THE HIGH COURT

[2020] IEHC 572

[2017 No. 4712 P]

BETWEEN

WARREN HARFORD

PLAINTIFF

AND

ELECTRICITY SUPPLY BOARD

DEFENDANT

JUDGMENT of Ms. Justice Bronagh O'Hanlon delivered on the 2nd day of June, 2020

Background to the case and pleadings

1. The plaintiff, a 45-year-old network technician employed by the defendant, for the previous twenty years, was instructed to repair a public light on Highfield Road, Rathgar, in the County of the City of Dublin. The plaintiff was directed to use an Ariadne ICIG machine furnished to him by the defendant on 14th December, 2014 instead of the usual "grumbler" machine which he used as a matter of practice in the past.

2. In the course of his duties on that occasion the plaintiff who had not been trained in the use of this machine for the purpose of cable identification by virtue of the inadequacy and lack of suitability or safety of the said equipment, was exposed directly to a 10,000-kilovolt live cable.

3. A personal injuries summons was issued on behalf of the plaintiff on 24th May, 2017 in which he pleaded that the defendant was guilty of negligence, breach of duty, breach of statutory duty and breach of contract in that the defendants failed to provide him with a safe system of work, a safe place of work and necessary and adequate equipment. The plaintiff's claim was that by virtue of the failure of the Ariadne ICIG cable he was caused to handle and to be exposed to a 10,000 kilovolt electric cable, as a result of which he sustained a medically recognised psychiatric injury which is ongoing, although he did not sustain physical injuries in this incident.

4. A full defence was delivered on 23rd January, 2018 denying the allegations pleaded. It was further argued damages were not awardable to the particular incident in that it was argued that the plaintiff's injuries were too remote and were not reasonably foreseeable and causation issue was also argued.

5. In open correspondence by letter dated 19th December, 2018 negligence was admitted, was claimed not to extend to matters relating reasonable foreseeability, causation or remoteness of the alleged personal injuries loss or damage. It was accepted in that letter by the defendants that the Ariadne equipment provided was unsafe and unsuitable and that the plaintiff was not trained in the use of that equipment. Nonetheless the nervous shock claim was strenuously defended.

The plaintiff's evidence

6. The plaintiff attended South Lotts Road, Ringsend on 12th December, 2014 where his supervisor allocated him the day's work and dispatched him with his crew of two people. He was given the Ariadne machine referred to above, although he hadn't been trained in

it and he had only seen it in use by one person prior to himself. He identified with reference to photographs, a switch box which he said basically had ten cables in it which were fused and which go in different directions to feed houses and estates. He had opened it, attached the Ariadne LCIG to it and reference was made to his seeking a trace on a cable at the lampstand where the fault had been reported and he put the tracer on the cable to identify the cable and the Ariadne equipment as applied to the cable was giving him a percentage reading of 28% which defied interpretation by him. He said that this machine was wrong and no matter what cable it was put on the signal went into every cable. He commenced stripping the cable and described how he opened it. The plaintiff described a complicated system to shut out the cable from the electricity supply as an MV cable is a 10,000-kilovolt cable which cannot be worked on live. He then continued to strip down the cable leaving three copper cores visible to confirm that he had the correct cable went as if to use his test lamps as readers of voltage to confirm same.

7. The plaintiff stood out of the hole and halfway out looked back, something caught his eye and did not look right so he went back into the hole felt around the cable and found three cores indicating to him that this was in fact a 10,000 kilovolt cable and the minute he realised that he got out of the excavated hole and rang his supervisor and the defendant company reported this as a P1 incident the highest classification of dangerous level of incident.

8. The plaintiff confirmed that if one sticks a test probe into a medium voltage 10,000 kilovolt cable it would burn a person explode or result in their death.

9. The plaintiff was upset at the investigation which occurred following the incident which had sought to blame him for having done something wrong and although he sought three changes to the statement in three respects, he was dissatisfied with the outcome of that. The Ariadne machine was withdrawn for use by network technicians and has not been used since the incident in question.

10. The plaintiff described how the cable was down to a wrap of paper around the individual core at the crucial point and that although he didn’t think the cable looked right when he looked back he denied that at that stage he thought it was a three core cable but he went into the hole had a feel around the cable and then realised there were three cores and he was touching the cable when working with it and he had not scratched through the final piece of insultation and had realised on visual inspection that there were three cores. When the plaintiff looked back into the hole, he did not think at that stage that it was a three-core cable. The plaintiff agreed that if he had not left the hole to get his test lamps from his van, he would not have seen that the cable looked wrong and would have stuck the test probes into it and thereby have been electrocuted. He realised that it was a medium voltage cable and was shocked by what could have happened and that on visual inspection he realised he was handling the wrong cable but he said to get visual inspection he had to strip the cable which meant that his hands were on the cable at different stages of the process of cable identification. The effects of this incident on him

as described in detail by him in court, are dealt with in the medical evidence of Dr. Fitzmaurice in particular.

Mrs. Harford's evidence

11. The plaintiff's wife gave evidence that prior to the incident she and her husband had a good marriage notwithstanding difficult life events concerning the loss of a baby and a health diagnosis in relation to another of their children. Mrs. Harford gave evidence of significant change in her husband following the incident and up to the date of hearing. Despite the help he sought and treatment he received from mental health services.

Expert evidence of Dr. Brian Fitzmaurice, Consultant Psychiatrist, St. James's Hospital

12. This witness's clinical opinion was that the plaintiff suffered and continues to suffer from concomitant post traumatic stress disorder and depression.

13. This witness explained that the ICD 10 is the current world health organisation's classification of psychiatric illness used by psychiatrists and that DSM V (diagnostic and statistical manual of mental disorders is the American Psychiatric Association document. He stated that ICD 11 is due to be published soon.

14. Having described post traumatic disorder as a well-recognised disorder, the opinion of Dr. Fitzmaurice was that between 40 and 50% of people who suffer from post-traumatic stress disorder will go on to develop a depressive disorder. He added that the co-occurrence and co-morbidity between post traumatic stress disorder and depression is remarkably common and that it is often many many months or years after the event before a person presents to a psychiatrist with this disorder. Dr. Fitzmaurice agreed that criteria A of DSM V is were a person is exposed to death, threatened death, actual or threatened serious injury or actual or threatened serious violence and he categorised the degree of exposure in the plaintiff's case in terms of his own clinical judgment to be one of threatened serious injury at least and he believed that it would have constituted a threat of serious injury potentially fatal. He found that the plaintiff fulfilled criterion A in that he found that there was direct exposure. he noted that the plaintiff had intrusive symptoms, intrusive memories, memories which wasn't recalling but that which were popping up into his mind which he described as one of the intrusive kinds of symptoms. He noted a lot of anxiety symptoms and psychological distress in the plaintiff which he felt were tied to the kind of memory of the incident which the plaintiff experienced. Following his interview with the plaintiff on 6th September, 2018 he formed the view that a person such as the plaintiff in a hole as described with the 10,000-volt live wire would have been in a situation constituting actual risk and actual danger.

