Neutral Citation Number: [2011] IEHC 362

THE HIGH COURT

1999 9989 P

BETWEEN

ANNE ENGLISH

PLAINTIFF

AND

SOUTH EASTERN HEALTH BOARD AND RAYMOND HOWARD

DEFENDANTS

JUDGMENT of Mr. Justice Ryan, delivered the 28th July, 2011

Introduction

1. The plaintiff Mrs Anne English is a 47 year old married lady with two teenage children who lives in Co. Tipperary. She was admitted to St. Joseph's Hospital, Clonmel on Monday 7th October 1996 with a suspected molar pregnancy, a very unusual condition where abnormal growth occurs instead of foetal tissue and which is dangerous and requires removal from the uterus. She did not in fact have that condition but the much more common complication of an ectopic pregnancy.

2. In the early hours of Wednesday 9th October the plaintiff began experiencing severe pain in her lower abdomen. She was distressed and shivering with an increased pulse and respiratory rate and significantly reduced blood pressure. The doctor on duty discussed her condition by telephone with the second defendant, Dr. Howard, who was the consultant obstetrician and gynaecologist in charge of the plaintiff. He directed that the plaintiff be transferred to the labour ward. Later that morning the plaintiff's condition had largely stabilised, her pulse rate and blood pressure returning to normal, although the acute abdomen remained and the plaintiff was recorded as being distressed and very pale. In an untimed note the plaintiff was recorded as suffering from pleuritic chest pain. Dr. Howard did not see the plaintiff when he did his rounds between 9am and 9.30am and did not see her until around midday. He then directed that the plaintiff be transferred to Our Lady's Hospital in Cashel (some 20 miles away) for a surgical opinion and noted the possibility that she might be suffering from acute retrocecal appendicitis.

3. The plaintiff was transferred to Cashel by ambulance on Wednesday afternoon. She was recorded as suffering severe and continuous pain, including shoulder pain, amongst other symptoms, and she was administered an analgesic. She was reviewed at 6.10pm, after which her condition was discussed with Dr. Fitzgerald, an SHO in Clonmel. The doctors in Cashel decided that Mrs English did not have retrocecal appendicitis or any surgical problem and that she was to be transferred back to St. Joseph's. She was kept in Cashel overnight for observation.

4. On Thursday 10th October at 11.50am the plaintiff was complaining of pain in the left side of her abdomen and she was catheterised. The doctor decided that she should be transferred back to Clonmel straight away. The note recorded "?? bleeding intraabdominally". It is likely that the plaintiff was bleeding as a result of her ruptured fallopian tube, which was the site of her ectopic pregnancy. In this critical condition, she was transferred back to St. Joseph's in an ambulance, accompanied by a doctor, arriving at approximately 1.40pm.

5. On arrival the plaintiff was seen by Dr. Howard and immediately transferred to the operating theatre, where anaesthetic measures had to be taken to resuscitate her. Dr. Howard performed a laparotomy and it transpired that the plaintiff had an ectopic pregnancy. She had suffered very substantial blood loss through the ruptured fallopian tube, which had to be excised. Some three litres of blood were removed from the plaintiff's peritoneal cavity.

6. The plaintiff made a satisfactory physical recovery from the operation. She was discharged from hospital on the 18th October. However, she claims that she was severely psychologically damaged by the incident and continues to suffer to the present day.

7. The proceedings were instituted in October 1999.

The Alleged Negligence.

8. The case against the defendants is first that Dr Howard failed to diagnose and treat the plaintiff's ectopic pregnancy in St Joseph's Hospital, Clonmel; secondly, that his decision to transfer the plaintiff to Cashel for a surgical opinion was unjustified; and thirdly, that the Cashel Hospital decision to transfer the plaintiff back to Clonmel was inexcusable. No criticism is made of the operation that Dr Howard performed when Mrs English returned to St Joseph's.

9. The following questions arise for consideration.

a. Was the second defendant Dr Howard negligent in

i. failing to diagnose or even to consider seriously ectopic pregnancy between the 7th October and the 10th October 1996?

ii. transferring the plaintiff to Our Lady's Hospital Cashel for a surgical opinion when she was in a seriously ill condition?

b. If so, did such negligence cause injury to the plaintiff?

c. Was Our Lady's Hospital Cashel negligent in sending plaintiff back to St. Joseph's Hospital, Clonmel on the 10th October 1996 when she was in a seriously ill condition?

d. If either or both defendants were negligent, how much of the plaintiff's psychiatric problems is attributable thereto?

e. Apportionment of liability between the defendants.

