Neutral Citation Number: [2013] IEHC 72

THE HIGH COURT

[2003/10829P]

BETWEEN

KAREN HURLEY AHERN AND GARRETT AHERN

PLAINTIFFS

AND

VICTOR MOORE AND THE SOUTHERN HEALTH BOARD

DEFENDANTS

JUDGMENT of Mr Justice Ryan delivered the 1st February 2013

Introduction
Following a failed sterilisation procedure carried out by the first defendant, Dr Moore, the first plaintiff Ms Karen Hurley Ahern became pregnant and gave birth by emergency caesarian section to a baby boy. Samuel was born with severe physical defects and he died at six months of age. The baby's unfortunate condition and his fatal illness were not caused by the ineffective sterilisation operation. The plaintiff had a painful and difficulty pregnancy and post-natal recovery. Samuel was transferred shortly after birth from Limerick to Our Lady's Hospital, Crumlin where he remained for the rest of his short life. His parents were distraught trying to keep watch by their baby's bedside while also caring for their two little girls at home. The whole experience has left lasting scars.

The plaintiffs claim that Dr Moore was negligent in performing the failed laparoscopic sterilisation. The operation involved affixing surgical clips to occlude Ms Hurley Ahern's fallopian tubes. The specific question is whether Dr Moore applied the clips to the fallopian tubes or to some other abdominal structure. Dr Moore is seriously ill and was unable to attend court. The evidence on the factual issue is that of Dr Cathy Burke, who as a specialist registrar delivered Samuel and did the re-sterilisation operation.

The defendants deny the claims and any entitlement to compensation. Even if negligence is established, they do not concede that the plaintiffs or either of them is entitled to recover damages. If the plaintiffs succeed, their claim for damages gives rise to disputed legal issues, including in particular whether the second plaintiff has any legal standing to claim compensation.

Chronology
The first plaintiff was born in 1971 and she is married to the second defendant but they have been separated since 2005. The plaintiffs have two surviving children, Abigail and Zoe, who were born in 1998 and 2000 respectively. They are also the parents of Samuel, who was born on the 10th October, 2002 and who died died aged six months on the 6th March 2003 from severe congenital abnormalities.

The plaintiffs live in Co. Limerick. The first plaintiff has a genetic blood clotting condition known as Factor V Leiden mutation which predisposes her to blood clot formation. It can cause a deep vein thrombosis or a pulmonary embolism and the risk in pregnancy for a person with Factor V Leiden mutation is much greater than for the general population. The condition makes pregnancy perilous but clots can occur in other circumstances. The plaintiff had blood clots in 1991 and 1997 when she was not pregnant.

The plaintiff's two successful pregnancies with Abigail in 1998 and Zoe in 2000 were delivered by Caesarean section. During those pregnancies, she had injections to prevent thrombosis and thereafter the drug Warfarin was prescribed for her for some time.

Ms Hurley Ahern discussed her condition with regard to future pregnancies with her General Practitioner Dr Margaret Murphy in 2000, following Zoe's birth. She was not able to use contraceptive pills because of her genetic condition. The doctor was of the view and Ms Hurley Ahern concurred that sterilisation would be appropriate. She and Mr Ahern had two girls who were healthy and the first plaintiff was happy with that family size in all the circumstances. The plaintiffs and Dr Murphy considered the situation and came to the conclusion that the best course to adopt was for Karen to have a sterilisation. The other plaintiff Garrett Ahern was himself willing to undergo sterilisation but the parties with the help of Dr Murphy came to the conclusion that such a step would not be appropriate.

In late 2000, Dr Murphy referred Ms Hurley Ahern to the first defendant, Dr Victor Moore, Consultant Obstetrician/Gynaecologist, at Tralee General Hospital with a view to her having a sterilisation. Her letter of 23rd August gave relevant information to the specialist: "She has a history of Factor V Leiden mutation and has had recurrent thrombosis. She has had three pregnancies with one early miscarriage and two live births both by C-section. She was treated with prophylactic Heparin during both the pregnancies and is currently on Warfarin 6mgs daily. She is 5 months postpartum." The letter also said that the patient was unable to use any hormonal contraception or the coil.

The operation was scheduled for the 11th January, 2001, but it did not take place because the plaintiff had a head cold. The procedure was rescheduled for the 8th February, 2001, when it was performed by Dr Moore.

Appropriate consent forms were presented to Ms Hurly Ahern and she signed them and no issue arises in that regard. Neither is there any issue in regard to information about the procedure or that there were certain risks involved that the procedure might not actually work. A point that is in dispute, however, is whether the first defendant's Registrar, Dr Vincent Malelekwa, now himself a Consultant Obstetrician/Gynaecologist, advised the plaintiffs that they should not have unprotected sex for a period of a year following the procedure. The first plaintiff gave evidence that the doctor did advise to that effect but he denies that and says that it would be contrary to medical science and to his own practice. Having regard to the cases made by the parties, the evidence and the issues that arise, the resolution of this question is of little importance in the decision.