15. This witness gave his clinical opinion that the symptoms in this case suffered by the plaintiff were quite subtle but he was satisfied that he had intrusive phenomena on a recurrent basis over weeks and months after the initial incident and that the plaintiff then developed chronic systems of post traumatic stress disorder and went on to develop a more depressive illness and that the effect of these intrusive symptoms is quite severe on the body and feelings and that the fact that a person such as the plaintiff did not wish to speak about them was quite consistent with the illness. This witness described the

plaintiff as having a moderate to severe depression as well as PTSD and that he fulfilled the criteria for a major depression disorder, distinguishable and referable to DSM V.

16. Dr. Fitzmaurice said that in his clinical opinion it is what a person thinks about what they have experienced or witnessed that is important and that any argument about delayed exposure did not change his clinical view. He disagreed fundamentally with Dr. Stephanie Bourke, Consultant Psychiatrist who gave evidence when called by the defendants who had found a mild depressive symptom and that the plaintiff did not meet the criteria on her view that he did not fulfil criteria A for post traumatic stress disorder.

17. Very importantly Dr. Fitzmaurice gave his evidence that there was no curative drug treatment for PTSD and while anti-depressant medications in some cases have modest effects in reducing symptoms, he said psychological treatments are the most effective treatments for PTSD. He noted that the plaintiff had been on Citalopram, Duloxetine and Mirtazapine. The plaintiff noted significantly that psychologists don't generally treat mild depression with pharmacological agents. He noted that the plaintiff had made efforts to access their psychological service with difficulties in the service at that time and he explained how that had worked out. Dr. Fitzmaurice was very adamant that the plaintiff's GP and every psychiatrist who had seen him noted that he had more severe symptoms than just mild depression and thus differed from Dr. Bourke in that regard.

18. In terms of prognosis he noted that the plaintiff has continued chronic symptoms from both PTSD and depression.

19. This witness categorised DSM V reference to a major depressive disorder as equating to a depressive episode in ICD 10 which is then categorised as mild, common moderate or severe and he said that a major depressive episode usually equates to a moderate or severe "depressive episode" and he said its recognisable psychiatric illness in both kinds of diagnostic modes.

20. The plaintiff was first seen by Dr. Fitzmaurice as a patient in July, 2017 at a standard out-patient appointment not for the purposes of legal report but that the request for same gave rise to the consultation he had with him on the 6th September, 2018. At his first meeting he had to ensure the safety of the plaintiff and had to deal with the possibility of suicide risk which he ruled out at that time.

21. It was the plaintiff's intrusive symptoms which brought him within the ambit of a diagnosis of PTSD according to Dr. Fitzmaurice. He said that although flashbacks and nightmares are part of PTSD and are common symptoms but the intrusive symptomology other than flashbacks and nightmares did not preclude the plaintiff from a diagnosis of PTSD and in that regard, he stressed the plaintiff having had intrusive thoughts. He noted that the GP had requested that the plaintiff be appraised by a psychiatrist and that the junior registrar who saw him in April, 2017 who worked under Dr. Fitzmaurice noted that he had PTSD symptoms alongside depressive symptoms.

22. This witness clarified that he noted that the plaintiff's situation was that he had suffered from avoidance within work rather than avoidance of work and that hyperarousal, intrusive images, avoidance of triggers/reminders were still present although not as severe nor as frequent nor as intense as before and he felt that this was probably attributable to the above average dose of Mirtazapine medication the plaintiff was on compared with previous treatments. He noted that the plaintiff was less depressed and that he had recently begun cognitive behavioural therapy. This witness diagnosed PTSD as present from the index event until in 2014 until June, 2019 and he expected that the CBT therapy if continued would require between six months to a year to have good effect depending on the frequency of treatment, six months of the therapy were weekly and a bit longer if it were fortnightly. His clinical opinion was that it was more likely that the PTSD had triggered the depression and that once the PTSD symptoms are gone and a person is relieved of that stress they are less likely to have a recurrence of depression although other life events can contribute to that but it wouldn't be caused by the PTSD in the first instance.

23. Dr. Fitzmaurice noted that Dr. Bourke's prognosis as a guarded one is inconsistent with a clinical conclusion by that expert of mild depression. This witness thought that shying away from talking about what had happened was quite consistent with a person effected by what are hot aversive memories which people do not like and which affect the body and feelings intensively.

24. Dr. Fitzmaurice made the point that he wouldn't expect a GP to identify all the subtle differences between various symptoms of PTSD back in 2013. He said some of these symptoms are actually quite subtle which take time to clarify and crystallise. He took the view that the plaintiff was suffering considerable intrusive phenomena on a recurrent basis that seemed to him to have arisen in the weeks and months after the index episode. He also makes the point that there is no curative drug treatment for PTSD that some anti-depressants have a modest effect and that Mirtazapine while it may have a good effect, it is still not curative and that psychological treatments are the answer for effective treatment for post-traumatic stress disorder. Although he sees the plaintiff as having greater severity of depressive symptoms either between moderate to severe. He said that every psychiatrist and his GP who have seen the plaintiff would put him as having much more severe than just mild depressive symptoms. He said he continued to have chronic symptoms of post-traumatic stress disorder and chronic symptoms from depression. He felt that in DSM V the idea of major depressive disorder is used and he said that equates to a depressive episode in ICD 10. He believed that major depressive episode equated with a moderate or severe depressive episode.

25. In July, 2017 the doctor said he was in a very busy review outpatient clinic and he said he was prioritising because he was confronted by somebody who was very depressed and was concerned about suicidal risk so he was putting in the most relevant factors in his assessment, and he said you have to adequately treat the depression because of the safety issues and he explained that while Dr. Dolan who saw the plaintiff on 25th May that year concluded that he had post-traumatic stress disorder symptoms but that in her

opinion he did not fulfil criterion A, although he had all the symptoms characteristic of it, and she believed that it was more of a theoretical risk that he had been exposed to rather than an actual risk.

