Neutral Citation Number: [2009] IEHC 221

THE HIGH COURT
2004 6479 P

BETWEEN

PAUL HEALY (A MINOR) SUING BY HIS MOTHER AND NEXT FRIEND, MICHELLE HEALY
PLAINTIFF

AND

THE HEALTH SERVICE EXECUTIVE AND ROBERT FITZSIMONS

DEFENDANTS

JUDGMENT of Mr. Justice John Quirke delivered on the 8th day of May, 2009

The plaintiff, Paul Healy, was born on 14th February, 2000, in Tralee General Hospital in County Kerry.

In these proceedings, it was claimed on his behalf that he suffered serious personal injuries a short time after his birth by reason of negligence and breach of duty on the part of the defendants. He sought damages from the defendants to compensate him for the injuries which he suffered and for the loss and damage which he has sustained and will sustain as a result of those injuries.

The first named defendant is the Health Service Executive which is the corporate body established by law with responsibility for the provision of health services within the State. Its responsibilities include the management, control and administration of Tralee General Hospital (hereafter "the hospital"), and the provision of paediatric, antenatal and post-natal care and services to patients, (including the plaintiff), who attend the hospital.

The second named defendant, Dr. Robert Fitzsimons, is a consultant paediatrician who, at all times material to these proceedings, practised his profession at the hospital and provided paediatric care to the plaintiff before, during and after his birth.

The plaintiff was born by normal vaginal delivery. Although he appeared to be in excellent condition at birth, there had been a natural interference with the return of his foetal intestine from his physiological hernia to his abdominal cavity. During a normal process of orderly return, the intestine undergoes systematic rotation and fixation. There was an interference with that process for the plaintiff and he was born with a malrotation, which is the term used to denote such an interference.

It was not claimed that malrotation could or ought to have been detected at or immediately after birth in the absence of symptoms indicating its existence. 55% of malrotations present within the first week of life and 80% within the first month.

Although malrotation may exist undetected for significant periods, it is generally accepted that once the diagnosis of malrotation has been established, surgical correction should be carried out in order to avoid the occurrence of what is known as a volvulus.

A volvulus is a twist or twisting of the intestine because it is not or is inadequately secured to the abdominal wall. The resultant knotting or corkscrew twisting of the intestine develops over time and involves an obstruction to the path of nutrients through the intestinal tract. It also results in intestinal obstruction and ischaemia consequent upon interruption of the blood supply to the intestine.

Intestinal obstruction causes bile to pour into the intestine and this causes bile-stained vomit. Consequently, bile-stained vomit is known by experienced and competent practitioners to be a highly characteristic symptom of volvulus.

Ischemia is the consequence of deprivation of blood and oxygen to the intestine, which, consequently, results in necrosis of the affected part of the bowel which becomes gangrenous. The resulting condition is called necrotising enterocolitis.

In these proceedings, it was claimed on behalf of the plaintiff, that, whilst he was relying upon the medical care and treatment provided by the defendants during the first four days of his life, he exhibited the classic symptoms of malrotation which should have been treated by the defendants as a surgical emergency.

It was contended that the defendants failed to recognise those symptoms and discharged the plaintiff from the hospital in the early afternoon of 17th February, 2000.

The plaintiff was brought back to the hospital by his parents and readmitted on the evening of 18th February, 2000, where an acute bowel obstruction was diagnosed and he was transferred by ambulance to Our Lady's Hospital in Crumlin (hereafter "Crumlin") in Dublin where surgery disclosed a malrotation and a small bowel volvulus. Thereafter, the medical and nursing treatment which he received was exemplary.

The surgical and medical staff in Crumlin did not expect him to survive during the first three or four days after his admission, but he did so. He remained in Crumlin for more than seven months during which time he required repeated extensive and extremely serious surgical treatment including five surgical laparotomies. He had repeated small bowel resections. Less than 1% of his small bowel remains.

The consequences of his injury have been permanent and catastrophic. Upon returning to his home, he required constant intensive care, including intravenous feeding in a totally sterile environment artificially created within his home. His parents have both abandoned fulltime gainful employment in order to provide him with necessary care.

He is now nine years old. In evidence, his mother provided a harrowing, detailed and often nightmarish account of what he (and his family) has had to endure constantly and continuously from the moment of his birth and throughout his childhood.

He will require ongoing medical care and treatment. The remainder of his life will be permanently blighted. He will suffer permanent distressing and embarrassing symptoms which will cause him to be socially isolated and will greatly diminish his capacity to obtain any kind of remunerative employment

All allegations of negligence and breach of duty were initially denied by the defendants and each defendant sought an indemnity or contribution from the other in respect of the plaintiff's claim for damages.

On the ninth day of the trial of these proceedings, the defendants expressly or implicitly acknowledged that the injuries, loss and damage which gave rise to these proceedings were caused by reason of the negligence and breach of duty of the defendants or one or other or both of them.

Accordingly, the plaintiff's claim against the defendants was compromised on terms which were acceptable to the plaintiff.

The issue which the court is now required to determine is whether the negligence of one or other or both of the defendants caused or contributed to the plaintiff's injuries, loss and damage and, if both defendants contributed, how liability should be apportioned between the defendants.

RELEVANT FACTUAL EVIDENCE

Mrs. Michelle Healy
The following relevant evidence was adduced by the plaintiff's mother and next friend, Michelle Healy:

1. The plaintiff (Paul) is the second of her four children. The family lives at Knockanish, Tralee, in County Kerry. At the time of Paul's birth, Mrs. Healy was thirty years old and had considerable experience caring for children. She had attended the births of many of her seven nieces and nephews and had nursed many of them during infancy. She was then the mother of one daughter, Rachel, who was three years old.

