THE COURT OF APPEAL

UNAPPROVED

Record Number: 2023/129
High Court Record Number: 2020/5533P
Neutral Citation Number [2024] IECA 244

Noonan J.

Power J.

Binchy J.

BETWEEN/

CATRIONA CRUMLISH

PLAINTIFF/APPELLANT

-AND-

HEALTH SERVICE EXECUTIVE

DEFENDANT/RESPONDENT

<u>JUDGMENT of Mr. Justice Noonan delivered on the 15th day of October, 2024</u>

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1. The plaintiff's claim in these proceedings arises from an alleged failure on the part of the defendant to detect and diagnose the fact that she was suffering from breast cancer when first seen on 4th May, 2017. Her cancer was subsequently detected five months later, in or about 12th October, 2017. The High Court dismissed her claim, essentially on the causation ground that her cancer was not detectable in May 2017. Accordingly, the High Court found it unnecessary to consider the issue of breach of duty. The plaintiff appeals to this Court and seeks a retrial. The principal judgment of the High Court (Gearty J.) was delivered on 14th March, 2023 with a subsequent judgment on the issue of costs on 25th April, 2023.

Facts

2. The plaintiff is a teacher who lives in County Donegal and was born on 29th March, 1982. At the end of March 2017 as the plaintiff was just turning 35, she felt two hard lumps in her right breast, described in the judgment of the High Court as being comparable in size to a pea and a peppercorn respectively. These lumps were felt by both her husband and her general practitioner and she was accordingly referred for assessment to Letterkenny University Hospital where she was seen on 4th May, 2017 by Mr. Michael Sugrue, consultant breast surgeon. Mr. Sugrue is the principal clinician responsible for the hospital's Triple Assessment Breast Clinic.

3. As explained in the judgment, triple assessment refers to the recognised approach to screening women for breast cancer, namely by clinical, radiological and histopathological assessment. The patient is first assessed by a clinician and then by a radiologist. At each stage, scores from 1 to 5 are assigned on the basis that 1 is normal, 2 benign, 3 that entities were found, probably benign but cancer is not ruled out, 4 is suspicious for cancer and 5 indicates malignancy. The letter "S" appears before the number where the grade is assigned by the surgeon and "R" by the radiologist. If surgeon and radiologist do not agree that there

is no cause for concern, the patient proceeds to the third stage, *i.e.* pathological tests which can be by needle aspiration or biopsy of the lump. The radiological assessment in this case was carried out by Dr. Conall Mac A'Bhaird, consultant radiologist.

4. Mr. Sugrue palpated the plaintiff's breast and found the pea sized lump in the lower outer quadrant on the right side. He was unable to palpate the smaller lump described by the plaintiff. Visualising the breast diagrammatically as a clock face, Mr. Sugrue measured the lump as being 15mm in diameter with a distance from the nipple of 10cm in the 8 o'clock position. He marked the spot on the plaintiff's breast with a marker for the assistance of the radiologist and also on a diagram in the assessment form. He ascribed a designation of *"S3"* to the lump.

5. The plaintiff was then sent for radiological assessment by both mammogram and ultrasound. The ultrasound was undertaken by Dr. Mac A'Bhaird and involves moving a probe around the area under examination in a variety of different positions, which can be seen in real time on a monitor, and from which individual images or screenshots can be captured. It also allows for virtual callipers to be applied to accurately measure the size of any abnormality detected. Dr. Mac A'Bhaird found *"Right breast, multiple small cysts up to 12mm in LOQR [Lower Outer Quadrant Right]"*. He applied a designation of *"R2"* to his findings, meaning benign.

6. As is common in such cases, neither Mr. Sugrue nor Dr. Mac A'Bhaird had any particular recollection of the plaintiff on the date in question and relied on the clinical notes and their normal practice when giving evidence. The plaintiff in her evidence said that she recalled Mr. Sugrue coming into the radiology area while she was there and speaking to Dr. Mac A'Bhaird and one of them used the phrase *"unusual cluster in the lower quadrant"*.

The plaintiff was reassured by Mr. Sugrue that she had cysts and they might become larger or smaller but she should not worry. She was then discharged.

7. The plaintiff's evidence was that, subsequently, the lumps got bigger and joined together in an oblong shape and in August 2017, she found a lump in her armpit and was referred back to the clinic in Letterkenny. She was seen by Mr. Sugrue on 9th October, 2017. Although the plaintiff's uncontradicted evidence was that Mr. Sugrue said to her that the lump had become substantially bigger, implying it was the same lump as observed in May, the clinical notes differ in recording that Mr. Sugrue found a lump at the 6 o'clock position in the same quadrant of the right breast. He measured it on this occasion at 4cm from the nipple, noting it as deeper in the breast. She was referred by Mr. Sugrue for radiology which was this time carried out by Dr. Katherine McGowan, consultant radiologist, who carried out a biopsy which was confirmed as HER 2-positive breast cancer on 12th October, 2017. The tumour was described as bi-lobed with two apparent foci, the larger measured 34mm and the other, 11mm at the widest point.

8. It is unnecessary to record the detail of subsequent events save to say that the plaintiff responded very well to treatment. However, her case is that she underwent significantly more treatment, including more extensive surgery, than would otherwise have been necessary had her cancer been detected in May. This, it is claimed, has led to significant permanent repercussions for her.

The pleadings

9. The personal injury summons was issued on 31st July, 2020. The facts alleged include that a triple assessment was not undertaken when the plaintiff attended Letterkenny Hospital and the defendant, its servants or agents failed to follow a recognised or approved procedure. This is clarified further in the particulars of negligence which plead, *inter alia*, that the

defendant failed to undertake histopathological examination and thereby carry out a triple assessment. It is further pleaded that the defendant failed to undertake fine needle aspiration or biopsy and failed to advise the plaintiff of the desirability of a triple assessment or biopsy.

10. Under the particulars of injuries, the plaintiff pleads at (iv):

> *"It is likely that the plaintiff had doubling time somewhere in the region of 45 days which should have given her a tumour of 15mm in May 2017 which was probably not node positive…"*

11. The replies to particulars at para. 4 clarify that when the plaintiff refers to a failure to carry out a triple assessment, what is meant by this is a failure to aspirate or biopsy the lump. Thus particular 4 states:

> *"Arising out of paragraph 3(iv), please identify precisely each of the three constituent parts of the 'triple assessment' which it is alleged was not undertaken at the time of the examination on 04 May, 2017.*
>
> *[Answer] This is a matter of expert professional opinion.*
>
> *In the presence of an S3 mass it is incumbent on the surgeon to complete triple assessment by sticking a needle into the lump, either a fine needle aspiration or a core biopsy to produce a diagnosis…"*

12. Updated particulars were subsequently provided which included the following:

> *"1. Failing to discern the cancerous lesion, which was at least 15mm, on ultrasound, in May 2017."*

13. The essential response of the defendant to these allegations appears in para. 3(b) of the personal injuries defence:

> *"The plaintiff was seen and appropriately clinically examined on 04 May 2017. The plaintiff was appropriately referred for breast imaging with mammography and ultrasound. There was no abnormality noted on imaging that warranted an image guided biopsy and there was an adequate explanation for the lump in the 8 o'clock position of the right breast where cysts were identified on ultrasound to explain the S3 lump in the right breast. No histopathological examination was required in the evaluation in May 2017."*

14. The central issue between the parties is accordingly clear. The plaintiff alleges that the lump, measured clinically by Mr. Sugrue at 15mm, and radiologically by Dr. Mac A'Bhaird as 12mm, was not a cyst but a cancerous tumour. The onus of proving this fact rested at all times on the plaintiff. If the plaintiff failed to establish that the lump was malignant, then clearly any alleged failure on the part of the defendant to stick a needle into it became irrelevant, as the judge found.

Evidence in the High Court

15. As in all personal injuries claims, the expert witnesses on each side provided a written report in advance of the hearing exchanged between the parties, which was then supplemented by their oral testimony. The plaintiff's experts were Professor Nigel Bundred, Professor in Surgical Oncology, Dr. Steven Allen, consultant radiologist and Professor Ian Ellis, consultant histopathologist. The defence called expert evidence from Professor Arnold Hill, consultant breast surgeon, Professor Michelle McNicholas, consultant radiologist and Professor John Crown, consultant oncologist.

16. In opening the case to the court, counsel for the plaintiff identified two breaches of duty upon which the plaintiff relied. The first was that following clinical and radiological assessment, the findings that emerged should have led the defendant to move to the third stage of triple assessment, being a fine needle aspiration or a core biopsy. He said that the plaintiff's experts would say that if this was done, the cancer would have been discovered. The second breach of duty identified in the opening was that the plaintiff's radiological expert, Dr. Allen, would say that based on what was found in October and working back, there was likely to have been a 15mm lesion in the right breast back in May that should have been seen on ultrasound.

17. During the course of her evidence, the plaintiff said that after the initial attendance at Letterkenny, the lumps that she had felt got bigger and joined together and formed what she described as an *"oblong shape"*. She confirmed that the lumps in question were the same ones she had originally discovered in the shower on 30th March, 2017 which grew and began to touch each other. She said that when she attended again in October, Dr. McGowan took a biopsy from the oblong lesion where the lumps originally were. She said the lesion was narrower in the middle and bigger on either side.

18. In cross-examination, she confirmed that Mr. Sugrue had only been able to feel one lump in the course of his clinical examination although she complained of two. It was put to the plaintiff that Mr. Sugrue's evidence would be that the lump he felt in May was not the same as the lump he felt in October but the plaintiff disagreed and said:

> *"So, in my mind and in my body as I felt it grow those two cysts grew and joined together to become one oblong mass which was the mass that Mr. Sugrue would have felt when I got back to him for the October appointment."*

19. Professor Bundred provided two written reports. His essential conclusion was that it was a breach of duty on the part of Mr. Sugrue not to stick a needle into the lump he palpated in the plaintiff's breast to produce a diagnosis. Even if the radiologist suggested that it was a cyst, it was incumbent on the surgeon to prove that by sticking a needle into it. Professor Bundred's reports, like those of the plaintiff's other experts, appear to proceed on the assumption that the lump which Mr. Sugrue measured at 15mm and Dr. Mac A'Bhaird at 12mm was a tumour that subsequently grew into what was seen in October 2017. Although his first report contains a short paragraph entitled *"causation"*, he appears to use causation in that context as referring to whether the tumour was likely to have been node negative in May 2017, the significance of which is that in that event, the plaintiff would not have needed an axillary node clearance.

20. To arrive at this conclusion, Professor Bundred relied on an academic paper by Peer *et al* from 1993 which considers the doubling time for breast cancer tumours in women. For reasons that will become apparent, it is not necessary to consider Professor Bundred's evidence in great detail but suffice to say, his conclusion based on the Peer paper was that the plaintiff had a likely doubling time of 45 days so that working back from the size of the tumour in October, this would give her a tumour of 15mm in May, corresponding with what Mr. Sugrue found.

21. In the course of his oral evidence, Professor Bundred was strongly challenged, first on the requirement to stick a needle in the lump and second, on his use of a 45 day doubling time which coincidentally aligned exactly with what was found in May 2017. He was asked about the National Cancer Control Programme (NCCP) Guidelines which inform the approach in this jurisdiction to triple assessment and in particular para. 6.13.5 which states:

> *"**Cyst Aspiration***

Cysts are only aspirated if they are symptomatic or if patients request aspiration. Asymptomatic cysts do not require aspiration…"

22. Professor Bundred said that he was unaware of the NCCP Guidelines until they were put to him in cross-examination. It was further put to him that Professor Crown would give evidence to the effect that the Peer paper did not provide a reliable guide for estimating tumour doubling time and Professor Crown would say that it was impossible to estimate the size of the tumour in May from one measurement taken in October. This latter proposition, which ultimately became the focal point of the judgment, was strongly disputed by Professor Bundred.

23. Dr. Allen gave evidence next. He also prepared two written reports. In his first report, under *"Opinion and Conclusions"*, he said at para. 5.3:

"It is interesting from the clinical history in relation to the ultrasound examination dated 4 May 2017 that at 8 o'clock in the right breast, 10cm from the nipple is the area where the S3 lump was present. This is subsequently at the site of the largest focus of malignancy that can be clearly demonstrated on the MRI examination, mammogram and ultrasound studies."

