[2019] IEHC 944

THE HIGH COURT

[2017 No. 7 C.T.]

BETWEEN

E.D.

APPELLANT

AND

THE MINISTER FOR HEALTH

RESPONDENT

JUDGMENT of Mr. Justice Bernard J. Barton delivered on the 26th day of November, 2019

1. These proceedings come before the Court by way of an appeal pursuant to s. 5 (15) of the Hepatitis C Compensation Tribunal Acts, 1997 to 2006 (the Acts) from the decision of the Hepatitis C Compensation Tribunal (the Tribunal) given on the 15th September 2017, whereby the Appellant’s application for compensation under s. 4 (1) (e) of the Acts was dismissed. This section in general makes provision for the categories of persons who may bring claims for compensation under the statutory scheme. The claimants with which s. 4 (1) (e) is concerned are the statutory dependants of any of the persons identified in sub paragraphs (a) (b) or (c) of s.4 (1) whose death was as a result of contracting Hepatitis C or where Hepatitis C was a significant contributory factor to the cause of death, namely:

   (a) a person diagnosed positive for Hepatitis C (HCV) resulting from the use of Human Immunoglobulin Anti-D within the State,

   (b) a person diagnosed positive for HCV through the transfusion of blood or blood products within the State,

   (c) the children or any spouse, of the persons at (a) or (b) above who themselves have been diagnosed positive for HCV.

2. The Appellant brings these proceedings on her own behalf and on behalf of the other statutory dependants of her mother, who died on the 16th February 2008, aged 67. While a number of questions are raised on the appeal, the central issue which falls for determination is whether or not chronic HCV was (i) a cause of death or (ii) a significant contributory factor to the cause of death. For the reasons which follow later, while satisfied the deceased did not die as a result of having contracted HCV, the Court is satisfied that the infection was a significant contributory factor to the cause of death.

3. The deceased contracted HCV on the 11th June 1977 as a result of receiving Anti-D which emanated from a batch of the product contaminated with the virus (subsequently identified as batch number 238). A stark difference of medical opinion emerged in the course of the proceedings concerning the part played, if any, by HCV in the cause of the deceased’s death. In the event the Tribunal was not satisfied that HCV had played an active role in the death (to a degree that could be said to be non-minimal), and consequently dismissed the application.

4. One of the ancillary questions which arises concerns the probative value of the ‘Death Certificate’ issued pursuant to the provisions of the Civil Registration Act 2004 (the 2004

Act). The certificate was admitted in evidence together with the deceased's medical notes, records, and correspondence relevant to the application. The Intensive Care Unit (ICU) 'Death Summary' indicates that the Coroner was informed of the death and had requested a post mortem. However, none appears to have been carried out or, if it was, no record of the result is contained in the papers made available to the Tribunal or the Court. The relevance of the certificate to the resolution of the main issue arises from the causes of death stated therein, the last of which is given as 'Hepatitis C certified'.

5. The Appellant contended that the certificate was prima facie and conclusive evidence of the cause of death. The Respondent argued that while the certificate was *prima facie* evidence it was not conclusive of the facts stated therein, furthermore, it was of little probative value when regard was had to the expert medical evidence. I shall return to these submissions in more detail later. The evidential status of a death certificate was considered by O'Neill J., in *R.B v. The Hepatitis C and HIV Compensation Tribunal*, [2005] IEHC 57, wherein he relied upon the content of the death certificate together with expert medical evidence to found the conclusion that HCV had been a significant contributory factor to the cause of death. Although the Tribunal adopted the construction placed on s.4(1) (e) by the learned judge, the evidential significance or otherwise of the death certificate was not addressed in its reasoning for the decision to dismiss the application.

6. The parties made comprehensive written and oral submissions on the issues which arose before the Tribunal, as they did on the appeal. In the interests of facilitating a comprehensive understanding and in order to place the issues in context it is considered necessary to set out in some detail the factual background to the application.

Background

7. The deceased was born in July 1940. She was young when she married in 1960 and was blessed with a large family. In 1994 she was diagnosed positive for HCV antibodies on ELIZA and on all four bands of the RIBA test. She was also found to be virus positive (genotype 1B) on PCR testing. Save for a short period of time in the mid 1990's the deceased was viraemic for 30 years before her death. Following diagnosis, she applied for compensation under the statutory scheme and was made an award by the tribunal on the 21st May 1998; the Court has had the benefit of reading the transcript of those proceedings.

