Neutral Citation Number: [2011] IEHC 213

**THE HIGH COURT**

**2009 652 P**

**BETWEEN**

**JADE KEANE (AN INFANT SUING BY HER**

**MOTHER AND NEXT FRIEND**

**GILLIAN KEANE)**

**PLAINTIFF**

**AND**

**THE HEALTH SERVICE EXECUTIVE,**

**DERMOT STONES AND BY ORDER OF THIS COURT**

**THE NATIONAL MATERNITY HOSPITAL**

**DEFENDANTS**

**JUDGMENT of Mr. Justice Ryan, delivered the 27th May, 2011**

**Introduction**

1. Jade Keane was born on the 21st March 2001 by ventouse delivery at the National Maternity Hospital. At birth she had an abnormally large head due to hydrocephalus. That is a condition that results from excessive accumulation of fluid and increased pressure in the ventricles of the brain. The problem was treatable if it was managed in time. Jade required surgery to by-pass the blocked canal that was causing the problem so as to permit fluid to flow out of the lateral ventricles and circulate in the brain and spine. Unfortunately, that did not happen in Jade's case until it was too late. The blockage remained while cerebrospinal fluid continued to be produced and pressure on the brain increased. For about six weeks during which she was neurologically normal, the extra fluid was accommodated by the baby's enlarging head and little if any brain damage occurred. But time ran out. When the condition was eventually diagnosed in early June 2001 and the necessary operation to insert a shunt in her brain was performed, it was too late to prevent severe brain damage and consequent devastating mental and physical disability. At that point the baby's head had increased because of hydrocephalus to a size that, according to Dr. Evans, a consultant paediatrician from Wales who gave expert evidence,

> "quite frankly, one never sees because if you had a head circumference of this abnormality, then in the developed world, you get some kind of intervention, well before you reach the last few measurements."

2. Jade needed urgent but not immediate treatment. The critical period in her case was about 8 or 9 weeks from her birth up to mid to late May 2001. If she had been treated appropriately in that window of time, she would have escaped all or nearly all of the terrible disabilities that now afflict her.

3. Each of the three defendants had professional obligations to the baby during this crucial phase. She was successively examined and her head circumference was measured first in the National Maternity Hospital where she was born, secondly by the public health nurses who monitored her early post-natal development and thirdly by the general practitioner who carried out a routine six week check-up and saw her subsequently. Each of the measurements was far outside the normal range but no action was taken until it was too late. The baby also displayed additional symptoms of abnormal cerebral development which were not understood by the nurses and the general practitioner. However, the cardinal indicator of the problem was the excessive head circumference and the hospital doctor, the public health nurses and the general practitioner in turn either missed this important and obvious symptom completely or responded extremely inadequately to it.

4. The plaintiff brought proceedings against the Health Service Executive, which is responsible for the public health nurses, the general practitioner Dr. Stones and the hospital. Each defendant admitted negligence in respect of failure at some point to take appropriate action in response to the baby's head circumference. However, they did not admit liability, so the plaintiff's claim was not an assessment of damages. The defendants contested liability on the ground of causation, their argument being that the baby's condition resulted from an event that occurred *in utero* and that their admitted failures did not cause the damage or, alternatively, the bulk of the damage. The action therefore began with liability and quantum in issue.

5. After seven days of the hearing, the National Maternity Hospital and the HSE settled the plaintiff's action for €4.75m. The settlement was approved by O'Neill J. It is accepted by Dr. Stones's representatives that the settlement was reasonable. The settlement disposed of the plaintiff's claim against all the defendants but the issue of contribution between them remained. The plaintiff ceased to have any involvement in the remaining dispute. The continuing parties agreed to treat the evidence that had been given on behalf of the plaintiff as if it was evidence in the contribution issue. The case then proceeded as a claim for contribution by the settling parties, the first and third defendants, against the second defendant, Dr. Stones. Further evidence was tendered on the contribution claim. The public health nurses who dealt with the plaintiff gave evidence, as did Dr. Stones. It was noteworthy that the National Maternity Hospital did not call any witness as to fact and specifically Dr. Christine Endig, who carried out the defective assessment of the baby. The Court also had the benefit of expert evidence adduced by the parties.

6. The Court's function in this matter is governed by sections 11 and 21 of the Civil Liability Act, 1961, which are as follows:

> 11(1): For the purpose of this Part, two or more persons are concurrent wrongdoers when both or all are wrongdoers and are responsible to a third person (in this Part called the injured person or the plaintiff) for the same damage, whether or not judgment has been recovered against some or all of them.

