

THE HIGH COURT

[4013P/2011]

BETWEEN

**THOMAS O'CONNOR (A MINOR SUING BY HIS MOTHER AND
NEXT FRIEND ANN O'CONNOR)**

APPLICANT

AND

**THE HEALTH SERVICE EXECUTIVE, CARTHAGE CARROLL
AND NIRMALA KONDAVETTI**

RESPONDENT

JUDGMENT of Mr Justice Fullam delivered on the 21 day of December, 2015

Introduction

1. This judgment is concerned with a claim for contribution pursuant to section 27 of the Civil Liability Act 1961 by the first defendant against the third defendant following the settlement of the main action as between the plaintiff and the defendants generally. The case involved a medical negligence claim in respect of the management of the plaintiff's birth at Sligo General Hospital on the morning of 6th September, 1996. The plaintiff suffered devastating injuries due to chronic partial hypoxic ischaemia prior to his birth, augmented by further insult in the first hour after his birth. He is a spastic quadriplegic and is completely dependent on others in all activities of daily living. This will continue for the remainder of his life. His life expectancy is significantly reduced.

2. The first defendant was sued as the employer of all medical staff at Sligo General Hospital (SGH). The second defendant was employed by the first defendant as a consultant obstetrician. The plaintiff also sued the second defendant in contract on the basis that he was retained privately by the plaintiff's mother and next friend for specialist obstetric treatment and advice. This contractual relationship was in issue.

3. The third defendant was a locum Senior House Officer (SHO) in Obstetrics on duty at the hospital on the 6th of September, 1996 and employed by the first defendant on a five month contract from 1st August, 1996. She commenced her duties on 17th August. Initially the first defendant brought the third defendant in as a third party on the basis that she was in charge of the management of the plaintiff's labour on the morning in question. The case proceeded on the basis that third party would be treated as a co-defendant for the purposes of determining contribution, if any, between the defendants on a finding of liability. The second defendant did not join Dr Kondavetti as a third party but it was agreed that the issue as to contribution could be determined without formal pleadings.

4. On day 14 of the hearing, counsel for the plaintiff informed the court that the proceedings between the plaintiff and all defendants had been settled and the settlement, which included the payment of a sum of €1,755,000 and undertakings relating to the provision of future care for the plaintiff, had been ruled by Mr Justice Cross. Counsel for the first defendant informed the court that his clients had agreed responsibility as between themselves and the second defendant and would be taking over the running of the remaining issue of the first defendant's claim for contribution against the third defendant Dr Kondavetti pursuant to section 27 of the Civil Liability Act 1961.

The Pleadings

The Plaintiff's case

5. The plaintiff issued a personal injury summons on the 5th May, 2011 against the HSE and Dr Carthage Carroll.

6. At paragraph (h) of the particulars of negligence the plaintiff alleged that the first defendant failed to notify the Second Defendant or the next appropriate Registrar or Senior House Officer or medical doctor of the entirely abnormal CTG results. In evidence the plaintiff's expert obstetrician gynaecologist, Mr Roger Clements said that if a Caesarean section had been done by 6 am, his opinion was that the foetus would have been spared all or most of the brain damage and its consequences.

7. At (ff) the plaintiff alleged that the first defendant, either through the midwifery or nursing staff or through the SHO (Dr Kondavetti), failed to inform the second defendant of the abnormal cardiotocograph (CTG) findings, in a timely fashion or at all.

8. The first defendant's defence was twofold. It denied that all the injuries suffered by the plaintiff occurred during the attendance of the plaintiff's mother at SGH and insofar as any injury was caused at SGH it alleged such injury was the result of negligence on the part of the third party. On 26th March, 2012 the first defendant got liberty to serve a third party notice on Dr Kondavetti.

9. In support of the denial that all the damage suffered by the plaintiff occurred during the two periods i.e. 04.30–09.00 and 09.25–09.55, the first defendant called Dr Eoghan Mooney, consultant histopathologist, in relation to the likely time of occurrence of damage to the plaintiff. Dr Mooney was of the opinion based on six slides taken on the 16th September, 1996 that the placenta was suffering from FTV (foetal thrombotic vasculopathy) at least six days before admission. FTV is associated

with neurologic damage in infants; it may cause injury directly or may drop the threshold for injury due to other factors. The slides also showed meconium staining. Dr Mooney was of the opinion that it was present for at least three hours and possibly much longer. The passage of meconium by the foetus may be a marker for an acute hypoxic event.

10. The particulars of negligence alleged against the second defendant at (f) that he failed, having been informed of the CTG monitoring or tracing results, by the servants or agents of first defendant, to react promptly or investigate early.

11. In his defence the second defendant states he was not informed of the abnormal trace by either the midwife or the SHO and, had he been informed, he would have attended promptly.

Pleadings on the Contribution Issue

12. In its statement of claim, at paragraph 8, the first defendant alleges that at all material times Dr Kondavetti was responsible for the clinical management of the plaintiff's mother during the course of her labour, she had been alerted to the findings of the CTG trace by the staff midwife on duty and she had personally examined the CTG trace and thereafter was responsible for the clinical management and direction of the plaintiff's mother's labour and delivery and birth of the plaintiff on 6th September, 1996.

In replies to particulars, the first defendant alleged, *inter alia*, that:

‘There was no requirement for the midwife to alert anyone else’;

‘The midwife had no recollection of alerting any other party’;

‘The midwife was directed by the third party to take the bloods’ (of the plaintiff's mother);

‘According to the midwife’s note the third party directed that the CTG was to recommence at 7.30’; and,

‘The Third Party was the SHO on duty on the night of the 5th and the morning of the 6th September, she was called by Staff Midwife Ms Geraldine O’Brien and she attended upon the plaintiff’s mother and was responsible for all clinical decisions made in respect of the clinical management of the plaintiff’s mother’s labour during that time period’.

