APPROVED **[2026] IEHC 319**

RECORD NO. 2023 2661 P

AN ARD-CHÚIRT

THE HIGH COURT

BETWEEN

James Kinsella

PLAINTIFF

AND

Ian Carter

DEFENDANT

Judgment delivered by Mr. Justice Tony O'Connor on 21st day of May 2026.

Introduction

1. This is a claim by the plaintiff for damages for psychiatric injury following the administration of an overdose at the defendant's hospital situated at Beaumont ("**the hospital**"). The hospital admits that on Tuesday 20 July 2021 it negligently administered a substantial overdose of medication to the plaintiff's wife ("**the deceased**"). The error caused a sudden and catastrophic medical event. The plaintiff was brought to the hospital shortly thereafter and was exposed to the immediate aftermath. The issue for determination is whether damages for the plaintiff's psychiatric injury (diagnosed subsequently as post-traumatic stress disorder ("**PTSD**")) are recoverable. The parties acknowledge that this is the first known time for a health service provider to argue in this jurisdiction that a nervous shock claim arising from an event caused by medical negligence does not constitute an "accident" within the framework described in Kelly v Hennessy [1995] 3 IR 253 ("**Kelly v Hennessy**"). If an accident within the meaning of Kelly v Hennessy occurred, it was submitted on behalf of the hospital, that the law only recognises a duty of care for the hospital to a patient and not to the spouse of a patient. Further the hospital characterised the claim as one for gradual distress and grief where there is an absence of shock induced by a single discrete event. The late onset of PTSD and a floodgates type argument for future claims were also part of the defence.

General

2. The plaintiff married the deceased in 1966. Among the accounts of joy-filled events throughout their long happy marriage was the story depicted in a photograph of the couple on a motorbike for an expedition on the 90th birthday of the deceased. It was apparent from the evidence that the plaintiff cared for the deceased at home with support from their children who live in the vicinity of the family home in North County Dublin. The claim for damages

which is brought pursuant to the Civil Liability Act 1961 ("**the 1961 Act**") on behalf of the statutory dependants of the deceased (four children and nine grandchildren together with the plaintiff) is uncontroversial. €61,368 is the agreed damages to include the maximum statutory sum for solatium under the 1961 Act. The deceased died on Monday, 2 August 2021.

Prior to the hospital

Ambulance service

3. Claire (youngest child of the couple) visited the family home on Saturday, 17 July 2021 and became concerned about the breathing of the deceased. After speaking with an intensive care nurse friend, Claire called the ambulance service whose team advised against bringing her to the hospital. On the following day, Bernadette (second eldest of the couple's four children) noticed how the deceased's "cough was catching her breath" despite an antibiotic treatment. Following Bernadette's call to the ambulance service, a team of two arrived and decided that it was best to transfer her to the hospital around 3:00pm. The plaintiff accompanied the deceased in the ambulance to the emergency department of the hospital. He stayed with her for the hours until she was admitted to a medical ward around 6:00am "for the management of probable congestive cardiac failure".[i]

Overdose error

4. Before presentation at the hospital, the deceased was on a daily dose of one 10mg Lercanidipine tablet which treats hypertension by lowering blood pressure. The "normal maximum dose is 20mg once daily".[ii]

5. The original Medication Prescription and Administration Record ("**MPAR**") for Lercanidipine on 19 July 2021 now has scribbled changes. The "System analysis review

report" ("**SARV**")[iii] following interviews with relevant staff members of the hospital identified that the timing for administration was changed such that the deceased did not get that medication until Tuesday 20 July 2021. The SARV also found that the admitting doctor had prescribed 80mg of Lercanidipine[iv] which is the dose now appearing on the MPAR. Before the critical administration, the ward clinical pharmacist had not undertaken a medication reconciliation despite the change in times for giving Lercanidipine and changes for two other medications. The 80mg dose of Lercanidipine was administered at approximately 08:45am on 20 July 2021 by giving multiple tablets. SARV in this regard referred to the policy about having knowledge of the medication being administered.[v] which prompted the authors of the SARV to make recommendations. At 11:30am on 20 July 2021, a registrar recorded the deceased as being "acutely hypotensive at approximately 09:30" following the erroneous administration. The hospital accepts liability in negligence for the recording and management of the pre-existing prescription for the deceased.

Following notification

6. Due to COVID-19 restrictions which were in place at the hospital, the plaintiff was unable to visit the deceased on 19 July 2021, although he dropped in some personal items to reception. At 11:40am on 20 July 2021, a staff member of the hospital returned Bernadette's earlier phone call for an update and Bernadette was advised that the deceased "had taken a turn". Claire took the plaintiff into the hospital while Bernadette proceeded to the hospital with her other two siblings.

7. The plaintiff gave a harrowing account of holding the hand of his unconscious wife and viewing a black substance coming from her mouth. The substance was a form of charcoal used to counteract the overdose. As he was leaving the hospital, the plaintiff stumbled and fell against a wall. The plaintiff's son ran to help, got him into a wheelchair and brought him

to the emergency department of the hospital from which he was ultimately released into the care of Bernadette.

