Libby is 23, there is a significant difference between the evidence of Ms. N.R. and of Ms. P. I fully accept that the plaintiffs are entitled to expect that in the absence of Mrs. Morrissey that Libby will have the best possible care. Essentially, Ms. P. sets out her recommendations based upon engaging persons on an informal cash basis, which is not acceptable. However, is must be said that Ms. N.R. does envisage a level of care which is in all probability unrealistic when Libby gets to her teenage years. Ms. N.R. is, of course, correct that nothing can replace the care of a mother and indeed, in teenage years and in the time when Libby will be doing her Junior Certificate and Leaving Certificate examinations, a mother's care is of vital importance, I do not believe that this can be properly substituted by any level of formal care and accordingly, I believe that the costings as proposed by Ms. N.R. which would actuaralise at over €787,000 cannot be fully sustained. There is no scientific method of performing the exercise but I believe that a sum of €500,000 allowed for the future care of Libby would be reasonable. It is entirely reasonable that costings be based upon the payment of carers who are vetted and whose tax situation is regularised.

241. In relation to domestic assistance for Mr. Morrissey, after Libby is expected to leave home, there is an element of speculation as to whether Mr. Morrissey will at that stage require further assistance but I accept the case being made out that he will. It is not unreasonable that some services which will be provided by Libby until she leaves home should be allowed thereafter. I note the actuarial valuations on behalf of the plaintiff are slightly less than €200,000 in this regard and that of the defendant are slightly more than €36,000. I find that the plaintiff's value as to Mr. Morrissey's needs is somewhat excessive. I will assess the sum of €75,000 under this heading is fair and reasonable in the circumstances.

242. In addition, I will allow a sum to Mr. Morrissey in respect of retrospective care at €13,468 and a sum of €6,532, for bereavement counselling. These figures add to a further €20,000 in special damages for the second named plaintiff.

(d) General damages for loss of consortium for the second named plaintiff
243. The second named plaintiff, Mr. Morrissey has already suffered what the law refers to as "*partial loss of consortium*". Loss of consortium refers not just to the physical aspect of marriage but also and more importantly, to the care and support a spouse gives and receives. The general damages for loss of consortium are independent of the fact that Mr. Morrissey is not entitled to any damages for his personal injuries as discussed previously.

244. I have come to the conclusion that Mr. and Mrs. Morrissey are a particularly devoted couple and, as Mr. Morrissey is already deprived of her society in so many ways and as he will be deprived of her society in its entirety in approximately two years time, he is clearly entitled to general damages.

245. Kingsmill Moore J. in *Spaight v. Dundon* indicated that general damages for loss of consortium should not be "*too generous*". As O'Flaherty J. pointed out in *McKinley v. Minister for Defence* [1992] 2 I.R. 333, that precept "*applies to any award for damages*". In McKinley, a husband was left sterile and impotent by an explosion and O'Flaherty J. stated "*a benchmark might be sought and found in the level of damages that are awarded for mental distress under the Civil Liability Acts in the case of the death of a spouse. It would seem clear, in principle, that damages for loss of consortium should be related to those recoverable for the death of a spouse*".

246. In *Coppinger v. Waterford County Council* [1996] ILRM 427, Geoghegan J. determined that the mental distress which results from the death of a spouse and for which damages are recoverable under Part 4 of the Civil Liability Act 1961, is not, in any way, an injury of a similar kind to loss of consortium and that there was no ceiling for damages in the case of loss of consortium. In that case, Geoghegan J. indicated the plaintiff had already suffered loss of consortium for ten years and would probably continue to do so for a number of sixteen or seventeen years and that this was infinitely worse than mental distress if the plaintiff's husband had died in an accident. Geoghegan J. awarded the plaintiff €60,000.

247. The general damages for loss of consortium for which Mr. Morrissey is entitled should clearly be damages that are at a level only recoverable in the High Court and, I believe that Mr. Morrissey's damages should reflect the nature of his loss, how it occurred and its future permanence, and accordingly, I believe that a sum of €60,000 is fair and reasonable in and not at all too generous in the circumstances.

(e) Damages for the first named plaintiff for the breach of duty of the first named defendant in relation to the nondisclosure of the results of the audits
248. As previously stated, the plaintiff is not entitled to general damages under this heading but is entitled to what is known as nominal damages. Nominal damages are not compensatory damages but are awarded where there is a breach of a plaintiff's right but no actual injury. Nominal damages must clearly be distinguished and distinguished in monetary terms from contemptuous damages which sometimes are awarded by courts in defamation cases where they find the defamation established but have little regard for the character of the plaintiff. In this case, the findings of the audits, even though they be educational, were within the definition of a "*harmful event*" in the first named defendant's disclosure policy and accordingly, they ought to have been disclosed. I accept that the first named defendant has admitted liability for the nondisclosure and that, to a certain extent, at least, in grappling with the issue of these audits and whether to disclose them, the HSE were, indeed, dealing with new issues that had not been dealt with before. However, the wrong done to the plaintiff by the nondisclosure of the audits was not inconsiderable and as I stated, previously should be marked by a specific amount and in the circumstances, I believe that an award of €10,000 under this heading is appropriate.