Liver Biopsies

8. It is not in issue that Hepatitis C viraemia causes progressive liver disease. During the years between diagnosis and the hearing in 1998 the deceased underwent three liver biopsies the first of which, in June 1994, showed early bridging fibrosis and widespread piecemeal necrosis, involving greater than 70% of the portal tracks, with moderate activity; liver function blood tests were also marginally abnormal. Consequently, double antiviral therapy of Interferon and Ribavirin was advised and undertaken with a positive response; PCR testing reverted to negative and liver function blood tests returned to normal. A second liver biopsy followed on the 20th March 1995; the result disclosed a marked reduction in liver inflammation.

9. Unfortunately, response to treatment was short lived. By July 1995 liver function blood tests were found to be PCR positive. A third liver biopsy was carried out three years later on the 24th April 1998. Although the inflammation seen in the sample was somewhat less than in the 1994 sample, it was greater than that seen in the biopsy of 1995. The result was indicative of continuing activity with slow progression of the disease. The deceased's treating physician at the time was Dr. John Crowe, Consultant Gastroenterologist. He gave evidence to the Tribunal at the hearing in 1998 and on the subject application.

Liver Disease Prognosis in 1998

10. In 1998 Dr Crowe prognosticated there was a greater likelihood the deceased would develop cirrhosis of the liver due to having reverted to positivity for the virus. He thought the disease would progress slowly but that by her mid to late 70s the liver was likely to be cirrhotic; either way she would almost certainly be compromised in terms of her overall health. While she was undoubtedly at greater risk of ill-health than a patient without the disease it was unlikely there would be any foreshortening of life expectancy.

11. This opinion is potentially significant in the context of the fundamental question under consideration and is one which Professor Crowe was prepared to stand over in his evidence on the hearing of the appeal, albeit without prejudice to his contention that Hepatitis C was not the cause of death. His treatment plan in 1998 had been to carry out further biopsies at three yearly intervals and if these showed progression of the disease to intervene with antiviral treatment, although at the time it was not anticipated such treatment would result in a clearance of the virus, particularly as the deceased was genotype 1B.

Tribunal Decision 1998; Subsequent PCR Testing; Viral Loads

12. The Tribunal accepted Dr Crowe's opinion and prognosis and found that the already established liver disease would likely progress to cirrhosis in later life and that there was a possibility but no more than a possibility of further progression to decompensated cirrhosis and/or hepatocellular carcinoma; the award was made provisional on the occurrence of either or both of these eventualities. Throughout the next decade the deceased tested PCR positive with a high viral load; it is notable for present purposes that the load of the test sample taken in November 2005 was 6.8 million copies of viral RNA.

13. This result is well above the accepted high viral load threshold of 800,000 international units per litre of blood (iu/l), which correlates to approximately two million copies of viral RNA; the viral load remained high until death. It is significant in the context of progressive liver damage/dysfunction that the level of load in later tests was higher when compared with the test results taken around the time of the first biopsy in 1994, which disclosed early bridging fibrosis and necrosis.

14. A further liver biopsy was carried out on the 11th April 2003; the result is also potentially significant. While it confirmed ongoing viral activity with mild portal fibrosis there was no evidence of cirrhosis. The outcome accorded with clinical assessment at the time; the liver was not palpable; the spleen was not enlarged, and oesophageal varices were absent, which supports the contention of the Respondent's experts that HCV was not

causing any significant liver damage and importantly was not causing liver dysfunction. However, no further biopsies were carried out prior to the deceased's death nor was an autopsy carried out thereafter to confirm this view.

15. It follows that the extent of any progression in the disease and any consequential deterioration in liver function post 2003 is unknown. Having regard to the viral load, the length of infection, the known impact of the virus on the liver and on the course of the disease, the Appellant's experts considered it was highly unlikely the disease had not advanced to significant fibrosis or cirrhosis in the intervening years, a conclusion disputed by the Respondent's experts. A whole-body MRI carried out in January 2008 showed a normal sized liver and spleen, furthermore, a gastroscopy carried out within a month of death showed no evidence of oesophageal varices, results which, in their opinion, while not conclusive, were contraindicators for cirrhosis

Diagnosis of Multiple Myeloma; Treatment; Consequences

16. As if she didn't have enough to contend with, other misfortunes were to be visited on the deceased. In October 2005 it was noted her serum globulins were raised with immunofixation revealing an IgG lambda paraprotein indicative of cancer of the immune system, accordingly, she was referred for assessment to Dr. Peter O'Gorman, Consultant Haematologist, under whose care she had also been admitted to hospital for treatment of what transpired to be her final illness. He confirmed a diagnosis of multiple myeloma.

17. The condition was initially quiescent but subsequently necessitated treatment with chemotherapy, treatment which was entirely appropriate and is not in issue. However, the consequences of the treatment, particularly the consequences of immunosuppression on an immune system already compromised by the viraemia, raised questions as to the deceased's ability to fight the acute sepsis and renal failure which led to her emergency hospital admission and ultimately to her death.