> 21(2): In any proceedings for contribution under this Part, the amount of the contribution recoverable from any contributor shall be such as may be found by the court to be just and equitable having regard to the degree of that contributor's fault, and the court shall have power to exempt any person from liability to make contribution or to direct that the contribution to be recovered from any contributor shall amount to a complete indemnity.

7. 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. The parties accept that the measure of contribution is fault and not the potency of their causative contributions.

**Background Facts**
8. **(1) The National Maternity Hospital**

The story began on the 23rd March 2001, when Jade was due to be discharged. She had been born two days previously and no abnormality had been noticed in the interim. In accordance with normal practice, Jade was assessed before she left hospital. Dr. Endig, a senior paediatric house officer, carried out the examination. She performed a number of tests and measurements and filled in the results on a standard form which specified the things to be assessed. Crucial in this case was the head circumference of the baby. Dr. Endig measured this at 39 cm, a result that showed the head size to be very large and off the scale of normality by a substantial margin. The doctor should have realised that this was grossly abnormal and that the baby needed to be referred to a specialist for examination and treatment. It would have been standard procedure to carry out an ultrasound examination. If that had been done, the doctor – it could have been Dr. Endig or someone to whom she referred the case – would have observed that the lateral ventricles in the baby's brain were enlarged. This is a typical feature of hydrocephalus. This head circumference measurement without more was an important symptom and the doctor should have realised its significance. Dr. Endig did nothing. She did not give evidence so the Court does not have any information as to how she came to make this grave error. The hospital admits negligence in respect of Dr. Endig's mismanagement of the assessment of the baby.

9. Although I have said that Dr. Endig measured and recorded the baby's head circumference as 39 cm, the position is not quite as simple as that. Another doctor in the hospital read the entry as 35 cm (which is in the normal range) and wrote that number as the head circumference in the discharge summary when he was sending routine birth information to the public health service and to the general practitioner who had been nominated to monitor the baby for its six weeks check-up. After some initial expressions of uncertainty by the hospital about this measurement which it is not necessary to explore or comment on, the position was clarified. It came to be accepted that the figure was 39 cm, which accorded with logic in medical terms having regard to the likely progression of head size over the weeks of Jade's infancy – over the relevant period with which we are concerned – and also with comparison of the numbers with other figures that were filled in on the same form by Dr. Endig.

10. The hospital admits that this assessment was substandard. Dr. Endig ought to have known that Jade's head was abnormally large and that she needed urgent treatment. The condition that led to the enlarged ventricles and the resulting enlargement of the baby's head was likely to progress and to cause damage or more damage to the brain, if left untreated.

11. If the doctor did not know what the normal range of head circumference was, standard charts were available showing normal sizes and growth progressions for head size (by circumference), length of body and weight. If the examiner had used a chart which was freely available in the hospital and plotted the head size it would have been obvious that this baby's head was much too large for a normal neonate. If the doctor was not competent to judge for herself, therefore, she should have used a chart. In failing to recognise the serious condition and to act appropriately she was negligent and the National Maternity Hospital is vicariously liable for this failure.

12. The baby was discharged from hospital with her mother following Dr. Endig's examination. The hospital sent discharge summary letters to the public health nursing service at Loughlinstown and to the nominated general practitioner, Dr. Stones which gave no indication of any problem and the baby was in effect discharged and notified to the relevant parties as being in all respects a normal, healthy baby. The baby should have remained in the care of the hospital but instead and because of the doctor's negligence the National Maternity Hospital had no further involvement with her care.

13. No disputes as to fact have to be resolved in relation to the fault of the hospital. The facts are evident from the form that the doctor filled in. Mr. McGrath S.C. for Dr. Stones expressed apprehension that the fault of the hospital might be less prominent in the result. This is no doubt to be borne in mind but I do not feel that my determination of the issue in this case is inhibited by not having heard testimony from Dr. Endig.

14. In relation to the public health nurses and Dr. Stones, there is some conflict of evidence but I propose to set out the evidence for the defendants before attempting to resolve these issues and to assess their impact on the case between the defendants.

15. **(2) The Public Health Nurses**

The public health nurses' involvement began with a home visit by nurse Anne Marie Callery on the 9th April 2001. On this occasion, the nurse measured Jade's head circumference at 42 cm but she did not advert to the abnormality. The mother was concerned about what appeared to be a bruise or lump at the back of the baby's head. The hospital doctor had noted this as a chignon feature. Nurse Callery felt it and reassured Ms. Keane that there was nothing to worry about, which the mother took to mean that the irregularity was from the ventouse delivery. The nurse's note said that she advised Ms. Keane to see the GP. It also recorded that the anterior fontanelle was wide and the posterior one was four fingers wide and was not closed. The posterior fontanelle usually closes soon after birth and this condition was unusual, particularly the width of the opening as measured in rough approximation by finger breadths. This feature tended to confirm the underlying condition that was signalled more clearly by the head circumference.