8. Bernadette gave evidence that she noticed that the plaintiff was shaking, shocked and found it hard to walk. Dr Mulholland (general practitioner and friend of the plaintiff) attended the plaintiff in Bernadette's home on 21 July 2021 because of the significant trauma in the hospital[vi].

9. The plaintiff was told for the first time about the overdose on Wednesday 21 July 2021[vii]. A cardiac arrest of the deceased on this day compounded the distress. The plaintiff who had cared for the deceased felt that he had let the deceased down. It is apparent that he wrongly attributed some blame to himself for the admitted wrongdoing by the hospital staff in administering excessive blood pressure medication. The recovery and relapse of the deceased until 2 August 2021 numbed the plaintiff. The shocking scene witnessed by the plaintiff on 20 July and the explanation given on 21 July 2021 affected the plaintiff as did the ongoing events during the following 12 days.

10. The plaintiff was seen by his general practitioner, Dr Mulholland on several occasions in a professional and social context. Dr Mulholland told the Court that the plaintiff had profound weakness, profound dizziness, loss of balance, insomnia, difficulty walking through loss of power in his legs, low mood, nausea and nightmares. Dr Mulholland described how the plaintiff had had a few dizzy spells previously but had no previous history of loss of balance, nausea, depression or anxiety. Dr Mulholland drew from his 40 years of familiarity with the plaintiff. Caring and genial are apt descriptions for the plaintiff. There is little doubt that the plaintiff was seriously traumatised on 20 July 2021 in the hospital. Dr Mulholland said that the word "Beaumont" in the context of making a referral in September 2021 sent the plaintiff into an "absolute panic mode". Ultimately the plaintiff overcame that aversion to the

hospital because he attended the cardiac unit in the hospital for a period from December 2021. He is disappointed if not angry with the hospital when the care of the deceased arises in his mind.

Identifiable events

14. The following are identifiable sudden events in the context of a potential chain of causation from the hospital's negligence to the diagnosis of PTSD: -

1. After "driving like a madman" to the hospital with his daughter Claire, the plaintiff arrived shortly after 11.00 on Monday, 20 July 2021. He pushed through a team of six to eight in scrubs to find the deceased unconscious with "black stuff" coming out of her mouth. A doctor indicated to the plaintiff that he did not know what was going on.[viii] . The doctor told him of the proposed transfer to another ward (actually "the critical care unit"). The plaintiff on exiting the hospital collapsed and was brought by his son having been observed by another daughter to the emergency department.[ix]
2. After observing a recovery of the deceased during the morning of 21 July 2021, the plaintiff was summoned back. In his rush, he hit against a doctor and his daughter, Claire, before "collapsing inside the curtain". At that stage, the plaintiff had learnt of two acute cardiac arrests suffered by the deceased. In fact, the deceased was resuscitated and had a big smile on her face after the plaintiff had recovered and returned to the private room of the deceased.[x]
3. Following the "stormy recovery" of the deceased from the evening of 21 July 2021 to bank holiday Monday on 2 August 2021, the plaintiff was in "total shock… very vacant and very lost all the time and… worried". [xi] However, the plaintiff and family members were further upset after the plaintiff returned for the second time to the hospital on 2 August 2021 accompanied by Claire. They found the deceased breathing

heavily and unconscious without anyone in attendance at the time of death. Claire and the plaintiff cleaned the mouth, hands and nails of the deceased and tidied her appearance before leaving the room.

4. Ms Jo Campion, psychologist, noted that the plaintiff during the consultation on 11 July 2022 "…became terribly distressed and upset …. and took a long time to compose himself after discussing [the deceased's] death". He said: "When she passed I was heartbroken. I may have said get a priest. We were left there. No one helped us. Clare cleaned [the deceased] up. We took out all the pipes and tubes. Nobody there for us. Nobody helped us. I said the Rosary. It was shocking. We were lost and didn't know what to do. No one came into the room after the monitor had been turned off. We were just left alone"[xii].

PTSD

11. Dr Paul O'Connell, consultant forensic psychiatrist confirmed that the plaintiff suffered PTSD in addition to serious grief. Dr O'Connell took account of the findings of intrusive memories, anger, grief and depression identified by Dr Jo Campion, psychologist, at her consultation with the plaintiff on 11 July 2022. Section 4 of the report of Dr Campion dated 26 August 2022[xiii], recorded how the events were perceived by the plaintiff as elicited by Dr Campion in 2022.

12. The cross-examination of Dr O'Connell was understandably brief because no expert was called to offer an alternative professional view about the diagnosis of PTSD, its causation and prognosis. Counsel for the hospital questioned Dr O'Connell on whether it was the witnessing of the deceased's condition on 20 July, the notification on 21 July and the deteriorating events over the subsequent days which caused the plaintiff's PTSD as opposed

to the shock on 20 July. In other words, was the PTSD due to a continuum of events as opposed to one single shock?

