Neutral Citation Number: [2011] IEHC 339

THE HIGH COURT

2008 4355 P

BETWEEN

H. M.

PLAINTIFF

AND

HEALTH SERVICE EXECUTIVE – NORTH EASTERN AREA

DEFENDANT

JUDGMENT of Mr. Justice Charleton delivered on 20th July 2011

1. H.M. is a young lady of thirty-three years of age. Ten years ago, on the 1st October 2001, she gave birth to her first child, a boy called James, in Our Lady of Lourdes Hospital in Drogheda. That delivery was not an easy one. It required intervention by forceps because a risk of hypoxia to the baby emerged, thus necessitating a swift delivery. Unfortunately, during the birth she suffered a third degree tear of her anal sphincter. This injury is frequently associated with a forceps delivery. She argues that intervention by forceps would never have been necessary, and thus the anal tear would have been avoided, had the labour been allowed to progress to a non-instrumental birth. She complains of a lack of ordinary care in the management of the delivery of James. It is argued on her behalf that her labour was rushed by the administration of the drug oxytocin, which has the effect of speeding up the process, and that this was not discontinued at the right time. It is also said on her behalf that the anal sphincter tear arose because an episiotomy cut was made at the wrong angle, one that was too close to the midline. A want of ordinary care is also pleaded in the diagnosis and repair of that anal sphincter injury, whether or not in the first instance it occurred through a want of care. All of these issues, testified to in evidence by expert witnesses on behalf of the plaintiff, are disputed by the defendant on behalf of the hospital and its staff.

2. There are therefore two main issues: the management of labour; and the response to the tear of the anal sphincter. A brief chronology will be set out and then these two issues will be considered in turn. Firstly, I need to refer to the applicable law. Since this is well settled by existing written judgments only a note is necessary.

Ordinary Care

3. H.M., while being treated in Our Lady of Lourdes Hospital in Drogheda, was entitled to a standard of care commensurate with a careful and competent system of the medical management of childbirth. Attending her in the birth of her son James were a midwife, Tracey Cotter, and an obstetrician and gynaecologist at registrar level, Dr. Devannay Sengottaiyan Rajeswari. The plaintiff, as their patient, was entitled to expect a standard of care commensurate with that which could be given by a careful and competent midwife and a careful and competent obstetrician and gynaecologist. The hospital system within which these medical people operated is also required to be such that it supports the competence and level of professional expertise that attends a busy maternity unit. Those professionals attending women in childbirth are entitled to the support which proper hospital administration provides to the professionals working within that system. The relevant test is set out by the Supreme Court in Dunne v. National Maternity Hospital [1989] I.R. 91 at 109 to 110 where Finlay C.J. approved the test in previous decided cases and offered this definitive summary:-

> "There was no argument submitted to us on the hearing of this appeal which constituted any form of challenge to the correctness of the statements of principle thus laid down, although there was controversy concerning their application to the facts of this case. The principles thus laid down related to the issues raised in this case can in this manner be summarised.
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> 1. The true test for establishing negligence in diagnosis or treatment on the part of a medical practitioner is whether he has been proved to be guilty of such failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care.
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> 2. If the allegation of negligence against a medical practitioner is based on proof that he deviated from a general and approved practice, that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualifications.
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> 3. If a medical practitioner charged with negligence defends his conduct by establishing that he followed a practice which was general, and which was approved of by his colleagues of similar specialisation and skill, he cannot escape liability if in reply the plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.
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> 4. An honest difference of opinion between doctors as to which is the better of two ways of treating a patient does not provide any ground for leaving a question to the jury as to whether a person who has followed one course rather than the other has been negligent.
>
> 5. It is not for a jury (or for a judge) to decide which of two alternative courses of treatment is in their (or his) opinion preferable, but their (or his) function is merely to decide whether the course of treatment followed, on the evidence, complied with the careful conduct of a medical practitioner of like specialisation and skill to that professed by the defendant.
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> 6. If there is an issue of fact, the determination of which is necessary for the decision as to whether a particular medical practice is or is not general and approved within the meaning of these principles, that issue must in a trial held with a jury be left to the determination of the jury.

In order to make these general principles readily applicable to the facts of this case, with which I will later be dealing, it is necessary

to state further conclusions not expressly referred to in the cases above mentioned. These are:

> "(a) General and approved practice" need not be universal but must be approved of and adhered to by a substantial number of reputable practitioners holding the relevant specialist or general qualifications.
>
> (b) Though treatment only is referred to in some of these statements of principle, they must apply in identical fashion to questions of diagnosis
>
> (c) In an action against a hospital, where allegations are made of negligence against the medical administrators on the basis of a claim that practices and procedures laid down by them for the carrying out of treatment or diagnosis by medical or nursing staff were defective, their conduct is to be tested in accordance with the legal principles which would apply if they had personally carried out such treatment or diagnosis in accordance with such practice or procedure.
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> … In developing these legal principles outlined and in applying them to the facts of each individual case, the courts must constantly seek to give equal regard to both of these considerations"

4. In any tort action the plaintiff bears the burden of proof. In Elliott Construction Limited v. Irish Asphalt Limited (Unreported High Court, Charleton J. 25th May, 2011) this Court analysed the burden and standard of proof that applies in civil cases. The relevant passage occurs at paras. 15 to 22 of that judgment. I have nothing to add to that, save to say this standard is applicable in all civil cases, though it is not usually necessary to give the detailed analysis set out in that case.

5. In that case, as well, this Court set out its understanding of the approach which a court of trial should take to the assessment of expert evidence at paras. 10 to 14. The evidence in this instance consisted of testimony of fact from the plaintiff, from the obstetrician and gynaecologist, from the midwife attending her, and from one other medical doctor who examined her prior to birth. Their evidence is considered on the basis of deciding which, if any, conflicting account is more probable. This approach takes cognizance of memory, reliability, consistency with any internal written record or subsequent statement, and the likelihood of accuracy and truth, having regard to the entirety of the evidence. In addition the Court heard a number of experts in obstetrics and gynaecology, and in colorectal surgery and in continence treatment. The approach of the Court to the experts is as set out in Elliott Construction.

6. A separate issue arises as to the Statute of Limitations. I will consider that under its appropriate heading.

Chronology
7. There follows a brief chronology of relevant events.

• January 2001: the pregnancy of the plaintiff begins.

• July 2001: the plaintiff awakes with a severe pain in the back of her leg. This is assessed in Our Lady of Lourdes Hospital in Drogheda and she is diagnosed with a trapped nerve injury. This eases and therefore falls out of relevance to the case.

• September 2001: the plaintiff visits the hospital on a number of occasions; an ultrasound scan indicates that the baby is small for dates. She is told to come back and on a later visit this finding is affirmed.