16. Two days later, the mother brought the baby to Loughlinstown clinic for a routine visit for the baby to be weighed. At another clinic attendance with Nurse Callery on the 19th April 2001 Ms. Keane according to her evidence reported some difficulty feeding her baby.

17. Nurse Callery should have observed that the baby's head was abnormally large and referred Jade for medical assessment. She examined the baby's head and actually palpated the posterior fontanelle but even that did not alert her to the abnormally large head. The inference is that Nurse Callery did not know that this measurement was too big and that the infant needed to be treated urgently.

18. The chronology next features another very significant series of encounters with the public health clinic and nurses at Loughlinstown which occurred between 10th May 2001 and 15th May 2001. Ms. Keane brought Jade to the public health clinic on

Thursday, 10th May 2001. A different nurse, Ms. Anne Marie Lee, examined Jade. She measured head circumference at 44 cm and noted that the anterior fontanelle was four fingers and that the posterior was not closed but was actually three fingers wide. She measured the baby's weight to be 9 lbs 1 oz. Nurse Lee testified that she immediately thought of hydrocephalus. She did not say that to the mother but decided to get her colleague who was dealing with the case to follow it up.

19. Nurse Lee spoke to her colleague, Nurse Callery, the next day and the latter tried to arrange for Jade to be brought in to see the Area Medical Officer on the following afternoon, Friday, 11th May. The nurse left a message with Ms. Keane's sister Sabrina but the message did not get through and the medical attendance did not happen.

20. Nurse Callery made a home visit on Tuesday, 15th May. Ms. Gillian Keane and Jade were not there and the nurse spoke to Ms. Carol Keane, the baby's grandmother, and noted:-

> "Home visit spoke to grandmother, baby seen by GP re head. GP advised head shape due to ventouse delivery. Baby not seen advised clinic re weighing also if Mum any concerns to attend National Maternity Hospital baby clinic".

21. Ms. Carol Keane confirmed that the note reflected the kind of conversation she had with Nurse Callery. Following this visit, the mother or grandmother phoned the National Maternity Hospital and were advised that because Jade was over six weeks old at the time, she would have to be seen by her GP or by the health clinic.

22. On the 31st May 2001 Jade, now aged ten weeks and one day, attended the clinic with her grandmother. Nurse Callery's note reads:-

> "9 lbs 13 ozs. Taking SMA White four times a day. Reduced in recent days. Advised feed on demand. Head circumference 47.5 cm. Anterior fontanelles 4 fingers. Posterior not closed three fingers. AMO appointment given 5th June 2001. I stressed importance of same or else to attend National Maternity Hospital to see paediatrician between 9:00 and 11:00 hours."

23. An appointment was made for the 5th June 2001 with the Area Medical Officer Dr. Catherine O'Malley.

24. On that date, when Jade was ten weeks and six days of age, the baby was examined by Dr. O'Malley. Dr. O'Malley told Ms. Carol Keane that she suspected hydrocephalus and would refer Jade to Crumlin urgently for admission. The doctor's note reads:-

> "Attended AMO clinic for referral to Crumlin Hospital. Head circumference 47.5 cm, tense. Posterior fontanelle 4 cm tense. Dr. O'Malley spoke to Dr. McMenamin in Crumlin for admission this week."

25. Dr. O'Malley wrote to Prof. McMenamin:-

> "Thank you for admitting Jade as discussed this afternoon. There have been concerns expressed by the public health nurse and she eventually attended a clinic today. Jade was born in Holles Street Hospital at 39/40 and it was a ventouse delivery. Birth weight was 3.45kg. Her mother has been worried because she is a slow feeder and she has noticed that she has a large head. They are living with Gillian's mother who was also concerned. Looking at the public health nurse's notes the head circumference at 7/52 was 44 cm. The head circumference today is 47.5 cm greater than the 98th centile. The anterior fontanelle is 12cm and very tense. The posterior fontanelle is 4cm.
>
> There is the sun setting sign."

26. The chronology concludes in so far as is relevant to this issue on the 11th June 2001, with an operation to insert a shunt in the baby's brain to by-pass the occluded channel, the aqueduct of sylvius. Although the procedure was successful, it came too late to prevent severe brain damage from the build-up of pressure that had taken place.

27. **(3) Dr. Dermot Stones**

On the 30th April, when Jade was 5 weeks and 5 days old, Ms. Keane brought her to Dr. Stones's surgery for her six week check-up. Dr. Stones was the nominated general practitioner for this examination. He was Ms. Keane's family doctor, as he was for her mother and other relations. The doctor's function at the six week examination is important. It is part of the monitoring of the baby's development and it is the first time since discharge from hospital after birth that the baby is seen by a doctor.