13. The case made at the hearing and in its submissions by the first defendant against the third party was significantly different to that pleaded. The first defendant did not call any expert evidence on the third party issue and relies on cross examination of experts called by the plaintiff and the third party as well as that of the second defendant who was a witness to fact. As appears from para. 8 of its statement of claim, the first defendant claimed that the third defendant was responsible for the clinical management and direction of the plaintiff’s mother during the course of her labour, had been made aware by the midwife of the abnormal CTG findings, had personally examined the CTG trace and thereafter was responsible for the clinical management and direction of the plaintiff’s mother’s labour and the delivery and birth of the plaintiff and that any damage caused during the management period was the responsibility of Dr Kondevetti. The first defendant now submits that Dr Kondavetti was in breach of her duty as an SHO, she had identified an abnormal trace, she did not share her concern with the attending midwife, she should have contacted Dr Carroll and/or at the very least requested Midwife O’Brien to contact Dr Carroll to inform him of their concerns. Had she done so Dr Carroll would have attended and the Caesarean section carried out at or around 06.00.

14. The third party's defence, filed on the 15th May, 2013 states, in essence, that she was called by the midwife at approximately 05.45 to 'clerk (*i.e.* admit) the patient' because Dr Carroll was going to perform a Caesarean section. The hospital practice required that a doctor take bloods, get the patient's informed consent to the Caesarean section, and formally admit the patient to the labour ward. She carried out these tasks and completed her notes starting same at approximately 06.00. She then returned to her room and thence to see a patient in the surgical ward. Her understanding was that the plaintiff's mother was under the care of the consultant obstetrician and the midwives. She pleads that once a care management plan has been put in place, *i.e.* to proceed to Caesarean section, it is not the role of the SHO to change that plan or to interpret the labour.

15. In summary, given the adoption by the first defendant of responsibility for the second defendant's conduct, the first defendant would be liable if the midwife failed to inform the consultant of the abnormalities in the CTG trace or, if the consultant, having been informed of the abnormal trace, did not react or did not react by promptly attending on Mrs O'Connor. The plaintiff would succeed on one or other of those premises. The issue is whether the acts or omissions of the third party were negligent and, if so, contributed to the damage suffered by the plaintiff.

Relevant Medical Personnel

16. The relevant staff were the second defendant, Dr Carthage Carroll, consultant obstetrician gynaecologist on call, the labour ward midwife, Ms Geraldine O'Brien and the third defendant, Dr Nirmala Kondavetti, who was a Senior House Officer (SHO) on call generally on the night and located in a building adjacent to the hospital. There was no registrar on duty or on call. There was a second midwife on duty on the post-natal side.

17. Dr Carroll was one of two obstetrician gynaecologists at Sligo General Hospital. The other was Dr Brendan Gill. Dr Carroll lived a five minute drive from the hospital.

18. Ms Geraldine O'Brien was the midwife on duty in the labour ward. Ms O'Brien trained as a nurse at North Down College of Nursing, Newtownards, qualifying in 1991. Between 1991 and 1993 she trained as a midwife at the Rotunda Hospital in Dublin. Her training involved exposure and interpretation of CTG's both from the theoretical and practical aspect, learning in the School of Midwifery and working on site on wards as a student midwife. The theoretical aspect involved text books on CTG monitoring, lecture notes, oversight by tutors and the passing of examinations in order to achieve her qualification.

19. Between 1993 and 1995, Ms O'Brien was employed as a midwife at the National Maternity Hospital. This was on the postnatal side and did not involve work with CTGs.

20. In February 1995 she commenced work as a midwife at Sligo General Hospital.

21. Dr Kondavetti was born in 1961 in India. She obtained her primary medical qualification, MBBS, in May, 1985. In September, 1990 she obtained a post-graduate qualification of Diploma in Gynaecology and Obstetrics. Following this she was appointed as a Medical Officer (with the title 'Registrar') in gynaecology and obstetrics in a primary health care centre in rural India. Between 1992 and December, 1995, she held the position of Registrar in obstetrics and gynaecology at a hospital in Nellore.

22. Dr Kondavetti had considerable experience of Caesarean sections in India but no training or experience of working with CTG's. Her first employment in Ireland was at Letterkenny General Hospital as a locum registrar in February 1996. She was the only applicant for the position. She informed Mr Davidson, Consultant Obstetrician Gynaecologist at Letterkenny, that she had no experience of CTGs. She was taken on as an unpaid supernumerary for two weeks prior to commencement of her appointment during which time she worked under strict supervision. She was recalled to Letterkenny for one week in April as a Locum SHO.

23. She had a subsequent appointment at Clonmel hospital for four weeks as a locum SHO in obstetrics. There was no exposure to CTG's with this appointment. In May, 1996 she applied to Sligo General Hospital for an appointment as Locum SHO in Obstetrics and Gynaecology. This appointment did not require experience with CTG's. Notwithstanding references from the two consultant obstetrician gynaecologists at Letterkenny, Mr Davidson and Mr Mc Auley, Dr Kondavetti was not interviewed for the Sligo position. Following the departure of the successful candidate, she was contacted by the Human Resources Department at SGH and offered a locum contract without an interview. Dr Carroll was on holiday at this time. The contract was for the period 1st August to 31st December 1996. She commenced work at Sligo General Hospital on the 17th August, 1996. She informed Dr Gill on her first day that she had no experience of CTG's. Between the commencement of her contract and the 6th September, Dr Kondavetti was attempting to get an understanding of CTGs from a book borrowed from the library of SGH which she read during her spare time.

The Law

24. The issue falls to be decided by reference to the principles of medical negligence set out in *Dunne v National Maternity Hospital* [1989] IR 91. In his decision, Finlay C.J. listed the first of the principles as:

'The true test for establishing negligence in diagnosis or treatment on the part of a medical practitioner is whether he has been proved to be guilty of such failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care.'