2. Her pregnancy with the plaintiff was uneventful and when she went into labour on the morning of Monday 14th February, 2000, she was driven by her husband, Peter, to the hospital. She was admitted to the labour ward at 6.20am and the plaintiff was born in seemingly excellent condition at 6.52am.

3. She had no recollection of any particular events on 14th February, 2000. She was administered painkillers and sedatives, having undergone an episiotomy during the birth.

She believed that the plaintiff was taken from her and brought to the nearby nursery so that she could sleep peacefully during the night of 14th February, 2000.

On Tuesday morning 15th February, 2000, her husband, Peter, and her three-year old daughter, Rachel, visited her and were introduced to the plaintiff. She noticed that the plaintiff was crying a little and was upset.

That afternoon, her husband returned alone, and she noticed that the plaintiff was still unsettled, was dribbling during feeding and was agitated and crying.

On the evening of the 15th February, 2000, Nurse Tarrant, with whom Mrs. Healy was acquainted, was on duty. Mrs. Healy confided in her that she was having trouble feeding the plaintiff because he was constantly crying and she was unable to feed him in the manner which she believed to be appropriate. It was suggested to her that she was overfeeding the plaintiff but she did not believe that to be the case, having regard to her experience with other infants.

Later that evening, Nurse Tarrant brought the plaintiff to the nurses station because it had proved difficult to settle him adequately.

The plaintiff was again taken to the nursery that evening so that Mrs. Healy could get some much-needed sleep. However, she was upset and worried about her newborn son.

4. When she awoke at 5.30am, she went to the nursery to retrieve the plaintiff and was disappointed to note that he was sleeping with a soother in his mouth. Although she did not approve of the use of soothers to help infants to sleep, she was happy to see him sleep and when he awoke, she managed to feed him. She said that within a few moments after she had commenced feeding him, he brought up a dirty yellow and green coloured vomit which soiled his clothing.

When her husband, Peter, came in to see her at approximately 11.00am, she asked him to feed the plaintiff whilst she reported the vomit and brought the stained clothing to the nurses station. She asked the nurses at the station to show the stained clothing to Dr. Fitzsimons.

5. Later in the morning, the plaintiff again brought up vomit which Mrs. Healy described as dirty green and yellow. She became frightened because her baby was constantly upset and had screamed and cried during most of the morning.

She fed him small amounts of feeding formula frequently, but he vomited again at approximately 1.00pm. The hospital's nursing notes for the plaintiff on that day recorded "1.00pm - vomited - small yellow fluid - save for inspection".

6. Mrs. Healy recalled becoming very agitated after lunch on 16th February, and returning to the nurses station accompanied by her mother. She recalled noticing that Dr. Fitzsimons was attending another patient in the bed opposite the nurses station. She was relieved to see him and retrieved the plaintiff's vomit-stained clothing in order to show to Dr. Fitzsimons.

When she approached him, he indicated that he would come over to see her in a moment. Shortly afterwards, he did so. Dr. Fitzsimons then examined the plaintiff and informed Mrs. Healy that he was not concerned by the colour of the vomit but wished to investigate possible Craniotabes which is a softness of the skull bones which can be a clinical sign of rickets.

Nurse Eileen Quirke (who is now deceased), was present during the plaintiff's examination by Dr. Fitzsimons. Nurse Quirke advised Dr. Fitzsimons that Mrs. Healy was possibly over-feeding the plaintiff. She offered to take Mrs. Healy and the plaintiff to the nursery so that she could be instructed in appropriate feeding practice.

In the nursery, after feeding the plaintiff, he again brought up a dirty yellow green vomit. The vomit was a "forceful" vomit and Nurse Quirke turned her gaze to Dr. Fitzsimons who was present at the nurses station and had observed the incident.

7. Mrs. Healy remembered "numerous vomits" on 16th February. She believed that there were more vomits than those recorded in the nurse's notes. She did not precisely recall a vomit which she would describe as "egg yolk yellow curdy coloured fluid" although the nursing notes recorded such a vomit at 7.00pm that evening. All of the vomits which she observed were the same - "a dirty yellow green colour".

The plaintiff remained with her in the ward during the night of 16th February. He was unsettled and she felt that he was not feeding adequately.

8. Her husband arrived at the hospital on the morning of 17th February and remained with her. A doctor arrived before midday. She mentioned to him that she thought that the plaintiff looked slightly jaundiced.

The doctor left the room. He returned within fifteen or twenty minutes and said that the plaintiff was well and that both he and his mother could be discharged from the hospital. Mrs. Healy advised the doctor of her worries about Paul. He told her "you are okay, you can get ready to go, your baby is okay."

9. Mrs. Healy and her husband returned home with the plaintiff. That afternoon, at approximately 3.30pm, the plaintiff vomited. Mrs. Healy noticed that the vomit was green in colour.

She did not telephone the hospital immediately because she had already expressed her concern to the nursing staff and to Dr. Fitzsimons in relation to the vomit and had been reassured that the plaintiff was well. However, he did not settle and was crying. Her sister was concerned.

The vomiting continued after subsequent feeds. She rang the hospital around teatime. She spoke to a nurse, advising her that Paul had been discharged from the hospital that morning and was vomiting. The nurse advised that, since she had been discharged from the hospital, any concerns which she had for her child should now be referred to her General Practitioner.

10. She decided to wait until Nurse Tarrant, (who had been attentive and helpful to her after Paul's birth), was on duty. She called the hospital later that evening and spoke to Nurse Tarrant who expressed surprise that she had been discharged.

