THE HIGH COURT

[2021] IEHC 183

[2018/2004P]

BETWEEN

KIM HANRAHAN

PLAINTIFF

AND

JOHN WATERSTONE, DOCTOR JOHN WATERSTONE CONSULTANT OBSTETRICIAN AND GYNACOLOGIST, NATIONAL REPRODUCTION (TRADING AS CORK FERTILITY CENTRE) AND BON SECOURS HEALTH SYSTEM COMPAY LIMITED BY GAURANTEE

DEFENDANTS

Judgment of Mr. Justice Kevin Cross delivered on the 11th day of March, 2021.

Introduction

1.1 The proceedings against the second named defendant Dr. John Waterstone, consultant obstetrician and gynaecologist were discontinued on the 17th July, 2020. The remaining defendants are sued as the medical specialists and clinics providing fertility services at a profit.

1.2 The plaintiff was born on the 29th May, 1972 and is now 48 years of age and married her husband Ambrose in 2003. The plaintiff was employed as a pharmacy technician and her husband works as a farmer. They reside near Carrick-on-Suir, County Tipperary.

1.3 The plaintiff's first child Jessica was born in December, 2008 as a result of fertility treatment provided by the defendants. The plaintiff's second child Ronan was born in 2015 and delivered by caesarean section with obstetric care provided by Dr. Waterstone. Ronan had a twin brother called Oran who tragically died in utero during the late course of the pregnancy and was delivered as a still birth.

1.4 As a result of the death of Oran High Court proceedings were initiated against Dr. Waterstone which proceedings settled in December 2018 and a significant six figure sum was paid by way of damages and the defendant also offered an apology.

1.5 These other proceedings are clearly relevant to this case in that I believe they have in many ways coloured the attitude of the parties and clearly the plaintiff still remains extremely upset and distressed by the circumstances of Oran's death.

1.6 The instant proceedings arise out of fertility treatment provided to the plaintiff in 2011 and 2012 and the alleged negligence of the defendants in the provision of this treatment.

1.7 The case proceeded for thirteen days in the High Court from the 15th December, 2020 until the 27th January, 2021. Very helpful submissions including an agreed relevant chronology were finally handed in to the court on the 23rd February, 2021. On application by both parties the court allowed the submissions to exceed any practice direction imposed limits. This is a case whose facts are extremely complicated and which turns on the facts and parties to such litigation should not be necessarily obliged to limit their submissions, merely to comply with arbitrary limitations. Any over prolix submissions can and should be dealt with in costs. There was no prolixity in either of the submissions in this case.

1.8 The only matter in which there seemed to be any agreement was ultimately through the good work of junior counsel on both sides and the special damages were agreed subject to liability in the sum of €14,000.

1.9 Without in any way diminishing the distress and pain and trauma of the plaintiff which I fully accept to be genuine, as counsel for the plaintiff stated at no stage was it claimed that this was a case that would result in particularly large damages.

History

2.1 In January 2006 the plaintiff was first referred to Dr. Waterstone by her GP as she had failed to become pregnant in the first years of her marriage. She was seen on the 31st March, 2006 and initially elected to proceed with what is known as IUI or intra uterine insemination which involves the insemination of the sperm inside the uterus with assistance of medication. But after three unsuccessful cycles of IUI Mr. Waterstone recommended IVF. On the first attempt with a single embryo transferred on day 3 of its life resulted in a successful pregnancy and the birth of Jessica on the 9th December, 2008 by caesarean section in South Tipperary General Hospital.

2.2 IVF or In Vitro Fertilisation is a technique used where a human egg is fertilised with sperm in a laboratory. During IVF treatment eggs are removed from the ovaries of a woman and fertilised in a laboratory with sperm provided by her husband, partner or a donor. One or two embryos, fertilised eggs, are implanted into the woman's uterus. The IVF cycle involves halting the natural menstrual cycle with injections and then further injections of fertility hormones are supplied to stimulate the ovaries so that the woman produces several rather than just one egg. When the eggs matured they are collected in the clinic with a procedure that involved using a needle with sedation such that there is no memory on the part of the woman of the process. The eggs are then fertilised in the laboratory with sperm provided by the donor and the fertilised eggs or embryos are grown in an incubator for a few days and a number of healthy embryos are transferred into the woman's uterus using a tube inserted and the woman then waits for a pregnancy test. The remaining healthy embryos can either be frozen for later use or "discarded". As described the process is highly invasive and can be painful and distressing for the mother.

2.3 On the plaintiff's first cycle of IVF in 2008 after the implantation, a further three what are called "blastocyst embryos" were preserved on day 6. A "blastocyst embryo" is the title given before the sac of cells is formed by approximately day 10 to 12 and it is only then referred to by the fertility profession as an "embryo".

2.4 On the 8th February, 2011 the plaintiff re-attended the defendant's clinic with her husband with a view to having a second child. She was at that stage 34 years of age becoming 35 on the 9th May, 2011. She was seen by Dr. Peter Wiegandt of the defendant's clinic, on that occasion and he performed a transvaginal ultrasound scan which he reported as normal. This is referred to as the "base line scan". It is important to ascertain whether a woman is considered to be suitable for the treatment. After the scan the plaintiff then commenced the first IVF treatment cycle which is of relevance to this case.