18. In Professor Crowe's opinion death was due to a combination of late stage multiple myeloma, immunosuppression, neutropenic sepsis and renal failure. He last assessed the deceased in February 2008, during her final illness and made a note of his clinical opinion in the hospital record ----chronic HCV was not a contributory clinical issue to the presentation which was primarily due to immunosuppression secondary to multiple myeloma, ----a view not shared by Professor Graeme R. Foster, Professor of Hepatology or by Professor Steven Schey, Professor of Plasma Cell Dyscrasias and Consultant Haematologist, both of whom gave evidence on behalf of the Appellant.

19. In fairness to Professor Crowe I should observe that when giving evidence he qualified his entry in the hospital notes by stating the situation was one of extremis; the deceased was by then gravely ill. I took his evidence in this regard to mean that medical treatment for HCV had nothing to offer particularly in circumstances where death was more or less imminent due to the consequences of multiple organ failure.

Death Certificate; Submissions

20. The principle controversy between the experts centred on the medical condition or conditions and the consequences thereof which caused or contributed to death. The death

certificate, dated the 28th February 2008, issued pursuant to the 2004 Act gives the medically certified causes of death as (i) neutropenic sepsis, (ii) immunosuppression, (iii) multiple myeloma and (iv) Hepatitis C certified. Professor Crowe gave evidence that had he been the physician completing the certificate he would not have included HCV as a cause of death though he considered it appropriate that HCV should have been recorded for other purposes. Professor Foster on the other hand considered the entry to be entirely appropriate.

21. As mentioned at the outset, it was submitted on behalf of the Appellant that the death certificate was *prima facie* and conclusive evidence of the causes of death, which included HCV. It was argued primacy should be accorded to the causes of death as certified despite medical evidence to the contrary adduced on behalf of the Respondent, particularly as the certificate was not impugned in any way; there was no assertion that the certificate needed to be corrected, amended or set aside.

22. Having admitted the certificate, the Respondent contended it was no more than prima facie evidence of the contents and argued that in the absence of clear statutory authority it did not assume a special evidential status determinative of the issue. The conclusion being urged on the Court in this regard by the Appellant would have far reaching consequences and would result in the usurpation of the statutory function in this regard vested in the Tribunal and, on appeal, in the Court.

23. When viewed in the context of sections 13 (4) and 42 of the 2004 Act the Respondent contended that the certificate merely evidenced the entry of the death and particulars thereof in the register of deaths. The record of the cause of death is not a record of a fact but rather is the record of a medical opinion given by a doctor at a particular point in time which, when regard was had to the evidence of the four consultants who gave evidence, ought to be given little if any weight; while the certificate had to be considered by the Court it was certainly not conclusive evidence determinative of the issue.

Significance of Biopsy and Liver Function Blood Tests

24. The experts also differed on the significance to be attached to the biopsy results, all of which predated the diagnosis of multiple myeloma which ultimately had to be treated with chemotherapy. Furthermore, it is not in issue that the deceased's blood and liver function tests produced abnormal results in the period leading up to her death, some of which were indicative either of underlying liver disease and or the consequences of treatment for the Multiple Myeloma; the experts differed on the cause. By way of example Hyponatraemia (low sodium concentration in the blood), which it is acknowledged was at significant levels in the deceased, is a well-recognised complication of liver failure, however, multiple myeloma and renal failure, amongst other conditions can also lead to Hyponatraemia and was the explanation proffered and considered more likely by Professor Crowe and Professor George E. Griffin, Professor of Infectious Diseases and Medicine at St Georges University, London.

25. The medical evidence offered on behalf of the Appellant took issue and postulated the proposition that the immunosuppression caused by chemotherapy on an already

compromised immune system due to HCV was material to the Appellant's ability to cope with the acute sepsis and renal failure and was thus a significant contributory factor in the cause/causes of death. The abnormal liver function markers in the blood tests were indicative of deranged liver function due to the effects of HCV, about which more follows.

HCV and Multiple Myeloma; Causal Connection Abandoned

26. These proceedings have a long and involved history. Suffice it to say for present purposes that when the application first came before the Tribunal in 2010 the Appellant sought to make the case that HCV was implicated in the cause of the Myeloma, a claim subsequently abandoned, as the causal connection was still a matter of ongoing debate in the medical and scientific community. When the hearing resumed before the Tribunal seven years later, on the 3rd April 2017, it was agreed that the issue was whether HCV had caused or was a significant contributory factor to the cause death.

Causes of Abnormal Blood Tests

27. Professor George Griffin wrote a report in December 2011 at the invitation of the Tribunal and subsequently gave evidence at the hearing in 2017 as he did on the appeal. Both he and Professor Crowe attributed the abnormalities seen in blood test results to the effects of the chemotherapy treatment administered to deal with the rapidly deteriorating Multiple Myeloma as a consequence of which the immune system was unable to cope thereby leading to sepsis and renal failure.

