THE HIGH COURT

[2024] IEHC 420

Record No. 2020 6621P

BETWEEN

CARMEL GERMAINE

PLAINTIFF

AND

MARY DAY

DEFENDANT

Judgment of Ms. Justice Egan delivered the 10th day of July, 2024

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Introduction

1. This judgment concerns the intersection of the doctrine of nervous shock with medical negligence.

2. The leading authority on nervous shock is *Kelly v. Hennessy* [1995] 3 IR 253. In that case, the plaintiff suffered post-traumatic stress disorder on being informed by telephone that her family members had just been seriously injured in a car crash and immediately afterwards saw each of them in an appalling condition in hospital. Hamilton C.J. set out the conditions that a plaintiff must satisfy to recover damages for nervous shock ("the *Kelly v. Hennessy* criteria"):

1. A plaintiff must establish that they suffered a recognisable psychiatric illness.
2. A plaintiff must establish that their recognisable psychiatric illness was shock-induced.
3. A plaintiff must prove that the nervous shock was caused by the defendant's act or omission.
4. The nervous shock sustained by a plaintiff must be by reason of actual or apprehended physical injury to the plaintiff or a person other than the plaintiff.
5. A plaintiff must show that the defendant owed them a duty of care not to cause them a reasonably foreseeable injury in the form of nervous shock[1].

[1] I refer to these 5 conditions and *Kelly v. Hennessy* criteria 1 to 5 respectively.

3. Although *Kelly v. Hennessy* arose out of a road traffic accident, it has been applied in a number of other contexts. Specifically, damages for nervous shock have been awarded to relatives who demonstrate that they have suffered a recognisable psychiatric illness by witnessing the injury or death of their loved one as a consequence of medical negligence. For example, in *Courtney v. Our Lady's Hospital Ltd & Ors* [2011] IEHC 226 ("*Courtney*"), O'Neill J. awarded damages for nervous shock to the plaintiff who witnessed the death of her young daughter as a result of a negligent failure to diagnose meningitis. In *Barry v. Health Service Executive* [2015] IEHC 791, Barr J. awarded such damages in connection with the death of the plaintiff's former partner consequent upon a negligent failure to diagnose bowel cancer. Liability was not in issue in either case.

4. In contrast, in *Morrissey v. HSE* [2019] IEHC 268, ("*Morrissey*") Cross J. determined that the negligent misreporting of Mrs. Morrissey's cervical smear did not give rise to recoverable nervous shock on the part of her husband because *Kelly v. Hennessy* criterion 5 was not satisfied. In *Mitchell v. HSE* [2023] IEHC 394, ("*Mitchell*"), O' Connor J. declined to award damages in similar circumstances.

5. This is the first medical negligence nervous shock case in which liability - specifically the fulfilment of several of the *Kelly v. Hennessy* criteria - has been in dispute. *Kelly v. Hennessy* criteria 2, 3 and 5 are all in issue for the first time. *Morrissey* and *Mitchell* both concerned the cervical screening program and the more general question of whether health care providers owe a criterion 5 duty of care to the relatives of their patients did not arise. This is also the first judgment in a relative's action for nervous shock in which, despite admitted breach of duty on the part of the health care provider, the patient in question has suffered no resulting injury.

Background Facts

6. The plaintiff is the widow of the late Thomas Germain deceased ("the deceased"). The deceased suffered from a condition called organising pneumonitis which affected the upper lobe of his right lung. This was treated successfully, but the deceased remained under surveillance at St James's Hospital (whose interests the defendant represents) in case of relapse. The plaintiff accompanied her husband for a chest x-ray on 2nd October, 2018, which was reported as normal. However, this chest x-ray showed an unrelated opacity in the right lung, which was not initially picked up by the reporting radiologist. Had this opacity been reported

and followed up clinically, the deceased would shortly have been diagnosed with lung cancer. Unfortunately, this did not occur and the deceased was informed by his treating consultant respiratory physician at St James's Hospital ("the consultant") that his lung condition had resolved and he was charted for review in October 2019. Arising out of the foregoing, breach of duty of care to the deceased is admitted.

7. The deceased suffered a gradual deterioration in his health over the course of October, November and December 2018. However, it is common case that the deceased's cancer was already incurable in October 2018 and that an earlier diagnosis would not have led to any change in treatment or prognosis. The admitted breach of duty did not therefore cause injury to the deceased.

8. The plaintiff pleads that on 23rd December, 2018, she witnessed the deceased's rapid deterioration (consisting *inter alia* of significant difficulty mobilising, severe headache and inability to move his arms). After speaking with her daughter, the plaintiff persuaded the deceased to attend the Hermitage Clinic ("the Hermitage") at 7:30 am on Christmas Eve. The deceased underwent tests and investigations and was diagnosed with high grade poorly differentiated non-small cell carcinoma.

9. Although the deceased was initially discharged home, a family decision was made that it would be better if he was cared for in the Hermitage. The deceased was an inpatient in the Hermitage for several weeks during which time he commenced a course of radiotherapy. The deceased ultimately decided that he did not wish to avail of community palliative care and indicated a preference to remain in the Hermitage rather than in a hospice or at home. Accordingly, he remained in the Hermitage until his sad passing as a result of metastatic lung cancer on 14th February, 2019. The plaintiff was not initially aware of her husband's terminal diagnosis as he *"didn't tell [her]*". Rather, she discovered that her husband's illness was terminal towards the end of January 2019 which was very shortly before his death.

10. The consultant wrote a letter to the deceased and to his general practitioner on 18th February, 2019 but, on discovering the passing of the deceased re-addressed this letter to the plaintiff. This letter ("the open disclosure letter"), ultimately sent in April 2019, accepted that there had been a failure in the care provided, that the deceased's cancer should have been diagnosed in October 2018 and offered an unreserved apology.

Issues and Summary of the Court's findings

11. It is accepted that the plaintiff suffered an adjustment disorder which is a recognisable psychiatric illness (as per *Kelly v. Hennessy* criterion 1). She contends that this is *shock-induced* (as per *Kelly v. Hennessy* criterion 2) as it resulted from witnessing the sudden and frightening deterioration of the deceased's condition (thus also satisfying criterion 4). The defendant maintains that what the plaintiff witnessed does not qualify as a *sudden shocking event* as required by criterion 2. It argues that this deterioration was part of a gradual arc of health decline; it was thus part of a continuum rather than constituting an "event" in itself.

12. *Vis a vis Kelly v. Hennessy* criterion 3, the plaintiff argues that, if the deceased had been correctly diagnosed, she would have been spared the shock to which she was exposed. She submits that the deceased would have had the benefit of palliative care and all attendant supports. This would have either prevented the deterioration or prevented her from witnessing it. Alternatively, with the benefit of such supports, the plaintiff would have had an opportunity to come to terms with the deceased's predicament thereby avoiding the shock and trauma of his sudden deterioration. The plaintiff claims that all of this was denied to her by the defendant's admitted breach of duty. The defendant contends that these arguments are not supported by the evidence in the case.

13. Finally, the plaintiff submits that criterion 5 is also satisfied because the defendant owed her a duty of care to avoid causing her foreseeable injury in the form of nervous shock. The defendant disputes this, relying upon a recent decision of the Supreme Court of England and Wales, *Paul v. Wolverhampton NHS* [2024] UKSC 1 (*"Paul"*) to the effect that, in general doctors do not owe a duty of care to the relatives of their patients.

14. In summary, I hold that the plaintiff's case cannot succeed. The primary basis for my finding is that she cannot satisfy *Kelly v. Hennessy* criteria 2 and 3. As regards criterion 2, the injury was not *shock-induced* in the sense that that expression has been interpreted. There was no "*sudden calamitous or horrifying event in the nature of an accident"*[2]. Nor can the plaintiff satisfy criterion 3. The defendant's negligence did not cause the deceased's deterioration, which is alleged to be the *sudden shocking event* witnessed by the plaintiff. On the contrary, I find that this deterioration and the plaintiff's exposure to same would have occurred in any

[2] *See Harford v. Electricity Supply* Board [2022] 2 IR 541 as discussed at para. 25 below

event. Further, the plaintiff's narrower argument on causation, namely that her nervous shock is attributable not to witnessing the deterioration itself but to witnessing it in an unprepared manner (i.e., without previous knowledge of the deceased's diagnosis) also cannot succeed. There is no evidence that, but for this factor, the plaintiff would not have suffered an adjustment disorder.

15. Lest I am incorrect in the above, I also examine criterion 5 which is a matter of some complexity. The defendant submits that healthcare providers generally owe no duty of care (either in a nervous shock context or more broadly) to the relatives of their patients, who are mere bystanders. This is primarily because, even if harm to relatives is a reasonably foreseeable consequence of medical negligence, there is said to be insufficient proximity as between a doctor and these relatives to give rise to a duty of care.

16. The Irish authorities do not elucidate how one should assess proximity, and hence criterion 5 duty of care, in a case such as this. Specifically, it is unclear whether, for the purposes of a bystander's nervous shock claim, proximity should be assessed on broader negligence principles (as the defendant contends) or whether, alternatively, proximity bears a specialised meaning in this context. The former approach would require a close proximal relationship between the doctor and the relative before a duty of care could arise. It will usually be very difficult for relatives to satisfy this requirement. By contrast, if in this context, proximity bears a somewhat specialised meaning, then other factors would also be of relevance to the assessment - for example whether there is a close proximal relationship as between the relative and the patient and whether there is close proximity as between the relative and the sudden shocking event caused by the medical negligence.

17. This is an issue of broad significance. Had it been necessary to determine this question, I would have requested further legal argument from the parties. However, on the facts of this case, this issue is not dispositive. As the plaintiff does not satisfy *Kelly v. Hennessy* criteria 2 or 3, the outcome of this case does not turn on the meaning of proximity. Furthermore, aside entirely from how one might interpret the proximity requirement, criterion 5 duty of care could not be made out in this case. It is clear from *Glencar* that the court must consider factors beyond reasonable foreseeability and proximity in deciding whether a duty of care arises. The court must also consider whether it is reasonable to impose the duty of care contended for. Here, the plaintiff contends in effect that the defendant was under a duty to shield her from the

psychological impact of witnessing her husband's deterioration in an unprepared manner. Even assuming that both foreseeability and proximity of relationship were made out, this is not a duty which it would be reasonable to impose.