2.5 The plaintiff was regularly scanned thereafter at the defendant's clinic and these scans were reported on all as normal. Unfortunately, the practice at the time was that only scans which contained any unusual matters or abnormalities were kept as a photograph and accordingly the vast majority of the scans are not available for inspection and could not be viewed in court or by any of the experts.

2.6 I will comment on and relate the progress of the treatment provided by the defendant in greater detail below but the essence of the case lies in the fact that all the scans were reported as normal up to June 2012 at a time when the plaintiff was undergoing IVF treatment. In June 2012 a fibroid was noted. The defendants continued with the IVF treatment. Mr. Waterstone removed a fibroid from the plaintiff's uterus on the 3rd September, 2012 and by that stage the plaintiff had already engaged in a number of IVF treatments despite the fact of the presence of this fibroid.

2.7 It is accepted by all the experts in the case that the presence of fibroids in the uterine cavity reduces the chances of a successful pregnancy by IVF. The location of the plaintiff's fibroid and whether or not it was present or intruded into the uterine cavity is a central feature of the case. It is also accepted that fibroids outside the uterine cavity but adjacent thereto may have an effect on fertility though it is not universally agreed that the removal of such exterior fibroids has any beneficial effect.

2.8 The first ground of the plaintiff's case is that, because fibroids are slow growing, the fibroid removed by Mr. Waterstone must have been present at the initial baseline scan undertaken by Dr. Wiegandt but it was not noticed by him or in any of the subsequent scans up to June 2012.

2.9 The plaintiff further complains that when the fibroid was noted its significance was not averted to or in any event the defendants wrongly decided that they would persist in their IVF treatment notwithstanding the presence of the fibroid which resulted in failure to conceive.

2.10 The second basis of the plaintiff's complaint is that when the fibroid was ultimately identified and removed in September 2012, it was removed by means of a laparotomy, an open abdominal myomectomy involving invasive surgery as opposed to a hysteroscopic myomectomy which would not have involved any invasive surgery. The plaintiffs contend that the fibroid ought not to have been removed at all if as the defendant submits it was a type 3 FIGO fibroid. The plaintiff also complains that this laparotomy was decided upon without any hysteroscopic examination of the plaintiff to ascertain whether a hysteroscopic myomectomy would be suitable. It is also alleged that if Mr. Waterstone was not in a position himself to provide a hysteroscopic myomectomy he should have referred her elsewhere for this.

2.11 As a consequence of these matters it is claimed that the plaintiff suffered the pain and distress of a number of failed IVF treatments which were "bound to fail" and also suffered the distress and pain not alone of the treatment but of its failure as well as the pain and

distress involved in the invasive laparotomy rather than a hysteroscopic procedure which would be much less invasive.

2.12 The defendants deny liability and contend that the failure to notice the presence of the fibroid before June 2012 was understandable and not negligent, that the fibroid was at all stages what is known as a "type 3 FIGO fibroid" (the different types of fibroid will be explained later) which was outside the cavity and which did not distort the cavity and accordingly it was reasonable to proceed with the IVF treatment as same had started. It is further claimed that while Mr. Waterstone could have advised leaving the fibroid in place, once it had been decided to remove it the decision to remove it by laparotomy was the correct procedure given its position and size.

2.13 As a result of what occurred the plaintiff claims that she underwent the first frozen embryo transfer in March 2011 which was unsuccessful in this cycle. There were at least three separate transvaginal ultrasound scans which were reported as normal without any fibroid being identified. Further, in March 2012 she returned for a second frozen embryo treatment cycle and she underwent a further baseline scan on 23rd February, 2012 which was again reported as normal. This transfer was the final blastocyst embryo which had been preserved at the time of the first pregnancy in 2008. A further blastocyst embryo was not viable and presumably had been "discarded". On this occasion while a positive pregnancy test was first recorded however on scanning there was found to be no pregnancy. Two further ultrasound scans were performed in this cycle and did not detect any abnormality.

2.14 In May of 2012, the previous attempts having failed and the supply of embryos having exhausted the plaintiff returned to the clinic and a scan was undertaken in the 3rd May, 2012 which was again reported as normal.

2.15 So at this stage the plaintiff had two frozen embryo transfers which were unsuccessful and accordingly if the plaintiff wanted further children she required a further "harvesting" of eggs which is an intensive and invasive procedure, as previously described. This the plaintiff decided to do.

2.16 On the 7th June, 2012 the IVF treatment was recommenced. This treatment involved medication which was described as "more aggressive" involving self-injections two to three times a day and on the 7th June, 2012 a baseline scan was carried out by a fertility nurse which recorded "no fibroids seen".

2.17 None of these scans previously referred to are preserved but on the 15th June, 2012 a scan was undertaken by a nurse who identified a fibroid and requested Dr. Wiegandt to review it and the fibroid was reported present, being 1.5 approximately centimetres in diameter. One single photograph of this scan has been retained.