28. Dr. Stones did not remember anything about the check-up on the 30th April or the other attendances and relied on his notes and what he said was his general practice in order to reconstruct the events. His note of the 30th April is as follows:-

> "Gaining weight. Bowels working daily. Sleeps a lot. Lungsv, Heart Sounds I, IIv Umbilicusv Length 21", Head circumference 16 3/4". [42.5cm] Fontanelles patent. SMA"

29. On the basis of his note, Dr. Stones said that this occasion was a normal, healthy baby coming for a routine post-natal check-up. He said had no reason to be alarmed: "I hadn't been given any indication from the mother that there was any concern afoot at all about the child. She seemed to be gaining weight, she seemed to be thriving. There were no concerns at all of which I was aware…" Dr. Stones said that he had established from the mother that she was content that the child was gaining weight, was thriving and that the child's bowel movements were regular. "The mother said the child sleeps a lot, which didn't alarm me because I have had three children myself – children, babies do sleep a lot when they are not hungry." Speaking more generally, Dr. Stones said that he wasn't alerted to any concerns of the family on any occasion.

30. Dr. Stones admitted that he fell below the appropriate standard on the 30th April 2001 "in recognition of the size of the head" but only in that respect. Otherwise, he said his examination was up to standard. It was done in accordance with his normal practice and was as comprehensive as is conducted by the average general practitioner.

31. On the 16th May, Ms. Keane brought Jade to Dr. Stones for routine injections. She did not recall any conversation on that date. The doctor recorded the vaccinations in his notes. In cross-examination by Mr. Hanratty SC, Dr. Stones admitted failing on this occasion to appreciate the significance of a seriously abnormal looking head.

32. On the 28th May, Ms. Carol Keane brought the baby back to Dr. Stones, whose note of the occasion was the following:-

> "Birth weight 7-10 ounces, off feeds. No fever. No vomiting. No diarrhoea. No constipation. No cough/shortness of breath/wheeze. Earsv. Lungsv. Throatv. Abdomen soft. Pale? Slightly anaemic. Prescribed Fer-in-Sol two drops twice daily."

33. In cross-examination, it was suggested to Ms. Carol Keane that Dr. Stones's note records her complaint that Jade was not feeding and reflects a thorough examination of the baby. In the circumstances, therefore, the absence of a reference to head size implies that she did not make any complaint about that. I think that is a reasonable point, as far as it goes, although the witness did draw attention to the photographs of Jade which demonstrate the presentation of the infant to Dr. Stones. It remains a mystery how he could have missed the head size when carrying out his examination.

34. Dr. Stones accepted that the appearance of the baby would have been even more abnormal at this time than when he previously saw her.

35. Dr. Stones's case essentially is that he was negligent in one respect, namely, that he failed to appreciate the significance of the head circumference that he measured on the 30th April but that in all other material respects he performed satisfactorily as a family physician in treating the baby. His contention is that the mistake he made was the same one that had been made by the doctor at the National Maternity Hospital and also by the public health nurses and these other parties actually had more relevant experience than he had in dealing with babies. In the result, his admitted failings are less than those of the first and third defendants. It was not clear how much real responsibility the doctor accepted for the avoidable disaster that befell this infant but his stance was intended to minimise his culpability.

**Conclusions arising from the undisputed evidence**
36. In regard to the conduct of the public health nurses, Nurse Callery made the mistake common to all the defendants on the 9th, 11th and 19th April 2001 in failing to observe that the baby's head was abnormally large. Nurse Lee thought that the baby had hydrocephalus when she saw her on the 10th May but failed to follow up properly, as she frankly accepted in evidence. The conduct of Nurse Callery on the 15th May represented additional failure on her part and/or that of Nurse Lee. If the latter properly communicated her concern about the baby's condition, Nurse Callery was negligent. If not, Nurse Lee was at fault. Nurse Callery's behaviour on the occasion suggests that she was not apprised of her colleague's diagnosis, nor was she fully aware of her anxiety. Nurse Callery was at fault in taking reassurance from her conversation with Ms. Carol Keane about the reported explanation of the general practitioner concerning the ventouse delivery. On behalf of Dr. Stones, Mr. McGrath criticised the HSE for failing to have growth charts available for the nurses to plot the progress of the infant. This point is a two-edged weapon: Dr Stones did have such charts but did not consult them, just as Dr. Endig had them available, to no effect.