18. The parties urge the court to determine whether, in general, health care providers owe a duty of care to the relatives of their patients. In light of the importance of this question, there is merit in setting the issues out clearly to identify the likely contours of future debate.[3] However, a court should not decide a question of broad import unless necessary to resolve the case at hand. Such questions are best decided in the incremental manner of the common law by reference to the specific circumstances of each case. In short, the court should only pronounce on the meaning of proximity in nervous shock and on whether health care providers owe a duty of care to the relatives of their patients in an appropriate case in which these issues squarely arise.

Criterion 1: Recognisable psychiatric illness

19. Criterion 1 requires the plaintiff to establish that she suffered a recognisable psychiatric illness. The plaintiff's diagnosis is of an adjustment disorder, characterised by anxiety and depressive symptoms. The unchallenged opinion of the plaintiff's psychiatric expert, Prof. Abbie Lane, Consultant Psychiatrist, is that the intensity and duration of the plaintiff's symptoms, some three years after the death of her husband brings her reaction outside the realm of typical grief which one would expect to have resolved.

20. An adjustment disorder is a recognised psychiatric illness which occurs in response to an identified stressor. Unlike post-traumatic stress disorder ("PTSD"), the precipitating stressor is not required to be "*outside the range of human experience such as to evoke significant symptoms of distress in almost anyone"*[4]. An adjustment disorder can therefore develop in response to an event which is less horrifying or dramatic than would generally evoke PTSD.

21. Recovery for nervous shock is not limited to PTSD and extends to "*any recognisable psychiatric illness*" including an adjustment disorder. However, the law requires that the recognisable psychiatric illness is *shock-induced* in the sense described below.

[3] See discussion at paras. 92 to 126 below.
[4] This is one of the elements of PTSD as enumerated by Denham J. in *Mullaly v Bus Eireann* [1992] ILRM 772

Criterion 2: Is the plaintiff's psychiatric illness *shock-induced?*

Legal principles

22. In *Kelly v. Hennessy* Hamilton C.J. cites Brennan J. in the Australian case of *Jaensch v. Coffey* [1994] 155 CLR 549 as follows:

> "*A plaintiff may recover only if the psychiatric illness is the result of physical injury inflicted on him by the defendant or if it is induced by shock. Psychiatric illness caused in other ways attracts no damages, though it is reasonably foreseeable that psychiatric illness might be a consequence of the defendant's carelessness."*

23. Brennan J. also stated:

> *"I understand 'shock' in this context to mean the sudden sensory perception – that is by seeing, hearing or touching – of a person, thing or event which is so distressing that the perception of the phenomena affronts or insults the plaintiff's mind and causes a recognisable psychiatric illness."*

24. This requirement may be briefly illustrated by the decision of the Supreme Court in *Fletcher v. Commissioner for Public Works* [2003] 1 IR 465 ("*Fletcher*"). The plaintiff, who had been exposed to asbestos dust as a result of his employer's negligence was advised by his medical consultant of a remote risk of contracting mesothelioama. He developed an irrational fear of contracting this disease resulting in psychiatric injury and sued for nervous shock. The Supreme Court held that the case could not succeed, firstly because there had been no sudden perception of a frightening event or its immediate aftermath of the kind necessary to sustain a claim in nervous shock and secondly because, for policy reasons the law should not be extended to allow recovery to a plaintiff who suffered no physical injury but developed an irrational fear of contracting a disease.

25. *Harford v. Electricity Supply Board* [2021] IECA 112 ("*Harford*") provides a further example. The plaintiff, who was employed as a technician was assigned the task of repairing a public streetlight. Because the plaintiff was given faulty equipment, he thought that the cable which he was handling was a low voltage cable. In fact, it was a medium voltage cable which, if handled, would have electrocuted him. The plaintiff did not in fact handle the cable and therefore suffered no physical injury. Nonetheless he excessively ruminated on the injury avoided and developed a psychiatric illness. The Court of Appeal determined that the plaintiff did not satisfy *Kelly v. Hennessy* criterion 2 because there was *"no sudden calamitous or horrifying event in the nature of an accident"* and thus *"no qualifying event"*. In so holding, Noonan J. noted that Lord Ackner's definition of *"shock"*, in *Alcock v. Chief Constable of*

South Yorkshire [1992] 1 AC 310 ("*Alcock*") which had been consistently approved in Ireland, defines "shock" as follows:

> *"'Shock', in the context of this cause of action, involves the sudden appreciation by sight or sound of a horrifying event, which violently agitates the mind. It has yet to include psychiatric illness caused by the accumulation over a period of time of more gradual assaults on the nervous system."*

26. *"Shock"*, so defined, is a compound concept requiring that the plaintiff *"suddenly"* appreciates a *"horrifying event"*. Although often the same thing, the crucial element is the shocking nature of what the plaintiff has witnessed rather than the character of the event in question. The final elements of this compound concept are that the plaintiff's psychiatric illness was caused by this sudden appreciation (*"the violent agitation the mind"*) and that the illness is thereby *shock-induced.*

27. In *Harford,* Noonan J. stated as follows:

> *"The requirement for the occurrence of a 'sudden' event, be it described as shocking, distressing, horrifying, terrifying or calamitous, has consistently been held in this jurisdiction to be a prerequisite to recovery for purely psychiatric injury."*

28. I use the expression "*sudden shocking event*" to embrace both the horrifying, terrifying or calamitous nature of what is witnessed and the suddenness of its appreciation.

29. The parties are agreed that the question is not whether the plaintiff perceives that a *sudden shocking event* has occurred but whether, objectively speaking that is so. As the Supreme Court stated in *Paul*, there is something invidious in the court being required to measure whether or not an event is sufficiently distressing or terrifying to qualify as a shocking event. There is no Richter scale of horror. On the other hand, whether an event is sudden, in either its occurrence or its appreciation, is more capable of objective definition and analysis.

30. As this case is said to involve a *sudden shocking event* unfolding over a couple of days- rather than over a couple of hours - it is important to emphasise that there is no need to adopt an overly restrictive interpretation of the concept. Whilst a *sudden shocking event* is something definitive, with an obvious beginning and an equally obvious end, there is no reason why it may not be played out over a period of many hours or possibly even days. In such circumstances, it will be a matter of judgment depending on the facts and circumstances of each case as to whether criterion 2 is satisfied.

31. In *Harford*, the emphasis was on the absence of a calamitous or horrifying event in the nature of an accident which Noonan J. noted could be referred to as a "*qualifying event"*. In other cases, the focus may be upon the fact that the psychiatric illness is caused not by the sudden appreciation of an admittedly horrifying event but by grief, sorrow and the necessity of caring for loved ones who have suffered injury. This is not because grief or hardship are rendered more endurable by a more gradual realisation but because compensation is not available for general grief and sorrow brought about over a period of time.

32. Therefore, as regards the *"violent agitation of the mind",* the plaintiff must demonstrate that from a psychiatric perspective witnessing the *sudden shocking event* in suit is the cause of their psychiatric illness. Prof. Lane expressed this in terms of the need to identify the precipitating factor for the psychiatric illness (in contradistinction to other factors which do not precipitate the illness but might aggravate or perpetuate its course). However, even if a plaintiff has developed a psychiatric illness as a result of exposure to a recognisable stressor, such that this stressor is the precipitating factor, the law still requires to be satisfied that this particular stressor is a *sudden shocking event*. In other words, a recognisable stressor, or a precipitating factor, clinically speaking and a *sudden shocking event*, legally speaking, may be different things. Whilst, there may well be an overlap, there is no merger of these clinical and legal concepts.

33. The illness must also be *shock-induced.* To tease this out further, the authorities make it clear that there may be cases in which a *sudden shocking event* (as defined above) has occurred, but where the aetiology of the plaintiff's psychiatric injury falls outside the bounds of nervous shock. In *Kelly v. Hennessy* Hamilton C.J. quoted part of a passage from Brennan J.'s judgment in *Jaensch v. Coffey* which it is worth setting out in full:

> *"Curial wariness of vague notions is, as Sir Owen Dixon said, perhaps the "reason that scorn of the law is more widespread among psychiatrists than anatomists" (Jesting Pilate (1965) p.18). The courts have insisted on proof of a demonstrable and readily appreciable cause of psychiatric illness - the cause itself being a result of the defendant's careless conduct - before damages for negligence occasioning psychiatric illness are awarded. A plaintiff may recover only if the psychiatric illness is the result of physical injury negligently inflicted on him by the defendant or if it is induced by "shock". Psychiatric illness caused in other ways attracts no damages, though it is reasonably foreseeable that psychiatric illness might be a consequence of the defendant's carelessness. The spouse who has been worn down by caring for a tortiously injured husband or wife and who suffers psychiatric illness as a result goes without compensation; a parent made distraught by the wayward conduct of a brain-*

damaged child and who suffers psychiatric illness as a result has no claim against the tortfeasor liable to the child."

34. This passage clarifies the purpose of the shock requirement in nervous shock and explains why a psychiatric illness caused in other ways attracts no damages though it is reasonably foreseeable that it might eventuate as a result of the defendant's carelessness. The requirement for a sudden shocking event is essentially a search for a demonstrable and readily appreciable cause of the plaintiff's psychiatric illness resulting from the defendant's careless conduct. Thus viewed the shock requirement is an aspect of causation and proximity, closely linked together, both of which are necessary to establish liability. One must consider not just what event precipitated or caused the plaintiff's psychiatric illness but also whether the manner in which the illness developed is such as to establish liability.

35. My task is clearly not to construe this requirement of a *sudden shocking event* as if it had appeared in legislation but rather to garner the sense of the words and the principles to be drawn from the authorities.