2.18 The plaintiff contends that due to the slow growth of the fibroids that the fibroid must have been there to be seen back to 2011 and that as a result of the presence of a fibroid the two IVF attempts were considerably less likely to succeed and in fact did not succeed

and further that the plaintiff was commenced the IVF treatment involving "egg harvesting" at a time when there was present a fibroid and that this ought not to have occurred. Accordingly, the plaintiff claims that the frozen embryo transfer in March 2011 and March 2012 and the IVF in June 2012 were all in effect "doomed to fail" because of the undetected fibroid in the endometrial cavity.

2.19 Dr. Wiegandt on examining the scan of the 15th June, 2012 and on rescanning on the 18th June was of the view that the fibroid did not distort the endometrium and did not protrude into the uterine cavity and that accordingly that it was safe to carry on with the first cycle of IVF because the fibroid would not be likely to affect fertility. One single photograph of the scan of the 18th June has also been retained. Dr. Wiegandt consulted with Dr. Waterstone and Dr. Waterstone agreed with Dr. Wiegandt's opinion.

2.20 Though a photograph of the scan of the 15th June and the 18th June have been preserved subsequent scans taken on the 20th and 21st June were not preserved. At that stage IVF process had commenced and the plaintiff was self-injecting and taking the medication in order to create the hypo stimulation required in terms of ovulation in order for the egg collection to take place. The egg collection was done on the 23rd June, 2012 and seven eggs were collected on that date. The process was of course painful. A further scan was then undertaken which specifically stated there was no abnormality detected which is not consistent with the scans of the 15th and 18th June. This scan has not been preserved either.

2.21 On the 26th June, 2012 two embryos were transferred into the plaintiff's uterus and two embryos were frozen and cryopreserved at the blastocyst stage. This transfer did not result in any further pregnancy and the plaintiff complained of bleeding and discomfort.

2.22 On the 12th July, 2012 the plaintiff had a consultation with Dr. Waterstone due to "concerns about fibroids" and as a result of this consultation it was decided that a laparoscopic myomectomy would be performed to remove the fibroid before further frozen embryo transfer cycle. The operation was performed on the 3rd September, 2012. The plaintiff contends that it was critical before the removal was undertaken that the nature of fibroid ought to have been identified by hysteroscopic investigation and that the plaintiff should have underwent a hysteroscopic myomectomy rather than the laparotomy as actually performed. The plaintiff contends that hysteroscopic myomectomy would have been much less invasive than the laparotomy undertaken. Surgery was performed on the 3rd September, 2012 and the fibroid was removed. Where the fibroid was and its significance is central to the case.

2.23 After the operation the plaintiff was unable to work for a period of six weeks. She had a post-operation review on the 1st November, 2012 and a scan was performed as normal and a decision to proceed with a frozen embryo transfer cycle on the harvested eggs was made.

2.24 In March 2014 the plaintiff underwent a frozen embryo transfer which was unsuccessful. At this stage there were no more frozen embryos left from the previous cycle of 2012. A

further cycle was undertaken and the plaintiff became pregnant with twins as previously stated one of whom died in utero and the second survived as a healthy child born in December 2015.

3. Terminology

3.1 Fibroids are growths which are normally benign and can affect fertility and the uterine cavity. The standard present classification of fibroids is in accordance with the FIGO scheme but fibroids are also classified under what is known as the ESGE classification and in order to complicate matters there is a third classification given by the Leuven Institute for Fertility and Embryology (LIFE) or sometimes described as the ESH classification.

3.2 Dr. Waterstone stated that he sometimes used the LIFE classification though it seems that at the time of these events the LIFE classifications were not generally used.

3.3 An important difference among fibroids are those which are submucosal which is inside or at least partially inside the uterine cavity "intramural" which are outside the cavity. A fibroid outside the cavity does not have the same effect on fertility as a submucosal fibroid does. In the FIGO classifications type 0 fibroid is a pedunculated fibroid in the cavity on a stalk. Type 2 FIGO is a fibroid less than 50% is intramural or outside the cavity and type 2 is a fibroid which is more than 50% outside the cavity and less than 50% inside. Type 0, 1 and type 2 fibroids are described in the FIGO classifications as "submucosal".

3.4 Under the FIGO classifications type 3 fibroids contact the endometrium but are 100% intramural or outside the cavity.

3.5 Other types of fibroid under the FIGO classifications are not relevant. The ESGE categorisation was not utilised in this case.

3.6 The LIFE classifications described type 0, 1 and 2 and type 3 as being "submucosal" though type 3 was entirely outside the cavity but it was described as submucosal, in the LIFE classification, because it abutted the endometrium.

3.7 The endometrium is a serrated area just inside the wall of the uterus (the uterine wall).

3.8 I will deal with the operation notes and records made by Mr. Waterstone later but he described the fibroid that he removed as sitting on top of the endometrium which the plaintiff originally understood him to mean a type 0 fibroid. I do not believe that this understanding was maintained by the plaintiff after the evidence and the plaintiff's contention is that the fibroid was a type 1 or type 2 FIGO type fibroid and the defendant's contention is that it was a FIGO type 3.

