

THE HIGH COURT

[2021] IEHC 650

Record No. [2015] 8590 P

BETWEEN:

MARGARET O'DEA

PLAINTIFF

-AND-

**THE GOVERNORS AND GUARDIANS FOR THE RELIEF OF POOR LYING WOMEN IN
DUBLIN**

DEFENDANTS

JUDGMENT of Mr. Justice Michael Hanna delivered on the 15th day of October, 2021.

1. The plaintiff in this action is Margaret O'Dea. She is a married lady, a carer and has three children. In April 2013 she began to suffer from severe post-menstrual bleeding. An ultrasound scan revealed that she had a fibroid uterus. She came under the care of Dr. (now Professor) Ronan Gleeson at the defendants' Rotunda Hospital in Dublin. She discussed the treatment options with him and, after thinking about it, Mrs. O'Dea consented to undergo a total abdominal hysterectomy. The operation took place the following October at the Rotunda Hospital.
2. The plaintiff's immediate post-operative condition was satisfactory and, after five days of uneventful rest and recovery, she was discharged from hospital. Subsequently, the plaintiff suffered from significant urinary incontinence caused by a vesico-vaginal fistula. This was presumptively diagnosed by Prof. Gleeson at his six-week check-up of the plaintiff and subsequently confirmed after cystoscopy by Mr. Killian Walsh, consultant urologist. The plaintiff underwent surgery by Mr. Walsh in Galway to repair the fistula in January 2014. The outcome of this surgery was satisfactory although it is clear that the plaintiff suffered grievous and debilitating symptoms subsequent to her initial discharge from the Rotunda Hospital and for some time after the repair surgery. She continues to complain of some ongoing symptoms.
3. The issue to be determined is whether the fistula was caused directly or evolved as a consequence of negligence on the part of Professor Gleeson during the hysterectomy. The resolution of that question turns on the expert evidence. The plaintiff's expert, Dr. Porter, a consultant obstetrician/gynaecologist, maintains that a vesico-vaginal fistula must have a cause. He says that cause could only have been damage to the plaintiff's bladder during the course of surgery. Such damage represents substandard care. Prof. Gleeson and the defendant's expert, Dr. Lenehan, also a consultant obstetrician/gynaecologist, do not dispute that the plaintiff suffered a fistula but strenuously deny negligence. They point, *inter alia*, to the impact of the plaintiff's prior history of obstetric and urological surgical intervention with attendant increased vulnerability of her bladder as well as the possible development of a haematoma, individually or in combination, as being more likely candidates for the origins of the fistula.

Background

4. The plaintiff was born on the 30th July, 1966. She has three children who were born in the years 1997, 2000 and 2003 respectively. Two of the births proceeded naturally. The middle child was delivered by caesarean section on 20th March, 2000. Some years after

the birth of her third child the plaintiff underwent a transvaginal tape procedure (TVT) to treat stress incontinence.

5. On the 29th April, 2013 the plaintiff presented to her General Practitioner, Dr. Barbara O'Beirne, complaining of severe post-menstrual bleeding. She was referred to Professor Gleeson at the Rotunda Hospital. The plaintiff underwent an ultrasound scan which confirmed that she had a fibroid uterus. She was subsequently seen by Professor Gleeson on 5th July, 2013. Having examined the plaintiff, he proposed two treatment options; either a total abdominal hysterectomy or endometrial ablation with a Mirena Coil.
6. The plaintiff elected to undergo a total abdominal hysterectomy. She was admitted to the Rotunda Hospital on the 22nd October, 2013 and the surgery was carried out by Professor Gleeson the following day. She was subsequently discharged on 28th October, 2013.
7. A few matters to be gleaned from the hospital notes are relevant. Firstly, as part of the preparation for the operation it appears that the plaintiff was "prepped" for the use of diathermy. There is no dispute that this was a standard and appropriate step and does not, of itself, indicate that diathermy was actually employed in the course of the operation. Secondly, the brief operation note indicates that the operation was not without incident. It reads to the following effect:

"total abdominal hysterectomy, conservation of ovaries.

Enlarged fibroid uterus 3 pedicles. Ovaries normal. Subtotal to gain access.

Angles to support vault.

Troublesome haemorrhage on the left.

Good haemostasis.

Thirdly, there was no record of estimated blood loss. Fourthly, apart from a mild and inconsequential post-operative infection, her recovery from the operation appears to have been satisfactory. A midstream urine specimen was sent to the laboratory on 26th October, 2013 and this showed an E. coli infection but no red cells in the urine. At no stage was blood observed in the plaintiff's urine.

8. On the 4th November, 2013 Professor Gleeson wrote to Dr. O'Beirne informing her of the surgery and commented that she had made a good post-operative recovery. The plaintiff attended Dr. O'Beirne on the 5th November, 2013 complaining of urinary problems and was prescribed antibiotics for a suspected urinary infection. The problems persisted and she returned to Dr. O'Beirne some seven days later following which additional antibiotics were prescribed.
9. On 5th December, 2013, the plaintiff attended a post-operative review with Professor Gleeson, following which he referred the plaintiff to Mr. Killian Walsh, a Consultant

Urologist. A cystoscopy was performed by Mr. Walsh on 12th December, 2013 and a fistula was discovered above her trigone. The fistula was subsequently repaired on 7th January, 2014.

10. A number of letters were exchanged between the doctors who treated the plaintiff during the material time. Two such items of correspondence from Prof. Gleeson to Mr. Walsh were referred to regularly during the proceedings. Although bearing different dates, it seems that they were both dictated on the 5th December and subsequent to the plaintiff's medical examination on that date. The first, bearing that date, states *inter alia* the following:

"...This is the lady we discussed on the phone today. Many thanks for the cystoscopy on Wednesday. She had a total abdominal hysterectomy on 23rd October. She had an enlarged fibroid uterus and the procedure was technically difficult. There was a troublesome haemorrhage on the left side Q/ the uterus, and I wonder if I have caught either the bladder or a ureter on that side..."

A letter dated 9th December, 2013 and also addressed to Mr. Killian Walsh states the following:

"... Very many thanks for seeing Margaret so quickly for me. You have previously performed a TVT for her. On 23rd October I performed a total abdominal hysterectomy for her. She had an enlarged fibroid uterus and my operative note suggests that she had a troublesome haemorrhage on the left-hand side. I obviously needed to put in some more sutures down at the left at the vaginal angle.

Margaret made a good post-operative recovery without any problems and I discharged her around about day 5. She came to see me on Thursday 5th December, saying that all was well for approximately' a week and then she began to have problems with her bladder. My concern is that performed a speculum examination and she had a pool of urine in the vagina. On questioning it seems as if she had a constant leak with no provoking factors. My obvious concern is that she has a fistula and the delay in its presentation may suggest that it is an ischaemic injury rather than a direct trauma..."

Both of the foregoing letters were sent to and received by Mr. Walsh. As to why two such letters were written, no definitive explanation was offered. It may well be that the first was written shortly after the consultation and at a time when Prof. Gleeson was, understandably, taken aback at what he had discovered. The second, clearly composed later, is rather more detailed and indicates, perhaps, more detailed reflection on all of the hospital notes. Two different secretarial assistants may have been involved in the typing with one using the date of dictation and the other the date of typing. In any event, I was not invited specifically to draw any sinister conclusion concerning the differences.

