Neutral Citation No. [2004] IEHC 427

THE HIGH COURT

No. 1997/4340 P

BETWEEN

MARGARET KELLY

PLAINTIFF

AND
MICHAEL LENIHAN

DEFENDANTS

Judgment of Mr. Justice Henry J. Abbott delivered the 2nd day of July, 2004

1. The plaintiff is a married woman born on 25th February, 1960 and on the 8th July, 1994 she gave birth to her third child in the National Maternity Hospital at Holles St. In the course of the birth, an episiotomy was performed on her, and she suffered a rectal tear of such a severe kind that it was beyond dispute a third degree tear. This rectal tear was repaired after the birth, but it is the plaintiff's case that she has suffered severe personal injuries consequent to and as a result thereof which have culminated in her having continuing, complaints, and most importantly, the consequences of a colostomy, which it is claimed was necessary, following the initial trauma, and its treatment.

The pleadings

2. The statement of claim was delivered on 21st July, 1998. It states that the defendant has been nominated by the Board of Management of the National Maternity Hospital Holles St. to defend the proceedings on its behalf. The statement of claim proceeds as follows:

> "3. On or about the 8th July, 1994 the plaintiff was admitted to the said hospital in order that she might undergo the necessary and appropriate procedures, treatment and management so as to give birth to her baby, which said procedures, treatment and management the said hospital in admitting the plaintiff, agreed, and undertook to provide in a competent and professional manner.
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> 4. In the premises, the defendant its servants and agents were under a duty to take reasonable care for the health, safety and welfare of the plaintiff whilst she was a plaintiff in the said hospital.
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> 5. The defendants negligently and in breach of duty failed to apply appropriate procedures, treatment or management to the plaintiff during the delivery of her said baby and failed to act in a competent and professional manner, and failed to take reasonable care for the safety of the plaintiff, in consequence whereof the plaintiff has suffered severe personal injury and has suffered and continues to suffer loss and damage."

3. As certain particulars of negligence were withdrawn and qualified either prior to or at the opening of the case it is appropriate to set them out as follows:

> (a) failing to take any or reasonable care for the safety of the plaintiff whilst she was a patient in the said hospital,
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> (b) exposing the plaintiff to a risk of damage or injury which was foreseeable and preventable,
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> (c) Failing to diagnose the persistent occipito - posterior position (hereinafter referred to in this judgment as the O.P. position) of the foetus,
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> (d) failing to appreciate the likelihood of perennial trauma by reason of the O.P. position of the foetus by failing to watch for signs of rupture in the centre of the perineum,
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> (f) failing to carry out an episiotomy which was clearly indicated in the circumstances,
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> (g) failing to carry out an episiotomy causing unnecessary perennial trauma,
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> (i) causing a third degree perennial tear in the bladder to occur during the course of the said delivery,
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> (j) failing to prevent the said third degree tear,
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> (n) causing the said sphincter to be damaged,
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> (o) failing to appreciate that an episiotomy was indicated having regard for the fact that the plaintiff had two previous episiotomies on the occasion of the births of her two other children and/or in the knowledge that the baby was likely to be large and/or by reason of the presence of an O.P. position, which said position is known to cause perennial trauma,
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> (p) instructing the plaintiff to "push" before the second stage of labour had commenced, contrary to established good practice.
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> (q) Failure to apply a normal standard of care during both the first and second stages of labour and during the post-natal period particulars relating to complaints about the repair of the third degree tear principally contained in particulars (k) (l) (m) were not relied on in the trial.

5. Particular H is as follows:

> "Opening or endeavouring to open the plaintiff's cervix manually in a manner contrary to standard practice in such circumstances."

6. Counsel for the plaintiff explained in opening the case that while this particular was part of the story that it did not seem to be a central feature of the case and that having regard to the advice obtained by the plaintiff's legal team, that their case rested elsewhere – "primarily elsewhere". The defence is as follows:

> 1. The defendant, his servants or agents did not fail to apply appropriate procedures treatment or management to the

plaintiff either in the manner alleged or at all,

2. The defendant, his servants or agents were not guilty of the alleged or any negligence, or of the alleged or any breach of duty, and the particulars thereof alleged in the plaintiff's statement of claim are denied as if set out here and traversed seriatim,

3. The plaintiff has not suffered the alleged or any injury, loss or damage as alleged or at all, in the particulars thereof alleged in the plaintiff's statement of claim are denied as if set out here and traversed seriatim,

4. The particulars of special damage are denied,

5. The plaintiff is not entitled to the relief claimed nor to any relief,

6. The extent that the particulars of negligence make allegations of fact, same are denied as is set out here and traversed seriatim,

7. Without prejudice to the foregoing, if the plaintiff did sustain the alleged or any injury (which is denied), same were sustained notwithstanding the exercise of reasonable care on the part of the defendant, his servants or agents. The evidence

The Plaintiff's Evidence

7. The plaintiff gave evidence as follows: she lives in south west Dublin, she has three children Sinead, Craig and Eoin. She was married in 1984, Sinead is the eldest daughter, Craig a son is next and Eoin the youngest is the son born on the 8th July, 1994. She had episiotomies with the two first children. Sinead was small being only six pounds fourteen ounces but the boys were heavy. She had no difficulties after the births of the two first children nor did she have any incontinence of her bowel. When she was married she was employed as what might be basically described as a quality controller in Glenabbey and she gave up this employment to look after Sinead when she was a baby. She went to Holles St. with Eoin in May and June of 1984 prior to his birth and she was told then that she was carrying a baby which would be the same weight as her last baby (Craig) who was eight pounds eight ounces. On about a week before Eoin's birth she went on her normal pre-natal visit to Holles St. on 2nd July, 1994 and she was given a date in Holles St. to be induced on the basis that she was overdue.

8. She was admitted to Holles St. about 11.00 and at 11.10 they brought her up to break her waters. She was in a ward until she was in labour. From 11.00 am until 3.00 pm she was in very bad pain but was not dilating until she thinks it was about 6.00 pm when she was examined and told she was in labour. She recalls the vaginal examination recorded about 6.15 pm. The nurse examining her told her that she was in labour and she recalls a subsequent examination about 7.15 pm when she went up to the delivery ward. When she went into the delivery ward at 7.15 pm or thereabouts she was told that she was dilated three cm. She had to walk up and down until she was further on. She got constant pains all the time, she got another examination and was told that she was now seven cm dilated. At that time the midwife said to her "if you bear with me I will try and make you ten." She recalls that when Eoin was born that she could actually feel the tear when she was delivering Eoin. When the midwife said to her "if you bear with me I will make you ten," she put her hand up into the plaintiff's cervix trying to make her ten, and that at that time the plaintiff was biting so hard on her lips, she could not even put a PASS CARD in between her lips; the blood was gushing out of them trying to push the baby out, - the plaintiff can't forget it. The pain which the plaintiff experienced was not the pain of the midwife putting her hand up to widen the cervix but was the pain of trying to push the baby. She was in a bed at this time, all the plaintiff remembers is that there was a nurse with her and the student kind of monitoring with the nurse. She remembers the head – she didn't know if you call it the midwife – coming in on different occasion having a look and going back out. But there was only one she recalled helping her at her bedside to push while she remembers the midwife's hand up her vagina trying to help her she does not recall anything being said in relation to the presence of the baby's head nor did anyone tell her what the position of the baby was. While there was a record that she had dilated to ten cm at about 9.55 pm she does not recall or remember anyone telling her that at the time. She was so anxious at pushing, trying to get the baby out. She just remembered from seven cm up to the time the baby was born, at the stage that the baby was born she could feel the tear but she had used her bowel as well and the soreness from using her bowel with the cut was a stinging sensation, and she related that to the tear.

9. After the baby was taken away for weighing and cleaning up a doctor was sent for, no doctor had attended her from the period 8.00 pm to 9.55 pm. in the delivery ward. The doctor then stitched up where the tear was, the plaintiff was taken off the ward, given a room of her own and given icepacks because of the swelling on the back passage. The plaintiff was in constant pain. She remained in that room for about five days. She brought her baby home and came back to the hospital after six weeks. That was for the six week check-up.

10. Dr. Valerie Donnelly saw her on that occasion, as she had made an appointment to see her with the six weeks check-up appointment as well. Dr. Valerie Donnelly had cared for her while she was in the room and she found out that Dr. Valerie Donnelly was in charge of third degree tears and found out that the plaintiff herself had received a third degree tear. She had no signs of incontinence before she left the hospital because she didn't use her bowels after she had Eoin, and she was given stuff on the day she was actually leaving the hospital to bring a motion on. When she got home, and she wanted to go to the toilet, she couldn't even get up her stairs without everything coming from her – the bowel would open and she wouldn't have any control whatsoever. That happened the first time her bowels opened after she went home from the hospital. That remained the position, she had leakage with her urine but the case does not hinge on this. She had a further six-week check-up return to the hospital and again was seen by Dr. Valerie Donnelly who examined her bowel with computerised equipment, and she was told by Dr. Donnelly that the nerves were damaged on the back passage due to the birth of Eoin. She was sent for physiotherapy in the Rotunda Hospital under Cathy Marshall but this didn't work because her complaint related to the nerves and not the muscles. She had a little machine attached to her bum that operated by pulses but Dr. Donnelly wasn't happy with that as it was doing no good whatsoever.

11. The plaintiff was then sent to the Mater Hospital to Dr. O'Connell. As a result of her contact with Dr. O'Connell she learned that the nerves on the back passage had gone in labour on the birth of Eoin, and that she had a blockage. She had a number of tests by Mr. O'Connell and initially took the conservative approach and tried to treat the plaintiff with medicines for stiffening her bowel and her stools. This treatment didn't work either. In Easter of 1995 the operation which Mr. O'Connell carried out on the site repaired the blockage but the plaintiff's understanding was that there was still damage done to the nerves which allowed her to get up the stairs to go to the toilet and that it wasn't just all emptying out when she needed to go to the toilet. The surprise was taken out of going to the toilet but she nevertheless had to go quickly and she still had leakage. While she recovered well from the operation itself it was very painful and sore. In October, 1995 she had an operation by Dr. Declan Keane on her bladder and this operation is not of concern

in this case.

12. She saw Dr. Donnelly again in December 1995 who tested and monitored her. Dr. Donnelly's conclusion was that while Dr. O'Connell did a grand job the nerves were still damaged. She sent her to a lady, the plaintiff thinks is Mrs. King, and some physiotherapy was done but this did not do any good. During all this time the plaintiff did physiotherapy at home with her own machine. In the period between December 1995 and the year 2000 things got much worse and the plaintiff was leaking more heavily then. At this stage the leaking compelled the plaintiff to wear pads every day she was scalded and sore every day. It was an awful experience. She couldn't go outside her door, and, constantly kept to the house. Her husband had to go out shopping for her because she was afraid to go out. The scalding meant that her skin was in a rash like state. The plaintiff had her own car, but with the leakage she could go nowhere with her children and she couldn't get to a toilet in time, if she needed to go, so it restricted her to the house to have a toilet at her side. She became dependant upon her husband to go out with her and then only to shops where there was a toilet, where she would use it at short notice. Her husband took voluntary redundancy from his job to enable him to help her and started off in a taxi job so that he could be there during the day with her and just work at nighttimes in the taxi. He had been a logistics manager with Johnson Brothers, her husband is returning to his former type of work as a logistics manager.

13. As things were not improving with the plaintiff Mr. O'Connell advised her to consider a colostomy. The colostomy was carried out in 2000 and the plaintiff described the result as absolutely brilliant towards what she was. She said that she could now go out and have a life which she didn't have, when she was confined with the leakage. There is a downside, however, insofar as she feels the need to make herself secure by going around with something in front of her, such as an item of clothing so that no-one will see that she actually has a colostomy. The plaintiff carried a coat in front of her while giving her evidence and explained why the coat is a sort of diversion so that people will not see the colostomy bag. She says that the colostomy bag is attached to the front of her stomach. The skin at the site of the attachment is very very tender. She has ulcers all the time that bleed and are very sore. She felt it was just due to the type of skin she had and she was told that she will always suffer with ulcers there around it. She never went to a skin specialist to see if there were any allergies causing this. The Mater Hospital provide a service for persons like the plaintiff with colostomies and this service includes a monthly visit to her by a stomacare nurse. These nurses look after the colostomy bag but despite that, they haven't been able to eradicate the ulceration. The plaintiff explained how she could now bring her children to the pictures and bring them to McDonalds restaurants if they wanted to. This was a new lease of life to her.

14. The plaintiff had a plan to return to work when Eoin was in primary school and would have preferred what she described as a little part time job. However she had no confidence in herself now going around the workplace with a colostomy. Her confidence in relation to going out has improved but her confidence in herself has not. Before the colostomy she was offered a job in a small restaurant and she still would not have the confidence to do it as it involved working with food. She said she would like to think that she would get a job in the future perhaps not with food. She was not able to take the further step of confidence into the employment market. She had a medical card while her husband became unemployed and before he had fully set up to drive a taxi. She had ongoing cost of €65 a month for colostomy pads and disposable bags. She also had the cost of medication known as imodium and fibro gel. She also got sudocream and air fresheners which are a continuing requirement. While she has a warm and loving relationship with her husband she is inhibited from having full intimacy with him. By reason of the way she has now been left.

15. An ongoing mental setup is that of embarrassment at going around the way she is and the way she has been left, she feels she is just like an old person. On a bad day she could have a big ball in front of her walking along the street if she is going to the toilet or if she passes wind. Explained that all these motions come out through the bag now and that is why she needs a security device put around her. On a good day she might have no wind and the bag is very flat and people wouldn't recognise it. More often than not the bag gives off an odour and this is a cause of embarrassment. While the bag is most noticeable when it fills out there is always a ring visible around the plaintiff. She has no control over what goes into the bag.

Cross Examination of the Plaintiff

16. Under cross-examination the plaintiff thought that she had presented in respect of Eoin's pregnancy fairly early on in the pregnancy when put to her that when she presented for the very first time in hospital on 13th April, 1994 which was in fact less than three months before Eoin was born, she said that that would have been probably around the normal time that she would have first gone on a first visit. It was put to her that whereas she had presented with the two other pregnancies after three months, in the case of Eoin she was six months pregnant at presentation. That proposition didn't seem to make much sense to her. She didn't recall difficulties arising from the late presentation in assessing when her date of delivery would be. She didn't recall that there would have been some thought that it wasn't exactly clear when the baby would arrive by reason of the entry on the records "too late for accurate dating" made on 13th April, 1994. She didn't recollect anything about the records showing that her last menstrual period was either mid September or mid October in 1993. The plaintiff didn't understand the suggestion that when the hospital was estimating a weight of 4.25 kilograms later in the pregnancy, it was in the context of a pregnancy where the hospital was unsure as to the date of delivery. The records showed that her first child Sinead was 3.14 kilograms (6 and 14 ounces to the plaintiff's recollection). The second child Craig was 3.96 kilograms and this child was in fact heavier than the third child Eoin. The plaintiff agreed that when she arrived in the labour ward at about 8.00 pm there is no doubt that she was in labour and it seems a fact that she was dilated to three cm. She remembers the midwife saying to her "you are 3 cm dilated". She didn't disagree that there was no great delay in her progress as far as going from 3cm to 7 cm dilation. When put to her that she had reached 10 cm by 9.55 pm she said that she didn't ever recall the midwife saying "its 10 cm." However she remembers the midwife calling and saying its 7 cm other than the midwife telling her that she was 7 cm and that if she bore with her that she would make her 10. The plaintiff said that when put to her that the midwife was communicating with her talking to her and encouraging her, she said that the midwife was there from 7 cm right up to 10 forcing her. And of course she was talking to her. The plaintiff knows that when the baby delivers it is 10 cm but she didn't recall the midwife saying 10 cm to her. The plaintiff knew that the second stage of delivery was reached at 10 cm dilation and the stage of dilation must be reached before there is going to be an effort made to deliver the baby and thats exactly what happened in the previous pregnancies. When put to her that the midwife was advising her when she should push the plaintiff replied "at 7, yes." Throughout the half hour it took to go from 7 to 10 dilation the midwife was telling her to "push push". The midwife didn't give her any advise on either panting or breathing she just kept asking her to push all the time. Although the plaintiff was in the height of pain she gave as much attention as she possibly could give to the midwife. Although the pain was such that she was bleeding from the mouth very badly, to the best of her knowledge she tried to follow the advice she was getting from the midwife. While Nurse Carroll was the midwife working in Holles St. at the time of Eoin's birth, it was put to the plaintiff that Nurse Carroll did not recall her and it was suggested to the plaintiff that Ms. Carroll would certainly not have sought to expand her cervix manually. In this context was asked was she sure it wasn't just a vaginal examination and the plaintiffs answer was "positive, positive".