4. The law

4.1 There is no dispute in this case but that the law applicable is that the standard in this case is as set out in the well-known case of *Dunne (an infant) v. National Maternity Hospital* [1989] IR p. 91. The Dunne principles have been summarised and reduced to one overreaching principle by Clarke C.J. in *Morrissey v. HSE* [2020] IESC p. 6 as being

"The standard of approach of a medical professional is to apply a standard appropriate to a person of equal specialist or general status acting with ordinary care. A failure to act in that way will amount to negligence". The issue of liability is in my view entirely dependent upon the facts that I find as established in the case. The plaintiff's obligation in relation to any issue of fact is of course to establish it to my satisfaction on the balance of probability.

5. The area of dispute

(A) The defendant's case

5.1 The main and central area of dispute in relation to the issue of liability is the nature of the fibroid present at the time of the plaintiff's treatment. In coming to my decision I am handicapped by the dearth of evidence in relation to the scanning and the confusion and unsatisfactory nature of the defendant's reporting on what was done. Unfortunately, as previously stated, there was no practice at the time of a clinic retaining images from the scans so the fact that the first image retained was one photograph of the scan of the 15th June, 2012 and that the only other scans retained at that cycle was one image of the scan of the 18th June, 2012. Later, a number of images of scans taken on the 12th July, 2012 at the time of the consultation in relation to the fibroid, were also retained. It is unfortunate and makes the court's task much more difficult that images of other scans were not retained, but of itself the absence of any photographic records of these scans, is not evidence of breach of duty against the defendants. No expert suggested that the unfortunate practice of not retaining scans was particularly unusual at the time. It is noted that the defendants now routinely retain images of scans taken.

5.2 The reports of the earlier scans before the 15th June indicates that they were "normal". This means that there were no fibroids identified. The report of the scan of the 15th June notes the presence of a fibroid and this scan was reviewed by Dr. Weigandt by means of the photograph that was retained and he decided on a further scan on the 18th June which photograph was also retained. Dr. Weigandt's note of his interpretation of the scan states:

> "*The above mentioned fibroid does not distort the endometrium and does not protrude into the uterine cavity. Plan continue cycle."*

The note also states "*ultrasound. Normal endometrium. Triple line*." The "*triple line*" was identified by Dr. Weigandt on the scan of the 18th June indicating three white lines on the scan with normal appearance before ovulation. This they said was reassuring is suggestive no distortion or penetration of the cavity.

5.3 After the scan and review on the 18th June Dr. Weigandt then consulted with Dr. Waterstone showing him the chart and his observations but not it seems the photographs and Dr. Waterstone agreed that there was no need for surgery at that stage and that the IVF cycle could proceed. There is no note of this consultation but Dr. Weigandt and Dr. Waterstone were both of the view that the fibroid would not negatively impact on the outcome of the fertility treatment.

5.4 As we have seen above this IVF cycle was not successful and on the 12th July, 2012 the plaintiff had a consultation with Dr. Waterstone due to "*concerns about fibroids*". The note of this consultation is brief and states "*concerns about fibroid – never seen until recently. Approximately 2 cm by 1.6 cm (diameter) and close to end (endometrium). Anterior. Plan myomectomy before FET (fertility egg transfer) cycle*".

5.5 On this occasion Dr. Waterstone took a number of scans and photographs of at least four of the different pictures have been retained. Dr. Waterstone concedes that the photographs are not very clear but states that he himself was absolutely clear that it was a type 3 FIGO fibroid which did not protrude into the uterine cavity or distort the endometrium. Dr. Waterstone was of the view that this fibroid was merely abutting the endometrium.

5.6 At that stage Dr. Waterstone was aware that there were a number of failed IVF attempts and a decision had to be taken as to whether the fibroid should be ignored again or the possibility of removing it should be considered.

5.7 Dr. Waterstone states in agreement with Dr. Weigandt that the fibroid had been reasonably ignored when first seen in June as another fresh stimulated cycle had commenced and egg collection had taken place but by July there were concerns about the diminishing ovarian reserve and that only six eggs were fertilised on the second "harvesting" and given the costs of the treatment a decision was made to proceed with the cycle in June 2012 but after the failure of that cycle on the consultation of the 12th July, Dr. Waterstone decided on balance with the agreement of the plaintiff that the fibroid should be removed.

5.8 Dr. Waterstone stated that there was good evidence that larger fibroids can impinge on the cavity and reduce the chance of success of fertility treatment. Notwithstanding the fact that the measurements on the fibroid had not indicated that it was particularly large or that there had been fast growth since June, Dr. Waterstone indicated that his advice was that if the plaintiff were a member of his family that the fibroid should be removed. The plaintiff agreed to proceed with the operation and there is no question in this case of lack of consent. Dr. Waterstone also indicated that the decision to remove the fibroid was a marginal one. Dr. Waterstone was adamant that the route of myomectomy i.e. proceeding with a laparotomy rather than first examining the fibroid by hysteroscopy was correct. Dr. Waterstone was of the view that a hysteroscopy would be of no advantage given the positon of the fibroid which could not have been viewed through the cavity as it did not protrude into it.