26. Dr. Fitzmaurice points out that in the diagnostic criteria in the ICD 11 draft (not yet enforced) that this actually removes the kind of semantics around exposure and actually classifies this new criterion A as being exposed to a horrifying or very upsetting event because in the sense that is what the toxic agent psychologically. He stresses that DSM V now represents thinking which maybe ten years old and that the current thinking and ICD 11 in its draft form on post-traumatic stress disorder is that the criterion A has moved from the semantics of exposure and exposure to what for how long to the fact that it is the individual who is exposed and when they are exposed to something that is very upsetting or horrifying, that fulfils the criterion and that is the psychiatrist understanding of what is psychologically toxic that actually then generates a syndrome of intrusive memories, or physiological arousal, of disruption of sleep of nightmares of flashbacks all of those different things. Dr. Fitzmaurice goes on to say the exposure to him is very clear that it is to an upsetting and horrifying event and that the plaintiff has had direct exposure to danger. Dr. Fitzmaurice stressed that while exposure is important in fact that it is what one actually thinks about the incident that generates the PTSD syndrome. He accepts that he can only speak of medicine rather than law. It was put to this witness that there wasn't a single mention of panic, intrusive thoughts, nightmares until later than this accident in the notes and records of Dr. O'Sullivan the GP. But that he does use the words "panic attack" in 2013 prior to the accident. This witness was of the view that the GP had described what constituted classic kinds of flashbacks in the form of intrusive memories, different to flashbacks, that the plaintiff didn't show classical symptoms of flashbacks and nightmares which are usually associated with people with PTSD but was presenting with more subtle forms of same. He said the fact that he doesn't have flashbacks and nightmares doesn't preclude him from PTSD because he has other intrusive symptomology other than flashbacks and nightmares. This doctor was of the view that the first doctor who saw the plaintiff on referral from the GP was of the view that he had PTSD symptoms alongside depressive symptoms and he said he concurred in discussion that these are the most likely diagnosis.

The evidence of Dr. Stephanie Bourke, Clinical Psychologist at Blackrock Clinic, Co. Dublin

27. This witness gave her assessment of the plaintiff as falling beneath the bar in terms of criterion A of the DSM V constituting post-traumatic stress disorder on the basis that there no injury, no visual trauma no aural trauma and that the incident itself was not in her opinion traumatic.

28. What is important to note about Dr. Bourke's evidence was that she confirmed she had only seen the plaintiff once before preparing her report and she had not been aware that the plaintiff had no experience of the Ariadne machine in question. This witness had relied on a history given by the plaintiff at one consultation and she agreed that she may have incorrectly recorded events in her notes of what had occurred. She agreed that she was not aware of the evidence that had been given by the plaintiff regarding the process

undertaken by him when the incident occurred. She was not aware that the plaintiff had handled a high voltage cable and he had not reported this to her in her interview with him.

29. This witness confirmed that the plaintiff had depression or episodes of depression which she conceded was a recognisable psychiatric incident which occurred as a result of the accident in question. She did note that Dr. Fitzmaurice had come to a different conclusion and that he had been the treating doctor.

30. Upon re-examination by Senior Counsel for the defendant this witness agreed that she did not have an understanding of the plaintiff's stripping of the cable in question. Dr. Bourke also agreed that she was not aware that the plaintiff had not been trained in the use of the Ariadne equipment.

31. This witness had told Dr. Bourke that he found it difficult to work following the accident and that he was avoidant of front-line electrical work that he would try and allow his colleagues do the cold face work. He began to have sleep difficulties and was very upset by the work base official report following the investigation after this accident which blamed him for the incident and he didn't agree with it and was quite upset by it. She noted that his GP had put him on anti-depressant medication some months following the accident and that he had accessed counselling/psychotherapy through the employee assistance programme at work but did not find the counselling helpful.

32. He was referred to a psychiatrist two years prior to her meeting him i.e. two years after the incident and had been placed on Duloxetine and Citalopram and was attending the outpatient in St. James's Hospital Psychiatric Services were he had a missed appointment for psychological counselling which was later explained by Dr. Fitzmaurice in the difficulties in providing a service at that time. He described to her lack of motivation, lack of sociability, racing thoughts, sleep difficulties with a recent diagnosis of sleep apnoea.

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35. As against this Dr. Bourke, Consultant Psychiatrist in her report of 18th June, 2019, while she agrees that he didn't have full details about the actual incident, under cross examination, nonetheless she notes that no one including the plaintiff was injured during this incident and that he reported that he was somewhat perturbed that it was only at the last minute that he recognised the danger of the cable, that he was thinking about the incident and what might have happened had he touched the cable.

36. Dr. Bourke couldn't deny that she couldn't relate his sleep difficulties totally to sleep apnoea or the use of CPAP machine and while she didn't give any reasons while she agreed he told her about rumination that that didn't meet the necessary criterion B1 for PTSD and she described his explanation to her as a form of rumination but she said typically in PTSD it's about the event in itself whereas rumination is more about "what if". She felt that the plaintiff did not report to her in his history the description of something to cause intense or prolonged distress after exposure to traumatic reminders in terms of criterion A, although she did accept that he met the criterion for depressive symptoms, she did not feel that he had an intensive prolonged distress reaction although the plaintiff had told her that he was avoidant of work. He said he didn't describe to her distress or anxiety. This witness denied direct exposure as compared with Dr. Fitzmaurice. She explained that it is still does not meet the criteria of her understanding of how one would come to the conclusion that a person has PTSD. She agreed that he did have visuals and she said there was a realisation around the event that it could have been potentially lethal and again she did not feel it met the criteria for what is meant by trauma related to PTSD. She said she couldn't deny that he did actually touch the wire. She agrees that there is a limited benefit for medication in the treatment of PTSD. She said that junior doctors in training are actively making assessments and diagnosis of psychiatric disorders. This witness agreed that persistence avoidance of reminders, triggers are essentially symptoms of PTSD. That certainly negative or alterations in mood or cognition or in the criteria of PTSD and that they are also in the criteria for depression. This witness described concern about the chronicity of symptoms and was guarded about the plaintiff's prognosis. She felt that the psychological process is difficult to put a time on but that it sometimes can take up to a year for therapy to work. In consideration of issues such as causation, proximity and whether the matter was reasonably foreseeable the plaintiff must establish not only that he was shocked but that his shock was caused by a sudden horrifying event.

Evidence of Mr. Michael Barry, employee of the ESB

37. This witness gave evidence that he was the plaintiff's supervisor on the date in question. He described the plaintiff's mood as very explanatory on 12th December, 2014 and as fine and in control of the situation. On the Monday following the investigation a re-enactment occurred in which the plaintiff took part. On Tuesday the 16th December the plaintiff went sick and went to his GP who provided a certificate and the plaintiff was off work until January, 2015. In July and August, 2015, the plaintiff then provided sick certificates from his GP Dr. O'Sullivan and this witness indicated that the plaintiff had the use of a buddy system for a couple of weeks. Work pressures and resources were part of the reckoning and he ceased to be the plaintiff's supervisor in July, 2016. He had not

noted that the plaintiff wanted to delegate duties or was afraid to do the work himself. He agreed that the plaintiff had never been officially trained to use the Ariadne LCIG machine nor had he any training in it and he agreed that it was probably because of the equipment issue the defendant had admitted negligence in the case. He believed that the plaintiff was probably justified in his complaints about the work-based report following this incident and the concern about his requests that it be amended. He did agree that this would have caused additional stress and distress to the plaintiff arising out of the accident. He noted that although the official report was amended on three occasions, that the plaintiff was unhappy with it and he fully agreed the Ariadne IG and also the LCTX testers were banned after the incident. He said it would have been an exceptionally frightening experience and that the medium voltage was between 10,000 and 20,000 volts. He said this was an infrequent occurrence and that he himself was exposed to one such incident twenty years before and that although he himself did not have an adverse reaction he accepted that the plaintiff did have an adverse reaction and that different people react in different ways.