25. The issue can be briefly stated as follows: whether, having regard to the *Dunne* principles, given her status as the SHO on duty (and her knowledge and experience in the interpretation of cardiotocograph machines) Dr Kondavetti has been guilty of negligence in carrying out her duties in the management of Mrs O'Connor's labour. Additionally, if negligence is found against the third defendant, whether and to what extent that negligence caused the plaintiff damage.

26. The third party issue, simply stated is whether Dr Kondavetti failed to act with the ordinary care of an SHO in carrying out her tasks. The first defendant must prove that there was a breach of duty and the plaintiff suffered damage as a result.

27. The issue concerns the interpretation of cardiotocograph traces (CTGs) and the relative duties of medical staff, on duty or on call, responsible for the delivery of the plaintiff on the morning of 6th September, 1996 at SGH.

Abnormal CTG Traces

28. The CTG monitors the foetal heart rate together with the measurement and frequency of the mother's contractions. The CTG commenced at 04.27. It was discontinued at 05.30 and reconnected at 07.06. It is accepted that the CTG traces were abnormal from beginning and remained so. The evidence of the plaintiff's

expert, Mr Roger Clements, was that by 04.40 the CTG traces showed the three indicia of foetal abnormality: contractions followed by late decelerations, loss of baseline variability and poor reactivity. There were no other abnormalities.

Late Decelerations

29. Late decelerations are an indication that when the uterus is contracting the placenta is very slow to refill. In a normal labour, with normal contractions, life improves for the foetus, because the turnover of blood in the placenta is improved by the uterus contracting. That depends on two things: on the placenta being entirely healthy and on the interval between contractions being sufficient to allow for refilling completely before the next contraction comes along to empty it. If the placental function is poor or the uterine contractions excessive, the retro-placental space may be emptied of oxygenated blood and the baby may subsequently become hypoxic.

Lack of Variability

30. A foetus has only one organ to control acidity and oxygenation, namely the placenta. If the baby accumulates acid metabolites because it is short of oxygen, then its blood becomes progressively more acidemic and will eventually lead to an adverse situation. In a healthy foetus, the heart rate varies by the millisecond. According to Mr Clements, normal variability would be between 10 - 15 beats per minute. Less than five beats per minute is effectively a straight line. The straight line leads, as Mr Clements put it, to a reasonable suspicion that there is some increase in acidity in the baby's blood. To find out the extent of the acidemia, a sample of blood is taken from the baby's head.

Lack of Reactivity

31. A healthy baby will respond to stimuli, e.g. contractions or prodding, by an acceleration of the heart. Mr Clements says that there are no accelerations in the

CTG's in this case. Therefore, because reactivity is the hallmark of foetal health, Mr Clements says this ought to raise concern in a midwife. He points out that initially lack of accelerations, or lack of reactivity, is not diagnostic of anything, but if it goes on for too long or if the foetus fails to respond to being prodded then it is a cause of concern.

Background to Birth

32. Prior to the birth of the plaintiff, Mrs O'Connor had four children by normal vaginal delivery at Sligo General Hospital under the care of Dr Carroll as follows- Cormac born on the 10th September, 1985, Rhona born on the 16th April, 1989, Jarlath born on the 19th April, 1990, and Sean born on the 13th December, 1993.

33. With her first child, Cormac, Mrs O'Connor was treated by the second defendant as a public patient and as a private patient with the other three children.

34. On the 19th August, Mrs O'Connor, without a referral, attended Dr Carroll for the first time at his private clinic. He referred her for an ultra sound on the 20th; this showed that she was 37 weeks pregnant. She was next seen by Dr Carroll at his clinic at SGH on the 22nd and again on the 29th August. On the 5th September, she attended Dr Carroll's clinic at SGH and was seen by a locum. At that consultation she was told that the birth of her baby was imminent.

35. At 21.00 that night she had a "show". Prior to leaving for SGH, she made arrangements with her husband for her children to be looked after. This took some time, following which her husband drove her to Sligo General Hospital.

Mother's Attendance at SGH

36. There is some conflict on the evidence as to when she arrived at the hospital and was first seen in the labour ward. Mrs O'Connor herself says she arrived around

midnight and presented to the Accident and Emergency Department and says she was then told to go to the labour ward (the SHO's note written at 6 am records that Mrs O'Connor had pains since 01.00). She says that her details were taken in the labour ward by Midwife O'Brien. These included general observations and listening to the baby's heartbeat. Her bloods and pulse were taken and the midwife examined her abdomen. She says she then sat with her husband for a couple of hours and was re-examined at 04.30.

37. The hospital's antenatal progress sheet written up by Midwife O'Brien records that Mrs O'Connor presented at the ward at 04.00.

Evidence Relating the Period 04.00 - 08.00

38. From this time until delivery by Caesarean section at 09.00, the care history appears from three sets of notes; those of Midwife O'Brien up to handover at 08.00 to midwives S. Flanagan and Keegan, the note of the SHO written at 06.00 after completing certain tasks and the note of Dr Carroll commencing at 08.30. In addition a statement written by Dr Kondavetti on the 17th September 1996 at the request of Dr Carroll is relevant. The relevant extracts are summarised below.

Midwife O'Brien's Note

39. The midwife's notes are divided into irregular periods of time, beginning with the largest from 04.00 to 05.20.

During this period the notes indicate the following sequence:

- “presentation of the mother at the labour ward;
- palpation of the abdomen to identify the position of the baby;
- taking of details of foetal heart;

- medical examination of the mother - noting an “odour of C2 H5O” (alcohol);
- blood pressure, pulse and “legs oedematous”;
- “CTG performed-recording poor reactivity on tracing, baseline 140 BPM. Dr Nirmala informed”;
- vaginal examination details.”

The last entry reads: “Dr Carroll informed of admission, to have bloods taken and prepare as for LSCS” (lower segment Caesarean section).