In the present case, what is the *sudden shocking event?*

36. Under the heading "*The sudden event*", the plaintiff's legal submissions state that the deceased's condition deteriorated slowly over time which caused concern but not shock as he had "*got a clean bill of health"* on 2nd October, 2018. The plaintiff submits however that there was a "*dramatic deterioration*" on the evening of 23rd December, 2018 as a result of which she brought the deceased to the Hermitage Clinic at 7.30 am the following morning. The plaintiff argues that this "*dramatic deterioration"* comprised a *sudden shocking event* which satisfies criterion 2 of *Kelly v. Hennessy*.

Factual evidence and medical records

37. In describing her husband's deteriorating health, the plaintiff states that "*there wasn't anything dramatic until Christmas, coming up to Christmas"*. However, the general tenor of the plaintiff's testimony does not really bear out a dramatic change and is more consistent with a gradual decline over the months and, more particularly weeks, prior to 23rd December.

38. The symptoms identified by the plaintiff as having particularly alarmed her on 23rd December were not new. By that time, the deceased had been experiencing tiredness as the weeks passed, he was not able to function as he had previously, his appetite had declined in

November and he had been experiencing weakness for a week or so. In addition, the deceased had begun developing bad headaches in the second week of December. The plaintiff had also noticed a difference in the way the deceased walked; it appears that over October and November he had become unable to walk any appreciable distance.

39. The plaintiff was clearly alarmed by the fact that the deceased was unable to lift his arms and dress himself on the evening of 23rd December. However, the deceased had been experiencing pain, and possibly weakness, in his arms from November (or the start of December at the latest). Therefore, even though the plaintiff stated that she worried that the deceased might be having a stroke as he was unable to lift his arms, this was clearly part of an evolving condition of weakness, tiredness, unsteadiness and disorientation all sadly attributable to advanced metastatic cancer.

40. Even if the deceased's inability to lift his arms had only commenced in the couple of days prior to 23rd December, this alone would not amount to a *sudden shocking event*. Part of what makes an event frightening is its suddenness. A *sudden shocking event* must involve a distinct change from what was there before. The emergence or worsening of such a symptom against a constellation of deteriorating symptoms over several weeks, if not a month, lacks the hallmarks of specificity, suddenness and urgency. Whilst this process of decline undoubtedly severely worried the plaintiff and led to her as she states, *"living on her nerves",* it was not in reality sudden or calamitous.

41. The medical records tell a similar tale. The deceased had attended his general practitioner on 10th December, 2018 with a two week history of short lived benign positional vertigo, loss of flexion, stiffness in the left leg and an episode of shaking when stretching for something overhead. More importantly, the deceased's presenting complaint at the Hermitage on the morning of 24th December, 2018 is recorded as "*unsteady gait x (for) <u>two weeks</u>*" (emphasis added). The Hermitage does not record any particular "event", or indeed any exacerbation the previous evening; on the contrary the presenting complaint is of a two week history. Under cross examination, the plaintiff accepted that the joint history which she and the deceased provided to the Hermitage was to the effect that the condition which had prompted his presentation had been coming on for a couple of weeks. Indeed, the plaintiff stated that she was asked by one of the admitting medics "*why didn't you come here sooner".*

42. Overall, the plaintiff herself did not attest to a *sudden shocking event* suddenly perceived by her. Rather she described a slow process of deterioration and a commensurately slow process of realisation on her part that hospital admission was unfortunately necessary. This is not sufficient to render the deterioration or its perception by the plaintiff a *sudden shocking event*. In many, if not most, sad processes of decline of a loved one, a realisation will occur that the position is serious and that medical attention is required.

43. I find that the deceased's deterioration and the plaintiff's appreciation that medical assistance was necessary were part of a continuum - a gradually unfolding state of affairs leading to a dawning realisation. Indeed, even if the plaintiff had perceived that something sudden and shocking had occurred on 23rd December, this would not alter the essential objective characteristics of what unfolded.

Expert evidence

44. An analysis of the expert evidence in this case supports the foregoing finding. The plaintiff and defendant's oncology reports (both admitted without formal proof) do not suggest that a sudden event occurred on 23rd December. Nor incidentally does the plaintiff's care report of Lena Walliman, registered general nurse (also admitted without the necessity for formal proof). The expert evidence of most relevance is that of Prof. Lane. What emerges as the cause of the plaintiff's adjustment disorder? Further, what history did the plaintiff provide to Prof. Lane concerning the existence or otherwise of a *sudden shocking event*?

45. The plaintiff was not diagnosed as suffering from a recognisable psychiatric disorder until first examined by Prof. Lane on 20th May, 2022. Although this post-dates the contended for *sudden shocking event* by almost four years, this is no objection to the plaintiff's claim. Criterion 2 only requires that the plaintiff establishes that the psychiatric illness was caused by exposure to a *sudden shocking event*. If so, then it is not necessary that the psychiatric illness is diagnosed at the time of its occurrence and it may be some time before a formal diagnosis is made. What is important, however is that the psychiatric injury is caused by exposure to a *sudden shocking event* rather than by stress prior thereto or by the wear and tear of its consequences over a period of time.

46. Prof. Lane's medical report does not in fact attribute the plaintiff's adjustment disorder to the events of 23rd December, 2018 or indeed to any particular sudden, dramatic or traumatic

event on that date. Prof. Lane's report recounts the plaintiff's *"shock at the deceased's deteriorating health over some months"... "leading up to the unexpected diagnosis around Christmas*". This is a description of events both pre-dating and post-dating the deceased's deterioration on 23rd December, 2018 (as the plaintiff did not come to understand that her husband had terminal cancer until well after Christmas in mid to late January 2019). Although Prof. Lane also refers to "*the sudden and unexpected deterioration and death*" of the deceased, this must necessarily be a reference to circumstances both on and after 23rd December, 2018. The report also refers to other events well after 23rd December, 2018 and states that the plaintiff was "*further distressed and shocked to learn*[5] *of the apprehension that the deceased might not have died if mistakes in his care had not been made".* In the opinion section of her report, Prof. Lane states that the plaintiff's adjustment disorder "*relates to the experiences around the time of her husband's death and her subsequent realisation that mistakes had been made and that the outcome could have been different".*

47. The defendant does not dispute that the plaintiff has sustained a recognisable psychiatric illness but submits that Prof. Lane does not attribute this illness to a sudden shocking event on 23rd December 2018 as required by criterion 2. Insofar as concerns Prof. Lane's report, the defendant is correct.

48. However, in her oral evidence Prof. Lane stated that although the plaintiff experienced a build-up of anxiety in the weeks and months leading up to Christmas, it was only at "*the sudden point in the days around Christmas… that her anxiety became intolerable or unbearable … almost like a straw that broke the camel's back".* This, *"tipped her then into extreme anxiety mood".* When asked specifically what had tipped the plaintiff over into that extreme anxiety Prof. Lane's response was "*I think what she saw in terms of the sudden change in her husband's health. I mean he had been deteriorating but there appears to be a very sudden point in the days before Christmas that brought about quite a different concern. And I think it is when anxiety and stress becomes intolerable or unbearable that then the person can't manage it, so they then tip over into illness."*

49. In cross examination, Prof. Lane accepted that her report was not clear in identifying the 23rd December as a *sudden shocking event* precipitating the plaintiff's illness. She was

[5] On receipt of the open disclosure letter of April 2019

however adamant that this was the precipitating event and that subsequent events, such as the deceased's diagnosis with terminal cancer in January 2019, his death on 14th February, 2019 and the receipt of the open disclosure letter were aggravating or perpetuating, but not precipitating, factors.

50. There is force in the defendant's argument that if, as Prof. Lane now says the dramatic deterioration in the deceased's condition on 24th December, 2018 was the precipitating factor, then it is difficult to understand why it was not identified as such in the report. Prof. Lane did not re-examine the plaintiff before giving evidence. She does not therefore base her identification of the precipitating factor upon any updated clinical assessment post-dating her report.

51. On the other hand, the defendant elected not to call its psychiatric expert to dispute Prof. Lane's identification of the precipitating event. Dr. Richard Blennerhassett, Consultant Psychiatrist, examined the plaintiff on the defendant's behalf. If Dr. Blennerhassett's view was that the plaintiff's adjustment disorder was not established on 23rd December, 2018 but was multifactorial in origin and attributable to the events both before and after that date, then he could have given evidence to that effect.

52. Therefore, whilst I fully accept that the court is not bound to accept the evidence of an expert, the bar for departing from uncontradicted expert testimony is nonetheless reasonably high. In this case, the evolution in opinion as between Prof. Lane's written report and her oral evidence does not meet that bar. I therefore accept Prof. Lane's opinion that the plaintiff's adjustment reaction was precipitated by the events of 23rd December.

53. Fundamentally, however, the satisfaction of criterion 2 does not depend upon Prof. Lane's opinion as to whether or not the plaintiff's adjustment disorder was precipitated by a series of events that are now presented as occurring suddenly. This is a necessary but not a sufficient requirement. It must be established that the precipitating event, viewed objectively, qualifies as a *sudden shocking event* and, separately, that the manner in which the precipitating event caused the plaintiff's psychiatric injury is recognised by the law as giving rise to liability - it must be *shock-induced*. Neither condition is satisfied here. For the reasons summarised at para. 43 the *sudden shocking event* consideration is not met in this case. Nor, for reasons which I now explain, was the plaintiff's adjustment disorder *shock-induced*.

54. Prof. Lane's description of the aetiology of the plaintiff's adjustment disorder is inconsistent with the legal requirement of a *shock-induced* illness. A "*straw that breaks the camel's back"* describes a series of gradual assaults on the plaintiff's psyche. The precipitating event, clinically speaking, may well have been the deceased's condition on the night of 23rd December, 2018, but the import of Prof. Lane's evidence is that this *"event"* was precipitative in large part because of the stress and worry experienced by the plaintiff over the preceding period.

55. I do not doubt that the long sequence of worry and stress described above was extremely difficult for the plaintiff and culminated in the realisation that she must take her husband to hospital thus tipping her into an anxiety state. However, this aetiology is not such as to permit recovery for nervous shock. Rather, the circumstances presented are the very essence of the scenario outlined by Brennan J. in *Jaensch v. Coffey*. The circumstances suggest a gradual wearing down of the plaintiff's nerves by caring for and worrying about her husband accompanied by mounting distress and strain at witnessing his deterioration. Such circumstances can of course cause a recognisable psychiatric illness as in this case. The development of many psychiatric illnesses may turn on a tipping point when stress, anxiety, worry or grief become overwhelming. It might often be that a particular event has propelled the plaintiff towards psychiatric illness. That however does not mean that in each such case the event in question qualifies as a *sudden shocking event* legally speaking. Whether or not it so qualifies will depend upon the nature of the event, the quality of the plaintiff's perception of it and the aetiology or manner of causation of the plaintiff's psychiatric illness.

