[Neutral Citation No. 2005 IEHC 415]

THE HIGH COURT

[1999 No: 9796P]

BETWEEN

MARY PYNE AND JOHN PYNE

PLAINTIFFS

AND
THE WESTERN HEALTH BOARD
AND DECLAN EGAN

DEFENDANTS

Judgment of Mr. Justice de Valera delivered on the 15th day of April, 2005

1. This is an action which has arisen from the tragic circumstances surrounding the birth of Olivia Pyne on the 4th June 1998. Olivia's parents Mr. and Mrs. Pyne were married in 1987 and having decided initially not to start a family Mrs. Pyne discovered subsequently that she had difficulties with infertility in particular a condition known as endometriosis.

2. Mrs. Pyne consulted Dr. Egan the second defendant and following treatment for infertility Mrs. Pyne discovered in October 1997 that she was pregnant.

3. This was a source of great satisfaction to Mr. and Mrs. Pyne as they had now been married for approximately 11 years.

4. I am satisfied from the evidence that Mrs. Pyne behaved entirely appropriately throughout her pregnancy and indeed took particular care to ensure that she complied with all instructions given to her and took all reasonable steps to ensure a successful pregnancy and subsequent delivery.

5. No one who was present in court during the opening days of this action could fail to be impressed by the dignity and fortitude of Mrs. Pyne and her husband and I have already indicated my admiration for the manner in which they have faced up to the tragedy that has come to them.

6. It is also important to remember when considering the events surrounding the birth of Olivia Pyne that the circumstances of a quiet courtroom in the morning and afternoon in Dublin are very different from those in the anti-natal delivery wards in Galway University Hospital on the night of the 3rd /4th June 1998. It is very easy to be wise after events have taken place and it should be borne in mind at all times that the conditions in which the protagonists in the matter under consideration found themselves were very different to those in which their actions were subsequently recounted and criticised within the walls of courtroom number twelve.

7. When Olivia was delivered early in the morning on the 4th June 1998 there was some concern for her condition arising out of the circumstances of her birth and within some weeks of her delivery it became apparent that she had in fact suffered grievously as a result of oxygen depravation in a period immediately proceeding her birth, a condition known as hypoxia. This caused her parents to make enquiries into the circumstances surrounding her delivery and this in turn lead to the issuing of proceedings by them against the first and second defendants.

8. The action having commenced on the 8th July 2003 a settlement was reached between the plaintiff and the first defendant (which settlement was ruled on the 4th day of the trial and the matter proceeded on the basis of the issue being tried between the first and second defendants with certain ancillary procedural orders).

9. This issue continued as between the first named defendant and the second named defendant for a further 11 days.

10. There are two fundamental matters which are not in dispute:

> Firstly, Olivia Pyne is most seriously physically and mentally handicapped.
>
> Secondly, this physical and mental handicap is due to oxygen deprivation, hypoxia, which occurred during labour immediately prior to her birth.

11. Mary Pyne was admitted to St. Catherine's ward University College Hospital, Galway, on the 3rd June 1998 under the care of Dr. Declan Egan for induction of labour.

> At 11.20a.m. on the 3rd June 1998 a prostaglandin tablet was inserted vaginally to induce labour.
>
> At 15.15 that day Mrs. Pyne was examined and a second prostaglandin tablet was similarly administered.
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> At 20.00 having already begun to experience some pain Mrs. Pyne vomited.
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> At 21.40 the membranes ruptured spontaneously and Mrs. Pyne suffered lower cramping pains.
>
> By 22.20 Mrs. Pyne was complaining of backache and pain in her legs.
>
> At 22.27 a CTG trace was commenced and this was discontinued at 22.47.
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> At 22.55 Mrs. Pyne was transferred from St. Catherine's (the anti-natal) ward to the labour ward, Dr. Egan having directed this transfer. Dr. Egan also directed an epidural anaesthetic at this time. Dr. Egan's instructions were given by telephone as he had last seen Mrs. Pyne at 19.50.
>
> At 23.15 an epidural block was sited by Dr. Flynn an anaesthetist.
>
> At 23.25 a vaginal examination took place.
>
> At 00.05 (on the morning of the 4th June, 1998) another vaginal examination was carried out.
>
> At 00.40 Olivia Pyne was delivered by means of a forceps delivery.