13. Dr O'Connell gave uncontroverted evidence that the plaintiff experienced an acute stress reaction following his exposure to the traumatic events beginning on 20 July 2021 and that such a reaction is a recognised psychological response to a precipitating trauma. Where those symptoms persist a diagnosis of PTSD may follow; the plaintiff was indeed later diagnosed with PTSD. Dr O'Connell opined that "…this thing registered with [the plaintiff] fully in the most awful way when she died rather than something that grew in his knowledge as events unfolded"[xiv]. He also said: "One would not expect an individual who has simply been bereaved to have such intrusive memories unless they are embedded in one's memory by virtue of the shock of that encounter". Although the Court cannot disentangle all the events, it accepts the evidence that the plaintiff's psychiatric condition originated with the traumatic experience on 20 July 2021. That condition developed over time and was reinforced by later events.

14. The Court is also satisfied that the plaintiff continues to suffer from a range of symptoms triggered by the shock in addition to the natural grief which merits damages under the 1961 Act for solatium.

15. The scene in the hospital room where the deceased passed away at 18.15 on 2 August 2021 did not help the plaintiff and his family in their grieving.[xv] This Court was not asked to determine whether the hospital complied with its "Policy for the care of a deceased patient." Suffice to say that a Clinical Nurse Manager clarified, as mentioned in the SARV, that "… the nurse caring for the patient or the nurse in charge normally disconnects any medical equipment from a deceased and families would usually wait in the family room while the deceased patient is laid out."[xvi]

16. Dr O'Connell distinguished between the plaintiff's immediate acute stress reaction and the later development of PTSD as a diagnosable condition. The fact that the condition "registered fully" at a later point does not displace the evidence that the psychiatric injury was triggered by the traumatic events beginning on 20 July 2021 but rather reflects the recognised clinical course whereby an acute reaction to trauma may evolve into PTSD if symptoms persist.

Quantum

17. "Category 4 B (b) serious PTSD" – €25,000 - €80,000 and "Category 4 B (c) moderate PTSD" – €10,000 - €35,000 in the Personal Injuries Guidelines were suggested by counsel for the plaintiff and the hospital respectively if the Court decided the issue of law in favour of the plaintiff. The relevant difference for the purpose of this claim may be decided by reference to the fact that the plaintiff has "… largely recovered and continuing effects will not be grossly disabling." The Court is satisfied from the evidence as to fact and the prognosis given by Dr O'Connell that the plaintiff "…remains prone to sudden unexpected distress, intrusive recollections, hopelessness and suicidal ideation". Category 4 B (b) best fits the plaintiff's condition because the "effects are still likely to cause significant disability for the foreseeable future".

18. The Court applies the principle of proportionality to the highest award of €550,000 and the element of fairness to both sides while acknowledging that any award of damages needs to recognise that the plaintiff is now 87 years of age. In the circumstances, the Court considers that if the law entitles the Court to award damages for nervous shock, a sum of €40,000 is fair and proportionate.

Pleadings

15. The personal injury summons issued on 6 June 2023 not only pleaded negligence in administering the overdose to the deceased but also pleaded that the hospital failed to provide an adequate explanation as to the circumstances of the overdose, failed to ensure that the plaintiff had adequate contact from a senior member of staff, failed to support the plaintiff immediately after the death of the deceased and failed to ensure that all healthcare professionals in contact with the plaintiff had access to appropriate training to provide support to the family.[xvii] Sufficient evidence was not led at trial for the Court to find those particular alleged breaches of duty

16. The defence delivered on 12 May 2025 admitted that there was a breach of duty on the part of the hospital in the care of the deceased but required proof of the other allegations made on behalf of the plaintiff. The hospital denied "that it owed any duty of care to the plaintiff in the circumstances of this case including in particular the circumstance where the plaintiff was not a patient, but was rather a relative of a patient to whom [the hospital] owed a duty of care".[xviii] It is for the Court to decide whether a duty of care existed as opposed to any expert having to give evidence in that regard. Dr. Mulholland in reply to the Court explained how doctors like himself and registrars who he trained, can balance conflicting duties of care in a medical crisis situation.[xix]

The Common Law

History of Common law

17. In the latter part of the 19th century the prevailing view was that physical injuries were real and mental injuries were imaginary. Claimants could only recover damages for psychiatric injury where they themselves suffered physical injury or were in imminent danger of suffering reasonably foreseeable physical injury due to actions by the defendant.

18. In Byrne v Great Southern and Western Railway Co of Ireland (1884) Court of Appeal Ireland (unreported but summarised in Bell v Great Northern Railway Co. of Ireland (1890) 26 L.R. Ir 428 ("**Bell v GNR**")), the plaintiff superintendent of the telegraph office at Limerick Junction station recovered damages of £325 from a jury for nervous shock. The plaintiff had received no physical injury but "got a great fright and shock" from the noise of a train crashing through the siding, permanent buffer and then the wall of the telegraph office.