56. I therefore find that there was no *sudden shocking event* and that the plaintiff's psychiatric illness was not caused by shock. As a result, criterion 2 is not satisfied.

Criterion 3: Was the plaintiff's nervous shock caused by a defendant's act or omission?

57. A causal link must be established between the breach of duty and the damage to the plaintiff. On the authority of *Quinn v. Midwestern Health Board* [2005] 4 IR 1, this means that the plaintiff must prove that "but for" the defendant's breach of duty she would not have suffered an adjustment disorder.

58. It is important here to distinguish between what must be demonstrated under criterion 2 and criterion 3 respectively. Under criterion 2, the plaintiff must demonstrate that her

psychiatric illness was *shock induced*. This requires a *sudden shocking event* which in turn caused psychiatric illness in the sense already discussed. Under criterion 3 the plaintiff must demonstrate that this *shock induced* illness was caused by the defendant's negligent act or omissions.

59. The parties are agreed that it is not necessary for the plaintiff to show that the deceased suffered injury as a result of the missed diagnosis. It appears to be common case that a plaintiff may recover in nervous shock where no *"actual"* physical injury has been inflicted on any person provided physical injury to the plaintiff or, it seems, to another has been "*apprehended"*. In such a case, it is not an injury sustained but the "near miss" which is the frightening event.

60. Prof. Jonathan Waxman, consultant medical oncologist, who provided an expert report on behalf of the plaintiff concludes:

> "*Given the extent of the disease at point of diagnosis it is extremely unlikely that a diagnosis in October 2018 would have led to any change in treatment or prognosis."*

61. The plaintiff emphasises that Prof. Waxman also states that with earlier diagnosis the deceased would have received chemotherapy and radiotherapy[6] to palliate the symptoms caused by the primary lesion or brain secondaries. The report of Lena Walliman registered general nurse, states that once diagnosed, the deceased would have been offered palliative care, assistance in mobilising, support from a local community nurse for pain and confusion and overnight support. On the basis of the foregoing the plaintiff submits that had the deceased been diagnosed in time, he is unlikely to have demonstrated the sudden deterioration which occurred on 23rd December, 2018.

62. The defendant argues that, even if one accepts that the plaintiff's adjustment disorder was caused by witnessing the deceased's deterioration, (irrespective of whether it is characterised as slow and gradual or as a *sudden shocking event*) the plaintiff would have witnessed it in any event. I cannot disagree. I find that the plaintiff's experts' reports are insufficient to establish on the balance of probabilities that with earlier diagnosis, treatment and support the deceased's symptoms would not have deteriorated in the manner that they did. There is really no way of knowing whether the deceased would have gone into hospital before or after he had experienced the deterioration said to comprise the *sudden shocking event*. It

[6] The plaintiff did in fact receive radiotherapy in the Hermitage.

cannot be assumed that the plaintiff would not have witnessed this deterioration on the counterfactual scenario.

63. Does this mean that criterion 3 is not satisfied? One must first understand what criterion 3 requires. The simplest interpretation of criterion 3 is that the *sudden shocking event* which the plaintiff witnesses must have been caused by the defendant's act or omission. This would mean that, although the relevant *sudden shocking event* can be a near miss, the near miss nonetheless result from the defendant's negligent act or omission.

64. In all of the cases cited to me, the *sudden shocking event*, whether it be an accident or a near miss, was caused by the defendant's negligence. In *Byrne v. Southern and Western Railway Company* (Court of Appeal February 1884 (26 LR (IR)) railway points were left open as a result of the railway company's negligence causing a train to crash through the wall of the telegraph office at Limerick Junction where the plaintiff sat. In *Victoria Railway Commissioners and Coultas* [1888] 13 AC 222 (PC) due to the negligence of the railway company, gates at a level crossing were left open allowing the plaintiff to drive onto the tracks as a train approached. In the traffic accident and aftermath cases cited, the *sudden shocking event* witnessed or "*suddenly appreciated*" by the plaintiff (i.e. the accident itself, the immediate aftermath or the appalling condition of loved ones in hospital thereafter) was in each case a direct result of the defendant's negligent act. Likewise, in the employer's liability cases, for example *Curran v. Cadbury* [2000] 2 ILRM 343. In that case, the event which the plaintiff witnessed when she turned on a conveyor belt while a fitter was inside it repairing it was occasioned by the defendant's negligence. To similar effect, in *Fletcher*, Geoghegan J. cited an observation of Brennan J. in *Jaensch v. Coffey* that *"the courts have insisted on proof of a demonstrable and readily appreciable cause of the psychiatric illness – the cause itself being a result of the defendant's careless conduct - before damages for negligence occasioning psychiatric illness are awarded*."

65. It is therefore doubtful that a plaintiff can recover damages for psychiatric injury consequent on a *sudden shocking event* which would have occurred irrespective of the defendant's negligence. Indeed, in the present case, Prof. Lane accepted that the plaintiff's adjustment disorder would have been precipitated by her husband's physical deterioration no matter when or how those symptoms had presented.

66. To meet this argument the plaintiff submits that even if the deceased's physical decline was unavoidable, earlier diagnosis would have ameliorated the manner in which she was exposed to this frightening event. Thus, she argues that, if the deceased's incurable cancer had been diagnosed at an earlier point, an advance care plan could have been formulated and the plaintiff would have received emotional support and bereavement care. Essentially, therefore the plaintiff submits that even if the deceased's deterioration was inevitable, earlier diagnosis would have ensured that her experience was less traumatic.

67. I am not convinced that criterion 3 causation is sufficiently granular to shift the focus from whether the defendant's negligence caused what the plaintiff witnessed to whether it negatively impacted the manner in which an inevitable event was witnessed.

68. In any event, the evidence does not establish that the plaintiff's lack of preparedness played a significant causative role. The plaintiff emphasised that the deceased's deterioration was particularly upsetting as she had understood that all was well. Prof. Lane made a comment to a similar effect. However, Prof. Lane did not address the plaintiff's state of preparedness or the potential of palliative care or counselling to prevent psychiatric illness. Prof. Lane did not opine that the plaintiff's psychiatric illness could be attributed to her lack of advance knowledge of the deceased's diagnosis. The court is effectively being asked to infer that knowledge of the deceased's terminal diagnosis would have cushioned the plaintiff from the psychological impact of witnessing his physical deterioration. This is by no means a given. Nor is it an inference that can be drawn without any expert testimony to support it.

69. As such, I am not satisfied that, but for the defendant's breach of duty the plaintiff would not have suffered nervous shock.

Criterion 4: Actual or apprehended injury

70. The plaintiff must demonstrate that her nervous shock was sustained by reason of actual or apprehended physical injury to herself or another person. Although the subject of a minor skirmish in written submissions, no issue was raised in argument as to compliance with criterion 4.

Criterion 5: Did the defendant owe the plaintiff a duty of care not to cause her a reasonably foreseeable injury in the form of nervous shock?

The requirement of a duty of care

71. It has been observed that a person "*is entitled to be as negligent as he pleases towards the whole world if he owes no duty to them"*[7]. The concept of duty of care is generally regarded as a control device whereby the courts may, as a matter of law, limit the range of liability within what they consider to be reasonable bounds.

72. The defendant clearly owed a duty of care to the deceased, its patient, but did it owe a duty of care to its patient's relative, the plaintiff? The plaintiff suggests that in medical negligence cases, a doctor's criterion 5 duty of care emanates from the duty of care owed by the doctor to their patient, in this instance the deceased. In other words, it is argued that the doctor's duty of care to a patient's relatives is derivative of (and indeed co-extensive with) the duty owed to their patient.

73. It does not seem to me that the duty of care in an action for nervous shock arising from actual or apprehended physical injury to another can simply be derived from the defendant's duty of care to the person injured or imperilled. That is not how criterion 5 is framed. Rather, criterion 5 requires the plaintiff to show that the defendant owed *him* or *her* a duty of care not to cause *him* or *her* a reasonably foreseeable injury in the form of nervous shock. Hamilton C.J. does not endorse the rigid distinction between primary and secondary victims or the associated control mechanisms. However, it is clear from criterion 4 that nervous shock by reason of actual or apprehended injury to a person other than the plaintiff was within his contemplation when framing the five criteria outlined. If criterion 5 were intended to mean that breach of a duty of care to the person injured was sufficient to give rise to liability to the plaintiff, then one would have expected it to be differently worded.

74. Furthermore, the significant reliance placed by the Supreme Court in *Kelly v. Hennessy* on *Jaensch v. Coffey* and on the judgment of Brennan J. in particular also augurs against a derivative duty of care. In *Jaensch v. Coffey,* Brennan J. emphasised that where psychiatric illness is caused by perceiving the consequences of the defendant's carelessness, typically a physical injury inflicted on another, it is not sufficient for the plaintiff to prove that the defendant has failed in their duty of care to that other. The plaintiff must prove that the

[7] McMahon & Binchy, *Law of Torts*, 4th Edn ("McMahon & Binchy"), para 6.01

defendant's carelessness was in breach of duty owed to the plaintiff specifically. Brennan J. observed that it is settled law that the duty owed to one is not to be regarded as secondary to or derived from the duty owed to the other. The logic of this is that where, as in this case, the nervous shock to the plaintiff arises out of actual or apprehended injury to another person (the deceased), the respective duties of care owed to the plaintiff and the deceased and the causes of actions arising from any breach thereof are independent of each other.

75. I therefore cannot accept the argument that criterion 5 permits of an essentially derivative duty of care.

Does the *Glencar* test govern the duty of care in nervous shock cases?