40. Midwife O’Brien accepts she made three alterations to the notes for the above period, namely, she rewrote the formula for alcohol, inserted “legs oedematous” and “Dr Nirmala informed”. The third party challenges the accuracy of the entry “Dr Nirmala informed”. This will be discussed later.

41. Three matters are referred to in the next period from 05.20 to 05.45. First the administering of Sodium Citrate and Zantac by the midwife, second, the taking of her bloods by the SHO, pursuant to Dr Carroll’s instructions for the LSCS, and the last entry reads- “05.30- CTG discontinued for repeat at 7.30.”

42. Dr Kondavetti disputes the timing of the taking of the bloods and the midwife’s interpretation that the discontinuance was on foot of a direction from Dr Kondavetti. These will be discussed later.

43. From 05.45 to 08.00 the periods are in 15 minute segments. There is nothing of relevance until 07.00.

07.00: “CTG recommenced. Beat to beat variability remains very poor. Baseline 135-140 BPM.”

07.45: "CTG continued variability remains poor regardless of the maternal position, lying on left lateral."

07.50: "Discussed with Dr Carroll. CTG continued."

08.00: "Handover."

Dr Kondavetti's Note

44. The SHO took Mrs O'Connor's history, family, social, obstetric and gynaecological. She carried out an examination, noted "Odour- alcohol- smells strongly", blood pressure and urine analysis. She also noted "CTG-130BPM, Sinusoidal pattern poorly reactive." She took a full blood count. Her impression was that the patient was on her sixth pregnancy, at term and in early labour.

Dr Kondavetti's Statement of 17th September, 1996

45. Shortly after the events of the 6th September, Dr Carroll contacted the Medical Protection Society and was advised that he should obtain statements of all medical personnel involved with the management of Mrs O'Connor's labour on the night/morning in question. Having looked at the hospital file, he spoke to Dr Kondavetti and asked her to provide a statement, which she did on 17th September.

46. In her statement, Dr Kondavetti said that at 05.45 she was bleeped by the nurses in the labour ward and told that Mrs O'Connor was in the labour ward and had to be admitted and that Dr Carroll wanted her bloods taken in preparation for a Caesarean section. When she arrived at the labour ward she took a history from Mrs. O'Connor, examined her, took a full blood count and obtained her informed consent for the Caesarean section. In addition, she read the CTG and recorded her findings as "130 bpm, sinusoidal pattern and poorly reactive". She sent the bloods to the laboratory; the laboratory received the bloods at 06.18. In evidence she said she returned to her room and was called to the surgical ward to admit a patient.

47. Period following Dr Kondavetti's departure

The blood results were phoned back to the labour ward at 06.30.

48. Mrs O'Connor's contractions increased from 1:10 at 04.30 to 1:5, at 06.40, at which point the pains are described as being stronger. Throughout this period, the foetal heart rate is described as regular.

49. The CTG was recommenced at 07.06, beat to beat variability was described as remaining "very poor" regardless of the maternal position, which was lying on left lateral. A similar observation was made at 07.45.

50. At 07.50, the midwife discussed the case with Dr Carroll shortly after his arrival.

Midwives' Handover at 08.00

51. Dr Carroll performed artificial rupture of the membranes (ARM); this showed thick meconium which was drained. The cervix was 3cm. Midwife Keegan's note at 08.10 reads "prepare for theatre – Emlscs – all preparations already carried out". At 08.35, Mrs. O'Connor was transferred to the theatre.

52. At 09.00, Thomas was delivered by Caesarean section by Dr Carroll assisted by two registrars Dr Mehmed and Dr Joseph.

53. On the 17th September, a CT scan was performed. This was the date of the written statement provided by Dr Kondavetti at the request of Dr Carroll.

54. On the 7th December 1996, Dr Carroll added a postscript to his surgical notes.

55. Following Dr Carroll's suggestion in a detailed letter of 11th December, 1996, the general manager of SGH sought a detailed report from Ms Craughwell, the Director of Nursing at SGH, relating to Mrs O'Connor's admission at SGH.

Evidence of Midwife O'Brien

56. Midwife O'Brien set up the CTG at 04.27. The traces were abnormal from 04.40. In her direct evidence she first dealt with her phone call to Dr Carroll. She said the purpose of the call would be to inform him of her assessment. He was the consultant on call. In her evidence she described how he was quite particular and usually liked a full assessment before being phoned. Dr Carroll would not have wanted her to phone him with half an admission or without all the information. She said she recalled telephoning him but thereafter she had to refer to her notes. She said that she would have done a full admission, phoned Dr Carroll with her purpose in ringing him being to inform him of her findings including the CTG and the vaginal examination and from there he told her to prepare Mrs O'Connor for Caesarean section. She was concerned about the CTG, poor variability, and of the lack of accelerations regardless of the mother's position. She said it would be routine for her to try and alter the mothers position to achieve a better blood flow to the placenta (and improve the reactivity on the CTG).

57. Midwife O'Brien said she would have called Dr Kondavetti because she "was concerned for the CTG" according to her own notes. She said she would not have called her to "clerk" a patient. She said that she would have bleeped Dr Kondavetti and then Dr Kondavetti would answer her bleep and there would have been a discussion as to what her concerns were or why she wished Dr Kondavetti to attend delivery. She was asked by Mr O'Brolchain, counsel for the first named defendant, if she was able to say whether she spoke to Dr Carroll first or second. She replied that when she looked at her notes, "it would appear I spoke to Dr Kondavetti first and then Dr Carroll". She said later that she called the two doctors available to her that night to voice her concerns for the CTG.

58. Counsel for the first defendant asked Midwife O'Brien to elaborate on her note - "05.30 CTG discontinued. For repeat at 7.30 hours". She said "for repeat at 7.30 hours" is how she would word an order or an instruction and she received that instruction from Dr Kondavetti who was the only doctor present in the delivery at that stage. The exchange went as follows:

"Q. I see. There were no other doctors?

