[2019] IEHC 896

THE HIGH COURT

[2014 No. 4685 P.]

BETWEEN

ANNE MARIE CLIFFORD

PLAINTIFF

AND

HEALTH SERVICE EXECUTIVE & KERRY GENERAL HOSPITAL

DEFENDANTS

JUDGMENT of Mr. Justice Cross delivered on the 5th day of December, 2019

1. The plaintiff was born on 31st May, 1971, and resides in Killarney, County Kerry and before the incident the subject matter of the proceedings she worked as a shop assistant. She has one 25-year-old son who is a photographer and in 2004 she suffered a traumatic termination of her relationship with her then partner and her mother dies tragically. As a result of these events she underwent a course of counselling which continued.

2. The plaintiff met her present partner, Mr. Soeren Kuhlmann, a dental technician around 2004 and they eventually cohabited.

3. The plaintiff and Mr. Kuhlmann tried for a baby but the plaintiff had difficulty in conceiving as she had only one fallopian tube but eventually she fell pregnant which resulted in the birth of a healthy baby daughter, Mia on 28th May, 2012.

4. It is the circumstances after the birth of Mia that are the subject matter of these proceedings.

5. After the birth of Mia, the plaintiff developed a significant haemorrhage which of itself is a recognised possible complication after delivery. The plaintiff’s case is that the defendants failed in their duty to take sufficient steps to stop the haemorrhage in time.

6. The plaintiff attended the defendants’ hospital on the evening of 26th May she was some 40 weeks pregnant at this stage and she was experiencing some spotting. She was admitted on the 27th and had a difficult course of labour until Mia was born at 14.54 on 28th May.

7. What was described as a “*small second degree tear*” was observed in the perineum and what was described as “*small bilateral grazes in the labia*”. Dr. C the SHO was contacted in order to repair the perineum, was present almost immediately and noted the presence of further vaginal bleeding. A massage was carried out as it was thought that the uterus was not well contracted.

8. Subsequently the plaintiff was given intravenous Oxytocin and large blood clots were expelled from the vagina. A haematoma was suspected inside the right labia and the registrar in obstetrics Dr. M was asked to attend at 15.08 hours due to the bleeding and possibility of haematoma. Dr. M attended at 15.24 and three minutes later the plaintiff was reported as not feeling well, a facial oxygen was provided and her blood pressure was recorded at 56/38mmhg which is extremely alarming but the midwife questioned the

accuracy of the measurement due to the fact that the plaintiff was responsive though feeling nauseous.

9. In the nursing notes it is stated that a further request for Dr. M to attend was declined at 15.16. I accept the explanation from Dr. C that as a matter of probability a midwife asked her whether Dr. M should be further contacted and she declined as she was aware that Dr. M was already on his way.

10. The plaintiff's blood pressure and pulse were regularly taken and the blood pressure had risen to the region of 80 which is low and of concern even for a postpartum and post epidural woman, and sometimes below 80 which is very worrying. The plaintiff however was responsive to questioning which was somewhat reassuring.

11. At 15.36 hours an intravenous of Gelofusine was provided and a second cannula was inserted at 15.44 and blood samples were collected for measurement.

12. The bleeding continued despite the fact that Dr. C was attempting to stitch and Dr. H, the consultant, was alerted at Dr. M's request at 15.48 and at 15.50 the blood bank in the hospital was contacted in order to cross match units of blood for operation and at 16.04 Dr. H advised a vagina packing after suturing in order to stem the bleeding.

13. The pack was inserted at 16.09 following the completion of the repair of the tear however a steady trickling of blood was noted at 16.22 it was noted that the blood clot was enlarging and at 16.25 Dr. M and Dr. Hughes agreed that the plaintiff should be taken to a theatre for operation and she was transferred to theatre at 16.37.

14. While the blood loss was described from time to time in the notes as a "*trickle*" it is clear that it continued throughout the period in the labour ward and thereafter and all the measures undertaken by the team failed to prevent it. In addition, the haematoma which was removed in the labour ward by Dr. M was described as the size of orange which is significant.

15. The blood loss prior to transfer was estimated at between 1,000 and 1,500 millilitres. This is a considerable degree of blood loss.

16. The plaintiff was taken to the operation theatre and as it agreed between the parties the operation was difficult, the procedure commenced at 17.25 hours and completed at 19.15 hours.

17. The operative findings were (a) large perineal haematoma, (b) second degree perineal tear, (c) well contracted uterus and (d) right paravaginal tear.