Dr Moore carried out the procedure on the 11th January 2001, by way of laparoscopic (keyhole) surgery. The standard procedure is to apply clips to close the patient's fallopian tubes, through which eggs travel from the ovaries to the uterus. Dr Moore's operation note is as follows:-

Routine transabdominal pneumo peritoneum verres needle

suprapubically

Two Filshie clips to each tube

Omental adhesion to dome of bladder

obscured left tube so was divided by using laparoscopic scissors. Gas

released

instruments and 2.0 Catgut to puncture sites.

Dr Moore is unfortunately very ill at present and was unable as a result to give evidence. The court did have the evidence of his registrar, Dr Malelekwa but he was not in attendance at the operation that was performed by Dr Moore.

The plaintiffs testified that they had obeyed what Ms Hurley Ahern said was the instruction that Dr Malelekwa had given her in that they used condoms for the rest of 2001 or almost all of that period. They began having unprotected sex at the end of 2001.

In April 2002 the first plaintiff discovered that she was pregnant. This came as a great shock to her and her husband and they were upset about it. However, they accepted the situation and the pregnancy proceeded. Ms Hurley Ahern was admitted to hospital in Limerick in October 2002 and Samuel was born at 34 weeks by lower segment Caesarean section, which was an emergency Caesarean section that was carried out by the Registrar Dr Cathy Burke, herself also now a Consultant Obstetrician/Gynaecologist. At that time she was Registrar to Dr Gerry Burke, the Consultant in whose care the plaintiff was being treated. Dr Burke also carried out at the same time as the Caesarean section a tubal ligation with bilateral partial salpingectomy – the partial removal of fallopian tubes on each side. Her operation note included the comment – "Findings at operation: Normal ovaries. Filshie clips x 2 on each tube - migration thru to broad ligament". The correctness of this important entry was the subject of a great deal of debate in the case and is considered below.

Obviously the plaintiff Karen Hurley Ahern should not have become pregnant after the sterilisation operation. But it does not necessarily follow that the procedure was carried out in a negligent manner. The liability question is whether Dr Moore did the procedure in a negligent manner such that it was ineffective. He said in his operation note that he put two clips – Filshie clips – to each of the first plaintiff's fallopian tubes. Dr Cathy Burke's note of her operation and what she found said that the Filshie clips had been on the fallopian tubes. The question of liability therefore, is whether Dr Moore did in fact put the Filshie clips on the first plaintiff's fallopian tubes or alternatively did he do so in a proper and effective manner.

The Expert Evidence –Dr Edozian and Professor Turner
The expert witnesses were in agreement that if Dr Moore applied the Filshie clips to Ms Hurley Ahern's fallopian tubes he was not negligent. If he did otherwise, that is, if he failed to fix the clips on either side, he was negligent. If he did put them in the proper place, the question arises as to how the plaintiff became pregnant.

Dr Leroy Edozian, an expert witness called by the plaintiffs, is a Consultant Obstetrician/Gynaecologist in the National Health Service at St Mary's Hospital, Manchester, a teaching hospital of the University of Manchester. Prof. Michael Turner, who testified for the defendants, is a Consultant Obstetrician/Gynaecologist at the Coombe Hospital and is Professor of those specialisations at University College, Dublin.

Dr Edozian criticises Dr Moore for failure to carry out the sterilisation procedure properly so as to ensure that it was effective and he is also critical of the treating surgeon's note keeping. Dr Edozian thought it was clear that Dr Moore had not in fact put the Filshie clips on the fallopian tubes, as he intended to do and as he thought he had done. He pointed to the doctor's note as to the difficulty he found, which he had to deal with surgically, namely, the omental adhesion and suggested that this would be a reason why the doctor had put the clips on the wrong part of the body. It would be unusual for a gynaecologist to apply two clips to each fallopian tube but it was not negligent to do so and there are some doctors who follow that practice. Prof. Turner agreed. But Dr Edozian made the point that it would be practically unthinkable to have a situation where two properly applied clips on each side would have permitted a subsequent pregnancy. The effect of applying a clip is in effect to cause the necrosis or death of the captured tube tissue and obviously two clips would have an even greater impact of that kind. One of the possibilities of failure, which is that the tube may re-grow or reconstitute itself in such a way that the egg may nevertheless flow from one part of the tube to another, is even less likely in the case of two clips on each side. Prof. Turner did not consider that re-canalisation, i.e. re-growth of one of the fallopian tubes as accounted for the situation that occurred here.