Evidence of Ms. Gertrude Hamilton

17. Evidence was given by Ms. Gertrude Hamilton an expert on midwifery. Her working career spanned from 1960 when she became a state registered nurse having trained at the Royal Infirmary Edinburgh to 1970 when she ceased being a Midwifery Sister at the Royal Maternity Hospital Belfast. In 1968 she received a Midwife Teacher's Diploma Kingston upon Thames Surrey, England and from 1970 to 1972 she was midwife teacher at the Royal Maternity Hospital Belfast. From 1972 to 1973 she was midwife teacher Paisley, Maternity

Hospital, Renfrewshire, Scotland. From 1973 to 1980 she was senior midwife teacher Creswell Maternity Hospital, Dumfries, Scotland and she taught the basic midwifery curriculum for ten years, both in classroom and ward sitting. From 1980 to 1985 she was liaison officer Northern College of Midwifery, and, in this post was linked between teaching and clinical staff, both in hospital and community, within a modular system of training. She ensured that clinical objectives were met, and helped to organise continuous assessment of students within a formal framework. She took part in counselling students throughout their training, and also participating in the in-service training of qualified staff. From 1985 to 1996 she was Board Secretary and Professional Officer Royal Colleague of Midwives (RCM) Northern Ireland, where she was responsible for the running of the Northern Ireland Office giving professional advice to midwife members and representing them before employers and disciplinary matters. She also represented members before the investigating Committee of the National Board for Nursing, Midwifery and Health visiting Northern Ireland the Health Committee of the United Kingdom Central Counsel for nursing midwifery and health visiting. She consulted with government departments and health authorities on matters relating to midwives, and the provision of maternity services within the province. From 1983 to 1988 she was elected midwife member of the statutory body in Northern Ireland, the National Board for nursing in midwifery and health visiting. Together with the senior mid wife teacher, Rotunda Hospital, Dublin 1, she initiated the joint RCM – Irish Nurses Organisation Midwives Section Annual Professional Conference.

18. Ms. Hamilton examined the records in the case. She explained that the records showed that the plaintiff's third baby was a normal delivery of an OP position.

19. Ms. Hamilton explained the OP position in the following manner -

> Normally the foetus is flexed in the uterus, (the OA position), and that means that the normal position is occipitoanterior, and that is by far the most common position of a baby. The important point about this OA position is that when it happens, the diameter that distends the vulval Orpheus and the perineum is smaller. With the plaintiff, with an OP position, instead of the foetus flexing as it was pushed down through the birth canal, the foetal spine was straightened and the neck straightens so that although the presentation remains normal, which is a vortex presentation, the larger diameters go through the pelvis and at the time of delivery its a larger diameter which extends the vulva and the perineum.

20. There was no reference in the records to the position of the foetus in the few hours before delivery. She found a record of vaginal examination by midwife O.D. at 19:15 hours and at that time the plaintiff was assessed to be in labour. She found that the record did not state what was the cervix dilation.

21. While there was a record of the vertex presentation there was no record of the position. The notes made by the midwives at 20 hours was that the vertex presented, the FHHR (foetal heart heard and regular) and that the cervical os was dilated to 3 cm and there was no mention of the position. Ms. Hamilton said that it would be normal practice for the midwife at the beginning of labour to ascertain what the position of the foetus was by abdominal examination and later on in labour by vaginal examination.

22. Ms. Hamilton's view on the failure to carry out such an examination was that given that the plaintiff then had what is put down as a normal OP delivery, it is a serious omission in that the midwives then were not influenced by what was an important point to have discussed with the plaintiff and what was likely to happen at delivery. Ms. Hamilton referred to Myles Textbook for Midwives 12th ed. edited by and Ruth Bennett and Linda Kay Brown, p. 405 (hereinafter referred to as Myles) dealing with malposition of the occiput and malpresentations. The diagrams show aspects of the OP position and the photographs show a diagrammatically aided comparison of the abdominal contour in the OP and OA positions. Ms. Hamilton said that the dominant feature in diagnosis apart from inspection where one sees the dip in the abdomen is that the back is actually difficult to locate. Normally the midwife carries out a palpation on one side of the mothers uterus and then on the abdomen and then on the other side. Palpation is to find where the back is. It is usually felt easily enough on the one side. In the OP position the back is actually quite difficult to find because it is a way over at the side, or it may even be directly over the mother's spine, in which case the midwife cannot feel it. The dip in the abdomen is just below the umbilicus. Another feature is hearing the foetal heart and it is heard easiest away out on the flank rather than just down from the umbilicus. An experienced midwife would find these indicators of an OP position easy to detect. Less experienced midwives would be taught how to notice them. If a less experienced midwife was delivering a mother of a child she would expect an experienced midwife to be available in order to oversee the inexperienced midwife. Apart from abdominal examination for the purpose of ascertaining the position of the foetus, during labour vaginal examination would determine the position. The midwife would feel for the sagittal suture of the foetal head. If the head is well flexed, then she will trace her finger back and would then feel the posterior fontanelle, which is where there are three sutures meeting. If it is a posterior position, then because the head is straight, it is the anterior fontanelle that she feels at the front of the head where there it is diamond shape, and where there are four sutures going in. Ascertaining this is part of the basic midwifery in England, but it does take experience, and it has to be learned clinically, as opposed to just theory. Thus at the vaginal examination noted for twenty hours with a dilation of 3 cm the sagittal suture could be felt in this early labour. Later on it would be easier to feel more of the foetal head. There was no recording of the position of the foetal head and this, she claimed, was very unsatisfactory as it does influence how the midwife would carry out the delivery.

23. Ms. Hamilton noted that the records showed that full dilation of the cervical OS occurred at 21.25 hours and that the baby was delivered at 22.23 hours. And in this context stated that it is essential that the midwife conducts the second stage of labour on the basis of an acute observation, previous history and assessment of progress.

24. She described the second stage as when the cervical OS is fully dilated. That is at the 10 cm, in a normal labour, with a full term baby. It would be 10 cm because this allows the head then to come through into the lower birth passage. The second stage is from full dilation of the cervical OS until the delivery of the baby. She was of the view that a vaginal examination should have been performed by the midwife to confirm full dilation, diagnose the position and assess descent of the presenting part. This is because the midwife really must look at every individual case, and the requirements that are necessary at that time, including the mother, and the mother's choices. In this case there was reason to assess the position given that the mother had two previous episiotomies, and very importantly, that the last one had extended and a tear had developed as well, so that the cut had been developed further by a tear. The other important observation to make at this stage, is that a vaginal examination is the only way that one can absolutely confirm that the mother is in second stage. The other signs are presumptive that the mother is pushing, the vulva is gaping, the anus is gaping. The midwife should have been alerted that this was a perineum that was unlikely to stretch well. This was because of the scar tissue, but the situation was made worse by the larger diameter which was going to come through by reason of the OP position. Ms. Hamilton's examination of the records did not show any vaginal examination after twenty hours when the plaintiff was in the delivery ward. She was not certain as to whether there was one at the time of transfer to the delivery ward, although she noted that the plaintiff said in her evidence that she was examined and told by the midwife that cervical OS was 7 cm dilated. The records indicate no evidence of the position of the foetus and there is no evidence or records that the possibility of an episiotomy was discussed with the plaintiff. The reference to "OA" in the nursing notes refer to "on admission" rather than the OP position or otherwise.

25. Dealing with the outcomes of a case of an OP position, Ms. Hamilton said that one involves a long internal rotation where the head in fact will rotate back into the more normal position and the head actually flexes as it goes down so that the occiput reaches the pelvic floor first. The OP position can sometimes correct itself and this is most often the case. The other outcome which Ms. Hamilton postulated which appears to be the case involving the plaintiff, involves a short internal rotation which results in persistent OP position. In this situation Ms. Hamilton said that the sinciput reaches the pelvic floor and rotates forward and the occiput goes into the hollow of the sacrum. The significance of this arrangement is that the diameter then is larger. Ms. Hamilton said that it is well documented that there is more risk of perennial trauma with the occipital frontal diameter that is extending the perineum. Normally it is a sub-occipito frontal diameter which is 10 cm. In the OP position it is 11.5 cm. In obstetric terms this is a big difference, it tends to cause more distension of the perineum, the perineum is more likely to tear or rupture. It is a significant risk. The signs would be the way that the perineum is stretching, and the midwife is taught to observe the perineum as it is stretching and consider that a tear is likely to happen, and that an episiotomy would be more appropriate. Miss Hamilton referred to a number of observations which she had outlined in her report where she said it gives rise to signs that severe perineal tear is likely to occur, as follows:

> (a) A perineum that resists the pressure of the descending head and does not stretch.
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> (b) A long perineum, particularly if it lacks elasticity or is oedematous (swollen).
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> (c) A trickling of blood from the vagina when the head is on the perineum which is due to laceration of the vaginal mucosa on the inner surface of the perineum which usually tears before the perineal skin.
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> (d) When the perineum has a bluish appearance in the mid line which later becomes white, shiny and transparent.
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> (e) If the fourchette begins to tear before the head is crowned and extensive laceration can be anticipated. On rare occasions a perineal laceration may start at the centre of the perineum, so called button hole or central tear.

26. The midwife would be looking for all these signs but in addition in the plaintiff's case, she would also have the added problem of having had two previous episiotomies and there would have been quite a considerable amount of scar tissue which would not have been stretching well. As Miss Hamilton was not at the birth she said it would be difficult to say what warning signs would have presented in the plaintiff's case but it is likely that there would have been. Short of actually being there at the delivery, she could not really say. The fact that there was an ultrasound indicating an estimated foetal weight of 4.25 kg. indicated a big baby and this was a third risk factor in addition to the first of OP position and second of two previous episiotomies and a tear. In terms of the management of the delivery of the baby, there should have been a decision to carry out an elective episiotomy which should have been discussed with the plaintiff and there should have been a diagnosis of the position of the foetus.

27. She referred to p. 405 of Myles which is used extensively as a midwives' textbook and by students because it gives a lot more detail on aspects of pregnancy and labour, and obstetricians also use it. On p. 409, under the heading 'Management of Delivery' it says:

> *"Due to the larger presenting diameters, perineal trauma is common and the midwife should watch for signs of rupture in the centre of the perineum 'button hole' tear, an episiotomy may be required."*

28. At p. 410, under the heading 'Maternal Trauma', it is stated:

> *"Forceps delivery may result in perineal bruising and trauma. Delivery of a foetus in the (OP) position, particularly if previously undiagnosed, may cause a third degree tear."*

29. Miss Hamilton said that these observations are such that a midwife would be aware of an OP position as a possible cause of a third degree tear. It is very significant that the plaintiff had two previous episiotomies because of the scarring and the fact of that itself would lead to a possible tear. Miss Hamilton said that, in view of the three risk factors she had referred to, a mediolateral episiotomy should have been carried out as opposed to a median episiotomy. In conclusion, Miss Hamilton said that she believed that the midwife did not act within a normal standard of care, given that there were three risk factors. Particularly the OP position and the previous episiotomies should have meant that she would have elected to do an episiotomy to reduce the risk of severe perineal trauma.

Cross Examination of Gertrude Hamilton

30. In cross-examination, when challenged about her experience of actually delivering babies, Miss Hamilton said that she last delivered a baby in Belfast about 30 years ago and that since then her role was that of a supervisor or a teacher and that she retired in 1992. Up to the date of her retirement she was required to do a statutory five-year refresher course in midwifery. She had prepared her report without speaking to the plaintiff, from the records and from other contributors to the medical reports for the solicitors, and her knowledge as a midwife and that her teaching experience in giving professional advice was equally as important in compiling her report. She also sought guidance from Myles. Miss Hamilton familiarised herself with the articles referred to in Myles and focussed in particular from the period when routine episiotomies came to be questioned in about 1982 up to the date of the birth of the plaintiff's third child. She noted the evidence that there was a lot of pain in the labour and blood from biting the lips of the plaintiff, and agreed that it can happen that the mother may not be able to give the level of co-operation that the midwife would hope for in terms of working as a team to ensure the successful birth, but that inability to co-operate is rare. The midwife monitors the wellbeing of the foetus and the progress towards delivery as well as the mother's condition. She would be particularly concerned with any delay in delivery and if there was a delay in delivery that might well manifest itself through foetal distress, through checking the foetal heart, and in the plaintiff's records there was no concern about the foetal condition. From the record of the heartbeat and liquor Miss Hamilton agreed that the baby was not in distress. Tears are not unusual and can happen very quickly but the midwife's job is to observe the perineum as the head is descending. In the plaintiff's case the second stage was 27 minutes from the beginning of the second stage to the delivery of the baby, so that suggested to Miss Hamilton that there was time for the midwife to adequately observe the perineum. She said that of course, the vital time is when the head is actually crowning and the pressure is put on the perineum. A tear will start as a small tear and if the midwife feels it necessary, she can act and prevent or limit the extent of the tear. She said that warning signs would show insofar as the skin might start to tear, which is a first degree tear and the midwife can decide then that an episiotomy should be done. In the plaintiff's case there were indications, because of her previous history, that the midwife could elect to do an episiotomy. It all happens in a short time, but it is part of her function, as the midwife, to do it.

31. The midwife watches very carefully, and then, observes the perineum, if it is thinning out, how it is distending, and makes a clinical judgment on what she needs to do, or not, at that time, and, she is also controlling the head. When it was put to her that the defendant would have to disagree with her that if a tear occurs in that way that a midwife can intervene at that stage and perform

an episiotomy, she said that if a very minor tear occurs then the midwife can interfere. She can start then to decide. It is not cut and dried, she has to go along with what is happening at the time, but if she ignores the warning signs, then the danger is severe perineal trauma, - not a small tear. When put to her that, notwithstanding monitoring of progress of infant and mother, tears will and do occur, and they do occur to the extent of third degree, she said that it was very rare for a third degree tear. She clarified that tears, of course, do occur.