• 30th September 2001: the plaintiff has a show late at night. Her membranes are ruptured. The hospital indicates that she should come in to be assessed with a view to delivery.

• 1st October 2001:

• 00.00: the plaintiff is seen by the midwife in Our Lady of Lourdes Hospital and is noted to have clear liquor and irregular contractions. The fact that the baby is small for dates is properly noted.

• 00.30: it is noted that the cervix is very posterior and is one fingertip dilated and beginning to efface. It is not possible at this stage to determine the position of the baby.

• 00.40: decelerations are noted on the cardio-tacograph (CTG) monitoring foetal heartbeat.

• 01.10: the midwife reviews the plaintiff. She notes a period of bradycardia. The progress of the labour is noted.

• 01.10: Dr. Rajeswari reviews the plaintiff. It is noted that the plaintiff has been admitted since 11.30 on the previous day, that she is not in pain or distress, that the cervix is 3 cm dilated and that she is 50% effaced.

• 01.30: the plaintiff is transferred to a four bedded area. A CTG is recommenced. The baseline is noted, as is the variability. The signs are regarded as stable, though the plaintiff is experiencing a lot of back pain.

• 01.55: variability is noted on the CTG.

• 02.00: the variability is improved and the baseline is noted.

• 02.20.: the contractions are noted as mild at 1:10, lasting 25 seconds.

• 02.30: oxytocin at ten units is commenced at 30 ml per hour (phr). The baseline and variability of the CTG are noted. The contractions remain irregular.

• 03.00: the Tens device is interfering with CTG and is discontinued. Oxytocin is at 60 ml phr. Although there is an electronic trace, the contractions are not picked up. This is not to be regarded as a want of care, as I am satisfied from the explanations given that this can sometimes happen and that the focus of the midwife will properly be on the management of the labour. Contractions are noted manually on the chart.

• 03.10: an early deceleration is noted.

• 03.30: oxytocin is increased to 90 ml phr.

• 03.40: the cervix is dilated to 4 cm.

• 04.00: early decelerations are noted on the midwife's chart and the administration of oxytocin continues at 90 ml phr.

• 04.09: a serious dip in the CTG chart is apparent. This could be an early deceleration. On moving into the next sequence, the chart shows what are, in the Court's judgment on an assessment of the expert evidence, variable decelerations. These are apparent from just after this point.

• 04.30: the midwife notes that the baby is having what she describes as early decelerations to 80 beats per minute. Dr. Rajeswari is called to review.

• 04.40: Dr. Rajeswari arrives. She remains throughout the remainder of the labour. The cervix is 4 cm to 5 cm dilated. The station is at the spines. Oxytocin is stopped on the basis that it may be recommenced if the CTG settles. This is to be reassessed in two hours.

• 05.00: the midwife notes what is described as early decelerations persisting to 80 beats per minutes. The Court's assessment of the decelerations, on hearing expert evidence, is that they are variable and that the depth of them and the lack of recovery indicate a potentially serious situation for the baby. Dr. Rajeswari noted type 1 decelerations on coming into the labour ward. A note of clear liquor is described as reassuring.

• 05.10: the midwife notes that the plaintiff is feeling an urge to push and transfers her to room 2.

• 05.20: progress is assessed. The cervix is noted to be fully dilated and the station at plus 1.

• 05.31: the perineum is noted to be infiltrated.

• 05.35: the doctor notes the cervix is fully dilated and that there is a small caput. In order to deliver the baby, in consequence of the situation that is developing, a metal vacuum cup is applied and tried. The cup slips.

• 05.39: Neville Barnes forceps are applied and an episiotomy is performed.

• 05.43: a living boy is born. The apgar scores are noted to be good. The midwife simply notes "sutured by Dr. Rabbee". I am satisfied that this is a mistake and that the suturing was done by Dr. Rajeswari, also commonly called "Dr. Raji". A later note by the midwife indicates that difene is given for pain. The note by Dr. Rajeswari from this time should be quoted in full. This says:-

• "C.R. fully dilated. Small caput plus fhtr 270/mt metal cup vacuum applied and tried 1 pull C contraction – the cup slipped. NB forceps. Episiotomy. Alive male baby delivered. Placenta complete. Episiotomy sutured in layers. (Unreadable) superficial fibres of the external sphincter gone and the same sutured. Low residue diet."

• 07.30: the plaintiff is admitted to a post delivery unit. Both mother and baby are noted to be well and breastfeeding commences.

• 17.00: the plaintiff is noted to be in lot of pain. She is reviewed by Dr. Rajeswari who attended the delivery and sutured the perineum. Pain medication is prescribed. Further notes are made that day but they are not relevant. In ordinary course the plaintiff returns home with her baby in the next day or two.

• November 2001: while at home the plaintiff experiences severe pain. After the birth she was in state of shock. She had very severe bruising. She was advised to avoid high fibre foods but she says that she did not know why. Nor did she know that her anus had been sutured. I accept her evidence on this. Anatomically the plaintiff complains that she did not feel the same as before; that she was very tender and her perineal area was different. Her bowel movements are very painful. Incontinence, however, is not yet a feature. She returns to work in ordinary course after some weeks.

• January 2002: the plaintiff continues to recover and incontinence is not a feature. Over a period of two to three years some few accidents of passing stool or staining occur. She notes as this issue progresses that she has to get to a toilet immediately and has less than one minute. This problem she describes as being not all the time initially, but a couple of times a year. This was not something she put down to the birth. I am satisfied that she did not have sufficient information to make any connection between the damage to her anal sphincter and this development, but I will return to this issue in a separate section. She recalls one problem with answering the door while, at the same time, being engaged with the baby, and having a toilet emergency. I accept her evidence. This developing continence fear leads to an absence of ordinary frequency in sexual intimacy. I am satisfied that, as yet, the plaintiff makes no connection between what she is experiencing from the point of view of toilet problems and the birth of her son.

• February 2006: the plaintiff again becomes pregnant. Her bowel problems become more noticeable during the pregnancy.

• August 2006: the plaintiff sees Dr. Máire Milner. She learns that she has a third degree tear of the anal sphincter. Since what was said on each side is in dispute in relation to the Statute of Limitations, I will return to it under a separate heading for the purpose of making findings of fact.

• 27th October 2006: a second baby, G., is born to the plaintiff.

• April 2007: the plaintiff consults with solicitors.

• July 2007: the plaintiff returns to work following her second baby's birth.

• 12th May 2008: the plaintiff's G.P. notes:-

> "third degree tear on first delivery, difficult forceps delivery. Second baby [lower segment caesarean section] but faecal incontinence worse since. Needs rigid routine to avoid accidents. Would like referral for assessment of same. [Blood pressure] 146/96 has been gradually going up. D/W Dr. Matthews… is management of the labour..."

• 29th May, 2008: a plenary summons is issued.