Cashel Hospital's Liability

10. One of these issues, Question c above, can be disposed of at the outset, having regard to the consensus of expert opinion in the case. The relevant witnesses were almost unanimous in their condemnation of the decision made at Cashel Hospital on Thursday 10th October to send the plaintiff back to Clonmel when she was critically ill. They dismissed the attendance of a doctor on the journey as being useless. Mr Roger Clements and Mr Malcolm Griffiths, experts called by the plaintiff, were unequivocal. The former said it was irresponsible. Mr Griffiths described the decision to transfer the plaintiff back to Clonmel, given her rapidly deteriorating condition at that time, as "reckless" because she had a very high risk of dying en route or arriving at the other hospital in a position where she could not be resuscitated. In his report, he described as "culpable to the point of gross recklessness" the transfer of the plaintiff from a unit with acute surgical facilities when she was requiring resuscitative measures to maintain her circulation. The consultant called by the hospital, Dr. Darling, said that if there was an operating theatre available in Cashel, considering the deterioration of the plaintiff's condition, to transfer her back was "perhaps a strange decision." If the facilities were available in Cashel at that time then the plaintiff should have been operated on there and then, he said. Mr Richard Keane SC for Cashel Hospital did not ascribe the transfer to any lack of operating facilities. Dr Peter Boylan, who was Dr Howard's expert witness, said that following the patient's serious deterioration in Cashel on Thursday morning 10th October, it was a "reckless" decision by the authorities at Cashel to transfer her back again to Clonmel when she was clearly suffering from internal bleeding, evident from the fact that she had been suffering shoulder tip pain and had experienced a collapse. It is therefore an irresistible conclusion that Cashel Hospital was negligent.

Dr Howard's Liability

11. No case can be made against Dr Howard prior to Tuesday 8th October when his involvement in Mrs English's care began. He saw her on his round and went along with the provisional or suspected diagnosis of a molar pregnancy. He did not review the case as a whole and just made a short note in the medical chart. The plaintiff's experts are critical of the care she received from the Thursday 3rd October, when she her general practitioner referred Mrs English for an ultrasound scan but Dr Howard is not responsible for anything that happened before the 8th October. The principal criticism is of his decision to transfer the patient to Cashel in the early afternoon of Wednesday 9th October. It is said that he should have thought of ectopic pregnancy as a possible diagnosis and taken appropriate action. And there was no reasonable basis for thinking that there might be a separate and coincidental pathology that warranted general surgery. These points are supported by the plaintiff's experts and by Dr Darling, who was called by Cashel Hospital. They are rejected by Dr Boylan, the consultant called by Dr Howard.

12. Having seen Mrs English on his round on Tuesday 8th, Dr Howard's next contribution to her care was when he discussed her condition on the phone with Dr Fathil at 2.50am the next day. The plaintiff was causing serious concern to the nurses who called the doctor on duty. He shared their anxiety and called the consultant at home. Dr Howard said that Mrs English should be moved to the labour ward where she could be closely monitored through the night. He saw her again at some time between mid-day and 1pm on Wednesday 9th October when he sent her to Cashel. This is the decision that is critical to Dr Howard's liability. At this point the patient still had significant symptoms but Dr Howard did not know what was wrong with her. If Mrs English had a molar pregnancy, which was the only suggested diagnosis that had been made up to then, the appropriate treatment was evacuation of the uterus. Had that procedure been undertaken, it would have been revealed that it was not a case of molar pregnancy so the conclusion would have been obvious that it was an ectopic pregnancy and a laparotomy would then have been done. Dr Howard was afraid that if he proceeded to do a laparotomy operation, he might discover that the plaintiff's problem was not gynaecological but surgical and that he would not be able to deal with it. He did not have a specific surgical condition in mind: it was general not specific anxiety. He thought of retrocecal appendicitis as an example of the kind of condition that he would not be able to handle, not because Mrs English's symptoms pointed to that ailment.