This evidence of Prof. Turner also has the consequence that the dispute I referred to above involving the advice that Dr Malelekwa may or may not have given to the plaintiff about unprotected sex does not arise. The significance of that advice and its relevance or potential relevance to the case is that any such regeneration and recanalisation of the tube could not take place in the immediate aftermath of the procedure and would take some considerable months to occur. But since Dr Edozian thinks it did not happen or it is extremely unlikely and rejects it and Prof. Turner also thinks that it did not happen, the question whether any such alleged advice by Dr Malelekwa might have been taken which would account for the delay in the first plaintiff becoming pregnant – simply does not arise in the circumstances.

There is in truth little enough difference between Dr Edozian and Prof. Turner, as I understand the evidence. They are agreed that there is a risk of failure of a sterilisation procedure, which is 0.5%. Some causes are due to clinical error and some are due to natural causes. But it is a rare circumstance. Prof. Turner and Dr Edozian as mentioned above are agreed that there was no regeneration of the fallopian tissues in this case; that eliminates one of the major causes of failure that could have come about in the absence of negligence on the part of the practitioner. Prof. Turner suggested a possibility – a fistula in the fallopian tube –which is admittedly even more extremely rare than any other non-negligent possibility. Dr Edozian dismisses this possibility more or less out of hand as being so utterly remote that it can be quite discounted. But actually Prof. Turner was careful to clarify that he was not proposing this as a theory as to what happened or as an account of what occurred as a matter of probability. He was suggesting a medical/scientific possibility – no more than that – which is of course no more than a remote possibility in order to account for the evidence that Dr Cathy Burke gave. In other words, assuming that Dr Burke is correct in the note that she made at the time of the operation that the Filshie clips that she found had actually migrated to the position where she found them from being properly affixed to the first plaintiff's fallopian tubes, then obviously one is at a loss to understand how the first plaintiff became pregnant. On that assumption – that Dr Burke's comment or record accurately reflects the factual situation, then it means that Dr Moore did in fact put

the clips on the fallopian tubes and one has to account for the fact that a pregnancy followed. This is the context, as I understand, in which Prof. Turner puts forward the possibility – admittedly extremely rare – of a fistula as a theoretical possibility that might have accounted for the pregnancy. Prof. Turner takes the factual statement made by Dr Burke in her operation note at face value together with the latter's evidence that if she had found evidence at operation that the original procedure had been improperly carried out, she would have noted it and reported to the consultant.

Dr Cathy Burke's Involvement and her Evidence
Dr Burke is a consultant in obstetrics and gynaecology in Cork, with memberships of the Royal College of Obstetricians and Gynaecologists and the Royal College of Physicians in Ireland in Obstetrics and Gynaecology. She was first asked to recollect this matter in November 2010 and had no clear recollection of it . She said that she was largely working off her note of the procedure. In fact, she was entirely dependent on the record she made at the time and the hospital notes.

She was a specialist registrar in obstetrics and gynaecology in the first year of the specialist registrar training scheme in Limerick, training under Dr Gerry Burke, the Consultant in charge of Ms Hurley Ahern's care. Her first involvement with Ms Hurley Ahern, as appears from the hospital notes, was on the 21st September 2002 when she examined and mapped out a treatment plan for the patient. A caesarean section was planned from the outset.

The plaintiff remained in hospital as her pregnancy progressed. When Dr Burke operated on the 10th of October 2002, the plan was for cesarean section and tubal ligation. That was recorded after midnight, at 00:55. The baby's gestational age was 34 weeks and one day. The caesarian section was an emergency procedure because the mother's membranes had ruptured and in the circumstances of having had two previous cesarean sections, the risk was that the patient would labour and potentially rupture the scar of her previous cesarean sections which could cause a poor fetal outcome and could also cause maternal problems such as bleeding.

The operation note times the start of the operation at 0257 and records that paediatric management of the baby began at 0300, which means that the delivery was effected very quickly.

The doctor proceeded after delivering the baby to perform the sterilisation, which she noted as "Bilateral partial salpingectomy with removal of Filshie clips." The first words meant that Dr Burke surgically removed a portion of each of the patient's fallopian tubes, which she sent for histological examination to confirm that the procedure had been done correctly. Then the operation note said: "Findings at operation: Normal ovaries. Filshie clips x 2 on each tube - migration thru to broad ligament".

This is the controversial evidence. The debate turns on this entry. Professor Turner takes the statement at face value to mean that Dr Burke found at operation that there were or had been two Filshie clips on each fallopian tube. If so, there was no negligence on Dr Moore's part.

Dr Burke interpreted her note as meaning that the clips were originally on the tube on each side but had migrated to a place that was lower in the abdomen than the fallopian tubes. She said that migration was relatively common. The Filshie clip is applied across the fallopian tube and part of the broad ligament is grasped with the clip applicator in order to ascertain that the entire tube has been traversed by the clip. The doctor performing a laparoscopic sterilisation can see the toe of the clip through the broad ligament. Over time where the tube is compressed, the blood supply is cut off and avascular necrosis of the tissue occurs. The result is that the clip falls and comes to rest lower down than where it was originally applied. Dr Burke was asked if she could say from the note that that was her finding and she carefully replied that it was her inference from it.