Nurse Tarrant advised Mrs. Healy to purchase another type of feeding formula called Wysoy. Acting on that advice, her husband, Peter, unsuccessfully attempted to purchase Wysoy in various shops in Tralee. Mrs. Healy again telephoned Nurse Tarrant. She was advised then by Nurse Tarrant that she should attempt overnight to feed the plaintiff with cooled water and sugar. She tried to do so but he cried constantly all night. She and her husband slept on a couch and upon a chair caring for him. When she fed the plaintiff, he vomited again. The colour of the vomit was green.

11. Her sister-in-law, Caroline, who had been a midwife by profession, arrived the next morning. When she saw Paul, she advised that he should be taken straight back to the hospital.

Having regard to the advice given by the hospital staff during her earlier telephone conversations, Mrs. Healy rang her General Practitioner, Dr. McCarthy, who advised that the plaintiff should be returned to the hospital immediately for admission.

It was necessary for Mrs. Healy to collect a letter of referral from Dr. McCarthy. She then travelled with the plaintiff to the hospital, together with her brother and sister-in-law, Caroline.

On arrival at the hospital, she was delayed whilst the staff tried to locate the records of her earlier confinement. She completed a patient assessment form. At 5.00pm her files were located.

She was taken to an upstairs ward where the plaintiff was examined at approximately 6.15pm. Within a few moments after his investigation, Dr. McCormack, who is a consultant paediatrician, arrived. He examined the plaintiff. After this examination, "everything changed" and Mrs. Healy was advised to have the plaintiff christened. A priest arrived in the room. The plaintiff was baptized.

He needed to be transferred urgently to Crumlin. An ambulance arrived at 9.00pm. It left with the plaintiff and nursing staff at 10.00pm and embarked upon the journey to Crumlin.

Ms. Breda O'Donoghue

1. Ms. O'Donoghue is a qualified nurse and midwife. She stated, in evidence, that she was assigned to duty in the post-natal ward of the hospital between 9.00pm and 9.00am on each of the three nights commencing on 14th February, 2000. Her duties included the provision of nursing care to the plaintiff and his mother.

The nursing practice within the ward was for each outgoing nurse to read aloud to each incoming nurse the medical nursing notes in respect of each patient for whom the incoming nurse was to be responsible.

She said she was satisfied that this practice was observed in respect of the plaintiff and his mother during the three nights commencing on 14th February, 2000.

She said that the nursing notes indicated that the plaintiff had had two yellow coloured vomits which would have been "unusual" in a newborn child. Dr. Fitzsimons had instructed that the plaintiff should be observed. She understood this to mean that any abnormal vomiting should be documented. It was the duty of the nursing staff to observe the baby and record any vomiting.

Dr. Fitzsimons had also directed that a midstream urinalysis should be undertaken in respect of the child.

Whilst her principal recollection in respect of the plaintiff and his mother was derived from her examination and consideration of the nursing notes, she recalled that she was instructed by the "day staff" at 9.00pm 16th February, 2000, to observe the plaintiff for yellow coloured vomit. The notes did not reflect any significant vomiting by the plaintiff on the night of 16th February, 2000. They did not reflect frequency of vomiting.

She said if the plaintiff had vomited as frequently and in the manner described by his mother during 16th February, 2000, and thereafter, then such vomits should have been recorded in the nursing notes.

She said her examination of the notes suggested that on the morning of 17th February, 2000, the plaintiff had been feeding every four hours and she therefore believed that he would have been fed at 8.30am and 12.30pm, although there were no notes indicating that this was the case.

She said the decision to discharge the plaintiff would have been made by the senior house officer.

She said that it is her understanding that weight loss of up to 10% in a bottle-fed infant and up to 15% in a breastfed infant was "normal".

She said that the mothers of newborn infants often call the hospital shortly after discharge for advice and assistance. This advice and assistance usually relates to feeding problems, jaundice and other birth-related difficulties.

She said that when this happened, it was the practice in the hospital for midwives and nurses to question the mothers in relation to the symptoms complained of. If a telephone call was made to

the hospital reporting yellow stained vomit in a newborn, the mother should be advised to see her General Practitioner or go to the Accident and Emergency Department of the hospital.

If a second call was made on the same day, then the mother should be advised to return to the hospital. If a third call was made, the same instruction should be given. Midwives did not have access to the notes of recently discharged mothers and infants when such telephone calls were made.

She said that if a mother telephoned shortly after discharge complaining about feeding difficulties and vomiting in newborn infants, the nurse or midwife should enquire as to the colour, consistency and frequency of the vomiting.

Ms. Rosemary Dillane

Ms. Dillane is a qualified nurse and midwife attached to the hospital. She was on duty between 9.00am and 6.00pm on 16th February, 2000. She was responsible for the provision of nursing care to the plaintiff and his mother in the post-natal ward in the hospital during that time.

She stated, in evidence, that she recorded various matters in the hospital nursing notes.

She said at 1.00pm, the plaintiff vomited a small yellow coloured fluid. It was the first time she had seen this colour in a non-breastfed child and she considered that it was not normal. She was so concerned that she removed the baby's clothing from under his head and brought it to Nurse Quirke (now deceased) who was the staff nurse on duty in the ward at that time.

Nurse Quirke was "also alarmed" when she saw the colour of the vomit. She preserved the clothing until a senior house officer, Dr. Sandhya, visited the ward. Her note recorded that Dr. Sandhya saw and examined the plaintiff prior to 6.00pm.

Her note also recorded that Dr. Fitzsimons saw the plaintiff before she, (Ms. Dillane), went off duty at 6.00pm. She had recorded "nil noted" in respect of Dr. Fitzsimons' examination.