A. No.

Q. Were there any other doctors on duty in obstetrics that night?

A. Dr Carroll was the only other doctor on duty.

Q. I beg your pardon?

A. Dr Carroll."

Cross Examination of Midwife O'Brien

59. Counsel for the third party put it to Midwife O'Brien that when she recommenced the CTG at 07.00 and the trace remained abnormal she had failed to contact the appropriate person.

"A. I tried to reposition Mrs O'Connor in the hope that it would improve the CTG.

Q. Is it possible that at the root of this case, Ms O'Brien, is a failure on your part to realise how seriously abnormal this trace was?

A. When I realised that the CTG was not to my satisfaction I contacted Dr Kondavetti and Dr Carroll and informed them of my concerns."

60. She was asked if it was her view that the abnormality which she saw on the trace could be put down to the consumption of alcohol by Mrs O'Connor. She said

that she didn't know. She hadn't written that in her notes and didn't remember considering that as a possibility. As of now, she didn't think alcohol would cause that effect on a CTG.

Evidence of Dr Carroll

61. Dr Carroll was a witness to fact as to the system in SGH. He stated that there was a system put in place in SGH by himself and Dr Gill of open access between the midwives and the consultants. He agreed with counsel for the third party that:

“There was an established channel of communication between the midwife and himself and between himself and the midwife, that he was managing the labour and delivery whether he had been given all the information or not”.

62. He said Dr Kondavetti was not in charge of the clinical management of Mrs O'Connor's labour. He further agreed that he would not expect the SHO “to have any say in what was done by way of carrying out a section or not carrying out a section or anything of that sort”.

63. Dr Carroll confirmed that it was always the practice that the interpretation of the CTG trace and its communication to the consultant were matters for the midwife rather than the junior doctor.

64. He gave instructions to Midwife O'Brien to prepare Mrs O'Connor for Caesarean section and some of the tasks required to be done by the SHO.

65. The second defendant said he simply was not told by Midwife O'Brien of the details of the plight of the foetus which, had he been told, he accepts would have required his immediate attention. He said that as soon as he became aware of the urgency of the situation *i.e.* on his arrival at SGH just before 08.00, he acted with all

due promptitude, care and skill. He said his telephone conversation with Midwife O'Brien was brief and concerned Mrs O'Connor's status as a patient. He accepts he did not ask any questions of Midwife O'Brien as to how Mrs O'Connor's labour was progressing.

Evidence of Dr Kondavetti

66. Dr Kondavetti gave her evidence on day 14 following the announcement of the settlement. Her evidence concerning her C.V. is set out earlier in the judgment.

67. Her counsel took her through two pieces of written evidence, the statement made by her on 17th September at the request of Dr Carroll and her note written in the labour ward at 6 am on the morning of 6th. Dr Kondavetti stated that she was not informed of the position by Midwife O'Brien as suggested in the midwife's note. She said she was bleeped once by the midwife at 5.45; the time would have been displayed on the bleep and when she phoned back, the midwife informed her of Dr Carroll's instructions, he was going to carry out a LSCS and she was required to come and clerk/admit the patient, take bloods and take an informed consent. She said the midwife would have contacted Dr Carroll first before she contacted her. There was no mention of CTGs in her phone conversation with the midwife. The reference to 'poor variability' in her statement was gleaned from what the midwives told her when she met them in the corridor. She included the reference to blood alcohol levels because of a query raised by Dr Carroll.

68. Dr Kondavetti said she wrote the labour ward notes starting at 6 am while simultaneously taking a history from Mrs O'Connor. She said there were no belts on Mrs O'Connor when she examined her. She got some information from the midwife's notes, temperature, urine analysis and the description 'poorly reactive'. She got the term 'sinusoidal' from a handbook on CTGs she had borrowed from the SGH library.

She said she didn't know the significance of 'sinusoidal'; she put it in because the trace appeared to her to be 'wavy'. She is now aware that the correct interpretation is shallow late decelerations, and that sinusoidal is a very rare thing to see. She didn't know that at the time. She accepts that she got it wrong. She said she got the 130 BPM from looking at the CTG. Dr Kondavetti said she did not instruct Midwife O'Brien to discontinue the CTG, it was not her role; she was the most junior person there and did not have any knowledge of CTGs at the time. She said that she was not the person in charge, that person was Dr Carroll and the midwife was looking after the time of labour. Further, she was not experienced enough to read a CTG properly and accepts that she got it wrong. She says she carried out the instructions conveyed to her from the consultant in charge to prepare Mrs. O'Connor for a Caesarean section in a diligent manner. She says it was not her function to interfere with his management of the case. In this sense she was a mere functionary of the system. She agreed with Mr Clements's explanation of her position at the conclusion of his evidence.

Cross Examination of Dr Kondavetti

69. She was asked why having written down that the CTG showed a sinusoidal pattern and was poorly reactive, she didn't ring Dr Carroll. She said she was only interpreting with her limited knowledge and wasn't sure whether it was right or not but the midwife is the most senior in interpreting the CTGs. It was already discussed with Dr Carroll and there was a plan made for a Caesarean section.

70. It was put to her that if she wasn't going to ring the doctor she should have made sure that the midwife did ring him. She said the midwife had already contacted the doctor and the plan was already made.

71. She said she did not give any instruction to the midwife to discontinue the CTG. She said that at the time Mr. Clements gave his opinion in evidence that any

midwife or junior doctor should have recognised the CTG as abnormal and it should have been reported to a senior doctor immediately, he was not aware of her background that she was new to the country, new to the system and had no knowledge of CTGs. She continued that if he had known he wouldn't have said that because at the end of his evidence he agreed that she had no knowledge on CTGs and did her duties as she was instructed.