Mr. Roger Clements

13. Dr Howard's decision making was severely criticised by the experts called by the plaintiff and by Cashel Hospital. Mr. Roger Clements, retired consultant obstetrician and gynaecologist, who is a well-known and respected expert witness in this area of medicine, was called by the plaintiff. He was critical of the doctors who saw Mrs English before Dr Howard came into the picture on Tuesday 8th. Mr. Clements described as "inexplicable" and "astonishing" the failure on Wednesday 9th October to perform a laparoscopy when it was noted that the plaintiff had pleuritic chest pain, indicating that she had blood in her peritoneal cavity which was irritating her diaphragm. Laparoscopy was "an essential diagnostic tool" at this point, according to Mr. Clements, and would have led to the ectopic pregnancy being identified and the fallopian tube where the ectopic was located could have been removed. In his opinion, the differential diagnosis was clearly an ectopic pregnancy but this was not considered, which he described as "incompetent"; in his view, a molar pregnancy should have been very far down the list of suspected symptoms because it is so rare. Nonetheless, he said, once a molar pregnancy was suspected, immediate action was required to confirm this as it is a potentially life-threatening condition. Mr. Clements said there were no real symptoms of retrocecal appendicitis: the plaintiff had no physical signs of an inflammatory condition, no fever and no raised white blood cell count. He described the diagnosis as "ludicrous" and said that it should have been possible to exclude retrocecal appendicitis as a diagnosis. Even in the event that retrocecal appendicitis was a possible diagnosis, Mr. Clements said that a general surgeon or even a gynaecologist could have dealt with it and the decision to transfer the plaintiff to Cashel was "irresponsible" and "extremely high risk". Under cross-examination it was put to Mr. Clements that there was a possibility the plaintiff had in fact become pregnant after a negative pregnancy test in September, in which case this would have been a very early pregnancy and consistent with her pregnancy hormone levels and the fact that a gestational sac was not showing on the ultrasound scan. Mr. Clements said this was "highly improbable, and that the "overwhelming probability" was that the plaintiff was pregnant at the time of the tests in September and that the negative test could be explained by virtue of the fact that pregnancy tests at that time during early pregnancy were not always reliable. He said that the snowstorm in the uterus pointed to this, as it required a pregnancy of sufficient duration for such tissue to appear. He said that in retrospect the snowstorm appearance must have been due to the disruption of the uterine lining from the plaintiff's ectopic pregnancy. He also pointed to another, positive pregnancy test in September.

Mr. Malcolm Griffiths

14. Mr. Malcolm Griffiths, consultant obstetrician and gynaecologist, said that if the plaintiff was suffering from a molar pregnancy, her uterus needed to be evacuated as soon as possible and the failure to do so amounted to "substandard care". The plaintiff's pregnancy hormone (hCG) levels were not consistent with a molar pregnancy because the figure was not high enough and strongly pointed towards an ectopic pregnancy. This should have been entertained as a differential diagnosis but it was not mentioned anywhere in the notes. The hormone level recorded in the hospital notes of 8th October was half the earlier figure, which, according to Mr. Griffiths would definitively rule out a molar pregnancy, which is characterised by dramatically increasing as opposed to falling hCG levels. According to Mr. Griffiths, it was "unacceptable" given the falls in the levels of hCG not to have performed a laparoscopy

on the plaintiff, which would have revealed the ectopic pregnancy. Mr. Griffiths' opinion was that the plaintiff had been pregnant since August 1996 and he dismissed the suggestion that she might have become pregnant after her tests in September but he thought it was irrelevant exactly how pregnant she was. The key figure in his view was the hCG value, which meant that a gestational sac should have been visible in the uterus in a normal pregnancy. He noted that nowhere in the medical records did anyone record a concern about an early intrauterine pregnancy.

15. In relation to the plaintiff's deterioration in the early hours of 9th October, Mr. Griffiths said that "2.50am in the morning is when the alarm bells really ought to have rung" and that there was "no safe explanation for her presentation on the early morning of the 9th." He said that the plaintiff should have been operated on promptly that morning and the failure to do so was sub-standard care. He agreed with Mr. Clements that the pleuritic pain which the plaintiff was experiencing was consistent with intraperitoneal bleeding. Mr. Griffiths thought that the diagnosis of possible retrocecal appendicitis was bizarre. He added that the indicators of retrocecal appendicitis such as fever and high white blood cell count were not present.

Dr. Michael Darling
16. Dr. Michael Darling, a consultant obstetrician and gynaecologist formerly of the Rotunda Hospital in Dublin, who retired from clinical practice in 2007, was called as a witness by the first defendant. He said that ectopic pregnancies can generally speaking be difficult to diagnose but in the plaintiff's case the positive pregnancy test, the absence of a fever, the other symptoms the plaintiff had developed by the morning of 9th October -- in particular the pleuritic pain which was indicative of intra-abdominal bleeding—meant that the possibility of an ectopic pregnancy should have been excluded before arranging her transfer to Cashel for a surgical opinion. In his opinion the proper course of action at that stage was to perform a laparoscopy to determine the source of the problem. As regards the diagnosis of suspected retrocecal appendicitis, Dr. Darling said that a person suffering from this condition would not necessarily manifest a raised white blood cell count or temperature in all cases. He said that in the circumstances and considering the plaintiff's symptoms at that time although retrocecal appendicitis was not likely, it was not off the "radar". That said, he thought that it may have been useful in terms of excluding the possibility of retrocecal appendicitis if a vaginal and/or rectal examination had been performed in Clonmel. In cross-examination by Mr. Hanratty S.C., counsel for the second defendant, it was put to Dr. Darling that there was a possibility that the plaintiff had become pregnant some time between the two contradictory tests in September 1996 and the positive test in October 1996. Dr. Darling agreed that it was possible, and that if an evacuation of the uterus had been performed prior to the 8th October that would have been precipitous and may have carried the risk of aborting a live pregnancy. In cross-examination by Dr. O'Mahony S.C., counsel for the plaintiff, Dr. Darling said that the hCG reading of 6,400 recorded on 4th October was indicative of pregnancy but was not diagnostic of a molar pregnancy, where one would expect that level to be multiples higher. He agreed that at this point ectopic pregnancy should have been a real differential diagnosis.