• 17th July, 2008: the plaintiff is referred to Dr. Geraldine Connolly, consultant obstetrician and gynaecologist. She notes that the plaintiff has "some incontinence as a result of a third degree tear which was interestingly made worse following the birth of her

second child, albeit by elective caesarean section".

• December 2008: the plaintiff sees Professor Michael Keighley in Birmingham.

• 27th April, 2009: a solicitor's letter is sent to the hospital complaining of negligence.

• March 2010: the plaintiff sees Dr. Paris Tekis in London on the issue of electrical stimulation with a view to managing or resolving her continence problems and fears.

Management of the Labour

8. The strongest case for the plaintiff in relation to the mismanagement of labour was put forward by Roger Varley Clements. He is a consultant obstetrician and gynaecologist of considerable eminence. His evidence was delivered clearly and with a strong appreciation of the possible counter validity of any opposing opinion. Nonetheless, his evidence consists of what is no more than an opinion on the proper management of labour. Unlike a fact, an opinion is subject to qualification and disagreement, and furthermore it is not necessarily definitive. He explained that as the foetus was growth restricted precaution was required. This therefore was, in his opinion, a high risk labour because the indications were that the placenta might be malfunctioning and, because of size, the baby's ability to tolerate labour might be less. The plaintiff was, however, a smoker and the lesser function in the placenta might be explained by that, at least to some degree. Mr. Clements indicated that at the end of pregnancy the blood supply from the placenta to the foetus becomes sluggish, but when labour commences the uterus acts as a secondary pump through contractions. The ratio of contractions to relaxation must, however, be appropriate. He would not have started oxytocin in order to speed up or properly establish labour. He felt that this was a little precipitous. He indicated, however, that he accepted that there was a difference of opinion on these issues. At the time indicated in the chronology, at 04.09 or proximate, he pointed out, and I accept, that a classic variable pattern had arisen in characteristic V shape, indicating the compression of the umbilical cord. This does not necessarily lead to hypoxia, but if it is carried on long enough and the contractions are strong enough, then that risk is manifest. This is especially so if there is a lesser performance by the placenta or if the baby is growth restricted. Both issues were present in this instance, in his opinion. His view was that the oxytocin administration to the plaintiff should have been stopped half an hour earlier. At the time when Dr. Rajeswari was called he said that there was a clear indication that the baby needed to be rescued. He put this down to oxytocin administration and the failure to stop it much earlier. Had this been done, he was of the view that the labour was such that it would have proceeded normally and that, over time, especially with a small baby, a vaginal delivery without assistance would, in his opinion, have been achieved absent oxytocin administration.

9. On the issue of decelerations, he explained the matter as follows:-

> "So this is entirely the kind of labour in which you would expect variable decelerations. Now, everything I have explained to [the court] so far tells you that variable decelerations in their classic form are harmless. They cause changes in blood pressure, changes in blood volume, but within the space of a contraction everything is back to normal. There is no hypoxia involved. But if variable decelerations go on long enough and if the compression becomes severe enough, then there will be slow recovery, excessively deep decelerations and a failure of the accelerations that produce the shouldering [shown on the diagram]. And those variable decelerations, which are subtlety (sic) different from the ones I describe, do contain an element of hypoxia. So babies don't withstand cord compression indefinitely. A healthy baby will withstand intermittent cord compression for many hours, but there will come a point in any baby's life when, if it goes on long enough, the baby becomes hypoxic and it is referred to as falling off a cliff. There will be a gradual reduction in the baby's metabolic reserve and suddenly the baby won't cope and you have got a serious bradycardia and that's how babies come to harm with cord compression."

10. I entirely accept this explanation. It is of general application to the rest of the analysis of the evidence. His view on the necessary discontinuance of oxytocin at an earlier stage than it was in fact stopped, was given in the following way:-

> ". . . the oxytocin effect doesn't disappear straightaway and that's for two reasons. The first is that once you have set the labour in motion, it has a momentum of its own and it carries on. But it's more than that. The oxytocin has a half life. Nobody knows what the half life of oxytocin is. Pharmacologists argue about it indefinitely. But it's measured in minutes. It's somewhere between 10 and 20 minutes so there will be a continuing effect. Although you are titrating against the uterus, you can't eliminate all of the drug. Some of it's in the circulation so it goes on . . . The cause [of these variable decelerations shown in the CTG Trace] was intermittent cord compression, exacerbated by the use of oxytocin and my view is that if the oxytocin had been stopped as soon as the decelerations became apparent, it probably wouldn't have mattered. But they weren't and the oxytocin went on for at least half an hour more than it should have done, by which time the rate of contraction – well the rate of dilation was clearly well above the norm for a first baby . . . I think . . . that the changes on the CTG, which continue to get worse and they continue to get worse right up until the end, was quite a clear indication to rescue this baby and there is no criticism of that decision. The criticism is that it needn't have happened if they hadn't given the oxytocin in the way they did. And they were right to intervene when they did, but that intervention, in retrospect, was probably completely unnecessary because this was a very small baby and small babies don't need assistance to get out very often, not if the mother has a decent size pelvis and the labour is dilating the cervix."

11. As against that view, which I respect, I have to take into account the contrary opinion given in evidence on behalf of the defendant by Dr. Rhona Mahony. Her analysis of the management of the labour convinces me that an equally probable opinion contrary to that of Mr. Clements is possible. Since the experts for both the plaintiff and the defendant accepted that the initial administration of oxytocin was appropriate, all that stands between them is the time at which it should have been stopped. Had it been stopped earlier, for instance at 04.00, the opinion for the plaintiff is that labour would have proceeded to a normal vaginal birth with no instrumental intervention. The difficulty which the Court has with that opinion is accepting that the problems which emerged at 04.40 would not have emerged on a slower labour, perhaps an hour or two later. Dr. Mahony's view was that the difficulty which emerged, necessitating an instrumental delivery, was one which would simply have been present in any event, though at a later time. In addition, the Court had the benefit of the evidence of the attending midwife, Tracey Cotter. She struck me as not only highly competent, but also completely honest. She had no recollection of the particular delivery, and was relying on her notes. Her decision to call in Dr. Rajeswari was correct. In terms of when Dr. Rajeswari might earlier have been called, she conceded that it was possible that Dr. Rajeswari could have been called at 04.20 or maybe 04.25. At that point the administration of oxytocin could also have been stopped. I find it difficult to see this timescale as involving a difference to the eventual outcome.