Pleadings

11. The plaintiff's personal injury summons issued on 23rd October, 2015. The indorsement alleges negligence, breach of duty and breach of contract against the defendant. The particulars are pleaded in fairly generic terms. Notably, a lack of consent is not pleaded. More particularly, the indorsement contains allegations that the plaintiff's vesico-vaginal fistula was the result of an unrecognised interoperative trauma to the bladder, that the damage to the bladder was secondary to placing a suture through bladder wall while closing the vaginal stump. It is also alleged that the defendant failed to properly supervise the care of the patient post-operatively.
12. The defence was delivered on 24th March, 2017. It concedes that the defendant and its servants or agents owe the plaintiff a duty of care. It also concedes that there was a contractual term that the defendants, its servants or agents would take all reasonable steps to ensure the safety and health of the plaintiff. It disputes negligence in respect of the performance and follow-up care of the hysterectomy and in particular that there was an unrecognised trauma, the allegation in respect of the suture and the allegation in respect of the alleged delay in treating or diagnosing the plaintiff's post-operative symptoms.

The Evidence

Mrs. O'Dea's evidence

13. The plaintiff gave evidence of her symptoms, treatment and medical history. She found the days following the operation to be difficult. After her discharge from the hospital, she started having severe urinary incontinence. She attended her G.P. on the 5th November and was given antibiotics to treat the incontinence and she returned again on the 12th November. She was prescribed another antibiotic. The plaintiff gave evidence that she was aware she had a follow-up appointment with Professor Gleeson at six weeks after the surgery.
14. The plaintiff explained that the Christmas period was very difficult for her. At the time she acted as a carer for her parents, who lived with her. Her father was in and out of hospice care during this period. Two relatives also died in early December, so the plaintiff attended two funerals while wearing incontinence pads. She found this deeply upsetting. She was also under pressure due to a number of assignments due in respect of the part-time diploma in IT she was undertaking at Dublin City University.
15. The plaintiff gave evidence that at the follow-up appointment Professor Gleeson appeared quite concerned and jittery in the course of and after his examination. He said something to the effect of "oh, this must have happened during the operation" or "I think I might have nicked the bladder during the operation". The plaintiff was unsure of the precise wording used by Professor Gleeson. She understood from him that her symptoms were caused by the operation.
16. Professor Gleeson left her and her husband alone to make a phone call. When he returned, he informed them he had contacted Mr. Killian Walsh, the consultant urologist

to arrange "a repair". The plaintiff gave evidence that her husband found it unusual that the phone call hadn't been made in their presence.

17. The plaintiff attended Mr. Killian Walsh who performed a cystoscopy on her. He diagnosed her fistula. He advised her that she would have to undergo an operation to have it repaired. In anticipation of this and with her ongoing symptoms, she experienced a most unpleasant Christmas. The operation, which took place the following January, lasted for 5 hours and was successful in outcome. Her existing caesarean scar was extended. Her recovery from the fistula and the surgery was prolonged, difficult and painful and she experienced pain and discomfort for up to a year afterwards.
18. She still feels that her bladder does not empty fully, and she has a slow urinary output. She experiences irritation if she drinks a lot of liquid. She says that after going to the bathroom, she often needs to return shortly afterwards. She is happy not to be incontinent anymore. However, the plaintiff was adamant that she has not made a full recovery. The plaintiff also gave evidence of her prior medical history. Mr. Killian Walsh had previously treated the plaintiff for urinary incontinence when she exercised. She had a TVT tape put in and considered that operation to be a success. She also gave evidence that her daughter Kelly was born by caesarean section on 20th March, 2000.

Mr. Porter's evidence — the plaintiff's expert gynaecologist

19. Mr. Richard Porter was called as an expert witness on behalf of the plaintiff. He is a retired consultant obstetrician and gynaecologist. He was director of maternity services for the Wiltshire Healthcare NHS Trust for many years and is a Fellow of the Royal College of Obstetricians and Gynaecologists.
20. Mr. Porter produced 3 reports prior to the trial. His initial report is dated September 2015. His 2nd report, dated July 2017, reiterates the substance of his first report but includes the hitherto unexpressed view that diathermy may have caused the plaintiff's bladder injury. His 3rd report, dated July 2021, reiterates the earlier reports but then includes a critique of the defendant's expert evidence. Mr. Richard Porter's revised report of July, 2017 was read into evidence. The report recites the plaintiff's medical history and then considers the management of the plaintiff's care by Professor Gleeson. In the report he noted that the vesico-vaginal fistula occurred at the midline of the bladder. He noted that a vesicovaginal fistula is a complication that occurs in 1 in every 1000 hysterectomies.
21. The post-operative management of the plaintiff by the hospital and Professor Gleeson was not faulted in any way. The plaintiff's discharge and follow-up appointment six weeks later were standard management for a hysterectomy which was believed to have gone in a standard manner.
22. Dr. Porter's view was that the correspondence from Professor Gleeson to Mr. Walsh demonstrated that Professor Gleeson had obviously suspected catching something with the sutures on the left. He said the second letter alludes to the possibility of sutures being involved and causative of the plaintiff's fistula.

23. Mr. Porter identifies the following possible causes of the plaintiff's fistula:
- a. An unrecognised penetration or laceration of the bladder during the operation;
 - b. Trauma during the operation which is recognised but is inadequately repaired;
 - c. Post-operative necrosis secondary to an infected haematoma or devascularisation either:
 - i. As a result of excessive diathermy to the bladder tissue; or
 - ii. As a result of a suture placed into or immediately adjacent to the lumen of the bladder.
24. Mr. Porter's report discounts the possibility of b) "trauma recognised but inadequately repaired". He does so on the basis that the operative note does not record any such trauma. He also discounts the possibility of a part of c) "necrosis secondary to an infected haematoma". He does so as there is no suspicion of an infected haematoma.
25. Mr. Porter considers the two possibilities that are left: a) "an unrecognised trauma during the operation which is recognised but inadequately repaired" and c) "necrosis secondary to devascularisation either (i) as a result of excessive diathermy to the bladder tissue; or (ii) a suture placed into or immediately adjacent to the lumen of the bladder".
26. In his report, Mr. Porter goes on to consider how an unrecognised trauma which led to the plaintiff's fistula might occur. He dismisses a relationship between the haemorrhaging at the left angle and the fistula. He says that they are not related because he understands the plaintiff's fistula to be at the midline of the bladder and not the left side of the bladder.
27. It is conceivable that unidentified damage happened at the midline of the bladder when it was reflected away from the uterine cervix. Reflection is a surgical term of art which in this instance means controlling the bladder to move it out of the way from the cervix. This was a necessary step in the plaintiff's surgery. In his report he noted that care must be taken during this step to ensure the bladder is not traumatised. He identified the plane of cleavage of the bladder during dissection as requiring particular care.
28. Sometimes before reflecting a bladder, a surgeon may need to dissect it from the uterine wall. This is more likely when, like the plaintiff, the patient has had a caesarean section. Dissection is a straightforward procedure unless the bladder is particularly adherent. Mr. Porter gave evidence that it is conceivable that a surgeon may inadvertently dissect off part of the bladder when it is especially adherent. A surgeon must take particular care during dissection to ensure that this does not happen.
29. He considered such a difficulty during dissection to be a possible explanation for the plaintiff's fistula that could not be excluded. He was, however, not prepared to say that it was a likely cause of the fistula. He contextualised that remark by observing that the plaintiff suffered a very rare complication during a straightforward hysterectomy. That complication required explanation.