Dr. Brendan Powell
17. Dr. Brendan Powell was a consultant obstetrician and gynaecologist at Clonmel when the plaintiff was admitted there in October 1996. He saw her on Saturday 5th October and also suggested a molar pregnancy. At that time he estimated the hospital was witnessing approximately four or five ectopic pregnancies per year and he could only recall two molar pregnancies in his almost 20 years in the hospital. Dr. Powell denied that the plaintiff's hCG levels of 6,400 recorded on 4th October were inconsistent with a molar pregnancy. He said that this could have been consistent with the genesis of a molar pregnancy, though perhaps not an advanced molar pregnancy. He also said that a rapid rise in hCG levels was a more relevant symptom of molar pregnancy than the level itself. As regards the arrangements with Cashel hospital, he explained that there was no facility for a surgeon to come to Clonmel because at Cashel there was almost inevitably only one consultant on duty at any one time and that person could not leave the hospital.

Dr. Raymond Howard, the second defendant
18. In his evidence, the second defendant Dr. Howard said that he trusted the negative pregnancy test of 12th September and that the plaintiff must have become pregnant shortly after this test. Dr. Howard rejected the assertion that an evacuation of the uterus should have been performed before 9th October until the diagnosis of molar pregnancy had been confirmed because of the risk of inadvertently performing an abortion of a viable pregnancy. He said that up until that date the plaintiff's condition could not be described as unwell. When he saw her around midday on 9th October he said she was now unwell and he "thought there was something definitely going on in the abdomen." He felt that he needed a surgical opinion to rule out any possible surgical emergency in the abdomen, which he did not feel he was qualified to do himself. He was afraid to open the plaintiff's abdomen only to discover there was a problem he could not deal with. He had very little experience in general surgery and had never performed an appendectomy. At this stage on 9th October he thought there was no definitive diagnosis possible for ectopic pregnancy because the ultrasound had not shown an empty uterus. He said that hCG levels are relative to how old the pregnancy is, and the levels recorded in respect of the plaintiff were consistent with an early pregnancy. The age of the pregnancy was difficult to gauge because there was a lack of information regarding the date of the plaintiff's last menstrual period. As regards the pleuritic pain being experienced by the plaintiff, Dr. Howard said that this was not an indicator of ectopic pregnancy or blood in the peritoneal cavity. He said that retrocecal appendicitis was written down more by way of example rather than his surgical diagnosis, in light of the abdominal pains the plaintiff was experiencing. His general concern was that there was some form of surgical problem, which could also include other conditions such as a splenic aneurism. He defended his decision to transfer the plaintiff to Cashel, saying that she was no longer in a state of shock at that time and it was a mere 20 minute journey. In transferring the plaintiff to Cashel, Dr. Howard said he was acting with the expectation that she would be returned to Clonmel promptly the same day if there was no surgical condition to be treated. When the patient was returned to Clonmel the following day, arriving in a seriously deteriorated condition, Dr. Howard said he suspected ectopic pregnancy at that stage and she was immediately brought to theatre. Under cross-examination by Dr. O'Mahony S.C., Dr. Howard agreed that ectopic pregnancies were far more common than molar pregnancies. The occurrence of the former is one in 300 and the occurrence of the latter is one in 3,000.

Dr. Peter Boylan
19. Dr. Peter Boylan, Clinical Director at the National Maternity Hospital, was an expert witness for Dr Howard. His strong view was that the plaintiff most likely did not become pregnant until some time after the negative hospital pregnancy test on 12th September 1996, and that the plaintiff's home pregnancy test would have been less reliable than a hospital test back in 1996. He said that ectopic pregnancies do not typically rupture later than 6-7 weeks into pregnancy, a new point it should be noted that was not put to the other expert witnesses. He said that the later positive pregnancy test, together with the ultrasound appearances, including the cystic changes indicated by a scan of 7th October were characteristic of molar pregnancy and this was a reasonable working diagnosis. As regards the hCG levels, Dr. Boylan said that these were not incompatible with a diagnosis of a possible molar pregnancy, as it could have been a very early molar pregnancy. He also said that the hCG tests carried out – with one exception, where the results were received only after the plaintiff had been discharged – were urinary tests as opposed to blood beta hCG tests, which is the more sensitive index. In Dr. Boylan's opinion, there was nothing to suggest the possibility of an ectopic pregnancy between the 3rd and 9th October and an early evacuation of the uterus might have inadvertently terminated a healthy early pregnancy which was not clear from the scan. As regards the pleuritic chest pain recorded on 9th October, Dr. Boylan said this was not indicative of abdominal bleeding, although shoulder tip pain was. He said that the decision by Dr. Howard to transfer the plaintiff to Cashel for a surgical opinion on 9th October was a reasonable one, particularly as the plaintiff was stable at that time and remained so until the

following morning at around 11.50am.