5.9 Dr. Waterstone and the experts called on behalf of the defendants disputed the contention on behalf of the plaintiff that the film of 12th July demonstrated a distortion of the uterine cavity. Whereas the plaintiff's expert contended that the right hand side of the cavity as viewed in the film showed a narrowing of the cavity and that this narrowing was caused by the fibroid intruding, the defendant and their experts suggested that the narrowing was in fact due to the angle that the film was taken and did not represent any true distortion of the uterine cavity.

5.10 The operation to remove the fibroid was performed by way of laparotomy by Dr. Waterstone on the 3rd September, 2012 and his operating note is of great importance. The relevant section reads:

> *"Anti (anterior) submucosa fibroid palpable ML anti (anterior) incision in uterus and fibroid shelled out carefully – right on top of endometrium and tiny opening made in endometrium. Incision closed with two vicryl interrupted sutures by eight."*

5.11 On the 7th September, 2012 Dr. Waterstone sent a letter to the plaintiff's GP with a cc to the plaintiff. This letter is controversial and Dr. Waterstone accepts that it was incorrect and misleading. The letter while dictated probably on the day after the operation was not typed and sent until the 7th and it says as follows:

> *"This couple with a history of sub fertility had a laparotomy and myomectomy on the 3rd of the 9th 12. Surgery was carried out through a repeat low transverse incision with excision of the old scar. Both tubes and both ovaries look normal. A 2cm anterior submucosal fibroid was removed through an anterior incision. This fibroid although small was very deep and protruding into the uterine cavity a tiny opening, inevitably, was made in the endometrium. The uterine incision was closed with interrupted 2.0 vicryl sutures with a fine PDS suture (continuous inverting to close the serosa) Kim made a good post-operative recovery and will come back in eight weeks' time for a post-operative review."*

5.12 It is the defendant's contention as stated above that this letter is a "mistake" and that he must not have reviewed the letter before it was sent. Dr. Waterstone referred to the first sentence which referred to the laparotomy and myomectomy apparently being performed on the "couple" when clearly it was performed on the plaintiff herself alone. I do not see that mistake as being any way significant. Dr. Waterstone at all stages maintains a philosophy of being in favour of "couples" and it is clear even to a lay person reading that sentence that the operation was only performed upon the plaintiff rather than her husband as well.

5.13 Dr. Waterstone also points out that the brackets ought to have been put after "inverting" rather than "serosa". I do not see that that either is a matter of significance. But Dr. Waterstone's explanation that these minor mistakes suggest that the letter as a whole was drafted without proper revision or care may be correct but do not explain the description of the fibroid as being "submucose" and in particular that it was found to be "protruding into the uterine cavity". The description of the fibroid as being "submucose" was also to be found of course in the operation note.

5.14 Dealing with the description of the fibroid as being "submucose" Dr. Waterstone states that it is submucose as defined by the LIFE classifications as it is "under" the mucosa and would have been under the mucose from the point of view of his operation. It is clear, however, that when giving a statement to his expert Professor Winfield Dr. Waterstone referred to the fibroid as being a FIGO type 3 and of course FIGO type 3 fibroids are not

"submucosal". It is of course true that LIFE type 3 fibroids are described as "submucosal".

5.15 Whatever the explanations in relation to the word "submucose" Dr. Waterstone had no explanation for describing the fibroid in his letter as being "protruding into the uterine cavity". If the fibroid was protruding into the cavity it was clearly a type 1 or type 2 fibroid. The only explanation given by Dr. Waterstone is that the letter was a "mistake".

5.16 The defendant's case is that the failure to keep the photographs of each of the scans was the common practice at the time. The defendant's expert radiologist Dr. Brophy agreed the fibroid must have been present to be seen by the time of the first scan of the plaintiff in 2011 as fibroids are slow in growth but Dr. Brophy contended the failure to observe and note it before the 15th June, 2012 cannot be defined as a breach of duty as the fibroid presents itself on the scans as a shade not dissimilar from its surrounding features. This opinion is of course given without the benefit of having seen the slides in question because no picture of them exists.

5.17 The defendant's case further is that the photograph taken on the 15th June supports the contention that the fibroid was not submucosal but was abutting the endometrium as there is no distortion of the cavity apparent from it. Accordingly, the defendant's experts and in particular Dr. Prentice and Professor Wingfield are of the opinion that to proceed with the IVF cycle in the circumstances was reasonable.

5.18 The defendant's experts start from their view of the fibroid as seen on the 15th June and the 18th June the opinion of the defendant's experts is that the fibroid as seen in the scans on the 12th July was not encroaching into or distorting the cavity but that the perceived distortion is probably due to the angle of the scan.

5.19 The defendant's experts and in particular Dr. Prentice and Professor Wingfield are also of the view that after the failure of the cycle that when Dr. Waterstone had a consultation with the plaintiff on the 12th July his decision to proceed to remove the fibroid because of "concerns" was not an unreasonable decision. All of the defendant's experts however indicated that had it been up to them that they would not in the circumstances have recommended the removal of the fibroid. The defendant's case is that the decision was not an unreasonable one in the circumstances and the making of that decision does not represent any breach of duty.