12. Principally, however, I am not convinced as a probability that the earlier stopping of oxytocin would have made a substantial difference which would not have later emerged further on in the timescale. In this regard I have paid particular attention to the evidence of Malcolm Griffiths, a consultant in obstetrics and gynaecology at the Luton and Dunstable Hospital in England. Giving

evidence for the plaintiff, his testimony was genuinely expert and I accept it. Concerning the decelerations from about 04.15 or 04.20, he said:-

> "Well, the last one could reasonably be called an early deceleration is the one just above and slightly to the right of 133. Then we have got the vertical axis doing the 200, 180, 160, that deceleration, and also subsequent decelerations must, by any standard, be called variable decelerations… They indicate probably a progressive degree of asphyxia within the foetus, but there are features of the trace which are maintained for some time, up to about 05:20, and the point where the cervix was found to be fully dilated, that suggests the baby is coping and compensating for the asphyxia that it is being exposed to. I say that because the baseline rate and the variability of the baseline rate, are reasonably well maintained. Subsequent to that, the baseline falls, the variability is less clear, and the decelerations seem to be there for more than the baseline. Then the recording just peters out, so we can't really see what is going on. So the baby was becoming progressively more asphyxiated but compensating metabolically for that asphyxia… Variable decelerations are generally regarded as being due to cord compression. Cord compression occurs in labour, it occurs more commonly with growth retarded babies, and it occurs more commonly where there has been rupture of the membranes. So, I think that this was due to cord compression. But the cord compression was brought about by each contraction, and the contractions were being brought about or enhanced by the Syntocinon [a brand name for oxytocin] that was being administered… If the Syntocinon had not been administered at all, then it is likely that the lady would have made less rapid progress in labour, would have reached full dilation, and probably would have achieved a vaginal delivery. But I think that the difficulty that I have is that there are, there are just too many unknowns for anybody to say with any confidence that there is an alternative scenario, which is that she wouldn't have progressed in labour so much, but the baby would have become distressed nevertheless, and there would have been a need for a caesarean section. So we have got the possibility; if we don't get full dilation we need to do a caesarean. We push ahead with too much Syntocinon and we get to full dilation, but the baby is compromised, and then two possibilities in between. I can't really say which of those individually would have happened, but one of them results in her having a caesarean section, and one of them avoids instrumentation, and another involves instrumentation… The Plaintiff had an episiotomy, and there is some evidence to suggest that there was an anal sphincter injury, and the anal sphincter injury and the episiotomy are statistically very much correlated with instrumental delivery."

13. My assessment of the evidence is that there is insufficient evidence to establish a probability that there was any failure of ordinary care by Tracey Cotter, as midwife, or by Dr. Rajeswari in the management of the labour. I am not convinced as a probability that stopping oxytocin at, in or around 04.00 or shortly thereafter, would not have led to a situation at a later stage where exactly the same situation that emerged from 04.30 on to the point of delivery occurred. My view is that it is probable that at a later stage in the labour instrumental intervention into the birth would have been necessary in any event. Therefore there was no want of appropriate care is managing the labour.

Anal Sphincter

14. There is no doubt that during the course of delivery, the anal sphincter of the plaintiff was ruptured. The extent of that rupture is a matter of dispute between the plaintiff and defendant. Whether that rupture arose by reason of a want of care in cutting the episiotomy with a view to ensuring a swift delivery remains in issue, notwithstanding the last finding. Even if it did not so arise, the identification and proper management of the tear was essential. The plaintiff claims that the repair was inadequate, however the rupture was caused, whereas the defendant claims that the response of the hospital to the tear was in accordance with normal standards of care at the time. While the present condition of the plaintiff has not been disputed, the future prognosis for her condition is the subject of controversy. The defendant claims that the plaintiff's condition has arisen due to pudendal nerve neuropathy and is not due to the anal sphincter tear. Since scientific literature was debated extensively during the course of the hearing, I first wish to refer to some of the relevant papers.

The Scientific Papers

15. Following a one day meeting entitled "Obstetric Anal Sphincter Injury; It Is Time to Re-think Practice as we Enter the Millennium?", held in Birmingham in January 2000, a consensus was published in the journal, Clinical Risk. This classifies perineal tears into categories of first, second and third degree. The first involves the vaginal epithelium only; the second involves injury to the perineal muscles; and the third involves injury to the anal sphincter. In relation to the third, if it is less than 50% of the external anal sphincter, it is classified as 3A; if it is more than 50%, it is classified as 3B; and if it involves the internal anal sphincter, it is classified as 3C. There is also a fourth degree tear which is not relevant. The normal risk of any third degree tear of the anus occurring during childbirth was reported as ranging between 0.6% and 2.3%. Not all tears are associated with anal incontinence and the reported figures varied widely between 20% and 57%. The cause of post-obstetric faecal incontinence was agreed by the experts at the meeting to be multifactorial. Whereas this includes sphincter injuries, it can also include pelvic floor trauma, perineal trauma and pudendal neuropathy. The most important cause in the immediate post-partum period is sphincter disruption. Such injuries are more common in instrument assisted delivery, with forceps delivery carrying the greatest risk. Many such injuries are not recognised at birth. This paper is a valuable and important publication in medical science. An important publication also arises by virtue of the guidelines issued in July 2001 by the Royal College of Obstetricians and Gynaecologists. This is entitled "Management of Third and Fourth Degree Perineal Tears Following Vaginal Delivery". Dr. Rajeswari, as a member of the college, will have received a newsletter indicating that the guidelines were available. Ordinary care by a hospital which has a maternity unit would require, in my view, a meeting proximate to the issue of the guidelines and a presentation and explanation. The issues set out in the guidelines are of critical importance to the avoidance of anal injury. The incidence of this problem places it as highly important. This important document should have been made available by the hospital to its staff at registrar, senior registrar and consultant level. In the alternative the guidelines might have been circulated by the hospital, over a computer system or manually by envelope. This was not done. There was no attempt at notification or discussion. Circulating guidelines on a statistically commonly occurring injury to women to doctors involved in childbirth in a maternity unit is ordinary care in the management of such a unit. These guidelines were brought into common practice by the hospital in the calendar year following this incident. There was no reason given in evidence as to why there should have been such a delay. In my view, these guidelines are perfectly clear. They provide for recognition of anal sphincter injuries. The guidelines recommend that all women who have a vaginal delivery should have a systematic examination of the perineum, vagina and rectum to assess the severity of any damage prior to suturing. All women who have had an instrumental delivery, or who have had extensive perineal injury, should also be examined by an experienced obstetrician trained in the recognition and management of perineal tears. Some controversy arose in the evidence as to whether on overlap repair, where one piece of muscle is put on top of the other, as opposed to end to end, is superior. Medical science has not yet resolved that issue. What is clear, however, under the guidelines, is that a repair should be carried out in an operating theatre under regional or general anaesthetic. I am satisfied on the basis of the evidence that I have heard that this is clearly likely to be associated with an improved outcome. I have taken into account the cogent evidence of Dr. Rhona Mahony. In particular I appreciate her honesty in indicating that on one occasion since the guidelines were issued, she carried out an anal sphincter tear without additional anaesthesia beyond what was given for the purpose of birth and without moving the patient to the operating theatre. This repair was adequate, however, in the circumstances because the patient had received an epidural block and the relevant level of muscle relaxation had already been achieved. The necessity for

particular conditions is set out in the guidelines in the following way:-

> "Repair in theatre will allow operation under aseptic conditions, with appropriate instruments, adequate light and with an assistant. Regional or general anaesthesia will allow the woman to be pain-free and the anal sphincter to relax, which is essential to retrieve the retracted torn ends of the anal sphincter. This also allows the ends of the sphincter to be brought together without any tension"

I note that this guideline is not presented in the context of any choice as between 3A and 3B tears. On my assessment of the evidence, it applies to both.