20. My conclusion in regard to Dr Howard is that he did not make a diagnosis before transferring Mrs English. Instead, he merely went along with the previously suggested diagnosis, which was of an extremely rare condition, without recording or addressing the possibility of one that was ten times more probable. Dr Howard said that ectopic pregnancy was always among the possibles as to diagnosis but there is no mention of it in the notes even as a possibility. I accept the evidence that his failure to exclude this diagnosis was negligent. In regard to the failure to treat the plaintiff for the condition he thought she had, he made the case that she could have had a very recent pregnancy which was too early to show up in the uterus and, if so, doing an evacuation would amount to abortion of a viable pregnancy. The problem with this defence is that it is no more than a theory that could account for a policy of non-intervention but there is no evidence that it did actually feature in the doctor's thinking at the time. This is an example of the retrospection that Mr Hanratty SC, for Dr Howard, deprecated in the evidence of the expert witnesses called by the plaintiff. Dr Howard did not know what was wrong with plaintiff, whether it was related to her obstetric condition or was something entirely different. He made no assessment of what her condition was or what were the possible diagnoses, based on the available information. He did not actually think the plaintiff had an acute appendix –she did not have the symptoms. He put down retrocecal appendix merely as a speculation of something that represented a surgical possibility but not on the basis of any evidence. In my opinion, Dr Howard's decision to send Mrs English to Cashel had more to do with his own anxieties than with medical analysis. The most temperate critic of Dr Howard was Dr Darling, whose opinion as to that defendant's failures of care were endorsed by the plaintiff's experts and were not refuted by Dr Howard or Dr Boylan. I accept the evidence of those experts and it follows that Dr Howard was negligent in each of the respects set out above.

Damages

The Plaintiff

21. The plaintiff had serious psychiatric problems before the events of October, 1996 and presented a bewildering complex of psychiatric issues. They included the psychological sequelae of prolonged sexual and other abuse by her father when she was a child and later. She suffered from auditory and visual delusions which may be attributable to the repercussions of epilepsy. She may have had post-natal depression previously. She was late in seeking psychiatric help and did not attend consultations that were arranged for her. There are family issues that brought intervention from social services. The assessment by her psychiatrist Dr O'Leary and her attempts to treat the plaintiff were probably compromised by insufficient information, especially in regard to her troubled childhood history, and some misinformation. Ms Campion, a clinical psychologist, came into the case too late to be able to distinguish between the many issues affecting Mrs English and also did not have a complete or accurate picture.

22. There are reasons to doubt the reliability of the plaintiff's recollection. Her evidence is in conflict in important respects with that of her general practitioner, Dr Durack, and his records. She claimed to have discussed the ectopic pregnancy with him much more often than he recalled. Of major importance in my view is a contradiction between her evidence as to the cessation of sexual relations with her husband and the general practitioner's records and evidence of treatment to promote conception. A minor but not trivial point is the documentary evidence that she consulted Dr Howard for a gynaecological complaint subsequent to the events of October 1996.

23. These are not the only complications in the assessment of damages. The plaintiff suffered a grief reaction to the loss of her pregnancy but that was not the fault of the defendants. She is entitled to such damages are appropriate to compensate for the physical and psychological injury she sustained during and because of the journey to Cashel, the time she was there and the return to Clonmel. The plaintiff gave evidence that she was aware prior to the outward trip of uncertainty and doubt on the part of the doctors in Clonmel but I found that unconvincing and quite improbable as something that might have been observed by the plaintiff at the time.

24. Referring to her condition at Clonmel hospital in the early hours of 9th October when she went into shock, the plaintiff described her abdominal pains as excruciating, saying she was terrified and believed she was in danger of death. By the time of her ambulance transfer to Cashel that afternoon, she said the pain was worsening and she was convinced she was going to die; she was weak and hazy. She said the journey was particularly difficult because she felt every bump along the way and this caused her a great deal of pain. Although it was a short journey, it seemed like "a lifetime". At 11.50am the following day, when she was recorded as complaining of abdominal pains once more, the plaintiff said that the pain was such that she was praying to die. When she was transferred back to Clonmel by ambulance, she found that journey particularly distressing and remembered blacking out from the pain and being resuscitated with oxygen. She described being extremely panicked at this stage, saying she did not know what was going to happen to her.

25. The plaintiff was very sore and nauseous after the operation by Dr. Howard to remove her ectopic pregnancy and it took a while for her to get her strength back. She explained how she had been elated at discovering she was pregnant originally and how her psychological state following the incident was one of shock, hating the fact that she had lost the baby and she described having feelings of guilt.