19. A few years later in Bell v GNR which arose from the Armagh rail disaster on 12 June 1889, a jury awarded in the Michaelmas term of 1889, £300 to Mrs Bell for her great fright and nervous shock which were reasonable and natural consequences of the circumstances. The plaintiff was not in the runaway part of the train but the plaintiff "… heard cries of 'Jump out; jump out: you'll all be killed.' The carriage doors were locked and she saw people jumping out through the windows." The plaintiff could not recall how she got out of the carriage. One of the medical "witnesses deposed that her condition might result in paralysis". Palles C.B. was critical of Sir Richard Couch for the Judicial Committee of the Privy Council in Victorian Railway Commissioners v Coultas (1883) 13 App Cas. 222 when "assuming as a fact, against the verdict of the jury, and without any special finding with regard to it, that the fright was, in that particular case, unaccompanied by any actual physical injury". This has been described as an exceptional instance of "innovative Irish jurisprudence in the common law"[xx].

20. Keane J in Sheehan v Bus Eireann and Power [2020] IEHC 160 examined the law with particular regard to duty of care, up to and including Kelly v Hennessy while describing how the English and Irish courts have taken different approaches. The judgments in the appeal from Sheehan v Bus Eireann and Power [2022] IECA 28 when dismissing the appeal from Keane J, considered the shock, reasonable foreseeability, proximity and reasonableness of imposition controls.

Immediate aftermath cases

21. In *Jaensch v. Coffey* [1984] 155 CLR 549 (**"Jaensch v. Coffey"**) the respondent developed a psychiatric illness because of what she saw and heard at the hospital to which her husband was admitted with serious injuries caused by the negligent driving of the appellant. The judgments of the Australian High Court and particularly that of Brennan J. created a mould for nervous shock claims. Brennan J. gave two examples where there would be no recovery: – "[T]he 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". The court decided that the respondent was able to recover damages for nervous shock which she suffered because of the injuries to her husband which had not been inflicted in her sight or hearing. Brennan J. stated: "… liability cannot rationally depend on a race between a spouse and an ambulance".

22. In *Kelly v. Hennessy* the plaintiff had learned of the crash in which her husband and daughter had suffered permanent brain damage. The plaintiff went into shock and commenced vomiting on hearing of the accident. Her condition was gravely aggravated on seeing the state of her family. She suffered from PTSD for five years and continued to suffer from depression at the time of the trial. While Hamilton CJ and Egan J affirmed the award of general damages to date in the sum of £35,000, they reduced the award of damages for the future from £40,000 to £20,000. Denham J (as she then was) dismissed the appeal on all grounds and focussed on proximity in establishing a duty of care including proximity of relationships, spatial proximity and principally proximity in time. The criteria set out by

Hamilton CJ to succeed in an action for damages for nervous shock are agreed by the parties to apply to the plaintiff's claim.

23. The hospital in these proceedings has focussed on the burden of the plaintiff to establish that his psychiatric condition was shock induced (criterion 2) and to establish a duty of care owed to the plaintiff by the hospital (criterion 5).

Previous awards in Ireland against hospitals.

24. In *Courtney v. Our Lady Hospital Crumlin and Others* (**"Courtney"**) [2011] IEHC 226, [2011] 2 IR 786, [2011] 2 ILRM 328, O'Neill J awarded €75,000 for "a significant depressive illness" caused by the trauma in the defendant's hospital. There the plaintiff had brought her daughter to the defendant's hospital where symptoms of meningitis had been overlooked for over four hours which led to the death of her daughter some 10 hours after their arrival at the hospital. The judgment makes no reference to submissions concerning the criteria in *Kelly v. Hennessy*.

25. In *Barry v. Health Service Executive and Mercy University Hospital* (**"Barry"**) (unreported judgment of 16 December 2015) [2015] IEHC 791, Barr J. awarded €95,000 and €75,000 for past and future suffering respectively to the former partner of a man who had died due to the admitted negligence on the part of the defendant hospital. The extensive judgment did not address any argument based on the *Kelly v. Hennessy* criteria. The facts relating to the shocking events stretched from 16 March 2010 to the death of the partner on 19 April 2010.

26. The Court is aware from ruling settlements that mothers who have suffered PTSD following delivery of their babies, have recovered damages to compensate them for the nervous shock arising from negligence during that limited period. Counsel for the hospital

submitted that mothers in those circumstances are patients of the defendant health care provider[xxi] while the hospital was not treating the plaintiff at the time of the incorrect administration of the Lercanidipine to the deceased.

Deterioration cases

27. *Morrissey v. H.S.E.* [2019] IEHC 268 (Cross J) **("Morrissey")** and *Mitchell v. H.S.E.* [2023] IEHC 394 (O'Connor J) (**"Mitchell"**) both concerned witnessing deterioration of a progressive disease until death following the negligent cervical screening of a spouse and daughter respectively. In *Morrissey*, Cross J. found that the screening service which misread survival smear tests of Mrs Morrissey in 2010 and 2013, did not owe a duty of care to Mr Morrissey. Mitchell related to a similar negligent misreading and then witnessing disturbing events which followed the misreading. One of the principal questions in Mitchell was whether the finding in Morrissey about the absence of a duty of care in the circumstances bound a judge of equal jurisdiction in accordance with the principles articulated by Clarke J. in *Re: Worldport Ireland Ltd. (in liquidation)* Unreported, High Court, 16 June 2005) [2005] IEHC 189. No evidence was adduced in Mitchell about the colposcopist or any duty which might be owed to a close relative when imparting information about the relevant cause of death.