16. Whereas it has been argued that guidelines have the status of advice, I am convinced from all of the evidence I have heard that the implementation of these guidelines is essential in order to avoid the distressing condition that may result in the event that women are left improperly diagnosed and treated after an anal tear. I do not accept that the guidelines were so new or so radical that they required a period of analysis, or trial, before acceptance. Even had they so required, my view is that the very important guidelines which emerged in July 2001 should have been in place by at least the time of the delivery by the plaintiff of her son on the 1st October 2001.

17. It is very definite that the angle of the episiotomy cut can affect the incidence of anal sphincter injury. In Eogan et Al (2005) it is clearly demonstrated that a larger angle of episiotomy from the midline is associated with a lower risk of third degree tear. The research therein published indicates that a medio-lateral episiotomy incision should be made at a sufficiently large angle to the midline in order to minimise the risk of sphincter disruption. It seems that the ideal angle is 45º. What can be expected of a doctor attending birth is that she or he would attempt to achieve such an angle in the context of the distortion of the perineum by reason of the descent of the baby's head. It can often be difficult, thereafter, to adjudge the angle of the scar. The authors state:-

> "A simple technique for evaluating the angle of an episiotomy from the midline was devised, which involved examination in the left lateral position and location of the episiotomy scar. The same measuring technique was used for cases and controls. The perineal midline was determined anatomically from the midpoint to the introitus. A piece of transparent plastic film was placed on the perineum, and the lines of the episiotomy and perineal midline were drawn using a permanent marker. The angle of episiotomy from the midline was measured using a protractor, with the film placed on a flat surface. Agreement between observers on both drawing and measuring the angle of episiotomy was evaluated using the coefficient of repeatability. Because of perineal dissension at vaginal birth, the entire perinial area is larger at the time of cutting an episiotomy then at 3 – month postnatal review; thus, an episiotomy scar may look different from a fresh laceration. The relative angles from the midline, however, remain equivalent, and consequently, the angle of episiotomy cut correlates with the angle of postnatal episiotomy scar."

18. This study demonstrates that the smaller the angle from the midline, the greater the risk that an episiotomy is likely to be associated with a third degree perineal tear. The increased likelihood of no tear increases as the angle moves from the midline to a 45º angle away from it, which is considered to be the best situation. Deciding, however, after eight years, as to where the episiotomy was cut is no easy matter. The estimates given in this case, by various experts, have ranged from 10º to 30º. The latter would be acceptable on the evidence presented before me. There has also been evidence which suggests that it is impossible to know where the scar represents the cut from the episiotomy, and where the tear begins. Differentiating one from the other is very difficult as a matter of medical science, even for experienced professionals. In addition, the plaintiff alleged that the episiotomy was cut before the forceps were applied. Had that happened, the likelihood of damage may have been increased and, as it so clearly departs from standard practice, it would provide some evidence of want of care. I cannot hold with the plaintiff, however, in relation to this allegation. The plaintiff was deeply shocked. The training of Dr. Rajeswari would make such an event highly unlikely. In addition, the plaintiff could not remember an examination of her anal area and was only in a position, understandably, to recall stitching and the pain associated with the birth and repair.

19. It is clear, however, from de Leeuw et Al (2001) that medio-lateral episiotomy, in contrast to a midline cut, protects strongly against the occurrence of third degree perineal ruptures. It is thus a primary method of prevention of faecal incontinence. These authors also agree that forceps delivery is a strong risk factor. Even with forceps delivery, however, I am satisfied on the entirety of the evidence that the degree of risk, if the episiotomy scar is properly cut at an appropriate medio-lateral angle, is less than 1%. Where the cut is on the midline, however, or close to the midline, that risk markedly increases. The issue, therefore, is whether the episiotomy was cut medio-laterally, or whether it was, in contrast, cut too close to the midline.

20. It is established in evidence that it is important to cut an episiotomy at a medio-lateral angle to the midline. Sworn testimony of Dr. Rajeswari is that that is precisely what she did. This was done at the correct stage when the perineum was distorted by the baby's head and, in addition, by the insertion of the forceps. Dr. Rajeswari struck me as being competent and experienced. It is highly likely that the episiotomy cut performed by her was effected with the intention of achieving a 45º angle to the midline. In approaching this task, at a time when a baby requires to be rescued, and in circumstances where the perineum is distended, some measure of appreciation is required. The standard required is that which is appropriate in the circumstances. In addition to that evidence I have heard, as I have indicated, conflicting views as to the scar. This was examined, and was drawn, by Mr. Clements. Other specialists have commented on that drawing. I might add that the drawing done on examination by Patricia Malone, a distinguished physiotherapist in the Mater Hospital, was executed from memory. It is no slight on her evidence that this is likely to be less reliable. Apart from the variation in angle, as testified to by experts, the real problem which I have in deciding whether a probability has been established that the episiotomy cut was too close to the midline is that I cannot say from the evidence where the cut began and ended and where the scar began. It is certainly the case that a scar extends into the anus but the evidence as to whether this resulted from the angle of the episiotomy cut and at what particular angle that cut was made is insufficiently probable for any finding of fact to be made in favour of the plaintiff.

Guidelines

21. The extent to which the anal sphincter is affected in the plaintiff has varied on the testimony of experts as between 8% and 20%. In addition, I have had the benefit of opinions of endo-anal ultrasound scans by Professor Keighley and Professor O'Connell. It is clear that the amount of the circle of the anus that is involved is less than one quadrant. On the basis of their testimony I would find it hard to consider this injury as a minimal one and as the best that could be achieved by competent surgical repair, even in ideal circumstances. My view is that the external anal sphincter injury exceeds 15%. I note the scan shows no involvement of the internal anal sphincter; quite a defect in the mid-anal canal region; no ascertainable defect in the puborectalis; and a defect in the low anal canal. It has been established in the evidence as probable that the defect in the anus is such as to be capable of causing the plaintiff's symptoms. It is not to be dismissed as minimal.