She went on duty at 9.00am on the morning of 17th February, 2000. She believed, from her examination of the notes, that the baby would have been fed at 8.30am and again at 12.30pm. There was no record of such feeds within any nursing or other notes.

She believed that the baby had settled and had not vomited because she had not recorded any vomiting in the notes. She felt that the plaintiff's mother was quite happy with the baby when she was discharged and had no concerns or worries about her child.

She agreed with Ms. O'Donoghue that it was not uncommon for the mothers of newborn infants to call the hospital shortly after discharge. She said that midwives advised such mothers to go to their General Practitioner or to the Accident and Emergency Department at the hospital.

Nursing staff had no access to patients' records on such occasions. If she had received such a call from the plaintiff's mother, and knew of the plaintiff's history, she would have advised her to go the Accident and Emergency Department of the hospital.

She said when instructed by a paediatrician to observe an infant in circumstances where there has been an unusual vomit, it is necessary for the nursing staff to observe and document subsequent vomiting.

Ms. Markey Tarrant

1. Ms. Markey Tarrant is a qualified general nurse and midwife. She was on duty in the hospital between 9.00pm and 9.00am on the two nights commencing on 15th February, 2000.

She confirmed that the nurses in the hospital report to one another by reading shift notes when they come on duty. She said that the plaintiff had been brought to the hospital's nursery on the night of the 16th February, 2000. She denied that the plaintiff had been with his mother that night and said that his mother's recollection of that fact was "incorrect".

She said on the night of 16th February, 2000, she distinctly remembered watching the plaintiff all night. She said she had been made aware that the child had had two yellow coloured vomits and was observing him to see (a) how he settled in, (b) whether he awoke for feeding, (c) when he fed and (d) whether or not he vomited. This was because the nursing notes indicated that Dr. Fitzsimons had instructed that the plaintiff should be observed.

She said that the "very small vomit" recorded in the notes would have been a "regurgitive" milk vomit. She said if it had been yellow stained it would have been documented and a doctor would have been contacted.

2. She said that on the following morning, she clearly recalled weighing the plaintiff in front of the plaintiff's mother in the nursery, "just to see if the weight loss …. (was)….excessive".

She had recommended that the plaintiff's mother should stay another day in hospital because she felt she was not content with her baby care and with the management of her baby. She said she did not think that Mrs. Healy was experienced with newborn babies.

3. She said that she received no more than one telephone call from Mrs. Healy on the night of 17th February, 2000. There was nothing alarming about the call. She did not receive a second call. She had never received two telephone calls from a recently discharged mother during one shift.

She said that although no note was made of the telephone call, she clearly recalled that the plaintiff's mother told her that the plaintiff was still vomiting. She was absolutely sure that she questioned Mrs. Healy about the frequency of the plaintiff's vomits and about the consistency and colour of the vomits. She could not remember the answers which she got to those questions. She believed that there had been nothing unusual in the answers which would have given her cause for alarm.

RELEVANT MEDICAL EVIDENCE

Mr. John Douglas Orr

Mr. John Douglas Orr is a consultant paediatric surgeon appointed. inter alia, to the Royal Hospital for Sick Children in Edinburgh.

He stated, in evidence, that it was clear from his examination of the nursing and clinical notes, that the hospital's nursing staff became concerned about the nature of the plaintiff's vomit (in particular the colour of the vomit), no later than 1.00pm on 16th February, 2000, when the nursing notes recorded as follows: "1.00pm - vomited - small yellow fluid - save for inspection". Part of the vomit was saved for inspection.

At 2.00pm, the preserved vomit was examined by Dr. Sandhya, who was a member of the hospital's medical staff. Dr. Sandhya's examination of the plaintiff included an examination of his abdomen. This examination indicated a suspicion that some type of intestinal obstruction might be giving rise

to the vomiting and, in particular, that the presence of bile might be the cause of the colour of the vomit.

At 7.00pm, the nursing notes indicated that the plaintiff had vomited and that the colour of the vomit was “egg yolk . . . yellow . . . yellow coloured, a curdy coloured fluid”.

The notes record that Dr. Fitzsimons was “re-informed” and directed nursing staff to. . . “observe and do MSU (Midstream Urinalysis)”.

Mr. Orr stated that general and approved medical practice in 2000, required that a paediatrician who observed or was informed that a newborn infant had vomited yellow coloured fluid on two consecutive occasions should immediately refer the infant for paediatric surgical opinion so that the baby could be investigated, inter alia, by way of a barium meal X-ray and/or by a qualified paediatric surgeon.

He said that the presence of bile-stained vomit is regarded across the whole of paediatric surgery as a matter of great urgency which requires immediate surgical treatment. The surgical investigation should take place at the nearest suitably equipped centre of investigation.

If the plaintiff had been referred for investigation to Crumlin within a reasonable time after 7.00pm on 16th February, 2000, an X-ray of his stomach and deuodenum would, as a matter of probability, have disclosed malrotation and potential volvulus.

Appropriate surgical steps would then have been taken and, as a matter of probability, the plaintiff would be a normal child suffering from no abnormalities today. There was a small chance that he might have required a resection of part of his small bowel but it is highly unlikely that he would have developed necrotising enterocolitis.

The decision made by Dr. Fitzsimons to direct the nursing staff to observe the baby was inappropriate but, in any event, observation after bile-stained vomit should continue for a period of not less than forty-eight hours and should include careful recording of the baby’s intake and output of food. In particular, a record should have been kept of any vomiting, including records of the times of feeding, the amounts of feeding, the times of vomiting and the nature, consistency and extent of the vomit.

