Neutral Citation No. [2005] NIQB 19 | *Ref:* **MORF5210**

Judgment: approved by the Court for handing down | *Delivered:* **01/02/2005**

(subject to editorial corrections)

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH

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JOSEPH OLIVER CULLEN

-v-

ARMAGH AND DUNGANNON HSST

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MORGAN J

[1] The plaintiff claims damages for personal injuries allegedly sustained by him as a result of his treatment in South Tyrone Hospital (STH) in November 1997.

[2] In the early afternoon of 14 November 1997 the plaintiff was carrying out work to the roof of a garage at his home. He stepped onto a Perspex cover and fell through it a distance of approximately 10 feet onto a concrete floor below. He sustained a laceration to his head and other injuries. He made his way to a neighbour's house and an ambulance was called. He was conveyed to STH where he arrived at 2.37 pm.

[3] He was seen by the casualty officer at 2.40 pm and she took a history that he had hit his head and left posterior chest wall. X-rays established that he had a fractured left clavicle and fractured ribs on the left side. He was given pain killing relief and admitted to the High Dependency Unit of the hospital. No complaint is made in respect of any of this.

[4] At 5 pm the plaintiff was examined by the admitting doctor. He was at that time a junior house officer who had commenced work in the ward on 1 August 1997. This was his first contract after qualification in the summer. The admitting doctor carried out what was described as a head to toe examination or secondary survey. The plaintiff's case is that the examination was

negligently carried out because the admitting doctor failed to detect a subluxation/dislocation of the distal interphalangeal (DIP) joint of the right middle finger which the plaintiff had sustained in the fall. The defendant put the plaintiff on proof that he had sustained such an injury in the fall and in any event contended that the fact that such an injury was not detected was not negligent in the circumstances.

[5] A subluxation of the plaintiff's DIP joint in the right middle finger was noted at STH at approximately 12.30 pm on 9 December 1997 some 25 days later. Closed reduction was not possible and the plaintiff went to Belfast City Hospital the following day. He was examined by Mr Calderwood who was also unable to achieve closed reduction and had to operate. Mr Calderwood's evidence is that the notes of the operation suggest that the subluxation/dislocation had occurred at least 7 days but no more than 4 months prior to the operation.

[6] It is common case that if such an injury is detected within 5 days it can normally be resolved by closed reduction rather than open reduction. In cases of closed reduction a greater degree of movement would be retained and it would be unnecessary to undergo operative treatment. In order to succeed the plaintiff first had to show on the balance of probabilities that at the time of his admission to the High Dependency Unit in STH he had a recent subluxation/dislocation of the DIP joint of the right middle finger. If the injury was sustained more than 5 days before his admission there is no basis for concluding that the plaintiff has suffered any loss by reason of its non-detection.

[7] Mr Calderwood was called on behalf of the plaintiff. He stated that the initial dislocation of the finger would have been painful. The finger would have remained painful for the first few days and thereafter pain would have subsided. It was quite common for the pain to continue at a lower level for a period of 12 to 18 months and sometimes longer. He considered that the other injuries sustained in the fall and the pain relieving medication given to the plaintiff would have masked to some extent the pain in the finger but he stated that anyone with normal feelings could not have suffered a subluxation of the DIP joint of the middle finger without feeling pain. Mr Maginn for the defendant agreed with all of this.

[8] The significance of this evidence lies in the fact that the plaintiff asserts that he suffered no pain in his finger throughout his stay in STH and thereafter. The only reference to pain in the STH notes is on 9 December 2004 when there is a record of a complaint of pain and stiffness in the finger. The following day he was examined at Belfast City Hospital and it was recorded that he did not have pain in the finger. In opening the case it was stated that pain only developed in the DIP joint shortly before 8 December 1997 more than 3 weeks after the plaintiff's fall. The absence of any complaint of pain in

the finger during his time in STH makes it difficult to accept that he had suffered a recent subluxation to the DIP joint of his right middle finger at the time of his admission.

[9] The case was opened on the basis that the plaintiff drew the attention of one or possibly 2 nurses to the condition of his finger on 18 November 1997 during his stay in STH. The first nurse was thin and it was stated that she looked at the finger, reassured the plaintiff and suggested that the plaintiff see his GP if the swelling did not go down. It was also expressly said that there was no pain in the finger at this time. That account seems inherently unlikely. At that time the plaintiff was in hospital being regularly reviewed by hospital doctors. In those circumstances one would have expected the nurse to have suggested discussion with the hospital doctor if the complaint was being related to the plaintiff's fall. It was also suggested that on the same day the plaintiff drew to the attention of a stouter nurse the swollen condition of his finger and she reassured him.