76. The next issue to consider is whether the re-statement of the duty of care as set out in *Glencar Explorations Plc v. Mayo County Council No. 2*, [2002] 1 IR 84 applies to the duty of care in nervous shock cases? *Kelly v. Hennessy* was decided in 1995. At that time, the primary Supreme Court decision on the existence of a duty of care on broader negligence principles was *Ward v. McMaster* [1988] IR 337, decided in 1988. In *Ward v. McMaster*, McCarthy J. considered that the duty of care arose from the proximity of the parties, the foreseeability of damage and the absence of any compelling exemption based on public policy. Not only was it for the defendant to establish such countervailing policy considerations but the *"exemption"* would have to be a *"very powerful one"* if it was to be used to deny an injured party his *"right to redress"*.

77. However, in *Glencar*, Keane C.J. stated:

> *"There is, in my view, no reason why courts determining whether a duty of care arises should consider themselves obliged to hold that it does in every case where injury or damage to property was reasonably foreseeable and the notoriously difficult and elusive test of 'proximity' or 'neighbourhood' can be said to have been met, unless very powerful public policy considerations dictate otherwise. It seems to me that no injustice will be done and they are required to take the further step of considering whether, in all the circumstances, it is just and reasonable that the law should impose a duty of a given scope on the defendant for the benefit of the plaintiff …"*

78. This has been described as either a three stage test or as a four stage test in which the elements necessary to establish a duty of care are (i) reasonable foreseeability (2) proximity of relationship (3) the absence of countervailing public policy considerations and (4) the fairness, justice and reasonableness of imposing a duty of care.

79. Is the existence of a criterion 5 duty of care in a nervous shock action now to be established by reference to the *Glencar* test?

80. In *Morrissey*, Cross J. considered Mr. Morrissey's nervous shock claim arising from the failure of the Cervical Cancer Screening Services to detect abnormalities in a smear sample taken from his wife. Cross J. determined the case on the basis of criterion 5, namely whether or not Mr. Morrissey was owed a duty of care. Cross J stated:

> *"I believe that approaching this case on the basis of the duty of care is more satisfactory than an analysis as is sometimes engaged in the courts in England as to distinctions between 'primary' and 'secondary' victims. The neighbour principle established by Lord Atkins in Donoghue and Stephenson ...is the principle basis for establishing a duty of care. However, since the decision of the Supreme Court in Glencar ... a court must consider three or four (and whether it be three or four is not of any great significance) preliminary considerations in cases where the issue of whether a duty of care is owed arises; i.e. is there reasonable foreseeability, is there proximity of relationship, are there any countervailing public policy considerations and finally the justice and reasonableness imposing a duty of care".*

81. Similarly, in *Sheehan v. Bus Eireann* [2022] IECA 28, the plaintiff suffered psychiatric injuries when she came upon a road traffic collision in which her car was struck by flying debris from the impact and in which she saw the remains of the driver who had caused the collision. Keane J. in the High Court held that the test for the existence of a criterion 5 duty of care was equivalent to that articulated by Keane C.J. in *Glencar.* On appeal Noonan J. agreed that the imposition of liability should be approached from the standpoint approved in *Glencar* and *Fletcher,* of reasonable foreseeability, proximity and the reasonableness of the imposition of the duty of care on the facts of the case.

82. It seems to be clear therefore that the existence or otherwise of a duty of care as between the plaintiff and defendant under criterion 5 is to be determined by the *Glencar* test. Indeed, I did not understand either of the parties before me to argue to the contrary. However, as explained below, it is not clear whether the requirement of "proximity" bears a specialised meaning in nervous shock cases where the plaintiff is a bystander who has sustained no actual or apprehended physical injury as a result of the defendant's negligence.

Broad explanation of the concepts of reasonable foreseeability and proximity

83. It might first assist to recall the distinction between reasonable foreseeability and proximity. Foreseeability proceeds on the principle that a defendant will only owe a duty of

care to a plaintiff if reasonable people in the defendant's position could foresee that their act or omissions might cause the relevant type of harm to people such as the plaintiff. The general principle is that the greater that should have been the awareness of the potential harm, the more likely it is that foreseeability will be established. As observed by McMahon & Binchy, proximity is more demanding than this. Whilst foreseeability is an element of proximity the latter requires "*something more".* Proximity involves the notion of nearness or closeness and generally focuses on the broader relationship between the parties from the perspective of both the defendant and the plaintiff.

Foreseeability alone is not sufficient to establish duty of care

84. The defendant argues, correctly, that foreseeability is generally a necessary but not a sufficient element of the duty of care in negligence. In *Fletcher,* Keane C.J. stated:

> *"However, the fact that it is reasonably foreseeable that particular acts or omissions will cause loss or injury to another person does not, of itself, give rise to liability in negligence. There must also be what judges have called, as the law has evolved, a relationship of "proximity" between the plaintiff and the defendant which gave rise to the legal duty to take care that the foreseeable consequence was avoided."*

85. In a similar vein, Geoghegan J. stated:-

> "*The trial judge decided this case in favour of the plaintiff on the basis that the plaintiff, in relation to his psychiatric injury had passed the test of 'reasonable foreseeability'. There is no doubt that the passing of such a test was an essential requirement. But, as is clear from all the leading cases in common law jurisdictions, 'reasonable foreseeability' is not the only determining factor.*
> *Elements such as proximity (a concept given wide meaning in the case law), reasonableness in the imposition of a duty of care in public policy may all play a role.*"

86. He later summarised this principle as follows:

> *"Reasonable foreseeability is not the only determining factor in establishing a duty of care. "Proximity" which is given an elastic definition in the decided cases, the reasonableness of the imposition of a duty of care and questions of public policy can be additional determining factors."*

Are the different elements of the *Glencar* test satisfied in this case?

Reasonable Foreseeability

87. Reasonable foreseeability has a particular meaning in the context of a nervous shock action. In *Kelly v. Hennessy*, Hamilton C.J. stated that to succeed in nervous shock, it is not enough for the plaintiff to show that there was a reasonably foreseeable risk of personal injury generally. Rather, the plaintiff must demonstrate a reasonably foreseeable risk that psychiatric injury (unassociated with conventional physical injury) will result. Having said that, it is not

necessary for a plaintiff to prove that a reasonable person in the defendant's position could foresee that any particular psychiatric illness might be caused by his conduct: it suffices that they could have foreseen that their conduct might cause some recognised psychiatric illness by shock. Nor is it necessary that the precise events leading to the plaintiff's shock were foreseeable.

88. In *Fletcher,* Geoghegan J. observed that the test of foreseeability, at least for psychiatric injury, is based on a person of "*normal fortitude*". It seems that this requirement is intended to exclude from compensation those who are peculiarly sensitive to psychiatric illness. However, once it is established that a person of reasonable fortitude might foreseeably have suffered psychiatric illness, the normal "*eggshell skull*" rule of remoteness of damage applies, so the plaintiff can recover for the full extent of the illness, even if it is exacerbated by an unanticipated predisposition to mental illness.

89. The defendant in the present case does not dispute that psychiatric injury to the plaintiff, as a person of normal fortitude, was a reasonably foreseeable consequence of the misdiagnosis of the deceased's cancer. As such and given that the foreseeability test is traditionally viewed as undemanding,[8] I will accept the plaintiff's submission that the defendant ought to have foreseen that a want of care in diagnosing the deceased's cancer could lead to grave consequences for the deceased and to consequent psychiatric injury to his wife, the plaintiff. In short, I will assume that the foreseeability requirement is satisfied and pass on to the next elements of the *Glencar* test.

90. The defendant argues that merely because it is foreseeable that relatives will suffer damage as a result of medical negligence does not mean that there is proximity as between those relatives and the doctor. It argues that the key aspect of the *Glencar* test is proximity of relationship to which I now turn.

Different approaches to proximity

91. It is apparent that there is a key difference between the parties as to the meaning of the proximity requirement. This difference is unlikely to present itself where a patient brings a nervous shock action for psychiatric injury resulting from actual or apprehended injury caused

[8] Generally, what must be established is that there was a "real" risk of psychiatric illness: the kind of risk which a reasonable person "would not brush aside as far-fetched or fanciful" (per. Lord Reid's judgment in *The Wagon Mound (No 2)* [1967] AC 617)

to themselves by their doctor's negligent treatment. A doctor undoubtedly owes a duty of care to their patient and proximity of relationship will be taken as read. However, proximity requires greater analysis in an action taken by a bystander, such as in the present case where the plaintiff is not a patient of the defendant but a relative of that patient.

Proximity derived from an assumption of responsibility

92. The defendant places significant reliance on *Paul* as supporting its argument that no duty of care exists as between a doctor and the relative of a patient. *Paul* arose from three related cases of nervous shock caused by medical negligence. In two of them, the plaintiffs were present when their father and their young daughter respectively died in shocking circumstances. In the third case the plaintiff came upon her daughter in similar circumstances a few minutes after her death. In each case, the plaintiffs claimed that the death was caused by the negligence of the defendant in failing to diagnose and treat a life threatening medical condition from which the deceased was suffering. Each plaintiff claimed compensation for psychiatric illness caused by the experience of witnessing the death, or its immediate aftermath. The Supreme Court of England and Wales considered whether there was sufficient proximity between a doctor and the relative of a patient to establish a duty of care. Ultimately the Supreme Court rejected the notion that a doctor who owes a duty of care to a patient also owes to members of that patient's close family a duty to take care to shield them against the risk of illness from the experience of witnessing the medical crisis of their relative consequent upon that doctor's negligence. The court determined that a doctor who treats a patient does not enter into a doctor-patient relationship with any member of that patient's family. The defendant in the case before me invokes the following reasoning of the Supreme Court in support of its submission that a doctor does not owe a duty of care to the relatives of patients.:

> *"131. ..Sometimes, however, proximity is established by a pre-existing relationship between the parties. A concept used to explain how such a relationship may give rise to a duty of care is that of assumption of responsibility. The core of this idea is that a person (A) who provides a service to another person (B) who reasonably relies on A's expertise in performing the service assumes a responsibility to B to perform the service with reasonable care and skill.*
> *132. By providing a service, whether under a contract for reward between the doctor and the patient or - as in the case of a patient entitled to treatment under the National Health Service - where the doctor is paid by the state, the service-provider assumes a responsibility towards the person to whom the service is provided, which gives rise to a duty of care.*
> *133. The scope of the duty will vary with the circumstances and will depend, critically, on the purpose for which the service is provided."*
> *136. Here the question is whether a doctor who owes a duty of care to a patient also owes a duty to members of the patient's close family to take care to protect them against*

the risk of illness from the experience of witnessing the medical crisis of their relative arising from the doctor's negligence.
137. It cannot be said that a doctor who treats a patient thereby enters into a doctor-patient relationship with any member of the patient's family and thereby assumes responsibility for their health…
138. Common to all cases of this kind, however, is a fundamental question about the nature of the doctor's role and the purposes for which medical care is provided to a patient. We are not able to accept that the responsibilities of a medical practitioner, and the purposes for which care is provided, extend to protecting members of the patient's close family from exposure to the traumatic experience of witnessing the death or manifestation of disease or injury in their relative. To impose such a responsibility on hospitals and doctors would go beyond what, in the current state of our society, is reasonably regarded as the nature and scope of their role.
139. There is no doubt that witnessing the death from disease of a close family member can have a powerful psychological impact additional to the grief and deep distress caused by the fact of the death... But although social attitudes and expectations may be changing, we would not accept that our society has yet reached a point where the experience of witnessing the death of a close family member from disease is something from which a person can reasonably expect to be shielded by the medical profession. That is so whether the death is slow or sudden, occurs in a hospital, at home or somewhere else, and whether it be peaceful or painful for the dying person. We do not mean in any way to minimise the psychological effects which such an experience may have on the person's parent, child or partner when we express our view that, in the perception of the ordinary reasonable person, such an experience is not an insult to health from which we expect doctors to take care to protect us but a vicissitude of life which is part of the human condition."

93. However, it is crucial to note that before embarking on the above analysis of the duty of care and considering proximity in particular, the Supreme Court first considered whether the rules on nervous shock applied at all to cases of *"medical crisis"* where the claimant's injury is caused by witnessing the death or injury of a close relative, not in an accident, but from a medical condition which the defendant had negligently failed to diagnose and treat. The Supreme Court stated:

> "*The key question which we have to decide is whether the rules that determine when the necessary proximity exists to give rise to a duty of care owed to a secondary victim in an accident case (or analogous rules) apply in cases of medical negligence where there is no accident."*

94. The court answered this question in the negative, holding that medical crises were in no way analogous to the kinds of accidents on which the nervous shock jurisprudence was based. Nervous shock required an accident, which the court defined as "*an unexpected and unintended event which caused injury (or a risk of injury) by violent external means to one or more primary victims*". By contrast, in cases of a medical crisis "*the event (or its aftermath)*

witnessed by the secondary victim is generally not an accident; it is the suffering or death of their relative from illness..."

95. The Supreme Court thus determined that witnessing a negligently caused medical crisis (or its aftermath) was not generally within the rubicon of nervous shock. This is somewhat reminiscent of Geoghegan J.'s statement in *Fletcher* that *Kelly v. Hennessy* should only be taken to relate to accident damage. [9] As in *Fletcher,* the Supreme Court in *Paul* then proceeded to determine on broader negligence principles whether a duty of care was owed by a doctor to a patient's relative. For the reasons set out in the extract above, it determined that, in this context, proximity was not made out.

96. In summary, *Paul* (1) excludes medical crises from the nervous shock paradigm and (2) holds that due to a lack of proximity doctors do not generally owe relatives a duty of care.

97. In the present case, the defendant does not argue that medical crises are excluded from the nervous shock paradigm. Rather both parties agree that this case should be approached as one of nervous shock. Regardless, the defendant relies on *Paul* to exclude proximity as between doctors and relatives and thus to foreclose a duty of care under *Kelly v. Hennessy* criterion 5. It argues that proximity must be assessed in the same manner as would apply in a broader negligence action brought by the relative against the doctor (which I shall refer to as free standing proximity). This is said to mean that proximity as between a relative and a doctor can only be based upon an assumption of responsibility on the part of the doctor for the health and well-being of the relative specifically (as opposed to the patient).

98. However, this overlooks the fact that, in *Paul*, the Supreme Court was not applying the concept of proximity in the nervous shock sense but proximity based on broader negligence principles, which it regarded as being different. Moreover, the court made it clear that, if it had approached the case as one of nervous shock to a bystander, then proximity would have been determined, in essence by the *McLoughlin /Alcock* control mechanisms.[10]

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[9] Similarly, in *Devlin v. National Maternity Hospital* [2008] 1 ILRM 401, Denham J. observed that the common law had evolved by reference to the occurrence of a specific event – a railway or car accident. She stated that *"the common law provides illustrations of successful cases where damages for nervous shock were awarded. However, those cases relate to perceiving an accident or its immediate aftermath."*

[10] As to which see para. 102 below

99. This undermines the defendant's essential premise that, for the purposes of criterion 5, relational proximity as between a relative and a doctor must be determined by reference to broader negligence principles on the basis of assumption of responsibility.

100. By contrast the plaintiff's approach, which is to emphasise the importance of a relative's relational proximity to the patient, their physical or spatial proximity to the *sudden shocking event* and the role of the *sudden shocking event* in causing the psychiatric illness suffered. Within the nervous shock rubicon, this approach to proximity is actually quite consistent with the *McLoughlin /Alcock* control mechanisms as referenced by the court in *Paul.*

101. The following legal question therefore arises: is it the law in this jurisdiction that proximity in a nervous shock action has a special meaning and is therefore to be distinguished from free standing proximity based upon broader negligence principles? If so, then criterion 5 proximity as between a doctor and the patient's relative, may not turn solely on the assumption of responsibility.

Does proximity have a special meaning in the context of nervous shock?

102. At this point it is necessary to consider the development of nervous shock in the courts of England and Wales. The landmark House of Lords decision on nervous shock is *McLoughlin v. O'Brian* [1982] 2 All ER 298. On facts not dissimilar to *Kelly v. Hennessy,* the plaintiff suffered psychiatric injury as a result of witnessing her family's condition in the aftermath of a road traffic accident caused by the defendant's negligence. The majority of the House of Lords favoured the test of reasonable foreseeability as the foundation of the duty of care. However, the minority, including Lord Wilberforce in particular, considered that there was a need for limitations on the extent of admissible claims particularly by bystanders - i.e. persons who later came to be known as *"secondary victims*". Lord Wilberforce identified the following elements as necessary for the imposition of a duty of care as between a plaintiff and the tortfeasor: proximity of relationship between the plaintiff and the person injured (relational proximity); proximity to the accident (spatial proximity) and proximity as to the means by which the shock was caused, which should be either by sight or hearing, attending at the immediate aftermath, or possibly through some equivalent thereof such as simultaneous television (temporal proximity). Thereafter, in *Alcock,* in which overcrowding attributable to negligent management on the part of the police caused death and injury to many in the Hillsborough stadium leading to claims for nervous shock by the relatives and close friends of

the injured and deceased persons, the House of Lords broadly adopted the approach of Lord Wilberforce in *McLoughlin*.

103. So, by the time that *Kelly v. Hennessy* came to be decided, established jurisprudence from the House of Lords viewed foreseeability of injury by shock as key in establishing liability. However, additional limitations, based largely on requirements of proximity were also levied upon bystanders. Crucially, proximity in this context, did not equate to proximity on broader negligence principles as per Lord Atkin's neighbour principle,[11] but was rather based on proximity of relationship, time and space and means of communication.

104. Against this background, what approach did the Supreme Court take to the duty of care, and proximity in particular, in *Kelly v. Hennessy?*

Kelly v. Hennessy

105. After setting out criterion 5, Hamilton C.J. observed that the question of who came within the scope of those to whom a defendant owes a duty of care was the subject of debate. Hamilton C.J then noted that:

> *"However, the question relevant to this appeal is whether the plaintiff came within the scope of the defendant's duty of care and the fact that she does so is not in issue."*

106. Because duty of care was not in issue in *Kelly v. Hennessy*, it is not easy to state with any certainty what legal principles might govern proximity in a case such as the present. Specifically, although it is clear that both foreseeability and proximity are separately required to establish a duty of care in a nervous shock action it is not clear what the latter entails.

107. Hamilton C.J. commenced his analysis of duty of care by quoting Lord Atkin's neighbour principle as articulated in *Donoghue v. Stevenson* [1932] 1 AC 562, in the development of the concept of duty of care:

> *"The rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyer's question, who is my neighbour? receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be – persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question."*

[11] As to which see para 107 below

108. The Chief Justice then stated:

> *"There is no doubt but that nervous shock and a psychiatric illness induced by it are reasonably foreseeable consequences of the defendant's negligence in this case.*
>
> *Nor is there any doubt but that the plaintiff came within the defendant's duty of care."* (Emphasis added)

109. In applying Lord Atkin's neighbour principle, Hamilton C.J. appeared, if not to equate foreseeability and proximity, to nonetheless treat the former as strongly indicative of the latter. This approach was also taken by Brennan J.'s highly influential judgment in *Jaensch v Coffey.*

110. Hamilton C.J.'s analysis of the duty of care also contains echoes of Lord Wilberforce's proximity requirements in *McLoughlin v O'Brian.*[12] Hamilton C.J. stated that:-*"…the law permits of the recovery of damages for nervous shock and psychiatric illness induced thereby where a plaintiff comes on the immediate aftermath of an accident."* This calls to mind Lord Wilberforce's requirement of proximity of the plaintiff to the *sudden shocking event* in terms of time and space. Hamilton C.J. also stated that *"The relationship between the plaintiff and the person injured must be close"* which is reminiscent of a further requirement suggested by Lord Wilberforce in *McLoughlin*, of close relationship to the person injured.

111. Whist clearly, foreseeability remains a *sine qua non* for a duty of care, the judgment of Hamilton C.J. does not analyse what is required to establish proximity as between the plaintiff and the defendant, as opposed to as between the plaintiff and the person injured (or imperilled) or as between the plaintiff and the *sudden shocking event*.