72. It was put to her that she knew that Dr. Carroll was not coming immediately and that she should have called him to come in immediately given the sinister trace. She said that she was not the one to contact the consultant; the system was that SHOs never contacted the consultant. It was suggested to her that she should have told the midwife that it was sinister and that she should get on to the doctor. She said that she didn't have any knowledge of the CTGs and who was she to instruct the midwife about the CTG with no knowledge. She said she had a very limited interpretation, which was wrong.

73. She said she would have called the doctor if the midwife indicated that she wasn't going to call him. She was then asked about a statement she made on the 9th November, 2012 in which she said that during her period of nearly three weeks in Sligo she was essentially learning as she went along about CTGs from a book. She said the references from the two consultants in Letterkenny were good references but they did not comment on anything to do with CTGs. She said the references were only for the SHO job and SHO means that they don't expect SHOs to interpret CTGs.

74. It was put to her that the midwife was entitled to rely on the SHO's examination and opinion that everything was good enough for her to be able to walk away. She said "I did not say that everything was good enough, I did not reassure her

about the CTG. I did the job I was told to do and then I left. I did not voice my opinion on the CTG with the midwife.”

75. It was put to her again that she was the person who had given the instruction to discontinue the CTG and that that then meant that she had become the doctor who was involved with this particular patient who was a public patient. She said she was only one of the doctors’ involved in the care, Dr. Carroll and herself. She said the patient’s status was already discussed with Dr. Carroll and the plan was made.

76. She was asked if she believed that she had no obligation at all in relation to alerting the consultant obstetrician about the abnormalities in the CTG. She said she believed that was the role of the midwife. The communication channel was between the midwife and the consultant pertaining to the trace. The midwife is more expert than she was.

77. She said she knew she would be required if Dr. Carroll was going to do a section that morning.

Issues of Fact

“Dr Kondavetti Informed”

78. The principal evidential issue related to whether Midwife O’Brien’s notes reflect the correct sequence of two phone calls, the first to Dr Nirmala and the second to Dr Carroll. Midwife O’Brien accepts that the words “Dr Nirmala informed” was an afterthought, one of three changes she made in her notes relating to the period 4.00 am to 5.20 am. There is no dispute that in the course of the phone call with Dr Carroll, he directed that preparations for a Caesarean section be carried out.

79. The issue of whether Dr Carroll intended the section to be carried out as a matter of the urgency is not really relevant at this point. Midwife O’Brien agreed with the suggestion put by counsel for Dr Kondavetti that she had conveyed to Dr

Kondavetti the understanding that a Caesarean section was to be undertaken. Both Mr Clements and Mr McKenna accepted that as the logical explanation for the instruction. However, Mr Boylan said the ‘just in case’ preparation was common in country hospitals.

80. In her evidence, Midwife O’Brien said that she was primarily relying on her note and not on her memory. She said that she does remember discussing with Dr Carroll in her phone call whether Mrs. O’Connor was a private patient. Everything else in her evidence is based on her notes. She also relied on a statement made on the 3rd March, 2014 for the purposes of the case. Dr Carroll said he based his evidence on the assumption that 05.15 was the time of the phone call from the midwife on a reconstruction of her notes. Dr Kondavetti relied on her statement of 17th September 1996 and her recollection.

81. Midwife O’Brien says that she made the three changes to her notes in the course of writing them up. Her practice was to record the events, review her note and, if necessary, make it more complete. She says there were three specific changes in the untimed period at the commencement of her notes between 04.00 and 05.20. These were: first, the crossing out of an incorrect formula for alcohol which she initialled; second the addition on the following line of the words “legs oedematous” and third, three lines further down, the addition of “Dr Nirmala Kondavetti informed”.

82. This addition comes after details of the CTG and suggests that the SHO was informed of the details of the midwife’s assessment before the midwife’s conversation with the consultant in charge and that the SHO was actively involved in the management in the management of the labour (Mr Clements had assumed this to be the position for the purposes of writing his report and in giving his evidence in chief. Having been advised by her counsel as to what her case would be, he revised his

initial opinion as to the responsibility of the third party). If midwife O'Brien's version is correct, and there was only one phone call between herself and the SHO, then, as that call preceded the call to Dr Carroll, it could not have involved the communication of the consultant's instructions. That would leave the position of there being no note of the SHO being informed of the consultant's instructions by the midwife.

83. Dr Kondavetti's recollection is that she was bleeped at around 5.45 by the midwife who told her when she phoned back, that there was a patient who had to be admitted and that Dr Carroll wanted her bloods taken as she had to be prepared for a Caesarean section. She said there was no discussion of the CTG in that phone call. She attended at the labour ward, took Mrs O'Connor's bloods which were sent to the laboratory, got her informed consent for the surgery, carried out a physical examination, and a comprehensive history while writing up her notes.

84. If the midwife's evidence is correct, *i.e.* that she first called the SHO to review the CTG, one would expect some note as to the SHO's view, advice or instructions as occurred immediately after the phone call to Dr Carroll. There is none. Dr Carroll's evidence in respect of the channel of communication and the system in practice at SGH supports the likelihood of Dr Carroll being the appropriate person for her to call on the night.

85. Overall, the court views Dr Kondavetti's version as being the more credible, particularly given the detail in the statement furnished to Dr Carroll on the 17th September, 1996. The court finds that there was one phone call between the midwife and the SHO and that occurred after Midwife O'Brien had spoken to the consultant on call. The import of the call was to tell Dr Kondavetti that she was required to carry out specific tasks pursuant to Dr Carroll's instructions to prepare Mrs O'Connor for

Caesarean section. The effect of that finding is that the reference to Dr Kondavetti should have appeared in the midwife's note after the reference to her phone call to Dr Carroll.