28. In *Germaine v. Day* [2024] IEHC 420 (Egan J), (10 July 2024) the defendant hospital had missed a relevant radiological finding in October 2018. The medical evidence established that the deceased's cancer was already incurable in October 2018 and an earlier diagnosis of treatment would not have altered the prognosis or treatment. The wife of the deceased suffered psychiatric injury from witnessing her husband's sudden gradual deterioration between December 2018 and his death in February 2019. Egan J. found that the plaintiff could not "satisfy *Kelly v. Hennessy* criteria 2, 3 or 5." The issue about whether the

missed diagnosis could be an accident within the meaning of *Kelly v. Hennessy* was not canvassed.

Submissions for the hospital

Overview

29. As mentioned, the hospital concentrated on the burden of the plaintiff to establish that his PTSD was shock induced (criterion 2 in Kelly v Hennessy) and that it owed a duty of care to the plaintiff (criterion 5).

Immediate aftermath/medical crisis

30. It was submitted that "the doctrine of nervous shock evolved in cases involving sudden traumatic accidents" and that "the common law has evolved by reference to the occurrence of a specific event of a railway or car accident" [xxii]

31. The Court was referred to the successful appeal of the defendants in *Fletcher v. Commissioners of Public Works* [2003] 1 IR 464 ("**Fletcher**") which related to a fear of contracting mesothelioma from historic work activities and the statement of Geoghegan J that *Kelly v. Hennessy* "… should only be taken to relate to accident damage".

32. It was submitted on behalf of the hospital that the overdose given to the deceased was a medical mishap during treatment which is not an external event of the kind contemplated in *Kelly v. Hennessy*.

33. By way of analogy *Harford v. ESB* [2021] IECA 112 [2022] 2 IR 541 (**"Harford"**) was cited. That concerned the overwhelming intrusive thoughts of what might have happened to the plaintiff if he had proceeded with repairing a public streetlight in the course of his work. The successful ground in that appeal related to the fact that "no horrifying" event

caused the plaintiff's psychiatric injury. The submissions quoted the following paragraph of the judgment in Harford:

> "[67] 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. Such an event was described by Geoghegan J. in Fletcher and Denham J in *Devlin* v. National Maternity Hospital [2008] 2 IR 222 ("**Devlin**") as an 'accident'".

34. The hospital also cited *Paul and Another v. Royal Wolverhampton NHS Trust* [2024] UK SC 1 [2025] AC 459 (**"Paul"**) where the UK Supreme Court decided three appeals relating to whether "… witnessing the death or injury of a close relative, not in an accident but from a medical condition which the defendant has negligently failed to diagnose and treat" could give rise to a claim for nervous shock.

35. It was submitted that "[T]here was no accident in any intelligible sense or within the meaning contemplated in *Kelly v. Hennessy*". By way of summary, the hospital, relying on *Paul*, submitted that an accident is an external violent unintended event while a medical crisis (as in the case before the Court), is an illness deterioration or harm arising during diagnosis or treatment. According to counsel, the incremental development of Kelly v Hennessy is a matter for the Supreme Court and Paul suggests that an event in a hospital is not an accident.

36. Reference was also made to *Paul* where it was stated that there is no difference between acts or omissions in psychiatric claims following clinical negligence.

Not a single sudden shock

37. It was also contended that the "continuum" of distressing events did not amount to a single sudden shock which is a qualification criterion under the *Kelly v. Hennessy* framework.

In other words, describing events as horrifying in ordinary language does not satisfy *Kelly v. Hennessy* criterion 2.

No duty of care

38. If the Court found that the plaintiff's PTSD was shock induced by an accident within the meaning of *Kelly v. Hennessy*, the hospital further submitted that there is no binding Irish authority which has established that a hospital owes a duty of care to the spouse of a patient. It was contended that extending the duty of care would conflict with the clinical focus on the patient, would tend to breach confidentiality and could interfere with medical decision-making. Irish courts have only recognised duties to third parties in limited contexts such as where economic loss is claimed and extending the duty of care of medical care providers to relatives of patients has not been recognised following a thorough debate in the superior courts of Ireland.

39. The Court was referred to analogous cases against State controlled entities resting with *Barlow, Woodstown Bayshell Fish Limited and Others v. The Minister for Communications, Marine and Natural Resources and Others* [2025] IESC 14 ("**Barlow**") which reviewed the scope of the tort of negligence in claims against a State controlled defendant. There, Murray J explained that the concept of assumption of responsibility as originally understood, is confined to the relationship of a character akin to contract and noted that it has been stated that liability under *Hedley v. Byrne* arises only where there exists a relationship "equivalent to contract".[xxiii]

40. Ultimately while the hospital extended its sincere apology to the plaintiff and his family for "the terrible error", contended that calling relatives to the hospital or giving information does not amount to assuming responsibility for their psychiatric well-being.

41. Counsel referred to the description of Murray J in *Barlow* that "assumption of responsibility may well have overtaken "proximity" as the slippiest in the law of tort"[xxiv]. The submission was that one must establish an assumption of responsibility[xxv] and here one cannot contend that "in administering medication to the deceased, the hospital was taking on a responsibility not just to the deceased but to the plaintiff and the four adult children."