28. Professor Griffin noted that by the 14th May 2007 the ALT level had risen to 287 iu/ml. In this regard a letter dated 16th May 2007 from Dr. Sibartie, SpR. Registrar to Professor Crowe, sent to the Deceased's G.P, referred to the ALT level as having jumped to this level from a reading of 93 in/ml the previous year, at which stage the viral load was also noted at 5 million copies viral RNA. The letter referred to a clinic held on the 14th May 2007 at which the option of commencing further combined therapy to treat HCV as well as the necessity of undergoing a repeat biopsy as part of such treatment was discussed with the Deceased.

Impact of Treatment on Damaged Liver ;

29. While Professor Griffin expressed the opinion that cirrhosis of the liver had not occurred by the time of her death he also expressed the view that as she undoubtedly had compromised liver function, the metabolic demand placed on the liver in the face of severe illness and treatment would have been great. As to the cause of death, he considered the dominant feature was sepsis syndrome arising in the course of chemotherapy for multiple myeloma exacerbated by reduced liver cell function induced by Hepatitis C, a very significant opinion in the context of the statutory requirement under s.4 (1) (e), however, he subsequently resiled from this opinion when giving evidence to the Court on the grounds that the abnormal readings had occurred far too quickly to be attributable to underlying liver damage.

30. When Professor Crowe was being examined in chief he was asked by counsel for the Respondent to comment on the opinion contained in Professor Griffin's report. His evidence was that he did not disagree with it, adding his own view that a person with a completely normal liver would stand a better chance of survival in the clinical context in

which the deceased found herself, though quantifying the prospects of survival in percentage terms was impossible. That said he did not accept any impairment of liver function was attributable to HCV, in his view the blood test results in the period leading up to death did not support the contention there had been recrudescences of HCV in 2008, as contended for by the Appellant's experts.

Liver Function Blood Test Results; Consequences

31. Liver blood tests are designed to demonstrate whether for example inflammation / cell damage has occurred or is occurring. The blood tests most frequently used as indicators or markers for liver disease are the aminotransferases, alkaline alanine aminotransferase (ALT) and aspartate aminotransferase (AST). Results in the range 7 to 56 units per litre for ALT and 10-40 units per litre for AST are considered normal. Following combined therapy treatment, the deceased's ALT and AST were found to be within the normal range however as the years passed levels gradually became elevated.

32. By way of example the ALT level recorded in October 2005 was 154 iu/l and although subsequent test levels varied they never normalised thereafter. On the 14th January 2008, just before the commencement of chemotherapy treatment, the ALT result was 230 iu/l, which in the opinion of Professor Foster was indicative of significant inflammation and compromised liver function at that point. ALT and AST results are not the only markers for liver disease others such as Albumin, INR (International Normalised Ratio), an assay evaluating the extrinsic pathway and common pathway of coagulation, and Bilirubin levels are also indicative.

33. The test results for these factors were also abnormal, though again the experts differed on causation and significance. Professor Crowe's view was that the levels in the period leading up to death showed, if anything, stability in liver function. Professor Foster took a different view but accepted the results could not be attributed solely to HCV as sepsis was also present and thus relevant.

Tipping the Balance

34. As to the status of the liver, his opinion was that the disease had probably progressed to early cirrhosis by the time of death, though this could not be definitively established. Nevertheless, while the extent of damage and consequential dysfunction could not be quantified in percentage terms, the capacity of the liver to fight the impact of chemotherapy, sepsis and renal failure was impaired as a result of the infection to an extent that tipped the balance against survival, conclusions in which he was supported by Professor Schey. While accepting HCV was not the primary or dominant factor in the cause of death, he contended the already damaged liver was a consequence of the infection and thus a significant contributory factor in the cause of that event.

Approach of the Tribunal

35. As stated at the outset, the Tribunal dismissed the application on the grounds there was no evidence HCV was a significant contributory factor in the cause of death. It appears from the transcript of the proceedings the Tribunal took the view that when regard was had to the wording of s.4 (1) (e) the traditional causation "but for" test had no

applicability to the determination of the issue with the result that a discussion on the divisibility or otherwise of negligent and non-negligent causes fell away.

36. Instead the focus was on what I shall call the second arm of the provision thereby rendering it unnecessary to consider and reach a determination on the causes of death required to satisfy the first arm. This approach involved the construction of the phrase 'significant contributory factor to the cause of death' contained in the second arm. As mentioned earlier the Tribunal adopted the construction placed on s.4 (1) (e) by O'Neill J., in *R.B. v The Minister*, supra. This appears to have resulted in the imposition upon itself of an obligation as decision maker to be satisfied that HCV had played an active role in the cause of death to a degree which could be said to be non-minimal.