30. Once reflection of the bladder is achieved, the surgeon must maintain complete anatomical separation of the bladder from the vaginal stump. In many cases this need only be a few millimetres. After the patient's cervix removed a circle is left in the vaginal wall. That circle needs to be closed by tying the vaginal wall together. If the bladder is not sufficiently reflected from the vaginal wall, the surgeon risks placing a suture through the bladder and damaging it. So, when the surgeon ties the vaginal wall together, they must carefully reflect the bladder in a manner that does not traumatise it, while ensuring the bladder is sufficiently reflected to avoid contact with a suture. The surgeon must also be conscious of not traumatising the ureters and giving them sufficient clearance from the vaginal wall. Mr. Porter described the reflection and separation of the bladder as "rule number one" in hysterectomies and a "potentially fraught" part of the operation.
31. Necrosis may occur when the suture penetrates the bladder and is tightly tied, meaning the bladder is not sufficiently reflected during the closing of the vaginal vault.
32. A surgeon during a hysterectomy at all times must be aware of where the bladder is. The surgeon has a duty to recognise and repair any damage that occurs to the bladder. Mr. Porter observes that Professor Gleeson's note of the operation does not record any activity at the midline of the bladder, where the fistula is said to be. The implication is that if intra-operative trauma occurred, it was not recognised and that means Professor Gleeson fell below the standard of care.
33. Turning to the issue of diathermy, Mr. Porter explained that it is a widely used surgical technique. Diathermy is used to stop bleeding when sutures are not necessary or appropriate. It works by applying high heat to tissue in order to cauterise. Diathermy needs to be applied with caution, and Mr. Porter gave said that all gynaecologists are aware of this. Diathermy is a powerful instrument and burns tissue unpredictably in areas beyond where there is visible charring. Diathermy demands special caution when it is applied to the bladder. The diathermy instrument should not be held down on the bladder; it needs be applied in a "*touch buzz*" manner. Otherwise the surgeon risks damage to the bladder tissue that leads to ischaemia, necrosis and ultimately to a fistula.
34. Mr. Porter said that he was "fairly certain" that diathermy was used in this case; he did not elaborate on his reason for this belief. He also gave evidence on damage caused by sutures.
35. Mr. Porter concludes that if either of the above diathermy or sutures, caused the fistula then Professor Gleeson exercised substandard care. This is said to be so as the duty of the surgeon is to know where the bladder is at all times and avoid diathermy or placing a suture through the bladder wall.
36. He concludes that the existence of a vesico-vaginal fistula is that the fistula is evidence of substandard care by Professor Gleeson. Vesico-vaginal fistulas do not occur by chance and that there has to be damage to the bladder for one to occur. Mr. Porter testified that

he was familiar with the legal standard of medical care in Ireland. He said that he did not believe that Professor Gleeson's actions could be construed as being competent.

37. In cross-examination by Ms. Egan SC it was put to Mr. Porter that he was not a reliable witness. Two particular grounds for this assertion were put to him. First, there were significant differences between his report dated September 2015 and his final report dated July 2021. In particular it was put to him that his final report concluded that the most likely causes of the fistula, either diathermy injury or a partial thickness tear, were not mentioned at all in his first report. Moreover, none of the causes he canvassed in his first report were being advanced at trial and in particular that Mr. Porter overlooked the plaintiff's midstream urine sample being clear of red blood cells during his first report. Mr. Porter said issues as to his reliability were a matter for the court.
38. In respect of the defendant's second challenge to Mr. Porter's credibility, Mr. Porter was referred to *Melissa Rich v Hull and East Yorkshire Hospital NHS Trust* [2015] EWHC 3395 (QB). Mr. Porter acted as an expert witness for the defence where certain steroid medication had not been provided in advance of the birth of the plaintiff. Paragraph 83 of that judgment contained the findings that Mr. Porter had " . . . failed to give objective and independent evidence to the court on a number of important matters". At paragraph 79 the trial judge noted "I regret to say that in my judgment Mr. Porter was being disingenuous". At paragraph 84 the trial judge noted that Mr. Porter's breach of duty is not so serious to oblige them to disregard his evidence all together, but it goes towards his reliability as an expert witness in that matter.
39. Mr. Porter explained that the trial judge's criticism concerned a very specific issue that came up during expert meetings and was one of 85 questions. Mr. Porter says he misunderstood that question and did not realise its implications. He did not consider the finding of the court fair nor did his instructing team.
40. It was put to Mr. Porter that he could not identify the cause of the fistula on the balance of probabilities whether unrecognised penetration or laceration, damage secondary to diathermy or a suture through the bladder occurred. Mr. Porter accepted that this was so.
41. It was put to Mr. Porter that Dr. Lenehan, the defendant's expert witness, would give evidence that the injury in this case could have been caused by diathermy or which would not have been obvious at the time surgery in Dr. Lenehan's view and therefore would not constitute negligence. Mr. Porter's position was that if enough diathermy was applied to cause subsequent fistulation then that amount of diathermy should not have been used.
42. Mr. Porter was questioned on the range of spread of diathermy. It was put to him that it was not always possible to tell how far diathermy would spread. Mr. Porter accepted this was so said that that was the effect of his evidence in chief. Ms. Egan put to him that the potential spread of diathermy is 2-22mm. Mr. Porter explained the number he has usually been given is 5mm for monopolar diathermy, which is the standard instrument used.

43. Mr. Porter was told that Dr. Lenehan would give evidence for the defendant to the effect that the bladder wall may have given way because a haematoma from the vaginal vault which caused ischemia, necrosis and eventually led to the fistula. This again would not have been obvious at the time of surgery.
44. Mr. Porter accepted that it was possible that an infected haematoma in the vaginal vault could cause a fistula but that such a haematoma did not arise here because the symptoms of an infected haematoma would have been obvious and would have had systemic signs. Such a haematoma would need to have been a sizable haematoma as the bladder is a distensible organ, and there is no evidence of a sizeable haematoma. In any event, for a haematoma to have such an effect there would need to be damage to the bladder at the time of the surgery.
45. Mr. Porter went on to say that vault haematomas are in general an unlikely cause of vesico-vaginal fistulas. This is said to be so because such fistulas occur at only one third the rate of incidence in vaginal hysterectomies than they do in abdominal hysterectomies.
46. It was put to Mr. Porter that the bladder wall was vulnerable and may have been affected by the plaintiff's previous caesarean section. Mr. Porter considered that this was fanciful.

The plaintiff's expert urologist witness

47. Mr. Patrick Keane, consultant urologist, was called on behalf of the plaintiff. He authored a report dated 27th December, 2018 after examining the plaintiff. His report recites her medical history. He notes that the plaintiff's memory was vague on the details of her catheterisation. He describes her incontinence as passing urine four to six times a day but that the plaintiff did not have nocturia.
48. After the plaintiff's surgery to repair the fistula, she experienced discomfort and frequency, which had somewhat settled. The report describes the repair surgery as successful. Since the surgery, and at the time of Mr. Keane's report, the plaintiff's symptoms are described as passing urine four to seven times a day but that she gets up once a night to use the bathroom. Drinking beer causes significant nocturia. The plaintiff's urinary flow is reported as much diminished, she feels poor bladder emptying and she practices double voiding. She also experiences a discomfort in her pelvic area which would last for a few hours and goes spontaneously but she is continent.
49. On the question of the fistula's causation the report makes a number of remarks. Mr. Keane considers direct trauma to the bladder during surgery as being an unlikely cause because there is no post-operative haematuria. Mr. Keane believes the fistula's cause to be tissue necrosis caused by diathermy during the operation. This happens by the diathermy desvascularising the vaginal vault or the base of the bladder, which classically leads to delayed presentation of the fistula.
50. As Professor Gleeson is an experienced gynaecologist troublesome bleeding would indicate a significant problem. The use of sutures and the use of diathermy risks ureteric injury. Mr. Keane writes that the bleeding suggests there should have been a high index

of suspicion of a future problem. He suggests that the interposition of a flap would have been prudent but failure to do so would not constitute negligence.