18. There was a further approximate 1,000 millilitre loss of blood during the operation.

19. There is no criticism of the defendants in relation to the events leading up to the birth of Mia. There is no criticism of the defendants in relation to the events in the operation

theatre. What the defendants are criticised however is in relation to the delay in sending the plaintiff to theatre after Mia's birth when the bleeding was identified.

20. Mr. D, the consultant obstetrician and gynaecologist expert called on behalf of the plaintiff who gave his evidence via video link criticised as unacceptable and substandard the level of care not in relation to the steps undertaken by the defendants' team once the bleeding and the tear was noted but rather the speed that those steps were undertaken and the fact that she had not been moved to the operating theatre by 16.01 rather than 16.37.

21. Mr. D stated that were the plaintiff to have been removed at 16.01 the blood loss would have been less and the trauma is likely to have been less as well.

22. A complaint about a 36-minute delay cannot be disregarded just because the time is relatively short. Significant trauma may occur due to that 36 minute delay and such a delay may indicate a breach of duty of care due to a lack of urgency.

23. The plaintiff claims that as a result of the defendants' negligence and breach of duty she suffered an unnecessarily traumatic experience, she required an extensive blood transfusion, after the incident the plaintiff was extremely traumatised by the events and suffered an ongoing significant psychological injury.

24. After the operation the plaintiff has no memory for subsequent events until approximately three days later when she woke on what happened to be her birthday. In the time after awakening she was advised both by the medical team and principally by her partner as to what had occurred. Her partner recounted how he on the evening of the operation was advised that it was "touch and go" for the plaintiff and that it was not clear that she would survive the night and that her family should be called.

25. When the plaintiff was discharged home she was very weak, she could not walk unaided naturally for some time, she could not tend to baby Mia and this was done by her partner and she suffered what she has described as a Post Traumatic Stress Disorder (PTSD). In this view she has been supported by the consulting psychiatrist called on her behalf, Dr. M, and also by her general practitioner, Dr. MCC, who's report has been agreed. The only dispute on this issue is that the defendants' consulting psychiatrist, Professor S, believes that rather than a PTSD she suffered symptoms of PTSD. Professor S's view is based upon the fact that the plaintiff has no recollection of the trauma herself but relies upon what she is told. Professor S accepts that under the American DSM criteria which are widely used in Ireland such second hand knowledge does qualify for PTSD but he relied upon the WHO guidelines in which the stressful event must be personally witnessed.

26. I think little turns on the distinction between PTSD and symptoms of PTSD as clearly the plaintiff was greatly affected and indeed traumatised by the incident. She was upset and tearful. She developed a reaction specifically to blood, doctors and the hospital. The plaintiff said that some three years ago she had turned a corner and was substantially better though whether or not it was the stress of giving evidence and the Court proceedings she clearly evidenced what I believe to be genuine distress in Court both

while giving evidence and listening to the case unfold. I find that the plaintiff did indeed meet the criteria of PTSD and that her psychological distress continues.

27. In addition to the above injuries as a result of the trauma she has undergone the plaintiff has been unable to resume physical intimacy with her partner and despite the fact that the plaintiff has been in attendance in regular counselling including counselling with specialist sex therapists she has been unable to resume intimate relations with her partner who is extremely supportive both to her and baby Mia.

28. I accept the plaintiff as a completely genuine witness who gave her evidence truthfully. Any inconsistencies are fully explicable by the fact that the plaintiff is clearly traumatised by recollection of the incidents herself.

29. I also reject any criticism of the plaintiff for initially pleading losses of earnings as a result of the fact that she had been able to return to her work she would have been earning but, as the shop in which she worked closed down shortly after Mia's birth, she is not now maintaining any claim for loss of earnings and similarly while she initially claimed for all her counselling bills of approximately €7,000 she has subsequently reduced this to limit it to the counselling that she has receipts for of some €4,000.

30. I fully accept that a plaintiff and her advisors may well have believed that there was a possible claim for loss of earnings which on advices of senior counsel were subsequently withdrawn and no criticism of the plaintiff is to be found on that basis.

31. Therefore, in addition to the immediate physical symptoms, the plaintiff suffered and is suffering from PTSD together with the anxiety symptoms, hypervigilant sensitivity to triggers, an avoidance of sexual intercourse as accepted by Professor S. There is no doubt that the plaintiff's life has been significantly damaged by the events the subject matter of the proceedings. The first real question in this case is that of liability. The second question should it arise is that of causation.

32. Mr. D is not critical of the steps taken by the defendants after they identified the tear and the bleeding, what he does criticise is the slow progress and the lack of urgency in transferring the plaintiff to operation theatre where the problem had to be dealt with. Clearly the fact that the plaintiff's stay in the operation theatre was considerable is indicative of the fact that the plaintiff was presenting with a number of problems of a serious and significant variety with possible life threatening implications.