24. As will subsequently become evident, this conclusion by Dr. Allen was strongly contested by both Mr. Sugrue and the defence experts. Dr. Allen goes on to say (at 5.4):

"… It is however in my opinion likely, that the solid mass, given the retrospective presumed May 2017 measurements provided from Professor Bundred's report of approximately 15mm, and given the superficial and peripheral location in the breast where the cancer was subsequently diagnosed, should have been visible on

ultrasound at this time point. It was in my opinion a breach of duty that this was not demonstrated." (My emphasis)

25. He repeats this conclusion at paragraph 5.8:

"In conclusion, in my opinion, given the right breast cancer was likely to have been 15mm in May 2017 and given the peripheral, superficial location of the clinical area of indeterminate change being where the cancer subsequently was diagnosed in October, I would recommend that not discerning this area on ultrasound in May 2017 was in breach of duty…" (My emphasis)

26. It is thus clear that Dr. Allen's opinion was reliant on Professor Bundred's estimate of the size of the tumour in May 2017 and also on the fact that it was at the same location as the October tumour, both of which issues were in dispute.

27. Shortly before the case commenced on 11th May, 2022, Dr. Allen provided a second report on 9th May, 2022 dealing with his review of the imaging. In this report, Dr. Allen repeats his view that the largest focus of the malignancy found in October 2017 was at the site of the S3 lump detected by Mr. Sugrue on 4th May, 2017. In this regard, Dr. Allen says (at para. 4.3):

"… The ultrasound imaging at diagnosis on 9 October clearly shows a very large and superficially sited solid irregular mass consistent with a carcinoma at 6-8 o'clock. Clearly this was not seen by the radiologist performing the scan on 4 May 2017 but I would argue that given its location, typical malignant appearance and the measurement that has been recommended of 15mm, it was a breach of duty not to have visualised this at the earlier timepoint …" (My emphasis)

28. Accordingly, Dr. Allen's view, following a review of the imaging, was underpinned by three facts in relation to what was seen on imaging on 9th October, 2017; first its location, which, as already noted, was in dispute; second, its typical malignant appearance and; third, the measurement that has been *"recommended"* of 15mm, being a reference to Professor Bundred's opinion. It seems clear that Dr. Allen's view was that the cancer should have been detected by Dr. Mac A'Bhaird because it had a *"typical malignant appearance"*. This tallies with evidence subsequently given by a number of witnesses, and in particular Dr. Allen himself, that the cancer that was found in October 2017 would have had the same appearance, albeit smaller, in May 2017.

29. Dr. Allen's view on this was expressed on Day 5 at Q. 252:

> *"Q. Yes. So can you just flesh that out for us when you say that 'a 15mm solid lesion should have been very easily visualised.'*
>
> *A. Well, if you have seen the picture on the subsequent page, that looks like an obvious cancer. That's what you'd see in an ultrasound, typical of what breast cancer looks like. Obviously the majority of breast cancers won't change the way they appear over a five month time period, they would just grow in size. So I would (sic), on the balance of probabilities, that will look like a 15mm smaller version of the subsequent cancer if you were to have scanned it in May. I cannot see how it would look like a cyst."*

Dr. Allen also offered the view that the cancer detected in October was in the same location as the 15mm lump in May and he was challenged on this in cross-examination. His view that the cancer should have been easily seen in May was buttressed by his view that it was in *"such a superficial part of the breast"* and *"such an easy bit I would say to assess"* – Q. 219-220 – and *"incredibly easy to assess on ultrasound"* – Q. 259

30. Discussing ultrasound, Dr. Allen said that it was particularly effective at distinguishing cysts from solid lesions. He agreed that it was difficult to interpret ultrasound screen grabs retrospectively and the radiologist doing the examination has the benefit of real time and is in a superior position. On Day 7, Q. 304, Dr. Allen was asked the following question in cross-examination:

> *"Q. In relation to his pictures, because I am dealing with percentages, he [Dr. Mac A'Bhaird] says that in his opinion he is – to the extent that he can put a percentage on it – he says high 90's, 98% certain that what he saw were simple cysts and that what he has identified are simple cysts. That's what his evidence will be. Would you expect that someone of his experience could have such a degree of confidence about a simple cyst?*
>
> *A. Yes, but people can have a bad day and people can make mistakes, and we know that there was a breast cancer in that part of the breast at that time. So it is very possible that, you know, it was the – it wasn't – he didn't evaluate it at that particular time as well as he should have."*

31. Dr. Allen's answer here is again in part predicated on the locations in October and May being the same, an issue about which he was challenged. He was further questioned on the likely appearance of the cancer if it was present in the same location in May (at Day 7, Q. 380):

> *"Q. But on ultrasound you have agreed with me that solid lesion in terms of tumour versus the non-solid, which is what the cyst is, they are not marginal or borderline, they are really, really significantly different, isn't that right?*

A. Less significantly different at 12 than they are 34 but they are different and should be identified as different.

381 Q. The only difference between 12 and 34 is the size?

A. Umm."

Dr. Allen agreed with Professor Bundred about the likely appearance of the cancer if present in May (at D. 7, Q. 386):

Q. The suggestion, and if I am correct or incorrect on the evidence I will be standing corrected on it, is I had understood and I think it was Professor Bundred had said that he would have expected the characteristics of what we see in the final image to be roughly similar except –

A. Smaller."

32. In further evidence given by Dr. Allen on Day 10 of the trial, he was again challenged about the location of the cancer found in October and remained adamant that it spread from the 6 to the 8 o'clock position. He also confirmed that, like Professor Bundred, he was unaware of the NCCP Guidelines. In the context of the dispute about the location of the lesion in October 2017, it was put to Dr. Allen that Mr. Sugrue did not feel any lump in the 8 o'clock position in October and Dr. Allen agreed that this is what the clinical notes showed but insisted that the MRI showed the cancer as extending from the 6 to the 8 o'clock position. He agreed that there was no cyst at the 8 o'clock position in October. Dr. Allen agreed that the clinical presentations in May and October were quite different concerning location.

33. When Dr. Allen was re-examined by counsel for the plaintiff, a new issue emerged. On Day 10, Q. 433 *et seq.*, the following exchange occurred:

"433 Q. Can you just take us through what else you prepared?

A. Yeah, there is only really one other thing I wanted to mention on this, and it is slightly difficult. Now breast cancers along this, would particularly be on the left, are often quite dark. You will notice here, and I will take the arrows off now, it is quite bright in the middle and this is to do with tumour necrosis, sometimes it outgrows the blood supply… It has become more necrotic and therefore a bit more liquid. You see liquid as bright change on this particular sequence in the breast. The darker periphery is more of a solid lump. This is quite dark in the middle. Again this again is in keeping with it being more fluid. It is slightly hypothetical but the tumour of course was potentially with, and we don't have any images, this perhaps looks a bit more liquid on ultrasound because of the tumour necrosis it might make it potentially more difficult to discern on ultrasound because obviously cysts are liquid, tumours are normally more solid but this particular tumour is showing a bit of a central cystic change and might therefore have been slightly more challenging to confirm on ultrasound as definitely –

434 Q. Is that a recognised kind of complication or feature in the assessment of, if I can call it, liquid prominent or liquid based entities in the breast?

A. Indeed, that is the thing. So you could be dealing with what we are looking at here, which is a slightly necrotic cancer.

435 Q. Yes.

A. I am in deep belief that on the pathology, on analysis, necrosis was found to be in the tumour and this is what we are seeing on the MRI.

436 Q. Yes. What relevance, if any, does that have on the importance of carrying out an aspiration to make sure you know what you are dealing with?

A. That is the thing you have to exclude, you have to make sure that you are not missing a necrotic cancer and just mistaking it for a cyst."

34. Dr. Allen appears to suggest here that the appearance of the cancer in May 2017 might have mimicked that of a cyst because of necrosis, thus leading to the necessity for aspiration. This evidence seems to be dramatically in contrast with Dr. Allen's previous evidence that the obvious cancer which was seen on imaging in October 2017 would have appeared precisely the same in May 2017, only smaller. He now appears to depart very significantly from that evidence, and indeed the evidence of all the other witnesses who dealt with this point. Later in his evidence, Dr. Allen confirmed (at Q. 578) that the cysts which had been shown on the ultrasound screen grabs taken by Dr. Mac A'Bhaird had all disappeared in the October images.

35. At the conclusion of his evidence, Dr. Allen was asked the following in re-examination:

"580 Q. Yes. What your – you know in terms of, and this isn't the done test now, this is a question of probability. Right? What is your view, having analysed this case, having been examined and cross-examined in great detail, what is your view of the probability, possibility, the whole spectrum of, you know, with 0% being impossible and 100% being certain, what is your view in this case of the thesis that there was a cyst there on the 4th May 2017 at 8 o'clock which effectively just disappeared and a new lesion actually developed thereafter?

A. *Well, based on the information I have from Prof. Bundred and Prof. Ellis, there was a 15mm cancer there. So it has to be there somewhere and I think [interjection]*

581 Q. It has to be what?

A. *It has to be there on ultrasound because it is very peripheral. It should have been seen. I suspect it was misinterpreted as a cyst.*

582 Q. Yes.

A. *And it was there all along but it wasn't actually a cyst."*

Again, Dr. Allen confirms in this exchange that his opinion is based on the alleged fact that there was a 15mm cancer present in May 2017 as opined by Professor Bundred and Professor Ellis.

36. Professor Ellis provided one written report. He had been provided with a copy of Professor Bundred's reports as he refers to the latter's conclusions. In the opinion section of this report, he essentially agrees with Professor Bundred's opinion on both the necessity to aspirate the cyst and also with Professor Bundred's views on the size of the tumour in May 2017. In his oral evidence, Professor Ellis again agreed with the opinion of Professor Bundred. He offered the view that it was necessary for the surgical and radiological scores to be concordant before a patient could be discharged without a needle aspiration. He considered it to be *"against all the guidelines"* and negligent.

37. In the course of his direct examination on Day 8, he said the following (at Q. 86):

"... So, we are left with the situation where <u>we know a cancer was present at that time, 1.5cms</u> which is not a small cancer, it is the median size that cancers are

> *detected by screening. And so we also know that there was carcinoma in situ so there would be more extensive in situ disease probably around that cancer.*
>
> *So had a needle been put in, I would advise on the balance of probabilities with the knowledge that a cancer was there at that site that even if a cyst had been aspirated there would still have been a residual mass because that's the most likely explanation for the clinical findings. There seems to be a discordance between the number of cysts, position of those and the size and the clinical size that was palpated which was 15mm. So I would advise on the balance of probabilities that there would have been a residual mass and that should have been biopsied … .*
>
> *We can't be certain but as I said from the reasons from the information I have available to me I would advise it is likely, more likely than not, that a mass would have been present and should have been biopsied."* (My emphasis)

38. While it has at all times been common case that the plaintiff had cancer in May 2017, it is in dispute that it measured 1.5cm, which is the assumption that underlies Professor Ellis's evidence above. The only basis for that suggestion is the evidence from Professor Bundred about doubling time, which as noted above was strongly contested by Professor Crown. Professor Ellis's opinion is also informed by the fact that the alleged 1.5cm cancer was *"at that site"*, in other words at the same location as the lump palpated by Mr. Sugrue.

39. It was put to Professor Ellis that Mr. Sugrue and Dr. Mac A'Bhaird, when they discussed the plaintiff's case in her presence, may have verbally agreed a concordance, even if not noted in the clinical notes, but Professor Ellis disagreed with this, suggesting it was mandatory to record such concordance by modifying the surgical score if necessary following radiology. There was also a deal of debate about the NCCP Guidelines and the meaning of paragraph 6.13.5 and Professor Ellis was of the view that if the plaintiff presented

with a complaint of a lump, that would be correctly classified as symptomatic and therefore requiring to go to the third stage of the triple assessment.

40. Like the other experts, Professor Ellis was extensively cross-examined about the location of the entity palpated in May versus that seen in October. He considered that both entities were in the same region and their positioning was not dissimilar.