5.20 Again informed by the view of the fibroid taken on the 15th June, 2012 the defendant's experts and in particular Professor Wingfield and Dr. Prentice were both of the view that the laparotomy as decided by Dr. Waterstone was the appropriate method of approach as if there was no incursion into the cavity a hysteroscopic procedure would not have been effective and would have been more disruptive or potentially disruptive of the plaintiff's internal organs than the laparotomy and also that there was no basis for assessment by hysteroscopy of the fibroid before the operative procedure.

(B) The plaintiff's case

5.21 The plaintiff's case as supported by the plaintiff's experts Dr. Papaioannou and Mr. Iskander take as their starting point, not the scan of the 15th June, 2012, but the letter from Dr. Waterstone to the plaintiff's GP dated the 7th of the September, 2012. This letter clearly states that the fibroid was "submucus" which means it was either type 0, 1 or 2 and further that it was "very deep" and "protruding into the uterine cavity" which indicates that it was either a FIGO type 1 or 2 and this description ties in with the operation note to the extent that the fibroid is described as submucus and the statement therein that it was "right on top of the endometrium" is suggestive that it might have been a type 0 fibroid.

5.22 The plaintiff's experts are strengthened in their view because Dr. Waterstone referred to using the FIGO classifications to his expert though he described it as a "FIGO type 3". Accordingly, the plaintiff contends that the description of the fibroid as being "submucosal" must be submucosal in accordance with the FIGO classifications which Dr. Waterstone stated that he was using.

5.23 The plaintiff's eloquent submission commences with the proposition:

> *"Given the substance of the defence to this claim, there are two fundamental propositions which must be accepted for this claim not to succeed:*
>
> *(a) In relation to transvaginal ultrasound scan imagery, a single scan image of the uterine cavity taken on the 15th June, 2012, when the cavity is free of fluid is superior to four scan images of the same cavity taken on 12th July, 2012 when it is filled with fluid (blood);*
>
> *(b) A letter dictated by Dr. Waterstone, a vastly experienced surgeon, in the aftermath of conducting surgery upon the plaintiff on the 3rd September, 2012 setting out the findings of it and then subsequently read and signed by him four days later on the 7th September, 2012 can be abandoned in the course of trial over eight years later, when none of the experts retained to prepare reports in support of the defence of the claim were ever informed of this, nor his legal representatives when taking a statement from him in anticipation of the trial."*

5.24 Taking from what is written in the notes by Dr. Waterstone on the 3rd September and the 9th September and the clear natural interpretation of the words as written, Dr. Papaioannou and Mr. Iskander go on then to view the photograph of the film taken on the 12th July which shows the cavity and shows the right hand side of it clearly thinner than the rest of it indicating they say that the fibroid is not alone pressing onto the cavity and distorting it but is as was found by Dr. Waterstone (as they interpret his operation notes and the letter) to be protruding into the cavity.

5.25 The plaintiff then contends that while the scan of the 18th June is difficult to interpret through its photograph the scan of the 15th June clearly shows the fibroid abutting the cavity at the very least. The plaintiff is of the view that given the fact that the fibroid had

penetrated the cavity at the time of the operation it had also probably penetrated the cavity in June 2012 and they contend that the scans of the 15th June and the 18th June support this contention.

5.26 Whatever about the scans of the 15th and 18th June the plaintiff submits that the scans taken in July 2012 at a time after the plaintiff had experienced significant bleeding which clearly demonstrate the contours of the uterine cavity which were not clear in the June scans and clearly demonstrate that the right half of the northern side was depressed and impinged upon by the fibroid in question. The plaintiff emphasises that the reason for this is that the uterine cavity was filled with blood in July 2012 and caused it to expand and become visible so that the encroachment of the fibroid is now discernible. Given the slow growth of fibroids this encroachment must have been also present in June though the images taken in June are it is agreed not as clear.

5.27 The plaintiff further contends that the failure to observe the scans prior to the 15th June and to notice the presence of the fibroid which was admittedly there was a breach of duty not on the part of the nursing scanners but on the part of the medical personnel overseeing same.

5.28 Given the presence of the fibroid abutting or intruding onto the cavity as seen on the 15th June the plaintiff contends that the decision to proceed with the IVF treatment was to expose the plaintiff to unnecessary distress as the treatment was almost bound to fail.

5.29 As the plaintiff had a fibroid which was found to be protruding into the cavity on operation as clearly follows from the ordinary reading of the contents of the letter to the GP and the operation notes especially as informed by that letter, the plaintiff experts contend that Dr. Waterstone first ought to have examined the position and presence and size of the fibroid with a hysteroscope from within the cavity and then proceeded to remove it hysterscopically rather than subject the plaintiff to an unnecessary laparotomy.

5.30 The plaintiff's experts Mr. Iskander and Dr. Papaioannou all state that these facts represent clear breaches of duty of the defendants.

6. Determinations as to fact

6.1 From the foregoing it is clear that what was the nature of the fibroid is of vital importance in the decision of this case.