26. The plaintiff said that prior to the events of October 1996 she was bubbly, sociable and outgoing and enjoyed a happy relationship with her husband. Since the incident she has experienced flashbacks and nightmares on a daily basis, her sleep has been seriously disturbed, she has lacked motivation, she has become irritable and her enjoyment of life has disappeared. She said that she experienced loss of libido and engaged in comfort eating. She was terrified of further pregnancies and this seriously affected her marriage: there had been no sexual relations since the ectopic pregnancy. She said the marriage is now a relationship that consists of little more than co-existence, though she described her husband as generally having been "very supportive".

27. She said that since the incident she does not socialise, does not go anywhere if she can avoid it, she is afraid of crowds and experiences self-loathing. She has been very low and feels hopeless, although things have improved recently, particularly thanks to the help of her husband, her General Practitioner Dr. Durack and her psychiatrist Dr. O'Leary, though there are still bad days and she continues to suffer from nightmares. According to her evidence, the plaintiff starting seeing Dr. Durack quite frequently after the incident to discuss her psychological problems and he referred her to Dr. O'Leary in November 2002. The plaintiff was prescribed anti-depressants, which she refused to take at first but eventually began doing so and continues to take them to this day. She has also been taking sleeping pills since 2003. However, the plaintiff did not accept treatment offered by Dr O'Leary, she would not attend counselling, did not take medication & did not attend psychiatry appointments.

28. In or about 2005 the plaintiff's children were placed in foster care for a period of some five weeks following an intervention of the social services after the children's school raised concerns about their welfare.

29. In cross-examination, the plaintiff acknowledged that she had been sexually abused by her father from the age of three until her

teenage years. She described the abuse by her father as physical, emotional and verbal and said that he remained abusive even after the sexual abuse had ceased. With reference to comments she had made to Dr. O'Leary, it was put to the plaintiff that it was the thought of losing her baby from the ectopic pregnancy rather than her treatment by the medical authorities that was the source of her problems. She said that she saw the two things as part of the same bundle and that she was still affected by the experiences in the hospital and the physical pain she experienced. The plaintiff also explained that up until recently she was under the belief that she had lost two babies and that she had suffered an ectopic and a molar pregnancy, despite the fact that her condition had been explained to her beforehand.

30. The plaintiff's evidence gave rise to concern as to credibility and reliability. She did not tell Dr O'Leary about her history and misinformed her about sexual relations after the ectopic pregnancy. She was slow to seek any advice or help and only did so around the time she instituted proceedings. Mrs English did not consult Dr Durack about the ectopic pregnancy for over two years yet she said he was a great help to her and she discussed her condition with him regularly in the period following the event. This is in complete conflict with his evidence.

31. No explanation was offered for the misinformation, for the non-compliance with therapy or for the non-attendance. The plaintiff sat in Court while information was obtained from Dr Durack about her efforts to become pregnant again after October, 1996 but no application was made to recall her to deal with this clear contradiction of what she had testified a short time before in an important element of the case. And Dr Durack sat in Court while an entry in his notes was interpreted. It read "post natal" and the inference was that the plaintiff suffered post-natal depression following the birth of one of her children. The doctor could have cleared the matter up one way or the other but there was no application to recall him. Uncertainty was apparently preferred to clarity.

Dr. Bernard Durack
32. Dr. Bernard Durack has acted as a general practitioner to the plaintiff since 1991. In his evidence he said that up until 1996 the plaintiff "seemed a happy lady who had two children and was anxious for more." Following the events surrounding the ectopic pregnancy in October 1996 the next record Dr. Durack had of meeting with the plaintiff was in February 1997, when he performed a pregnancy test on her which was negative. In May of that same year he prescribed her Clomid, a fertility drug. He prescribed the same drug again in June.

33. His first record of a reference to the ectopic pregnancy was in February 1999 when the plaintiff complained to him that she could not sleep, that she had psychological problems relating to the ectopic pregnancy and that there was no intimate relationship between her and her husband at that time. According to Dr. Durack's notes, he prescribed her sleeping tablets and suggested she attend the psychiatric services. In October 1999 it would seem the plaintiff requested counselling but as things transpired she did not attend for psychiatric help until 2002.

34. Dr. Durack met regularly with the plaintiff over the following years, mostly on matters not connected with the ectopic pregnancy. In January 2011 Dr. Durack met with the plaintiff for an in depth interview for a medico-legal report requested by the plaintiff's solicitors. His conclusion in that report was as follows:-

> *"In summary, Anne has had on-going and unresolved post-traumatic and morbid pre-occupation with the events surrounding her ectopic pregnancy since that time. The interview seemed to drag up one angst after another. She feels that her mental state, marriage and family life have been badly affected by her stress reaction. Anne has been attending the psychiatric services for many years and has been taking anti-depressant medication since February 2003.*

It is difficult to see that there will be any improvement in her mental state given the elapsed time since the event and the lack of psychological progress."