41. The first witness for the defence was Mr. Sugrue. He was taken through his training and background in the normal way, in the course of which it emerged that he had experience of carrying out ultrasound examinations himself on occasion. In direct examination, he was asked (at Day 11, Q. 237):

> *"Q. You heard what Dr. Allen has said about the operation of the ultrasound, and I know you have said you carried out ultrasounds yourself on different parts of the body, but in relation to the characteristics or – would you be able to help us or have you a view about its abilities to distinguish between simple cysts and tumours?*
>
> *A. Yes. I mean when you saw those images which you have, Judge, in the book, the ultrasound in September shows a simple cyst. Multiple simple cysts.*
>
> *238 Q. Yes.*
>
> *A. In October as we –*
>
> *239 Q. In May.*
>
> *A. Sorry, in May. Excuse me. Thank you. In May.*
>
> *240 Q. Yes.*

A. In October you've got a barn door cancer. It is just straightforward, complex, internal shadows. A medical student would recognise the difference between ... [interjection]"

42. This brought forth an objection from counsel for the plaintiff that Mr. Sugrue, who was present as a witness of fact, was purporting to give expert evidence. Ruling on the objection, the judge indicated that in her view, the witness was not purporting to give evidence as an expert and she did not consider him to be an expert in radiology. She felt this was more appropriately a matter for submission at the conclusion of the case. Mr. Sugrue's evidence was otherwise in accordance with the factual summary above. He was robustly cross-examined about a number of matters, including his CV and the fact that he had been involved in a previous piece of litigation arising from the death of a patient.

43. Dr. Mac A'Bhaird also gave factual evidence in line with the summary described above. When asked how good ultrasound is at making the distinction between tumours and cysts, he said that they were *"chalk and cheese"* and tumours are quite easily differentiated from cysts - Day 14 Q. 105. In the course of his direct examination, he was asked about the October imaging at Day 14, Q. 442:

"Q. – That in effect that image shows what has been described earlier in the trial as a barn door cancer. It is put to you that that is what you missed, although smaller?

A. No.

443 Q. And It is put to you that if you take Prof. Bundred's theory that you missed a 1.5 tumour when you were carrying out an ultrasound of Mrs. Crumlish on 4th May 2017. That is what you missed, Dr. Mac A'Bhaird?

A. Well, first of all, this is a solid, irregular mass, which is bi-lobed and it is full of echoes, it is, as you have described it, a barn door tumour. Secondly, there was nothing similar to this on the previous scans. Also I have on the previous scans, on the May scan that I did myself I had numerous cysts shown, some of them as small as about 3mms or 4mms and in my opinion there is no way that I would miss a solid lesion of 1.5cms. Given the size of the breast and the area that I covered I cannot see that that would have happened.

444 Q. How confident are you in the view that you have just expressed to the court?

A. I would be highly confident in it."

44. Professor Crown was the first expert to be called on behalf of the defence. His first report was in fact not concerned with the issue of liability at all but rather with the extent to which the plaintiff had been adversely affected by the delay in diagnosis between May and October 2017. However, in his second report dated 17th May, 2022, six days after the trial started, Professor Crown analysed Professor Bundred's reports and took issue with his thesis on doubling time. In his report, and indeed in his oral evidence, I think it fair to say that Professor Crown was very critical of Professor Bundred's views on doubling time and the Peer paper upon which Professor Bundred relied.

45. In essence, Professor Crown was strongly of the view that there was no established reliable scientific basis for predicting the size of a tumour on the basis of one measurement only, in this case in October 2017 in order to determine the probable size of the tumour in the previous May. As already indicated, this sharp disagreement between Professor Bundred and Professor Crown became the focus of the judgment, leading to complaints from the plaintiff's counsel that the nature of the defence was not clearly pleaded and in fact did not

emerge until later on in the trial when Professor Crown gave his evidence on days 17 and 21.

46. The next expert called on behalf of the defendant was Professor Hill who had provided the usual report in advance. Professor Hill's report concentrates on the issue of liability. Professor Hill's opinion regarding the positioning of the entities seen in clinic in May and October 2017 was as follows:

> *"I only had the clinical notes available to me but I can comment that in May 2017 the lump was recorded clinically as being present at the 8 o'clock position in her right breast and in October 2017, it was recorded clinically as being at the 6 o'clock position in the right breast. There was no note made in May 2017 of a lump being present at the 6 o'clock position and indeed, there was no imaging abnormality identified at the 6 o'clock position at that time."*

His overall view was that the third limb of the triple assessment was not necessitated when no imaging abnormality had been detected.

47. In the course of his oral evidence, Professor Hill was asked by the judge about the fact that the plaintiff's evidence was that the lump she had in May was the same, albeit that it was bigger in October. The following exchange occurred on Day 19 at Q. 300 *et seq.*:

> *"300 Q. Ms Justice Gearty: Thank you, Professor. I want to ask you because this is the real concern for me. I have evidence from the patient herself that the lump felt in May by herself and her GP and Mr. Sugrue did not go away and that seems to me to inform the plaintiff's case, which is that it was the same lump, albeit bigger in October and therefore should have been diagnosed in May. That is one of my main problems. Mr. Sugrue says that due to his*

careful measurements he is confident that the lumps were different entities, the first he says was a cyst and the second was a sizeable cancer in October but in a different part of the breast albeit in the same quadrant of the same breast. Can you help me with that?

A. *Yeah, it is a really important issue, and I can only go by the notes. What we have is a very diligent recording saying it is at 8 o'clock, 10cm from the nipple in May.*

Then when she comes back in October he measures 4cm from the nipple at the 6 o'clock position. Now they are definitely different positions.

301 Q. *Umm, hmm.*

A. *I hear you, if the patient says the lump was still there. I think she may, I would expect in May she felt the lump, let us take the one at 8 o'clock, and that was deemed to be cysts, I think it is reasonable that she would continue to feel that area, okay? The real issue is when you look at what happened in October, a 3.5cm lump picked up at 6 o'clock 4 cm's from the nipple and what we know is that at the 8 o'clock position there was a 7mm abnormality, there was a second cancer picked up, do you recall that on the imaging? That was in the region of 8 o'clock, 7mm, separate from the 3.4cm lump in October. So my belief is the 3.4cm lump at 6 o'clock, 4cms from the nipple, is different to what she was feeling. I would suspect that Mrs. Crumlish continued to feel the 8 o'clock position where there were cysts that created nodularity for her and she would have continued to feel that. What I think has happened is there is a separate, and this is just based on the pathology*

and the findings that we have, there is a separate 3.4cm cancer starting at 6 o'clock.

I hear you when the patient says I still felt it I would agree she did but at 8 o'clock when we did the pathology and the analysis with the imaging there was a 0.7mm tumour there at 8 o'clock as a separate satellite tumour on the pathology.

When we looked at all of the imaging there was the 3.4cm and then there was a satellite one, which I think was in the region of 8 o'clock.

I think it is fair to say that the 3.4cm cancer was not at 8 o'clock, it is a different position.

302 Q. I see.

A. In reviewing this case my belief is that she continued to have those cysts that she felt but I think a fast growing aggressive cancer started at 6 o'clock 4cms from the nipple.

303 Q. I see.

A. From looking at the case number.

304 Q. I do understand from your evidence that these aren't things one can be definitive about in terms of measurements and precision?

A. I think I put it in my report, I think the real challenge here was maybe there was a perception in October of overemphasising that this was a new lump. That might have been wrong. I look back on all of these cases in clinical

> *practice and say: how can we improve? How can we do better? What was the fundamental issue here? I think it was a communication one, whereby I think Mrs. Crumlish might have, rightly, felt that that wasn't listened to, that she still felt that lump that she quite rightly said to you I had it all the time. I think what was probably benign and that it was a new cancer at 6 o'clock though unfortunately happened in the circumstances. I think it was the way that was managed and communicated what (sic) has led us to here."*

48. Professor McNicholas was the last expert called who prepared three reports. In the first report, she commented on the particulars of negligence in the personal injuries summons, the first of which was failing to carry out a triple assessment. In relation to that, she observed:

> *"However, at any triple assessment clinic, only a small proportion of the patients have a biopsy. When the clinical examination is not suspicious and the radiology does not find an abnormality, no biopsy is performed. This is my experience for the majority of patients. Biopsies are generally performed by the radiologist when an abnormality is found on imaging …"*

49. She considered that the treatment received by the plaintiff was completely acceptable. In her second report, Professor McNicholas disagreed with Professor Bundred's statement that *"failure to biopsy an S3 mass was a breach of duty"*. She said *"there are numerous times at every clinic a woman with an S3 finding at radiology is either normal or shows a finding that may explain the presentation, that a biopsy is not performed."*

50. Her final report was prepared in September 2022 during the interregnum in the hearing for the long vacation. In this, she conducted a further review of the relevant images. In this report, she confirmed, as Dr. Allen had agreed, that cysts were easily differentiated from

tumours on ultrasound which *"is excellent at deciding if a palpable lump is suspicious. It is particularly good at finding cysts."*

51. Professor McNicholas attached a number of images to her report with comments. In these comments, she fundamentally disagrees with Dr. Allen on the location of the tumour in 2017. Accordingly, in a comment on one of the plaintiff's CT scans, she says:

> *"The main tumour in October is clearly at 6 o'clock. In fact more than half of it lies medial to 6 o'clock, which is towards 5:30 on the clock face. There is an adjacent smaller lesion extending a little laterally and a third lesion at 8 o'clock. This third lesion (red arrows) is 2.5cm from the nipple (white arrow)."*

Commenting on two further images, she says:

> *"The original presentation was of a lesion at 8 o'clock but 10cm from the nipple. If you measure 10cm out from the nipple at 8 o'clock on the CT scan, there is no abnormality on the October scan in this location. It is at the very edge of the breast tissue (white arrow)."*

52. The disagreement therefore between Professor McNicholas and Dr. Allen could hardly be more stark. She also disagreed with Dr. Allen's evidence that the tumour had necrotic features, saying *"on the ultrasound the tumour is clearly solid and not cystic."*

53. At the conclusion of the evidence, counsel for both parties made submissions both orally and in writing to the court. It is clear from the oral submissions that the plaintiff did not dispute that the first issue to be determined was the causation issue. Accordingly, counsel for the plaintiff submitted:

> *"So the question one, the truth probably boils down to this or a version of this: was there a detectable cancer in May 2017? And that is an issue of fact. It does involve looking back but that is not unusual, the courts in lots of cancer cases had to look back and do their best to the find the jurisprudence on the practice of the courts. If the answer to that is yes, and in a way only if the answer to that is yes, does the court then proceed on.*
>
> *If Mrs. Crumlish did not have a detectable cancer in the May that, in truth, is the end of the position from the plaintiff's point of view. Because any breach of duty in terms of what happened on the 4th May would be the moot if the cancer was not detectable.*
>
> *So if the cancer is detectable on the 4th May, and that is an issue of fact for the court."*

54. Counsel accordingly fairly and correctly conceded that the first issue to be considered was the question of causation and if that was not established, then that was the end of the case and there was no requirement for the court to go on and consider the issue of breach of duty.

Judgment of the High Court

55. At the outset, the judge addressed the central issue:

> *"1.1 This is a medical negligence case in which a key causation issue arises: whether the size of this plaintiff's tumour can be estimated reliably by using statistical data and a mathematical formula."*

56. The judge says that it is not in issue that the plaintiff had cancer in May. She noted the plaintiff's argument that the defendant failed to adhere to all the required steps of triple assessment, particularly where there was no concordance between the results of clinical and

radiological examinations. She detailed the facts and the plaintiff's relevant medical history as I have outlined it above. She summarised the plaintiff's case in negligence and said:

> *"4.17 Before any alleged negligence can be considered, however, the plaintiff must establish that the larger lump she palpated in her breast in May was a tumour. If that cannot be established, or if it is likely to have been a cyst, then the failures described, whether or not they constitute negligence, probably did not cause the alleged injuries."*

57. In a section of the judgment titled *"Memory, Records and Routine"*, the judge referred to the plaintiff's evidence of overhearing a conversation between Mr. Sugrue and Dr. Mac A'Bhaird concerning the presence of an unusual cluster in her right breast. In this regard, the judge said:

> *"6.8 If the words 'an unusual cluster' were used, this court cannot interpret this as meaning anything significant in terms of the diagnosis or presence of a tumour at that time, which is the basis of the plaintiff's case. There was no expert evidence which suggested that this phrase was, or could be, relevant to the issues in the case. The plaintiff's case is not that the two men noticed something unusual and tried to cover it up and, plainly, such a theory would not be just speculative but baseless. Given this context, there is no reason for the court to decide whether the words were used at all.*"

58. Regarding the appearance of the lump on ultrasound, the judge said:

> *"6.11 The evidence from all experts was consistent in respect of the visual appearance of simple cysts, which are very different in appearance from tumours. Fluid is black on ultrasound images, making the fluid filled cysts easier to distinguish*

from tumours, which are grey, to put it very simply. A cyst also tends to be well defined, with a smooth border, unlike most cancers."