6.2 I have come to the conclusion that it cannot be said *a priori* that the failure of the defendants to identify the presence of the fibroid prior to the 15th June represents a breach of duty. The plaintiff is of course obliged to prove on the balance of probabilities every factual aspect of her case and there is an absence of evidence on this point due to the absence of the slides. This is not a case of evidence being destroyed and inferences to be taken from the destruction of such evidence rather it is a case that evidence was never going to be preserved and that was the custom of the time and accordingly from the admitted fact that the fibroid was there to be seen I cannot conclude that the failure

to notice it prior to the 15th June was of itself a breach of duty in accordance with the *Dunne v. National Maternity Hospital* principles.

6.3 It is noted that all of the witnesses including Dr. Waterstone expressed surprise that the fibroid had not been noted before the 15th June but surprise that it had not been noted is not sufficient to establish a breach of duty in its failure to note it and the defendant's experts gave some explanation as to why it may have been missed given the colour of the fibroid and the grey nature of the slides.

6.4 The decision on liability then largely depends upon whether I accept the plaintiff's or the defendants' view as to the nature of the fibroid. It is of course incumbent upon the plaintiff to establish on the balance of probabilities that their view is correct.

6.5 If I find that the fibroid was at all times a type 3 FIGO fibroid that abutted the cavity when first observed on the 15th June, 2012 and never protruded into the cavity or distorted it, then the decision by the defendants to continue with the IVF treatment cannot be criticised as a breach of duty. If the fibroid was not encroaching or distorting the cavity then the plaintiff had already commenced the cycle, stopping the cycle then and there would have resulted in the plaintiff who had commenced the cycle in circumstances where there were concerns that her supply of eggs was diminishing, but would have given the plaintiff no chance of conception. In those circumstances the decision to continue in those circumstances was not unreasonable.

6.6 Further in those circumstances, assuming it to be type 3 FIGO fibroid, the decision of Dr. Waterstone to remove the fibroid after the consultation on the 12th July, 2012 was in itself not an unreasonable one or in breach of the *Dunne v. National Maternity Hospital* principles, notwithstanding the fact that the defendant's experts all said that they themselves would not have removed it. The plaintiff is not making a case for lack of consent. Though there are some differences between the account of the consultation on the 12th July between the plaintiff and Dr. Waterstone as to the nature of what was said at this consultation, essentially the plaintiff agreed to have the fibroid removed when Dr. Waterstone indicated that were a member of his family in the situation of the plaintiff that that is what he would advise too. The fact that none of the experts would have removed a type 3 fibroid themselves is not equivalent to the plaintiff making the case that the decision to remove it was negligent. The plaintiff's experts were critical of a decision to remove a type 3 fibroid if that is what was found, but on balance I have come to the conclusion that if it was indeed a type 3 fibroid then the decision to remove it was not a breach of duty.

6.7 If I accept the defendant's contention that the fibroid was a type 3 fibroid and had not protruded into the cavity then the decision to proceed by laparotomy was the correct decision and I accept the evidence in this regard from the defendant's experts Professor Wingfield and Dr. Prentice.

6.8 If however, the plaintiff is correct in her view and the view of her experts that the fibroid as discovered was in fact a type 1 or type 2 fibroid that had penetrated into the cavity as

is apparent from the ordinary language of the letter to the GP and also flows from the reading of the operation note itself, (especially the operation note as informed by reading the letter to the GP) then I fully accept that the interpretation of the slides of the 15th June and the 18th June by Dr. Papaioannou and indeed Mr. Iskander is correct and it is likely that it shows some distortion of the cavity. This interpretation is also fortified by having regard to the slides taken in July 2012 some of which at least show that one end of the cavity is narrower than the other and support the plaintiff's contentions.

6.9 If the fibroid was indeed protruding into the cavity as stated by Dr. Waterstone in his letter of the 9th September, then as the fibroid is slow growing it follows that on the balance of probabilities the fibroid must have been distorting the cavity in June. Accordingly, for the defendants to proceed with the IVF treatment in June 2012 was clearly to expose the plaintiff to unnecessary pain and injury and distress on an exercise that was almost certainly going to be pointless and would amount to a breach of duty in accordance with the *Dunne* principles.

6.10 Again if the plaintiff's view of the fibroid is correct and the fibroid was penetrating into the cavity then a hyteroscopic evaluation should first have taken place to see where in the cavity the fibroid was and with a view to excising it hyteroscopically rather than through a laparotomy. All of the defendants' experts' hostility to hyteroscopic evaluation is based upon their belief that the fibroid was not penetrating into the cavity. Accordingly, if the plaintiff's experts are correct and the fibroid was clearly penetrating into the cavity at least by July 2012 then it is clear that a hyteroscopic evaluation should have taken place with a view to proceeding to remove it hyteroscopically.

6.11 It follows from the above that the liability in this case will hinge upon my view as to what and where the fibroid was when it was removed by Dr. Waterstone.

7. Conclusion

7.1 I have come to the conclusion in this case that none of the witnesses were in any way attempting to be dishonest and that the significant disagreement between the experts resulted from the different starting point both set of experts took in the case. The defendant's case started with the film of the 15th June, 2012 and use that slide to base their conclusions as to the fibroid and then interpret the following scans based upon their original conclusion. The plaintiff's experts started with the letter from Dr. Waterstone and his operation notes to inform a view as to the proper interpretation of the photograph of the 3rd July and further to inform the view as to what was observed on the 15th June.