42. The hospital also argued that expanding liability to relatives by medical care providers in clinical care cases is novel, opens indeterminate liability and essentially requires a determination by the Supreme Court as claims for nervous shock fall within an exceptional category.

Discussion

Accident

43. At first glance the overdose was an accident and was immediately catastrophic. In the context of *Kelly v Hennessy*, the term "accident" is not confined to road traffic or industrial mishaps. An accident denotes a sudden, unintended and externally caused event which is capable of producing a direct and shocking sensory impact. What is essential is not the setting in which the event occurs, but its character. It gives rise to an immediate and perceptible affront to the senses. An event may therefore qualify as an accident where it involves a discrete and unexpected occurrence, distinct from the gradual progression of illness or the cumulative effects of distress, and where it constitutes the type of shocking or calamitous episode contemplated in the authorities. Here, the deceased had been admitted for symptoms which were unrelated to the overdose and the facts can be distinguished readily from those in *Germaine, Mitchell* and *Morrissey*.

Hospital setting

44. The Court exercises caution when deciding whether an accident which occurs during the care of a patient is an event within the meaning of the *Kelly v. Hennessy* framework. The Supreme Court in Kelly v Hennessy did not mention accidents to patients while in the care of a hospital. Equally it did not exclude the witnessing of a catastrophic event in a hospital. The overdose falls within the description of a "qualifying event" in *Harford*. It was "shocking, distressing, horrifying, terrifying [and] calamitous".

45. Counsel for the plaintiff countered the submission for the hospital that the overdose was a medical crisis (thus excluding it from being an accident) by using the analogy deployed by Abraham Lincoln when mocking his opponent's argument, that a man can prove a horse chestnut to be a chestnut horse.

46. Excluding an event in a hospital by applying additional terms to a "shocking event" or "accident" does not avail the hospital. There is a crucial difference between a misread x-ray months prior to deterioration or death as in *Germaine* and the administration (following admission to hospital), of an overdose of a patient's pre-existing prescription regime. The severe overdose was of a medication which the deceased had taken daily prior to her admission to the hospital. The overdose was not an integral part of the discretion afforded doctors when diagnosing, prescribing or caring for patients. The admission of the wrongdoing cannot be qualified by relying upon some need to prioritise the deceased or the discretion of hospital staff when caring for the deceased.

47. In regard to the hospital's citing of *Paul*, the Court notes that:-

1. Central to the UK Supreme Court judgment in *Paul* was its reliance on the concepts of primary and secondary victims which have not been adopted in this jurisdiction;
2. *Paul* confined itself to, "medical crisis" following medical diagnosis;

3. The UK Supreme Court specifically left over the hypothetical "examples… posed in argument such as a scenario where a doctor injects a patient with a wrong dose or a wrong drug, inducing an acute adverse reaction which is witnessed by a close relative". [xxvi]

48. Requiring the Supreme Court to decide whether *Paul* limits Kelly v Hennessy to a sudden shocking and horrifying event caused outside a hospital is not necessary in these proceedings. The Court is conscious not to extend the controls found within the Kelly v Hennessy criteria. Those controls have been relied upon since Kelly v Hennessy was delivered in November 1995. Courtney and Barry indicate that the exclusion of events in hospitals was not argued or possibly contemplated until the commencement of these proceedings.

49. The overdose was an external event and it was not akin to an illness; it came from outside the body of the deceased. The hospital had no possible justification to administer the overdose of a drug which had been taken as a standard daily dose by the deceased before admission.

Subsequent identifiable events

50. The disclosure on 21 July 2021 about the cause of the overdose and the scene at the death bed were also identified. Those events cannot be disentangled but there is clear evidence that the plaintiff had a direct perception of the aftermath on 20 July 2021 before those further events. The plaintiff was affected on 21 July 2021 and by other events up to and including the passing of the deceased on the thirteenth day after the overdose. The two further identifiable events added to the effect on the plaintiff. The impossibility of assessing the full effect of those other events on the plaintiff's psychiatric condition should not preclude the

Court from taking into account all of the evidence adduced at trial when applying the controls of Kelly v Hennessy.

Temporal Proximity

51. The requirement for an "accident" or "shock" in criterion 2 of *Kelly v. Hennessy* imports a temporal proximity limit on the aftermath of the triggering event for a nervous shock claim. So, in Devlin and Fletcher, the claimants failed to pinpoint an immediate proximity in time. In this claim, the plaintiff as in *Kelly v. Hennessy* witnessed the immediate aftermath in a hospital and exhibited symptoms of shock by collapsing which prompted attendance at the emergency department of the hospital. A second fall occurred on the day that the plaintiff was told what had occurred.

52. Here there was a specific event which is not wholly different from a railway or road collision. Excluding the overdose on 20 July 2021 from the definition of a sudden event by referring to two subsequent events involving the hospital staff cannot in all fairness avail the hospital. The drivers in Jaensch v Coffey and Kelly v Hennessy could not have avoided liability to the plaintiffs for nervous shock if they compounded the trauma by, for example, assaulting the plaintiffs after the negligently caused collisions.