59. In posing the rhetorical question, *"what was the pea sized lump?"*, the judge recorded the plaintiff's position that support for the fact that the pea sized lump was a cancer came from the fact that it was in the same position in the breast as in May and the MRI in particular was relied upon in that regard. This is a reference to the evidence of Dr. Allen. The plaintiff also relied on her own evidence that the pea and peppercorn sized lumps did not go away but merged and became bigger. She also noted the defendant's contrary argument that in fact the October cancer was in a different position than the lump in May and further, the entity in October was an obvious cancer which, if present in May, would not have been mistaken for a cyst.

60. The judge then referred to the witnesses of fact for the defence, Mr. Sugrue and Dr. Mac A'Bhaird, and said with regard to their evidence (at 8.1):

"... The court viewed both these defence witnesses as experienced doctors and reliable witnesses as to fact."

She considered that the close cross-examination of Mr. Sugrue in respect of his CV had no bearing on the case other than to confirm a long and excellent history in treating patients and training medical doctors. The court devoted a section of the judgment to an analysis of the Peer paper which it is unnecessary to consider for the purposes of this judgment as will become apparent.

61. In a lengthy section of the judgment entitled *"Expert evidence"*, the judge considered in turn the evidence of the experts on both sides in the clinical, radiological and pathological fields. While the evidence of Professor Bundred has limited relevance for the purposes of

this appeal in the circumstances hereinafter appearing, some of the judge's observations on that evidence are relevant to other issues canvassed in the appeal. At para. 10.18, the judge commented:

> *"Professor Bundred's calculations as to doubling time are based not only on the Peer paper data but on his theory that the pea sized lump felt in May was the same as the tumour in October. The defence argue that these are different entities. This line of defence was clear from the pleadings, in which the lump is described as having been a cyst. If Peer's data alone cannot identify the previous size of this tumour, or not with any accuracy, the estimate of 15mm is not reliable. If there is no assumption about what was palpated in May, we are left with only one measurement, that taken in October, no indication as to when the lump formed and no way of telling where on the growth curve this cancer is at any given time."*

62. The judge was of the view that Professor Bundred's selection of a 45-day doubling time could not be justified by reference to the academic literature he relied upon which specified a wide range of potential doubling times and Professor Bundred advanced no convincing reason for why he selected 45 days, other than that it was the only figure that tallied with the plaintiff's case. As such, she was of the view that it suffered from confirmation bias.

63. In her consideration of Professor Crown's evidence, the judge referred to another academic article on the issue that was co-authored by Professor Ellis, who also gave some evidence about doubling time although that was not his primary focus and he largely adopted Professor Bundred's view. In that regard, the judge said (at para. 10.30):

"... Professor Ellis was co-author of a relevant article but was not called as the expert on doubling time. Although the court will nonetheless describe his views, they cannot be relied upon in this context as he was not the expert relied upon."

64. The judge also touched on this point later in the judgment at para. 10.63:

"The rules of procedure require that there is only one expert in relation to any issue in a case and the court must disregard evidence from other witnesses. Here, the expert was Professor Bundred."

This issue is considered further below.

65. The court then turned to a consideration of the evidence of the radiological experts, first Dr. Allen. With regard to Dr. Allen's evidence on the size of the tumour in May 2017, the judge found (at 10.52):

"... He referred to his colleagues Professors Bundred and Ellis as being the source of his information that the tumour must have been 15mm in May. He relied on this to assert that it must, therefore, have been visible and that it was negligent not to see it."

She referred to Dr. Allen's evidence that the appearance of the cancer would not have changed over a five month time period and what was seen in October on imaging would have appeared as a 15mm smaller version in May – *"I cannot see how it would look like a cyst"*. Of Dr. Allen's evidence, the judge said:

"10.57 The picture painted by Dr Allen's evidence was that while many cysts may not be readily identifiable, this tumour, had it been 15mm in May, would look nothing like a cyst but would be an obvious cancer. He later added, under cross-examination,

that he would expect a 15mm entity to be found quite easily in a 422g breast, at the periphery of the breast, as this lump was."

66. In this section of her judgment, the judge made the following important finding of fact (at 10.59):

> *"... the 15mm pea-sized lump in May, in respect of which the radiologist gave evidence that there was a 12mm cyst on ultrasound, but of which there is no image, was probably not the tumour that appeared at some point before October as the latter could not have been mistaken for a 15 or 12mm simple cyst 5 months earlier. To find otherwise is to reject the eye-witness evidence, effectively, of a radiologist who knew exactly what he was looking for, and where it was, and who recorded his findings, taking images of some of the surrounding cysts".*

67. The judge then turned to the pathology experts and in a passage relating to Professor Ellis's evidence, which became controversial in this appeal, the judge said:

> *"10.62 In respect of the possible mis-diagnosis in May, Professor Ellis concluded 'I believe on the balance of probability that had any of those cysts been aspirated at the time there would still have been a palpable mass.' This means that the cysts were not simple cysts at all. This may simply have been a slip, but if it reflects his views, it cannot be correct. The cysts shown in the ultrasound images were described by all radiologists as simple cysts and no other witness suggested that any one of them would probably have been cancerous in May. To this extent, and if not just a slip of the tongue, the witness expressed a view contrary to that held by the radiologists and I prefer the view that the cysts seen in the images taken in May were correctly identified as simple cysts. ..."*

68. Although, as I have said, the judge considered that the rules of procedure required her to ignore Professor Ellis's evidence on doubling time, she nonetheless considered it before arriving at the following finding of fact (at 10.73):

> *"… The probability is that the doubling time was faster than 45 days and the tumour, which was there in May, was smaller than a pea-sized lump, which leads to the conclusion that the lump was probably a cyst."*

69. In a section entitled *"The clinical experts"*, the judge noted that the plaintiff's case relies very heavily on the evidence of Professor Bundred and in further considering his reliability as a witness, she made a number of significantly critical comments about Professor Bundred's evidence, his approach to it and the inconsistencies it contained.

70. In an important passage for the purposes of this appeal, the judge, in a consideration of the surrounding facts, said the following:

> *"11.27 In May of 2017, Dr. Mac A'Bhaird probed the marked point on the breast where the lump was and found evidence of multiple cysts. The type of cancer found in October means that if it was already 15mm in May it was an obvious cancer. Wherever its location in the lower right quadrant, if it was indeed the same entity as the lump, that lump was peripheral and would have been very different in appearance from a cyst. The evidence establishes that if this entity was 15mm, it would probably have been obvious to the radiologist as it looked nothing like a cyst. If the 15mm lump was a cyst, this becomes a much easier case to explain.*
>
> *11.28 The report of a radiologist was accepted as being the definitive description of what he saw, in normal circumstances. The only evidence that suggests that the radiologist missed a 15mm cancer is the evidence in relation to doubling time. If the*

> *range in the Peer data is not sufficiently reliable to estimate the size of what was present in May, then there is no evidence to support the proposition that the radiologist missed a 15mm cancer. It is unfortunate that the entity, although seen on screen, was not captured in an image but this does not appear to the Court to constitute negligence and every relevant witness agreed on this point. I do not ignore the evidence of the Plaintiff in this regard. While she could palpate a lump in May, nothing that she felt with her fingers can help the Court with identifying whether the lump was a tumour and this is considered further below."*

71. In another section titled *"The plaintiff's experience"*, the High Court considered in detail the plaintiff's evidence concerning the lumps she first palpated in her breast in March 2017 and that she said these did not disappear but joined together and grew and were ultimately biopsied in October 2017. In this regard, the judge said:

> *"12.5 As the Plaintiff herself said in evidence, she spent over a year focusing on treatment and recovery. It was many months later when she began to question what had happened and look for explanations. While she, with hindsight, was satisfied that the lumps she felt in May and October were the same, the nature of simple cysts, the nature of what was seen in October, the ultrasound screen shots and a written report as to what was seen that day in May in a very specific and small area of the breast do not support that conclusion. There is no doubt that the Plaintiff's evidence was sincere, but the Court has to consider reliability also. Again, one must note that the Plaintiff was not taking notes or creating any record of what she could feel, nor was she measuring or noting its size or location. As Professor Crown put it, retrospection makes things easier.*

12.6 In relation to this evidence, Professor McNicholas said that she was aware that the Plaintiff felt that what she had in October was the same lump she had felt in May. Asked if she doubted this, she replied, 'I don't doubt that that's what she feels but, you know, what was found on imaging is different.'"

72. That this was also reflected in the evidence of Professor Hill was adverted to by the judge who noted that, at the judge's invitation, Professor Hill had addressed the plaintiff's evidence that the lump she felt in May never went away but became bigger. Referring to his evidence, the judge said:

"12.8 At the eight o'clock position in May there were multiple cysts, as is clear from the imaging, and these created nodularity for her, in the witness's view, which she would have continued to feel. The witness took the view that there was a separate 34mm cancer starting at six o'clock not at 8 and in a deeper position in the breast than the peripheral lump palpated in May. Clinically, this witness took the view that the locations were different, although close. Professor Hill's view was that looking at the pathology was definitive, rather than looking at an MRI in which the position of the breast would distort attempts to locate an entity. This is interesting given the pathologist, Professor Ellis's, view that he would defer to the clinician as to where the entities were located.

12.9 Professor Hill's evidence was very helpful. His answers were clear, including this sympathetic and persuasive account of how the Plaintiff may have believed that the lump in her breast had not disappeared. Similarly, Professor McNicholas had no hesitation in offering the view that her experience did not accord with the imaging. Neither witness discounted the Plaintiff's views or questioned her honesty, but Professor Hill explained ways in which such physical phenomena might arise."

73. This evidence led the judge to the following conclusion:

"12.10 The most persuasive conclusion, in the Court's view, is that there probably were distortions or lumps in the Plaintiff's breast that did not disappear over the 5-month period described but, without more details in terms of measurements and location over time, this general evidence does not establish that the entities the Plaintiff could feel in May or in March were the same as the tumour in October.

12.11 The radiologist's report in May, coupled with the clear evidence as to what the tumour would look like had it been there at that point, weigh against this conclusion and persuade me that the Plaintiff, despite a genuinely held view that the lumps were the same, cannot provide evidence sufficient to counter the defence case on this point."

74. On the question of the location of the entities found in the plaintiff's breast, the court first discounted the evidence of Professor Bundred for reasons that are not necessary to elucidate. With regard to Professor Ellis, his evidence was that he would defer to a clinician. This left Dr. Allen's evidence, on which significant reliance is placed by the plaintiff in this appeal. The court's comments on this are therefore pertinent:

"13.3 As noted, the lump palpated in May was marked at 6 o'clock [this is clearly intended to mean 8 o'clock] *on the breast and measured as being 10cm from the nipple on the very periphery of the right breast. Dr Allen pointed out that this entity was very near the surface and with very little breast tissue around it so, referring to the radiological imaging 'the accuracy should be as high as it could possibly be.' As to movement of the breast and potential difference in location of a tumour in terms of palpation, he deferred to clinicians as being the relevant experts. Shown two ultrasound images of the entities in May and in October, his evidence was: 'As to*

whether they are the same thing, I think it is difficult to say because I wasn't there in May doing that ultrasound.'

13.4 On the topic of location, [Dr. Allen] made the suggestion that the lump measured in May could not have been 10cm from the nipple as this would have been on the chest wall, the breast not being large enough to accommodate that measurement. This led to some robust challenges. Insofar as it is necessary to resolve this issue, the Court is satisfied that it is unlikely to be correct. Firstly, the measurements taken were not questioned or corrected by the Plaintiff or by the radiologist on the day, nor has the Plaintiff ever suggested that the clinician marked the wrong part of her body and, crucially, the process whereby this was queried by reference to the Plaintiff's breast in 2022 ignored the fact that she had undergone reconstructive surgery in the meantime. There is no reliable basis for the Court to find that the initial measurement of 10cm went outside the area of breast tissue as suggested and indeed the theory was not raised again in submissions. This theory reduced the reliability of the witness's evidence in respect of location of any entity but I remained confident that his views on the radiological aspects of his evidence, as to the appearance of cysts and tumours which was his area of expertise, were reliable."

75. The judge went on to express a preference for the evidence of Professor McNicholas, saying (at 13.5):

"… In respect of location, Professor McNicholas was of the view that the cancer, in October, had started in or around the 6 o'clock position on the clock face, given what she was seeing in radiology in all the imaging, whether MRI or ultrasound. She allowed that the tumour in October was large and spread across and over 6 and 8

o'clock. She explained that the largest entity was probably the origin of the cancer and the focal point, in her view, was 6 o'clock. While Dr. Allen disagreed and said it stretched from 6 to beyond 8 o'clock, having viewed the images in question, the evidence on the whole appeared to this Court to establish a likely focus nearer 6 o'clock than 8." (My emphasis)

76. This led the judge to the following conclusion (at 13.7):

"... I have reached a tentative view on the likely location of the focus of the lesion in October, namely that it was at or near 6 o'clock. Most witnesses took the view that it was very difficult to be precise about the exact location of an entity in living tissue. Despite some more firmly stated views, the evidence on this issue was very mixed and there was insufficient evidence to positively prove that the tumour found in October originated in the same location as the pea-sized lump in May.