37. Dr. Stones made the mistake common to all the defendants on the 30th April of not observing the abnormality and diagnostic significance of the baby's head size when he measured her head circumference. He also failed to notice the head size at subsequent consultations on the 16th May and 28th May. Dr. Stones admitted in cross-examination that the appearance of the baby's head would have been even more abnormal on the 28th May but still he failed to notice it. On this latter date it is probably the case that the damage had already been done to baby Jade.

38. The National Maternity Hospital made the common mistake on just one occasion but its responsibility is high because it is a centre of excellence as a tertiary care facility.

**Conflicts of Evidence**
39. The evidence revealed differences between the accounts given by the baby's mother and grandmother and that of Dr Stones in respect of attendances with him. There was also a significant difference between Ms. Gillian Keane and Nurse Anne Marie Lee as to their encounter on the 10th May. However, nothing turns on that because the nurse not only recognised the problem of the baby's head size but was able to identify what she thought was the medical condition that was causing it. In the circumstances, it is irrelevant whether or not the mother mentioned the head size. It does not in any way add or subtract from the nurse's failure to follow up the case properly.

40. The baby's mother said in evidence that she was becoming increasingly concerned about Jade in the period between her visit to the Loughlinstown clinic on the 19th April, and the 30th April when she first visited Dr. Stones with the baby. Her main worry was the size of Jade's head; she also thought that the child's feeding had gone downhill and that she was sleeping a lot more than she had been. She said that she told the doctor that she was concerned that Jade's head looked too big,

> "so he said he would measure the head circumference for me. So I had Jade in my lap and he took the measurement and he said, 'it is a normal measurement and I will write it in the notes' and he said I had nothing to be concerned about."

41. She complained about feeding, saying that the baby was slow and difficult to feed. In regard to sleeping, there had been a worrying change since discharge from hospital:-

> "When she first was released from the hospital, she was sleeping normally. Like, she'd wake for her feeds and then she'd go back to sleep after she had been fed. But at that stage, she was starting to sleep more and we were having difficulty waking her for feeds and stuff."

42. Dr. Stones's evidence about these consultations was based on his notes and not on any specific recollection. This is entirely understandable considering the time since these events took place. The doctor relied on his usual practice plus his notes in reconstructing the events. Obviously, the reliability of his evidence depends on the accuracy and completeness of the notes. The note keeping was criticised by Dr. Wahlrab, a general practitioner expert witness. It is no doubt desirable that a doctor should keep proper notes because that will assist in dealing with a patient: it will help the doctor to know what the previous history was when he comes to diagnosing a new condition on presentation. If the doctor is replaced by a locum, good notes will be even more important. There may be a correlation between keeping good notes and being a good doctor in general. It may be part of being a good doctor to maintain proper notes and records. That, however, is not the issue here. A person who is in the position of not remembering the events at all and of having to rely on his notes in order to testify puts himself at a disadvantage if his records are inadequate.

43. Counsel for Dr. Stones, Mr McGrath SC, argues that the notes plus Dr. Stones's normal and regular practice constitute a solid basis for his client's rebuttal of the evidence based on recollection of events many years ago that was given by the baby's mother and grandmother. It seems to me that this depends on the accuracy of the notes, the adequacy of the usual practice and the evidence of the practice that the doctor claims to be his normal *modus operandi*. It was said that it was Dr. Stones's practice to record findings of significance where things were wrong or abnormal but that was not what actually happened, as he conceded in cross-examination by Mr. Hanratty S.C. for the first and third defendants.

44. On the six week examination on the 30th April, Dr. Stones did not do what he said was his normal practice. He did not have the hospital discharge summary to hand; if he had consulted it the baby's head circumference would have shown a truly astonishing growth since birth, because the discharge summary wrongly stated that the measurement was 35 cm. If the mother's information about the baby's sleeping pattern was completely normal, it is curious to say the least that the doctor recorded it. In his evidence he said that babies do sleep a lot, a response to the recorded information about sleeping that was dismissive and somewhat patronising. A small but telling point arose in relation to weighing the baby. Dr. Wahlrab said that it was not sufficient or proper practice to record that a baby was gaining weight. The proper practice was to weigh the infant and record the weight so that the comment would be informed by factual information. Dr. Stones did not dissent from this; however, he said that his weighing scales were not accurate and so he did not use them. Besides, the local pharmacies had accurate scales for mothers to use if they were concerned about their babies' weights. I find this to be careless and indifferent and it undermines Dr. Stones's evidence that his normal practice was that of a careful medical practitioner. The implication of the doctor's evidence was that his weighing scales had been out of order for some time and that he was unconcerned to replace the equipment or have it repaired.