37. The Appellant had advanced the case that HCV had caused or materially contributed to the death of the deceased on the established principles of the material contribution test, a case also advanced on appeal. In this regard it was submitted the approach taken by the Tribunal was erroneous since it resulted in a failure to consider evidence which supported findings that HCV had caused or materially contributed to the death, such as the death certificate and evidence that the septic illness had been exacerbated by reduced liver cell function induced by HCV.

Decision

38. The Court is not concerned, as a matter of law, with the correctness of the approach taken by the Tribunal to the determination of the application or with the construction placed on the relevant part of s.4(1) (e); the appeal proceeds by way of a rehearing *de novo*. Even if the Court were so concerned, the seminal decision of the Supreme Court in *C.M. v The Minister for Health* [2017] IESC 76, which is material to the construction of the provision, had yet to be handed down. For a discussion of the principles enunciated and the application thereof see *A.C. v The Minister* [2019] IEHC 431; and *B'OK v Minister for Health* [2019] IEHC 457.

Burden of Proof

39. With regard to the establishment of the case in general suffice it to say for present purposes that the ordinary rules of law apply; the onus of proof lies on the Appellant to establish, on the balance of probabilities, either that the deceased "*died as a result of having contracted Hepatitis C, or…Hepatitis C was a significant contributory factor to the cause of death*…". Pertinent to the construction of the second arm of this provision it will be noted that the word 'to' rather than the word 'in' is used in connection with the cause of death.

First Arm of s. 4 (1) (e)

40. Insofar as the first arm of the provision is concerned it was submitted on behalf of the Appellant that satisfying the requirement death was due to HCV was not materially different to the test in a negligence action whereby causation is established once the evidence is sufficient to show that the relevant wrongful act caused or materially contributed to the injury complained of. In this regard the Court was referred to the decisions of the UK Court of Appeal in *Bailey v. The Ministry of Defence and Anor* [2009] 1WLR 1052 and the judicial committee of the Privy Council in *Williams v. the Bermuda*

Hospitals [2016] UKPC 4 at paragraph 60, where the principle was applied that a defendant found to have "….*caused or contributed to an indivisible injury, … will be held fully liable for it, even though there may well have been other contributing causes*…".

41. As mentioned earlier, Mr Rogers argued that the death certificate was admissible as *prima facie* evidence probative of the causes of death recorded therein, which included Hepatitis C. The correctness of the details in this regard had not been challenged nor had any application been made to have the certificate corrected or otherwise amended as provided for under s. 41 of the 2004 Act. Nor was there any evidence of an Inquest having been held to establish the causes of death, notwithstanding the record in the notes that the Coroner had been notified and a request made therefore in accordance with the Coroners Act 1962 (the 1962 Act).

42. It followed in the circumstances that the certificate was conclusive evidence of the facts stated therein and consequently was determinative of the requirement that HCV was a cause of death. Alternatively, he argued that the certificate was conclusive evidence for the purpose of satisfying the requirement of the second arm, namely, that HCV was a significant contributory factor to the cause of death.

43. On behalf of the Respondent it was submitted that when regard was had to the evidence of the experts it was not open to the Court to find that HCV had caused the death, moreover, when viewed in the context of sections 13(4) and 42 of the 2004 Act the certificate was merely evidence of the entry in the Register of the fact of death and the particulars thereof. The record of the causes was not evidence of the cause of death as a fact but rather was evidence only of a doctor's opinion in relation thereto at a given point in time. In the absence of statutory authority, the recording of 'Hepatitis C certified' on the certificate as one of the causes of death had no special status, accordingly, it was neither evidentially conclusive nor determinative.

44. In this regard the Court was referred to *Director of Public Prosecutions v Cullen* [2014] 3 I.R. 30; and *Director of Public Prosecutions v. Avadenei* [2017] IESC 77 where in another context the nature and evidential status of certificates issued under the provisions of the Road Traffic Acts 1961 to 2010 was considered. Those statutes confer on certain certificates an evidential status they would not otherwise have; there is no equivalent provision in the Acts. The death certificate was no more than prima facie evidence of facts stated therein, to which very little weight should be given, having regard to the medical expert evidence, addressed as it was to the second arm of s.4(1) (e).

Death Certificate; Statutory Provisions; Certificate as Evidence of Contents;

45. The admissibility of a death certificate as *prima facie* evidence of the facts stated therein is not in question. Suffice it to say that in common law the admission of public documents is an exception to the rule against hearsay. The public document exception is subject to the satisfaction of certain requirements as follow:

(i) the document was created for the purpose of the public making use of and being able to refer to it;

(ii) the document was compiled by a public official in pursuance of a common law or statutory duty; and

(iii) the document was brought into existence with the intention of being retained indefinitely for inspection by members of the public.