13.8 ...There was no evidence to suggest that a woman could not have a cyst, that creates a lump, in one quadrant of the breast while a separate cancer was growing in the same quadrant. Given the evidence that cysts are a common feature in the female breast, this does not seem to be a coincidence that should cause concern nor does it require a link between the two."

77. After a lengthy and detailed analysis of all the evidence, the judge gave her conclusions and made a number of critical findings of fact. At para. 15.2, the judge said:

"...It seems to the Court ... that the Plaintiff has not established that there was a 15mm cancer in May or that the pea-sized lump palpated was one and the same as the cancer detected in October. It is more likely that the radiologist's report is accurate as to what was seen and the 12mm cyst caused the lump. If this is so, had it

been aspirated, it would probably have disappeared. None of which would have prevented the continuing growth of a separate cancer in the same quadrant of the breast.

15.3 As a matter of fact, I am satisfied that the radiologist did probe the marked area. Bearing in mind the evidence of Dr. Allen, I am satisfied that Dr Mac A'Bhaird did not see an obvious tumour in May, the same as the tumour in October, but smaller. Noting how Dr. Allen and Professor McNicholas described simple cysts and noting all the relevant facts of this case, I am satisfied that a radiologist of this experience probably did not miss a 15mm tumour completely, nor did he see an obvious tumour and mistake it for a simple cyst. He probably saw what was described in his report: a 12mm cyst."

78. The judge continued in the same vein at 15.7:

"The Plaintiff's allegations of negligence in respect of aspiration and concordance only arise if the tumour was detectable in the first place. Looking at Dr. Allen's evidence, and at his report, it is clear that the basis for his view of the case was that the doubling time theory of Professor Bundred was accurate and reliable. The only two views of the case that he could put forward (that the radiologist did not, in fact, check the marked area or that he did but still somehow missed this obvious cancer) were not the only possible views. The one he did not consider, as it was not referred to in Professor Bundred's report, was a cancer growing at a rate faster than the range recorded in the Peer data, a cancer that was present, but not detectable in May. The radiologists all agree that the tumour in October was not different in appearance to the tumour in its early months of development. The evidence of what was seen on ultrasound in May, including images of simple cysts and a measured

cyst of 12mm at the site of the pea-sized lump, establishes that the lump was probably a simple cyst. The Plaintiff has not proven that the pea-sized lump was a tumour, although all agree that the tumour probably was present in May. If so, it was probably undetectable at that point."

The appeal

79. As the appeal evolved, particularly following oral argument, it became clear that the essence of the plaintiff's complaint is that the High Court was wrong to treat the issue of doubling time as dispositive of the claim and in doing so, ignored the evidence of Dr. Allen, Professor Ellis and the plaintiff herself on critical issues. It was said that this came about because the defence case was not properly or fairly conducted and further, because the judge erred in her treatment of the expert evidence. It was submitted that, contrary to the judge's view, Professor Bundred's evidence about doubling time was not the only evidence that supported the presence of a 15mm cancer in May 2017 and there was significant other evidence that the High Court failed to consider.

80. Thus put, the issues seem relatively net which makes it puzzling, to say the least, why it was felt necessary to deliver a notice of appeal containing 68 grounds of appeal, some of which include multiple sub grounds. This Court has frequently commented on the fact that such prolixity of pleading does not assist the Court, a matter that was also the subject of comment by the Directions Judge when this matter came before her. The fact that the plaintiff found it possible in her written submissions to reduce the grounds to ten, three of which were not actively pursued, and further still in oral submissions, suggests that a more focused notice of appeal might have been considered. It is also relevant in that regard to note that fully 28 of the 68 grounds of appeal related to the issue of doubling time, which was at the commencement of the hearing of the appeal entirely abandoned as an issue by

counsel for the plaintiff who advised the Court that he would be placing no reliance on Professor Bundred's evidence.

81. While this was a welcome development from the point of view of narrowing the issues, and it is perhaps understandable that issues crystalise more clearly in the run up to an appeal, it does indicate that it ought to be possible to avoid such lengthy notices of appeal. The pleading of every conceivable ground of appeal on the basis of the more the better is generally unhelpful, as is the case in any other form of pleading. It places an unnecessary and avoidable burden on the members of the Court in having to consider extensive grounds of appeal and accompanying submissions, only to find them abandoned on the morning of the hearing. It may also, in an appropriate case, have costs implications.

82. The surviving grounds of appeal, as they appear in the appellant's written submissions, can, I think, be summarised as follows:

The High Court erred in:

(1) Dismissing the claim on the basis that tumour doubling time was dispositive;

(2) Failing to give any, or any adequate, consideration to the evidence of Dr. Allen and Professor Ellis and wrongly interpreted that evidence;

(3) In relation to the rules of procedure concerning the admissibility of expert evidence;

(4) Relying upon evidence that was never put to the appellant in order to assess whether she was a reliable witness;

(5) Failing to assess the reliability of the evidence of Mr. Sugrue by reference to matters put to him in cross-examination.

83. I think it fair to say that additional grounds of appeal emerged in the course of oral argument which can be summarised as follows:

(1) The defendant's real defence was that the plaintiff suffered from an interval cancer and this was never pleaded;

(2) The defendant's real defence was not disclosed until close to the end of the hearing when Professor Crown gave evidence.

84. In his oral submissions, counsel for the plaintiff said there were two main themes to the plaintiff's appeal; first that the central issues were not determined because the judge failed to consider significant parts of the evidence, apart from doubling time, which counsel submitted established the presence of a detectable tumour in the plaintiff's right breast in May 2017; and second, because the defence case was not properly or fairly conducted for the reasons I have referred to. Accordingly, counsel took significant issue with the statement of the High Court that *"at trial, the plaintiff's case rested predominantly upon the use of tumour doubling time."*

85. Counsel emphasised that he was not challenging any of the High Court's findings on tumour doubling time, hence Professor Bundred's evidence effectively fell out of the picture. For the same reason, counsel submitted that the judge was wrong to state at para. 11.28 of the judgment that:

> *"The only evidence that suggests that the radiologist missed a 15mm cancer is the evidence in relation to doubling time. If the range in the Peer data is not sufficiently reliable to estimate the size of what was present in May, then there is no evidence to support the proposition that the radiologist missed a 15mm cancer."*

86. I think it fair to say that the plaintiff's challenge to this conclusion became the anchor sheet of her appeal. As counsel candidly conceded, if the plaintiff failed to persuade the Court that this statement was an error, the appeal falls away. Counsel submitted that there were numerous factors in evidence other than tumour doubling time to indicate that the plaintiff had a detectable cancer on 4th May, 2017 and he proceeded to list nine matters as follows:

(1) It was common case that the plaintiff had cancer in May 2017.

(2) The plaintiff gave uncontroverted evidence of a conversation between Mr. Sugrue and Dr. Mac A'Bhaird in which one of them said there was *"an unusual cluster in the lower quadrant"*.

(3) The plaintiff's evidence was that after 4th May, 2017, the lump did not go away but grew larger and coalesced with another mass to form one oblong shape and this evidence was never challenged.

(4) The 15mm entity in the plaintiff's breast in May 2017 was either a cyst or a cancerous lump but could not be both. It cannot convert from one to the other.

(5) The mass became bi-lobed when seen on MRI in October 2017 which fits with the plaintiff's evidence about the pea and peppercorn sized lumps coalescing and forming an oblong.

(6) Dr. Mac A'Bhaird failed to take an image of the largest entity in the plaintiff's breast which he measured at 12mm. It was not explained why there was no such image despite Dr. Mac A'Bhaird's evidence that it would invariably be his practice to take one.

(7) The plaintiff's evidence was that the biopsy which was taken in October 2017, which transpired to be malignant, was taken from the same lump as the one present in May 2017.

(8) The defendant did not call Dr. Katherine McGowan, the consultant radiologist who saw the plaintiff in October 2017 and took the relevant biopsies.

(9) It was not correct to say, as the judge held, that on 9th October, 2017 the plaintiff had a cancer which was at the 6 o'clock position 4cm from the nipple.

87. In the course of his submissions, counsel for the plaintiff referred the Court to the October 2017 MRI scans which he submitted demonstrated clearly that cancer was present at the 8 o'clock position, and this confirmed the plaintiff's evidence. In fact, counsel said that the tumour extended from 6 o'clock to 7 o'clock and to 8 o'clock.

88. With regard to Dr. Allen's evidence, counsel submitted that the court had failed to consider his testimony about how a necrotic cancer could be mistaken for a cyst on screening. Similarly, it was said that the judge misinterpreted the evidence of Professor Ellis in concluding that he made a slip in saying that if the cysts had been aspirated, there would have been a residual mass. Counsel said that:

> *"But in the context of the lump not being aspirated, in that context, the learned trial judge didn't see or put together the significance of Dr. Allen's evidence that it could contain, in his view, necrotic fluid, and Professor Ellis' evidence that if you don't carry out the aspiration something which could appear cystic can mask an underlying tumour."*

All of this led, counsel said, to four conclusions:

(1) The judge did not consider the nine facts above.

(2) She did not properly consider the radiological evidence.

(3) She did not consider the histopathology evidence.

(4) She did not consider the fact that the lump was not actually aspirated.

89. Turning to Mr. Sugrue's evidence, counsel's complaint was that he was allowed to be treated as an expert witness when he was a witness as to fact and the judge failed to give proper consideration to the reliability of his evidence.

The proper approach of an appellate court

90. Since one of the central features of this appeal is a fairly trenchant criticism of the trial judge for failing to engage appropriately, or in some instances at all, with the evidence before reaching her conclusions, it is, I think, therefore important to say something about how appellate courts approach their task where such a case is made. It is somewhat trite to say that since *Hay v O'Grady* [1992] IR 210, findings of fact made by a trial court will not be disturbed on appeal if they are based on credible evidence. In that regard, it is immaterial whether there is a significant, and perhaps even greater, body of evidence that might support a different conclusion.

91. Complaints of non-engagement with the evidence are commonly made by appellants, as they are in this case. However, the authorities demonstrate that complaints of non-engagement must be approached cautiously by an appellate court and the threshold for success is high. That this is so is well illustrated in the judgment of the Supreme Court

(MacMenamin J.) in *The Leopardstown Club Limited v Templeville Developments Limited & Anor* [2017] IESC 50. There, MacMenamin J. observed:

> *"6. What follows from this, and the authorities cited above, is that appeal courts are bound by a trial judge's findings of fact, when they are based on cogent evidence. Moreover, again applying the principles enunciated in Hay v. O'Grady, appeal courts should be slow to adopt inferences other than the trial judge's, again where they are based on factual material.*
>
> *7. Save where there is a clear non-engagement with essential parts of the evidence, therefore, an appeal court may not reverse the decision of a trial judge, by adverting to other evidence capable of being portrayed as inconsistent with the trial judge's primary findings of fact.*
>
> *8. 'Non-engagement' with evidence must mean that there was something truly glaring, which the trial judge simply did not deal with or advert to, and where what was omitted with (sic) went to the very core, or the essential validity of his findings. There is, therefore, a high threshold. In effect, an appeal court must conclude that the judge's conclusion is so flawed, to the extent that it is not properly 'reasoned' at all. This would arise only in circumstances where findings of primary fact could not 'in all reason' be held to be supported by the evidence. (See Henchy J. in M v. An Bord Uchtala, cited earlier, quoting his earlier judgment in Northern Bank Finance Corporation v. Charlton [1979] I.R. 149). 'Non-engagement' will not, therefore, be established by a process of identifying other parts of the evidence which might support a conclusion, other than that of the trial judge, when there are primary facts, such as here. Each of the principles in Hay v. O'Grady are to be applied."*

92. That it is not always necessary for the trial judge to explain the reason for a particular conclusion, when it may reasonably be inferred, is highlighted in another judgment of the Supreme Court from the same year, *Donegal Investment Group Limited v Danbywiske* [2017] IESC 14 where Clarke J. (as he then was) said:

> *"8.8 It is, in my view, important to emphasise that the exercise which an appellate court has to carry out when scrutinising the judgment of a trial judge is not one to be conducted in a mechanical way so as to encourage parties to attempt to find some element of the findings of the trial judge which is said to be insufficiently explained. It must be recalled that a judgment is arrived at the end of a very open and transparent trial process. The case will have been fully pleaded, the evidence fully heard and submissions made on both sides. In many cases, and in particular in the Commercial Court, there will be further procedures including the exchange of witness statements and expert reports. Against that backdrop it will often be possible readily to infer why a particular finding was made even if there is no express statement in the judgment. The parties will know how the case ran. An appellate court can read the record of the case. The judgment needs to be read in the light of the case as made and defended before the trial judge."*

93. Clarke J. went on to explain that there may be cases where it is simply not possible to ascertain why the trial judge made a particular finding of fact which is significant to the outcome or which cannot be as safely inferred from *"the run of the case and the structure of the judgment itself."* In those circumstances it may be necessary to allow an appeal.