32. She asserted that the occurrence of a third degree connoted a want of care by the midwife, but when pressed in relation to that proposition she resiled from it to the extent that she said that each case depended on its facts, and that she was here to deal with the plaintiff's case. She did not teach her students such a proposition, but that it was the midwife's role to carefully observe the perineum. She agreed that the weight of the plaintiff of 17 stone 3 pound on presentation on 8th July, 1994, suggested that an abdominal examination would be more difficult for such a large lady, because the midwife is feeling through the abdomen. In labour, the vaginal examination would be more helpful. She agreed that when the vaginal examination was performed at 20.00 hrs. when dilation was 3 cm there was a limited amount of information it could give. It would be a lot more difficult at 3 cm stage, to diagnose the position, although in early labour, the sagittal suture can be felt. Generally an early labour because of difficulties of recognition of the head structures, the midwife would rely on her abdominal examination, and, later in labour the vaginal examination is useful- it's not a question of one or the other. When it was further put to Mrs. Hamilton that it would be extremely difficult to get any reliable information from an abdominal examination she accepted that it would be more difficult, but wouldn't accept that it was impossible. She also believed that if it was difficult, it should have been noted. This is because her concern was that there is no reference to the position of the foetus in the plaintiff's case when she was admitted for induction of labour. She said that while there was a note of full dilation at 21.55 hrs. there was no note of any vaginal examination. Without a vaginal examination a judgment as to full dilation is assumptive only, based on the way in which the mother is acting, the desire to push, the gaping of the vulva and the anus, and sometimes, even the head being visible. It was put to her that the midwife in this case would say that the note of full dilation was made in foot of a vaginal examinations. It was put to her also that a vaginal examination would be of limited use even at full dilation in terms of diagnosis of the OP position. She admitted that she omitted to include in her report references to possible difficulties presented by caput succedaneum, (herein after referred to as caput) on the head frustrating the discovery of the position of the saggital suture and other indicators on the head. She explained that this caput or swelling is mostly associated with protracted labour and as this was a short labour she considered that it probably was not a factor in the case. But she said that in circumstances where the fontanelle and sutures really can't be felt the pinna of the ear may be identified. She was not saying that these are easy things to do. But she would expect an experienced midwife to do it. There will always be caput because there is always moulding, but the question is how much this would mask. An excessive caput can mean that the baby is not descending properly and would indicate that a doctor should be requested. In a short labour there would be some caput and certainly an inexperienced midwife may have difficulty. An experienced midwife would be able to carry out the vaginal examination more accurately. She agreed that there was no delay either in the first stage or the second stage or labour, and it was put to her that the information would in fact contra indicate an OP position. She agreed that the text books would say that with the OP position the labour tends to be delayed, but mothers are not textbooks and a delay in labour is not always present. Such delay would be more noticeable with a mother with a first baby. She agreed that on p. 409 Myles stated in relation to diagnosis that "descent is slow". She agreed that not all OP positions are diagnosed and a midwife can find herself doing a facetebepubis having not diagnosed OP. It is unusual but it does happen in relation to a change in practice concerning a episiotomy from the early 1980's. She said that while midwifes can take account of research findings, they still have to make the clinical judgments at the time of delivery. There are conflicting research findings as to whether an episiotomy protects the perineum. An episiotomy carries with it its own danger of infection as does a tear and it is not a guarantee against a tear. When it was put to her that an episiotomy itself can go on to tear, she agreed and stated that in fact it did so with the plaintiff's previous delivery, and that itself should have alerted the midwives to the possibility of severe perennial trauma at this delivery of her third child. An episiotomy does not necessarily prevent a third degree tear but its strongly protects the perineum and reduces the risk of a third degree tear. The medio lateral episiotomy directs a tear away from the anal sphincter, although if there is a massive perennial trauma then the anal sphincter could still be torn, but it reduces the risk of that considerably. That is the main reason for doing it. A midwife is taught that it is a very serious matter indeed to have a mother's anal sphincter torn at the end of the delivery, because it is a difficult condition for doctor's to deal with subsequently. Everything is aimed at reducing the risk of a third degree tear.

33. She acknowledged that in the last decades, since she had been actually practicing as a midwife in Belfast up to 1972, there had been a significantly different approach which might have been called more conservative or cautious approach to the performance of episiotomy. She acknowledged that there was a study in the Rotunda Hospital in relation to routine episiotomy in Ireland in 1984 but that clinical study did not negate the necessity to use clinical judgment and that for her the outstanding feature was that there were three risk factors. She added that there was research done in Holland over 1994 and 1995 involving 284,783 vaginal deliveries. The results of the study were published in an article entitled "risk factors for third degree perennial ruptures during delivery by J. W. Leeuvw, P.C. Struijk, M.E. Vierhote, H.C.S. Wallenberg (hereinafter referred to as the Wallenberg Study) and she referred to the summary of the conclusion in the head note to the article on page 62 A as follows:

> "Medialateral episiotomy protects strongly against the occurrence of third degree perennial ruptures and may thus serve as a primary method of prevention of faecal incontinence"

34. It was put to her that the West Berkshire rupture study conducted in 1984 provided little support either for the liberal use of episiotomy or for claims the reduced use of the operation decreases post partum morbidity. She said she was not talking about routine episiotomy as envisaged by the West Berkshire study in the case of the plaintiff. She acknowledged that an episiotomy is more likely in the mother having her first baby. That is because the tissue has not been stretched before. When it was put to her that it was not possible to be definite in relation to prediction of a tear and that it was a question of monitoring the situation Ms. Hamilton agreed.

35. Despite the scan predicting that it was going to be a big baby the baby that in fact was delivered was not particularly big and they don't know that until it has happened. The monitoring record of the labour showed there was good progress and no indication of stress. If you are concerned about stress then an episiotomy would be considered appropriate. She would not accept that the tear in this case was simply unavoidable. She agreed that while it may not be possible to perform an episiotomy because of the progress of events and in a multiparous patient the second stage can be very quick, but in the plaintiff's case, it was not. Failing episiotomy there must have been warning signs that the perineum was not stretching well. It sometimes happens that nowtihstanding the attention of the midwife you can get a perennial trauma to the extent of third degree tear, but it can mean that there has been mismanagement. It was put to Ms. Hamilton that 40% of mothers in the Coombe have episiotomys having their first baby, but of those having their second only 10% have episiotomys.

Mr. Pearson's Evidence

36. Mr. James Francis Pearson an obstetrician gave evidence. He qualified in medicine in 1960 and in 1963 took a diploma in obstetrics. In 1965 he became a member of the Royal College and in 1978 he became a fellow of the Royal College of Obstetricians.

He has recorded a number of distinctions and prizes. In 1977 he was a distinguished lecturer in the Rotunda hospital in Dublin. In 1980 he took up a readership at the University of Wales and retired from that in 1999. He was appointed as honoury consultant in obstetrics and gynaecology in South Glamorgan which is the University of Wales hospital. He practiced obstetrics during that time and he had a special interest in foetal monitoring and obstetric anaesthesia. These specialties have a bearing on this case insofar as he wrote several papers on the various mechanisms of labour and studies thereof. He remains an examiner of the Royal College of obstetrics and gynaecology. He wrote a report on the plaintiff's case in 1997 having received the documentation and records in relation to the prenatal care admission and labour. In evidence he explained these records in detail. He described the OP position and confirmed that this presents a much larger diameter to dilate the vulva, and said that it was a common cause of tearing as a result of this. The obstetric notes in general are scant, a vaginal examination is not described in great detail, for instance, the descent of the head through the pelvis is not noted which would normally be the case, if the midwives had known about the OP position they would have done something to minimise the foreseeable damage such as a tear. He dealt with the question of procedures, and noted the implementation of the protocol for the after treatment of third degree tears. He wasn't in a position to say whether the anal canal was torn and confirmed that the notes indicated that the sphincter was torn.

37. In relation to the problems associated with the OP position he referred to p. 384 of Myles as follows:

> "The long OP frontal diameter causes considerable dilation of the anus and gaping of the vagina whilst the foetal head is barely visible and the broad by parietal diameter of the head distends the perineum and may cause extensive bulging of the perineal tissues."

38. This description merely expands upon the fact that an OP is associated with larger presenting diameters, he referred further to Myles as follows:

> "Due to the large presenting diameters, perennial trauma is common and the midwife should watch for signs of rupture in the centre of the perineum (buttonhole)."

39. If you get a buttonhole tear this is a very late sign and in his opinion was the developments should never have got that far. The next thing that may happen is that the buttonhole tear will extend in both directions and disrupt perineum. This buttonhole starts from the middle rather than from the edge of the perineum. The majority of OP positions that present as such, may rotate during the course of labour. They will either rotate to a transverse position or may rotate to an interior position and the problem is gone but a small proportion of them, maybe about 15%, will make the short rotation come to lie in OP at delivery. When it is present at delivery it is known as persistent OP (POP). As the birth was recorded as OP by definition it can be said that the position was POP.

40. Those who are faced with the notes have no better way of judging foetal weight than the estimate made on ultra sound even with its imperfections of an error plus or minus 10%. This means at 50% of the time the actual weight of the baby could be 0.4 grams heavier than the 4.25 kilograms estimated in the ultra sound scan prior to birth. He referred to "Bisher Obstetrics On the Newborn" in relation to management at the POP "There are a number of options available depending on the abnormality present. Posterior rotation has occurred (but……..), and this is best managed by wide episiotomy perhaps aided by forceps of vacuum extraction, wide means wide of the medial lien of the anal sphincter".

41. He referred to Hibbard on "the principles of obstetrics" chapter 3 page 541 referring to the problem

> "the second stage of labour is likely to be longer than average. The otiput exerts considerable pressure on the perineum and when the head has reached the outlet a generous episiotomy is indicated to avoid undue delay and unnecessary perennial trauma."

42. Mr. Pearson confirmed that there isn't a standard text book that does not emphasise the danger of pereneal trauma in the POP. Vaginal examinations were performed at three cm and 10 cm dilation, although neither of them were written up in any detail, but were plotted on the diagram. Recounting the plaintiff's evidence in relation to the midwife seeking to widen the cervix and pushing constantly, he stated that apart from the undesirable nature of this practice, in any event the midwife had time enough to observe some of the premonitory features of an OP, one of which is a tendency for the patient to experience bearing down just before the cervical dilation, because of the pressure being exerted by the malpresenting head on the rectum. When a woman tries to bear down before she is fully dilated, the thing to do is to try and encourage her not to bear down. Various manoeuvres are tried to prevent the premature bearing down on the undilated cervix, which will cause structural damage if persisted with. However, such premonitory findings if not made would not be the fault of a midwife.

43. Although it is unlikely that the midwife stayed with her hand in the vagina to try to stretch the cervix for an hour, she must have had ample time to identify the bony land marks on the foetal head and to make an accurate diagnosis of the foetal presentation at 3 cm any midwife could not be criticised for missing an OP. However at full dilation or nearly full dilation a midwife should, in the absence of anything that might obscure the diagnosis, feel the fontanelles and be able to make a positive diagnosis, especially in a situation where the labour was brief. The second stage was relatively short and there hadn't been time for the swelling of the caput to accumulate, which is normally a feature of prolonged labour. So, it is unlikely, on the balance of probabilities, that the bony landmarks would have been obscured, and should have been readily appreciated at 10 cm dilation by the examining midwife.

44. There is nothing in the notes to say that there had been difficulty in identifying the position of the foetus. In such a situation one expects the midwife or obstetrician to write "caput" or "query OP" or something alike where there has been difficulty. The problem with the notes here is that it only records cervical dilation which doesn't record anything else. It doesn't record station, it doesn't record position, absence or presence of cap or moulding. It simply records cervical dilation these are omissions from the notes from which Mr Pearson could gain no information. Mr. Pearson concludes from the notes and his consideration of the case, that the OP position was not diagnosed by the midwife, and it took her by surprise. At the 10 cm dilation the examiner won't feel any cervix at all as the cervix has virtually disappeared. The uterine cavity is in perfect continuity with the vagina so there is no cervix to feel. At that stage by examination with two fingers the midwife can feel a hemisphere being the baby's head.

45. Full dilation (10 cm) is often diagnosed by midwives without recourse to a vaginal examination. The suggestion of Mr. Pearson was that the 10 cm entry was not the result of a pelvic examination but was simply signifying "full dilation" using the so called external signs of full dilation – these are as follows:

1. Urge to bear down

2. Visible presenting part

3. Anal dilation

46. When these signs are present it means that the head is down on the pelvic floor, the only bar to delivery being the perineal body.

47. In the event, it took 27 minutes from full dilation to delivery. The head should not be left on the perineum for this length of time in a multiparous woman (who should deliver quite quickly) without evaluating for calls. This would be by palpation of the foetal head, which should lead to the diagnosis of an OP position, which, in turn, would mandate an episiotomy to avoid perineum rupture. There is no indication to rotate the head when the baby is coming in an OP position, and it should be delivered either spontaneously, or, with low forceps, and of course, if using a forceps, one always does an episiotomy anyway.

48. He said that as the plaintiff already had two episiotomy's, presumably to avoid perennial tearing in her previous pregnancies, it would seem to have been prudent to plan an elective episiotomy in the present case, knowing this baby was likely to have been even larger than her two previous babies, having regard to the antenatal weight foetal weight prediction of over 4 kilograms. Even if there wasn't an OP, the prediction would have been that two previous episiotomy's together with a predicted 4.2 kilograms more or less would mandate an episiotomy. There was no virtue in not doing an episiotomy, he referred to the Sleep paper on the West Berkshire study regarding the effectiveness of episiotomys in saving perineal trauma. He stated that the situation remained controversial until relatively recently when the Dutch (Wallenberg) study, when with larger enough numbers have been reported showing that episiotomy had a powerful significant protective effect against severe perennial trauma. He conceded that the Sleep paper was published in the eminent British medical journal which had a wide circulation, and people started applying the lessons in it very quickly. The paper was published in 1984 but the plaintiff's first baby was born a year later. She had an episiotomy, and then the next baby was born in 1991. When this sort of attitude towards episiotomy was in full swing and she had an episiotomy? So Sleep doesn't appear to have greatly influenced the practice of midwifery at the national maternity hospital with respect to the plaintiff's case. These episiotomy's were done in Mr. Pearson's belief when the midwives felt that the perineum was about to go. The results of the Dutch (Wallenberg) study were not known at the time of the delivery of the plaintiff in this case. Mr. Pearson had dealt with the Wallenberg article and the factors referred to in it, which point to the benefit of episiotomy in preventing pereneal damage, and refers to the editor's note accompanying the article as follows:

> "The magnitude of the protective effect is so great that it is likely that an episiotomy really does protect against third degree tear. The authors suggest that the randomised trial was too small to detect the protection offered by episiotomy and … probably the only change in practice is to consider a policy of episiotomy in women of a large infant and a long second stage of labour for delivery spontaneously."

49. Mr. Pearson added that of course the question of OP stills hold good and the OP is an additive factor to be taken with these conclusions.

50. Mr. Patrick O'Connell consultant colon rectal surgeon gave evidence of the manner in which the repair of the torn perineum and sphincter had been carried out. He confirmed that he ws making no criticism of the repair in the defendant hospital. The plaintiff presented to him when the repair had been done with a serious alteration in her continence of faeces. He explained that at first he took a conservative approach towards treatment and explained that one would look towards restoring continence in a number of ways, one of which is restoring the integrity of the sphincter itself. Secondly, is trying to optimise the function of the sphincter as one finds it. Thirdly is to modify bowel habit so that whatever the condition of the sphincter the continence outcome might be better. When she was referred to Mr. O'Connell, he had a description of her condition from Dr. Donnelly who had treated her. After a period of some months in his care, he decided that the plaintiff would need surgery which was carried around Easter of 1995.