51. Mr. Keane says it was unwise to take out the patient's catheter. This contributed to the plaintiff's fistula. Optimum management would have been to leave a catheter in for seven to ten days and then performing a cystogram before removing the catheter.
52. Mr. Keane's report points out that his views on the plaintiff's treatment come from a urological perspective and that for a urologist to cause a fistula in benign disease would be substandard care. Whether the hysterectomy was performed competently or not is a question for a gynaecological surgeon.
53. Mr. Keane's report is optimistic on the plaintiff's prognosis. He agrees with Mr. Lennon that the plaintiff now has minimal symptoms and that she will not suffer urological sequelae.
54. It was put to him that it would be normal to remove a catheter within 24 hours. Mr. Keane stated that in uncomplicated cases this would be so, but the plaintiff's case was not such a case. The plaintiff's case had documented heavy bleeding in a procedure performed by an experienced gynaecologist. He considered that an alarm should have been going off.
55. Mr. Keane was pressed on his remarks in his report that he considered the competency of the hysterectomy was a question for a gynaecologist. Under cross-examination he conceded that his views on the removal of the catheter reflected standard practice for a urologist and that he was not advising on the standard practice of a urologist.
56. Mr. Keane was questioned in cross examination on the plaintiff's continuing symptoms. He considered that she had a successful repair but that it was not surprising that she would suffer mild voiding dysfunction and symptoms of the type described in the report. He did not consider that they would cause serious problems for her.
57. Mr. Keane was also questioned on the haematoma which the defendant suggests caused the plaintiff's fistula. He explained that a haematoma is a *sine qua non* for an erosion of the bladder tissue but does not itself erode the bladder. A haematoma can cause a fistula by causing the vaginal wall and bladder to fuse where there is bleeding on both surfaces. It is the abrasion between these surfaces that causes the fistula. Mr. Keane gave evidence that if he were called into the theatre by a gynaecologist to address such bleeding, he would put a piece of tissue between the bladder and vagina. He further stated that in light of the haemorrhaging in the plaintiff's operation, Mr. Keane suggested that it would have been wiser to have an x-ray post-operation to confirm that the bladder had healed.
58. Mr. Keane accepted that it was not possible to know whether diathermy was used during the operation. His evidence was that if diathermy was not used then suturing could have been. This would have been particularly dangerous given that a surgeon's visibility would

be occluded by haemorrhaging. His suspicion was therefore that diathermy was used and it would be highly unusual if it were not.

59. It was put to him that Dr. Lenehan would give evidence that sutures were used to control the haemorrhaging at the left vaginal wall. Mr. Keane stated that suturing in that region was the commonest cause of ureteric injury. He also suggested that controlling haemorrhaging on the vaginal side with suture could have caused the plaintiff's fistula. This was possible as the suturing, in a figure-of-eight pattern, would have been done blindly and the midline structures of the bladder could have been bunched in with other tissue to tie the suture off. He accepted that he was disagreeing with Mr. Porter's evidence on this point.
60. He was then cross-examined on Dr. Lenehan's opinion that the fistula was caused by a haematoma formed post-operatively which rested against the plaintiff's bladder, which was vulnerable due, in Mr. Keane's view, to excessive suturing or diathermy and there would also need to be a similar vulnerability on the vaginal side. He accepted the plaintiff's previous caesarean could lead to a weakness in her bladder. This was a factor that meant that the surgeon should have had his "antenna up" that something might happen at the bladder.

Evidence of Professor Gleeson

61. Professor Gleeson gave evidence of his experience as a gynaecologist and obstetrician. He gave evidence that he was very experienced performing hysterectomies. He began performing them in 1984. He estimates that he has performed between 800 and 1000 hysterectomies. He was a trainer for the Royal College of Physicians and took a trainee every six months during his tenure at the Rotunda.
62. Professor Gleeson says that he remembers his consultation with the plaintiff reasonably well. He had been surprised that she elected to undergo a hysterectomy. He considered hysteroscopic surgery a preferable option for the plaintiff's complaint. It is a day-case procedure. His routine was to advise patients as to the risks of hysterectomies including a risk to the urinary system. Professor Gleeson says that these are risks he would have specifically advised the plaintiff on. He suggested that she consider her options and talk to her GP. A few weeks later she indicated her choice to undergo a hysterectomy to Professor Gleeson.
63. Professor Gleeson explained his surgical note to the court. He said that it was a straightforward three pedicle hysterectomy. The plaintiff's fibroids were small, tangerine sized. The haemorrhage at the left vaginal angle was the only unusual feature of the surgery but it was not highly unusual. It happens in about 5-10% of hysterectomies he performs.
64. To address the haemorrhage, Professor Gleeson's evidence was that he applied small directed sutures, not big figure of eight sutures. He said that he was very cautious applying those sutures as it is a classical area for problems. The ureter runs very close to

the area. Professor Gleeson made a point of noting that he was very proud to have never caught a ureter during his career.

65. Professor Gleeson considered it completely untrue that he perforated the bladder. That is a very basic thing and his evidence was that he would have noticed that and documented it.
66. Professor Gleeson went on to explain the manner in which a patient's bladder is dissected and reflected during the surgery. He makes a small incision at the peritoneum to slowly get it off the uterus and cervix. This is done using either blunt or sharp dissection. He accepted that as the plaintiff had a previous caesarean that made it more difficult to get the bladder off the uterus and cervix but he would have recorded any particular difficulty during the plaintiff's operation.
67. Professor Gleeson does not recall whether he used diathermy during the operation. He said that he does occasionally tip diathermy on the bladder and that he is always extremely conscious of the dangers of diathermy. He says that he would not have used diathermy at the left vaginal angle and instead used sutures on the basis that diathermy is a blunt instrument. Particular caution has to be exercised at the vaginal angles because that is where the ureter is situated.
68. Professor Gleeson explained that he closes the left vaginal vault using sutures. He says he enters sutures from the front of the vagina going backwards in order maintain vision of the bladder and avoid penetrating it. The conventional way to close the vaginal wall is to go from back to front. Therefore, Professor Gleeson says he is "100% certain" that he did not place a suture in the bladder.
69. Professor Gleeson then explained that a mid-stream urine test is taken three days after surgery and used to test for infection. The test also detects red blood cells. In the plaintiff's test no such cells were detected. Professor Gleeson says that if the bladder were penetrated it would bleed and this would be detected as red blood cells in the test. Further, the plaintiff's catheter output was clear. Therefore, in Professor Gleeson words, this was proof that there was no breach of the bladder.
70. There were no other indicators to give Professor Gleeson cause for concern during the plaintiff's postoperative care. The plaintiff's immediate post-operative experience was standard as was removing her catheter after 24 hours.
71. For that reason, Professor Gleeson was shocked at the plaintiff's follow-up appointment six weeks after the surgery. He had no suspicion of a fistula. Having examined the plaintiff at the follow-up appointment he arranged her referral to Mr. Walsh.
72. It transpired that two referral letters were sent to Mr. Walsh by Professor Gleeson. One refers to a clinic date of the 5th of December and the other refers to a clinic date of the 9th of December, though the only clinic date the plaintiff attended was on the 5th of December. Professor Gleeson was not sure how the two letters came about and he

accepted that only saw the plaintiff once. He suggested that sometimes secretaries put the wrong dates on letters.