94. These principles were revisited by this Court in *McCormack v Timlin & Ors.* [2021] IECA 96 where Collins J. in a consideration of the functions of review by an appellate court said:

> *"57. However, as I noted in McDonald v Conroy (at para 17), the appellate self-restraint mandated by Hay v O'Grady has an important quid pro quo, namely the requirement for 'a clear statement .. by the trial judge of his findings of fact, the inferences to be drawn, and the conclusions to be drawn.' The decision of the Supreme Court in Doyle v Banville [2012] IESC 25 has developed this aspect of Hay v O'Grady significantly.*
>
> *58. Of course, the exception must not be allowed to swallow up the general rule. Accordingly, appellate courts must be astute not to permit Doyle v Banville inspired complaints of 'non-engagement' with the evidence to be used as a device to circumvent the principles in Hay O'Grady: Leopardstown Club Limited v Templeville Developments Ltd [2017] IESC 50; [2017] 3 IR 707, per McMenamin J at paragraphs 109–111. Only complaints that go 'to the very core, or essential validity, of [the trial judge's] findings' will suffice (para 110)."*

95. In *Twomey v Jeral Limited & Ors.* [2022] IECA 177, the appellants complained of a failure on the part of the trial judge to engage with the evidence of defence witnesses, and in particular, of one medical witness whose evidence was not mentioned at all in the judgment of the High Court. Dealing with the trial judge's assessment of the evidence, speaking for the Court, I said:

> *"28. The starting point in any consideration by an appellate court of the trial judge's assessment of the evidence is of course the seminal judgment of the Supreme Court in Hay v O'Grady [1992] IR 210, the principles of which are by now so well-known that repetition is not required. Findings of fact by a trial judge that are supported by credible evidence bind an appellate court. More recent judgments have tended to emphasise the need for trial judges to explain their train of thought, at least*

to a sufficient degree to enable the appellate court, and of course the parties, to understand how a particular result is arrived at – see for example Doyle v Banville [2012] IR 505 and Donegal Investment Group plc v Danbywiske & Ors. [2017] IESC 14.

29. The degree of analysis or explanation required from a trial judge is of course entirely case dependant. Simple cases may require only basic elucidation of reasons by the court of trial, whereas in complex cases the converse may be true. Even in the absence of explicit reasoning, it may be possible in many cases to infer with reasonable confidence why a particular outcome ensued. Appellate courts should not encourage 'rummaging in the undergrowth' of the evidence in an effort by appellants to demonstrate some minor point that may have been, apparently at least, overlooked by the trial judge but where the overall rationale is perfectly clear.

30. Courts of trial are now, more than ever, expected to operate in a way that is efficient and cost-effective. This would be entirely defeated by a requirement on the part of a trial judge to parse and analyse every minute piece of evidence before the court, lest he or she be criticised for failing to do so by an appellate court. The requirement to give a reasoned analysis must be proportionate to the issue with which the court is concerned. …

…

32. Naturally, trials will usually call for more analysis than straightforward motions. However, here again, it cannot be the function of a trial judge to record and analyse every piece of evidence from every witness and every submission made before it is safe to arrive at an overall conclusion. Were that to be the standard, judgments would become little more than transcripts of the evidence. …

> *33. Appellate courts are entitled to, and do in fact, assume that the trial judge has taken account of all the evidence in reaching a decision. That remains the position whether it is expressly so stated or not. It is for an appellant to establish that a particular conclusion reached by a trial judge is one that cannot be sustained on the evidence. That means all the evidence and not exclusively the evidence identified by the judge in his or her decision."*

96. This Court revisited the issue in *Davey v Sligo County Council and Ors.* [2023] IECA 39 (at para. 49):

> *"… As the authorities demonstrate, the necessity for engagement and analysis of evidence is required in order to enable the parties, and indeed an appellate court, to understand the reasons why one side won and the other lost. There is little room for doubt in this case. Appellants not infrequently elevate this requirement to an art form in itself, subjecting courts of trial to criticism for failing to mention one piece of evidence, or analyse another. What is required is that the judgment 'engages with the key elements of the case made by both sides and explains why one or other side is preferred' – Doyle v Banville [2012] IESC 25 at para. 10."*

Findings of fact

97. In the course of her judgment, the trial judge made a number of important findings of fact which included:

1. Many of the systems used by Mr. Sugrue are exemplary: he takes meticulous measurements so much so that he uses a ruler as well as marking the breast itself and drawing an accompanying diagram – 6.3.

2. The evidence of all experts agreed that the visual appearance of simple cysts is very different from tumours - 6.11.
3. Mr. Sugrue and Dr. Mac A'Bhaird are experienced doctors and reliable witnesses as to fact – 8.1.
4. The cross-examination of Mr. Sugrue in respect of his CV had no bearing on the case – 8.2.
5. Dr. Mac A'Bhaird gave the impression of a witness trying to be helpful and not seeking to mislead – 8.3.
6. Professor Bundred's calculations as to doubling time were based not only on the Peer paper but on his theory that the pea sized lump felt in May was the same as the tumour in October – 10.18.
7. Professor Bundred assumed that the lump in May was cancer and it seemed likely that he chose a doubling time of 45 days as it gave exactly the result that he expected – 10.24.
8. Dr. Allen relied upon the opinion of Professors Bundred and Ellis that there was a 15mm tumour present in May in order to assert that it must, therefore, have been visible and it was negligent not to see it – 10.52.
9. Dr. Allen's evidence painted a picture that the tumour, had it been 15mm in May, would look nothing like a cyst and would be an obvious cancer in a location in the breast where it could easily be found – 10.57.
10. The 15mm pea sized lump found in May was probably not the tumour found in October – 10.59.
11. The doubling time was probably faster than 45 days and the tumour which was there in May was smaller than a pea sized lump, leading to the conclusion that the lump which the plaintiff felt was probably a cyst – 10.73.

12. By the end of his evidence about the location of the tumour in May, Professor Bundred began to suggest that the peppercorn sized lump, being one third of the size of the pea sized lump, was the potential cancer that had been missed which contradicted his own calculations about doubling time – 11.15.

13. If the cancer found in October was 15mm in May, it would have been obvious to a radiologist as it looked nothing like a cyst – 11.27.

14. The report of a radiologist was accepted as being the definitive description of what he saw, in normal circumstances – 11.28.

15. The only evidence suggesting that the radiologist missed a 15mm cancer is the evidence in relation to doubling time. If the Peer data is not reliable, there is no evidence to support the proposition that the radiologist missed a 15mm cancer – 11.28.

16. The plaintiff's own evidence did not establish that the entities she could feel in May or March were the same as the tumour in October – 12.10.

17. The evidence as a whole appeared to establish a likely focus of the October cancer nearer 6 o'clock than 8 – 13.5.

18. The likely location of the focus of the lesion in October was at or near 6 o'clock – 13.7.

19. There was insufficient evidence to positively prove that the tumour found in October originated in the same location as the pea sized lump in May – 13.7.

20. The plaintiff failed to establish that there was a 15mm cancer in May or that the pea sized lump palpated was one and the same as the cancer detected in October – 15.2.

21. It was more likely that the radiologist's report was accurate as to what was seen and the 12mm cyst caused the lump which, had it been aspirated, would probably have disappeared – 15.2.

22. Dr. Mac A'Bhaird did not miss a 15mm tumour completely nor did he see an obvious tumour and mistake it for a simple cyst. He probably saw what was described in his report, namely a 12mm cyst – 15.3.

23. It was clear from Dr. Allen's evidence and reports that the basis for his view of the case was that the doubling time theory of Professor Bundred was accurate and reliable – 15.7.

24. The plaintiff had not proven that the pea sized lump was a tumour, although a tumour probably was present in May. If so, it was probably undetectable at that point – 15.7.

Was there evidence of a detectable tumour in May 2017 other than doubling time?

98. The judgment of the High Court is primarily concerned with doubling time and runs to 65 pages. It analyses that issue extensively, in a painstaking manner and, it must be said, very convincingly. This is because the first and, as it transpired, decisive issue which the court had to consider was whether there was sufficient evidence to establish the likely presence of a 15mm malignant tumour in the plaintiff's right breast on 4th May, 2017. It was expressly conceded by counsel for the plaintiff in closing the case that if the court was not satisfied of this fact, that was the end of the case.

99. Although counsel for the plaintiff at the hearing of the appeal sought to downplay to an extent the importance of the doubling time issue, perhaps unsurprisingly having just jettisoned Professor Bundred's evidence in its entirety, there is no escaping the fact that by the end of the trial, this issue had become front and centre. Various complaints are made

about the defence in this regard, perhaps with some justification, that the doubling time issue only clearly emerged at the end of the case following Professor Crown's evidence. The plaintiff says that it was not even mentioned in any of the defence expert reports exchanged before the start of the trial. The other side of the coin, however, is that Professor Bundred's report appeared to only mention it in passing and then primarily for the purpose of suggesting that the plaintiff's cancer was probably not node positive in May. The primary thrust of his report was that it was negligent not to have carried out a needle aspiration, a proposition advanced in ignorance of the NCCP Guidelines.

100. It is perhaps a somewhat remarkable fact, and one to which the High Court was clearly alive, that the entirety of Professor Bundred's reports proceeded almost on the assumption that the 15mm lump seen in May must have been the same entity, albeit smaller, that was detected in October: hence his efforts to promote the only doubling time, 45 days, that would establish this fact, despite the fact that any other within the wide range available in the Peer data would have disproved it. This was described by Professor Crown as the *"Goldilocks phenomenon"* and it is not difficult to see why the judge considered that this evidence was the product of confirmation bias. There were myriad other reasons given by the trial judge for rejecting Professor Bundred's evidence on this issue.

101. That evidence is no longer directly relevant in this appeal, as it was belatedly abandoned, but its significance remains in the fact that it clearly underpins the evidence of both Dr. Allen and Professor Ellis. Dr. Allen's reports are, as found by the judge, predicated on the presence of a 15mm tumour in May. He made clear, initially at any rate, that this looked nothing like a cyst, was in an area of the breast which made detection easy and therefore ought to have been seen. I have highlighted relevant extracts of his evidence in that regard already.

102. However, after he had given evidence for several days, a completely new theory emerged, and then only on re-examination, namely that contrary to his earlier evidence, the cancer might actually look like a cyst, or the cyst could be masking a cancer, hence the necessity to aspirate it to establish the position one way or the other. This proposition did not appear in any of Dr. Allen's reports. That was not the only new issue raised by Dr. Allen who suggested that the 10cm measurement from the nipple taken by Mr. Sugrue on 4th May, 2017 could not be correct.

103. I have already noted the judge's comments on this which, in my view, justified her conclusion that this reduced the reliability of his evidence in respect of the location of any entity. Despite this, she still considered that his evidence on the radiological appearance of cysts and tumours could be relied upon. That evidence concurred, at least initially, with that of Dr. Mac A'Bhaird and Professor McNicholas.

104. Counsel sought to persuade this Court that the judge had ignored Dr. Allen's evidence concerning the MRI scan and took the Court through the scan in an effort to demonstrate what it showed and why the judge was wrong about it. I do not accept that the judge ignored this evidence, and that conclusion does not follow from the fact that she did not canvass it extensively. She was well aware that the MRI in particular was relied upon by Dr. Allen to show that the October tumour was in the same position as the pea sized lump in May – see para. 7.2. It is also clear that the judge reviewed the MRI images before coming to her conclusion – para. 13.5.