51. This surgery involved the performance of a standard repair by opening the perineum, identifying the sphincter, repairing laxity of the vaginal wall by repair of the rectocele. Having identified the two ends of the sphincter and excised some scar tissue which was between the ends of the sphincter he then overlapped in the manner that was described by Alan Parks in his so called "Parks anal sphincter repair". Both anatomically and functionally there was initially a good result. There is a scoring system called the pescatori which scores features of continence and come to a grading of continence in that regard. For instance zero would be perfect continence and 20 would be daily gross incontinence. Whereas the plaintiff had been 20 out of 20 on that score she went back to 8 out of 20. This improvement continued for some time but then monitoring of the plaintiff showed that between 1997 and 2000 things began to disimprove to the point where Mr. O'Connell thought a more radical approach would be required. In October, 2000 he advised her that she might have to have a colostomy and this was carried out in 2001. It was a necessary procedure by virtue of the symptoms that the plaintiff was describing. Her life had become dominated by this and she was de facto housebound by her incontinence. The best alternative deemed at the time, was to offer her a colostomy.

52. At the time of his last consultation with the plaintiff, prior to the hearing, Mr. O'Connell said that the plaintiff seemed very content with the functional outcome and her quality of life had improved because of that. Under cross-examination he agreed that the plaintiff suffered damage to the duodenal nerve, and while this is caused by child birth he conceded that the damage to this nerve is caused by the foetal head during the later stages of pregnancy, but does not relate to the conduct of actual birth. He said that the plaintiff probably will have a colostomy for life, and that he is aware that she has had some ongoing pain and soreness associated with the connection of a colostomy appliance.

53. Professor John Monson, Colo-Rectal surgeon, gave evidence describing aspects of foetal incontinence, although he did not examine the plaintiff. He said that foetal incontinence is a condition that represents a spectrum of severity from minor incontinence to very major incontinence. For patients who have major foetal incontinence – that is unintentional leakage of gas, liquid or solid faeces – it is an absolute catastrophe in their life. In many instances, women describe it as destroying their life. These individuals frequently become not virtually but absolutely housebound. They become so socially incapacitated that all forms of social, interaction cease further. It usually expresses an extreme strain on the home life in terms of marital and sexual relations, which are damaged, if not destroyed. It is a benign, and, in one sense, non life threatening condition, which has almost a greater effect on the quality of life than any other condition one could mention. It is worst in young women who might be considered to be in the prime of their life. It frequently happens suddenly and without warning. His opinion was that it was a perfectly reasonable option for the plaintiff to have a colostomy carried out by a Mr. O'Connell. The treatment options for patients with persisting sever and foetal incontinence are difficult, to say the least, with uncertain and generally not very good outcomes. One always has to listen carefully to the views of the patient, as to how much their incontinence is disabling them, and to what extent they have reached a stage, where they are willing to accept a colostomy. This is because colostomy is not a trivial step and has very significant long term consequences. Mr. O'Connell and the plaintiff may have come to that opinion and he had no criticism of that opinion.

54. The ulceration problem described by the plaintiff around the stoma for the colostomy bag is quite common, given the incidence of skin related complications, following stoma formation. In a colostomy the incidence tends to be relatively low but not uncommon. For example in many large units in comprehensive stoma care services they will give a rate of approximately 10 to 15% of patients who

have some difficulty with stoma appliances. So, it is not uncommon there are risks associated with colostomy recognised in the literature, these include issues such as prolapse of the stoma where the bowel falls outside the abdominal wall, retraction of the stoma, where the opposite happens. Instead of the stoma being on the surface it disappears back in. a narrowing of the outlet of the stoma, otherwise known as stenoisis, where scar tissue usually narrows down the opening; herneation around the stoma, so called parastomal hernia, where as a result of the persons stoma in the abdominal wall the abdominal wall musculature becomes weaker and the plaintiffs develops hernia beside the stoma. It was Professor Mason's opinion supported by his experience and the literature that both the abnormality of the plaintiffs pudental nerve and the muscle injury of the sphincter, were both factors making a contribution to the loss of the continence following a sphincter injury, but the vast majority of the loss of continence comes from the muscle injury rather than the potential nerve injury. The aetiology of pudental nerve injury is multifactorial and, at best, poorly understood and its impact on continence is a mater of some dispute internationally, whereas the impact of a third degree tear on continence and muscle sphincter is a matter of considerably less dispute and, therefore, in his opinion, unquestionably the overwhelming cause of the incontinence.

55. Under cross-examination he admitted that the conduct of labour, of itself does not influence damage of the pudental nerve, but that pudental nerve damage can be interdependent with muscle tearing.

56. Mr. Kelly the plaintiff's husband gave evidence that they were married in 1984 and that he was a Logistics Manager. His company was going through a transition and there was an offer of voluntary redundancy which he availed of to give him flexibility of time to be able to look after the plaintiff and the children. He took up taxi driving. He described the plaintiff's disabilities in terms of routine domestic activities and socialising. While the plaintiff was brave, her humour could deteriorate from time to time.

57. He gave evidence of additional tasks taken on by him in the home. He said that the plaintiff had ceased employment to look after the children but that her plan was to return to work when Eoin went to school.

58. Ms. Coughlan a Rehabilitation Consultant gave evidence of what the plaintiff might have achieved had she returned to work without her injuries. She could have worked anything between 20 and 30 hours per week and the rates of pay would be in the region of 6, 7 to 8 euro per hour in the retail sales industry and after four years could go up to 10.04 per hour. With her injuries she could be encouraged to seek support from FAS, who have taken over from the National Rehabilitation Board, to activate a rehabilitation plan that could eventually lead to some form of niche, or part time employment, further down the road. While it would be good for her to get involved in some type of rehabilation programme and employment, getting back into the workforce will be a transition in which the plaintiff will face serious problems. Her best hope of a job would be in a niche retail job in a small shop, where she is familiar with the people and feels comfortable with them. She would have to have access to a bathroom and not be put under pressure to work on her own without assistance part-time hours in the morning would suit her when there isn't a rush or perhaps filling in for people when they have gone off on breaks and the like. In any event the plaintiff would want to be fairly selective about the environment she works in. She agreed that if the plaintiff recovered her confidence then her employment prospects would improve and the likelihood of her taking up part-time employment would become all the more probable.

59. Dr. Quigley the plaintiff's General Practitioner gave evidence that while the plaintiff had some bladder incontinence prior to 1994 it had been effectively repaired in 1995. He described the plaintiff as a very jolly, resilient person and not the complaining type. He outlined the problems the plaintiff had up to the time of her colostomy and said that he counselled her favourably about the colostomy. He agreed that the plaintiff had a very positive response towards the colostomy. He said that there are ulcerations on her body as a result of the colostomy and they are difficult to clear up because the bag is there at all times. While hopefully this complaint will clear up the chances of it being permanent are reasonably high. As well as attending her GP, the plaintiff attended the hospital on a regular basis to have the stoma and a variety of subjects dealt with. This treatment may include physiotherapy and a nurse visits her regularly to check that everything is ok. He didn't think that it was an option to have the colostomy reversed in the plaintiff's case. It is an ongoing hindrance and inconvenience 24 hours a day requiring constant checking and management sometimes it requires changing twice a day. It involves smells and odours and the plaintiff has to be extremely careful to use strong deodorants and that sort of thing.

60. Under cross-examination he agreed that the plaintiff was jolly and coped well and that until the colostomy in 1994 the only treatment was the administration of immodium to improve bowel movement. Immodium could be obtained over the counter rather than by prescription. He agreed that the plaintiff was very happy with the colostomy that she considered herself no longer to be housebound, that she was able to go to McDonalds with the children and do the normal things that a mother with a young family would do.

61. Dr. Valerie Donnelly gave evidence that she was Registrar in Holles Street Hospital when the plaintiff was admitted on 8th July 1994. She didn't think that she saw her during her admission, and her first dealings with her, so far as she was aware were on the 18th August after she had the baby. She said she had been involved in research into perineal damage, damage to the bladder or anal canal. It was some pioneering work that was being done in the hospital. Her role included seeing all women after delivery who had problems in that area. So she would have seen the plaintiff for what would be called a post natal visit. She consulted her in relation to urinary and faecal incontinence. The urinary incontinence was dealt with by Dr. Keane in Holles Street in October 1995 and as a result of the witnesses referral the plaintiff was operated upon by Mr. O'Connell in the Mater Hospital in April 1995. She said that there was some improvement in the plaintiff's faecal incontinence for a time. She also sent her for physiotherapy in the Rotunda Hospital in relation to the faecal problem. The plaintiff telephoned her after Mr. O'Connell's operation in April 1995 and informed her that things had disimproved, but she didn't see her as she had moved to a different department for training in the hospital, and she was aware that Dr. Michelle Vines followed on in the treatment of the plaintiff from her. Dr. Donnelly is now a consultant obstetrician gynaecologist in full-time private practice in Mount Carmel Hospital in Dublin.

62 Under cross-examination she confirmed that she had researched the role of episiotomy and the likely benefits or disadvantages of same in the delivery of babies and wrote an MD thesis on related aspects as well as episiotomy. Dr. Donnelly confirmed that notwithstanding considerable care on the part of the midwife, one can suffer a tear even to the extent of a third degree tear. Diagnosis of the OP may be quite difficult at times, especially if there is a lot of moulding or caput on the baby. The large mother puts limits on the likely information to be obtained from an abdominal examination. The vaginal examination at 3cm dilation is unlikely to offer very much useful information concerning the position of the baby. Caput making diagnosis of the OP position may occur in a diagnosed short labour.

63. She said that from all the evidence, which she had reviewed from the beginning of evidence based on obstetrics to at least what was known at the time she completed her MD in 1997, her opinion was that an episiotomy provides no protection for a third degree tear. She outlined serious risks to the mother of an episiotomy. She said that there was no evidence to support the proposition by Mr. Pearson, Consultant Obstetrician, that where an POP is diagnosed an episiotomy is mandatory. The foetal weight of 4.25 kilograms diagnosed by the ultra sound scan was not a large baby by modern standards and there are many babies now weighing up to 4.5, 4.6

kilograms.

64. She said there was no significance in the previous episiotomies of the plaintiff carried out in relation to babies weighing 3.14 kilograms and 3.96 kilograms.

65. Notwithstanding that Dr. Donnelly said that the scar tissues from the previous episiotomies would have been tight and wouldn't "give", an episiotomy would make no difference. She thought that the outcome would not be any different if an episiotomy had been performed other than that associated with allowing the mother to tear. OP occurs in about 7% of vaginal deliveries, sometimes in quick deliveries an OP not diagnosed in multiparous mothers. Women who have a precipitous labour and delivery are much more likely to have a third degree tear. This reflects absolutely nothing on the midwife. The information on the partogram of the plaintiff does not suggest an OP and Dr. Donnelly would certainly have been surprised that the way labour went so quickly. There is nothing in the literature to be found which will state that the unfortunate of risk of a tear in a precipitous labour can be prevented as yet. If a tear occurs in a multiparous woman who has had previous episiotomies the usual area that gives is that which has been previously cut (the scar tissue).

66. She said that she was certainly aware that there is a school of thought that where, if one has an episiotomy, one should have recurrent episiotomies thereafter. The literature shows the instances of episiotomy on a first time mother is much higher than on subsequent babies. It would be quite rare to perform an episiotomy on a third time in her experience.

67. Dr. Donnelly referred to her MD thesis. In one of the chapters which deals with world literature supporting or not supporting the routine of episiotomy. Dr. Donnelly pointed out that she had never seen a study looking at a case such as the plaintiff's where there were two previous episiotomies and an OP. She had no idea from whence Mr. Pearson had come to the conclusion that the three indicators dictated an episiotomy. She said that the only instance where an episiotomy should occur is where the baby's head is held up in delivery so that the head is freed solely in the interest of the survival of the baby.

68. She referred again to the school of thought that once an episiotomy had been performed that episiotomies should be preformed in the future. She said that from the early 1990s that was no longer considered the case, after some studies had been done on the subject. Since the early 1990s the role of episiotomy has become less and less crucial. Prior to that there would have been some units who would almost have had a 100% episiotomy rate for everybody, and now it is down in most units to about 10 – 15%, and, episiotomies are only performed when absolutely necessary . Dr. Donnelly said that she is in a different school of thought on episiotomy to this school of recurrent episiotomy. She is in a school of thought based on the evidence available and which says that it not necessary to do recurrent episiotomies. While Dr. Donnelly was not really sure of the practice in the small maternity units in Ireland most of the bigger units such as Cork, Galway, Dublin and Limerick are striving to reduce their episiotomy rate to as low as they possibly can.

69. On re-examination Dr. Donnelly clarified the purposes of examination at full dilation stage and said that very often an OP presentation at this stage may rotate. She described the developing stages of labour and their indications up to the crowning of the head. She said when an episiotomy is to be performed it is performed when the head is crowned. Examinations in labour are kept to a minimum as there is a risk of infection. She said that the broader skull presenting in the OP position is more critical than the second stage of labour because the bony pelvis cannot accommodate the shape of the baby's head or may not be able to accommodate it. In the final stage of labour the baby is way beyond the bony pelvis, and now at the perineum. At this stage it is correct to say that the posterior aspect is somewhat broader. Very often OP babies require a forceps delivery, because they don't descend and those who have a forceps delivery have an increased risk of a third degree tear. Dr. Donnelly did not know of any study which looked at an OP position for a baby who has a normal delivery. She said that because OP occurs in 7% of women and third degree tears in multipars occur in 0.6%. It is almost impossible to study that situation because we are studying an incident of 7% of 0.6%. She dealt with various studies referred to in her thesis and said that as the Wallenberg study was published in 2001 she would not have agreed with it in 1997. The Wallenberg study points to strong protection of mediolateral episiotomy against the occurrence of third degree perineal rupture, and the possibility that it might thus serve as a primary method of faecal incontinence. The Wallenberg study was based on a large Dutch population and dealt with routine episiotomy. A scar on the perineum indicates that there was either a tear or an episiotomy and Dr. Donnelly indicated that two scars indicating episiotomies on a woman would not mean anything to the midwife unless the midwife herself had delivered the two other babies concerned. Dr. Donnelly conceded however, that she would enquire if a woman presented with two previous episiotomies scars, she would discuss her thoughts on episiotomy and the reasons why she had such a procedure. Having a big nine pound baby in relation to the previous episiotomy is not significant. If Dr. Donnelly was presented with a delivery where an old episiotomy scar was beginning to tear, she would let it tear, as there was always a chance that it would not tear and stitching would be avoided. The plaintiff had two previous deliveries without a third degree tear. She was very very unfortunate to have one in her third baby. Dr. Donnelly was not in a position to know the extent to which Myles Textbook for Midwives would have been used as a means of instructing trainee midwives. The procedure to be observed from the emergence of the sinciput under the sympthysis pubis as stated on p. 409 in Myles Textbook for Midwives 1993 edition was referred to and she said that that was the opinion of the authors of the book, only, and that she was not too sure what they actually based it on. She accepted the perineal trauma is more common with an OP. She provided midwifery services for all births in Mount Carmel, and Dr. Donnelly, rather than the midwife, performed any episiotomy which was required.

70. Ms. Marian O'Neill gave evidence that she practices as a midwife in the National Maternity Hospital having completed her midwifery training in 1980 she went to Holles Street in 1983, worked for a year in the post natal ward, and in 1984 went to work in the labour and delivery unit. She was one of the midwives who was part of the management of the plaintiff in the delivery.