73. Responding to Mr. Porter's evidence, Professor Gleeson said that there was no unrecognised penetration or laceration of the bladder during the procedure. There was no blood in the plaintiff's catheter. Professor Gleeson considered any suggestion that trauma was recognised during surgery but inadequately repaired to border on the slanderous. Professor Gleeson stated that any such event would be recorded in the operating note.
74. However, Professor Gleeson agreed with Mr. Porter in respect of the third possibility: that the fistula may have been caused by post-operative necrosis of a small area of bladder epithelium caused by an infected haematoma. Professor Gleeson considered this to be the main possibility.
75. He rejected the fourth possibility referred to by Mr. Porter: that the fistula was caused by excess of diathermy to the bladder tissue or by a suture in or immediately adjacent to the bladder lumen.
76. Professor Gleeson did not consider this hypothesis to be tenable. In respect of diathermy, though Professor Gleeson does not remember if he used it, his evidence was that if he did he would have been exceedingly careful. He does not like applying diathermy to the bladder. In respect of the suture, Professor Gleeson did not put a stitch in or near the bladder. He did not believe that the concept of a partial thickness tear made any sense as the wall of the bladder is so thin and any tear would make a hole in the bladder. Even a partial thickness tear would cause haematuria. In respect of the dissection of the bladder, Professor Gleeson's evidence was that he was extremely careful, particularly given the plaintiff's previous caesarean section.
77. Under cross examination Professor Gleeson was questioned about whether he knew the cause of the fistula. He said that he had been surprised by the patient's symptoms but on examination of the plaintiff the fistula diagnosis, although presumptive, was fairly clear. He did not know the fistula's cause at that point and accepted that he speculated in writing to Mr. Walsh about whether he may have caught something during the surgery. At trial Professor Gleeson's view was that the fistula was caused by an infected haematoma.
78. Professor Gleeson was also asked about the haemorrhaging during the operation and why his surgical note did not record the volume of blood loss. Professor Gleeson said that the particular volume of blood was insubstantial and not worth recording.
79. It was put to Professor Gleeson that the surgery was not in fact straightforward. His letter dated 9th December, 2013 to Mr. Walsh described the operation as technically difficult. Professor Gleeson said that he overstated things in that letter but did not accept that it was an inaccurate report of the operation. Professor Gleeson's evidence was that his subjective view of the operation would not influence Mr. Walsh and the letter set out the material facts that mattered.

80. On the same theme, it was put to Professor Gleeson that this letter described the plaintiff's fibroids as being enlarged and that the radiologist's report on the plaintiff's ultrasound described the fibroids as being moderately large. Professor Gleeson did not accept that the fibroids were large. He gave evidence that fibroids can range in size from peas to a 40week pregnancy. In respect of the radiologist's report, Professor Gleeson stated that it reflected a radiologist's perspective, though he accepted such reports were routinely made by radiologists.
81. Finally, it was put to Professor Gleeson that Mr. Lenehan's report states that "the operative notes indicate that this was a complicated operation". Professor Gleeson disagreed with that assessment.
82. Professor Gleeson accepted that to catch the bladder with a stitch would not be appropriate and would fall below the standard of care for a surgeon of his skills and abilities.
83. Professor Gleeson was cross-examined on the two letters he sent to Mr. Walsh. He was unable to explain why two letters issued. He suggested that it may have occurred because of secretarial error. Professor Gleeson stated that he did not think he had any discussion with Mr. Walsh before sending the second letter. In the second letter Professor Gleeson says that "I obviously needed to put in some more sutures down at the left of the vaginal angle". This was amended in handwriting to read "at the left at the vaginal angle". Professor Gleeson denied that this referred to him feeling that he should have put in more sutures than he did. Instead, he says it was meant in a historic sense that he had been right to put in extra sutures.
84. Professor Gleeson accepted that if the bladder or ureter was caught or ischaemic injury occurred, he was responsible for it. He did not accept that any of those events would be a lapse of care by him. His evidence was that clinical medicine is not an exact science and that things be done correctly to the best of one's abilities but there may still be a less than good outcome. It was put to Professor Gleeson that on his evidence the operation had been straightforward and that there was nothing to excuse any of the events that may have caused the fistula.
85. Professor Gleeson accepted that diathermy could cause ischaemia which would lead to tissue necrosis and the fistula. Professor Gleeson stated that though he could not recall whether he used diathermy, he could not rule out that it caused ischaemia even though he would have used diathermy carefully. Professor Gleeson accepted that excessive diathermy would be negligent.
86. Responding to Mr. Porter's second report, Professor Gleeson accepted that the general possibilities canvassed in the report were theoretical possibilities. Professor Gleeson accepted that if there was unrecognised trauma to the bladder then this would not be consistent with the actions of a competent gynaecologist particularly where there was no record of any untoward event during the surgery at least insofar as unrecognised trauma

described putting a hole in or tearing the bladder or cutting a ureter. He did not see any damage to the bladder and did not believe he caused any unrecognised trauma to the bladder.

87. Professor Gleeson did not deny or accept that the burden of evidence in the case suggested that excessive use of diathermy was the cause of the plaintiff's fistula. His position was that it was a possibility alongside an infected haematoma.
88. He did accept that if excessive diathermy were used it amounted to substandard care. Again, he caveated his position that that proposition depended on what was meant by excessive. His evidence was that it is not possible to predict a fistula developing from excessive diathermy and not possible to recognise that excessive diathermy had been applied. He noted that there was nothing to suggest he had used diathermy in the area of the bladder and there was no significant bleeding that he could recall in the bladder area. He considered that diathermy is so insignificant that it was not worth recording. He accepted that diathermy is used as a matter of course by reason of how regularly it is used.

Evidence of Dr. Lenehan

89. Dr. Lenehan is a Consultant Obstetrician and Gynaecologist. He was engaged to advise and gave evidence on behalf of the defendant.
90. Dr. Lenehan acknowledged the sequence of events, as outlined by Mr. Walsh, whereby the plaintiff was operated on by Dr. Gleeson on the 23rd of October, 2013. Postoperatively there were no untoward complications but that subsequently she developed urinary symptoms and following a check up on the 5th of December, having noted urine in the area of the vagina, Dr. Gleeson realised that a fistula had occurred.
91. Dr. Lenehan was referred to the two letters written by Dr. Gleeson to Mr. Walsh raising the question of whether or not Dr. Gleeson, during the course of the operation on the 23rd of October, might "have caught either the bladder or a ureter" on the left side of the uterus. The second of these letters was more detailed and included details of how Dr. Gleeson had found, on examination, "a pool of urine in the vagina" on the 5th of December, 2013, some six weeks after the operation in October.
92. In the context of these proceedings. the witness acknowledged that it would be a shocking thing for a doctor to discover urine in the vagina so soon after an operation he had performed and he explained that "this almost certainly means that she has a fistula, in other words, a communication between the urinary tract, whether that be ureter or bladder, and the vagina". He explained that if such "communication" happened some weeks after an operation it was more likely to be as a result of ischaemia, or in other words a lack of blood supply, or devascularisation of the area rather than a direct trauma which would tend to be an issue immediately after the operation.
93. The four possible causes of a fistula occurring as initially identified by Mr. Porter in his expert report of September 2015 were put to the witness. Mr. Porter had himself

acknowledged that two of these i.e. "a trauma recognised but inadequately repaired" and the fistula arising "as a result of post-operative necrosis of a small area of bladder epithelium secondary to an infected haematoma" could be discounted. Dr. Lenehan agreed with the proposition that, as there was no blood in the MSU/post-operative urine specimen, a third of these possible causes, i.e. an unrecognised penetration or laceration at the time of the primary operative procedure, could also be discounted.