112. In her judgment, Denham J. viewed the case as turning on the issue of proximity, which she then stated: "*may include (a) proximity of relationship between persons, (b) proximity in a spatial context; and (c) proximity in a temporal sense"*. This also echoes the policy considerations identified by Lord Wilberforce. Denham J. decided that, on the facts of *Kelly v. Hennessy,* there was a sufficiently proximate relationship and sufficient spatial and temporal proximity to entitle the plaintiff to recover.

113. Geoghegan J. observes in *Fletcher*, that in ordinary motor accidents the court does not normally have to consider aspects of the tort of negligence other than reasonable foreseeability.

[12] This is noted by McMahon & Binchy, para 17.57

The "neighbour" of a motorist for the purposes of negligent liability is the person whom, it can reasonably be foreseen, the motorist may injure through the negligent use of their motor car. It has always been considered reasonable that liability should arise in such circumstances and, as a result reasonable foreseeability and proximity effectively merge. This reflects the fact that, where physical injury is caused by negligent conduct, the courts do not generally look for the existence of a prior relationship between the parties.

114. The same logic might explain the approach to nervous shock claims arising from motor accidents. It is taken as being reasonably foreseeable that an accident caused by dangerous driving has a high propensity to cause injury by nervous shock to the close relatives of the person injured. This results in a merger of reasonable foreseeability and proximity. Consequently, as in *Kelly v. Hennessy,* the courts have not analysed the rationale for a finding of proximity as between a negligent motorist and the relative of the person injured. Rather the focus is on other kinds of proximity as discussed at para. 110 and 112.

115. This does not hugely assist in ascertaining what precise factors might establish proximity on the part of a bystander in a nervous shock case where the underlying negligent act is of an entirely different character - in this instance, clinical misdiagnosis.

Proximity post Kelly v. Hennessy

116. *Kelly v. Hennessy* remains the only Supreme Court case analysing the factors necessary to give rise to a duty of care to a bystander. The proximity required to establish a duty of care in such circumstances was not analysed in *Fletcher* for several reasons: first, because the Supreme Court found that the absence of a *sudden shocking event* meant that the case was not one of nervous shock at all; second, because the plaintiff was not a bystander and was in fact the only victim of the defendant's negligence; and third because proximity was not in issue as the plaintiff was the defendant's employee. *Fletcher* did not revolve around proximity but on the third and fourth elements of the *Glencar* test - public policy considerations and the fairness, justice and reasonableness of imposing a duty of care.

117. The next consideration by the Supreme Court of nervous shock was *Devlin v National Maternity Hospital* [2008] 2 IR 222 in which the plaintiffs developed a psychiatric illness on becoming aware that certain of their stillborn baby's organs had been removed and retained by

the defendant hospital. However, as the plaintiffs had not satisfied *Kelly v. Hennessy* criterion 4 of an actual or apprehended injury, duty of care was only briefly touched on.

118. Although the Court of Appeal comprehensively analysed the nervous shock jurisprudence in both *Harford* and *Sheehan*, the facts of those cases did not necessitate an analysis of proximity in the case of a plaintiff who is a bystander. In *Harford*, the plaintiff was the only person involved in any putative "event" and the case turned on his failure to establish either a *sudden shocking event* under criterion 2 or actual or apprehended injury under criterion 4. *In Sheehan*, Noonan J. noted that the primary/secondary classification developed by the English courts and its associated control mechanisms had not been adopted in this jurisdiction. However, both Noonan and Collins JJ. determined that even if the distinction between primary and secondary victims were accepted, the plaintiff was *"far from being a mere bystander or spectator*"[13]. As the plaintiff had been put at risk by the collision, she was a primary victim of the deceased's negligent driving. In considering whether the deceased owed the plaintiff a duty of care Noonan J. held that it was reasonably foreseeable by the defendant that the plaintiff might suffer personal injury, either physical, psychiatric, or both, as a result of his negligence. Noonan J. then stated that:

> *"Proximity considerations only arise in the sense intended by Lord Atkin of the plaintiff being a person so closely affected by the actions of the defendant as to be reasonably within his contemplation when directing his mind to those actions. Other proximity factors discussed in the context of the English cases dealing with secondary victims, and in particular, proximity of relationship, are irrelevant here."*

119. What is not clear is whether some or all of those proximity considerations might have been relevant if the plaintiff had been a bystander who was not directly imperiled by the deceased's negligent driving.

120. *Kelly v. Hennessy* therefore remains the last word (at least of the authorities opened to me) on proximity where, as in this case, the plaintiff is a bystander. *Kelly v. Hennessy* lends some support to an argument that in the case of a bystander, proximity emerges, in part at least, from factors such as proximity to the person injured or imperiled by the *sudden shocking event* or proximity to the *sudden shocking event* itself.

[13] Per Collins J.

121. It is therefore arguable that, in nervous shock, the *sudden shocking event* not only limits recoverability (through the imposition of criteria 2 and 4) but also infuses the duty of care (in the context of criterion 5). It may be that the requirement for a *sudden shocking event* is both a perimeter of liability in nervous shock and a potential gateway into such liability. If so, the factors which might establish proximity in a nervous shock case in which the plaintiff sues *qua* bystander will not necessarily be the same factors as would establish free standing proximity in a stand-alone negligence action.

Causal proximity/Confluence of proximities

122. Although the defendant presses assumption of responsibly as the only basis for establishing proximity, it is worth recalling that although often approached as a search for a pre-existing relationship between the plaintiff and the defendant, even free standing proximity based on broad negligence principles can be broader than that. In *Fletcher* Geoghegan J. characterised proximity as a concept given "*a wide meaning"* and "*an elastic definition*"[14].

123. In *Jaensch v. Coffey,* Deane J. stated of Lord Atkin's neighbour principle:

> *"Lord Atkin did not seek to identify the precise content of the requirement of the relationship of "proximity" which he identified as a limitation upon the test of reasonable foreseeability. It was left as a broad and flexible touchstone of the circumstances in which the common law would admit the existence of a relevant duty of care to avoid reasonably foreseeable injury to another. It is directed to the relationship between the parties in so far as it is relevant to the allegedly negligent act of one person and the resulting injury sustained by the other. It involves the notion of nearness or closeness and embraces physical proximity (in the sense of space and time) between the person or property of the plaintiff and the person or property of the defendant, circumstantial proximity such as an overriding relationship of employer and employee or of a professional man and his client and causal proximity in the sense of the closeness or directness of the relationship between the particular act or cause of action and the injury sustained…"*

124. The identity and relative importance of the factors which determine proximity will vary in different categories of cases and from case to case and may also involve value judgments on matters of policy and degree.

125. Similar considerations were referred to in *Paul.* Lord Leggatt and Lady Rose stated:

> *"As regards other factors relevant to whether the necessary relationship of proximity exists, the extent of the control which a doctor may be seen as having over the risk of injury to members of the patient's family and the directness of the causal link between*

[14] See paras. 86 and 87 cited above

the doctor's negligence and the materialisation of that risk will depend upon the particular facts of the case."

126. Arguably, criterion 5 proximity engages circumstantial and causal factors in the sense discussed by Deane J. and by Lord Leggatt and Lady Rose in the above passages. Further, whilst it is clear that the Irish Courts are opposed to drawing hard and fast lines or devising inflexible control mechanisms, considerations of relational, spatial and temporal proximity were expressly referenced by Hamilton C.J. and Denham J. in *Kelly v. Hennessy* itself. Proximity is quite resistant to definition but, at least in the context of criterion 5, it may encompass a confluence of proximities such as this. It may be that the greater the confluence of proximities, the more likely it is that a duty of care will be found to exist. Indeed, such a confluence of proximities may be particularly pertinent in an action for nervous shock. Such confluence reinforces the relevance of the *sudden shocking event* which, after all, is a central element in the nervous shock paradigm.

Assessment of proximity and duty of care in the present case

127. The Court is presented with a stark choice. If it accepts the defendant's submissions and determines that proximity may only be established on the basis of assumption of responsibility, this is likely to exclude a duty of care and rule out nervous shock claims by patients' relatives in the majority of medical negligence cases. Conversely, if one can look beyond assumption of responsibility and also assesses proximity by reference to factors such as those discussed at para. 126 above, proximity might be established in a considerably broader range of medical negligence cases. I should however emphasise that even on the latter approach- and assuming that reasonable foreseeability and proximity are established- the court would still be required, under *Glencar* to assess whether it is reasonable to impose the criterion 5 duty of care contended for on the facts of each case. The point, however, is that, if proximity cannot be established, one does not even reach that stage of the enquiry as duty of care is foreclosed.

128. The legal submissions of both parties were thorough. However, the question discussed, namely whether proximity in a nervous shock action is different to free standing proximity based upon broader negligence principles, was not fully argued. Moreover, the Irish authorities provide little guidance on how to approach proximity in a nervous shock action brought by a bystander and no guidance at all on the issue in a medical negligence context.

129. As I have determined that this plaintiff does not satisfy criteria 2 and 3, it is unnecessary to determine this issue in the broad manner argued by the parties. In any event, as I now explain, irrespective of how proximity is interpreted, I am not satisfied that the defendant owed the plaintiff the duty of care contended for.

130. I first assume that the defendant is correct and that criterion 5 proximity is based on the doctor's assumption of responsibility. If so, proximity as between a doctor and a patient's relative will be difficult to establish. The purpose for which the doctor provides health services is to treat the patient and not to care for the patient's relatives. There is generally no expectation, or even authority, for a doctor to afford care to non-patients. The position is different when treatment is provided by a doctor not just for the benefit of the patient but also for the specific benefit of a relative (or other third party), such as in the case of a failed vasectomy, for example.