Evidence of Mr. Liam McDonagh, ESB employee

38. This witness explained that he became the plaintiff's supervisor on 10th July, 2016. He believed that the plaintiff worked as normal and he did know that the plaintiff had been out of work with stress issues. He confirmed that they had received a memorandum banning the Ariadne LCIG after this incident and he could 100% understand how a person would become "freaked out" by what had happened.

Submissions on the law

39. Both sides accept that it is not necessary for there to have been a physical injury to the plaintiff and refers to *Byrne v. Southern and Western Railway Co.* Court of Appeal February [1884] discussed in *Bell v. Great Northern Railway Co.* [1890] 24 LR (I.R. 424).

40. The defence submissions refer to the Supreme Court decision of *Fletcher v. The Commissioners of Public Works* [2003] 1 I.R. 481 that in *Fletcher's* case he had been told that there was risk, albeit a very remote one of him contracting a painful and potentially lethal disease. By comparison the defence argued that in the instant case the plaintiff became aware that he was working unwittingly with a 10V cable and the argument is made that there was not any risk whatever of injury not to mention a remote one and that he had no reason to be apprehensive of physical injury. It is submitted that in the common law in Ireland where the aftermath cases relate either to an event or the situation in its immediate aftermath. Reference is made to *Courtney v. Our Lady's Hospital and Others* [2001] IEHC 211. It is argued that there must be an event or at most a series of event that is events that are horrific in nature. Reference is made to *Kenny v. St. James's Hospital* unapproved judgment of 4th June, 2014 (O'Hanlon J.) and it was submitted that the Kenny case is a classic example of a nervous shock case squarely and unambiguously satisfying the five *Kelly v. Hennessy* requirements.

41. Reference is made to *Keeve v. HSE* [2019] IEHC 370 which involved a discussion where there was a preliminary issue. MacGrath J. noted that there was a general reluctance in this jurisdiction to extend the duty of care owed in respect of psychiatric injury/nervous

shock as evident in the Supreme Court decision *in Fletcher v. The Commissioner of Public Works* in Ireland where it was held that it was unreasonable to impose a duty of care on employers to guard against mere fear of disease even if such fear might have led to a psychiatric condition. *Devlin v. the National Maternity Hospital* reaffirmed the principles in *Kelly v. Hennessy* and *Fletcher v. The Commissioner of Public Works*. Nervous shock sustained by the plaintiff must be by reason of actual and apprehended physical injury to the plaintiff or a person other than the plaintiff and that damages for nervous shock could only be awarded where a person has perceived an accident or its immediate aftermath and suffered a recognised psychiatric illness. MacGrath J. while he reviewed the Australian Authorities, he was not in any sense indicating that Irish Law should adopt the extension suggested in the Australian cases. Mahon J. in *Curran v. Cadbury Ireland Limited* [2000] 2 ILRM found that the plaintiff was a participant in and not a mere observer of the accident. It is submitted in relation to the decision of Denham J. in *Devlin* which refers to perceiving the accident or its immediate aftermath and that the event in the case of a primary victim must have caused the plaintiff to have fear/apprehension of impending physical injury to himself and it is submitted that a person's internal realisation, as opposed to perception or appreciation by the senses will not suffice.

42. The defendant's submissions are to the effect that for the plaintiff to be successful the plaintiff must come within the five requirements identified by Hamilton C.J. as set out above. Reference is made to the Law of Torts (4th Ed. 2013) Mahon & Binchy by counsel who argue that since the requirement in condition II in *Kelly v. Hennessy* was that a shock must be a sudden horrifying event or a non-broken series of horrifying events and not a psychiatric illness caused incrementally over a period of time, the plaintiff in this case must establish that he was shocked by a sudden horrific event. Reference is made to *East Donegal Cooperative Livestock Mart Limited v. Attorney General* [1970] I.R.317 in relation to actual or apprehended breach of constitutional rights and reference is made that there must be a prevention of "the threatened or impending infringement of the guarantees and put to the test an apprehended infringement of those guarantees. In this regard it is argued that there must be proof of actual and real danger or a strong probability like in the case of *Szabo v. Esat Digiphone Limited* where Geoghegan J. quoted with approval from the decision in *Attorney General (Boswell) v. Pembroke Joint Hospital Board* [1904] I.R. in that regard. The defendant cited the case of *Fletcher v. Commissioner of Public Works* [2003] 1 I.R. 481 and argued that in that case the plaintiff had a stronger basis for a claim in "nervous shock" in which he was unsuccessful than the plaintiff in the present case as the former had an apprehension of injury in the future in that there was a remote possibility of developing Mesothelioma whereas in the present when the plaintiff became aware that he had been unwittingly working a 10,000 KV cable he was not at risk of injury nor had any reason to be apprehensive of one.

43. Essentially the defendant's submissions are to the effect that in terms of the nervous shock jurisprudence the present case ought to be assessed similarly to the Supreme Court's assessment in *Fletcher* and reaffirming that for the plaintiff to succeed the conditions set out in *Kelly v. Hennessy* must be met. Reference is made to *Jaensch v. Coffey* [1984] 155 C.L.R. 549 that the psychiatric illness must be induced by shock. In

which there is a differentiation from the development of a psychiatric illness caused over time by various assaults on the nervous system by quoting Lord Ackner in *Alcock v. Chief Constable of Yorkshire* [1992] 1 AC 310 at pp. 400 - 401 and "shock it is submitted in the context of this cause of action involves a sudden appreciation by sight or sound of a horrifying event, which violently agitates the mind". Lord Ackner continued by holding that there would be no finding for liability in a nervous shock claim where there was no sudden participation of a frightening event or its immediate aftermath. Reference is made to *Devlin v. The National Maternity Hospital* [2008] 2 I.R. 239 and the submission is made that the receipt of bad and sad news did not satisfy the fourth condition in *Kelly v. Hennessy.* It is submitted essentially with a review of a number of authorities that the present case lacked the necessary elements such as there being a horrifying and shocking event and the apprehension of physical injury and it is argued in these submissions that what was experienced was a subsequent realisation that physical injury had been avoided. It is further argued that this is a near miss situation. It is also argued that the injuries are to remote in law and were not reasonably foreseeable by the defendant whether in respect of the plaintiff or in respect of any person of ordinary fortitude. It is argued that this work was something the plaintiff did and in respect of which he used all his skills and experience in his daily work and Dr. Bourke's evidence is referenced in that regard. In her opinion not only did he not meet criteria A for a diagnosis of post traumatic stress disorder but she denied that he met criteria B either and felt that he did not describe intrusive symptoms but rather depression although she accepted that she had met him several years after the event. Though she noted that he continued to ruminate she did not contain that view in her report and that would be a factor which would qualify him for criterion B1. She accepted that he described avoidance as per criteria C and felt he didn't describe to her intense or prolonged distress or anxiety and she felt his difficulties going to sleep at night could totally relate to sleep apnoea or the use of a CPAP machine and could not deny that this may have been as a result of the accident. She agreed that his man clearly had visuals in that he had clearly seen the event and that there was a realisation around the event that could have been potentially lethal but she was still of the view that this was not sufficient for a diagnosis of PTSD. She could not deny that the plaintiff did touch the wire in question she accepted that Dr. Fitzmaurice had referred to hyperarousal persistent avoidance of reminders and triggers in his reports as well as negative alterations in cognitions, and mood associated with traumatic events.