45. It is asking a lot of the note for the 30th April to use it to support all the inferences that Dr. Stones draws and to reject outright the evidence of Ms. Gillian Keane about her visit to the doctor. But that is Dr. Stones's position. Ms. Keane's evidence about that visit is that she was concerned about the baby's head size and said that to Dr. Stones who, in response, measured the head and said that it was a normal measurement, which he would record in the notes. She complained that Jade was slow and difficult to feed. She was concerned that the baby was sleeping a lot, which was a change from when Jade first came out of hospital, at which time she seemed to be sleeping normally. Now, the baby had to be woken up for feeding. I found this evidence to be credible and probable and preferred it to the suggested inferences to the contrary.

46. On the basis of the evidence, my conclusions as regards what happened during the visit on the 30th April are as follows. Ms. Keane did complain to Dr. Stones about Jade sleeping a lot and about feeding difficulty and – crucially – about the baby's head size. Dr. Stones measured the head circumference and reassured Gillian without giving the matter any serious consideration. I base this on her evidence, which I accept and which is not refuted by his evidence which relies on his notes and his general practice. Dr. Stones did not properly investigate Ms. Keane's complaint about feeding; he treated as unimportant the information she gave that the baby was sleeping a lot but he did actually record it; he did not consult the hospital referral letter; he did not check a growth chart or enter the data on it.

47. If measuring head circumference was indeed part of Dr. Stones's routine practice, it seems to me that it would have been more likely for him to recognise the abnormality, because he would presumably have had some criterion in mind or alternatively he would have had his charts to hand and would have been able to check it. In fact, on the evidence, he should actually have noticed just from looking at the baby that her head was enlarged to an abnormal size. He was dealing with a baby who he thought or assumed was normal and he had no reason to believe she was not well. It is likely in those circumstances that he took the measurement in response to comments from the mother and gave her bland reassurance. This is also consistent with his attitude to this young mother: he thought that her concerns were groundless because if he had actually taken her concerns about sleeping seriously, he might have investigated further. He did not do so and he said in cross-examination by Mr. Hanratty that he would have had in mind that she was a first time mother – the implication being that she did not know anything about babies. Dr. Stones's behaviour as described by Ms. Keane in measuring and then reassuring her is consistent with the rest of his examination and assessment of the baby on that occasion.

48. The context of the grandmother's visit to Dr. Stones on the 28th May, according to the mother's evidence, was that Jade had been deteriorating between the 15th and the 28th May. Her feeding was very bad and she was sleeping a lot more as well. The grandmother's evidence about this attendance with Jade was that she was also very worried and thought the baby had really deteriorated. She said that she mentioned her head size, with other complaints that she was quite unwell. Dr. Stones reassured her and said that Jade looked a bit anaemic and he prescribed an iron supplement. His note of this attendance includes the fact that the baby was off feeds but does not refer to head size. I am not satisfied that Dr. Stones ignored a specific complaint about head size on this occasion. It was late in the progress of Jade's deterioration at this stage and it is doubtful that any further failure on Dr. Stones's part at this time made much difference. Three days later, on Thursday 31st May, the unfortunate child was back in the public health clinic and was given an appointment with the Area Medical Officer for the following Tuesday but it still took until the 11th June for the operation that was urgently needed at the end of March.

49. Did Dr. Stones refer to the ventouse delivery? The fact is that the baby was delivered by ventouse delivery and her head was somewhat distorted or unusual in shape and not just in size/circumference. On the 15th May, Nurse Callery went to the house and spoke to the baby's grandmother who mentioned the head and said that Dr. Stones had reassured that the head was normal and that the shape was caused by the ventouse delivery. The question is whether the case can be made against Dr. Stones that he actually misled the Public Health Nurses by providing this information. He would also have misled the family of course, but that is another question. Dr. Stones said that he did not say this and would not say it and indeed that he could not have said it because it was not correct and he knew it was not correct. It was similarly discussed with Nurse Callery in the course of her evidence as to whether she knew or ought to have known that a ventouse delivery could not account for head size and would in fact be very unlikely to be still evident in a baby of six weeks. This is medical information that no expert is going to want to admit not knowing. The grandmother made the comment but Dr. Stones did not say it to her and she was giving it as second hand information that came from the baby's mother. But the mother herself did not remember that being said. It seems likely in the circumstance that this information was passed on from Gillian to her mother Carol concerning Jade and the source of the information could have been Dr. Stones. On the other hand, the two people involved in the conversation either say nothing about it or deny that it happened and I do not think it is reasonable in the circumstances to make a finding against Dr. Stones on this ground.