131. The plaintiff relies upon *ABC v. St Georges NHS Trust* [2020] EWHC 455 ("*ABC*"). The claimant's father who had killed her mother was convicted of manslaughter by reason of diminished responsibility and detained at the second defendant hospital under the care of a consultant forensic psychiatrist. Neurological investigations by the first defendant led to a diagnosis that the claimant's father suffered from a hereditary disease. The claimant, who had become pregnant, was known to the second defendant's clinical team through her engagement in family therapy under its auspices. She was not informed by the defendant of her father's diagnosis. The claimant alleged that, in order to enable her to make an informed decision on her pregnancy, the defendants owed her a duty to disclose to her the hereditary disease suffered by her father (their patient). The court found that the second defendant owed the plaintiff an attenuated duty of care only, namely, to balance her interest in being informed of her genetic risk against her father's interest and the public interest generally in preserving medical confidentiality. However, this duty arose because the claimant was a patient of the second defendant through its family therapy team or was otherwise in a relationship analogous to that of a patient undergoing therapeutic intervention. As such the second defendant had taken on clinical responsibility for the claimant which created a close proximal relationship and a consequent direct duty of care to her. This factual matrix is entirely distinguishable from the present case in which it could not possibly be said that the plaintiff was a patient of the defendant.

132. Further examples of duty of care to non-patients might arise in a case of infectious disease or in circumstances where a doctor acquires knowledge of ongoing child abuse by a patient. As in *ABC*, the duty of care in such cases will be worked out by incremental extension of the common law on a case by case basis. However, such examples provide no basis for a general duty of care to relatives.

133. In the present case, the plaintiff argues that the consultant had, or ought to have had, her in mind at all times because (a) she attended all medical consultations with the deceased, (b) she attended the index consultation on 2nd October, 2018 and was assured that the deceased was in good health and (c) the consultant was so concerned about the plaintiff's welfare that he sent her the open disclosure letter setting out the errors in the care and offering condolences and apologies.

134. These factors are insufficient to demonstrate that the consultant had assumed responsibility for the health or well-being of the plaintiff. The plaintiff attended these medical consultations not for her own benefit but for the deceased's benefit and to complement the advice and treatment afforded to him as a patient. It is clear that the consultant had the plaintiff in mind when he made open disclosure of the missed diagnosis. However, this does not imply that a separate duty of care owed by the consultant to the plaintiff had arisen at an earlier point in time during the provision of medical care to the deceased.

135. In short, proximity as between the plaintiff and the defendant could not be established in this case under an assumption of responsibility approach. Therefore, if that defines the proximity requirement under criterion 5, the plaintiff's case fails to satisfy it.

136. Secondly, my ultimate finding that duty of care is not established in this case would not be altered by the application of specialised proximity considerations as discussed at para. 126 above. The plaintiff is the deceased's wife, she witnessed the deceased *collapse"*[15] on 23rd December, 2018 and developed a psychiatric illness as a result. These factors are of course reminiscent of the proximity considerations referenced in *Kelly v. Hennessy* relational, spatial and temporal proximity. However, proximity alone does not give rise to duty of care.

[15] As she characterises it

137. Duty of care is no more than a convenient shorthand for a relationship between two parties which makes it fair and reasonable that one owes the other a duty of care. This requires that there is something about the relevant relationship, or in the overall circumstances, which gives rise to the duty of care. Almost all patients have relatives and doctors must be taken to know this. Doctors must also be taken to know that their patients' relatives might foreseeably be negatively impacted by witnessing the result of clinical negligence on the doctor's part. If these factors alone established not only proximity but also a duty of care, the number of potential plaintiffs in a medical negligence action could be multiplied by the number of potentially impacted family members.

138. Even if both reasonable foreseeability and proximity of relationship with the defendant were made out in this case, a duty of care requires more than that. Neither foreseeability nor proximity were in issue in *Fletcher*, yet duty of care was not made out on the remaining elements of the *Glencar* test. This was essentially because the Supreme Court was not satisfied that it was reasonable to impose the duty of care contended for.

139. A general requirement that a doctor consider the health of parties other than the patient is likely to give rise to unexpected consequences and to wide and uncontrolled liability. There might even be a conflict between the doctor's duty to the patient and that allegedly owing to the relative. One can readily foresee how a doctor's duty of confidentiality to their patient could deter a doctor from acting in a manner which would otherwise be in the relative's best interests. For example, a patient who is given an upsetting diagnosis might decide not to inform their relatives for some time. In such circumstances, a doctor is not generally expected to contemplate breaching doctor-patient confidentiality in order to disclose the patient's private health concerns to family members.

140. As the plaintiff accepts, relatives of patients who witness injury as a result of medical negligence are not *per se* entitled to compensation. The reasonableness of imposing a duty of care owed must be established on the facts of each case. It is hard to identify any distinguishing feature of this case which gives rise to a duty of care. How, it might be asked, is this case different from other cases of misdiagnosis?

141. The plaintiff points to the factors already discussed at para. 133 above, namely her attendance at the consultations and the open disclosure letter sent to her. However, it is

commonplace for relatives to attend medical consultations. Although open disclosure letters are not yet commonplace, they are clearly to be encouraged rather than discouraged. In considering whether it is just and reasonable to impose a duty, one does not only consider what would be just and reasonable between the parties but also what is just and reasonable in the public interest. It would seem entirely contrary to the interests of patients, to good healthcare practice and thus to the interests of broader society, to hold that a relative's attendance at medical consultations or their receipt of an open disclosure letter gives rise to a direct duty of care owed by a treating doctor.

142. Moreover, under the *Glencar* test, I am required to "*consider whether, in all the circumstances, it is just and reasonable that the law should impose a duty of a given scope on the defendant for the benefit of the plaintiff …"* .What, then, is the particular duty said to have been breached in this case? What is said to have caused the injury to the plaintiff?

143. Specifically, the plaintiff contends for a duty on the part of the defendant to shield her against the risk of psychiatric illness in witnessing a deterioration in its patient's health in an unprepared manner. This is not a risk which doctors ought to have in their reasonable contemplation when directing their mind to the medical care of their patients. Indeed, the duty of care contended for involves imposing upon the defendant hospital a duty over and above any duty owed to its patient, the contours and scope of which are vague and uncertain.

144. Establishing a duty of care to relatives in a particular case will always be a context driven analysis. In general, it is reasonable to hypothesise that the further one moves from the consequences of the original clinical negligence the less likely are the circumstances to be within any potential duty of care based on the doctor patient relationship. Indeed, in *Paul*[16], the Supreme Court attached importance to the extent of the control which a doctor may have over the risk of injury to members of the patient's family and the directness of the causal link between the doctor's negligence and the materialisation of that risk. In this case, it is not at all clear what steps were realistically available to the defendant to fulfil the duty of care contended for. There is also little direct causal relationship between the negligence in misreading the x-ray of 2nd October, 2018 and the materialisation of the psychiatric injury to the plaintiff. The precipitating event, the deceased's deterioration, would have occurred regardless of any

[16] See para. 126 above

negligence. The plaintiff must clear too many hurdles to connect the misinterpretation of the x-ray with her adjustment disorder. Causal proximity, if any, is very tenuous in this case.

145. Contrast this case with *Courtney,* the plaintiff brought her two year old daughter, Aisling to hospital because she appeared hallucinogenic. She stayed overnight with Aisling repeatedly requesting medical attention. The child developed a rash and purple spots and was placed on a drip. The plaintiff was ultimately informed that Aisling was being treated for meningitis and the child was connected to a variety of medical equipment. Aisling's condition rapidly deteriorated, she was brought to the intensive care unit and suffered a fatal heart attack. On the facts of *Courtney,* the defendant hospital was in a position to respond to and control the events causing the plaintiff's psychiatric injury. There was also a direct causal link between the defendant's negligence towards Aisling and the psychiatric injury suffered by Ms. Courtney. Perhaps one could also analyse a case such as *Courtney* as a systems failure[17] in the provision of a public health service which might more readily support a finding of proximity and also duty of care as between the hospital and the relative in question. Either way, the causal proximity is strong. The hurdles facing Ms. Courtney's nervous shock claim were few and relatively easy to clear.

146. The present case is at the other end of the spectrum. The plaintiff's case is that she suffered harm as a result of witnessing the deceased's decline in an unprepared manner. This is hard to describe as anything other than a remote consequence of the defendant's negligent misdiagnosis of the deceased's cancer.

147. In this particular case it matters not whether the duty of care contended is excluded because of lack of proximity or because considerations of countervailing public policy render it unfair, unjust or unreasonable to impose it. Suffice it to say that the present circumstances cannot in my view establish the duty of care contended for.

148. The plaintiff therefore cannot satisfy *Kelly v. Hennessy* criteria 2, 3 or 5 and it therefore follows that her claim in nervous shock must fail.

[17] The plaintiff suggests that this case is an example of a systems failure. I disagree. Events stem from the incorrect reporting of the x-ray of 2nd October 2018 and from the subsequent failure by the clinical team to follow up on the addendum radiology report correcting this error.

Fletcher* analysis beyond *Kelly v. Hennessy

149. The plaintiff submits that *Kelly v. Hennessy* does not set out a compendious code for the circumstances in which a bystander may recover damages for psychiatric injury. She argues that this court ought to assess, in a manner similar to *Fletcher,* whether the defendant owed the plaintiff a free standing duty of care. The plaintiff argues that even if she fails to satisfy the *Kelly v. Hennessy* criteria, it is nonetheless reasonable to impose liability on the defendant.

150. *Kelly v. Hennessy, Fletcher* and *Harford* are binding on this court in a case in which a plaintiff alleges that they have suffered psychiatric injury as a consequence of actual or apprehended injury to another person. There may in due course be a revision of the boundaries of recovery for nervous shock. Ultimately that would be a matter for the Supreme Court in a future case where it arises.

151. Besides, even if *Kelly v. Hennessy* did not set out a compendious code, this would not avail the plaintiff. Duty of care would still have to be established on the *Glencar* test. Outside the realm of nervous shock, many of the specialised proximity considerations discussed at para. 126 would not apply and sufficient proximity of relationship would be commensurately more difficult to establish. In any event, even if such proximity were established, the plaintiff's case would still fall at the next hurdle: the duty of care contended for is not one which it is reasonable to impose.

152. Whilst I have great sympathy for the plaintiff who undeniably has suffered psychiatric injury in addition to the heartbreaking loss of her husband, I am unable to find in her favour.

Appearances

Declan Doyle SC, Alan Keating SC and Alannah McGurk BL for the plaintiff instructed by Michael Boylan LLP

Eoin McCullough SC and Rory White BL for the defendant instructed by the State Claims Agency