22. It is established in evidence that it is important to pursue a proper repair of this area. I do not regard this as being novel science

but as ordinary sense. In this regard, scientific papers published beyond 2001 were referred to. These show a study in statistical patterns. As far as the Court is concerned, the operative scientific publication is the guidelines from July 2001. In Hayes et Al (2006) 121 women who had immediate repair of obstetric third degree tears were interviewed, were explored by anal ultrasonography and had their analorectal physiology examined. Immediate repair shows an excellent outcome: 65% were completely without symptoms; 19% had minor flatus or mild urgency issues which caused no compromise to the quality of their live; and 16% had embarrassing faecal incontinence. The positive outcome could therefore be regarded as 84%; the degree to which the compromised 16% were suffering was not quantified in the study. However, the highest proportion of severe issues was in those with an internal anal sphincter defect. The authors comment:-

> "It might be argued by some that a proportion of the women would have had few, if any symptoms even if there had been no repair of the third-degree tear. However, we would not advocate this approach, as failure to restore the anatomy of the sphincters and perineal body inevitably leads to repair by fibrosis resulting in deformity and scarring which is frequently associated with soiling, impaired rectal evacuation, dyspareunia, perineal discomfort and problems with anal hygiene. The manometric findings indicate a very poor correlation between anal pressure measurements, symptoms or injury. However, the presence of an intact IAS and EAS was associated with higher anal pressures then in those with injury to the IAS or EAS alone or in combination. Defects in the IAS were relatively easy to identify by anal ultrasonography but interpretation of the anal ultrasonography with respect to the EAS defects was much more difficult. Scarring of the EAS was commonly observed, presumably as a consequence of the repair. When we compared the women with a scarred but intact EAS and those with no scarring, we found identical symptomatology and manometric results, suggesting that scarring of the EAS alone had no influence on symptoms of bowel incontinence."

23. Turning now to the nature of the repair, I am satisfied that Dr. Rajeswari did what the hospital required her do at that time. The issue is whether that procedure was incorrect. I was particularly impressed by the explanation of the functioning of the internal anal sphincter provided by Dr. Rhona Mahony and her description of the interaction of the fibres. This accords with what I understood from the evidence of Professor Keighley and I am content to rely on the evidence of both of them. It is established as probable on the evidence that the injury to the anus was a 3B injury. The injury did not involve, as Dr. Rajeswari's notes seem to indicate, a few superficial fibres. Instead, I am satisfied that the anal ultrasonography establishes that a more extensive injury existed after childbirth along the track of the external anal sphincter. The real difficulty for an attending doctor, in this context, is identifying the torn ends, which retract, and bringing them together for repair. The degree of retraction can vary depending on the classification of the injury as 3A or 3B in accordance with the guidelines. I am satisfied that the guidelines apply to both, as they apply to a complete tear of the external anal sphincter. I do not accept any view expressed in evidence to the contrary. In that regard, I continue to be influenced by the expert and honest approach of Dr. Mahony and what she said about her single experience, that she could remember, of not following the guidelines. The issue as to whether this repair was improperly described by Dr. Rajeswari is not necessarily determinative of liability.

24. The attending doctor described the injury that she thought she saw in accordance with the current hospital procedures. If the plaintiff had been treated under correct hospital procedures, in place through appropriate measures from 2002, I am convinced the description would have been more reliable and the repair under general or regional anaesthetic much more suitable. Professor Griffiths stated in relation to this repair:-

> "It wasn't conducted in an acceptable manner according to the standard of practice that pervaded at the time and it failed to ensure an adequate examination. I can only imagine that "a few fibres gone" implies a less than adequate examination and I know that the plaintiff didn't have an anaesthetic to allow a fuller examination. So they are not assumptions. But I don't know what the fuller examination would have found because, as you say, I have made an assumption as to the nature of the injury… As an obstetrician rather than a colorectal surgeon, I deal with sphincter injuries at the time that they occur and I am more interested in their depth, rather than the quadrant affected and my assumption, which may or may not be wrong, is that this was more than simply a superficial tearing of a few fibres. That was the assumption that I've made. I may be wrong in that assumption and, that's fine, but I have not gauged that according to how many degrees there were or how many – if you've got a ring and the ring is broken, the ring is broken, is how I see it as an obstetrician".

25. What is clearly established in the evidence is that the hospital should have had in place procedures whereby the guidelines would be followed in appropriate cases. This is clearly one of the appropriate cases. Had the hospital appropriate procedures or had it disseminated appropriate information, the plaintiff would and should have been immediately brought to theatre and an assistant would have been sought. Proper lighting would then have been available. In addition it is clearly established on the evidence that general or regional anaesthesia was necessary. The emphasis in the evidence on the fact that anaesthesia had already been provided for the purposes of childbirth, and the cutting of the episiotomy scar, is a complete irrelevancy. The purpose of regional or general anaesthesia is to relax the muscle so that the torn ends of the anal sphincter may be identified, brought together, and repaired. Regrettably, this was not done. The result is that the anal sphincter of the plaintiff is compromised. The responsibility, in that regard, attaches to the defendant hospital in the management and organisation of a busy maternity unit. Ordinary care demands that such a unit be kept reasonably up to date in important thinking in medical science. Since these guidelines were extremely important, involving a commonly occurring injury, and making practical and difficult to dispute suggestions, they should have been implemented. At the very least the hospital should have ensured that they were discussed between the hospital staff or the subject of a circular by electronic or paper means. Instead, the entirety of the evidence convinces me that the hospital did not expect to deal with anal injuries in this way and had no procedures in place in its busy maternity unit to which Dr. Rajeswari could reasonably have been expected to turn. That is a fault in hospital management and not in the individual doctor. In 2002, however, as I understand it, the guidelines were implemented. Had the guidelines been implemented in 2001, the year prior to that, it is clear on the evidence that a better outcome, with a probability of no compromise to the anus, would have been established. It is also clear that as soon as the guidelines were implemented by the hospital that Dr. Rajeswari would have followed them.

Pudendal Nerve Neuropathy

26. I have carefully considered the view of Professor Ronan O'Connell that what the plaintiff is suffering from is due to pudendal nerve neuropathy. Were this so, there would have to be a finding that the plaintiff had suffered from an incident of the risk of childbirth with no fault of the defendant. The recurring themes for this injury involve multiple births, a prolonged second stage of labour and instrumental delivery. Professor O'Connell's view, in addition, is that there was a change of bowel habit, occurring spontaneously, in or around the second pregnancy of the plaintiff, or some time before that. I cannot see why this should suddenly occur and persist on to the present time. I am grateful to Professor O'Connell for his expert assistance on this area which has clarified many issues from the point of view of his wider expertise in treating these distressing conditions. I do not consider, however, that pudendal nerve neuropathy has occurred in this case.