The doctor said that if she had had any suspicion that the four clips had been originally applied to the broad ligament, she would have documented where they were and informed the relevant consultant that the procedure had been incorrectly performed in the first place. She rejected Dr Edozien's reference to a cover up. She did not know Dr Moore at the time .

Dr Burke said that it was easier for a gynaecologist to make a mistake by attaching clips to the round ligament than it was to attach them to the broad ligament when performing a laparoscopic sterilisation. However, she agreed with Mr McMahon SC in cross-examination that medical journals contained examples of both causes of error and failure. The two main areas of misapplication are the round ligament and the broad ligament.

In cross-examination Dr Burke said that the question of how Ms Hurley Ahern became pregnant did not occur to her at the time. Her focus after delivering the baby was to perform the planned sterilisation and was not to ascertain what had caused the failure of the sterilisation in the first place. She was not in an investigative frame of mind. Her priority was delivering the baby and carrying out the sterilisation procedure, as opposed to proving why the sterilisation had failed.

She did not recall examining the Filshie clips or whether the fallopian tubes were transected. She could not remember how the clips were being held on the broad ligament. Dr Burke accepted in retrospect that it was important to ascertain whether there was a fistula that would account for the failure of the original procedure and the pregnancy. Her primary objective in taking the small samples of fallopian tube was to provide a specimen to demonstrate that her sterilisation procedure was correctly done by giving a full cross-section of the fallopian tube. She did not think that she needed to provide histological evidence of why the sterilisation had failed.

Dr Burke accepted that there was no subsequent discussion or inquiry as to why the previous sterilisation had failed. It appeared that nobody in the hospital gave Ms Hurley Ahern in the two weeks that she remained an in-patient any information of how or why her sterilisation had failed.

Dr Edozian's was critical of the record made by Doctor Burke after she had performed the Caesarean section and re-sterilisation. He went so far as to say that Doctor Burke intended it to be misleading but I do not think that there was any such motivation. It is however the case as Doctor Burke accepts that the note of the operation is not as complete as it ought to be. Specifically, Dr Edozian says that the surgeon should have noted and specified the location where the clips were found and should not have suggested that the clips had migrated to the broad ligament from an original position on the fallopian tubes. He concluded that Dr Moore applied the clips to a structure is other than the fallopian tubes and in doing so he fell below the standard of care required of a surgeon in his position. In his view, although it was possible for a clip to migrate, the likelihood that all four clips left their original correct position within a matter of months was extremely low. It was equally unacceptable if the Filshie clips were applied to the broad ligament, where they were found by Dr Burke.

Liability
Dr Burke candidly acknowledged that she gave her evidence relying on her operation note and not any memory of the procedure. Her motivation was not investigative at the time but was directed to treatment: this was a 3 am emergency caesarian section and her

priorities were the safety of the mother and her baby and doing the tubal ligation. That explains why she did not remove all of the fallopian tubes and simply excised a sample for the purpose of subsequent histological confirmation the she had successfully carried out the sterilisation. She did not actually direct her mind to the question of how the patient became pregnant following sterilisation procedure. She was not the consultant in charge of the plaintiff's care. She was not looking for evidence of what went wrong and did not examine the fallopian tubes, which would have provided the crucial evidence. If for some reason it was not possible to see the fallopian tubes, it would have been important to say that.

Dr Burke's operation note is not and could not be an accurate description of what she observed; the fact that she refers to the Filshie clips having migrated necessarily implies that they were not in their original position, wherever that was. There was no recorded evidence to justify the inference that they were correctly located prior to their migration. There is no evidence to show where the clips were before they migrated.

I think the doctor assumed that Dr Moore did his operation properly and did not set out to establish whether that was actually the case. I accept that if she had indeed noticed something obviously wrong, she would have reported it, which means that she did not notice anything amiss. However, she was not alive to the issue of the failed sterilisation and was not looking out for evidence. A general obligation to report evidence of malpractice or error, which I accept Dr Burke would have observed, together with failure to make any such report do not, in the circumstances of this case, constitute evidence of sufficient weight or specificity to refute the plaintiff's case.

If Dr Moore performed the sterilisation properly, one must look for an explanation of the pregnancy. The only possibilities raised are extremely rare. Operator error is one of recognised causes of failure.

In my judgment, Dr Burke's operation note and her evidence do not absolve Dr Moore from liability by confirming correct application of the clips. It follows and I accept Dr Edozian's evidence that the probability is that he did not do so. I also accept this expert's opinion that if two clips were applied on each side there was no question of recanalisation. There was no reasonable probable explanation for the pregnancy if the sterilisation was carried out properly.

