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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION

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Between:

SEAN MALLON

Plaintiff

and

MARY McKEEVER

Defendant

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KEEGAN J

Introduction

[1] This case comes before the court in relation to a net issue raised by the defendant. The plaintiff's claim is out of time and an application is required to extend time pursuant to Article 50 of the Limitation (Northern Ireland) Order 1989 ("Article 50"). Whilst it is accepted that an Article 50 extension is necessary the plaintiff contends that any limitation point should be dealt with at the trial rather than as a preliminary issue. The defendant contends that the issue of limitation in this case should be dealt with as a preliminary point. Mr McCaughey BL appeared on behalf of the plaintiff and Mr David Dunlop BL on behalf of the defendant. I am grateful to both counsel for their oral and written submissions.

Background

[2] On or about 19 March 2002 the plaintiff was engaged by the defendant to paint the exterior of the defendant's premises to include a corrugated tin roof of an adjoining outhouse. The plaintiff was a painter and decorator who had been asked to attend at the premises having been observed painting property close-by. During the course of his work the plaintiff fell having slipped from a ladder. He fell from a height which is variously described as between 6-12 feet onto concrete. The plaintiff sustained a number of injuries as a result of this fall including a fracture of his left

shoulder, a chest injury and a compound fracture of his left tibia and fibula which extended into the ankle. His left leg was placed in a temporary external fixator and then a formal Ilizarov frame.

[3] Approximately 11 months after that intervention the plaintiff required a bone transport procedure as a result of delayed union. Subsequently, he underwent multiple operations for pain in the lower leg and ankle. In 2007 he had a total left ankle replacement. In 2013 he underwent a total below the knee left leg amputation. The entire medical history is comprehensively set out in a report from Mr A Henderson, Consultant Orthopaedic Surgeon, which is dated 26 October 2016 and to which I refer in some detail as follows.

[4] This report sets out a review of the clinical records from 19 March 2002 when the plaintiff attended at accident and emergency at Craigavon Area Hospital. The report also comments upon the medical attention given at the Ulster Hospital in 2002 where the plaintiff was transferred. It then refers to extensive treatment at Musgrave Park Hospital from 2002. This extends right through to 2012 when the plaintiff was seen by Mr Alasdair Wilson at the Orthopaedic Outpatient Clinic. At that stage the plaintiff was referred for assessment and counselling regarding the possibility of below knee amputation. On 14 October 2013 a left below knee amputation took place.

[5] This report refers to the fact that at the date of injury in March 2002 the plaintiff sustained a number of injuries in the fall including the fracture to his left shoulder which was largely un-displaced and managed conservatively with little long-term disability. He also had a chest injury which settled with conservative treatment. The problematic injury was a compound fracture of his left tibia and fibula extending into his ankle joint. The report states:

> "That it was immediately recognised by the medical staff in Craigavon A&E that this was a serious and complex problem that would require specialist management and he was transferred to the Ulster Hospital."

[6] The report references the fact that there were a number of key clinical events and complex decisions to be made throughout the plaintiff's treatment starting in 2002. The report states that the initial injury to the left lower leg was severe and included a significant open wound with some contamination and there were a number of comminuted fracture fragments identified. It says that the initial treatment of wound debridement with the application of temporary external fixator was the standard treatment for this type of serious injury. The report refers to the high energy nature of the injury, the fracture comminution, the compound wound and the fact that the plaintiff was a heavy smoker all pre-disposed him to a less than ideal outcome in terms of early wound healing and satisfactory bone union. The doctor opines that these issues will have also increased his risk of developing a soft tissue infection in the limb. Approximately 6 weeks from the date of his injury it

became apparent that fracture healing in the distal tibia was particularly slow. The doctor opines that this situation is a recognised complication of this type of injury in the circumstances outlined.

[7] Dr Henderson refers to the fact that the bone transport and subsequent bone healing took place in a satisfactory manner, although it was some 8 months before it was possible to remove the frame. During this period the plaintiff had a lot of problems with pain and a number issues of pin site infection. The doctor opines that pain and pin site infection are not uncommon sequela in this type of fracture and surgical treatment. During the initial 10 months of his treatment, the plaintiff also had a problem with the development of venous thromboembolism in his leg. There was a suspicion, never completely confirmed, that he might have had a pulmonary embolism and he required treatment with anticoagulants for a period of months. The doctor notes that venous thromboembolism is a complication which can occur following major trauma. The plaintiff had previously had varicose vein surgery which alters the dynamics of blood flow in the leg and can be a contributing factor for venous pathology.