If the plaintiff had not been discharged and had remained under observation in the hospital on 17th February, 2000, it is probable that he would, between 3.00pm and 3.30pm, have had a green coloured vomit, (his third recorded bile-stained vomit) and would have been immediately referred to a paediatric surgeon for investigation and potential treatment.

If the plaintiff had been referred for surgical investigation at 3.00pm or 3.30pm on 17th February, 2000, he would, as a matter of probability, have arrived in Crumlin twenty-four hours earlier than he did and would, consequently, as a matter of probability, have been successfully treated and would not have developed necrotising enterocolitis.

Dr. John Puntis

Dr. John Puntis is a consultant paediatric gastroenterologist and general paediatrician who is, inter alia, appointed to Leeds General Infirmary.

Dr. Puntis stated, in evidence, that the apparent decision by Dr. Fitzsimons to continue observation of the plaintiff after the second yellow coloured vomit was a decision which was below the requisite standard expected of a paediatrician.

If the consultant paediatrician directed nursing staff to observe an infant who had a bilious vomit, then the child should be observed for at least forty-eight hours and acceptable practice required that the instructions to observe should be in writing. The doctor making the decision to discharge an infant in those circumstances should discuss that decision with the consultant paediatrician.

It was "unacceptable" for a paediatrician to order observation after two bile-stained yellow vomits "because of the risk of malrotation and of volvulus occurring".

A decision to take action and to investigate, rather than to continue observation, was required at that time. He agreed with Mr. Orr that any observation undertaken by the hospital's staff arising out of information that a baby had vomited a yellow coloured substance should have involved:

". . . a detailed input/output chart, a record of every feed, how much was taken, how long the baby took to feed, if there was vomit, the nature of the vomit in terms of its colour, and estimation of the amount and also recordings of urine being passed and the bowels being opened; that is what I would expect to happen."
He noted that no chart was available because no adequate record was kept. Such a chart was necessary because of the "shift" system in hospitals which requires staff members to come on duty for eight or twelve-hour periods. On arrival, each staff member requires detailed information on relevant matters affecting patients.
Medical undergraduates are taught that bile-stained vomiting in infants must be regarded as having a surgical cause until it has been investigated and surgical problems have been excluded. This is a very basic message which is conveyed at an early stage to medical students.

He said that bile-stained vomit has a spectrum from pale yellow to dark green and any competent paediatrician would have an understanding of that.

The nursing notes recorded weight loss of 9.5% during the first three days of the plaintiff's life. This weight loss was a factor which should have been taken into account when the plaintiff was discharged on 17th February, 2000.

Since the plaintiff was bottle-fed, his weight loss exceeded the upper margin of permissible weight loss by over 50% and was above average. This was consistent with poor intake or significant vomiting or both, and when taken together with a history of bilious vomit, feeding difficulties and constant unsettled behaviour, it should have alerted the hospital staff to the fact that it was inappropriate to discharge the plaintiff and his mother and to assure them that all was well.

Noting that the nursing records indicated continuous and serious concerns expressed by the mother in respect of her child from early on the morning of 16th February, 2000, until the baby's discharge, Dr. Puntis observed that nursing staff and paediatricians should take the concerns of patients, and, in particular, the mothers of newborn infants, very seriously.

Having regard to the concern expressed by the mother and the medical staff in relation to yellow coloured vomits at 1.00pm and 7.30pm, it was difficult to understand the inadequacy of the recording of the baby's feeding between 7.30pm on 16th February, 2000, and the time of his discharge after midday on 17th February, 2000.

The number of feeds was not recorded and no information was recorded as to whether or not the vomit was bile-stained. This was inadequate and unsatisfactory since the child had been unsettled,

had demonstrated feeding difficulties and had a history of bile-stained vomits during the previous day.

It was inappropriate to discharge the plaintiff after midday on 17th February, 2000, because both the nursing and the medical staff had shown concern at the possibility of underlying pathology resulting from two bile-stained vomits.

He said it would have been wrong to discharge the baby until the nursing and medical staff had been satisfied that these vomits had not been caused by reason of malrotation and volvulus. The decision to discharge the child was "unacceptable and below [the] standard of what would be expected from a paediatrician".

When the plaintiff's mother telephoned the hospital between 3.00pm and 3.30pm on 17th February, 2000, she should have been advised to immediately return to the hospital in the event of the plaintiff having "a bilious vomit".

Dr. David Anthony Ducker

Dr. David Anthony Ducker is a neonatal paediatrician who, is inter alia, now appointed to All Saints Hospital in Chatham. He was formerly lead clinician at Midway Hospital.

Dr. Ducker endorsed the evidence of both Mr. Orr and Dr. Puntis. He said that yellow coloured vomit in a newborn infant required clinicians to undertake a "differential diagnosis".

This requires the paediatrician to list and consider the diagnoses which are possible, and to seek to exclude each diagnosis, commencing with the most serious.

This was required because very serious injury or illness requires immediate treatment and must be eliminated first. Therefore, malrotation and volvulus must be considered at a very early stage because of their potentially catastrophic consequences and because they require immediate and urgent emergency measures.

He said that a yellow coloured vomit, in the absence of anything yellow being taken by mouth, is bile. Noting that this is "basic physiology" he continued:

"The stomach content either is what you take in by mouth or what comes back up from the lower gut. If you have not taken any yellow stained substance in, then it must be what is coming up from the gut. The contents of the stomach itself would be mucousy. It may be bloodstained in gastroenteritis but it is not yellow."

Two yellow vomits from an infant are sufficient to require surgical opinion.

A combination of (i) 9.5% weight loss, (ii) yellow vomit and (iii) fractiousness in a newborn infant requires admission for investigation. Under no circumstances should such a child be discharged from hospital.