71. Prior to the arrival of the plaintiff in the delivery suite Sister O'Neill had no contact with her.

72. She had no recollection of meeting the plaintiff, but explained that her role with the plaintiff as the midwife in charge would be to do the initial examination on the plaintiff. She would meet the plaintiff and whoever is with her and assess her. She looked at the delivery record on which she said she had made a note at 20.00 hours "VE" – an abbreviation for vaginal examination; "VX" – an abbreviation for "vertex" and "PRES" – an abbreviation for "presentation". The cervix was three centimetres dilated, the amniotic fluid that was draining was clear liquor. "FHRR" – "foetal heart heard and regular". Just above she had written a note "ARM" – "artificial ruptured membranes" which was the induction of labour. The reason that such rupture was performed earlier in the day was because the plaintiff was overdue, post date. Her description of her role after 8 p.m. was as follows:-

> "a student midwife would have been allocated to take care of this lady in labour, I would have been supervising her care. She would come to me and tell me if there was any problem with anything, if she was worried about anything. It would be her responsibility to check the foetal heart rate every 15 minutes and if she observed any abnormality she would tell me immediately".

73. There is no record that her attention or assistance sought at any stage. She had been in attendance during the hearing and heard the evidence to date. At three centimetres dilation it is impossible to ascertain the position, but the most important thing she would want to discover at that stage is that it is the baby's head that is presenting that it is the vertex or crown of the head that is presenting.

74. While the OP would be an observation she would try to make when she would do the examination, it wouldn't have any bearing on the management of the lady in labour. A midwife will only anticipate the normal, and only when there are signs of anything being abnormal will she report it to the medical team or try to make further investigations herself. A partogram of the plaintiff showed that progress of the labour was very good: it was a fast labour.

75. In regard to the influence of the previous episiotomies of the plaintiff on the management of labour Sister O'Neill said that it wouldn't change the management of labour. The midwife will only make the decision about whether or not to do an episiotomy when the baby's head is stretching the perineum, that decision cannot be made during labour. The ultrasound result indicating a weight of 4.25 kilograms would not have changed the management of labour. The midwifery team would wait for normal progress to take place.

76. When the cervix is dilated the usual finding would be that the baby's head is in the mid cavity of the pelvis. The head may have to travel as far as 5 or 7 centimetres before it reaches the perineum. That is what is happening during the 27 minutes that the mother is pushing. In the early part, when the mother is moving the baby's head during the contraction, it is still receding back to its original position between contractions.

77. A large percentage of mothers will have some degree of tearing during a vaginal delivery. The midwife expects this.

78. One of the specific things the midwife will be doing is trying to control the speed of the delivery of the baby's head over the perineum. At the stage the baby's head has reached the perineum the mother's contractions are very strong. The midwife tries to get the mother to pant through the contraction, when the baby's head is coming over the perineum, because if she pushes the perineum can rupture. But sometimes it is beyond the mother's control, and she does push despite her best efforts. In that situation there is a strong possibility that the perineum will tear. The midwife can do absolutely nothing about that.

79. In her career Sister O'Neill said that it has never been good midwifery practice to do an episiotomy without good reason.

80. In relation to the three risk factors, the OP, the previous episiotomies, and the ultra sound assessment of a big baby, Sister O'Neill said that they would not have a bearing either individually, or collectively, in relation to how she would treat the plaintiff. In regard to performing an episiotomy: she would make her decision about doing an episiotomy when she saw how the perineum was stretching, not before that.

81. Under cross examination Sister O'Neill confirmed that having carried out the vaginal examination at 8 o'clock and found clear liquor and FFHR she left the scene and a student midwife was left to manage the plaintiff from that point on. Such midwife was supervised by her. The name of that student was noted on the back page of the chart (16). The fact that the plaintiff had an episiotomy on a previous occasion might not necessarily have been obvious at the examination at 8 o'clock because the perineum hasn't begun to stretch at all at that stage. Sister O'Neill said that she would have noted from the chart that the plaintiff had previous episiotomies, but she was not able to point out anywhere on the chart which indicated that episiotomies were recorded in the plaintiff's chart.

82. The checks that Sister O'Neill would do before leaving the student midwife to manage a mother in delivery was to know that the student was capable and competent of caring for the woman in labour, and that she knew to come and get help from one of the midwifes if she had any problems. Of the checklist to be made at the 8 o'clock vaginal examination, one is that the baby's head is presenting, that it is the leading part of the baby. She would know from the chart and from speaking to the mother that she had two babies before. She explained the chart of the plaintiff in 1994 and the previous charts. She said that the estimated foetal weight of 4.25 kilograms was slightly above the average range of 3.5 to 4 kilograms. This average range has now increased to between 4 and 4.5 kilograms.

83. The predicted baby weight of the 4.25 kilograms did not have any significance for her when she saw it. She would still expect the mother to deliver the baby herself. She agreed that a larger baby gives rise to a greater risk of a tear. She said that as far as she was aware there is a risk of a third degree tear in every vaginal delivery. There is a greater risk of a tear in the perineum when the baby is large, but as far as she was aware, the risk of a third degree tear is no different to any normal vaginal delivery. The student midwife would not have any responsibility when the perineum was stretching. If the perineum was tearing none of that would be her responsibility that would be the responsibility, - of the midwife in attendance. The midwife in attendance in the plaintiff's case was Marie Carroll. The next entry on the chart was made at 22.22 hours (10.22 p.m.), that entry was made by Nurse Carroll who was with the plaintiff from 21.55 as was documented on the left page. The state of full dilation was documented at 21.55, it could be taken by the court that between 20.00 and 21.55 hours the student midwife was looking after the plaintiff on her own supervised by either Sister O'Neill or Nurse Marie Carroll.

84. This supervision involves the midwife checking that she is managing the labour, that she is checking the foetal heart at intervals of 15 minutes and that she is helping the mother with her contractions. A routine examination would have been necessary at 22.00 hours to assess the progress in labour in accordance with the protocol or practice relating to multipars. In fact as the examination occurred at 21.55 it would have been indicated by the strong desire on the part of a mother to push. The contractions might be every two minutes, and there would be a short time to carry out the vaginal examination to determine the position as a baby. If the midwife knew the baby was in the OP at that stage it would not have altered the management of the delivery.

85. The diameters of the presenting head as between the OP and the OA presentations are really only relevant to the bony part of the pelvis. The perineum can stretch to accommodate the diameters. The passage in Myles at p. 409 which reads "due to the larger presenting diameters perineal trauma is common and the midwife should watch for signs of rupture in the centre of the perineum ('button hole tear') an episiotomy may be required" was quoted to her for comment. Sister O'Neill's answer after some clarification was "can occur, not, definitely will occur… can." She agreed that perineal trauma is common but there isn't any way to predict how the perineum will stretch until the baby's head is at that situation where it is stretching. The baby's head is crowned when it is not sliding back between contractions. The baby would not be on the perineum for the full 27 minutes of the second delivery. The most time might be 10 minutes. A decision to carry out an episiotomy would not be made before you see how the baby's head is stretching the perineum. The primary reason for an episiotomy would be foetal distress, if the baby's heartbeat is slowing and the baby needs to be delivered quickly. Another reason would be the failure of the baby to progress on the second stage, that is to say, if the baby's head reached a position on the perineum, and over the next two or three contractions was not advancing any further. She thought that only once in her professional career had she seen button holing of the perineum as is mentioned in the Myles textbook.

86. She said she would not consider an episiotomy where she saw that a tear commencing on the top of the perineum or where a tear appeared imminent, because a tear is a common occurrence. In a normal delivery an episiotomy is a very invasive procedure with, sometimes, consequences for the mother afterwards. She did not believe that steps should not be taken to prevent a third degree tear but in her experience, and from reviewing the literature, performing an episiotomy does not prevent third degree tear. It does not offer any more protection to the anal sphincter. It was not essential for a midwife to determine the position of the baby, as it would not change the management and care of the mother in labour and even if one did determine an early labour that the position was OP. Two thirds of these babies will rotate to anterior position during labour or even sometime during the second stage of labour. Midwifery skills would be applied in the case of every delivery. The flexing of the head in order to assist would usually be in issue in somebody having a first baby. In subsequent babies the delivery of the head is so rapid that there is no assistance needed from the midwife. In response to the suggestion that in this case the midwife should have been alerted that the perineum would tear or was likely to tear, she said that tears are common in a lot of deliveries. She did not agree that third degree tears were preventable.

87. On re-examination she said that the student midwife was the principal observer during the first stage of labour and then the senior midwife is responsible for the care of the mother throughout the second stage in the delivery of the baby.

88. Nurse (Sister) Marie Carroll gave evidence that she made an entry on the notes on labour and signed at 22.22. She qualified as a midwife in the National Maternity Hospital and worked there until 1995. She then left and moved down the country and she now works in a neo-natal unit. There were 18 midwifes in the labour ward and they delivered on average 6,500 babies per year. She confirmed and identified full dilation at 21.55. The only way they confirmed full dilation was by vaginal examination, - it was never presumptive. The student midwife would have sought the assistance of a midwife to come to her prior to such vaginal examination. The vaginal examination involves the cervix being fully dilated and one would also seek the position of the baby and the station of the baby but it is not relevant at this stage, because it is not going to alter your management of the woman at this stage. She explained that when a woman is in the second stage of labour she has a strong urge to push with each contraction. So, in the first stage of labour, she may be lying on her side or she may be walking around the room or on all fours or she can adopt whatever position is suitable for her. But to facilitate her delivery easier, most women are positioned lying on their back and they put their hands around their thighs to aid their delivery. So with each contraction, you encourage the mother to push as best you can with each contraction. By that, she meant that they would take a big breath and they would hold their breath for as long as possible and push with each contraction. Some people can find that very easy to do and others not so easy. They are overwhelmed sometimes with the pain. But that is your job. You are standing there positioned right beside her and you try to do the best you can to encourage her as she is pushing. As she is pushing, you can see the descent of the presenting part each time. So when you see it, you can encourage her by saying "I see a little bit more" or "I see a little bit less" or you know whatever you see at the time.

89. From the partogram she could see the plaintiff's labour progressed very quickly she was admitted at 8 o'clock and she was fully dilated within two hours.

90. The position of the head would not be of significance unless there was no progress in the second stage of labour. If there was no progress you would look for ways to find out why there wasn't progress.

91. By the standards of the hospital 30 minutes would be the maximum time the plaintiff would have been allowed to have her baby in the second stage of labour. She had her baby within that period at 27 minutes. If the baby is in a undiagnosed OP and the baby's head is crowned you still don't know whether it is in the OP or OA. If she had known that the baby was OP it would have no impact on her management on the basis that they were episiotomy scars there from previous births. She would still observe how the perineum stretched. In her experience the only indications for an episiotomy were foetal distress button holing of the perineum, or failure to progress. She disagreed with the proposition that because of the previous episiotomies being a risk factor, they should direct her to perform a further episiotomy as each midwife makes her decision at the time of the delivery. As the baby's head is crowned you try with the next contraction to prevent a tear by gently delivering the head. By that she meant that the mother might be encouraged to pant during the final contraction. But sometimes with a mother who is not a first baby it happens so quickly that you just don't have a chance. It is difficult to predict what will be the last contraction to actually deliver the baby. It is more difficult with first babies but each delivery is different. Ante natal training of mothers helps in relation to the panting technique but sometimes nature just overcomes all the classes in the world, and you have no control of the delivery and neither does the mother.

92. When the baby's head is on the perineum the midwife must watch her very carefully for signs of foetal distress. This is not something on which you would spend a lot of time – you wouldn't spend more than one or two contractions with the baby's head on the perineum, so crucial is the time for the baby.

93. Under cross examination Nurse Carroll repeated the three indications for an episiotomy i.e. foetal distress, no progress of labour, and button holing. Nurse Carroll herself only saw one as a student midwife and never saw one as a qualified midwife. It wasn't the hospital policy at the time of the two previous episiotomies of the plaintiff to record the indication for an episiotomy. She said that you don't see the beginnings of a third degree tear when the baby's head is crowned, it is only during the delivery of the baby's head that it occurs. It is not something that you can anticipate beforehand.

94. When the quotation from p. 409 of Myles was put to her for comment, in relation to something she should have thought of as a preventative measure, she stated that you anticipate that there may be a tear in every single delivery – it's not unusual. She said her only concern in the second stage of labour is that there is a descent of presenting part that there is no sign of foetal distress, that the baby's heartbeat is satisfactory and that there is clear liquor draining, and that the perineum is stretching, regardless of whether the baby was OA or OP. While scar tissue would not give as freely as a perineum that wasn't sutured before, that would not mean that the perineum is not capable of stretching as an episiotomy is on only one side of the perineum. You keep the history of the patient in mind, but you always anticipate the normal. She referred to the difficulty of ascertaining the baby's fontanelles with a view to determining the position, and stated Myles seems to deal with the ideal world, which was not always reflected in reality, as far as the presence of caput or moulding was concerned. When it was put to her that there is no point in finding out about the position if the baby is delivered and the mother is ripped apart, she said that there wasn't, but you are observing how the pressure of the presenting part of the perineum is with each contraction. You can very clearly see with each contraction how much of the head is pressing against the perineum. Some perineums are very elastic and some of them aren't quite so elastic. There is a very fine line there between the two. She disagreed with the proposition put to her that the proper course to have taken in the plaintiff's case was an elective episiotomy before any damage was done and before a button hole tear would have appeared.

95. The next witness to give evidence on behalf of the defendant was Dr. Keane. Dr. Keane was appointed Assistant Master in Holles Street Maternity Hospital in about 1994 and left to take up a position as Consultant Obstetrician in the John Radcliffe Hospital in Oxford in 1996 and 1997 and then came back to Holles Street National Maternity Hospital to take up his current position as Master on 1st January 1998. He qualified in medicine in UCD in 1985 passed his membership of the Royal College of Obstetricians in 1990. He received a doctorate in medicine from UCD in 1992 and membership of the Royal College of Physicians in 1993, he spent three years

practising in Holles Street from 1987 to 1990 and then spent four years in Bristol in similar practice. He explained that the Master of a maternity hospital in Dublin is effectively the Chief Executive Officer of the hospital as well as being the clinical Director. So he sets out the policies and procedures for the hospital for the seven years while he is in office. He had been kept informed in relation to the issues canvassed and debated in the case during the trial. He said that the OP presentation would not make any difference to the management of the labour and he disagreed with Dr. Pearson's view that OP alone would indicate necessity for an episiotomy. In relation to the proposition that the effect that the plaintiff had two previous episiotomies, his view was that it had very little relevance to the approach that might be taken for the third delivery.

96. He explained that if one looks at the ball park figures in Holles Street where they deliver 8,000 a year, nearly 50% of first time mothers will require an episiotomy and roughly 10% of second time mothers or subsequent mothers need an episiotomy. So that the fact that a mother has an episiotomy in her first delivery bears no relation to the subsequent pregnancies. Even the fact that Mrs. Kelly had one on her second, bears little relation to her subsequent delivery. At the end of the day it's the progress of the baby's head during the course of the second stage of labour that is going to determine for the midwife whether or not the episiotomy is required. The foetal weight would have very little influence if none at all on the decision as to whether to do an episiotomy. He said that units that employ a greater episiotomy rate probably have a lesser tear rate. Units that have a lower episiotomy probably have a greater tear rate. Probably at the end of the day what is more important is your intact perineum rate. The reason for the higher intervention of episiotomies in the first deliveries is that the perineum has less ability to stretch not having been stretched before. He said that apart from the appearance of button holing where a nurse might perform an episiotomy, if she feels that the woman is at risk of tearing and tearing badly, the predictability of the severity of the tear is not possible. He stated that there is significant medical literature that has now been published both in Metanalysis and review articles that shows, unfortunately, that third degree tears cannot be avoided by a routine performance of an episiotomy. In fact, if you look at most medical or obstetrical textbooks ten years ago, that might have been given as a reason for performing an episiotomy. It has been shown, unfortunately that in the medical literature that episiotomies do not prevent third degree tears at all.