Discontinuance of the CTG

86. There is no reference in the midwife's notes to any instruction or source of any instruction to discontinue the CTG. In her evidence Midwife O'Brien said the wording of her note indicated to her that it referred to an instruction and the only qualified person on site who could give such instruction was Dr Kondavetti. This is a serious allegation. Her evidence was not based on recollection. She agreed in cross-examination that there was room on the line to put in "*done at request or instruction of Dr Nirmala*," that she had the expertise to commence or discontinue the CTG, and that there was nothing directive about 07.30. Notwithstanding Dr Kondavetti's "direction to repeat at 7.30", the midwife recommenced the CTG at the earlier time of 07.00.

87. Dr Boylan said that such an instruction would be almost unprecedented. All experts agree that a CTG showing a non-reassuring trace should not be discontinued. Ms Craughwell, Director of Nursing at SGH, agreed that she would expect a midwife to record an instruction to discontinue.

88. If Dr Kondavetti had given such an instruction, the midwife would have known from her training it was wrong, recorded the fact in her notes with some explanation of the resumption time of 07.30 and alerted the consultant. As appears from her description of the trace as "sinusoidal", Dr Kondavetti did not know how to interpret CTG readings and was not in a position to give instructions to an expert midwife or engage in informed discussion. The court has no difficulty in rejecting this assertion. I am satisfied that Dr Kondavetti did not give any such instruction.

89. The discontinuance of the CTG has no consequences in the circumstances of this case as the abnormality which was established early did not change.

Time of Dr Kondavetti's Arrival at Labour Ward

90. Midwife O'Brien's notes record that three things happened and were recorded between 05.20 and 05.45. First, opposite 05.20, Sodium Citrate and Zantac are recorded as having been administered. Next, that Dr Kondavetti had taken bloods and the last entry at 05.30 states that the CTG was discontinued. If each event was recorded in the correct sequence, it indicates that the bleep by Midwife O'Brien, and Dr Kondavetti's appearance at the labour ward in response thereto, must have been earlier than 05.30 and clearly before the time of 05.45 as claimed by Dr Kondavetti in her statement and evidence. As regards the statement, Dr Carroll said he went through the hospital file of the events before talking to Dr Nirmala on the 17th September. He said he remembered that she had been called at 05.45 to the labour ward because she was asked to participate in the preliminary tasks, drawing of blood *etc.*. He said he thought she did that in a very responsible way and that her note was very clear. Dr Kondavetti's statement and evidence suggest the CTG straps were not affixed and therefore the CTG was not running when she looked at the trace. In her statement, Dr Kondavetti states that she was told by the nurses that they were going to repeat the CTG.

91. In cross-examination, Dr Kondavetti said she got the reading of 130 BPM from looking at the CTG strip on the recording graph of the CTG. In cross-examination, when shown the printout, she was unable to identify a reading of 130 BPM and accepted the possibility that she may have seen the reading from looking at the live screen. Mr Clements' evidence was that the tasks carried out by Dr Kondavetti could not have been completed in the 15 minutes between 05.45 and 06.00

when she started writing up her notes. He said the tasks would have taken half an hour, which would indicate Dr Kondavetti was in the labour ward at around 05.30. On the other hand, Dr Kondavetti's evidence was that it was after 6 am that she took a history from Mrs O'Connor and wrote her note as Mrs O'Connor gave her answers.

92. The taking of Mrs O'Connor's bloods was a procedure which did not require the removal of the CTG belts and could have occurred before or after the discontinuance of the CTG by the midwife. Dr Kondavetti says in her statement that she was told by the nurses that "they are going to repeat the CTG". This suggests that when the nurses spoke to Dr Kondavetti the CTG was inoperative and presumably the belts were removed. On Dr Kondavetti's evidence, that conversation would have taken place in the corridor as she arrived to carry out her tasks. If Dr Kondavetti's version is correct then she would have arrived after 05.30. That would be consistent with the telephone conversation between the SHO and the midwife taking place after 5.20.

93. On balance, I would be satisfied that Dr Kondavetti arrived at the labour ward before 05.45 and that she proceeded to carry out the physical examination of the patient and the remainder of her tasks after 05.30 when the CTG was discontinued and the belts were removed by the midwife. However, there is a conflict of evidence on the question as to whether she was present before 05.30 which I am unable to resolve.

The Third Party's Failure to Act on Becoming Aware of The Abnormal Trace

94. It is submitted by the first defendant that, on the evidence, as Dr Kondavetti was aware that the CTG was abnormal, albeit due to a misunderstanding, she nevertheless was under a duty to inform the midwife or Dr Carroll of the abnormality.

95. In her defence, Dr Kondavetti says once she carried out her instructions she left the labour ward to go to a room and carry out her tasks in the surgical ward believing that the management of Mrs. O'Connor's labour was in the hands of the midwife and Dr Carroll and a decision had been made for Caesarean section and there was no further need for her to intervene.

96. In this regard she said that she did not have sufficient understanding of CTGs and their interpretation to intervene.

97. The HSE's case against Dr Kondavetti was also based on her C.V. which indicated significant obstetrical experience in India post-qualification. In cross-examination by counsel for the first defendant, before being appraised of Dr Kondavetti's actual knowledge of CTGs, the plaintiff's expert Mr Clements flagged a note of caution against reaching any conclusion as to her experience of CTGs. *"I don't want to create a difficulty, but I am always a little bit concerned about assuming that hospitals in rural India have all the gadgets and tricks that we have in the developed world and this case is all about familiarity with the CTG. Clearly, at Letterkenny, she would have seen CTGs and would have been asked to make a judgment on them. I just don't know whether they would have had CTG machines in these Indian hospitals."* When advised in cross-examination of the reality of her experience and understanding of CTGs and the nature of her case, Mr Clements revised his initial view of Dr Kondavetti's responsibilities as an SHO.

98. In relation to Dr Kondavetti's description of the trace being "sinusoidal", the Court asked Mr Clements: "Well, to this extent, if she writes it down and appreciates that the baby is in severe trouble, what is her duty, regardless of her understanding?"