Where observation is directed in relation to a newborn baby who has had a bilious vomit, it should be undertaken for at least forty-eight hours, and a chart should be maintained containing a record of all feeding, including input and output. A record of all vomiting should be maintained, including amount and consistency and, in particular, a record of the colour of the vomit.

Dr. Robert Fitzsimons

No evidence was adduced which identified the precise time on 16th February, 2000, when Dr. Fitzsimons was first advised that the plaintiff had vomited bile-stained fluid. Clinical and nursing notes record that he was notified before 6.00pm on that day and "re-informed" between 7.00pm and 7.30pm that evening.

I accept the evidence of Mrs. Healy that Dr. Fitzsimons examined the plaintiff in her presence in the manner and at the time outlined by her.

Dr. Fitzsimons chose not to testify in these proceedings. The expert and other evidence of his negligence and his breach of duty of care to the plaintiff was not challenged on his behalf.

FINDINGS

Factual evidence

I accept the evidence adduced by Mrs. Michelle Healy in relation to the events which occurred in the hospital during 15th, 16th and the 17th February, 2000, and in relation to what occurred upon her return to the hospital on the 18th February, 2000, and thereafter.

In particular, I accept, without qualification, her evidence as to what occurred on the evening of 17th February, 2000, (including her telephone conversation with the hospital's nursing staff members).

It follows that I am satisfied as follows;

(a) The plaintiff vomited on a number of occasions during 16th February, 2000.

(b) The vomit was bile-stained. Mrs. Healy was concerned by the colour of the vomit which she described as yellow and dirty-green.

(c) Mrs. Healy brought her concerns to the attention of the nursing staff. She brought the plaintiff's stained clothing to the nurses station on a number of occasions and she asked the nursing staff to show the stained clothing to Dr. Fitzsimons.

(d) The nursing staff did not investigate the concerns of Mrs. Healy with sufficient urgency and did not record adequately the plaintiff's "numerous" bile-stained vomits on 16th November, 2000.

(e) At 1.00pm, Ms. Rosemary Dillane recorded that the plaintiff had vomited what she described as "small yellow fluid". This record probably resulted from Mrs. Healy's concerns and the fact that Mrs. Healy had brought the baby's stained clothing to the nurses station.

(f) Dr. Sandhya probably inspected the stained clothing at 2.00pm and directed that the plaintiff should be observed for further vomiting.

(g) During the afternoon, the observation undertaken by the hospital's nursing staff was not adequate and the plaintiff's vomits were not properly recorded. At 7.00pm, the plaintiff had a further bile-stained vomit which was recorded as "egg yolk yellow curdy-coloured fluid". This was recorded.

Dr. Fitzsimons was advised (probably for the second time) that the plaintiff had vomited bile-stained liquid. He directed that the plaintiff should be observed for further vomits (and that a midstream urinalysis should be undertaken).

(h) The standard of observation and, in particular, the recording of the observation which was undertaken in respect of the plaintiff during the evening and night of 16th February, 2000, and the morning of 17th February, 2000, was quite inadequate and below the standard which was required for the nursing of newborn children in the plaintiff's circumstances.

The more appropriate observation procedures for infants which were apparently in place within another unit within the hospital, should have been adopted by the nursing staff. Alternatively, the plaintiff should have been transferred to that other unit for appropriate observation.

ISSUES

The following issues require determination:

1. Did negligence by Dr. Fitzsimons cause or contribute to the plaintiff's injuries?

2. Did negligence by the hospital cause or contribute to the plaintiff's injuries?

3. If the answers to questions 1 and 2 above are "yes", did the negligence of the hospital comprise a novus actus interveniens which broke the chain of causation between the negligence of Dr. Fitzsimons and the plaintiff's injury?

4. If the answer to question 3 is "no", apportion liability between the two defendants.

FINDINGS

Dr. Fitzsimons

Arising out of the medical testimony, I am satisfied, on the evidence as follows:

(1) When green coloured vomit is noted in a newborn infant, a surgical emergency is created and the baby must be immediately referred for surgical intervention. This is because green coloured vomit indicates the presence of bile in the vomit and the likelihood of intestinal obstruction as its cause.

(2) When yellow coloured vomit is noted in a newborn infant, it is general and approved medical practice for treating paediatricians and nursing staff in a maternity hospital to regard the yellow colour of the vomit as denoting the likely presence of bile in the vomit, and the consequent need to be alert to the risk of possible intestinal obstruction as the cause of its presence.

(3) Where one yellow vomit in a newborn baby is noted, bile should be presumed by the paediatric and nursing staff to be its cause, unless and until it can be excluded. At a minimum, the baby must then be closely observed and monitored.

(4) Where a second yellow vomit is noted in a newborn baby after observation and monitoring, then the treating paediatrician and hospital nursing staff should assume the vomit to be bile-stained unless and until bile has been excluded.

Accordingly, the child should be immediately referred for surgical investigation and intervention.

Dr. Fitzsimons was notified that the plaintiff had vomited yellow coloured fluid on at least two occasions. His decision to continue observation of the plaintiff after he had been notified of the second bile-stained vomit was a decision which was below the requisite standard expected of a paediatrician and was not consistent with general and approved medical practice in this jurisdiction at that time.

General and approved medical practice at that time required that Dr. Fitzsimons should have immediately referred the plaintiff for investigation, either by way of a barium meal X-ray or by a paediatric surgeon.

By failing to refer the plaintiff for such surgical opinion or X-ray, Dr. Fitzsimons was negligent and in breach of his duty to the plaintiff.