Dr. Zubaidah O'Leary
35. In her report dated 14th January 2003, consultant psychiatrist Dr. Zubaidah O'Leary made an assessment of the plaintiff based on meetings she had had with her, the first of which took place in November 2002. Dr. O'Leary's conclusion was that the plaintiff was undergoing an "adjustment reaction with prolonged depressive reaction following an ectopic pregnancy which she had 6 years ago." Dr. O'Leary added that the plaintiff also had symptoms of post-traumatic stress. She also noted that since aged 4-5, the plaintiff had been having "somatic hallucinations" of her grandmother and that she had heard her father's voice on occasion, stating that these experiences may be due to the plaintiff's underlying epilepsy (which the plaintiff denied).

36. Dr. O'Leary's next report, dated 15th February 2010, drew on various meetings with the plaintiff since 2003. The plaintiff was discharged from the psychiatric care service for failing to attend on a number of occasions but was re-referred in 2006 following the intervention of social services. Dr. O'Leary's conclusion in that report was that the plaintiff continued "to have symptoms of post traumatic stress disorder with nightmares and flashbacks of the ectopic pregnancy events", that her mood had been "clinically mildly depressed", and that there were also issues of childhood sexual abuse. The report recommended the plaintiff attend a psychologist to help her deal with issues of post traumatic stress disorder and childhood sexual abuse (which was only disclosed by the plaintiff to Dr. O'Leary in 2008 following the death of the plaintiff's mother) but noted that the plaintiff had declined this treatment. In her most recent report of 21st March 2011, Dr. O'Leary made the following diagnosis:

> *"Ann was married and had a happily married life but since the ectopic pregnancy experience she had recurring flashbacks and anxiety symptoms, when confronted with issues or matters pertaining to babies. She showed avoidance behaviour since then. Her sleep is chronically disturbed but then her day sleep pattern is probably aggravating her night time sleep pattern. There [are] chronic feelings of low mood with lack of intimacy with her husband for the last 13 years since she had the ectopic pregnancy as both are fearful of recurrence of the same experience if she becomes pregnant.*

However her relationship with her husband has improved. She is looking forward to improve her relationship with her teenage daughter and she is optimistic for the future. In my opinion she has symptoms of the post traumatic stress disorder and the flashbacks will lesson over time and it is recommended that she continues to attend out-patient clinic and family therapy sessions."

Ms. Jo Campion
37. Ms. Jo Campion is a senior clinical psychologist who met with the plaintiff on 1st March 2011 and carried out a psychological assessment over a period of two and a half hours. Ms. Campion noted that the plaintiff had suffered petit mal epilepsy since childhood and that she was raised in an unhappy home with a very controlling and abusive father. However, she said that "in spite of these factors Anne had no history of depression and had not come to the attention of the psychiatric services prior to the index event." Ms. Campion's clinical diagnosis was that the plaintiff suffers from post traumatic stress disorder, depression, anxiety, self-esteem problems and continuous episodes of self-blame. She linked the PTSD to the two days of being transferred from one hospital to another in an ambulance when she was in a fragile physical state and emotionally distressed and able to sense the "panic and

indecision" surrounding her care, as apposed to what she described in her direct evidence as "the ectopic pregnancy per se" and the inevitable sadness that the loss of a baby will give rise to. Ms. Campion's prognosis was a guarded one, although she did say that if the plaintiff engaged with the appropriate psychotherapy she believed that there could be improvements.

38. In cross-examination, it was evident that the witness did not have a complete or accurate picture of the plaintiff's history. In fairness, it would be demanding the impossible from an expert witness to expect her to isolate the trauma associated with a particular 24 hour period in circumstances that were themselves devastating and that happened more than 14 years previously.

Dr. Richard Horgan
39. Dr. Richard Horgan is a consultant psychiatrist who appeared as a witness for the first defendant. He examined the plaintiff on two occasions, in February 2003 and the March 2011. In his reports he described the plaintiff as a poor historian whose memory was lacking in detail. Dr. Horgan's opinion was that the plaintiff suffered from major mental health problems "but they related to her developmental history, history of temporal lobe epilepsy, history of psychosis and a pre-morbid history of obsessive compulsive disorder and social anxiety disorder." Referring to evidence of the plaintiff's experiencing auditory and visual hallucinations, he said this indicated that the plaintiff is psychotic and probably has been psychotic for many years (pre-dating the ectopic pregnancy episode) but has been left untreated.

40. Similarly, he was of the view that the plaintiff's social anxiety disorder and obsessive compulsive disorder predated the ectopic pregnancy. Dr. Horgan thought that long-term sexual abuse would have had a significant effect on the plaintiff. He said that temporal lobe epilepsy can lead to personality change. Dr. Horgan thought that the medical events surrounding the plaintiff's ectopic pregnancy and in particular her hospital transfers made little more than a marginal contribution to her difficulties. His assessment was that her distress in relation to the events of October 1996 was due to the fact that she had an ectopic pregnancy, rather than the treatment she received, and to her fear of having another ectopic pregnancy.