44. Counsel for the defence referred to *Walters v. North Glamorgan NHS Trust* [2002] EWCA Civ. (1792) where Ward L.J. held that a series of events over a 36 hours culminating in the death of a baby constituted an event however it required a sudden and direct visual impression on the claimants mind of actually witnessing the event or its immediate aftermath.

45. Reference is made to *Courtney v. Our Lady Hospital and Others* [2011] IEHC 211 and while this was an assessment of damages only by O'Neill J. he did observe orbiter at para. 5 that the claimant had sustained intense shock in reaction to a horrific event and this

case took into account that the circumstances of the case demonstrated that an event can occur over a period of hours to cause a shock induced "injury".

46. Reference is made to *Singleton v. HSE* [2008] IEHC 270 O'Hanlon J. where the five conditions in *Kelly v. Hennessy* it is stated had to be met for a claim to be successful in nervous shock. This case it was decided on the lack of credibility of the plaintiff and her inability to come within the five points in *Kelly v. Hennessy* and was distinguished from the decision of O'Hanlon J. in *Michelle Kenny v. St. James's Board* where the claimant had suffered a recognised psychiatric disorder as per DSM V in reaction to a shocking/horrifying event which was in fact the fact that she had received a false positive HIV blood result delivered over the phone which caused an immediate, current, rational and continuing apprehension that she was suffering from a life-changing medical condition.

47. Reference is made in these submissions to MacGrath J. in *Keeve v. Health Service Executive* [2019] IEHC 370 and a discussion concerning other jurisdictions in relation to the established duty of care and the criterion to permit recovery for nervous shock which is caused in a gradual manner (*Jaensch v. Coffey* [1984] HCA 52 and *Annetts v. Australian Station* [2002] HCA 45 etc. It is noted also that there are a variety of interpretations on this area of law depending on the different states in Australia and that the *Keeve* case referred to a discussion around O. 29, r. 18 and it was not a full hearing on a particular case but it was the balancing as to whether or not the notice of motion reliefs ought to be acceded to in the *Keeve* case. It was argued that *Curran v. Cadbury Ireland Limited* [2000] 2 ILRM where a claimant could recover damages for psychiatric illness without physical injury, the present case it is argued in these submissions lacked the necessary elements such as there being a horrifying and shocking event and the apprehension of physical injury and it is argued that all that was experienced was the subsequent realisation that physical injury had been avoided.

The plaintiff's legal submissions

48. Reference is made to *Mullaly v. Bus Eireann* [1992] 1 LRM 722 where Denham J. dealt with the issue of foreseeability in nervous shock. The Supreme Court accepted that all of the events which gave rise to the plaintiff's disorder were caused by the defendant. It was found to be negligent. The court also concluded that there was a legal nexus between the actions of the defendant and the resulting aftermath of the accident to which aftermath the plaintiff had been exposed. The defendant's duty of care was found to extend to injuries that were reasonably foreseeable, including psychiatric illness caused by its negligence. This case involved a plaintiff who travelled to a hospital on hearing that members of her family were involved in an accident and in the hospital, she witnessed distressing and appalling scenes arising out of the injuries to her family and developed post-traumatic stress disorder.

49. The parameters of *Kelly v. Hennessy* [1995] 3 I.R. 253 sets out the criteria which must be met to succeed in a claim for nervous shock.

(a) The plaintiff must be suffering from a recognisable psychiatric injury.

(b) The recognisable psychiatric injury must be shock-induced.

(c) The nervous shock must in turn be caused by the defendant's negligent act or omission.

(d) The plaintiff must adduce evidence that there was actual or apprehended injury to themselves or to another person.

(e) The Plaintiff must show that the defendant owed him/her a duty of care not to cause reasonably foreseeable injury in the form of 'nervous shock'.

50. In this case the Supreme Court found that the plaintiff was entitled to damages as against the defendant for psychiatric injury caused by the defendant's negligence, and that where a plaintiff witnessed the aftermath of an accident concerning injuries to a person or persons with whom the plaintiff had a close relationship, damages were recoverable. The submission is made that on the evidence in this case of Dr. Fitzmaurice and Dr. Bourke, the plaintiff suffered and continues to suffer from recognisable psychiatric injury, arising out of the incident in question, albeit that Dr. Bourke, expert for the defendant, limits the recognisable psychiatric injury suffered to one of mild depression only.

(a) The plaintiff's post-traumatic stress disorder and/or depression were induced by the shock of his exposure to the 10,000 kilovolt cable

(b) The defendant was and admits that it was negligent.

(c) The plaintiff gave evidence that he apprehended injury to himself.

(d) The defendant owed the plaintiff a duty of care not to cause reasonably foreseeable injury and that it was foreseeable that if exposed to the risk of electrocution or death the plaintiff would and did suffer a recognised psychiatric injury.

51. The submission was made that *Alcock v. Chief Constable of Yorkshire Police* [1991] 4 ALL ER, it is submitted that in this case the plaintiff was primary victim having been physically present at and physically exposed to the risk of potentially fatal electrocution and thus the issue of distinction between primary and secondary victim does not arise and that in that regard *Alcock* is of little use by reference to the instant case.

52. The submission in this case is that in order to refute the defendant's contention was that the plaintiff did not realise the cable was a 10,000 kilovolt wire until after he had exited the hole in which he was working. The submission on behalf of the plaintiff is that while no precise evidence was given of the amount of time which passed it is submitted that the plaintiff's realisation that he had been exposed to potential fatal electrocution could not have been more than a few seconds after the physical handling of the live cable.

53. Reference is made to the leading textbook on post-traumatic stress disorder by Ms. Gillian Kelly quoting the Australian case of *Annetts v. Australian Stations Pty Ltd*. [2002] 211 CLR at 31. It is noted that the High Court in that case found that there was sufficient

proximity between the parents and the defendant as the boys' employer and that in combination with reasonable foreseeability of harm there was a duty of care even though the boys' parents did not witness their son's death.