The hospital

(1) Mrs. Healy complained repeatedly to the hospital's nursing staff that the plaintiff had vomited on a number of occasions during 16th February, 2000. She advised them that the vomit was bile-stained. She had brought the plaintiff's bile-stained clothing to the nurses station on a number of occasions on the 16th November, 2000, and had expressly requested that the stained clothing be shown to Dr. Fitzsimons.

The hospital's nursing and medical staff did not investigate the concerns of Mrs. Healy with sufficient efficiency or urgency and did not record adequately the plaintiff's numerous bile-stained vomits on that day.

By failing to properly investigate and record the plaintiff's symptoms and condition and, in particular, his bile-stained vomits on that day, the hospital's nursing and medical staff fell below the requisite standard expected of a nursing and medical staff at a general hospital and failed to act in accordance with general approved medical and nursing practice within this jurisdiction at that time. Accordingly, the hospital's nursing and medical staff were negligent and in breach of their duty to the plaintiff in that respect.

(2) The practices and procedures adopted by the hospital's nursing and medical staff in February, 2000, relative to the observation and monitoring of newborn babies who had vomited bile-stained liquid, were inappropriate and inadequate and were below the requisite standard to be expected within a general regional hospital within this jurisdiction in the year 2000.

I am satisfied, on the evidence, that, at that time when a consultant paediatrician directed the observation of a newborn child for bile-stained vomit, general and approved medical practice required that the child should be observed for at least forty-eight hours and a chart should be maintained by nursing staff containing a record of all feeding, including input and output. In particular, a record of all vomiting should be maintained including the amount, consistency and colour of the vomit.

By failing to apply those minimum requisite standards to the observation of the plaintiff in these proceedings, the hospital was negligent and in breach of its duty of care to the plaintiff.

(3) I accept the evidence of Dr. Puntis that the decision to discharge the plaintiff from hospital on 17th February, 2000, was unacceptable and below the standard to be expected of the hospital's medical and nursing staff at that time. I accept the medical testimony of all three experts that it was wrong to discharge the plaintiff until the nursing and medical staff had first satisfied themselves that his bile-stained vomits had not been caused by reason of malrotation and volvulus.

It was also inappropriate to discharge the child when the nursing notes had recorded a weight loss of 9.5% during the first three days of his life. This weight loss was consistent with poor intake or significant vomiting or both and with the plaintiff's history and the possibility of his underlying pathology. I accept also that the plaintiff's parents should have been warned that they should return to hospital immediately in the event of the plaintiff suffering from a bilious vomit.

The decision by the hospital's medical and nursing staff to discharge the plaintiff on 17th February, 2000, was a decision which was inconsistent with and below general and approved medical practice within this jurisdiction at that time.

(4) The advice given by the nursing staff when Mrs. Healy telephoned on 17th February, was inappropriate and incorrect. By failing to direct Mrs. Healy to return with the plaintiff immediately to the hospital, the nursing staff within the hospital failed to adopt and apply general and approved medical practice and were negligent and in breach of their duty of care to the plaintiff.

Novus Actus Intrveniens

On behalf of Dr. Fitzsimons, it has been argued that the failure by Dr. Fitzsimons to immediately initiate a surgical investigation of the plaintiff when he became aware that the plaintiff had twice vomited bile-stained liquid was not the immediate or proximate cause of the plaintiff's injury, loss and damage. It is contended that other negligent acts and omissions on the part of the hospital and medical staff of the hospital were interposed between the alleged negligent acts and omissions of Dr. Fitzsimons and the injury and damage to the plaintiff.

It is argued that the negligent acts and omissions of the hospital's nursing and medical staff on 16th and 17th February, 2000, comprised a novus actus interveniens which gave rise to and caused the plaintiff's injury and consequent loss and damage. Mr. Fitzgerald S.C. relied upon the decisions of the Supreme Court in Conole v. Redbank Oyster Company & Ors. [1976] I.R. 191, Crowley (An Infant) v. Allied Irish Banks Limited. [1987] I.R. 282, and Hayes v. Minister for Finance [2007] 3 I.R. 190, in support of his contention.

In each of those cases, the court had little difficulty in separating the causa sine qua non from the causa causans and in identifying the novus actus which broke the chain of causation between the plaintiff's injury and the defendants' conduct. In that respect, those cases can be readily distinguished on their facts from the facts of the instant case. In this case, there was concurrent negligence and breach of duty by Dr. Fitzsimons and by the medical and nursing staff of the hospital during 16th February, 2000. At that time, both defendants were responsible for the medical care and treatment of the plaintiff and both were in breach of their duty of care.

On 17th February, 2000, there were further acts of negligence and breach of duty on the part of the nursing and medical staff of the hospital. Arguably, Dr. Fitzsimons also remained in breach of his duty of care to the plaintiff on 17th February, 2000.

In Hayes v. Minister for Finance [2007] 3 I.R. 191, Kearns J. cited at pp. 206 to 207, with approval, a passage from McMahon and Binchy 'Irish Law of Torts' 3rd Ed. (Dublin 2000), p.77, which discussed the principles applicable to what the authors described as "the vexed question of novus actus interveniens". It reads as follows:

"From the case law we may state the following propositions with some degree of confidence:

1) If the third party's act is wholly unforeseeable then the original defendant will not be liable.

2) If the third party's act is intended by the original wrongdoer, or is as good as programmed by him, or if it is an inevitable response to defendant's act or is very likely, then the original defendant is still considered to be the operative cause in law. The third party's intervention in these circumstances is not a novus actus which will break the chain of causation between the plaintiff's damage and the defendant's conduct. This is even more obviously true where the intervening event is not a voluntary act at all: where A pushes B against C.