My conclusion does not in any way imply rejection of Professor Turner's evidence. His opinion as I said above was based on the proposition that Dr Burke's findings at operation established that Dr Moore put the Filshie clips in the proper positions. That defence proposed is not based on fact but rather on assumption on Dr Cathy Burke's part. He agreed that re-canalisation was not a reasonable probability and the fistula theory was admittedly an extremely remote possibility. Its only relevance was to establish a theoretically possible explanation for the pregnancy if it were to be accepted that the clips were properly applied.

Damages
I propose to address first the entitlement of the first plaintiff, Ms Hurley Ahern.

The plaintiff's evidence was that this, her third pregnancy was very difficult and quite different from her two previous pregnancies.. She got seizures. She was in hospital more often. She suffered acute morning sickness and from migraine. She and Garrett were planning to marry in June 2001 and she discovered she was pregnant in April. She was shocked; she was facing another operation; she would require more injections; she was worried because her pregnancy had progressed so far without injections whereas in each previous pregnancy she had been put on injections at once—now months had gone without any.

The baby was due in November but she went into hospital in late September with toxemia, blood pressure and bleeding. It was during that admission that her waters broke, precipitating the emergency intervention by Dr Cathy Burke.

When her waters broke she said that she became panicky. After the operation, she began to realise there was something wrong with her baby. When she went to see him he was in an incubator and weighed only 3 lbs 3 ounces. She stayed with about half an hour and then they took him away to the ambulance to bring him to Crumlin Children's Hospital. She remained in hospital for another two weeks and immediately on her discharge she drove to Dublin to see her son, Samuel, who was christened before he left Limerick.

It was good to see him but she missed her children at home, whom she had not seen for three weeks. She and the second plaintiff were going up and down to Dublin. On one occasion when they were in Dublin, her mother had a stroke while she was minding the girls.

Seeing the baby after his operation was very hard because his chest was left open for therapeutic reasons. The hospital was very good but it as a very painful time. They spent Christmas at home with the girls and New Year in Dublin with Samuel.

In early 2003, he became very ill. They were at home at the time and the hospital rang and said Samuel had had a massive heart attack. He had been dead but the doctors had resuscitated him. They made their way to Dublin. Samuel was on life support. The parents had to make the decision to turn off the machines. Over a period of days they came to the inevitable, irresistible conclusion. Ms Hurley Ahern held him in her arms.

They waited and then brought him home in the car. It affected the girls significantly but in different ways and continues to do so. Ms Hurley Ahern is conscious of the need to acknowledge their feelings and to help to work through them.

Dr Margaret Murphy, the plaintiff's General Practitioner, confirmed that it was a difficult pregnancy. Ms Hurley Ahern was very anxious and upset initially. She suffered with severe migraines and she had an admission to the Regional Hospital with seizures at 26 weeks pregnant. She had another admission in September at 29 weeks pregnant where they thought she might have a DVT clot in her leg. She did not have a DVT but, again, it added to her anxiety around the pregnancy. She saw Dr Murphy nine times during the pregnancy. She had an emergency section at 34 weeks. She had been having bleeding and contractions and went into hospital.

They were up and down to Dublin a lot. The baby had a lot of surgery done and was very ill. Ms Hurley Ahern was very upset by the whole thing but kept positive that, hopefully, Samuel would be all right.

Submissions
The Plaintiffs submitted that in *Byrne v. Ryan* [2009] 4 IR 542, which raised a variety of issues as to liability and vicarious liability as well as damages, Kelly J adopted the reasoning of the House of Lords in *McFarlane v Tayside* [2000] 2 AC 59 in ruling against a claim for care costs until adulthood but awarding damages for the pain, suffering and inconvenience of childbirth and for having the sterilisation repeated. Although the defendant in *Byrne* expressly conceded such entitlement, that was sensible and reasonable. The speeches in *McFarlane* support this basis of claim.

Damages are not limited to the moment of birth and no longer—the principle is remoteness of damage not a precise timescale.

In regard to the claim of the second plaintiff, the submissions cited the obiter comment of Baroness Hale in *Parkinson v St James and Seacroft University Hospital NHS Trust* [2002] 1 QB at 294:

> Finally, I must say something about fathers. Most children still live in two-parent households in which the father plays an important part in their lives. Even when they live apart, we attach a great deal of importance to trying to preserve as good and as close a relationship as possible between the child and the parent with whom he is not living. We also expect a financial contribution from that parent. But this is not a debate in which the differences between the sexes can be ignored. The primary invasion of bodily integrity and autonomy is suffered by the mother. If the object of the operation was to prevent that particular mother becoming pregnant, the proximity between her and the defendant is as close as it can be. Even if the object of the operation (and later advice) was to render the father infertile, the proximity between his partner and the defendant is quite close. In both cases the nature of the harm to her is entirely clear and predictable, although it may vary in degree. Of the two types of harm, one can only be suffered by her. The other in my view is properly conceptualised as the obligation to care for and bring up the child. That too is, in the great majority of cases, primarily born by her. However, there are cases where it is shared, more or less equally, or where the primary carer is the father. My tentative view is, however, that, if there is a sufficient relationship of proximity between the tortfeasor and the father who not only has but meets his parental responsibility to care for the child, then the father too should have a claim. However, the issue does not arise in this case, and so it is unnecessary to express a concluded view.