94. The fourth possible cause, identified by Mr. Porter in this initial report, being "devascularisation by a suture placed into or immediately adjacent to the lumen of the bladder" was put to Dr. Lenehan by counsel for the defendant. It was also pointed out by Ms. Egan that Mr. Porter expanded on this possible cause at paragraph 16 of his report wherein he stated: "[T]he alternative possibility is that damage was secondary to the placement of a suture through the bladder wall whilst closing the stump. When the suture is tied tightly the possibility exists of tissue necrosis resulting in a bladder defect". Dr. Lenehan stated that he did not believe that this was a likely cause of the injury in this case. He stated that "the absence of blood or haematuria would preclude that. I think we can definitely out rule [sic] that".
95. It was then put to Dr. Lenehan that Mr. Porter further expanded on this fourth possible cause in a revised version of his report enclosed with an e-mail to the plaintiff's solicitor in July 2017, wherein this cause was revised to read "devascularisation either as a result of excessive diathermy to the bladder tissue or by a suture placed into or immediately adjacent to the lumen of the bladder".
96. Dr. Lenehan described the operation on Ms. O'Dea as a complicated operation and that there were large fibroids which probably caused difficulty of access or even visual access to the uterus. He described the need for clamping of major blood vessels during the course of such an operation and the suturing of other, smaller branches of blood vessels. He noted that Dr. Gleeson alluded to the fact that he needed to "put those extra sutures in". However, he went on to opine that the suturing of this area did not compromise either the ureter or the bladder and he confirmed that the fistula was in a different location, i.e. the midline of the bladder, to that identified as the problem area in the operation notes.
97. He did however refer to the potential for damage to be caused by ischaemia/lack of blood supply and/or by the formation of haematoma/bruising and, in his expert report, he expressed the view that in this case the vesicovaginal fistula which occurred was as a result of ischaemic injury due to a diathermy close to the bladder or the development of a haematoma.
98. In coming to this conclusion, Dr. Lenehan noted that in the aftermath of the operation and up to the time of her discharge five days later no evidence of red blood cells was found in her urine which was described as clear. He stated that "if there was any significant trauma to the bladder you would expect bloodstained discolouration of the bladder". He described the lack of such discolouration as very reassuring.

99. Dr. Lenehan stated that diathermy is used very routinely during surgical practice to seal off blood vessels and secure haemostasis. He went on to state that "normal use of diathermy is not necessarily negligent" and such use "would be within the realms of good practice". He stated that he would find it hard to imagine diathermy as a primary cause of devascularisation because that would involve the use of diathermy in an excessive way or very close to the lumen of the bladder, although he accepted that excessive use of diathermy would be negligent. The witness emphasised that diathermy is applied to blood vessels and not to tissue. Further on in his evidence, in relation to sealing off blood vessels, he stated that diathermy "is not used excessively if it is used to seal them off". As an example of where diathermy might do more than seal off blood vessels Dr. Lenehan added that "if your hand slipped and you daithermied the bladder tissue, that conceivably could happen. but there's no evidence that I can see that something like that happened"
100. Notwithstanding Dr. Lenehan's evidence in relation to the use of diathermy generally, the lack of evidence to the effect that such treatment was used specifically in the treatment of the plaintiff was noted by the court. Apart from a reference to the fact that she had a diathermy pad on her right thigh, the witness acknowledged that there was no mention of diathermy in the hospital notes. Further on in his evidence Dr. Lenehan stated that the use of diathermy would not normally be stated in such notes. He also agreed with counsel for the plaintiff that Dr. Gleeson himself didn't know if he used diathermy in the operation.
101. Dr. Lenehan's evidence in relation to diathermy might be summarised by his assertions that (i) it is commonly used and a very necessary part of operations in terms of achieving haemostasis and minimising blood loss; (ii) diathermy can be appropriately used but cause damage which is not apparent at the time of the operation; (iii) there is no evidence that diathermy was used improperly in this case; (iv) diathermy was one of three contributory factors likely to have caused ischaemia/devascularisation (the others being haematoma and the presence of scar tissue).
102. When considering a haematoma as a possible contributory factor to the formation of the fistula in the plaintiff's case, Dr. Lenehan, in his oral evidence, expressed the view that sutures would not have caused damage to the area in the midline which he said was too far away for it to have caused [that] devascularisation but that there could have been an indirect cause where blood can track down and form a haematoma. Significantly, Dr. Lenehan acknowledged that there is an element of guesswork in concluding that a haematoma formed this way in Mrs. O'Dea's case.
103. As regards the presence of scar tissue, Dr. Lenehan noted that prior to the operation carried out by Dr. Gleeson on the 23rd of October, 2013, the plaintiff had a history of having had a caesarean section on the birth of her second child and also previous bladder surgery in the form of a TVT procedure. Dr. Lenehan gave evidence of how procedures such as these may result in the creation of scar tissue which may compromise the supply of blood to specific areas of the body leaving them vulnerable to an adverse reaction.

104. Dr. Lenehan described the previous caesarean section as very relevant. He explained that with a caesarean section one has to dissect the bladder off the front of the uterus in order to deliver the baby. He said that when this heals up it heals with scar tissue, which he explained is compromised by the fact that the blood supply is not the same as "native tissue". The witness stated that when a surgeon is carrying out a hysterectomy subsequent to a previous caesarean section, one is "often confronted with a situation where, when you look at the interface of the bladder and the uterus, it is almost as if glue is stuck on it. Everything is stuck down. So, you have to dissect that out very carefully and you are dissecting out an area that is now scar tissue rather than native tissue. It is more likely to bleed because surgery, of its nature, is traumatic you are causing a bit more bleeding which of its nature is damaging blood vessels [and] can further devascularise the area".
105. In emphasising the relevance of a prior caesarean section, Dr. Lenehan continued: "Studies have shown that the incidence of bladder injury is double in people who have had caesarean sections prior to hysterectomies. So, it is very relevant in terms of not being a more difficult procedure, the blood supply already compromised to the area and you in dissecting out, are causing a bit more trauma to the area as well". He added that "it may be thinned out, that whole area, and you have got to dissect carefully into that interface it's certainly a much more delicate area".
106. In relation to the TVT procedure, Dr. Lenehan explained that this was a procedure carried out for urinary stress incontinence. It involved putting a tape into the bladder and, in stating that this has to "have some influence on the bladder", his evidence was "the application of a foreign body in the area has to cause some scar tissue and reaction".
107. Dr. Lenehan accepted that it is not evident from the operation notes that the scar tissue in the plaintiff's case resulted in particular difficulties for Dr. Gleeson. Notwithstanding the lack of reference to the presence of scar tissue in the notes, Dr. Lenehan, when being cross-examined by counsel for the plaintiff, stated that in his opinion "the operative note is quite adequate and doesn't leave deficiencies for anyone else".
108. Dr. Lenehan was referred to page nine of Mr. Porter's most recent report, wherein Mr. Porter, in reference to the cause of the injury suffered by the plaintiff, stated "I believe that the two most likely candidates are diathermy injury leading to delayed tissue necrosis or partial thickness tear of the muscular tissue of the bladder". Dr. Lenehan stated that, as far as he was aware, a partial thickness tear of the bladder had not been raised before this more recent report but he would have expected that if a partial thickness tear had occurred it would have been documented. He opined that "it was unlikely that an experienced surgeon like Professor Gleeson would not have said that, particularly in the context of he did mention other deviations". Ultimately, Dr. Lenehan confirmed the view expressed in his medical report wherein he stated:

"In summary, this is an unfortunate case where the plaintiff developed a vesicovaginal fistula following hysterectomy. The evidence in this case would suggest that

this occurred due to ischaemia rather than direct trauma to the bladder. This is a well-recognised complication of the operation and its occurrence does not indicate that the procedure was carried out in a sub-standard fashion. It is my opinion that her care in the Rotunda Hospital was at all times in accordance with acceptable standards of care.