97. Most episiotomies are done on the basis of factors as they present themselves in labour they are not elective procedures. He said that they were 453 multiparous women who gave birth vaginally to a baby in the National Maternity Hospital from 1996 to 2002. If you exclude instrumental deliveries, i.e. ventouse or forceps only 2 of the 453 women had a third degree tear. So a very low percentage of these women had a third degree tear and 40% of these women delivered vaginally without the need for an episiotomy. So if Holles Street were to do routine episiotomies on all women with persistent OP on a second or subsequent pregnancy they would be doing a very high number of episiotomies for what is, at the end of the day, a very low risk of third degree tear. Speaking anecdotally on the basis of his hospital figures, and on the basis that he delivers personally roughly one patient a day, he considered that an episiotomy was not required in the plaintiff's case. Routine episiotomy was never the practice in any hospital in which the witness had been employed, and it had been displaced a generation ago. The conclusions of a paper by S. Anthony and Others entitled "Episiotomies and the Occurrence of Severe Perineal Lacerations" in the British Journal of Obstetrics and Gynaecology for December 1994, under the heading "results", was put to him as follows:-

> "After correction for other variables the use of medeolateral episiotomy was associated with more than four times lower risk of third degree lacerations".

98. He agreed that that was a significant finding but said however that it would not be borne out by the more recent Metanalysis and review articles. He agreed that the OP position was associated with a greater risk of tear. To deal with the propositions being put to him Dr. Keane referred to a paper entitled "Vaginal Birth and Perineal Trauma" dealt with in a review article in Current Opinion in Obstetrics and Gynaecology 2000 Volume 12 pp. 487 to 490 and quoted the following conclusion of that paper

> "the proponents of routine episiotomy claim that it avoids spontaneous uncontrolled tears and relaxation of the pelvic floor, but these advantages are difficult to substantiate. Either first or second degree perineal tears ….., so any argument that episiotomy prevents such spontaneous tears is inconsequestional. A growing body of evidence suggests that episiotomy offers no protection against third and fourth degree tears which are associated with adverse sequalae, a recent overview by Myers-Helfgott emphasised the emphasis of scientific evidence to support a role for liberal and elective episiotomy in the reduction of third degree lacerations during childbirth."

99. The results of other studies and including the Wallenberg study were debated in cross-examination with Dr. Keane and he said that the results of none of the studies put to him would give an answer to either of the two fundamental issues as to why he was in court giving evidence. The first of these issues was, does an OP position necessitate the use of an elective episiotomy? The second such fundamental issue is would the performance of that elective episiotomy have resulted in a third degree tear not occurring? In relation to the Wallenberg study Dr. Keane was referred to Table 1 on p. 384 thereof, where it was stated that there is a relative risk of 0.56 from which counsel suggested that there is a 44% less chance of a third degree tear with the mediolateral episiotomy. Dr. Keane agreed that that was a reduction, but it did not prevent a tear, and further agreed that it was a significant reduction – statistically significant. He agreed that OP increased the risk of perineal trauma.

100. He accepted the proposition on page 386 of the Wallenberg Article that:

> "foetal presentation appears to be an important discriminating factor for the occurrence of third degree perineal ruptures. As previously reported a persisting OP of the foetal head increases the risk of anal sphincter damage".

101. There was further discussion with Dr. Keane in relation to the low occurrence of third degree tears in non-instrumental deliveries of multiparous women. He was asked to comment upon the graph in the Wallenberg Study plotting a positive relationship between weight and third degree tears in multiparous women and also the statement in p. 409 relating to the possibility that an episiotomy may be required and Dr. Keane emphasised that Myles said "may". Dr. Keane did not know why the episiotomy was carried out on the two occasions of previous births of the plaintiff and said that the fact that the plaintiff experienced a tear with the episiotomy after the second birth indicated that episiotomy is not a guarantee against a tear. He said that if the lady is progressing well in the first stage and in the second stage of labour, and she appears to be delivering her baby extremely well, and pushing extremely well, and there are signs of that foetal head coming without the need for episiotomy, then what happened in her previous pregnancies bears no relevance to this. Neither does the estimated weight on an ultrasound scan.

102. Looking at his hospital's records approximately 36% of mothers in 2002 and 35% in the index year of 1994, had a baby weighing between 3.5 and 4 kilos and this is the highest percentage category. It is almost the norm now for Ireland because we have the largest babies in Europe. To do a routine episiotomy for babies of this size would be bad practice. He said that an episiotomy would not be indicated merely by the perineum going white.

103. Ms. Aideen Keenan, a mid-wife, then gave evidence on behalf of the defendant. She is now working in the Rotunda Hospital in

the position of superintendent of the delivery suite. That is a Clinical Midwifery Manager, Grade 3 post. She has been involved in recent months prior to the hearing in some project management, so she was not on the delivery suite at that moment. Her general registration came through January 1984, after training in Jervis Street Hospital from 1980 to 1983. Thereafter she worked as a staff in intensive care in a coronary unit in Jervis Street Hospital until 1985 when she left to undertake midwifery training in Cumbria Hospital, Tunbridge Wells, Kent, England. Her training extended from November 1985 to November 1987. Upon qualifying she got experience for a year in Tunbridge Wells in ante-natal, post-natal and six months delivery suite experience. She then moved to Royal Free Hospital in Hampstead in London in July, 1998 and practised as staff mid-wife in the delivery suite until June, 1989 when she was promoted to a junior sister's post and practised both in the delivery suite and the post-natal ward until January, 1990 when she was promoted again to senior G grade Community Midwifery sister. That was practising midwifery in all care settings both in the hospital and the home setting. In line with changes that were taking place in the health service in England she was promoted to Clinical Midwifery Manager in 1993 until she left London in October, 1996 to return to the Rotunda. The maternity unit in Tunbridge Wells in London where she worked were 2,500 to 3,000 and 3,500 respectively. Her position would be one level in rank above Sr. O'Neill who gave evidence earlier. She explained the various degrees of tears and agreed that Myles would have been one of the main books, but by training time in 1994 a lot of education was going through evidence-based practice, and students were advised to go and research the literature that was available.

104. The partogram indicated that the labour in effect progressed well within the normal range of a multiparous mother. She disagreed that the three factors mentioned by Ms. Gertrude Hamilton together constituted clinical reason in England in 1994 for carrying out an episiotomy and said that it did not, in the two units she practised within. She said that both the National Maternity Hospital and the Rotunda Hospital had started compiling statistics on computer from June 1996 onwards. She reviewed the statistics relating to OP multiparous deliveries, to identify their outcome in terms of perineal trauma. These were spontaneous vaginal births, so that she could look at what were the outcomes, both in terms of perineal trauma, and weight of the baby. She produced a table from which she concluded that after looking at the weights, the first thing that struck her, was that the weights were quite variable in terms of OP. When she looked at the intact perineum count, there were 64 mothers who had an intact perineum there were 86 mothers who had a first-degree tear, there were 41 mothers who sustained a second-degree tear, two mothers that sustained a third-degree tear and 65 mothers who had an episiotomy. The conclusion she drew from that as to the efficacy or otherwise of an episiotomy was as follows:

> "When one looks at the range of weights, particularly the intact perineums in the first-degree tears, there is a considerable number that are 4 kg. or greater. One would just think that if all those mothers, because of the presentation of an OP, had sustained an episiotomy performed on them it is a considerable number of implemented second-degree tears or surgically-performed second-degree tears on mothers who would have had no trauma or minimal skin trauma."

105. A third-degree tear damaging the muscles in the anal sphincter is a rare phenomenon and the incidents within maternity units were 1.7% but she was not sure of the actual statistics. She said that as a midwife you would not see it that frequently. It would not be something you would meet every day or every month.

106. The midwife manages the second stage by using the midwife's powers of observation and also her ability to get the mother to assist in the delivery process itself. It is very important that the baby's head is on the perineum and the perineal tissue is stretching, and it does become paper-thin. It is very important that the midwife tries to gain the mother's control by getting the mother to work with the midwife in controlling her breathing and pushing. At that time, if the mother has not had an epidural, where she is pain-free, the mother has considerable pressure, a lot of pain, and, is usually very distressed, and her body's instinct is to give one big push to get rid of the pain, and to get rid of that tremendous pressure. From the midwifes' perspective, they are trying to allow the perineum to stretch up very slowly for the head to come down very slowly, to allow those tissues to expand and to get used to the feeling of the head actually behind the perineum. If the mother is able to just pant without taking a deep breath and pushing, (which actually puts more pressure on a natural contraction), the pressure on the perineum is decreased.

107. There is a lot of pressure from the internal involuntary powers. The muscles are pushing on the baby from the top of the uterus. The muscles of the uterus itself push on the baby's bottom. The pressure goes down the baby's spine onto the baby's head. It is the head that pushes its way through the birth canal. It opens the cervix first then pushes its way through the birth canal. In the second stage the mother's own external or voluntary powers come into play. When she fills her lungs she usually holds her breath and she takes a deep breath and pushes down, and it is her diaphragm that is pushing also on the uterus, pushing on the baby's bottom all the way down that is actually increasing the force on the baby coming down through the birth canal. She said that if you can imagine the amount of pressure that is there when the baby's head is on the perineum that is already stretched up, it is realised that the midwife wants just the involuntary power of contraction to ultimately deliver the baby. The midwife does not want the mother to push at that time. What can happen is that when the perineum is stretched up really beautifully, the mother might give an involuntary big push and the baby shoots through the perineum. There is an explosion rather than a controlled descent, that is why the midwife usually talks very slowly and calmly to the mother to try to get her listening to her and breathing with the midwife. Very often the midwife is doing the same breathing herself to try to actually get the mother to imitate her.

108. Whether the midwife can anticipate the explosion of the baby through the perineum depends really on what kind of control the mother and the midwife have on the process and the relationship between them. The midwife in doing this is doing something that she is quite skilled at, because she is involved in it all the time. She usually coaches the mother during the labour but obviously there will be times when, through no fault of the mother, and through no fault of the midwife, the mother may actually take a deep breath and push. A mother who breaks the rules, so to speak, and takes a deep breath with a view to pushing may push for 20 to 30 seconds but she may stop if she hears the midwife saying, "Stop, I want you to pant, pant, pant". If the mother does that, the pressure is off. The involuntary contractions of the uterus muscles cause the mother to want to push.

109. The stretching of the perineum is really dependent upon the baby's head coming up onto the perineum and staying there for a while. As the baby comes down the perineum is stretched and it will be quite thin at that stage and if there has been previous scar tissue you can see the scar tissue and sometimes you can see where there were individual sutures that were put in if they were interrupted sutures. You are observing that and also how the head is staying there as well as watching the baby's condition in terms of any distress. You are also watching to see is the perineum looking okay. This is extremely uncomfortable for the mother so you are trying to get the mother to breathe, not to push, not to bear down because the tissues are very slowly expanding and getting comfortable with that expanded feeling. Once that process has happened and once the head is crowned, after that you just ask the mother to pant. You do not want the external (voluntary) forces by the mother taking a deep breath and pushing. Once the baby's head is crowned in the next contraction, if it is an OP, you will start to see the forehead and bridge of the nose.

110. In the plaintiff's case the labour does not appear to have behaved in what we would deem to be a usual OP labour by way of it being slow. There are no indicative factors by way of the labour being slow or any foetal distress. Usually in an OP position because of the way the head comes down through the pelvis and because there is uneven dilation in the cervix or an uneven pressure on the cervix to dilate, labour can be slow and as some of these babies turn mid-cavity, that can actually involve a long labour as well.

111. If the OP is diagnosed when the midwife sees the forehead or the nose, your window of time to actually perform an episiotomy, even if you wanted to, is actually gone at that point, because you would not get a scissors in to perform that, because the space is totally limited and your baby is almost out anyway. When you see the forehead and the nose, - that is the contraction that is actually delivering the baby. She referred to Jennifer Sleep in the West Berkshire trial and in the follow-up of that trial she looked at the outcome of episiotomies and also found that they do carry significant sequelae in terms of perineal pain and resumption of sexual relations following birth. She said she knew that some episiotomies can extend to third-degree tear as well. Episiotomy carries a risk of infection, but a tear carries this risk also. She was referred to p. 409 of Myles and asked if the record showed any sign of a rupture in the centre of the plaintiff's perineum in the nature of a buttonhole tear and she said there was nothing to suggest that in the records or the transcripts relating to the birth.

112. On cross-examination Miss Keenan agreed that the scar tissue is something a midwife would note. She was asked to explain the episiotomy for the plaintiff's second baby when there was no indication of foetal distress or non-progress of labour. She suggested one explanation that as the plaintiff's previous baby was a 3.1 kg. baby and her second baby was a 3.96 kg., which is a bigger baby, the midwife, while observing the perineum stretching and taking all her other observations and clinical experience into account, perhaps felt that the scar tissue was at the last point just prior to delivery. One explanation could be that the scar tissue was actually holding up the delivery at that very last point when the head is just about to crown or had crowned. Alternatively, at the last minute perhaps she saw signs of buttonholing or some indication where she felt, in her clinical judgment, an episiotomy was required. She referred to p. 211 of Myles indicating that a midwife should use her skills to avoid the intervention of an episiotomy if at all possible. She agreed that the occurrence of the scar tissue and the predicted weight of the baby of possibly 4.2 kg. or 10% more or less would indicate the greatest precaution would have to be taken to avoid a tear. While a mother sometimes has an involuntary urge to push at 7 cm. dilation, a midwife would not in her opinion direct a mother to push on a cervix that is 7 cm. It would not be correct to do so. The OP position tends to make a mother want to push at the 7 cm. dilation stage or thereabouts, but a midwife would not encourage that. The only circumstances in which the pushing of the mother from 7 cm. dilation would have a bearing on whether to do an episiotomy is if the labour is going to be slower and sometimes in such situations the perineum itself can become swollen because there is pressure. The mother is putting pressure down in that area and because of the swelling which would be visible that could impede stretching of the perineum. Any kind of pressure can restrict blood flow and there can be some swelling in the perineal area. She agreed that a contemporaneous record in relation to the position and state of the baby's head on the perineum would have been advantageous in assessing the outcome but that, while she encourages the taking of such contemporaneous notes, this is not always possible given the pressure of the occasion. She agreed that in her report to legal advisers prior to proceedings, which was available to the parties, she agreed that the position of the foetus in the pelvis is a crucial matter for the midwife to have regard to before and during her decision to do an episiotomy. An experienced midwife can tell whether the perineum has stretched to its limit or not.

113. On re-examination she said that if the cervix had been damaged or had become oedematous or swollen that would also be capable of being palpated by the midwife. If that damage occurred from whatever cause to the cervix, she would have expected that to be documented and there was no evidence in the available records that such an event occurred. If the cervix were damaged it would slow the first stage of labour and there was no evidence from the partogram or elsewhere in the medical records of the plaintiff to indicate that delay had occurred either at the first or second stage. The plaintiff's third baby, Eoin, had a birth weight of 3.86 kg. which comes within the 3.5 to 3.99 kg. category which is a 35% grouping of deliveries for the year 1994 on the basis of extract from the 1999 report of Holles Street Hospital showing the statistical analysis of hospital population by numbers and birth. She confirmed that there is a legal requirement to insert the data into the computer for the purpose of ensuring that the clinical report of the relevant year is comprehensive and accurate and the information comes from the mother's medical records in respect of which there is a legal requirement to keep it and keep it accurately.