27. On the evidence, the opinion of Professor Keighley emerges as more probable. In the course of their evidence both Professor Keighley and Professor O'Connell discussed the importance of nerve tests with a view to settling any such controversy. I am satisfied that these tests are invasive, unpleasant, and not sufficiently definitive as to require me to make any finding of fact against the credibility of the plaintiff. In the course of his evidence, Professor Keighley spoke as to what was looked for in any diagnosis of pudendal nerve injury. In addition to the points that I have mentioned concerning what tends to be its usual background, he said:-

> "I have already spoken, explained to you, that are three components that we look for. One is anaesthesia, she has none. One is perineal descent, she has none. The other is failure of contraction of the sphincters in the pelvic floor, it is reduced, but she has some. So, in my clinical judgment, there is no evidence of pudendal neuropathy, and in any event it doesn't fit with the obstetric history".

28. By that he was referring to the fact that there was no long second stage labour or several births in the instance of this plaintiff. These reasons are, of themselves, sufficient to establish a probability that pudendal nerve neuropathy is not the cause of the plaintiff's issues. I would also find it peculiar when this possible condition took four years to emerge and that in relation to physiotherapy treatment and subsequent examinations, there is at least some evidence of improvement. In that regard, Professor Keighley disagreed with Professor O'Connell. He put it in this way:-

> "Well, I would disagree with him and I will tell you why because she has obviously improved very considerably and her anal manometry has improved too, suggesting that as a result of intense physiotherapy, her muscle function has improved, as is often the case with physiotherapy. You would not expect a neuropathic muscle to improve with physiotherapy. It doesn't. It's like a neuropathic arm – it doesn't improve because it has no nerve supply. The fact that she has improved clinically with physiotherapy I think is a strong argument against pudendal neuropathy and, as I keep saying, there are no clinical signs of pudendal neuropathy when you examine her… Well, as I have said, the fact that she has poor sphincter contraction and that the sphincter contraction seems to improve with physiotherapy, there is a manometry recording on page 177 of this bundle which suggests that her maximum squeeze pressure went up to 80cm of water on 28/7/10 and that seems to be objective evidence that her sphincter muscle has improved, which would be completely against a neuropathy. And… on 12th October, she measures the pressures again and the maximum pressure has now gone up to 100cm of water. You wouldn't expect these results if it was a neuropathy."

29. In making this finding I have regard to Professor O'Connell's disagreement on this point but the balance comes out clearly in favour of the plaintiff as a probability against pudendal nerve neuropathy.

The Future

30. As to the prognosis for the plaintiff I would rely strongly on the evidence of Professor O'Connell. I do not believe that she will reach the stage where it is necessary to consider vagal nerve stimulation. The probability is against that. Good results have been achieved in consequence of reawakening awareness of the pelvic floor through physiotherapy. In the future, the recovery that has occurred should be maximised by physiotherapy recommended exercise. It is clear that this will be a burden on the plaintiff's life, but it equally apparent that she has ample intelligence and determination in following through in the amelioration of her injury. I also believe that she will achieve good results in psychotherapy with the expert assistance of Mary Carroll. On the other side, however, I must take into account that the plaintiff is now 33 and the future is long and managing the problem will require serious effort.

Statute of Limitations

31. Personal injuries are defined by s. 2(1) of the Statute of Limitations Act 1957 as including "any disease and any impairment of a person's physical or mental condition". Section 11(2)(b) of the Act of 1957 provided that:-

> "An action claiming damages for negligence, nuisance or breach of duty (whether the duty exists by virtue of a contract or of a provision made by or under a statute or independently of any contract or any such provision), where the damages claimed by the plaintiff for the negligence, nuisance or breach of duty consist of or include damages in respect of personal injuries to any person, shall not be brought after the expiration of three years from the date on which the cause of action accrued."

32. The above provision was deleted by s. 3(2) of the Statute of Limitations 1991. The limitation period in respect of personal injuries is now governed by s. 3(1) of the Act of 1991, as amended by s. 7 of the Civil Liability and Courts Act 2004, which establishes a two year limitation period:-

> "An action, other than one to which section 6 of this Act applies, claiming damages in respect of personal injuries to a person caused by negligence, nuisance or breach of duty (whether the duty exists by virtue of a contract or of a provision made by or under a statute or independently of any contract or any such provision) shall not be brought after the expiration of two years from the date on which the cause of action accrued or the date of knowledge (if later) of the person injured."

33. Section 5A of the Act of 1991, as inserted by s. 7 of the Act of 2004, states that:-

> "(1) Where the relevant date in respect of a cause of action falls before the commencement of section 7 of the Civil Liability and Courts Act 2004, an action (being an action to which section 3(1)… of this Act applies) in respect of that cause of action shall not be brought after the expiration of—
>
> (a) 2 years from the said commencement, or
>
> (b) 3 years from the relevant date,
>
> whichever occurs first.
>
> (2) In this section 'relevant date' means the date of accrual of the cause of action or the date of knowledge of the person concerned as respects that cause of action whichever occurs later .

34. Section 7 of the Act of 2004 was commenced on 31st March 2005 by S.I. No. 544 of 2004. If the relevant date in this instance (being the accrual of the cause of action or the date of knowledge, whichever occurs later) was before 31st March 2005, then the limitation period is the earlier of:

> i) 2 years from 31st March 2005, i.e. 30th March 2007; or

ii) 3 years from the date of knowledge.

If the relevant date was after 31st March 2005, the 2 year limitation period set out in s. 3(1) of the Act of 1991, as amended, applies.

35. Section 2 of the Act of 1991 defines the "date of knowledge" as:-

> "(1) … the date on which [the person] first had knowledge of the following facts:
>
> (a) that the person alleged to have been injured had been injured,
>
> (b) that the injury in question was significant,
>
> (c) that the injury was attributable in whole or in part to the act or omission which is alleged to constitute negligence, nuisance or breach of duty,
>
> (d) the identity of the defendant, and
>
> (e) if it is alleged that the act or omission was that of a person other than the defendant, the identity of that person and the additional facts supporting the bringing of an action against the defendant;
>
> and knowledge that any acts or omissions did or did not, as a matter of law, involve negligence, nuisance or breach of duty is irrelevant.
>
> (2) For the purposes of this section, a person's knowledge includes knowledge which he might reasonably have been expected to acquire—
>
> (a) from facts observable or ascertainable by him, or
>
> (b) from facts ascertainable by him with the help of medical or other appropriate expert advice which it is reasonable for him to seek.
>
> (3) Notwithstanding subsection (2) of this section —
>
> (a) a person shall not be fixed under this section with knowledge of a fact ascertainable only with the help of expert advice so long as he has taken all reasonable steps to obtain (and, where appropriate, to act on) that advice; and
>
> (b) a person injured shall not be fixed under this section with knowledge of a fact relevant to the injury which he has failed to acquire as a result of that injury.