53. As for temporal proximity, as mentioned previously there is a big difference between a misread x-ray months prior to deterioration or death as in *Germaine* and the administration of a gross overdose of a patient's pre-existing prescription regime. The wrongdoing on the part of the hospital and its temporal proximity to the trauma caused to the plaintiff are clear. The Court does not accept the argument for the hospital that the continuum of two further identifiable traumatic events (explanation given on 21 July 2021 and the care of the deceased around the time of her passing away on 2 August 2021) negate the symptoms which were

shown on 20 July 2021. The later events caused distress but the effects of the shock on 20 July 2021 had not dissipated during the period up to the time of death.

54. The Court is satisfied that the plaintiff's psychiatric injury was "shock-induced" within the meaning of Kelly v Hennessy. That requirement is concerned not with an artificially narrow conception of a single isolated instant. It is whether the injury arises from a sudden and horrifying appreciation of an event or its immediate aftermath; it is not a gradual accumulation of distress. The evidence established that following the overdose on 20 July 2021, the plaintiff experienced an immediate and overwhelming reaction, including physical collapse and acute distress, consistent with an acute stress response to a traumatic event. The further distressing events which occurred in the ensuing days did not constitute independent causes of injury but rather reinforced and sustained the initial shock. For the sake of clarity, the Court is satisfied that the plaintiff's psychiatric condition was rooted in and directly attributable to a qualifying shock within the framework described in Kelly v Hennessy and not to a process of gradual grief or attrition. Where, as here, a traumatic event gives rise to an immediate shock, the fact that the consequences unfold over a short period and are reinforced by closely connected events does not deprive the injury of its shock-induced character.

55. The requirement of "shock" in *Kelly v Hennessy* is directed to the distinction between injury caused by a sudden and horrifying event or its immediate aftermath and injury arising from the gradual accumulation of grief, distress or anxiety. It does not require that the entire psychiatric condition be attributable to a single instantaneous moment, nor does it exclude cases where the traumatic event continues to have immediate and unfolding consequences over a short period.

Duty of care

56. The issue is not whether a general duty is owed by hospitals to relatives of patients but whether the facts of this case establish a duty within the framework of *Kelly v Hennessy.* The hospital correctly submits that its duty of care to the deceased arose in the hospital patient relationship which is protected by the regard for confidentiality and the latitude afforded by the law to medical practitioners. The plaintiff only became a patient when he attended the emergency department following his fall after the shocking event. The Court approaches this issue conscious that the law permitting claims for nervous shock is exceptional in character and that duties to victims who are witnesses are not presumed.

57. Irish law has not adopted the "primary/secondary victim" taxonomy which is used in England. Neither has it recognised a general duty on the part of hospitals to relatives of patients. Further the Court acknowledges that the question is not what good medicine aspires to but whether the law recognises an obligation of care in the circumstances which have been established.

58. The conclusion that a duty arises in this case does not represent a novel extension of the law, but the application of established principles governing recovery for psychiatric injury to a factual situation involving a sudden, defendant-caused event and immediate psychiatric impact on a person in close proximity. The decisive feature is not moral proximity but legal proximity created from contemporaneity and control as may be explained as follows: -

i) The negligence of the hospital did not consist of a diagnostic omission remote in time but of a serious overdose of a daily medication which was administered in the hospital and which precipitated a physical dramatic collapse.

ii) The plaintiff arrived at the hospital within a short period of that event before its consequences were stabilised.

iii) The plaintiff perceived the physical manifestations of the overdose while they were ongoing.

iv) The plaintiff suffered a physical collapse himself within the hospital which required assessment in the hospital.

v) The manifestations of the shock occurred while the hospital was actively managing the crisis which it had caused.

59. The plaintiff was not merely a distressed relative informed after the fact; he was a person present at the scene of the event's aftermath which was a period when the hospital retained control of the situation giving rise to the shock. This is distinguishable from gradual deterioration after misdiagnosis, psychiatric injury arising solely from grief, witnessing illness unfold or distress arising after the involvement of the hospital.

60. The psychiatric injury to the plaintiff originated in the immediate aftermath of the catastrophic overdose. The duty of care recognised in this case does not amount to a general duty owed by hospitals to relatives of patients. It is confined to a qualifying sudden event where there is immediate temporal proximity, direct perception by the plaintiff with a physical manifestation of shock and where the hospital had continuing control of the situation. The principle of proximity emanating from Donoghue v Stevenson [1931] AC 562 [43] is that a person must take reasonable care to avoid acts or omissions that could reasonably be foreseen as likely to injure neighbours. The features of how the relationships evolved are described earlier; a caring husband accompanies his elderly wife to the hospital which took over her care. The Court is satisfied that the constraints adhered to in its deliberation preserves the exceptional nature of nervous shock liability and does not expose healthcare providers to indeterminate liability.