**The Law**

50. Before considering how contributions are to be assessed, a decision must first be made as to whether the National Maternity Hospital is to be included among the contributors. This arises because of a submission by counsel for the National Maternity Hospital, Mr. Hanratty, that the actions of each of the other defendants constituted a *novus actus interveniens*, which meant that the hospital's negligence was not an operative element in the failure that caused the baby's injuries. He relied on *Conole v. Redbank Oyster Co. Ltd*. [1976] I.R. 191 to support this argument. I do not accept that this is a case where that principle arises. This is for three reasons. First, the decisive element in *Conole* was the change that came about when the defective vessel survived a near miss on one journey, which alerted the operator to its dangerous condition. When the vessel sank on another outing, the catastrophe was the fault not of the boat builder but of the operator who authorised the journey in the knowledge of the danger to the passengers and crew. A critical change of circumstance came about because of the knowledge of the vessel's dangerously defective condition. No such decisive element is present in this case. Secondly, it would appear, as Mr. McGrath S.C. for Dr. Stones argued, to be inconsistent with the statutory basis of the claim for contribution to assert this exemption. Section 11(1) of the Civil Liability Act 1961 provides:-

> "For the purpose of this Part, two or more persons are concurrent wrongdoers when both or all are wrongdoers and are responsible to a third person (in this Part called the injured person or the plaintiff) for the same damage, whether or not judgment has been recovered against some or all of them."

51. Section 22(1) provides:-

> "Where the claimant has settled with the injured person in such a way as to bar the injured person's claim against the other concurrent wrongdoers, the claimant may recover contribution in the same way as if he had suffered judgment for damages, if he satisfies the court that the amount of the settlement was reasonable; and, if the court finds that the amount of the settlement was excessive, it may fix the amount at which the claim should have been settled."

52. In *O'Sullivan v. Dwyer* [1971] 1 I.R 275 Walsh J. said:-

> "It is quite clear that no question of the apportionment of fault arises at all unless both the plaintiff and the defendant have contributed causatively. If the defendant has not contributed causatively there can be no verdict against him, and if the defendant has contributed causatively but the plaintiff has not then there is no question of apportionment of fault."

53. Thus, a contribution claimant has to have a liability to the plaintiff. Thirdly, it would be wholly anomalous and illogical for a party to settle an action and then to seek to recoup its settlement payment in full from another defendant on a basis that would have afforded a defence to the plaintiff's claim. The principle of *novus actus interveniens* is, accordingly, not relevant to the question now before the court.

54. In relation to contribution, the Court's function in this matter is governed by section 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. The parties accept that the measure of contribution is not the potency of their causative contributions.

55. In addition to its use in the provisions relating to contribution between defendants, the concept of fault is also the determinant of contributory negligence. Therefore, decisions on the meaning of that term in the context of s. 34 of the Act are also helpful for applying section 21. In *O'Sullivan v. Dwyer* the Supreme Court considered fault in the context of s. 34(1), which requires that the damages recoverable by a negligent plaintiff be reduced as the Court thinks just having regard to "the degrees of fault of the plaintiff and defendant." Walsh J. said that:-

> "[D]egrees of fault between the parties are not to be apportioned on the basis of the relative causative potency of their respective causative contributions to the damage, but rather on the basis of the moral blameworthiness of their respective causative contributions. However, there are limits to this since fault is not to be measured by purely subjective standards but by objective standards. The degree of incapacity or ignorance peculiar to a particular person is not to be the basis of measuring the blameworthiness of that person. Blameworthiness is to be measured against the degree of capacity or knowledge which such a person ought to have had if he were an ordinary reasonable person: see the judgment of this Court in Kingston v. Kingston. To that extent the act can be divorced from the actor. In many cases greater knowledge may attract a greater share of the blame or fault, but so also may greater ignorance. Fault or blame is to be measured against the standard of conduct required of the ordinary reasonable man in the class or category to which the party whose fault is to be measured belongs; but both common sense and public policy require that ignorance of the law is not a factor to be taken into account in the diminution of fault." (emphasis added)

56. The point about greater knowledge was raised on Dr. Stones's behalf to argue that the hospital was more at fault than he was. It was submitted that the hospital had more expertise and thus ought to be fixed with a bigger proportion of responsibility and fault. Mr. McGrath cited two cases: *Connolly v. Dundalk UDC* (Unreported, Supreme Court, 18th November 1992) and *Healy (A Minor) v. HSE and Fitzsimons* [2009] I.E.H.C. 221. There is, however, an important distinction to be made between a case of successive episodes of discrete negligence, as here, and circumstances in which the more expert person and the less expert are dealing with the same event, incident or situation. The latter is not the situation here: each defendant successively and in his/her own area fell below standard. In *Healy*, the patient was in the care of the hospital and the consultant at the same time so that it was the same event or situation that they were dealing with. Similarly, in *Connolly* the local authority engineers and the outside specialists were concerned with the same question of plant design, installation and operation.