54. In *Dooley v. Cammell Laird & Co. Limited* [1951] 1 Lloyd's Rep 271 this was a work based accident where the plaintiff believed that he had killed or seriously injured co-workers who were in the hold of a ship, when in fact no injury was caused to them, but the plaintiff suffered a psychiatric injury as a result of his mistaken belief. O'Donovan J. stated in that case: "if he the driver of the crane concerned fears that the load may have fallen upon some of his fellow workmen, and that fear is not baseless or extravagant, than it is, I think a consequence reasonably to have been foreseen that he may himself suffer a nervous shock".

55. Reference is made to *Curran v. Cadbury Ireland Limited* [2002] 2 ILRM at 343 where the plaintiff turned on a machine at work when unknown to her a fitter was inside the machine carrying out repairs. As a result of the screams and commotion which occurred and her belief that she had either killed or seriously injured another person as a result, she suffered a serious psychiatric illness. The Circuit Court held that the plaintiff qualified as being within the range of persons to whom a duty of care was owed and that as an employee of the defendant and that the duty extended to protecting an employee from non-physical injury. The court also found that there were clear failings on the part of the defendant in respect of the system of work and that the plaintiff had suffered a compensatable injury, reasonably foreseeable in all the circumstances. McMahon J. noted that "the questions that rightly exercise the court's in *Mullaly v. Bus Eireann* and *Kelly v. Hennessy* … need not concern us in the present set of circumstances. The control mechanisms which courts feel necessary to introduce in the case of bystanders and aftermath victims are not required here.

56. With reference to *Fletcher v. The Commissioner for Public Works* [2003] 1 I.R. 464 the Supreme Court refused to extend the parameters of the law in nervous shock where the plaintiff was found in the absence of physical injury to seek recovery for psychiatric injury due to what they described as irrational fear of contracting a disease, following negligent exposure to health risk by the employer. Public policy was an issue in terms of fear of disease cases and the undesirability of awarding damages to plaintiffs who had suffered no physical injury and, when the psychiatric condition was solely due to objectively irrational and medically unfounded fears of contracting a particular disease. In that case Keane C.J. (as he then was) stated that if the risk in that case of Mesothelioma was probable, it would be unjust and anomalous that the defendants would escape liability. At an earlier point in this judgment I expressed the view that the law would be in an unjust and anomalous state if a plaintiff who was medically advised that he would probably suffer Mesothelioma as a result of his negligent exposure to asbestos could not recover damages for a recognisable psychiatric illness, which was the result of him being so informed. I am so satisfied that in cases where there is no more than a remote risk that he will contract the disease, recovery should not be allowed for such a psychiatric illness. The submission is made that this situation is entirely distinguishable of the objectively

irrational fear of contracting a disease as in *Fletcher*. The medical examination and evidence in *Fletcher* was that the plaintiff's pulmonary function was normal and that he had no pleural plaques. The danger of developing further pulmonary disease as a result of exposure was very remote. It is further submitted that no public policy issues arise in the instant case. It was submitted that there is no question in this case of the plaintiff's fear of electrocution or death being irrational, whether subjectively or objectively, or that his fear was in anyway unfounded, or that the plaintiff was not a person of reasonable fortitude. It is submitted that the plaintiff sustained a sudden shock upon realisation that he had been exposed to the cable and not by chronic stress or deprivation such as might arise when coping with serious illness. The plaintiff was exposed to the sudden appreciation, by sight of a potentially horrifying event, namely, the possibility of electrocution, which violently agitated his mind.

57. Reference is made to the later case of *Devlin v. National Maternity Hospital* [2008] 2 I.R. 222. The Supreme Court affirmed the five criteria/principles laid out in *Kelly v. Hennessy* and held that in the absence of physical injury they dismissed the case specifically because criteria (d) of *Kelly v. Hennessy* was not satisfied. The court found that there was no evidence that the plaintiff's or any other persons suffered any physical injury, in circumstances were the organs of the plaintiff's deceased infant had been retained by the hospital following post-mortem, although there was criticism of the failure to obtain consent for such practice. The submission is made that the factual matrix presented to the court in *Devlin* is entirely distinguishable from the instant case in circumstances where the plaintiff in the instant case was exposed to a 10,000 kilovolt voltage cable and the risk of fatal electrocution and where this factual circumstance undoubtedly satisfies criteria (d) in *Kelly v. Hennessy*, that the nervous shock sustained by the plaintiff must be by reason of actual or apprehended injury to the plaintiff or to a person other than the plaintiff.

58. Reference is made to *Barry v. HSE and Mercy Hospital Limited* [2015] IEHC 791 damages were awarded for nervous shock arising out of the circumstances of the death of a child from Meningococcal sepsis over a number of hours. It is submitted that both medical witnesses ad diem on a diagnosis of depression in the plaintiff although Dr. Bourke expert for the defendant expressed the view that it was mild depression whereas Dr. Fitzmaurice who was the expert for the plaintiff viewed his depression as moderate to severe and the argument is made on behalf of the plaintiff that in the circumstances of his incident in which he narrowly escaped fatal electrocution if that is not acceptable to this Court as satisfying criterion A of DSM V classification of post-traumatic stress disorder, there is uncontroverted evidence before the court that the plaintiff suffered a separate and distinct medically recognised psychiatric illness, namely depression, arising as a direct consequence of the negligence of his employer, which said negligence is admitted. It is therefore submitted in the light of the foregoing that the plaintiff fulfils all the criteria laid down in *Kelly v. Hennessy* and that there are no policy reasons as to why the court should be concerned with the imposition of *Alcock* – type control mechanisms.

59. Quantum comparators referencing *Purcell v. Long* [2015] IEHC 385, *S.C. and Minister for Health and Children and the Hepatitis C and HIC Compensation Tribunal* [2012] IEHC 49 as well as *O'Hara v. Minister for Public Expenditure and Reform* [2018] IEHC 403 and *Nolan v. Wirenski* [2016] IECA 56 are referred to.

Findings of fact

60. Applying the principles of *Kelly v. Hennessy* to the instant case it is clear that the third limb admits to the defendant's negligent act or omission. In this regard it is noted that the plaintiff is an employee of the defendant and that in asking him to use equipment in which he is not trained and which he assumed to be safe given that he was being directed to use this equipment would be safe to use. Negligence is admitted but it is argued that causation, proximity and reasonable foreseeability must be proven by the plaintiff in order to come within the definition of nervous shock in order to be awarded damages. There is no doubt but that the plaintiff did suffer a shock and that it was the shock of his exposure to a 10,000-kilovolt cable which he had handled and in respect of which he apprehended threatened serious injury at least as a result of direct exposure to live electric cables in this incident.