[8] Dr Henderson also comments that in the months following his frame removal, he had quite a lot of pain in the foot and ankle. By August 2003 fracture healing appeared to be satisfactory. The plaintiff had a good range of ankle movement but a painful subtalar joint. He was rehabilitating under the care of a physiotherapist and he was placed on a long-term orthopaedic review. The plaintiff was reviewed in August 2004 and was noted to have ongoing problems with pain in ankle and hind foot. This was of such severity that he was unable to get back to work. At this point, 2½ years from the date of his indexed injury, the doctor comments that it is normally reasonable to expect that plaintiffs will have reached a plateau of recovery. Further management is aimed at dealing with post-traumatic arthritic change and soft tissue damage. However, the plaintiff had to have a number of interventions. He had surgery to remove residual metal work in the ankle.

[9] The question of ankle joint replacement was raised and referral was made to Mr Alasdair Wilson, Consultant Orthopaedic Foot and Ankle Surgeon, for a discussion around total ankle joint replacement. By 3 August 2006, a decision was made to proceed with left ankle replacement. Dr Henderson opines that the decision to carry out a left total ankle replacement was not straightforward and a number of surgical options would have been considered in this case. None of the surgical options would be considered to be perfect. The ankle replacement took place and the plaintiff made a good initial post-operative recovery. His wounds healed and there is no record to suggest any significant soft tissue infection. The post-operative course appears to have been straightforward for the first few weeks but unfortunately his ankle and hind foot pain never settled and by January 2008 there was concern that he may have developed a chronic pain syndrome and he was referred to the chronic pain clinic. He attended at that clinic and thereafter he had to attend with psychology due to issues with social withdrawal and motivation. A discussion was thereafter made about the possibility of below knee amputation.

Once this discussion was begun Mr Wilson very appropriately referred the plaintiff to the rehabilitation team at the Amputation Rehabilitation Clinic run by Dr Graham. This ultimately proved to be useful and the surgery was undertaken in October 2013.

[10] The conclusion from this report is as follows:

> "In conclusion, Mr Mallon has had a long and complex clinical course following a very serious injury in March 2002. The nature of the injury, together with the number of predisposing issues contributed to a chronically poor clinical course characterised by non-union, delayed union, episodes of superficial infection and chronic pain in the ankle and hind foot. Extensive efforts were made during this period to get a satisfactory lower limb for Mr Mallon with a range of surgical and non-surgical interventions. Complex treatment decisions were made around the management of the fracture and the ultimate management is post-traumatic hind foot arthritis. As a consequence he has ultimately ended up with a painful below knee amputation and remains troubled with chronic pain which is significantly disabling and limiting to his life style. It is unlikely that he would be able to work productively going forward with his current symptom complex."

[11] It follows from the above that the plaintiff did sustain a serious injury and he had extensive medical intervention from 2002.

[12] Another distinguishing factor in this case relates to the characteristics of the defendant. The defendant and her brother who is a witness were both elderly at the time of the incident. It is reported that the defendant was 84 at that time. Her brother is reported to be a couple of years younger. The defendant is now 99 years of age. It is noted that her health has deteriorated from the time of the incident when she was in good health to a situation where she is not in good health and has experienced some medical difficulties including blindness which came upon her in 2016. It is noted in a report of Dr K M Marshall of 9 March 2017 that she would not be fit to travel to court or submit to cross-examination. There are further issues in relation to the brother of the defendant who is a witness in terms of ability to attend at court or give evidence given his increasing frailty caused by old age.

[13] The case is therefore made on behalf of the defendant that the plaintiff has significantly prejudiced the defendant in relation to her ability to give evidence upon the trial of this action. The same case is effectively made in relation to the witness.

[14] It is clear that the plaintiff has delayed commencing proceedings from the date of the accident in 2002 for a period of 13 years. Once the Writ was issued it also took the plaintiff over one year to proceed and serve a Statement of Claim. An Unless Order had to be obtained in relation to the Statement of Claim being filed. The issue in terms of the delay is summarised by Mr McCaughey BL at paragraph 8 of his skeleton argument wherein he states that:

> "The plaintiff maintains that any delay in commencing proceedings is legitimate and justifiable given that the seriousness and significance of his injury was not fully understood until his leg was amputated in October 2013. The state of the plaintiff's knowledge and indeed the state of medical knowledge is highly relevant."

Legal Issue

[15] Order 33 Rule 3 of the Rules of the Court of Judicature (Northern Ireland) 1980 permits the court to determine any issue as a preliminary issue. Order 33 Rule 3 reads as follows:

> "3. The Court may order any question or issue arising in a cause or matter, whether of fact or of law or partly of law, to be tried before, at or after the trial of the cause or matter, and may give directions as to the manner in which the question or issue shall be stated."