Conclusions - damages
41. The plaintiff was subjected to a terrifying ordeal and put in a near-death situation. The transfer and return caused real distress to the plaintiff and contributed to the overall psychological impact of the ectopic pregnancy and the loss of a baby.

42. The plaintiff had serious psychological problems prior to her ectopic pregnancy. Only a part of her psychological difficulties can be attributed to the medical events surrounding her ectopic pregnancy. And a smaller element of that is attributable to the added trauma caused by the defendants' negligence. I find the analysis of Dr Horgan to be more persuasive that those of the plaintiff's experts. Her distress in relation to the events of October 1996 was due to the fact that she had had an ectopic pregnancy and lost her baby rather than to the treatment she received. However, I think the impact of the negligent care was more than marginal but it was transient whereas the failed pregnancy continued to affect Mrs English.

43. The plaintiff is a vulnerable and psychologically scarred individual. She is confused and until recently seems not to have understood fully what occurred in October 1996. She also strikes me as someone who is somewhat disturbed and she has experienced hallucination type experiences involving her dead relatives. She is obviously in need of treatment and has received some but it has been intermittent and ineffective to date and the plaintiff has not been compliant. Ms Campion was somewhat critical of the treatment the plaintiff had received.

44. Finally, although the procedure which the plaintiff ultimately underwent to remove the ectopic pregnancy would have been necessary regardless of any negligence on the part of the defendants, the severity of it would have been less pronounced. She would in all likelihood have avoided a vertical abdominal incision and instead have had a transverse suprapubic incision, and she would not have necessitated large-scale blood transfusion.

45. In his submissions it was suggested by Mr. Hanratty S.C. for the second defendant that it was the transfer back from Cashel that caused the damage to the plaintiff. Even if Dr. Howard was negligent, it was submitted, the causative connection between that negligence and the damage sustained was broken by the intervening negligence of the doctors in Cashel. I do not accept this argument. The plaintiff described in graphic detail the pain and trauma she experienced over the course of the 9th October and in particular the ambulance journey from Clonmel to Cashel, which took place on the direction of Dr. Howard. She was in pain when she arrived and spent a difficult night at the hospital while she was under observation. It seems to me that it was only when she had deteriorated the following morning and the decision was taken by the doctors at Cashel to send her back to Clonmel that a new act of negligence took place. Up to that point the trauma experienced by the plaintiff flowed from the failure by Dr. Howard to diagnose her condition and his decision to transfer her to Clonmel. Dr. Howard therefore contributed significantly to the damage suffered by the plaintiff in terms of her pain, suffering, distress and her consequential psychological sequelae.

46. On behalf of the first defendant it was argued by Mr. Keane S.C. that whatever damage occurred to the plaintiff was simply a recurrence of the same problem that had occurred at 2.50am on the 9th October at Clonmel. It was asserted that Cashel hospital bore no causal responsibility for it. Again, I must dismiss this submission. The negligence on the part of the authorities at Cashel exacerbated the trauma that the plaintiff had already experienced and it is clear from the evidence that the transfer back to Clonmel by ambulance was the nadir of the plaintiff's traumatic experience. It follows that the first and second defendants are concurrent wrongdoers.

47. In view of the very long time since these events took place and having regard to my view that the consequences of the defendants' negligence were transient, I make a global award of damages in the sum of €75,000.

Conclusions - contribution
48. Each of the defendants has sought an indemnity or contribution from the other in respect of the plaintiff's claim for damages. The Court's function in this matter is governed by s. 21(2) of the Civil Liability Act 1961. The question is what contributions it is just and equitable for the defendants to be ordered to make, having regard to their respective degrees of fault. It is a matter of assessing the defendants' respective moral blameworthiness as opposed to the potency of their respective causative contributions.

49. To all intents and purposes the plaintiff was Dr. Howard's patient. Dr. Howard first saw the plaintiff on 8th October, at which time there was sufficient information for a diagnosis of likely ectopic pregnancy. When the plaintiff deteriorated the following morning and showed symptoms of bleeding, Dr. Howard was slow to respond and when he did finally see the plaintiff his continued failure to spot the ectopic pregnancy and his decision to transfer her to Cashel was a serious mistake. That said, the plaintiff's condition was stable at that point and there was no immediate risk to her life as far as Dr. Howard was aware. The following morning at Cashel, however, it would seem that the plaintiff's ectopic pregnancy finally ruptured and it is no exaggeration to say she was close to death. The decision to transfer her from Cashel in this state amounted to gross negligence.

50. Considering the respective degrees of fault, I apportion the contributions as to 60% on the first defendant and 40% on the second defendant.