A useful discourse on the subject is to be found in Declan McGrath's work Evidence 2nd ed. Ch. 5-para 152 et. seq.

45. While a duly issued death certificate satisfies these criteria, the common law exception in general has been supplemented by an array of statutory provisions that allow for the admissibility of certain classes of public documents, including death certificates. Subject to the provisions of s.68 of the 2004 Act, which provides for compliance with and satisfaction of certain requirements, section 13 (4) provides:

> *"Evidence of an entry in a register and of the facts stated therein may be given by the production of a document purporting to be a legible copy of the entry and to be certified to be a true copy by an tArd-Chláraitheoir (The Registrar General), a person authorised in that behalf by an tArd-Chláraitheoir, a Superintendent Registrar, an authorised officer or a registrar."*

The role of Registrar of Births and Deaths is a creature of statute, arising from the Registration of Births and Deaths Registration Act 1863, as amended by several pre and post-independence statutes.

46. Section 42 of the 2004 Act provides for the recording and certification of the cause of death as follows:

"42.—(1) On the death following an illness of a person who was attended during that illness by a registered medical practitioner, the practitioner shall sign and give to a qualified informant (within the meaning of section 37) a certificate stating to the best of his or her knowledge and belief the cause of the death, and the informant shall give the certificate to any registrar together with the form specified in section 37 (1) containing the required particulars in relation to the death.

(2) Where a registrar is given a certificate under subsection (1), the Registrar shall enter in the Register, together with the required particulars—

(a) the cause of the death concerned stated in the certificate, and

(b) the name and address of the registered medical practitioner concerned."

47. A 'Death Notification Form' as specified by s.37 (1) was duly completed by Dr. Suzanne McPherson. She was a member of the medical staff at the Mater Misericordia Hospital where the deceased, whom she attended, was an inpatient at the time of her death. She certified having last seen the deceased alive on the 15th February 2008, some hours before her death the following day. The content of the form was used by the registrar to

enter the relevant details of death in the Register of Births and Deaths and was admitted in evidence. On the 28th February 2008 a 'Death Certificate' in respect of the death was issued by Karen Talbot, registrar, in accordance with the relevant statutory provisions.

48. The obligation placed on a doctor completing the death notification form is to state to the best of his or her knowledge and belief the causes of death. Part 1 of the form is concerned with certain personal details of the deceased and with medical certification of the causes of death under three headings, namely:

(i) the 'Disease or Condition directly leading to death', meaning the disease which caused the death, against which 'Neutropenic Sepsis' was inserted,

(ii) the 'Antecedent Causes' of death, meaning any morbid conditions giving rise to the cause at (i) above, stating the underlying condition last, against which the conditions 'Immunosuppression' and 'Multiple Myeloma' were inserted, and

(iii) 'Other Significant Conditions' contributing to the death but not related to the disease or condition causing the death, against which 'Hepatitis C' was inserted.

49. Dr. McPherson was required to state her registered medical qualifications, which she gave as MB BCh BAO (Batchelor of Medicine, Batchelor of Surgery). No question arises in relation to her capacity or competency in relation to the completion of the death notification form; she was not called as a witness. The deceased was a patient of Dr Peter O'Gorman, Consultant Haematologist, under whose care she had been admitted, however, the Court was given to understand there was a difficulty in securing his attendance without subpoena and he did not give evidence.

50. Although there was no evidence he had been consulted by Dr McPherson before she completed the notification form there was evidence of a general hospital practice to the effect that if the doctor completing notification form and certificate was not the consultant under whose care the patient had been admitted, the causes of death would be discussed with the consultant before completion of the form.

Death Certificate as Conclusive Evidence of Cause of Death; Conclusion

51. I cannot accept the submission that the absence of a challenge to the correctness of the death certificate renders it conclusive evidence of the facts stated therein and thus binds the Tribunal or the Court as the case maybe. I accept the Respondent's submissions in this regard and am satisfied that in the absence of statutory authority to the contrary the certificate falls to be considered and is to be treated as no more than *prima facie* evidence of the facts stated therein.

52. While I recognise that a death certificate is used for a myriad of important legal and social purposes including the making arrangements for the funeral and interment of the deceased, the administration of estates and the redemption of life insurance policies to mention but a few, it is quite clear from the provisions of the 1962 and 2004 Acts that no special evidentiary status is conferred on a death certificate as contended for on behalf of the Appellant. If it were otherwise one could envisage a situation where arising from the

death of any of the persons specified in s.4 (1) (a), (b) and (c) a qualifying claimant could be wrongfully excluded from admission to the statutory scheme by reason of the omission of HCV as a cause of death from a death certificate.