61. The Court does not favour the absolutism of the hospital's position that its duty to the deceased negates a duty to the elderly and caring spouse of the deceased. In the circumstances of this case, there is no need to address what might be described as parallel or

non-competing duties of care. There is no suggestion of a breach of duty of care on the part of the hospital to the plaintiff while he was assessed and treated in its emergency department. Dr. Mulholland's answer to the Court that "the ethos in medicine should be first of all do no harm" was enlightening for scenarios where competing duties may arise. This Court does not need to determine any issue which may rely on this ethos. In any event, the hospital did not adduce evidence to ground the form of absolutism suggested on its behalf given the issues which the Court has to decide. Further, the existence of a duty of care in the present case does not depend upon the establishment of an assumption of responsibility in the sense discussed in Barlow nor upon the recognition of a generalised duty owed by healthcare providers to relatives of patients.

Is the Court extending the scope of Kelly v Hennessy?

62. The Court has considered the submission that the recognition of a duty of care to a non-patient in the presenting circumstances could constitute a novel extension of the law more properly reserved to the Supreme Court. The Court as a court of first instance is not confined to the mechanical application of authority to identical facts. It applies established legal principles to new factual situations provided that no departure from binding authority is involved. The framework governing recovery for psychiatric injury has been authoritatively set out in Kelly v Hennessy, and the fifth criterion expressly requires an assessment of whether a duty of care arises. The present issue therefore falls within that established analytical structure. The Court is satisfied that the recognised control mechanisms—namely proximity, foreseeability, and a sudden shock-induced event are present. The duty which arises here does not represent the creation of a new category of liability; rather the Court is applying settled principles to a factual matrix which was not perhaps previously addressed to the same extent in earlier reported judgments. In those circumstances, the Court finds that the

duty requirement is met while it confines its conclusion to the specific facts without recognising a general duty owed by healthcare providers to relatives of patients.

Orders

63. The plaintiff is entitled to an award of general damages in the sum of €40,000 together with the agreed sum of €61,368 for the claim under the 1961 Act.

64. The application for the distribution of the solatium and other orders will be heard at 10:30 on Friday, 5 June 2026.

Appearances

Jonathan Kilfeather SC, Alan Keating SC and Caroline McGrath BL instructed by Gerrard L McGowan Solicitors for the Plaintiff.

Eoin McCullough SC and Rory White SC instructed by Mason Hayes Curran Solicitors for the Defendant.

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[i] Paragraph 1.2 of the System Analysis Review Report – Tab 3 of Booklet of Core Medical Records.

[ii] Paragraph 5 of the System Analysis Review Report – Tab 3 of Booklet of Core Medical Records.

[iii] Admitted as evidence without any questioning thereon.

[iv] Third entry on p. 11 of the Medication Prescription and Administration Record.

[v] Paragraph. 6.1.6 of the System Analysis Review Report.

[vi] General Practice Notes Page 17 of 53 and Qs 14 -17 of Dr Mulholland – Day 2.

[vii] Page 644 Vol 2 of Beaumont Hospital Records which indicates that a doctor spoke with the plaintiff about the overdose after an entry for 15.30 and before another entry for 23.00.

[viii] Evidence of plaintiff – QS 96 – 110 day one and evidence of Claire Kinsella QS 97 – 103 day 3.

[ix] Evidence of Bernadette Kinsella – Qs 34 – 35 day 3.

[x] Evidence of plaintiff QS 117 – 121 day 1 and evidence of Claire Kinsella question 138 – J3.

[xi] Evidence of Bernadette Kinsella - Q68 - Day 3.

[xii] Page 6 of Jo Campion's report 26 August 2022.

[xiii] Part 4 of the report was admitted as evidence.

[xiv] Question 425, Day 1.

[xv] The Plaintiff's account of the scene is contained in his answers to Qs 142 to 154 of Day 1. Paragraph 6.2 of the System Analysis Review Report details the interviews with the family, staff and review of clinical notes and hospital policies.

[xvi] Page 19 of the Systems Analysis Review Report.

[xvii] Sub paragraphs 9 (h), (m), (n) and (q) of the Personal Injuries Summons.

[xviii] Sub Paragraph 7 (1) of the Defence.

[xix] Questions 174 -194 of Day 2.

[xx] This extrajudicial quote from 2003 is attributed to Ronan Keane CJ by Julie O'Donoghue in her 2022 article "Nervous Approach to Nervous Shock: A critical evaluation of the contemporary Irish jurisprudence governing claims for damages for negligently inflicted psychiatric injury." Trinity College Law Review Vol XXV 142. The author gives a thought-provoking view of the law in this area.

[xxi] See pages 127 and 128 of Day 4 for the exchange between the Court and Counsel.

[xxii] Para 33. of Denham J. judgment in Devlin v. National Maternity Hospital [2008] 2 IR 22.

[xxiii] Para. 84 of the defendant's submissions delivered on 18 March 2026.

[xxiv] Paragraph 159 of Barlow, Woodstown Bay Shellfish Limited and Others v. The Minister for Communications, Marine and Natural Resources and Others [2025] IESC 14.

[xxv] Pages 160 -161 Day 4.

[xxvi] Paragraph 123 of Paul and Another v. Royal Wolverhampton NHS Trust [2024] UK SC 1 [2025] AC 459.