105. The judge's view of Dr. Allen's evidence was undoubtedly coloured by the matters to which I have referred and which she considered reduced the reliability of his evidence regarding the location of the entity. There is little doubt but that the judge preferred the evidence of Professor McNicholas concerning location of the tumour in October to that of

Dr. Allen, that the focus of the tumour in October was at 6 o'clock rather than 8. While counsel sought to persuade us that the MRI showed otherwise, I am satisfied that the judge's determination as to what was to be seen on the MRI is one she was entitled to make and is not a finding with which this Court should interfere. The location of the tumour was a matter of dispute between the experts, a dispute which the judge had to resolve, and she did so.

106. In his reports, Dr. Allen suggested that the largest focus of the tumour in October was at 8 o'clock, 10cm from the nipple. This evidence was however contradicted by the clinical evidence of Mr. Sugrue who said it was clinically at 6 o'clock, 4cm from the nipple. Further, both Professors Hill and McNicholas gave evidence to the effect that the focus of the lesion was at 6 o'clock and there was little or nothing at 8 o'clock. Accordingly, a clear conflict emerged on the evidence and it was for the trial judge to resolve that conflict. She did so and gave clear reasons for her conclusions.

107. The contrast between the reports of Dr. Allen and Professor McNicholas is stark. As I have said, Dr. Allen suggested that in October, the main focus of the tumour was in the 8 o'clock position at 10cm from the nipple. In contrast, Professor McNicholas says in her second report that in October, the tumour is to be seen mainly at 6 o'clock and towards 5.30 o'clock. A third lesion was found at 8 o'clock but 2.5cm from the nipple. In the October scan, Professor McNicholas said that there was no abnormality in the 8 o'clock position 10cm from the nipple. The conflict could hardly be more obvious.

108. It is true to say that the judge did not expressly comment on the theory introduced very late in the day by Dr. Allen that the tumour might look like a cyst because it might be necrotic. I have already expressed the view that this was completely at odds with his own earlier evidence and that of Mr. Sugrue, Dr. Mac A'Bhaird and particularly, Professor McNicholas. The judge found as a fact, and was entitled to so find on the evidence, that a

cyst would look nothing like the October cancer and indeed, this was Dr. Allen's own initial evidence quoted above.

109. Even if the judge did not say so in terms, the inference is inescapable from all her findings that she rejected the masking hypothesis. The fact that she did not explicitly refer to this piece of evidence does not mean, contrary to what counsel for the plaintiff submitted, that she ignored it, overlooked it or failed to consider it. The authorities cited previously make this clear.

110. Asking this Court to review the MRI scan, counsel was in effect suggesting that this Court should conclude on the basis of its perusal of the scan that Professor McNicholas's evidence must have been incorrect. As I have said, that was a matter for the trial judge, and her alone, once based on credible evidence. I am accordingly satisfied that there is no basis for the suggestion that the judge overlooked or ignored Dr. Allen's evidence in some way so as to render her conclusion unsound.

111. It follows inexorably from the evidence of Professor McNicholas that, if that evidence is correct, and the trial judge clearly accepted it as such, then the lesion found in October was not in the same position as the lump found in May. It therefore follows as night follows day that the lump in May was a cyst. To find otherwise is to ignore the evidence of Professor McNicholas, Professor Hill, Mr. Sugrue and Dr. Mac A'Bhaird, rather than the converse as the plaintiff suggests.

The evidence relied upon by the plaintiff

112. As indicated above (at para. 86) counsel for the plaintiff relied on nine factors and evidence which he submitted indicated that the plaintiff had a detectable cancer on 4th May, 2017, which the trial judge failed to take account of. These were as follows:

1. It was common case that the plaintiff had breast cancer on 4th May, 2017. That is certainly true and was accepted by both sides. It does not establish that the cancer was detectable.

2. The plaintiff gave uncontroverted evidence that she overheard a conversation between Mr. Sugrue and Dr. Mac A'Bhaird in which the phrase *"unusual cluster in the lower quadrant"* was used. While counsel referred to this as an item of evidence that supports the presence of a 15mm tumour in May, I cannot see how that follows. I have already set out the judge's finding on this issue at para. 57 above. This finding by the judge was not challenged in any way and appears perfectly logical.

3. The plaintiff's own evidence is that the May lump grew, the pea and peppercorn coalesced and this was not challenged. This is also reflected in point 7 below concerning the plaintiff's evidence that it was the May lump that was biopsied in October. Counsel complained that it was never put to the plaintiff that she was wrong about any of this. Counsel is correct in this submission. The cross-examination of the plaintiff did not include any suggestion that she was mistaken in her recollection.

   However, before the trial even began, it was abundantly clear that a central feature of the defendant's case would be that the October and May entities

were in different positions and could not be the same. That is clear, for example, in the report of Professor Hill of 20th February, 2021, to which I have referred. Even before that, it was clear from the medical records that the defendant's evidence would be that the entities were in different locations. In his letter of 9th October, 2017 to the plaintiff's GP, Mr. Sugrue said that clinical examination revealed the lump to be in the 6 o'clock position 4cm from the nipple. The position was confirmed by the radiologist, Dr. McGowan who said in a letter to Mr. Sugrue of the same date:

> *"RIGHT BREAST ULTRASOUND*
>
> *In the right breast at the 6:00 position there are two adjacent hypoechoic masses which are probably in continuity with each other, covering a distance of 3.4cm. A little microcalcification was identified within both of these masses which are in keeping with malignant neoplasm. There is a further small 7mm hypoechoic lesion at the 8:00 position which may represent further neoplasm…"*

In contrast to the evidence later given by Dr. Allen, Dr. McGowan identified the October tumour as being in the 6 o'clock position with a second small 7mm lesion at the 8 o'clock position, which of course could not correspond with a 15mm lesion from May. Thus, when Mr. Sugrue, Professor Hill and Professor McNicholas gave evidence, it can have come as no surprise to the plaintiff's legal team that the defendant was making the case that the October entity could not be the same as the May entity because they were in different locations. That position was copper fastened by the later September 2022 report of Dr. McNicholas to which I have referred.

When Mr. Sugrue gave evidence in accordance with his clinical records concerning the positioning of the two entities, it was open to the plaintiff's counsel to make the familiar objection that this was never put to the plaintiff. The remedy for such complaint is equally familiar, namely, to recall the relevant witness and put it to her. No application to recall the plaintiff was made on this question. It seems to me that it is not open to an appellant to complain on appeal of unfairness in a trial because certain matters were not put to witnesses without, first, having made that complaint to the trial judge and second, applied to recall the relevant witness.

Leaving that point aside, the complaint is that the judge failed to have regard to the plaintiff's own evidence that the May and October entities were one and the same. It was said that the plaintiff knew her own body better than anybody else and this was powerful evidence supporting the presence of a 15mm tumour in May. Whilst one might argue that this was the effect of the plaintiff's evidence, it does not by any means follow that the High Court ignored it. The converse is the case. The judge was clearly concerned about this as is evident from her exchange with Professor Hill to which I have referred above. Professor Hill, like Professor McNicholas, did not doubt the plaintiff's honesty or the sincerity with which she held this view.

Professor Hill gave an explanation for how the plaintiff may have felt this way which the judge appears to have accepted. However, the stark fact is that the plaintiff's evidence about the location of the tumour was flatly contradicted by the evidence of the four defence witnesses which I have mentioned. Both could not be right and the judge, for reasons she explained

clearly and in detail, preferred the defence evidence to that of the plaintiff herself. That was a conflict she was obliged to resolve and she did so. Accepting the plaintiff's evidence on this point would necessarily involve rejecting the evidence of Mr. Sugrue, Dr. Mac A'Bhaird, Professor Hill and Professor McNicholas. Instead, the judge accepted the latter evidence and explained why.

4. The May lump could only be a cyst or a cancer. One cannot become the other. Although not entirely clear, I think the point here is that if the plaintiff says it was the same lump all along, then it was cancer all along. I have already dealt with this.

5. The mass found in October was bi-lobed which fits with her evidence of the larger and smaller entities merging and growing. That may be so but comes back to the same issue about the plaintiff's evidence already discussed.

6. Dr. Mac A'Bhaird took no image of the largest lump he measured at 12mm. It was said that there should have been an image and it was Dr. Mac A'Bhaird's invariable practice to take such. That may be so but appears to me not to advance matters one way or the other and certainly is not evidence, as counsel submitted, of the presence of a 15mm cancerous lesion in May.

7. The plaintiff's evidence was that the May lump was the same as that biopsied in October – I have already dealt with this at 4 above.

8. The defendant did not call Dr. McGowan, who carried out the biopsies, to give evidence. That simple statement was the extent of counsel's submission on this point. I fail to see how this is in any way relevant to establishing that

the plaintiff had a 15mm tumour in May, particularly when Dr. McGowan's letter to Mr. Sugrue embodying her findings is among the clinical records and not disputed. Counsel submitted that it was not correct to say that on 9th October, 2017, the plaintiff's cancer was in the 6 o'clock position 4cm from the nipple, as found by Mr. Sugrue. To establish this point, counsel referred the Court to the MRI scan, as interpreted by Dr. Allen, to show that Mr. Sugrue's evidence, the evidence of Professors Hill and McNicholas and the letter of Dr. McGowan were all incorrect. I have already commented on this and am satisfied that this could not amount to evidence of the presence of a 15mm cancer in May.

The pathology evidence

113. In the course of his submissions, counsel for the plaintiff said that there were four significant errors in the judgment of the High Court which gave rise to the requirement for a retrial. These were:

1. The judge failed to consider the nine factual matters above – I have considered this.

2. The judge did not consider the radiological evidence adequately or at all – again already considered.

3. The judge did not properly consider the pathology evidence and was mistaken in her approach to it.

4. The lump found in May was not aspirated.

114. Counsel said with regard to the evidence of Professor Ellis that the judge was wrong to consider that he had made a mistake in saying *"I believe on the balance of probability that had any of those cysts been aspirated at the time there would still have been a palpable mass."* The judge said that this meant that the cysts were not simple cysts at all. She said it may have been a slip but if it reflected his views, it could not be correct. She gave reasons for reaching that conclusion. In his radiology report on 4th May, 2017, Dr. Mac A'Bhaird said that there were five small simple cysts in the plaintiff's right breast, the largest being about 12mm in diameter.

115. Thus, Professor Ellis's evidence appeared to be that had any of these five cysts been aspirated, there would have been a residual cancerous lesion. This is a proposition to which no other witness subscribed and indeed it is entirely contrary to all the other evidence in the case, both as to fact and expert. It is understandable therefore that the judge may have considered that this was a slip by Professor Ellis. However, she went on to say that if it was not a slip, it could not be correct and explained why she reached that conclusion, which appears to me to be unimpeachable.

116. A significant feature of Professor Ellis's evidence was that, like Dr. Allen, his report and evidence proceeded on the assumption that Professor Bundred's evidence on doubling time established the presence of a 15mm *"or larger"* cancer in May. Professor Ellis also espoused the thesis that one could think something is a cyst when it is actually a cancer because it becomes necrotic and looks like fluid. As noted earlier, this was also the thesis belatedly adopted by Dr. Allen when he returned to give evidence after Professor Ellis. This evidence was given with a view to establishing the necessity for an aspiration, apparently, if Professor Ellis was correct, of any cyst-like entity detected on radiological examination.

117. It is manifest that the judge did not accept this proposition. She found as a fact that the 15mm May entity was probably a cyst and gave a multitude of reasons for that conclusion. If she was to accept what Professor Ellis was suggesting, it would mean rejecting the evidence of all the defence witnesses in their entirety and clearly, the judge was, for the reasons she explained, not prepared to take that course. As with other aspects of the plaintiff's evidence, it can readily be inferred why the judge did not accept the evidence of Professor Ellis and Dr. Allen on this point, even where that is not explicitly stated.

118. The authorities to which I have already referred make clear that the task of a trial judge is to come to a reasoned conclusion so that the parties can understand why one side succeeded and the other did not. A minute analysis of every aspect of the evidence is not what is required when the reasons for the court's decision are plain to see from the judgment. In truth, when one reduces the plaintiff's complaints on appeal to their essence, she is saying that the judge should have preferred the evidence of the plaintiff's experts to that of the defendant. While this is couched in terms of failing to have regard to one piece of evidence or another or failing to interpret it properly, it seems to me that this is what it comes down to at the end of the day and as such, as a ground of appeal it is not sustainable. Nobody reading the very thorough and comprehensive analysis contained in the judgment of the High Court could be left in any doubt as to why the plaintiff's claim failed.