114. Dr. Michael Turner, Consultant Obstetrician and Gynaecologist attached to the Coombe Hospital, Dublin, gave evidence. He graduated from UCD in 1978, took membership of the Royal College of Obstetricians and Gynaecologists in London in July, 1984 and Member of the Royal College of Physicians of Ireland in November of 1984. In 1988 he was awarded a Mastership of the Art of Obstetrics and the subject of his thesis was on the management of labour. He was subsequently elected Fellow of the Royal College of Physicians and Fellow of the Royal College of Obstetricians and Gynaecologists. He was appointed as Consultant in 1990 to the Coombe, Meath and Adelaide Hospitals and in 1992 he took up the post of Master of the Coombe Women's Hospital, which is a seven-year post. He is the recipient of a number of prizes and awards in relation to his area of interest in the field of obstetrics.

115. He has served on the Executive of the Institute of Obstetricians and Gynaecologists in Ireland. He said that as a member of the Gynaecological Visiting Society of Great Britain and Ireland he was familiar not just with the practice in Ireland but also with the practice in Great Britain and spent five years of his training in London. He was elected an Honorary Fellow of the American Gynaecological and Obstetric Society and on the academic side he is at present on the editorial board of the Journal of Obstetrics and Gynaecology in London and reviews papers on obstetrics and gynaecology for journals in Ireland, Britain, Europe and the United States.

116. An OP is a difficult diagnosis to make in the first stage of labour and he said also that you can't diagnose with certainty from palpating a woman's abdomen whether the foetus is in the OP or not. In three quarters of patients with an OP the baby turns during the course of labour. The size of the mother makes abdominal diagnosis more difficult. In clinical practice both here and in Britain obstetricians and midwives do not attempt to make the diagnoses of OP in the first stage of labour by abdominal examination. There are very few studies that actually tested the reliability of the diagnoses where somebody makes a diagnosis in labour and then the baby is delivered. OP is often a retrospective diagnoses and POP is often only evident when the baby is coming though the birth canal and is delivered. In practice he tends to rely much more on the pattern of the second stage of labour for the purpose of diagnosing OP. He finds that much more useful because even if you know the diagnoses of an OP position with any degree of reliability it wouldn't necessarily alter how you would manage the second stage of labour.

117. It is not the standard practice to perform a routine right medialateral episiotomy in a woman who has had two previous episiotomies because the perineum has been distended twice. The plaintiff's case is in many respects unfortunate but also in his experience highly unusual.

118. Ultrasound tests are notoriously unreliable in respect of bigger babies and big Mothers. The purpose of the ultrasound in this case was to assess the liquor volume because the patient had gone overdue. It was not primarily to estimate the foetal weight in a large mother, as it is sometimes necessary to do ultrasound to determine the presenting part of the baby i.e. to test for a breach presentation. He did agree with Dr. Pearson in relation to the three indicators for a routine episiotomy and said that an episiotomy is performed under anaesthetic and is a surgical procedure which carries with it its own risks.

119. He said that in the Coombe the instance of third degree tear was in the order of about .34 to 1% and a third degree tear is approx 5 times more common in first time mothers compared to a multi gravida woman. To show how unusual the plaintiffs case was,

Dr. Turner stated that he looked at the Coombe figures for 2001. There were 7546 women delivered in the hospital. Of these 4387 were multi gravidas and there were only twenty third degree tears which gives an incidence of 0.6%. Of the twenty, sixteen were associated with OA. Twelve of those were delivered by the midwifery staff and they had a normal delivery. Four of them were delivered by the medical staff and they had a ventouse. There were four mothers where there was an OP and of the four, three were delivered by ventouse and one by forceps. In 2001 just over seven and a half thousand mothers delivered, there was not a single multi gravid patient who had POP and a third degree tear where the woman was delivered vaginally by the midwifery staff. Of the twenty multi-gravida who had a third degree tear, 13 of them were less than 4kgs. and 7 of them were greater than 4kgs. In that year there were 1,194 women delivered where the actual birth rate was greater than 4kgs. and there were seven third degree tears on those patients. If every woman who had a baby greater than 4 kgs., and who did not have a caesarean section had an episiotomy there would be nearly one thousand extra women who would have ended up having a routine episiotomy. He gave further figures indicating that as the pregnancies increased the percentage of third degree tears for women in OP decreased from 0.7% for first births to 0.34% in second births and 0.24% in third births. What was interesting is that if you looked at the thirty women expecting their third baby in the Coombe last year the only one that had a third degree tear was a woman where the baby was born before arrival at the hospital and the care was not supervised by a mid-wife or an obstetrician.

120. The partogram indicates a labour which is highly satisfactory in the plaintiff's case, and it is the sort of progress that you would expect a woman who had two previous virginal deliveries to make, in both the first and second stage of labour. He said that he was aware of no evidence to suggest that if the plaintiff had an episiotomy, that she would have been spared suffering a third degree tear, and pointed to the literature which shows of women who had a third degree tear about forty to fifty percent of them have also had an episiotomy. Looking at the Coombe, the women who had third degree tears with OP all had episiotomies done in association with instrumental vaginal delivery. He said that an episiotomy remains part of the decision making process of a mid-wife when she is assisting in the delivery of a mother. It is not a simple exercise and he does not know how third degree tears occur with certainty and said it was an accepted complication of child birth.

121. Under cross-examination Dr. Turner said that he agreed that the bigger the baby is, the harder it is for the mother to push out. Having worked for twenty years he had not seen an ultrasound used to forewarn the clinicians whether midwives or medical people, that the baby would be a big baby. Experienced clinicians know that an ultrasound estimation of a big baby is unreliable, and even if it was reliable it would not change the way the labour is being conducted.

122. The following letter from Dr. Robert Boylan dated 13th July 1994 to Dr. Quigley the plaintiffs GP was put to Dr. Turner

> "Dear Dr. Quigley,
>
> > This patient has a normal delivery of a healthy male infant weighing 3.860kg on 8th July 1994. There were no complications and mother and baby were discharged on 12th July 1994. Mrs. Kelly is blood group A Rhesus Positive. Rubella is positive. The baby is being bottle fed and the baby did receive the VCG vaccination."

123. . Dr. Turner said that in his opinion the letter was not correct but that that was all he could say as he couldn't answer for how Dr. Boylan had written it. He agreed that from the partogram it was quite plain that at 23 hours there was a repair of a posterior tear. Again Dr. Turner's attention was drawn to the following note on the nursing cardex of the plaintiff under the entry for 8th July

> "23:25hrs. New baby transferred from delivery at 23:25 following above. Mothers uterus well contracted. Locia average. Perineum bruised and oedematous. Infants colour and cord normal. Temperature etc".

124. And on the left hand side of that column the further entry was drawn to his attention

> "third degree tear".

125. He confirmed that these entries indicated a third degree tear and were a clear record of such in the plaintiff's case.

126. Dr. Turner said that for somebody like the plaintiff who had two previous babies vaginally and who delivered in Dublin the chances of her delivering a baby that resulted in a third degree tear in a delivery supervised by a midwife is of the order of about 1,000 to 1 and there are no features in the first or second stage of the plaintiff's labour that would lead one to suspect that the baby was likely to cause a third degree tear. These features would be, for example, that the plaintiff would have had a long first stage of labour and would probably require oxytocin to augment the first stage of labour or alternatively there would be prolongation of the second stage of labour, and in particular there would be prolongation of the active phase of the second stage of labour where there is active maternal pushing. It was put to him that he took that view in a report which was completed before he had heard the evidence of the plaintiff. He was reminded that the plaintiff said that in the course of the first stage of labour when she was attended, the midwife on finding her to be 7 centimetres dilated said to her "if you bear with me I will make you 10" and inserted her fingers in an effort to do so and that secondly the plaintiff said that during all of that period up to the time she was 10 centimetres she was pushing and was encouraged to push. Dr. Turner was asked did that have any effect on his opinion as first expressed. He stated that it didn't, and that he was still of the view that the complication could not have been anticipated or predicted. He said it wasn't standard practice to encourage a woman to push in the first stage of labour because the cervix is not fully dilated, and it is not technically feasible to actually push the baby through a cervix that is not fully dilated. To attempt to do so would risk the truamatisation of the cervix in particular. From Dr. Turner's review of the medical records he could not find any objective evidence in the records that the cervix was traumatised during the course of labour. Dr. Turner pointed to the difficulties of patients recalling instructions in the course of a very traumatic experience like childbirth and there are also practical difficulties with nurses and doctors because they cannot recall conversations they had in a particular situation. Very often a third degree tear is not discovered until after the labour sometimes for a long time after. Failure to discover may be the result of the mother pressing her legs together in scissors fashion and adiposity makes it difficult to see the perineum. He agreed that as a generalisation there is a greater risk of tear with a baby in the OP. A tear is not a predictable event. Sometimes you may think the perineum is going to tear and it may not. Sometimes you may think that it may only be a superficial tear, but, to your surprise, the tear is deeper than anticipated. It is not an easily predicated human event. He said that it is not always the case that it would be evident to a midwife or doctor at the time of the crowning that it was likely that a tear was about to occur. He agreed as a generality with the evidence of Dr. Keane and Nurse Keenan as summarised that there was a point where it is generally evident that a tear is going to occur when the baby's head is crowning. He also agreed that at that stage at the end of the second stage of labour the midwife or doctor can anticipate that a tear may occur and decide what to do about it and he added that sometimes they may decide to do nothing about it. He said that they may decide to do nothing about it because they might hope that the patient might get away with a first degree tear without any suturing. However if the midwife thought she was going to have a large second degree tear the midwife might decide to do an episiotomy.

127. He agreed of the 93 women who had OP babies in 2001 and 22.6% of them had episiotomies. Dr. Turner was not in a position to say why the women had episiotomies whether by reason of instrumental delivery or otherwise. He said nevertheless that the purpose of these figures to show that in current practice in Dublin that it is not standard practice to perform an elective episiotomy in a woman who has a POP and who is delivering vaginally. He disagreed that the fact that the plaintiff had two previous episiotomies would dictate that there would be a further episiotomy in the third delivery. He said that even when women who have had a third degree tear with a previous baby there is a lot of debate within the speciality as to whether you should do an elective episiotomy next time around. It was put to him that he had stated in his report prior to the trial that "it is reasonable to assume that this obstetric complication is related to the fact that the baby was in the OP position at delivery in contrast to the patient two previous vaginal deliveries." He agreed that that was stated in his report. He said that it was not always possible to determine a POP at crowning. Sometimes the diagnosis is not evident until after the baby's head has come through the birth canal. It is always a consideration for the midwife as to what the position of the baby is irrespective of whether the mother had an episiotomy in the past or not.

128. It was put to him that if the midwife did not seek to examine whether the baby was coming OP or OA she would not be able to determine whether there was a greater risk of a tear. He said that he was not sure that it was a greater risk in the situation where the head is crowning because the evidence is not there in the literature that at the point of labour when the head is crowning and in a labour where the second stage is progressing normally any indication that an episiotomy in those circumstances will prevent a third degree party in somebody who is in an OP. He said that it is not just simply the diameter of the baby's head that matters; that other factors come into play – where for example, the distensabilty of the mother's perineum; how good the mother is at actively pushing the baby out or not; whether there is a forceps on the baby's head or not which would leave less room. There are thus several other factors which come into play. He said that in the past obstetricians have adopted a somewhat over mechanical approach to childbirth where people are thinking solely in terms of the mother's pelvis and the baby's head. It is now realised that this is misplaced and there are other factors that are important. So it depends on how good the mother is at pushing the baby out and it depends on how efficient the uterine contractions are.

129. At this juncture Dr. Turner expressed the view that caution should be exercised in using the literature including the Wallenberg study. It was put to him that several quotations extracted by counsel for the plaintiff all pointed in the one direction that episiotomy protected against third degree tears and that the risk of a third degree tear increased with the weight of the baby. Dr. Turner cautioned that the Wallenberg study should be read in the context of the study having been done in Holland where there is an extraordinarily high number of births carried out by midwives in the home. The difference of the examined population may explain the difference in the incidence of third degree tear which at 1.94%, is higher than in Dublin. He also pointed to the statement in the Wallenberg article that "higher parity appears to be a protecting factor for third degree perinenal ruptures", the odds halved for each following delivery up to a maximum of 6 and stated that this quotation supported the evidence which he had been given.

130. He said that the Wallenberg paper puts together women who have had a POP delivered by the midwife and those who are delivered by instrumental vaginal delivery. He said that if the two categories are separated it is debateable as to whether there is a relationship between OP and third degree tear. He did not think it was a particularly good paper in relation to the graph plotting baby weight and perineal trauma. He said that there was no separate treatment for parity and that the trend should correct for parity. Also he said that the total episiotomy rate in the study was 34.4% which was about twice the number of episiotomies done in the Coombe, and despite the fact that they were doing twice as many episiotomies in Holland they still have a much higher incidence of third degree tears. He did not see how people could use the paper on the Wallenberg study to prove that episiotomy reduces the incidence of third degree tear. In fact you could argue the opposite insofar as in Holland they have twice the incidence of episiotomy than there is in the Coombe.

131. He said that it was not his understanding of the transcript that Dr. Keane accepted that the use of episiotomy had the effect of reducing the effect of third degree tear by about 44%. It was put to him that the question put to Dr. Keane was on the basis of the study of the relative risk of mediolateral episiotomy against no episiotomy as indicated on that table 1 on p. 384, and there is a relative risk of 0.56. He said that there was an important qualifying phrase indicating that he did not say that episiotomy reduces the incidence of third degree tears by 44%.

132. He said that the normal reasons he would do an episiotomy, where a woman had two previous vaginal deliveries and was only 27 minutes in the second stage of labour, would be if there was foetal distress or failure to progress in the second stage of labour and from his review of medical records there was no evidence of either of those problems. He agreed that one of the midwives from Holles Street did say that episiotomies could be carried out to save the perineum, but that as he was working off the medical records he was not in a position to judge from medical records what the state of the perineum was when the midwife was in charge. There were no figures available to indicate the percentage of episiotomies carried out by midwives to save the perineum in primigravidas but he said that approximately 40% of first-time mothers would have an episiotomy. Of those, approximately 20% would be in association with an instrumental delivery where there was foetal distress or failure to progress in the second stage of labour. That leaves about 20% carried out by midwives and in many of those, the midwife would proceed where the baby was distressed because the baby would be delivered quickly without having to call the doctor. About a quarter of the 20% performed by midwives would have been for the prevention of tears, as a 'guesstimate'. He agreed that the circumstances where an episiotomy are generally evident in each case. On re-examination he agreed that it is probably easier for a midwife to assess the likely progress of a tear in the case of a first-time mother as one of the difficulties you have sometimes with a second or third baby is that the process can be a lot quicker and sometimes the baby can be pushed out very quickly. Sometimes the decision making has to be made a lot quicker in those circumstances.

The Submissions

133. The plaintiff's submissions may be summarised as follows:

> What the case is about is whether or not in the particular circumstances of the plaintiff's case, with her previous history, and if proper observations were made a mediolateral episiotomy should have been carried out. It had nothing to do with routine episiotomies. In the course of the case the medical literature which was introduced clearly established that a mediolateral episiotomy significantly reduced the risk of a third degree tear.