They submitted that the claim here is that the first plaintiff has a blood condition making pregnancy more complicated and a cause of anxiety; she was in hospital for two weeks after the birth; thereafter she had a traumatic period of six months until Samuel's death. In those circumstances, it would be utterly unreal to deny the mother or father damages. Moreover, there were actual special damages incurred solely because of baby's condition.

The defendants submitted that the second plaintiff has no claim because he sustained no injury; neither is there a question of nervous shock.

Travel expenses and earnings losses during Samuel's illness are pure economic loss and therefore not compensatable.

The first plaintiff's claim in respect of the physical effects of pregnancy and birth is of a kind that was expressly conceded but not decided in *Byrne v Ryan*: there is no entitlement because pregnancy, with all its features of discomfort and pain, including that of the birth process, is a natural condition and not an injury. This echoes counsel's submissions in *McFarlane*.

The emotional toll of this pregnancy and its aftermath did not amount to nervous shock or psychiatric illness.

Discussion
The questions of principle and logic and policy that arise in assessing damages in cases of failed sterilisations have been debated in courts around the world. There is one Irish case, *Byrne v Ryan* [2009] 4 IR 542, but the issue that arises here was expressly conceded, so it was unnecessary for Kelly J to adjudicate on the question.

One approach that has been adopted in some United States cases and in Australia is to award damages that consist of or include the estimated cost of rearing the child to adulthood. The parents have been put to such expense, prospectively, by the negligence of the doctor who performed the operation or misinformed the patient about the result. This applies in the case of a normal, healthy child being born but obviously the damages will be increased if the baby is disabled and/or in need of special care and attention. This mode of assessing damages is said to accord with the principles of tort law and logic, a point on which there appears to be much agreement.

But the House of Lords rejected that approach in the leading case of *McFarlane v Tayside*, which held that as a matter of legal policy it is unacceptable to award damages for the birth of a normal, healthy child to compensate for the cost of his upbringing. It has been observed subsequently that the reasons given by their Lordships are different but the essential point is that a person cannot be compensated for the birth of a normal, healthy child. Such a claim was for pure economic loss which was not shown to be fair, just and reasonable. Considerations of distributive justice also militated against such an award. Their lordships did allow compensation for the pain and discomfort of the unwarranted pregnancy and childbirth.

Where the baby was born disabled, as was the case in *Parkinson v St James etc NHS Trust*, the Court of Appeal allowed a claim for the extra costs occasioned by the baby's disability, i.e., expenses over and above the normal cost of rearing the child. The majority of the court felt that such an approach was in accordance with *McFarlane*, which proceeded on the basis of a normal, healthy child.

Another permutation arose in *Rees v Darlington Memorial Hospital NHS Trust*. The House of Lords rejected a claim in respect of living expenses of a normal, healthy child who was born to a mother who was afflicted with a progressively worsening disability. The claim was that the mother's condition meant that rearing the child would involve additional expense.

Kelly J adopted the reasoning in *McFarlane* in ruling against the claim for care costs until adulthood in *Byrne v. Ryan* but allowing damages for the additional operation and for the pain, discomfort and inconvenience of pregnancy and delivery. However, although the case is a veritable compendium of clinical negligence issues, they did not include this point which was conceded. The defendants in this case are challenging the limited basis of award adopted in *McFarlane*.

In *McFarlane v Tayside*, Lord Slynn of Hadley could see no reason in principle why the plaintiff should not be awarded damages of the nature in issue in this case:

> My Lords, I do not find real difficulty in deciding the claim for damages in respect of thev pregnancy and birth itself. The parents did not want another child for justifiable, economic and family reasons; they already had four children. They were entitled lawfully to take steps to make sure that that did not happen, one possible such step being a vasectomy of the husband. It was plainly foreseeable that if the operation did not succeed, or recanalisation of the vas took place, but the husband was told that contraceptive measures were not necessary, the wife might become pregnant. It does not seem to me to be necessary to consider the events of an unwanted conception and birth in terms of "harm" or "injury" in its ordinary sense of the words. They were unwanted and known by the health board to be unwanted events. The object of the vasectomy was to prevent them happening. It seems to me that in consequence the wife, if there was negligence, is entitled by way of general damages to be compensated for the pain and discomfort and inconvenience of the unwanted pregnancy and birth and she is also entitled to special damages associated with both—extra medical expenses, clothes for

> herself and equipment on the birth of the baby. She does not claim but in my view, in principle she would have been entitled to prove compensation for loss of earnings due to the pregnancy and birth.