3) If the third party's action is foreseeable (though not probable or likely,) then the courts will look especially closely at the nature of the intervenor's act in addressing this problem. If the intervenor's act is criminal or reckless in the subjective sense, then it is likely to be considered as a novus actus. Similarly, if the third party's act is intentional . . . . If the intervenor's act, however, is merely careless, negligent, or perhaps even grossly negligent, it may not be considered sufficiently strong to break the chain of causation between the original defendant and the plaintiff's injury, although much will depend on the facts of the case . . . ."

When Dr. Fitzsimons directed that the plaintiff should be observed for feeding difficulties (and in particular, for vomiting) on 16th February, it must have been foreseeable to him that the standard of observation within the post-natal unit of the hospital was such that the plaintiff's serious symptoms might well be missed by the nursing staff.
He had been a consultant paediatrician within Tralee General Hospital for some time and was familiar with its practices and procedures. It was therefore foreseeable by him (although it may not necessarily have been probable or likely) that the plaintiff might be discharged (as he was) on 17th February, 2000, without having been adequately observed for symptoms indicating a probable malrotation and a potential volvulus. He made no further enquiries about the plaintiff's condition. He failed to follow up upon his own recommendations for the plaintiff's investigation and possible treatment.

The members of the nursing and medical staff of the hospital were in serious breach of their duty to the plaintiff when they discharged him from hospital on 17th February, 2000. They were also in serious breach of their duty of care to the plaintiff subsequently on 17th February, 2000, when they gave his mother entirely inappropriate advice and instructions when she telephoned the hospital on three separate occasions.

They had been in serious breach of the duty of care which they owed to the plaintiff on several occasions on 16th February.

However, the proven negligence of the hospital's nursing and medical staff during the night of 16th February, 2000, and throughout 17th February, 2000, did not comprise a novus actus sufficient to break the chain of causation between Dr. Fitzsimons' negligence and the injury which the plaintiff suffered.

Dr.Fitzsimons was the most senior person responsible for the care of the plaintiff and for his medical treatment immediately after his birth and whilst he was a patient in the hospital. The members of the hospital's nursing and medical staff were entitled to look to Dr. Fitzsimons for direction and supervision in the care and treatment afforded to the plaintiff after his birth and while he was in the hospital. Dr. Fitzsimons was negligent and failed in his duty to provide appropriate care and treatment to the plaintiff.

He also failed to provide the direction and supervision which the nursing and medical staff at the hospital were entitled to expect from him.

Although this concurrent negligence by Dr. Fitzsimons did not discharge the separate and independent obligations and duties which the medical and nursing staff owed to the plaintiff, it did not absolve Dr. Fitzsimons from his separate and independent liability to the plaintiff either.

I am satisfied that both defendants are jointly and severally liable to the plaintiff in respect of his injuries and his consequent loss and damage. They are concurrent wrongdoers who have, by their

negligence and breach of duty, jointly and separately caused the plaintiff's injuries and his consequent loss and damage.

The plaintiff is, accordingly, entitled to recover judgment against both defendants, jointly and severally, to compensate him for the injuries which he has suffered and the consequent loss and damage which he has sustained.

CLAIMS FOR CONTRIBUTION AND INDEMNITY

Each of the defendants has sought an indemnity or contribution from the other in respect of the plaintiff's claim for damages. Both defendants concurrently failed to discharge their duty of care to the plaintiff.

Dr. Fitzsimons, as the plaintiff's consultant paediatrician, had a particular duty of care to the plaintiff. By reason of his seniority, experience and qualifications, he was the person with overall responsibility for the plaintiff's medical care and treatment whilst he was in the hospital.

If he had discharged his duty of care to the plaintiff and had referred him for surgical investigation within a reasonable time after 7.00pm on 16th February, 2000, an X-ray of his stomach and duodenum would, as a matter of probability, have disclosed malrotation and potential volvulus. Appropriate surgical steps would then have been taken and the plaintiff would now be a normal child suffering from no abnormalities.

Is the hospital entitled to an indemnity or contribution from Dr. Fitzsimons in respect of its separate, independent liability to the plaintiff?

The plaintiff would not have suffered his injury if the nursing and medical staff of the hospital had not failed to discharge their separate and independent duty of care to the plaintiff on the evening of 16th February, 2000, and during 17th February, 2000. They failed repeatedly to discharge that duty during that time.

Is Dr. Fitzsimons entitled to an indemnity or contribution from the hospital in respect of his separate, independent liability to the plaintiff?

Dr. Fitzsimons' seniority and his obligation to provide direction and supervision to the hospital's nursing and medical staff cannot be overlooked.

Central to the question for determination is the fact that, if Dr. Fitzsimons had discharged his duty of care to the plaintiff shortly after 7.00pm on 16th February, 2000, then the plaintiff would not, as a matter of probability, have suffered injury. His negligence caused the plaintiff's injury but was not its sole cause.

Although imperilled by the negligence of Dr. Fitzsimons, the plaintiff was independently entitled to appropriate care and medical treatment from the hospital's nursing and medical staff on the evening and night of the 16th February, and during 17th February, 2000.

If he had received the standard of care and medical treatment to which he was entitled from the nursing and medical staff, then he would not have been discharged from hospital on 17th February, 2000, and, as a matter of probability, his mother would not have been given inappropriate advice and he would have been referred for surgical investigation no later than 17th February, 2000.

In consequence, he would not, as a matter of probability, have developed necrotising enterocolitis and have suffered the catastrophic consequences which followed.

In the circumstances, and having regard to Dr. Fitzsimons' seniority and qualifications, I find that the hospital is entitled to a contribution of 75% of its liability to the plaintiff from Dr. Fitzsimons.