The defence case

119. In his submissions to this Court, counsel for the plaintiff complained that the defence case was unfairly presented, the effect of which was to lead the judge into error. It was said that there were four reasons for this:

1. The real defence was that the plaintiff developed an interval cancer and this was never pleaded.
2. Mr. Sugrue's credibility was not correctly analysed by reference to the evidence.
3. The defence case was not put to the plaintiff.
4. The true defence was not disclosed until almost the end of the trial when Professor Crown gave evidence.

120. Dealing with the first point, an interval cancer was explained as a cancer which is not apparent on a first screening but appears on a subsequent screening. While cancer may or may not have been present at the time of the first screening, it was not detectable at that stage. The cancer accordingly manifests in the interval between the first and second screens or scans and is so described. Counsel for the plaintiff complained that this case was never pleaded before the trial commenced and on one view, that is true.

121. However, the defence makes clear that it would be contended that there was no abnormality on imaging on 4th May, 2017 other than cysts which did not require histopathological examination. In other words, the defence was clearly saying that there was no detectable cancer in May. In those circumstances, as was pointed out in debate with counsel, it is difficult to understand how, on the defendant's case, the cancer that was apparent in October could be described as other than an interval cancer.

122. I cannot see therefore how it can be said that this somehow led to an unfairness in the way the defence was conducted or in respect of the conclusions arrived at. While these complaints are couched in terms of complaints against the defence, they are, in reality, complaints about the fairness of the trial conducted by the judge. As in the case of things not being put to witnesses, if an unfairness arises from a novel proposition being advanced for the first time at trial, a remedy is available.

123. If a party claims they are taken by surprise by such a development and prejudiced in consequence, the remedy is to make an application to the trial judge, usually for an adjournment so that, if necessary, pleadings on both sides can be amended to reflect the real issue that has arisen. Such an application will normally also be accompanied by an application for costs on the basis that the necessity for the adjournment or whatever other remedial action is deemed appropriate arises by virtue of the other party's failure to plead the case properly in the first place.

124. What is not available to a party, however, is to allow matters to proceed and then complain on appeal that an unfairness arose which necessitates a retrial. That is, in substance, what the plaintiff claims here.

125. The same comments apply with equal force to the third and fourth points about the defence not being put to the plaintiff and not being disclosed until the end of the case. These are all matters that require resolution at first instance and a party who does not seek that resolution cannot complain about it on appeal. The defendant's alleged failure to disclose its real case until the end of the trial is precisely such a matter and may be relevant to the proper allocation of costs. In this case, a subsequent hearing took place on the issue of costs which resulted in a second reserved judgment from the High Court and this point was canvassed in detail in support of a modified costs order, which was ultimately declined by the court.

126. As regards Mr. Sugrue's credibility, as already pointed out, the judge found Mr. Sugrue to have been meticulous in his approach to clinical assessment, an experienced doctor and a reliable witness as to fact. The plaintiff's complaints about Mr. Sugrue's credibility are many, including that his CV was inappropriately laudatory of his achievements and status, having been written by himself. Perhaps more significantly, a complaint was made

stemming from the fact that in the course of cross-examining one of the plaintiff's experts, counsel for the defendant suggested that Mr. Sugrue had never been involved previously in litigation, which transpired to be incorrect.

127. He was in fact involved in an earlier case where a patient had died and in which liability was ultimately admitted by the HSE. There is nothing in the transcript to suggest that the judge did not take all of this on board in her assessment of Mr. Sugrue's reliability as a witness. Here again, the complaint is that she did not reach the conclusion that the plaintiff wanted her to reach. The judge's view was that the previous case was of no relevance and for my part, I equally struggle to understand its relevance.

128. The assessment of the credibility of a witness is, perhaps more than any other issue in a case, quintessentially a matter for the trial judge. Although not unheard of, it is a relatively rare event for an appellate court to find that a trial judge erred in their assessment of a witness's credibility. The witness concerned in this case was Mr. Sugrue, who gave evidence before the trial judge over four days. For this Court to conclude that the judge was wrong in her assessment of the reliability of his evidence would require something truly extraordinary. As MacMenamin J. pointed out in *The Leopardstown Club Limited v Templeville Developments Limited & Anor* (*op. cit.*) a finding of credibility is a finding of fact – at para. 3. It is subject to the same *Hay v O'Grady* rules as any other finding of fact and will not be interfered with if there is credible evidence to support it. This complaint is accordingly in my view unstatable.

129. Insofar as the complaint about Mr. Sugrue being permitted to give expert evidence is concerned, the judge made clear when this objection was made that she would not regard his opinion evidence as the evidence of an expert and the weight to be accorded to it would reflect that. It is invariably the case in professional negligence claims that the professional

defendants will themselves be experts and will often express views on issues which are not, strictly speaking, evidence of fact, as distinct from opinion evidence. It is for the judge to control such evidence and make appropriate rulings where necessary. That is what occurred here when Mr. Sugrue gave evidence about the appearance of cysts versus cancer on radiology and it was objected to and dealt with.

130. This evidence from Mr. Sugrue had no potential for introducing unfairness in the case in any event because it tallied fully with that of the radiological experts, Dr. Allen and Prof. McNicholas. There is accordingly no substance in this complaint as a ground of appeal.

Expert evidence

131. The law in relation to expert evidence was most recently considered by this Court in *Duffy v Brendan McGee & Anor* [2022] IECA 254. This was referred to by the trial judge in guiding her in her approach to the assessment of the expert evidence in this case. There is no contest on this point. However, an issue does arise in relation to the judge's assessment of the admissibility of the expert evidence. One of the plaintiff's grounds of appeal is that the judge erred in this regard.

132. Order 39, rule 58(3) of the RSC provides as follows:

> *"Save where the Court for special reasons so permits, each party may offer evidence from one expert only in a particular field of expertise on a particular issue. Such permission shall not be granted unless the Court is satisfied that the evidence of an additional expert is unavoidable in order to do justice between the parties."*

133. I think the first thing to be said in this regard is that the rule is a rule of procedure and not a rule concerning the admissibility of evidence. It is an attempt to rein in the proliferation of expert evidence in all cases, particularly those involving clinical negligence. These are

frequently very high value claims, particularly in the area of obstetrics, where a plaintiff sustains injuries at birth. In the present case, the plaintiff's claim for special damages alone exceeds €3.6m. It is easy to understand why, in such cases, there was a significant temptation to call multiple obstetric or other experts to buttress the claim or defence to the maximum extent possible.

134. However, the effect of such approach was to greatly increase the costs associated with such litigation. It had the potential for unfairness insofar as the party with the deepest pockets can afford the greatest number of costly experts. It was also a significant issue in terms of the use of scarce court time where the calling of multiple experts on a particular topic will inevitably significantly increase the length of what are already trials typically running into weeks rather than days. In this case, for example, most of the expert witnesses gave evidence on multiple days, despite the fact that, as required by S.I. 391 of 1998, each had provided in advance reports which were required to contain the substance of their evidence. Viewed in that light, the policy considerations behind the introduction of this rule are clear.

135. In medical practice nowadays, it is common to adopt a multi-disciplinary approach to diagnosis and treatment of patients and this case provides a good example with at least three different medical disciplines being potentially involved in the triple assessment approach to breast cancer screening. Inherent in this, however, is that there may be elements of overlap between the expertise of various witnesses concerning a particular issue. Again, this case provides a good example. Professor Bundred was called as a clinical expert who gave the controversial evidence concerning tumour doubling time which ultimately was rejected by the High Court. Professor Ellis was called as a pathology expert, but it so happened that he

was the co-author of one of the leading papers dealing with the issue of doubling time and was thus clearly an expert in this field also.

136. In his written report, Professor Ellis did not purport to deal with the doubling time issue other than to agree with and accept Professor Bundred's view. He simply says in his report concerning Professor Bundred's views on the size of the tumour in May 2017 that *"I would support his assessment"*. The main thrust of his report, however, like that of Professor Bundred, was the alleged failure to aspirate the 15mm lump which he considered to be a breach of duty. In his oral evidence, he did give evidence concerning doubling time, without objection from the defendant.

137. For ease of reference, I repeat the judge's observation on this:

> *"10.1 Only one expert is permitted to give evidence in respect of a particular field of expertise to avoid an unnecessary proliferation of evidence and of experts. One aspect of this case that appeared to trespass on this important procedural rule was that all the expert witnesses had taken part in multi-disciplinary teams [MDT's] for many years. In this context, each was frequently asked about subjects which were, more appropriately, issues for another witness but about which they had long years of general knowledge. ...*
>
> *10.2 Insofar as possible, the Court has restricted each expert to his or her area of expertise and relies only on the relevant witness. To do otherwise affects the quality of the evidence and its reliability, as it would emanate from a person with less subject matter expertise who collected the specialised knowledge in a general and collateral way, albeit at a high level and in a professional capacity. To rely on evidence from a witness other than the proffered expert would also jettison a procedural rule which exists not only to ensure that the Court acts on the best evidence but also to provide*

> *a reasonable and predictable structure for the litigant in this and in all similar cases."*

In applying this rationale to the evidence of Professor Ellis, the judge said the following (at para. 10.30):

> *"... Professor Ellis was co-author of a relevant article but was not called as the expert on doubling time. Although the Court will nonetheless describe his views, they cannot be relied upon in this context as he was not the expert relied upon. Counsel for the Plaintiff accepted this ..."*

138. This is further reflected in the comment of the judge at para. 10.63:

> *"... The rules of procedure require that there is only one expert in relation to any issue in a case and the Court must disregard evidence from other witnesses."* (My emphasis)

139. The plaintiff complains that the judge was in error in adopting this view and I agree with that submission. As I have already said, O. 39, r. 58(3) is a rule of procedure, not a rule of evidence. It says nothing to the admissibility of evidence in a particular case. Thus, where an expert is called on one particular topic, but also gives evidence on another, such evidence might be the subject of objection by the opposing party before it is given on the basis that it infringes the rule. It might also of course be objected to on the ground that it is not within the relevant witness's area of expertise, which is a different point.

140. However, if the evidence is given without objection, it seems to me that the court is not free to disregard it but must treat it in the same way as any other expert evidence. As I have said, Professor Ellis gave this evidence without any objection from the defendant and accordingly, it was in my view incumbent on the court to consider it. As it happens, and

notwithstanding what the trial judge stated at para. 10.63, the court did consider it. Thus, the judge said (at 10.64):

> *"Professor Ellis's evidence regarding doubling times is set out here, however, lest there be a view that his opinion might have led to a different result in the case had the Court been entitled to rely upon it. Insofar as it went, it was unlikely to do so. …"*

141. In the light of that observation by the judge, it is difficult to see the basis for the plaintiff's complaint in this regard. The height of the plaintiff's submission appears to be that this approach was *"troubling"* and undermined *"a correct evaluation of the expert evidence adduced at the trial on behalf of the appellant."* Beyond that, no example is given or relied upon and it seems evident from the judgment itself that the only circumstance in which it had a material bearing was in relation to the evidence of Professor Ellis regarding doubling time. That, however, is immaterial, first, because the judge set it out anyway and said it would have made no difference but second, and more importantly, because the plaintiff has now entirely abandoned the case concerning doubling time.

142. It is accordingly in my judgment clear that this ground of appeal is not made out.

Conclusion

143. In the event, I am satisfied that the judge was correct in concluding that the only evidence of the existence of a 15mm tumour in the plaintiff's right breast on 4th May, 2017 was the evidence given by Professor Bundred, which was based on tumour doubling time. Once that evidence was rejected for the detailed reasons given by the judge, all the other evidence concerning breach of duty became irrelevant, as the judge found and as counsel for the plaintiff conceded. Accordingly, the case failed at the first causation hurdle. One must of course express sympathy to the plaintiff on the very significant illness she suffered, the

ensuing difficult treatment and the residual sequelae of that illness. It is, however, fortunate that the plaintiff has responded very well to that treatment as all parties agree.

144. I would accordingly dismiss this appeal for the reasons I have given. While the plaintiff's notice of appeal also appeals the costs judgment of the High Court delivered on 25th April, 2023, no separate grounds of appeal have been advanced regarding that judgment so that the latter appeal is simply contingent on the main appeal succeeding and therefore falls away.

145. With regard to costs, my provisional view is that as the defendant has been entirely successful, it should be entitled to its costs of the appeal. If the plaintiff wishes to contend for an alternative order, she will have a period of 14 days to deliver a written submission not exceeding 2,000 words and the defendant will have a similar period to respond likewise. In the absence of receipt of such submissions, an order in the terms proposed will be made.

146. As this judgment is delivered electronically, Power and Binchy JJ. have authorised me to record their agreement with it.