Lord Steyn addressed the contention of the defendants in that case and this:

> Counsel for the health authority argued as his primary submission that the whole claim should fail because the natural processes of conception and childbirth cannot in law amount to personal injury. This is a view taken in some jurisdictions. On the other hand, it is inconsistent with many other decisions, notably where limited recovery of compensation for pain, suffering and distress is allowed. I would not follow this path. After all, the hypothesis is that the negligence of the surgeon caused the physical consequences of pain and suffering associated with pregnancy and childbirth. And every pregnancy involves substantial discomfort and pain. I would therefore reject the argument of the health authority on this point.

Lord Hope of Craighead considered some of the authorities in the United Kingdom and elsewhere which, he said, were with only a few exceptions, all one way on this point. He cited with approval *Udale v. Bloomsbury Area Health Authority* [1983] 1 W.L.R. 1098, in which Jupp J. said at p. 1104:

> where a healthy child was born following a sterilisation operation, it was conceded that the mother was entitled to damages for (1) the original operation which had turned out to be useless; (2) the shock and anxiety of an unwanted pregnancy; (3) the anger at the thwarting of the decision which she and her husband had taken not to have more children; (4) the ordinary symptoms of pregnancy during the early stages, which she thought were due to illness or disease, and the taking of unnecessary drugs to overcome them; (5) her fear, after the pregnancy was diagnosed, that the drugs may have harmed or deformed the child; (6) the operation for resterilisation after the birth; and (7) her loss of earnings for about 11 months made necessary by the pregnancy and birth.

Lord Hope pointed out that similar approaches were adopted In *Thake v. Maurice* [1986] Q.B. 644, *Allen v. Bloomsbury Health Authority* [1993] 1 All E.R. 651, *Allan v. Greater Glasgow Health Board* 1998 S.L.T. 580. He also referred to the position in Canada:

> "Lax J., sitting in the Ontario Court (General Division) in *Kealey v. Berezowski*, 136 D.L.R. (4th) 708, 742 said that, having become pregnant as a result of a failed sterilisation, the mother was entitled to the damages which flowed from the pregnancy, labour and delivery as well as the necessity to undergo a second sterilisation process. It appears from his observations, at p. 743, that he would also have awarded her damages for sick days taken off work during pregnancy, for lost overtime and for other elements of loss of income attributable to this period had there been adequate proof of these items."

The claim is not limited to the moment of birth and no longer. Lord Hope said that the principle was remoteness of damage not timescale:

I should however like to emphasise that I do not think that it would be right to regard the mother's claims for solatium and for any financial loss attributable to the pregnancy as terminating at the precise moment of the child's birth. The pleadings do not suggest that a claim is being made in this case for any discomfort, pain or distress after the delivery or for any loss of income during the period when the second named pursuer was recovering from it. But it is not difficult to imagine that there may be cases where the mother experiences physical or emotional problems after the birth or sustains loss of income during that period which is attributable to the effects upon her of the pregnancy. I would prefer to limit the scope for the recovery of damages under this head by applying the normal rules as to the remoteness of damage rather than subjecting the claim to a strict and, as I see it, unreasonable and unrealistic timetable.

Like Mr Justice Kelly, I think that the approach of the House of Lords in *McFarlane* is to be preferred and I adopt the conclusions of their lordships in that case. It is of course correct to say that the speeches do not follow the same lines of reasoning but that does not detract from the status of the case as an authority representing mainstream thought on this topic in the common law world. In this jurisdiction, there is also as Kelly J points out, a Constitutional dimension that supports the central conclusion.

I propose to apply the principle as to the award of damages as stated in *McFarlane* for the following reasons.

It is clear from the above quotations that a plaintiff in the relevant situation is generally allowed a measure of general damages for the failed sterilisation, the pregnancy, the delivery and the extra operation, to enumerate some of the sequelae of the defendants' negligence. In some cases, there were express concessions in that regard, which happened in *Byrne*. That was not the case in *McFarlane*. The submission by counsel that there should be no recovery was rejected. The other authorities do not support this position. Indeed, the debate internationally is not whether the plaintiff is entitled to any award but whether it should be very substantially greater. The consensus of authority in this country (admittedly by concession), in the United Kingdom and elsewhere in the common law world is to allow recovery of this nature.

It will be noted from the cases that the point has been conceded in different jurisdictions. I think that is of some significance; the fact that counsel entrusted with the defence of these important cases have adopted that position indicates acceptance of what they consider to be not worth contesting.