[16] Article 50 gives the Court a discretion to allow the plaintiff to proceed with an action for personal injuries notwithstanding that the time limited by Article 7 of the Order has expired. Article 50(1) reads as follows:

> "50.—(1) If it appears to the court that it would be equitable to allow an action to proceed having regard to the degree to which—
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> (a) the provisions of Article 7, 8 or 9 prejudice the plaintiff or any person whom he represents; and
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> (b) any decision of the court under this paragraph would prejudice the defendant or any person whom he represents,
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> the court may direct that those provisions are not to apply to the action, or are not to apply to any specified cause of action to which the action relates."

[17] In essence Article 50 requires the court to engage in a balancing exercise weighing the prejudice to the plaintiff if the time limit is not extended against the prejudice to the defendant if it is extended. The outcome of this balancing exercise will obviously depend upon the particular facts of each case. I was referred to two decisions of Gillen J in relation to limitation points namely *McArdle v Marmion* [2013] NIQB 123 and *Walker v Stewart* [2009] NIQB 292. It is clear from these authorities that the decision making in this area is highly fact sensitive. However, I am not actually determining the question of whether the limitation period should be extended. I am looking at the issue of whether or not it should be determined as a preliminary point.

[18] In that regard the main authority that I was referred to is a case of *Cooke v Western Health and Social Service Board* (3 March 2000). This was a clinical negligence case where the plaintiff had been admitted to hospital for a gallstone operation. She was subsequently discharged from the hospital having undergone operative treatment. It is important to note that in that case the plaintiff alleged that during the course of her treatment there was a failure to diagnose and properly treat her complaints thereby occasioning personal injuries, loss and damage as set out in the Statement of Claim. There was also a particular issue in that case about the length of time taken to obtain of a specialist liability report. In any event in that case the judge decided that the point of limitation would be best dealt with at the trial rather than as a preliminary point.

[19] Gillen J decided that the *Cooke* case was a case where a preliminary hearing would occasion an unnecessary increase in cost, delay and effort. In particular he relied on the fact that both counsel had indicated that medical evidence was likely to be called in the determination of the preliminary issue and so it could not be determined on affidavits alone. He also determined that the question of possible prejudice would require a judge to trawl through an extensive amount of notes and records to establish the absence or presence of any prejudice occasioned to the defendants or their witnesses by passage of time. Counsel in that case indicated that the question of prejudice may also involve discussion of the state of knowledge of medical practitioners in 1991 when the operation was performed and again in later years. For all of the particular reasons in that case the application for a preliminary point was rejected.

[20] This case is of some vintage however the principles applied hold true given that the Court retains a discretion to decide on the appropriateness of a preliminary hearing on the particular facts of a case pursuant to Order 33, Rule 3.

Conclusion

[21] Having considered the papers, the written arguments and the helpful submissions of counsel, I have decided that this is a case where the limitation issue should be dealt with by way of preliminary point. I have determined this on the particular facts of the case and I summarise my reasons as follows:

(i) The fact of the matter is that the plaintiff sustained significant injuries at the time of this event in 2002. That in itself is unsurprising given the nature of the fall. There were a number of injuries some of which healed without complication. However, from the outset the leg injury required extensive medical intervention which was not straightforward and it was clearly a problematic injury.

(ii) I have the benefit of reading the comprehensive report of Mr Henderson. It is important to note that this is not a clinical negligence case like the *Cooke* case. In my view this case is clearly distinguishable from that authority. Upon reading the report from Mr Henderson it is my view that the medical history is clear. Counsel can comment upon the various issues raised by way of submission and affidavits can be filed if necessary. There is no suggestion that medical knowledge changed significantly over the 13 years of intervention. I am far from convinced that medical evidence will be necessary for the determination of the limitation point in this case. If I am wrong about that I cannot see that any evidence would be extensive or particularly involved.

(iii) It was not suggested that the issue of the plaintiff's knowledge countervailed against a preliminary hearing. In fact that issue is at the heart of the limitation point. There was no suggestion that the plaintiff was incapable at any stage throughout the 13 years. Again in the first instance an affidavit can be filed.

(iv) I also consider that the age and characteristics of the defendant and the defendant's witness are significant factors which, in my view, support the proposition that the limitation issue should be heard as a preliminary point. It is very clear that given the elderly and frail nature of the defendant and the defendant's witness there is a live argument in relation to prejudice which is best dealt with as a preliminary issue.

(v) I am not persuaded that there would be such duplication of effort cost or delay in having a preliminary hearing on limitation to militate against that course. To the contrary I consider that on the facts of this case it would be preferable to deal with the limitation issue as a preliminary point.

[22] I therefore cannot accept Mr McCaughey's helpful articulation of the reason why he asserts that a preliminary hearing should not take place. In reaching my conclusion I express no view about the ultimate outcome. However, in all of the circumstances I allow the application made by the defendant that a preliminary hearing should now be convened in relation to the limitation point as soon as possible.