36. The Supreme Court has considered the issue of "date of knowledge" in personal injuries cases arising from medical negligence in two decisions: Gough v. Neary [2003] 3 I.R. 92; and Fortune v. McLoughlin [2004] 1 I.R. 526. These cases were recently comprehensively analysed by Dunne J. in Naessens v. Jermyn & Anor. [2010] IEHC 102, (Unreported, High Court, Dunne J., 26th March, 2010). In Gough v. Neary Geoghegan J. set out (at 128) the Spargo principles (from the judgment of Brooke L.J. in Spargo v. North Essex Health Authority [1997] 8 Med. L.R. 125 at 129):-

> "(1) The knowledge required to satisfy s. 14(1)(b) [of the equivalent U.K. legislation] is a broad knowledge of the essence of the causally relevant act or omission to which the injury is attributable;
>
> (2) 'attributable' in this context means 'capable of being attributed to', in the sense of being a real possibility;
>
> (3) a plaintiff has the requisite knowledge when she knows enough to make it reasonable for her to begin to investigate whether or not she has a case against the defendant. Another way of putting this is to say that she will have such knowledge if she so firmly believes that her condition is capable of being attributed to an act or omission which she can identify (in broad terms) that she goes to a solicitor to seek advice about making a claim for compensation;
>
> (4) on the other hand, she will not have the requisite knowledge if she thinks she knows the acts or omissions she should investigate but in fact is barking up the wrong tree: or if her knowledge of what the defendant did or did not do is so vague or general that she cannot fairly be expected to know what she should investigate; or if her state of mind is such that she thinks her condition is capable of being attributed to the act or omission alleged to constitute negligence, but she is not sure about this, and would need to check with an expert before she could be properly said to know that it was."

37. Geoghegan J. also referred (at 129) to the following passage contained in the judgment of Judge L.J. in Spargo who in turn quoted Donaldson M.R. in Halford v. Brookes [1991] 1 W.L.R. 428 at p. 443:-

> "The word (knowledge) has to be construed in the context of the purpose of the section, which is to determine a period of time within which a plaintiff can be required to start any proceedings. In this context 'knowledge' clearly does not mean 'know for certain and beyond possibility of contradiction. It does, however, mean 'know with sufficient confidence to justify embarking on the preliminaries to the issue of a writ, such as submitting a claim to the proposed defendant, taking legal and other advice, and collecting evidence'. Suspicion, particularly if it is vague and unsupported, will indeed not be enough, but reasonable belief will normally suffice."

38. In Fortune v. McLoughlin, McCracken J. stated at 534:-

> "The knowledge referred to in [s.2(1)(c) of the Act of 1991] is knowledge of attribution, in other words knowledge that there was a connection between the injury and the matters now alleged to have caused the injury... If a plaintiff is to have knowledge within the meaning of s. 2(1)(c) of the Act of 1991, she must have knowledge at least of a connection between the injury and the matters now complained of to put her on some inquiry as to whether the injury had been caused by the matters complained of. At what stage she is put on inquiry must be a matter to be determined in each case... It should be emphasised that the plaintiff's knowledge of these matters is largely a question of fact…"

39. The resolution of this issue involves a conflict of evidence as between the plaintiff and Dr. Máire Milner, who has no specific recollection of the plaintiff. She was appointed as the consultant obstetrician to Our Lady of Lourdes Hospital in Drogheda in 2001. She first saw the plaintiff on the 1st August 2006. She recorded the review of old notes. She believes that she wrote in her own note that there were "no continence probs." Her view was that she would always ask in these circumstances about continence because it is a life altering issue. She looks at the patient in the eye, she said. She fairly conceded, however, that she could not say that every patient was going to say that they had continence problems. What emerges from the evidence in this case is this kind of problem is deeply embarrassing, especially for women. She also has a practice of asking about wind and about staining. She is satisfied that any alteration in bowel habits she would have noted. She has no reference to any continence problems in her own medical notes. If she had been told of such problems, her practice would have been to examine the perineum and organise follow-up tests. The delivery by caesarean section, in her view, had already been requested.

40. Whereas the plaintiff was closely cross-examined as to prior and subsequent statements which are said to inconsistent with her case, I remain convinced that she is a witness of truth. Despite the excellence of the questions put to the plaintiff, I find her core evidence to be convincing. I am satisfied, in addition, that the first time that she knew that she had suffered a third degree tear was at the consultation with Dr. Milner. Whereas she places this in June 2006, it seems more probable that this occurred in August 2006. It is also clear that the plaintiff has been grossly embarrassed and upset by her injury. She disagreed strongly with what Dr. Milner stated in evidence, indicating that she had told her, on being asked, about continence problems and flatus. She probably, she concedes, did not mention sexual difficulties. Her view was that she told Dr. Milner that she had continence problems during the course of the pregnancy which had exhibited frequent problems for her. Dr. Máire Milner struck me as highly competent and concerned. I consider that it is probable that the plaintiff mentioned some issues which she had with continence up to that time. I also regard it as reasonable to recall her shock on realising that there was a problem and it seems to me to be probable that this inhibited conversation. What is crucial, however, is that the realisation that she had suffered an injury at the time of the birth of her son James occurred only at this much later time. The commencement by the plaintiff of legal proceedings on 29th May 2008 is therefore in time.

Damages
41. I do not regard a need for vagal nerve stimulation therapy as being a probable result of the plaintiff's difficulties. The figures given in relation to that involved an initial outlay of £10,000 sterling, together with maintenance of £2,000 sterling per annum. The plaintiff has already improved with physiotherapy and I have already indicated my view as to what is established on the evidence as to the probable future course of the plaintiff's problem. Special damages are proved in the sum of €2,400. In addition, a reasonable sum of money should be added for future psychotherapeutic intervention. Whereas I was not given figures in relation to this, it seems to me to be reasonable to allow for a sum of €5,000. I have had regard to the Personal Injuries Assessments Board Book of Quantum. The High Court always finds this work to be useful in the sense that it gives a foundation set in 2004 as to the measure of compensation for particular injuries. With rapid deflation since September 2008, these figures have again returned to keen relevance. For temporary bowel issues, figures are given as between €40,900 and €50,300. For serious and permanent bowel conditions, the latter contemplating a permanent, as opposed to a reversible, colostomy, the figures mentioned are between €51,500 and €113,000. It seems to me that the plaintiff is toward the middle end of that range. Psychosexual problems have also to be taken into account. I am convinced, however, that with the allowance for psychotherapy these will improve considerably. I take into account, as I must, what the plaintiff has suffered and will have to do to lead a reasonably normal life into the future. The Court therefore awards general damages of €40,000 to date and €40,000 into the future. The total award is therefore €87,400.

Result
42. There will be judgment for the plaintiff in the sum of €87,400.