53. Considering the several provisions of sections 4 and 5 of the Acts on foot of which claims may be brought and awards made arising from the death of a person caused by or where HCV was a significant contributory factor to the cause of death, it is I think notable in the context of the issue under consideration that the Oireachtas chose not to enact any provision to confer an evidential status on a death certificate other than that provided for by s.13(4) of the 2004 Act.

54. Having considered the submissions made together with the terms of s.4 (1) (e) I am satisfied that the proper approach to be taken by the Tribunal or, on appeal by the Court, where a death certificate issued in accordance with the provisions of the 2004 Act is relied upon to support any claim made under s.4 of the Acts is that it should be received as *prima facie* evidence of the facts stated therein. In so far as the certificate states the cause or causes of death, such is, in essence, the statement of an opinion by a registered medical practitioner and the Court so finds in respect of the certificate relied on in these proceedings; it is *prima facie* evidence of the causes of death given by Dr McPherson to the best of her knowledge and belief, no more and no less, a conclusion the meaning of which is particularly relevant in the present context.

55. The Latin expression prima facie, literally translated, means 'of first impression', 'at first sight' or more colloquially 'on the face of it' which used as an adjective in conjunction with the word 'evidence' means 'sufficient to establish a fact or raise a presumption unless disproved or rebutted'. A *prima facie* case means a case where the evidence adduced is such that in the absence of any evidence to the contrary the court or other tribunal of fact would be entitled to make a finding and give a verdict in favour of the party carrying the legal burden of making out the case.

56. It follows that the establishment of a *prima facie* case calls for an answer from the opponent in the absence of which the party making out the case will be entitled to a finding, judgment, or award as the case may be, the corollary to which is that evidence to the contrary adduced by an opponent, if accepted, may lead to the rebuttal of a legal presumption, if any, and/ or rejection of the case advanced.

HCV as a Material Cause of Death;

57. As we have seen, the medical evidence adduced on behalf of the Appellant consists of the relevant medical notes, hospital records, including scans, liver blood tests and medical correspondence over many years relating to the conditions, including HCV, affecting the deceased before her death. In addition to this evidence, the Appellant relied upon the death notification form and death certificate as well as the expert medical evidence of Professor Foster and Professor Schey.

58. The evidence of these experts in relation to the part played, if any, in the death or cause of death was challenged by Respondent's experts, Professor Crowe and Professor Griffin.

Although there was some debate about the causes of death, in the final analysis there was broad agreement between them that HCV was not the immediate, predominant or direct cause of death, a conclusion which, incidentally, is also fairly reflected in the content of the death notification form.

Causes of Death; Conclusion

59. In my judgment it follows that the causes of death recorded in the certificate must be viewed in light of the expert evidence and the content of the death notification form completed by Dr McPherson. In the circumstances I am satisfied, and the Court finds that the Deceased did not die as a result of contracting HCV but rather as a result of a combination of causes. In this regard the immediate or direct cause of death was Neutropenic Sepsis; the immediate antecedent causes or underlying conditions were Immunosuppression and Multiple Myeloma. Consequently, while the requirements of the first arm of s. 4 (1) (e) have not been met the question remains as to whether HCV was a contributory factor to the causes of death and if so whether the contributory factor was significant.

Construction of the Second Arm of s. 4 (1) (e); Approach to Interpretation.

57. Consequent upon these conclusions the Court is now concerned with determining whether or not HCV was a significant contributory factor to the cause of death which, a task which, given the issue, involves a construction of the second arm of s. 4 (1) (e). The approach to be taken by the tribunal or, on appeal the Court, to the construction of any provision contained in 'Redress" statutes, as the Acts have been described, is mandated by the decision of the Supreme Court in *C.M. v. The Minister (supra).*

58. The words are to be construed "as widely and liberally as can fairly be done" or as it was put by McKechnie J. at para 63 of the judgement of the court "Redress" provisions "…are even more deserving of such generous, indulgent and permissive an approach as the Act or a disputed provision thereof will allow". The adoption of this approach does not mean a court is unfettered in construing such provisions, on the contrary, while entitled to be as generous as the terms of the provision reasonably permits the construction cannot be so expensive as would render the interpretation *contra legem*. The Tribunal understandably adopted the construction placed on the second arm by O'Neill J. in *R. B. v. The Minister (supra*), however, that construction must now be viewed in light of the decision handed down subsequently in C.M.

Contributory Factor; Meaning

59. I accept the submission made on behalf of Appellant that a contributory factor is one which influences an event or condition by increasing its likelihood, accelerating its occurrence or by effecting the severity of its consequences. The existence of a contributory factor does not mean that the relevant event would not have occurred without the presence of that factor, on the contrary, this would define a factor as a cause of the event rather than as a contributory factor thereto.