[10] In his evidence the plaintiff said that he vaguely recollected mentioning his finger to the thin nurse around midday on 18 November 1997. He said that he called her over to look at it and she rubbed it and examined it before reassuring him. He then described how he called over the stouter nurse later that afternoon. She looked at it and reassured him. He accepted that during his stay in hospital he was examined at regular intervals every day by nurses and doctors enquiring as to his well being but on none of these occasions had he mentioned any problem with his finger and there was no note in the hospital records during his stay concerning his finger.

[11] In the course of his evidence the plaintiff claimed that he had mentioned the condition of his finger to 2 nurses after his release from the ward when he was having his clavicle bandages tightened. He claimed that he told them that the swelling had not gone down. There is no note in the records of such a complaint.

[12] The plaintiff's letter of claim was dated 28 January 1998. That letter recorded the complaint as follows:

> "Our client was treated for his injuries at STH and brought to the attention of one of your employees a swollen finger. He was advised that this was merely inflammation and that he should see his GP."

[13] In interrogatories sworn on 16 November 2004 the plaintiff claimed that he had drawn the swollen nature of his finger to the attention of 2 or 3 employees at the hospital on 18 November 1997 but made no mention of any later complaint and expressly stated that the finger had not been examined.

[14] In replies to particulars served on 28 June 2002 the plaintiff was asked to specify precisely every complaint made by him and answered:

> "The plaintiff complained of pain generally during his stay in hospital between 14 and 19 November 1997."

According to his evidence there was no pain during this period and consequently this answer contradicts his evidence.

[15] The plaintiff's evidence on a number of other issues was contradictory. Much of this may have come about as a result of his difficulty in remembering accurately events which occurred some time ago. I consider, however, that differences and contradictions in the plaintiff's evidence about the making of complaints are so great that I could not accept his evidence of complaint as reliable. So much was recognised by those acting on behalf of the plaintiff as the allegation of complaint was abandoned in the course of the trial.

[16] I am satisfied on the evidence that he was alert and capable from an early stage of his admission. It is the agreed medical evidence that a subluxation of the DIP joint of the right middle finger will cause immediate pain which will persist and swelling which will develop within hours and persist. If either or both of those conditions had arisen as a result of this fall it is highly likely that the plaintiff would have complained of them. The fact that he did not do so strongly supports the view that he did not suffer such an injury in the course of his fall.

[17] If, however, the injury was not suffered as a result of the fall it is necessary to consider when it may have occurred. There is nothing to support the occurrence of the injury during the plaintiff's stay in hospital. After his release on 19 November 1997 he was reviewed on 21, 24 and 28 November and 2 and 9 December to have his bandages tightened. If he had suffered a recent DIP injury during this period it seems likely that he would have taken the opportunity to alert the medical staff to his condition. Given his other ailments it is also less likely that he would have been engaging in activities which might have exposed him to such an injury.

[18] One of the peculiarities of this case is that on 9 December 1997 the plaintiff attended for review at approximately 9 am with Mr Kolar in respect of his shoulder. No complaint was made about the finger. At 12.23 on the same day he re-attended and complained of pain and stiffness in the finger. That raised the possibility that he had injured the finger in the course of the morning. That possibility can be discounted because of Mr Calderwood's findings at operation which established that the injury was at least many days old by the time he operated on 10 December 1997.

[19] I have concluded that it is much more likely that the plaintiff sustained his injury in the months prior to November 1997 rather than at the time of or subsequent to his fall. I note that he attended reasonably regularly with his GP but the notes suggest that there was no attendance between 30 July and 5 November of that year. On the balance of probabilities I consider that his injury occurred during that period but that he did not seek treatment for it. The failure to detect it at the time of his admission therefore made no difference to the outcome.

[20] There was a difference of view between Mr Maginn and Mr Calderwood as to the requirements of the examination on admission. Mr Calderwood contended that it was necessary for the admitting doctor to carry out a physical inspection of the fingers requiring the patient to open and close his hand. Mr Maginn was of the view that it was sufficient to have carried out a normal grasp test on 2 fingers and to have squeezed the hand as a whole in the course of the examination. Such an examination was carried out by the admitting doctor in this case and would have been likely to detect a recent injury of this kind in his opinion. It is inappropriate for me to express any view on that difference in this case. I have found that there was no recent injury of the DIP joint to be found by the admitting doctor and consequently this is not a case of such an injury being missed.

[21] For the reasons set out above the plaintiff's action must be dismissed.