7.2 Having observed the witnesses I have come to the conclusion that not alone were none of the witnesses intentionally attempted to deceive me but in particular all the expert witnesses gave their evidence firmly and reasonably on the basis of their interpretation of the facts.

7.3 Inconsistencies or errors in evidence usually arise from witnesses as to fact genuinely at a distance convincing themselves that a particular point of view is correct. In addition, of

course some witnesses do deliberately lie to courts. This may be rare but it does happen and courts must be aware of this.

7.4 If the plaintiff's interpretation of the facts is correct then Dr. Waterstone was deliberately attempting to deceive the court by his insistence that the fibroid was a type 3 FIGO fibroid that did not distort the cavity. If Dr. Waterstone's evidence was incorrect I do not believe that there can be any innocent explanation. Dr. Waterstone's evidence as to what he found in this operation is clear i.e. that it was a type 3 fibroid and I cannot see how he could be merely failing to recollect what was there given the importance of the issue. The letter to the GP is so stark at least that his testimony is highly unlikely to be the product of lack of recollection. Either what he said is correct and therefore the letter a terrible mistake, or he was deliberately attempting to deceive.

7.5 I have given the matter some great deal of thought and conscious of the fact that I may be doing an injustice to the plaintiff I have come to the conclusion that the evidence does not support deliberate deception by Dr. Waterstone.

7.6 Accepting that Dr. Waterstone was not deliberately attempting to deceive it follows that I must accept his contention that the letter to the GP was a terrible mistake and that Dr. Waterstone has a recollection of this surgery which is correct and that unfortunately this correct view was not reflected in Dr. Waterstone's correspondence or indeed properly reflected in the operation note.

7.7 To address the plaintiff's submissions referred to above the scan of the 15th June, 2012 is not necessarily superior to those of the 12th July, 2012 but the distortions of the cavity clearly to be seen in the scans of the 12th July, when the cavity was filled with fluid do not necessarily and did not in this case represent a distortion caused by the fibroid but rather must be due to the angle of the film as the defendant's experts maintained.

7.8 Secondly, in view of the evidence in this case, the letter of the 7th September, 2012 to the GP can only be explained either by Dr. Waterstone deliberately attempting to deceive the court or by the fact that the letter was entirely mistaken and careless. There are indeed great difficulties in accepting that an experienced practitioner such as Dr. Waterstone was careless and mistaken in his correspondence as he now claims however I am not prepared to find deliberate deceit. If I believed there was a third innocent explanation for Dr. Waterstone's testimony as to what he found in the operation, then I may well have come to an entirely different conclusion as to the nature of the fibroid.

7.9 I have come to the conclusion as a matter of probability that Dr. Waterstone was correct that the fibroid he removed merely abutted and touched the wall of the cavity causing the tiny hole to appear which had to be sutured and that the fibroid was not ever a type 1 or type 2 fibroid that could have been removed hysteroscopically.

7.10 As stated above this conclusion leads me also to conclude that the interpretation of the fibroid of Dr. Weigandt and Dr. Waterstone from June 2012 was probably the correct one.

The fibroid was not at that time protruding into or distorting the cavity and accordingly it follows that the decision to proceed with the IVF treatment was not a breach of duty.

7.11 It also follows that the interpretation of the slides taken in July which on the face of it support encroachment are as a matter of probability caused by the angle that the slides were taken as stated by the defendant's witnesses.

7.12 A successful pregnancy as a result of IVF treatment can never be either guaranteed or stated to be the likely outcome. It should be noted that at least a superficial reading of the defendants' own publicity is suggestive of a claim to a greater chances of success than is actually achievable but it should also be noted that the first attempt of IVF after the removal of the fibroid was itself also unsuccessful. Happily, the final attempt resulted in the birth of Ronan but sadly also resulted in the stillbirth of Oran.

7.13 It must also be stated that the plaintiff's sincere views and the understandable opinion of the plaintiff's experts Dr. Papaioannou and Mr. Iskander, the integrity of whose evidence I fully respect, were caused by the circumstances and wording of the letter to the plaintiff's GP of the 7th September, 2012 and the fact that no explanation for what was written was given until Dr. Waterstone himself gave evidence in which he stated that the letter was a mistake and accepted that it was inaccurate. This letter also gives reasonable support to the plaintiff's interpretation as to the contents of the operation note. I do not accept the characterisation of the letter or indeed of the operation notes as being "subjective" as suggested by the defendant in their submissions. The letter and the reading of the notes as informed by the letter clearly supported the contentions of the plaintiffs that the slides of July 2012 showed encroachment and given the slow nature of the growth of the fibroid this encroachment must also have been there in June of 2012. Accordingly, the plaintiffs mistake which I find to be a mistake was an entirely understandable one.

7.14 I accept on the balance of probabilities Dr. Waterstone's explanation for the letter as being a mistake though had he clearly set out his explanation for the letter and how the operation note was to be interpreted notwithstanding that letter, these proceedings might well have been avoided. In this regard, the conduct of the defendant was to a significant extent responsible for the bringing of this case.

7.15 It follows from the above that the plaintiff's claim must be dismissed.

Kevin Cross

Dated 11th March, 2021