33. On behalf of the defendant evidence was given by Professor M that the treatment was adequate for a community hospital in 2012. In particular, he stated that there was an appropriate escalation of the protocols following a bleed. The first step was communication and the midwife promptly communicated to the SHO, Dr. C, who subsequently communicated it to the registrar, Dr. M, who subsequently communicated it to the consultant, Dr. H, who operated with indeed the assistance of a second consultant.

34. The next step was resuscitation which was carried out by fluid and the oxygen and cross matching of blood, the third step was the monitoring and the fourth step was the arresting of the problem which was appropriately done first by tone in relation to the uterus and then by medication and stitching and attempt to blood clot, all of these remedies were carried out by the team led initially by Dr. C and subsequently by Dr. M and the midwives. Professor M was not of the opinion that the haemorrhage was massive but he did not dispute the fact that it was significant. The blood was regularly described in the notes as trickling, Professor M conceded that in a major national maternity such as the one that he worked in the steps taken would have been done somewhat more rapidly but that the treatment was acceptable and that the blood pressure stabilised though because it did not improve clearly the bleeding was continuing and the plaintiff remained unwell while in the labour ward.

35. In addition to the expert evidence I heard the evidence from defence witnesses, Dr. C, the SHO, and Dr. H, the consultant. Dr. M, the registrar, was apparently unavailable.

36. The test in relation to professional negligence in medical cases as that has set out by the Supreme Court in *Dunne v. The National Maternity Hospital & another* [1989] IR 91.

Dunne held that "*the true test for establishing negligence in diagnosis or treatment on the part of a medical practitioner is whether he has been proved to be guilty of such failure as no medical practitioner of equal specialist or general status and skill should be guilty of if acting with ordinary care.*

2. If the allegation of negligence against the medical practitioner is based on proof that he diverted from a general and improved practice that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualification.

3. If a medical practitioner charged with negligence defends his conduct by establishing that he followed a practice which was general and which was approved of by his colleagues of similar specialisation and skill he cannot escape liability if in rely the plaintiff established that such practice has inherent effects which ought to have been obvious to any person giving the matter due consideration." The fact that the allegations are against the hospital itself rather than a particular medical practitioner does not alter the fact that the principles in Dunne must mutatis mutandis be applied.

37. Mr. D stated that the fact of such a bleed, and the quantity of blood loss of approximately 1.5 litres before the plaintiff was taken to surgery indicates a very significant life threatening incident and meant that the speed of the defendants' reactions was unacceptable. Professor M on behalf of the defendants indicated that all reasonable steps were undertaken and that while in a major maternity hospital it might have been done somewhat faster that no real criticism can lie against the defendants.

38. I accept the evidence of Professor M that the defendants followed the approved practice of a regional hospital at the time and the plaintiff has not demonstrated under the third part of *Dunne* (above) that this practice had inherent defects which ought to have been obvious to any person giving the matter due consideration.

39. Accordingly, the only issue in liability is whether the plaintiff has established on the balance of probability that the defendants were guilty of a failure such as no practitioners of equal specialist status or skill would be guilty if acting in ordinary care and I have come to the conclusion that the evidence from Mr. D while entirely honest in his opinion fails to meet that standard. I accept the evidence of Professor M that while the reactions of the hospital were not as rapid as would occur in a major maternity unit that still they were not unacceptable. The time difference between what is advocated by Mr. D and what actually occurred is some 36 minutes.

40. It is not necessary for a finding of professional negligence for an expert witness to follow the wording as set out in *Dunne* (above) it is for the Court to assess whether the evidence in its totality meets that test. I fully accept that the hospital might have acted more rapidly and referred the plaintiff to theatre sooner but in preferring Professor M's analysis on this point to that of Mr. D other than concluding that things might have been done more rapidly, I cannot conclude anything more. Specifically I cannot conclude that the defendants were in any way negligent.

41. Accordingly, I do not have to consider issues of causation and whether the complained of delay of approximately 36 minutes would have resulted in any real extra loss to the plaintiff. However, in the interest of completeness I believe it is likely that had the plaintiff been taken to the operating theatre at 16.01 she would still have lost a significant quantity of blood, over 1 litre, and the repair would have taken a considerable time in theatre and accordingly she is likely to have been in a dangerous position and to have suffered as a result some psychological damage. However, I do believe that had the matter been dealt with sooner the plaintiff clearly would have suffered less of a blood loss and probably less psychiatric trauma however that is speculation and it is given my findings in relation to liability ultimately unnecessary speculation.

42. Accordingly, the plaintiff must fail in her case against the defendants and the case must be dismissed.