134. Dr. Keane, the Master of Holles Street Hospital, when the Wallenberg study was being put to him, gave evidence that this study appeared to show that there was a 44% less chance of a third degree tear if a mediolateral episiotomy was carried out. People would never carry out a procedure in serious medicine unless there was a greater than 50% chance of something happening. It was submitted that if there was a 30% or 25% chance that a thing might happen, is a significant thing, (as in the present case), that you have to take measures to guard against that happening. It cannot be said just because the chance of the procedure is only 1 in 4 it should never be used. The test should be that once there is a reasonable or realistic prospect of damage occurring that reasonable precautions have to be taken to prevent that on the standard laid down in *Dunne v. Holles Street* [1989] I.R. 91. It was submitted

that the failure to carry out an episiotomy in the face of such 44% greater chance had in the wording of p. 109 in the report of *Dunne v. Holles Street* judgment:

> "Inherent defects which ought to be obvious to any person giving the matter due consideration."

135. I was referred to the third criterion of medical negligence as set out by Finlay C.J. in *Dunne v. Holles Street* as follows:

> "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 had inherent defects."

136. It was submitted that the practice which appeared to be contended for on behalf of the defendant in this case of carrying out no episiotomies or virtually no episiotomies except in cases where you can virtually see a tear developing, that to act in that manner is to follow a practice which has inherent defects in it, which ought to be obvious to a prudent and careful midwife. The plaintiff relied on *McGee v. National Coal Board* [1972] 3 All E.R. 1008 and the dictum of O'Flaherty J. in *Best v. Wellcome Foundation Ltd*. [1993] 3 I.R. 421, with regard to *McGee v. National Coal Board*.

137. The plaintiff also invited the court to consider the evidence and the poor state of records together with the inaccurate letter of discharge dated 13th July, 1994 in reaching a conclusion in relation to the question of the finding of negligence.

The Defendant's Submissions

138. It was submitted that the plaintiff's case shifted from time to time from a claim, on the one hand that a planned episiotomy should have taken place irrespective of what was happening on the perineum and, on the other hand, that an episiotomy which was going to take place in response to what was happening on the perineum. Mr. Pearson primarily was the champion of the planned episiotomy approach and that approach was met by a weighty respected body of medical opinion that says that approach is an inappropriate approach. The witnesses from Mount Carmel, Holles Street Hospital, The Coombe Hospital and Rotunda Hospital and Ms. Keenan's background all gave support and weight to the school of thought supporting the defendant's approach. In relation to the second approach of the plaintiff's advisers which was championed mainly by Mrs. Gertrude Hamilton, failing the first approach, the defendant submitted that there was no evidence in the case which would allow the court to second guess the clinical judgment of the midwife on this occasion. In fact there were no indications or causes for alarm or the introduction of an obstetrician by reason of the monitoring of the labour. The elasticity in the perineum is clearly going to be superior in a perineum that has been stretched by a history of vaginal delivery. The discharge letter of 13th July, 1994 has nothing to do with the delivery. If there was pushing at the 7 cm. stage there would have been damage to the cervix and there was no evidence of such. The plaintiff suffered complications at childbirth not through any want of care on the part of the midwifery staff at the National Maternity Hospital.

The Law

139. The criteria for establishing medical negligence are set out in the judgment of Finlay C.J. in *Dunne v. Holles Street*. The onus of proving some positive act of negligence on the part of medical staff rests on the plaintiff and the doctrine of *res ipsa loquitur* does not apply to medical negligence as stated in the judgment of the Supreme Court in *Beatrice Lindsay v. Mid-Western Health Board* [1993] 2 I.R. 177. In *McGee v. National Coal Board* [1972] 3 All E.R. 1008, Lord Wilberforce at p. 1012 stated:

> "It is a sound principle that where a person has, by breach of duty of care, created a risk, and injury occurs within the area of that risk, the loss should be borne by him unless he shows that it had some other cause. Secondly, from the evidential point of view, one may ask, why should a man who is able to show that his employer should have taken certain precautions, because without them there is a risk, or an added risk, of injury or disease, and who, in fact, sustains exactly that injury or disease, has to assume the burden of proving more: namely, that it was the addition to the risk, caused by the breach of duty which caused or materially contributed to the injury? In many cases . . . this is impossible to prove, just because honest medical opinion cannot segregate the causes of an illness between compound causes. And if one asks which of the parties, the workman or the employer should suffer from this inherent evidential difficulty, the answer as a matter in policy or justice should be that it is the creator of the risk, who ex hypothesi must be taken to have foreseen the possibility of damage, who should bear its consequences."

140. In *Best v. Wellcome Foundation Ltd.* [1993] 3 I.R. 421, O'Flaherty J. said with regard to the *McGee v. National Coal Board*:

> "The case would, I venture to think, find frequent resonance in our courts."

The Facts – Background Findings

1. The plaintiff was admitted to the National Maternity Hospital on 8th July, 1994 and, according to the records mandated by administration at the time, had an uncomplicated first and second stage of labour which was marked at the end thereof by a rupture of the perineum in the nature of a third degree tear.

2. The third degree tear, while repaired, caused serious faecal incontinence in the plaintiff which in 1995 had to be treated with a colostomy and provision of a colostomy bag.

The colostomy bag arrangement for the plaintiff is most probably a permanent feature for the rest of her life.

3. An ultrasound scan made prior to admission for labour indicated that the plaintiff would have a 4.25 kg. baby which is in the upper range of baby size and the baby as born weighed 3.95 kg.

Findings

The Midwifery Regime

1. The practice in Dublin Hospitals, Holles Street, Rotunda, Coombe and Mount Carmel, shows that a policy of restrictive use of episiotomy in multiparous is effective in keeping third degree tears down to levels below or comparable to international comparators. However, this practice is based on a high level of care by midwives ensuring measured breathing and pushing of the mother, culminating in a breathing and panting process which restrains the natural urge to

push, and facilitates the beneficial uterine contractions as the baby's head is crowned, and is about to pass through the perineum. This breathing and pushing control is combined with close and informed observation by the midwife of the crowning of the head, and stretching of the perineum, and monitoring of the labour in terms of time of the second stage and possible distress of the baby, as monitored on the foetal heart monitor, to allow, (in certain cases in the judgment of the midwife), an episiotomy to be carried out, to facilitate delivery and/or to avoid serious perineal tears including third degree tears. These combined skills and roles of the midwife, which are necessary to ensure the success of the policy of restrictive use of episiotomy, shall be referred to in these findings and judgment as "the midwifery regime".

The Risk Factors

2. While increase in baby size, POP and previous scarring of episiotomies in earlier pregnancies are factors indicating that there might be some risk of tearing of the perineum, the reliance in Dublin hospitals on the improved stretchability of the perineum resulting from previous vaginal deliveries and the midwifery regime means that, notwithstanding that risk, a planned episiotomy would not take place by reason only of any or all of these factors.

Equally competing Schools Of Thought

3. The episiotomy is an invasive and risk-laden surgical procedure and its disadvantages over a whole population of mothers must be balanced by obstetricians with any possible advantage to individual mothers who avoid serious second degree or more, especially third degree tears. It is within the competence of obstetricians and midwives professionally to decide where that balance lies. Internationally at least, there are several schools of responsible obstetric opinion as to where and how that balance ought to be struck.

The Wallenberg Study

4. The Wallenberg study upon which the plaintiff's experts most relied to argue for a planned episiotomy in the plaintiff's case related to a large population in Holland is not authority for a planned episiotomy in the Irish context for the following reasons:

(a) The figures were derived from a population with a much higher proportion of midwife-assisted home births.

(b) The episiotomy rate and the rate of third degree tears were very much higher than that of the (albeit smaller and anecdotal) population study put forward by the defendant's experts from Holles Street and the Coombe.

(c) The graph indicating a high correlation between baby size and third degree tears did not discriminate between primiparas and multiparas.

(d) The alleged 44% chance of success of an episiotomy derived by the plaintiffs counsel in cross-examination from table 1 of the Wallenberg study article is a fallacy when applied to one mother such as the plaintiff. To arrive at the relative risk statistic 100 or so women would have to have had an episiotomy but at least 97 of them would not have needed it. To assess the chances of success in a way in which it is sought to be used by the plaintiff, it is necessary first of all to ascertain with certainty the existence (or the 100% chance) of the malady – in this case the tear – , and then apply the relative risk statistic. On the basis that there was incontrovertible evidence that the chance of the plaintiff getting a third degree tear in Dublin is 1000 to 1 the magnitude of the fallacy is highlighted.

The Student Midwife

5. I hold that the evidence indicating that the student midwife told the patient to push at the first stage and this command was not altered appropriately in the second stage, either by student or midwife, so that the care of the midwifery regime was not established to ensure in optimum fashion that the plaintiff was at least risk of an explosive, uncontrolled delivery, giving rise to a perineal tear.

This conclusion, although based on evidence of the plaintiff which was uncontradicted, should be tested as it begs credibility to the extent that it is an unusual account and inconsistent with established professional practice. Nevertheless, I accept it as credible for the following reasons

(a) the plaintiff by her presentation and demeanour was a credible witness.

(b) the lack of discretionary notes and comments in the records in relation to the state of the perineum, the state of control or otherwise reached by the plaintiff as regards pushing and breathing.

(c) the account of the plaintiff that the student midwife told her that she was going to try extend the cervix manually (although this was acknowledged by the plaintiff not to be primarily part of the case made in negligence).

(d) the non appearance of the student nurse as a witness for the defendant given that the plaintiff persisted uncontradicted (if challenged) in her evidence in that regard

(e) the errors in the letter of discharge of the 30th of July 1994 generally showing a situation in regard to management and information systems which would tend to allay suspicion of the credibility of the plaintiff's allegations being made against a respected professional medical background.

(f) The evidence of Nurses O'Neill and Carroll that they would not have made such a suggestion to the plaintiff.

6. While there is no evidence that the POP and/or previous episiotomy scars arising from earlier births increase the risk of

a hold up at crowning stage and perineal tear to the extent that a planned episiotomy would on balance be indicated, there nevertheless were factors which on any of the evidence, articles or textbooks would make the rigorous application of the midwifery regime all the more critical in avoiding a third degree tear by last minute intervention of the midwife in a non planned discretionary episiotomy such as was envisaged as Ms. Hamilton as her second option failing a planned episiotomy.

7. As episiotomies are in fact carried out in an estimated 5% of multiparas for the sole purpose of avoiding a tear of the perineum, and as this arises from the same type of observational approach as the midwifery regime although the protocol for management of multi powers is, in other respects, different for multi powers. There is no effective difference between such episiotomies and those envisaged by Ms. Hamilton as a second option failing a planned episiotomy.

8. While in the ordinary circumstances of application of the midwifery regime the OP POP and scarring from previous births from episiotomies on previous births would not have increased the risk of a tear significantly, the lack of the application of the midwifery regime as held in these findings would have very significantly increased that risk having regard to the fact that a third degree tear suffered by the plaintiff as a third multi power had only a 1,000 to 1 chance of occurring with normal care. This view is reinforced by the evidence of Dr. Turner that in one instance the only woman from a section of mothers admitted to the Coombe was with a third degree tear was a woman who delivered before arriving in the hospital.

9. At 3.95 kilograms the baby size was not a significant factor in the management of labour as events turned out.

Conclusions

141. On the authority of *Dunne v. Holles Street* I find that the application of the more restrictive use of episiotomy school of medical opinion to the plaintiff's case is not one which could be rejected in favour of the school of medical opinion represented by the plaintiff's experts for a more liberal or planned use of episiotomy in the plaintiff's case, both schools of medical opinion are respected by obstetric experts and midwives internationally and whatever choice might have been made between them in the plaintiff's case could not give rise to a claim of negligence no matter what the tragic consequences to the plaintiff were.

142. However, so critical is the management regime to the effectiveness of the restrictive use of episiotomy school of medical opinion represented by the defendant's expert witnesses and Dr. Valerie Donnelly I consider that on the balance of probability the tear caused to the plaintiff arose by reason of the non establishment or breakdown of the management regime in her case.

143. If I am incorrect in my view in relation to the probabilities of causality, I am of the same view in relation to the liability of the defendants in negligence by reason of the application of the case of *Magee v. National Coal Board*. This is because defendants have by their choice of school of opinion predicated its success upon a high duty of care that is represented by the management regime, the breach of which exposes and exposed the plaintiff to a risk or added risk, of a tear. Notwithstanding that honest medical opinion may not be able to segregate the causes of the tear (contrary to my first conclusion above) between alterative causes, some of which sounding in negligence, and others not, the plaintiff should not suffer from any inherent evidential difficulty in this situation and, the answer is that as a matter of policy or justice, it should be the defendant (who was the creator of the risk by the non application of the midwifery regime), who must be taken to have foreseen the possibility of damage, and who should bear its consequences.

Damages

144. The plaintiff as a result of the damage to her anal sphincter was severely incontinent, while she got some relief initially from treatment she eventually became practically housebound and hampered functionally and socially and her relations with her family and husband inevitably suffered notwithstanding her smiling personality and good humoured nature. By her own account the colostomy operation has dramatically changed her life for the better and she said that she could now take her children out to McDonalds as a result. Her husband gave evidence that notwithstanding her positive outlook and good humour there is still strains arising from her inability to do all the chores in the house. For instance he hovered until such a stage as he had to get wooden floors by reason of his bad back he took time off work and became a taxi driver for a while so that he would be available during the day to take her shopping. She says that she is hampered socially by the stoma and the evidence from both herself and her husband was that it is embarrassing socially by reason of odours and threats of odours. She has got into the habit of carrying a coat or an article of clothing in front of her where the appliance is. She has an irritable stoma where the bag is attached and there is irritation and scalding at its site which to date has not yielded to any satisfactory treatment. Her condition will be permanent where as she had anticipated to go back to work while the children were at school when her last baby Eoin was 4 or 5. I consider that she would certainly have returned by the time he was 7 in July 2001. For a twenty hour week she might not have expected to earn more than £3,500 per annum net with tax even with her good experience in the employment market prior to marriage by reason of the hours that she might have to take off. There is no saying into the future that she will suffer at least a differential of €2 per hour after tax by reason of her reduced employability and capacity to work as a result of the constant imposition of the colostomy bag and the inevitable restrictions it places upon her. Her intentions to return to work even in an incapacitated state is quite impressive and I consider that it is reasonable for her to take two years to make the transition back to work after the hearing of this case is concluded by judgment. Mr. Lynch, actuary, gave evidence that the multiplier would be in the region of 900 per Euro lost per week into the future from November 2002 having regard to the fact that the marginal rate of tax will be 42% as the plaintiff's husband will have exhausted his combined personal allowances and still be liable for that amount therefore. I consider that the actuary multiplier of 900 should be used on a weekly loss net of tax of €40 making loss into the future for impaired employment prospects of €36,000. No reduction is made in respect of Reddy v. Bates as there may be a counter balancing consideration arising from the fact that the plaintiff may have had a hope of returning to full-time employment with the children out of their schooling and by reason of the fact that the multiplier of 900 may, in fact, be a little high having regard to the fact that twenty months or so has elapsed since it was first mooted in evidence by the actuary. Past special damages are agreed at £5,000 and future cost of colostomy appliance is estimated at the higher estimated figure of €2,032 per annum applying the actuarial multiplier and rounding down at €48,000 on the basis of the foregoing and having regard to all the evidence given the damages to which the plaintiff is entitled may be listed in broken down form as follows

Damages for past pain and suffering	€50,000
Damages for future pain and suffering	€100,000
Loss of wages for five years from 2001	€16,500
Loss of wages from commencement of employment to retirement aged 65	€36,000
Past agreed special damage	€5,000
Future cost of colostomy appliance	€48,000

Total	€255,500