Another way of approaching the question in light of *McFarlane* is to say that such experiences as the plaintiff had during this time are allowable in principle, as the speeches of their Lordships acknowledged and as has been accepted in subsequent cases, and there is nothing in the circumstances that would justify invoking a principle or policy to deny recovery. This is not a case in which the exclusion principle identified in McFarlane arises.

It is clear therefore that the first plaintiff is entitled to damages, in accordance with these authorities. But that is not the end of the matter. Can she recover damages for the six-month period post Samuel's birth? It has not been submitted that a distinction should be drawn in time to establish a cut-off point but the general objection to any award must be borne in mind. There is no concession in this regard.

I agree with Lord Hope that there is not a rigid timescale involved and that the question is one of remoteness of damage. Applying that test, I think that the period of Samuel's life has to be included. Obviously, the dreadful trauma of Samuel's illness and death would not have happened absent the defendants' negligence but I do not think that is sufficient. If I am wrong in that, no issue arises. It is arguable that such period is to be taken into account on the ground of foreseeability. But tragic events like that do happen with pregnancies. However, on a test of remoteness as advanced by Lord Hope, it seems to me that the post-natal six month

period is and must be properly included.

I think it would be difficult to justify a rule that cut off recovery in respect of tragic and affecting circumstances that framed and exacerbated the recoverable pain, suffering and inconvenience. The experiences that followed and resulted from the negligence in this case were a continuum. That might not arise in other circumstances; no two cases are the same as a review of the permutations of facts in the cases reveals. The defendants were negligent. The plaintiffs suffered injury, loss and damage as a result. It would be illogical as well as unjust to deny recovery of any damages or indeed of any significant part of the damages. The traumatic experiences and losses are in principle recoverable and there is no countervailing consideration in this case. The injury, pain, suffering, inconvenience, disappointment, nuisance and mental distress must together be taken into account. They arise from the defendants' wrong and amount to or are intimately associated with the compensatable injuries and furnish the context of the suffering that resulted.

I propose accordingly to approach this case on the basis that all of the events up to Samuel's death are to be taken into account in assessing compensation.

The plaintiffs decided on sterilisation for serious health reasons and in consultation with their general practitioner and not simply for family planning purposes. They were of course entitled to decide that Ms Ahern would be sterilised for purely family planning reasons but the case is arguably stronger because sterilisation was medically warranted and was actually the reason for deciding on it.

The plaintiffs by reason of the negligence of the defendants have suffered in a variety of ways including pain and suffering and loss and damage. The course of their lives was irrevocably altered by the pregnancy because it is clear that even though Samuel died, the circumstances of his birth, illness and death will stay with the plaintiffs for the rest of their lives. Karen suffered the pain, discomfort and inconvenience of the pregnancy which were more acute because of her medical condition that warranted sterilisation. So there was a lot of extra worry because of the risk that she would get clots.

It is of course the case that the plaintiffs did not suffer physical or psychological injury. They did not suffer nervous shock. The first plaintiff did not suffer a blood clot. Baby Samuel's condition of severe disability was not a consequence of the defendant's negligence. However, the the first plaintiff, and the second plaintiff to a significant extent also, suffered a series of adverse consequences by reason of the defendant's negligence:

1. Frustration of their decision as to sterilisation.

2. Worry about pregnancy.

3. Risk of blood clots.

4. Bodily changes and discomfort of pregnancy.

5. Pain of childbirth.

6. Hospitalisation for two weeks.

7. Distress at discovery of baby Samuels's condition.

8. Disruption of family life during Samuel's illness in his six months of life.

9. Anxiety and upset at his deteriorating illness.

10. Mental distress on his death.

11. Travelling and separation.

12. Continuing feelings of bereavement after Samuel's death.

13. Expenses of travelling and overnight stays in Dublin.

14. Unspecified earnings losses of the second plaintiff.

Items 13 and 14 remain in dispute. If no agreement is reached some further debate will be necessary to determine these claims if they are allowed.

There is no doubt that the first plaintiff is entitled to a substantial award of general damages, which I assess in the amount of €100,000.

The second plaintiff
Although he has undoubtedly suffered some of the detriments and distresses that I have described as afflicting the first plaintiff, I am obliged to find that Mr Garrett Ahern is not entitled to damages. I do not consider that the law permits recovery of compensation in his case. He undoubtedly suffered severe distress and emotional anguish. But the law sets a barrier to the right to compensation for such painful experiences. It requires proof that the claimant suffered a defined psychiatric injury. I do not underestimate the trauma that Mr Ahern experienced. However, there is no legal rule that would permit me to award him damages. The height of the case as advanced on his behalf is a passing comment by Baroness Hale in Parkinson which is obiter and conditional. It would be necessary to invent a new head of claim to compensate Mr Ahern. Any monetary expenses laid out by him come into the category of pure economic loss unassociated with injury and are also incapable of being recovered.