60. Put another way, a contributory factor is a fact or circumstance which influences the occurrence, the nature or severity of an event but its elimination may well not prevent the happening thereof. In my judgement it is quite clear from the words employed in the

second arm of the provision that HCV as a contributory factor is required to contribute to the cause of death rather than the event itself; any other construction would risk rendering the second arm of the provision superfluous.

61. It is apparent on any view one takes of the expert medical evidence that whatever illness or problem the deceased was being treated for, including her multiple myeloma, HCV was consistently identified by the physicians who treated her over many years as a comorbid condition. It is not in dispute that the effect of immunosuppression carries with it the risk of negative consequences, one of which is the ability of the immune system to deal with a virus infection, although once again the experts disagreed as to whether recrudescences of HCV had occurred following the commencement of chemotherapy and consequential immunosuppression.

Multifactorial Causes of Death

62. The causes of death were clearly multifactorial. Having considered all of the medical evidence I am satisfied that it is simply not possible to identify the proportion which each cause played. As mentioned previously, in his evidence to the Court Professor Griffin resiled, for reasons given, from the opinion he had expressed in a report written for the assistance of the Tribunal, namely that the prime cause of death was sepsis syndrome in the course of chemotherapy for multiple myeloma exacerbated by reduced liver cell function induced by Hepatitis C. Professor Crowe when asked essentially agreed with that view and explained that the prospects of survival without the infection would have been better albeit that it was not possible to quantify the prospects in percentage terms.

Conclusion; Contibutory Factor to the Causes of Death

63. Having regard to that evidence, the evidence of Professor Foster and Professor Schey, which I accept, and having due regard to the finding made in relation to the death certificate as *prima facie* evidence of the facts stated therein I am satisfied and the Court finds as a fact that HCV was a contributory factor in Neutropenic Sepsis and the consequences of Immunosuppression, and was therefore a contributory factor to identified causes of death about which there is no issue. However, this conclusion does not determine the issue *in quo* since the Court has to be satisfied not only that HCV was a contributory factor but was a 'significant' contributory factor to the cause thereof.

Meaning of 'Significant' Contributory Factor; S. 4 (1) (e)

64. The word 'significant' is an adjective meaning sufficiently great or important enough to be worthy of attention; noteworthy, meaningful, the opposite to insignificant, meaning too small or unimportant to be worth consideration.

Giving the words of the second arm of the provision as wide and liberal a construction as the words themselves permit the utilisation of the word 'significant' conveys and was intended to convey a sense of meaningfulness and thus best understood as 'meaningful', accordingly, HCV must be a meaningful contributory factor to the cause of death if an applicant is to qualify under the second arm of the provision for admission to the statutory scheme.

65. It is difficult to envisage anything more significant in this sense than an event, condition or other circumstance affecting the prospects of survival, literally the difference between life or death. I am satisfied and find on the evidence that the deceased's ability to fight the sepsis, the predominant direct cause of her death, was impaired due to HCV albeit that the impact on the prospects of survival cannot be quantified in percentage terms.

66. It does not follow as a matter of law, however, that the inability to quantify the prospects of fighting the illness successfully must lead to the conclusion in the circumstances of the case that HCV was not meaningful to the identified causes of death with which it was associated as aforesaid. In this regard the completion and content of the death notification form is of some significance.

67. Dr. McPherson was required to make a judgment call in the completion of the death notification form and in certifying the causes of death. It may well be coincidental that the use of the phrase 'significant conditions contributing to the death' utilised in the death notification form prescribed by s. 37 of the 2004 Act is coincidental with the wording of the provision *in quo* but having inserted details of the disease or condition directly leading to the death and details of any antecedent causes the doctor completing the medical certificate is otherwise only required to give details of "other significant conditions" contributing to the death.

68. This section of the form calls for a qualitative assessment of conditions contributing to the cause of death other than the disease or condition which was the direct or antecedent cause. Only those conditions considered to be contributorily significant are required to be inserted. In response Dr. McPherson inserted 'Hepatitis C' and in doing so she knew her opinion in this regard would be used in the registration of the death, the details thereof and in the issuance of a death certificate upon which reliance would be placed for a myriad of different reasons.

Ruling

69. In expressing this opinion Dr. McPherson was supported and her opinion was, in particular, corroborated by Professor Foster. Consequently, I am satisfied, and the Court finds that HCV was a significant contributory factor to the cause of the deceased's death and thus the onus of proof carried by the Appellant with regard to establishing the requirement contained in the second arm of s. 4 (1) (e) has been satisfied. Accordingly, I will allow the appeal and remit the application back to the Tribunal for the purposes of assessing compensation and making an award; the Court will so order.