109. When queried by the court as to whether he was of a school of thought which basically, in the absence of gross and apparent negligence, he would seek to excuse, using that word in its broadest sense, the appearance of a fistula after a hysterectomy in circumstances such as in the instant case, Dr. Lenehan stated "I would, no, [sic] not excuse bad practice but I don't see any evidence of it here" and he also confirmed that in the absence of evidence he was assuming correct practice in this case.
110. It was put to Dr. Lenehan that a lot of weight has been attached to the mid-stream urine test and the fact that Dr. Gleeson did not mention this in either of his letters to the urologist, Mr. Walsh. Dr. Lenehan explained that after Dr. Gleeson made his findings on foot of the plaintiff's six week post-operative tests "after the event, when it has happened, the priority is to identify the location, which he would not have known at the time" and he added [w]hat he knew at that point of time was that unfortunately she had a fistula but Mr. Walsh was going to be the person who would identify where it was. Now the exact causation doesn't influence the management of the fistula".

Decision

111. A report by Mr. G.M. Lennon, Consultant Urologist prepared for the defendant was agreed. Counsel were invited to make submissions on the evidence and did so. No significant controversy arose with regard to the relevant law to be applied in determining the issue of negligence in this case. Counsel for the defendant, Ms. Egan submits that there are two things the plaintiff has to establish: Firstly, that Prof. Gleeson was negligent and, secondly, that his negligence caused the fistula. Ms. Egan refers to *Dunne v National Maternity Hospital* [1989] IR 91 in which case Finlay C.J. stated:

"The true test for establishing negligence in diagnosis of 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 would be guilty of acting with ordinary care.

This principle was very recently accepted and restated by the Supreme Court in the case of *Morrissey v HSE* [2020] IESC 6 Clarke J. stated:

"In substance, the legal standard of care applied in any clinical negligence claims or indeed other professional negligence claims requires the court to assess whether no reasonable professional of the type concerned could have carried out their task in the manner which occurred in the case in question. "

112. Hyland J. observes in the case of *Freeney v HSE* [2020] IEHC 286:

"The correct standard of approach is one of fact in each case as identified at paragraph 6.13 of Morrissey. As observed there and in the following paragraphs, it is not for me to determine the standard of approach or impose my own views as to the requisite standard of approach. Rather, it is the standards of the profession itself as demonstrated by the evidence that upholds the standard required. As noted at paragraph 6.37 of Morrissey, it is necessary to tender expert evidence as to the appropriate standard of approach for the relevant professional. "

113. Medical negligence cases present a complex threshold to an injured plaintiff. This is the case where the injuries are clear-cut in origin. Alas, matters are even more complicated when, as in this case, there is significant debate as to what was the cause and whether or not negligence lay at its root. There is no doubt that the plaintiff suffered a fistula. This extremely serious condition required a five-hour repair operation. I found the plaintiff to be a pleasant and truthful lady and accept that, notwithstanding the successful treatment of her complaint, she continues to suffer from continuing, unpleasant symptoms.
114. Dr. Porter on behalf of the plaintiff prepared three different reports over the years of his involvement in the case. He sets out a number of possible causes, some of which he discounts at the outset and others which, as the case evolved, he disposed of or modified. In the final analysis, his views on potential negligence in this case are founded upon one or both of two propositions: firstly, the plaintiff's bladder was injured by the excessive use of diathermy or careless suturing; secondly, either or both of the foregoing caused a partial thickness penetration of the plaintiff's bladder, leading to the development of the fistula. Diathermy first made its appearance in Dr. Porter's second report in 2017. The proposition that there had been a partial thickness injury to the plaintiff's bladder emerged in his third report which was prepared in July, 2021, shortly before the commencement of the trial. The last report also contains an extensive critique of the expert reports which had been obtained on behalf of the defence and which had been exchanged prior to the proceedings.
115. Dr. Porter was stringently criticised in cross examination, in the defendant's evidence and by Dr. Lenehan for the manner in which he advised on numerous possible causes for the fistula. At times, this criticism was a little unfair. I accept that Dr. Porter prepared his report with a view to assisting the court. In light of this, it was perfectly appropriate for him to enumerate causes which he then went on to discount. However, I found the circumstances in which he introduced what amount to cornerstones of the plaintiff's case so late in the day to be less than satisfactory. In his second report, diathermy was added as a possible cause almost in a "cut and paste" fashion. In an email to a solicitor he baldly stated that, in effect, he had overlooked including this in his "argument". I must confess, given the significance that the topic of diathermy generated, that I found it surprising that it did not seem to feature at all in his initial consideration. After all, it was apparent from the hospital notes that the plaintiff had been "prepped" for diathermy prior to the operation: (it is fair to say that diathermy is a possible cause or contributor to the fistula did not appear to have occurred to Prof. Gleeson either in his letters to Mr. Walsh, albeit

perhaps understandably in the circumstances in which they were written). The late emergence of the partial thickness damage I find even more troublesome. He argues that this may explain the absence of blood or haematuria in the plaintiff's uterine post operatively; such finding was inconsistent with penetrative injury to the bladder.

116. Dr. Gleeson, of course, did not produce a report on the matter being the main actor on behalf of the defendant. However, his correspondence is important and I have set out at the outset of this judgement two letters which he dictated, I believe, on the same day, namely 5th December, 2013 and both of which were addressed to Mr. Walsh, the consultant urologist in Galway. I believe the shorter one, namely that which is dated the 5th December, was the first in time and is reflective of a genuine state of shock on Dr. Gleeson's part at what he discovered in his examination of the plaintiff. That letter taken in conjunction with the plaintiff's truthful account of what Dr. Gleeson (as he then was) said during the course of his examination of the plaintiff not only bears this out but indicates to me a willingness on the part of Dr. Gleeson to concede openly that he may have been responsible in some way for the development of the fistula. His presumptive diagnosis was, of course, correct but he was not, at that stage, to know that the fistula was located at some remove from the left angle of the vagina where he had to deal with the haemorrhage and put down extra. sutures. The second letter was dictated, I believe, after he had read fully the hospital notes and had come to the reassuring conclusion that the fistula was likely to be ischaemic rather than traumatic in origin. In neither letter does Dr. Gleeson contemplate the involvement of diathermy in the development of the fistula. Given his openness to accepting responsibility for what occurred, it is not unreasonable to assume that were he to have used diathermy and were it to have been used to the extent that it might have caused damage to the bladder, that probably he would have alluded to it at that time.
117. Dr. Lenehan first reported in this matter in 2016. I presume that his report was not made available to the plaintiff's solicitors until much later, although I am not aware when this occurred. He first raised the possibility of diathermy as being a causative or contributory factor in the development of the fistula. He also suggested a haematoma (as had Dr. Porter) possibly as being materially instrumental in the plaintiff's injury. Finally, he highlighted the plaintiff's previous surgical history of Caesarean section as well as her TVT procedure; his evidence was to the effect that these procedures could have disturbed the integrity of the surface of the plaintiff's bladder thereby unavoidably rendering it more susceptible to damage during the course of or subsequent to the hysterectomy and/or as a consequence of the development of a haematoma. Dr. Lenehan laid considerable stress upon the difficulties which, he believed, probably faced Prof. Gleeson during the course of the operation when separating or dissecting the bladder from the uterus. He painted this as being a difficult and delicate procedure as a consequence of the plaintiff's previous surgical history. The difficulties faced by a surgeon in the circumstances as described by him contrast significantly with the description of the operation provided by Prof. Gleeson. He described the separation of the bladder from the uterus as causing no problem to him and that, bluntly, this was a standard operation whose only complication was the

haemorrhage; this was dealt with within a few minutes and with blood loss so minimal that it wasn't even measured after the operation.