61. It is clearly the case on the evidence of both Dr. Fitzmaurice and Dr. Bourke that the plaintiff suffered and continues to suffer from a recognisable psychiatric injury arising out of the incident in question although Dr. Bourke, expert for the defence, limits the recognisable psychiatric injury suffered to one of mild depression only. In that regard Dr. Fitzmaurice is utterly convinced that the post traumatic stress disorder suffered by the plaintiff and depression dated from the date of this incident in December, 2014. It was not a case of late onset, the accumulation of difficulties leading to late onset PTSD or depression rather it was the case of late diagnosis of same. Depression was identified by his general practitioner a number of months after this incident and his form seeking damages and preliminary application to the personal injuries assessments board although not filled in by the plaintiff himself, most likely filled by his solicitor, note shock as an issue.

62. Dr. Fitzmaurice was very firmly of the view that it is not precise moment of realisation for the plaintiff which is crucial to this diagnosis is rather how upsetting it is to the person. Dr. Fitzmaurice concluded that the plaintiff's exposure was sufficiently upsetting and horrifying to fill criterion A which causes people to have the distinct disorder of PTSD. He felt that it wasn't a classical presentation of PTSD but that there were more subtle symptoms of this disorder which did not preclude him from making the diagnosis because of the presence of the plaintiff's intrusive symptoms. It is in comparing and contrasting the evidence of the two psychiatrists, firstly it must be stressed that Dr. Fitzmaurice was the treating psychiatrist who on the first interview was ruling out suicidal ideation in order to ensure the safety of his patient that is clear from what is said in his evidence. He is then asked to provide a medico legal report and assesses the plaintiff fully at that point pointing PTSD and depression. He puts the depression in the moderate to severe range. He notes very importantly that pharmacological agents are not the cure for PTSD and that

the plaintiff requires between six and twelve months as stated above of therapy before he will recover fully depending on the frequency of treatment whether weekly or fortnightly.

63. Dr. Bourke is guarded in her prognosis of mild depression but agreed that she didn't have full information and had only of what actually happened or what the plaintiff had actually done during this incident i.e. actually handling this live cable with its one paper insulation at that point and she wasn't his treating psychiatrist and had had just one interview with him.

64. I have no difficulty in concluding having considered a great range of legal authorities in this issue and all of the evidence put before me including other evidence in the case that the plaintiff's post traumatic stress disorder and/or depression were induced by the shock of his exposure to the 10,000 kilovolt cable. I understand fully that it wasn't diagnosed fully for a considerable period of time but accept the explanations of Dr. Fitzmaurice in that regard which were credible and reasonable. In short the presence of intrusive symptoms rather than the more classical signs such as flashbacks in relation to PTSD and his noting that the GP had actually referred this plaintiff to the psychiatrist in the knowledge that he had depression but he referred him for further investigation given the persistence of his symptoms. The GP did not attend the trial as he was on vacation although he was on standby for the three days of the hearing. These things happen in cases and after much debate the plaintiff decided that he didn't intend calling the GP and wished to proceed in the case although the defendant's preference would have been initially in any event to have cross-examined the GP. No adverse inference was drawn by this Court against the plaintiff in that regard.

65. The plaintiff appeared as nervous and under strain throughout the entire hearing. A mistake had been made in relation to his solicitor including a claim for future loss of earnings and that was very adequately explained to the court and that claim was withdrawn before the case began.

66. This Court can't accept Dr. Bourke's contention in her direct evidence that there was no visual trauma given the explanation of the plaintiff as to what had occurred. The plaintiff clearly got a shock and a very bad one which caused both PTSD and depression. It is quite clear in my view that the nervous shock was caused by the defendant's negligent act and/or omissions towards the plaintiff. The plaintiff certainly apprehended injury if not death to himself in this incident. Given the defendant's clear duty of care not to cause reasonably foreseeable injury in the form of nervous shock to an electrical network technician doing dangerous work and given failure to adequately protect and train the plaintiff in relation to the use of the Ariadne machine which was later removed from use, this was a reasonably foreseeable event. It is clear to this Court that the event in question had a very detrimental affect on the plaintiff. Evidence from his wife gives a pre-incident and post-incident view of this man who was known to be a hard worker. His work colleagues gave very fair evidence, Mr. Barry bearing testimony to the plaintiff's professional management of the reconstruction of this incident and noting that for the plaintiff the incident itself would have been an exceptionally frightening experience, given

that a medium voltage was between 10,000 and 20,000 volts. He noted significantly, and this is also borne out in the evidence of Dr. Fitzmaurice, that although Mr. Barry himself did not have an adverse reaction when he himself was actually exposed to one such incident twenty years before, he accepted that the plaintiff did have an adverse reaction and he agreed that 100% that different people react in different ways.

67. His supervisor Mr. Liam McDonagh also accepted that they had received a memorandum banning the Ariadne LCIG afterwards and that he could 100% understand how a person would become "freaked out" by what happened.

68. I note the decision of Hanna J. in the matter of the Hepatitis C Compensation Tribunal Act, 1997 and in the matter of s. 5(9)(a) and in the matter of s. 5(15) of the Hepatitis C Compensation Tribunal Act, 1997 as amended by the Hepatitis C Compensation Tribunal (amendment) Act, 2002 between *W*. applicant *v. the Minister for Health and Children* respondent Hepatitis C and HIV Compensation Tribunal notice party [2016] IEHC 692.

69. This case came to the Court by way of an appeal from the Hepatitis C and HIV Compensation Tribunal (the Tribunal). The Tribunal made an order awarding the applicant no damages pursuant to s. 4(1)(e) and s. 5(3)(a) and (b) of the Hepatitis C Compensation Tribunal Act, 1997 (as amended) in respect of his proceedings for post traumatic stress disorder and nervous shock following the plaintiff's son's death. The Tribunal found that the applicant failed to establish that he had suffered a psychiatric "injury" above the effects of normal grief, distress and bereavement. Compensation for loss of society was awarded. The plaintiff's son had been born a haemophiliac and went on to develop Hepatitis C and HIV. The father had dropped his son off to the hospital in 1994. There was nothing unusual in that it was the part of the way of life giving his condition. The parents were called to the hospital but not told what to expect. The applicant was called into to see his son but was not told precisely what to expect and only to find his son laid out dead. The Judge accepted the medical evidence and the unanimous view of the doctors in that while DSM is an invaluable protocol and tool it is not a mere checklist but Hanna J. took the view that one must weigh heavily the essential and important ingredient of the diagnosis of experienced medical professional coming to an informed view aided by the collected wisdom and guidance to be found in DSM V or indeed in ICD 10 which he noted was occasionally mentioned but seemed to lag somewhat behind DSM V in popularity of reference when evidence was given before that court. He felt that two of the psychiatrists in particular gave evidence which more easily accorded with and explained his understanding and reading of the plaintiff on hearing his evidence. He noted that the Tribunal in that case did not have the advantage of hearing either the applicant Mr. W. or indeed Mrs. W. He received fresh evidence therefore at this appeal hearing he felt that the various indices set out in DSM V had been met and he accepted the diagnosis in that case.