57. It is of course the case that a higher standard will be applied to an expert: he or she is judged by the care expected of a person of similar status. Less obvious clues should trigger action by a more expert person. But all the professionals who are the subject of this plaintiff's claim fell substantially below the standard to be expected of competent persons of their own branches of knowledge and expertise. The question that arises is whether the specialist hospital is more blameworthy than the general practitioner or the nurse for missing the same obvious symptom that they all should have noticed and acted on.

58. In *Carroll v. Clare County Council* [1975] I.R. 221, again in relation to s. 34, Kenny J. speaking for the Supreme Court said at p. 227:-

> "I think that 'fault' in s. 34 of the Act of 1961 means a departure from a norm by a person who, as a result of such departure, has been found to have been negligent and that 'degrees of fault' expresses the extent of his departure from the standard of behaviour to be expected from a reasonable man or woman in the circumstances. The extent of that departure is not to be measured by moral considerations, for to do so would introduce a subjective element while the true view is that the test is objective only. It is the blameworthiness, by reference to what a reasonable man or woman would have done in the circumstances, of the contributions of the plaintiff and defendant to the happening of the accident which is to be the basis of the apportionment."

59. In *Patterson v. Murphy* [1978] I.L.R.M. 85, Costello J., having referred to Carroll above, stated at p. 102:-

> "Following this test I should consider the blameworthiness of the contribution which each defendant made to the damages which the plaintiff suffered by reason of the acts complained of – the test of blameworthiness being an objective one and applied by reference to what a reasonable man or woman would have done in the circumstances of the present case."

60. Also of note is the relatively recent case of *Larkin v. Joosub* [2007] 1 I.R. 521, where Finlay Geoghegan J. adopted the passages cited above from *Carroll* and *Patterson* in determining a contribution issue under s.21 of the Act.

**Conclusion**

61. My overall factual conclusions are that each of the defendants or their servants or agents were grossly inept in their treatment of this baby. Collectively, their negligent incompetence extended from when the child was two days old until late May 2001, when it was too late to avert disaster. The key question to be determined by this Court is whether, adopting Kenny J.'s interpretation of the term "degrees of fault" to mean the extent of departure from the standard of behaviour to be expected from a reasonable man or woman in the circumstances, there is anything to distinguish the respective degrees of fault of the three defendants in this case.

62. Although the National Maternity Hospital's role in Jade's care was brief, its fault was grave. The hospital is a tertiary centre for obstetrics and a recognised centre of excellence. It has all the relevant specialist expertise and equipment. In this respect it had superior facilities compared with the other defendants. The hospital's fault has to be measured by reference to its status as a specialist facility, which tends to increase it. Moreover, although the hospital was guilty of a single occasion of negligence – in contrast to the other defendants – I think it is reasonable to say that because the hospital was the first port of call for Jade as a newborn baby, the failure by Dr. Endig to conduct a competent assessment of the baby is all the more blameworthy.

63. Dr Stones was seriously at fault in his dealings with this baby and fell substantially below a proper standard and it is no excuse to say that others were also at fault, nor does it afford any mitigation to propose that his treatment was otherwise satisfactory when the conduct in question amounts to blatant incompetence.

64. An aggravating factor, as it were, in assessing his culpability is the fact that his was a repeated mistake. Moreover, his inadequate response to his concerns of Ms Gillian Keane compounds his fault. I also think that Dr. Stones, in contrast to Dr. Endig, for example, saw the baby in the latter stages of her condition, when her head was swollen to such a size that his failure to notice something was wrong is quite extraordinary. For an experienced general practitioner, these failings are very serious indeed. Dr Stones had the advantage of seeing the baby three times and having available the information that her mother and grandmother could give him. He and the public health nurses were in a position to notice other signs such as the size of the baby's anterior and posterior fontanelles which adds to their fault but must be seen in the context of their failure to observe the most striking symptom.

65. In the case of the public health nurses, once again it was a case of repeated negligence. There was a collective failure of a most serious kind and the first defendant bears vicarious liability for this. While it might in some cases be a relevant consideration to say that nurses do not possess as much medical knowledge or expertise as doctors, I do not think this is a case where it arises. The nurses should have noticed Jade's symptoms long before they did and acted on foot of them by ensuring that she received the necessary attention as a matter of urgency.

66. In light of the foregoing analysis, it seems to me that there is nothing to distinguish the degree of blameworthiness of the National Maternity Hospital, the public health nurses and Dr. Stones in regard to the tragedy that befell baby Jade. Having regard to what I perceive to be the equal degree of fault of each of the defendants, I determine it to be just and equitable to apportion contribution between them accordingly, so that the first, second and third defendants shall contribute one third each.