12. I am satisfied, on the evidence adduced in this matter over a period of 15 days that Olivia Pyne's present condition is as a result of oxygen deprivation (a condition know as hypoxia) in the period between the onset of labour on the evening of the 3rd June 1998 and her delivery at 00.40 on the morning of the 4th June 1998 – this is not a matter of contention between the defendants.

13. I am also satisfied that had Olivia been delivered at an earlier time, as would have been possible, on the balance of probabilities she would not have suffered the hypoxia which has been the cause of her present condition.

14. Initially in this action there were several allegations of negligence against Dr. Egan the second defendant but the evidence as it was lead at the hearing centred on the allegation that Dr. Egan's use of prostaglandin a recognised birth inducing preparation at 4 hourly intervals was inappropriate and in the circumstances negligent.

15. It was accepted that the prostaglandin manufacturers recommendation was for the administration of a second tablet of prostaglandin to take place if required 6 to 8 hours after the initial dose.

16. A number of eminent medical practitioners specialising in obstetrics gave evidence on this point and it is clear that there is no common or indeed even majority opinion among practitioners. I cannot detect from the evidence in this action sufficient unanimity among the medical fraternity of a sufficiently widely accepted opinion on the appropriate use of prostaglandin to allow me to hold that Dr. Egan's method of use was negligence (in accordance with the principles laid down in *Dunne against The National Maternity Hospital*).

17. I am reinforced in this view by the fact that Dr. Egan has been following this practice of prostaglandin usage for many years and has had no other similar event occur.

18. It has been urged on me, following the decision of the Supreme Court in *Dunne against The National Maternity Hospital and another* that even if a particular practice, in this instance a 4 hour prostaglandin repeat dose, was in general use and approved by colleagues

> "If such practice had inherent effects which ought to be obvious to any person giving the matter due consideration"

19. Such practice should be deemed to be negligent. Of course I accept the Dunne decision as a correct exposition of the relevant law but there is no sufficient evidence in this matter to support the contention that this was a practice with obviously inherent defects.

20. Nor am I satisfied that the administration of a second dose of prostaglandin caused the "tumultuous" labour (to quote the word graphically, and uniquely, used by Dr. Clements). There was evidence from Dr. Turner among others which I found persuasive that Mrs. Pyne's labour, while abrupt and intense, was not unique or even particularly unusual and I am not satisfied that, on the balance of probabilities, an excessive dose of prostaglandin caused this form of labour.

21. Therefore I can find no negligence by Dr. Egan.

22. As I have already indicated I accept the evidence that had Olivia been delivered earlier it is probable that she would not have suffered the injuries which now afflict her. I also accept the evidence, particularly from Dr. Clements and Mrs. Foster (which I found particularly persuasive) that the supervision and attention from the nursing staff (in which term I include midwives) fell below a proper standard.

23. In particular the failure to:-

> (1) Monitor the foetal heart prior to 22.27 on the 3rd June, 1998
>
> (2) Record the duration or frequency of contractions prior to the transfer to the labour ward.
>
> (3) Notify Dr. Egan of the delay in transferring Mrs. Pyne to the labour ward.
>
> (4) Appreciate the significance of the read-out of the CTG monitor and in particular the tachycardia which it disclosed.
>
> (5) Carry out a vaginal examination prior to the epidural procedure or postpone the procedure until such examination had taken place.
>
> (6) Continuously monitor Mrs. Pyne by CTG prior to 22.27 and subsequent to 22.47
>
> (7) Summon Dr. Egan (or as suggested by Mrs. Foster a registrar or other doctor) as soon as foetal distress was, or should have been, detected. Prevented an early diagnosis of foetal distress.

24. Because of these failures foetal distress was not identified sufficiently early (as it could and should have been) and remedial action which could have avoided the subsequent tragedy was delayed beyond a point at which it could have succeeded. These failures were caused by the negligence of some members of the theatre staff for whose actions the first defendant is liable.

25. As already indicated I find no negligence or breach of duty by Dr. Declan Egan the second named defendant. I find that the first named defendants were negligent, and in breach of their duty to the plaintiff.