118. Dr. Keane, the urologist to give evidence on behalf of the plaintiff, described the haematoma as a *sine qua non* of the fistula and, as we have seen, raised the possibility of large, "figure of eight" sutures having been used during the course of the response by Prof. Gleeson to the haemorrhage or, alternatively, the use of diathermy.
119. This case comes down to a finding of fact in the absence of direct, physical evidence pointing to the cause of the development of this fistula. There is no objective evidence to indicate the presence or otherwise of injury indicative of thermal or other intraoperative insult to the bladder. Since there can be no scientific certainty as to the cause of this fistula I must, therefore, rely upon the varying and contrasting professional opinions as to what occurred. In this regard, considerable importance must be attached to the impression that the various professional witnesses made upon me.
120. I regret that I found Dr. Porter to be the least persuasive of the expert witnesses. I found the extent to which he amended his views from those first expressed in his initial report up to and including the trial to be unimpressive. It is, of course, often entirely appropriate for expert medical witnesses to adjust their views, for example when confronted with information or perspectives of which they were previously unaware, notwithstanding reasonable diligence and enquiry. It is a question of degree. In this case, it seems to Dr. Porter exceeded the leeway that a court should ordinarily allow to a medical witness in such circumstances. It is remarkable that neither of the pillars upon which his evidence of the trial rested, namely diathermy and partial penetration of the bladder, appeared in his first medical report. In that report, he appears to have paid scant, if any, attention to the fact that the hospital notes record the plaintiff as having been prepared for diathermy nor did he take sufficient or any account of the fact that, post operatively, the plaintiff's urine was free of blood and, indeed, without any red blood cells. I'm satisfied that the latter point was clear from the results of the mid-stream urine test and was thus contradictory of a penetrative injury to the bladder during the operation. As regards the former point, I have already observed that I found the introduction of diathermy by way of addendum into the second report as being unsatisfactory. By the same token, I found the "late in-the-day" introduction of the possibility of a partial-thickness penetration of the bladder wall to be somewhat opportunistic and, regretfully, more than a little unconvincing.
121. In all of this, it is ironic that Mr. Porter's first report does refer to an infected haematoma as being a possible cause of the fistula although he does dismiss this. As already indicated, Dr. Keane referred to this as being relevant. Both Prof. Gleeson and Dr. Lenehan were strong in their evidence in identifying an infected haematoma as being a highly significant factor in the formation of the plaintiff's fistula. Importantly, Dr. Lenehan, in his evidence, described how the plaintiff could have had an infected haematoma which did not manifest itself in observable illness such as sepsis. I was concerned that this specific proposition had not been put with sufficient clarity to Dr.

Porter coming, as it did, at the very end of the defence evidence. I afforded the opportunity to the plaintiff's lawyers to invite Dr. Porter to respond to this. He did not do so.

122. I found Prof. Gleeson to be an impressive and forthright witness. I'm satisfied that, when first he was confronted with the plaintiff's problem at the check-up examination, he did not hesitate to "put his hands up" to the possibility that error on his part could possibly have led to the plaintiff's predicament. It is not surprising that his first thought as to the possible cause was the difficulty he encountered with the haemorrhage. His immediate response, very properly, was to contact Mr. Walsh and to take all appropriate steps in the plaintiff's interests. I believe that the first and shorter letter dictated by him reflects his concern about the difficulties with the haemorrhage and that his mind was focused at that time on that particular complication. The second letter was probably dictated later and at a time when he had an opportunity to review the full extent of the hospital notes in greater detail. Although at that stage he would not have been aware that the fistula was located at a remove from the area where he had dealt with the haemorrhage, he nevertheless had the reassurance from the subsequent urine tests that it was unlikely he had penetrated either a ureter or the bladder during the course of his operation.
123. I accept Prof. Gleeson's evidence that he is experienced in the use of diathermy; he is an instructor in its use and has taught many currently practising doctors. He is fully aware of its risks. I accept his evidence that he does not often use it and does so reluctantly and sparingly. Whereas he does not rule out the possibility that he may have availed of its use during the course of the operation, he cannot remember doing so. Taking the evidence as a whole, I am not persuaded that Prof. Gleeson did use diathermy during the course of this operation. I believe it is probable that, had he done so, it is likely that he would have raised this as a possible cause of contributor to the development of the fistula in his correspondence with Mr. Walsh.
124. I accept Prof. Gleeson's description of the operation with particular reference to the ease with which he was able to separate the plaintiff's bladder from the uterus. I am not persuaded that this phase of the operation revealed any visible damage to the surface of the plaintiff's bladder such as would have caused him to employ sutures or diathermy.
125. I am satisfied that the only complication which occurred during the course of the surgery was that as noted in the surgical note prepared by Prof. Gleeson. This comprised a haemorrhage at the left angle which was repaired with sutures. The sutures did not catch or otherwise damage either the surface of the bladder or the ureter. I do not accept that large, "figure of eight" sutures as described by Dr. Keane were used. I'm satisfied that the stitching was such as caused no damage to the plaintiff's bladder or ureter.
126. I am not persuaded that any untoward damage was caused or encountered by Prof. Gleeson during the course of the operation. I'm satisfied, on the balance of probabilities, that there was no penetration or tear, partial or otherwise, of the bladder surface specifically at the midline and at the site where the fistula appeared. As I have already

indicated I am not satisfied that it has been established that Prof. Gleeson used diathermy at any stage during the course of the procedure.

127. I'm satisfied on the balance of probabilities that the operation proceeded without difficulties apart from the troublesome haemorrhage. This was, undoubtedly, a complication but was one whose resolution was well within Prof. Gleeson's skill set and experience. Nonetheless, I think his description of the procedure as being complicated in his correspondence with Mr. Walsh was probably focussed on this aspect of the operation which, in his mind at that time, he identified as a possible cause of or contributor to the development of the fistula. That apart, I accept Prof. Gleeson's description in his evidence of the operation as presenting no other difficulty.
128. I am not satisfied that any physical act or omission by Prof. Gleeson during the course of the hysterectomy operation caused or contributed in any way to the formation of the fistula. From the evidence available to me it seems the most likely cause of the fistula was the development of a haematoma which became infected and which interfaced with the surface of the plaintiff's bladder. I accept Dr. Lenehan's evidence that as a result of the previous caesarean section surgery the integrity of the bladder surface was compromised. This, in turn, lead to the development of the unfortunate but unavoidable outcome suffered by the plaintiff.
129. The burden of proof lies with the plaintiff. In the circumstances, I am not persuaded on the balance of probabilities that the fistula, which the plaintiff undoubtedly suffered, was caused or contributed to by any negligent act on the part of the defendants or their servants or agents. In the circumstances, I must dismiss the plaintiff's claim.