70. This Court had noted the further submissions sent by agreement of both parties by correspondence dated the 14th April, 2020 *Lisa Sheehan and Bus Eireann/ Irish Bus and Vincent Power* [2020] IEHC 160. This very interesting judgment of Keane J. was

delivered on 3rd April, 2020 and centres on the nature and scope of the duty of care not to cause a reasonably foreseeable psychiatric injury to a person who is not directly involved in the accident caused by that breach of duty and whether the law recognises the right of recovery for the psychiatric consequences of witnessing an accident, if the primary victim is the tortfeasor rather than a blameless third party. The court is not concerned in the instant case with the second limb of Keane J.'s decision.

71. Regarding the first limb and the scope of the duty of care not to cause a reasonably foreseeable psychiatric injury to the plaintiff in this case, she was diagnosed with classic post-traumatic stress disorder acute stress reaction to what she experienced at the scene of an accident. She was treated by a clinical psychologist for eye movement desensitisation and reprocessing ("EMDR"), (as was the plaintiff in the instant case) therapy and counselling. The independent expert medical professional called on behalf of the defendants expressed the opinion that the plaintiff had experienced a moderately severe post traumatic stress disorder after an initial stress reaction at the scene of an accident, together with a depressive adjustment reaction which had improved but which had a persistent psychic social impact on her. He noted that the plaintiff was to continue with therapy and medication and gave a guarded prognosis that it would certainly take further time for recovery.

72. Having reviewed the law as set out in *Bell v. Great Northern Railway Co.* and *Mullaly v. Bus Eireann* cited above and in *Kelly v. Hennessy, Alcock, White, Curran v. Cadbury and Fletcher*, the learned High Court Judge came to the conclusion that in relation to the fifth limb in *Kelly,* the test for the existence of a duty of care is that articulated by Keane C.J. in *Glencar Exploration Plc.* in that "a rigid primary/secondary victim distinction, entailing an inflexible adherence to the *Alcock* control mechanisms has no role to play in the application of either. While the learned trial judge did not accept that it was necessary to apply the definition of primary victim as set out, he did conclude that if necessary, she was primary rather a secondary victim for the purposes of the law and liability for negligently inflicted psychiatric injury. He came to the conclusion in this case that the plaintiff did expose herself to danger in providing assistance at the scene of the crash on a dark roadway and that she came within the range of foreseeable physical injury in doing so. He concluded that the defendants did owe the plaintiff in this case a duty of care not to cause her a reasonably foreseeable injury in the form of psychiatric illness and he identify no consideration of public policy which dictated otherwise. He felt that it was just and reasonable that the law should impose that duty on the defendants for the benefit of the plaintiff. He felt that there was no dispute but that the plaintiff satisfied each of the other elements of the test taking into account *Nolan v. Wirenski [*2016] 1 I.R. 461 (at 470). He awarded general and special damages in a total award of €87,238. Its relevance here is that it shows a variation as an example of a primary victim.

73. The evidence in this case must be viewed in the round. There is no doubt but that the plaintiff presented throughout as a very anxious individual and was exceptionally anxious in court albeit very polite. I have no reason to doubt the man's credibility or earnestness. While technically he is still employed as a network technician in the ESB he carries out a

role away from cables and in a sales area. The event which occurred which was horrifying one to him, viewed in its entirety and which he perceived by sight causing him to have shock and fear and which he found to be a horrifying experience which occurred when under direction he used a new machine and he unwrapped as he was obliged to do, cables with his hands firstly the layer with pitch on it, then paper then lead and again to the point where there was a layer of paper between himself and what turned out to be a live cable. This was the event and to an experienced network technician with the ESB who was skilled in his job and with twenty years' experience and a hard worker, this was the horrifying event where he apprehended and suffered sudden perception of real danger to himself, in direct exposure to same.

74. He was a primary victim if it necessary to make that distinction and as we know from the psychiatric evidence of Dr. Fitzmaurice, whose evidence I fully accept, it is the effect on him which is important in relation to that incident. The equipment he was using had misidentified the cable as being safe to handle and this exposed him to at least the risk of serious injury and possible death bringing him within criterion A for PTSD. The description of intrusive symptoms brings him within criterion B and persistence and avoidance of stimuli associated with the traumatic events working with cables for examples and discussions regarding the work bring him within criterion C. The negative alterations in cognitions and mood bring him within criterion D and the marked alterations in arousals and re-activity bring him within criterion E and his symptoms certainly lasted longer than one month bringing him within criterion F. The disturbances not attributable to the psychological effects of a substance or other medical condition which deal with criterion G and H. The medical evidence suggests that the PTSD is not associated with dissociative symptoms, nor has there been delayed expression of the PTSD.

75. The plaintiff fulfils DSM V criteria for a major depressive disorder, secondary to and overlapping with symptoms from the primary diagnosis of PTSD. His treating psychiatrist believes that the sitation has improved since 2018 with a reduction in his hyperarousal, intrusive images and avoidance of triggers/reminders.

76. This Court prefers the analysis of Dr. Fitzmaurice over that of Dr. Bourke as outlined above. The logic of the situation is that there was one incident which evolved seconds which caused visual shock to the plaintiff where he was in fear of at least serious injury, if not death. He was the only victim fully accepting that the medical standard for PTSD and the legal ones are distinct. Nevertheless, the late diagnosis does not mean late onset of PTSD and the effect of his usual realisation and understanding on the plaintiff are what caused PTSD and depression. There is significance in the fact that in all the circumstances of the plaintiff's working life, faulty equipment led to a reasonably foreseeable event which caused the nervous shock suffered. This case stands on its own facts in that the PTSD itself is not a classic presentation of the disorder.

Conclusion

77. The court has fully analysed the authorities and believes that the burden of proof has been discharged by the plaintiff and that he has proven beyond reasonable doubt his case. On the balance of probabilities, it is being clearly demonstrated to the court that

this was a reasonably foreseeable injury and the plaintiff comes within the definition as set out in *Kelly v. Hennessy*. The plaintiff continues to suffer from recognisable psychiatric injury and his PTSD and/or depression were induced by the shock of his exposure to the 10,000 kilovolt cable. The defendant was and admits that it was negligent. The plaintiff has proven to the court that he apprehended injury to himself. A duty of care not to cause reasonably foreseeable injury is owed by the defendant to the plaintiff and that its exposed to the risk of electrocution or death, the plaintiff would and did suffer a recognised psychiatric illness. The plaintiff is entitled to general damages in the sum of €80,000 plus items of special damages which were agreed in the sum of €3,107.30.