Summary
249. The first named plaintiff is entitled to:

Damages in respect of failure by first

named defendant in relation to the audit €10,000

As against all defendants:

General damages €500,000

Miscellaneous special damages (agreed) €12,508

Cost of home adaption (agreed) €70,000

Occupational therapy (agreed) €55,000

Loss of earnings for life €50,000

Care costs €60,000

Total to first named plaintiff €747,508

+€10,000

Total €757,508

250. The second named plaintiff is entitled to:

General damages for loss of consortium €60,000

Loss of first named plaintiff's income €600,000

Loss of pensions, company care and share options €150,000

Cost of care for Libby €500,000

Cost of domestic assistance €75,000

Retrospective costs and bereavement counselling €20,000

Total €1,405,000

Damages to the first named plaintiff +€757,508

Grand total €2,162,508

I assess that sum as being fair and reasonable in all the circumstances.

(I) The liability of the various defendants

251. The plaintiffs' damages of €10,000 for the failure of the first named defendant to disclose the audit results are the responsibility of the first named defendant. In relation to the other heads of damages, the defendants are all Concurrent Wrongdoers under the Civil Liability Act 1961. Each of the defendants is responsible for the same damage or for damage that cannot be distinguished.

252. The first named defendant no less than the second and third named defendants have a liability to the plaintiff as the organisers and being responsible for the cervical smear tests. The first named defendant determined the standard to be applied in relation to screening. The first named defendant determined the international standard to which the laboratories were expected to conform. The first named defendant provided for the manner in which the screening should be conducted and how it should be reported. It was public policy for smear tests to be provided by the HSE free of charge. The first named defendant chose rather than provide the service themselves to contract out the screening programme to the second and third named defendant. Had the first named defendant not so contracted out the screening service, it was a service they would have provided themselves. The first named defendant also paid for the service. Kelly J. (as he was) held in *Byrne v. Ryan* [2007] that a party with a liability cannot evade of that liability to someone of the status of the plaintiff merely by engaging competent professional persons to perform tasks which they themselves are obliged to do so. The first named defendant has responsibility for all aspects from the cervical screening programme and has accepted same in its various reports under the Quality Assurance Guidelines published in 2009.

253. The detailed submissions of the first named defendant are, in my view, misguided. The primary liability is not based on agency and the decisions of *O'Keeffe* and other matters cited are not, in my view, relevant. I accept the principles of *Woodland v. Essex County Council* [2013] UKSC 65, and the five tests outlined therein. The first named defendant has a primary liability.

254. The first named defendant also is liable to the plaintiffs vicariously for the activities of the second and third named defendant. The first named defendant has control over the laboratories in what they do by virtue of their contractual arrangement. They also have control over the manner in which the laboratories are obliged to perform the contract.

255. It would have been preferable in this case had the first named defendant merely put liability in issue but admitted from the start that were any of the slides negligently read that then they had a liability and pleaded that they were entitled to an indemnity against the laboratories in respect of same. Given my views in relation to the first named defendant's entitlement to an indemnity/contribution referred to below, nothing would have been lost by the first named defendant in taking that position.

256. However, it would be unreasonable to expect the first named defendant to admit liability just because the slides were misread. Each case must be assessed on its own merits and, as we have seen from the issues involved in the 2012 slide, the fact of misreading does not necessarily involve negligence or breach of duty. I have concluded that the first named defendant is not to be penalised for taking such a decision in relation to liability before there has been any judicial pronouncement on that topic.

257. I have held that that the plaintiffs' losses result from the failure to properly assess the 2009 and the 2012 slides. It is impossible to differentiate between the losses resulting from one or the other. All the defendants are in relation to the 2009 and 2012 slides and the losses that flow therefrom concurrent wrongdoers as defined in the Civil Liability Act 1961.

258. Accordingly, it would seem:-

(a) The first named plaintiff is entitled to a decree in the sum of €10,000 against the first named defendant in respect of the failure to report the audit results.

(b) The first named plaintiff is entitled to a decree in sum of €747,508 against the defendants jointly and severally.

(c) The second named plaintiff is entitled to a decree in the sum of €1,405,000 against the defendants jointly and severally.

259. Under the contract between the HSE or its agents and the laboratories, the HSE are entitled to an indemnity against *"all costs, claims, actions, proceedings, demands, losses, awards, penalties, fines, liabilities and expenses of whatever nature incurred by (HSE) its employees, subcontractors or agents caused by or arising out of any act, neglect, breach of contract, breach of duty, breach of statutory duty, error, default or omission of the (laboratory) its employees, subcontractors or agents in connection with the performances of the services".*

260. These losses are clearly within the scope of clause 16 of the contract. While the first named defendant has a liability vis-à-vis the plaintiff which it cannot evade, the causa causens of the plaintiffs' damages, apart from the non-disclosure of the audits, are the acts and omissions of the second and third named defendant. Accordingly, the HSE is entitled under the contract to an indemnity against the laboratories for all matters other than the HSE's liability in relation to the audits.

261. Were it not for the existence of the indemnity clause, I would still hold that the HSE is entitled to a contribution, amounting to a complete indemnity on the basis outlined above that the causa causens of the losses were the actions or inactions of the laboratories.

262. Accordingly, the HSE is entitled to an indemnity against the second and third named defendants in respect of the entirety of the plaintiff's claims save the sum of €10,000.