99. In reply, Mr Clements stated:

“Well, I think I can only understand Dr Kondavetti’s position in this way, that she really did not understand CTGs. She wrote down “sinusoidal pattern” because she realised that it wasn’t normal, but the word isn’t here being used in the way that I defined it, and she thought that the decision had already being made that this baby is going to be rescued. I can find no other way of explaining her behaviour because, clearly, she is saying that this CTG is abnormal, but she is being told that Dr Carroll has been told; he has ordered preparations for Caesarean section. She is very junior, she is very inexperienced, she thinks it is in somebody else’s hands. I don’t need to make a decision.”

Expert Evidence on Responsibilities of an SHO

100. The court had the benefit of the evidence on this issue from the following experts in obstetrics and gynaecology: Mr Roger Clements, Mr Patrick Boylan and Mr Peter Mc Kenna. The first defendant did not call any expert obstetric evidence (and in cross examination adopted selected evidence from other experts).

101. Mr Peter Mc Kenna on behalf of the third party said the primary person looking after the patient in labour is the midwife. The midwife’s role in an obstetric unit was to manage the care of the mother. He said that that one of the more important roles of a midwife is to operate the CTG and to interpret the traces and if there was any concern in relation to the CTG the midwife should contact the registrar or the consultant if there was no registrar. He said that once a channel of communication is opened up between Midwife O’Brien and Dr Carroll, the SHO has no role other than to take orders that were given. He said that he found the allegation that Dr Kondavetti had overall responsibility at the relevant time for the management of the labour and delivery “incomprehensible”. He said that SHOs are very much there in a learning

capacity and they are there to implement decisions that more experienced doctors and more experienced midwives would be making. This applied to Dr Kondavetti. She was “a mere functionary in the system”. He said once she had carried out the tasks assigned she had no further role as the decision making process had been opened between the midwife and the consultant. It would be quite extraordinary to expect her to butt in and interfere in the management plan that had been set out. Mr McKenna said that he had never been contacted by an SHO from the labour ward, and said it was unheard of. He said that nothing flowed from Kondavetti’s incorrect note of “sinusoidal pattern” since the decision to prepare the mother for Caesarean section had already been made. At the conclusion of his evidence in chief, Mr McKenna said that Dr Kondavetti’s actions on the early morning in question most certainly did not fall below the appropriate standard for somebody in her position as an SHO. He said that it was so unfair as to be unthinkable that somebody who is in the country for a couple of months, and has worked for even shorter, gets to carry the can for a problematic outcome. He said ‘unfair’ putting it mildly.

102. In cross-examination, he told Ms Scully that the interpretation of CTGs might not be “rocket science” but it was not easy either. He said that Mr Clements was incorrect in his opinion that alcohol would not have had an impact. There was scientific evidence that it does. He said that “one of the difficulties with this CTG is that it is very difficult to interpret. In this case you had very poor variability, with shallow decelerations, and this combination to me would indicate either this baby was not, its brain wasn’t functioning optimally at the start of labour, or, and/or, it was being affected by either drugs or alcohol. So this is a very unusual CTG.”

103. The court asked Mr McKenna the following: “If [Dr Kondavetti] had a doubt or query as to whether this was an urgent situation and it wasn’t being addressed,

what is her function or her role or duty in those circumstances?” His answer was: “I very much doubt if she did appreciate the gravity of the situation, but the onus is on any doctor if they do appreciate that treatment is being withheld to get back on the case again and to contact the consultant. So I would agree if she appreciated the gravity of the situation that that is what she should have done, but there was nothing to suggest that she did and when I say ‘nothing to suggest that she did’, I am referring to the fact that there is nothing in her training that would have equipped her to have arrived at a decision that what was happening was inappropriate”.

104. In re-examination by Mr McGrath, he was asked:

“Can you explain then how it is that she is not to be held responsible if she did not appreciate the gravity of the situation?

A. Well, I don’t think she could have understood the gravity of the situation. Her training and her C.V. up until this date would not have equipped her to understand the gravity of it.”

105. Mr Peter Boylan, called on behalf of Dr Carroll, said he would expect the consultant to rely on the midwife rather than the junior SHO locum, that it was the usual practice that the SHO would carry out the midwives instructions and not *vice versa*. He said Dr Kondavetti’s job “would really be to do effectively as instructed by the midwife, certainly with a more junior doctor they would effectively report to the midwife when they came on duty and would be asked to perform certain tasks by the more senior midwife or the midwife looking after the patient that would be standard operating procedure”. Asked if it would be reasonable for Dr Kondavetti to consider that she had no further role beyond doing what she was specifically asked to do, he said “I think it is, yes.” In relation to Midwife O’Brien’s belief that she discontinued

the CTG on the instruction of Dr Kondavetti he said it would “almost be unprecedented” and that he would not expect someone of Dr Kondavetti’s experience to override a midwife.

106. The plaintiff’s obstetrics expert was Mr Roger Clements. His evidence in chief was based on the understanding that a three-tier system operated in Sligo General Hospital, that is a system which consisted of (a) junior doctors, nursing and midwifery staff: (b) a registrar and (c) a consultant obstetrician on duty or on call. In the course of his cross examination, it emerged that the staff on duty were nurses, two midwives (ante- and post-natal) and a Senior House Officer on call generally. There was no registrar on duty or on call. There was an obstetric consultant (the second defendant) on call. He said in a two tier system (with no registrar) such as in SGH on 6th September, the midwife contacting the consultant directly would be the usual thing to do, and a two tier system placed a greater responsibility on the consultant.

107. Mr. Clements was also under the impression that Ms. O’Connor was a private patient of the second defendant. Given the terms of the settlement, this question does not need to be determined by the court; it was accepted that it does not affect the second defendant’s duty.

108. Mr. Clements’s opinion, in so far as it related to the second defendant, was conditional on the resolution by the court of the factual issue as to what midwife O’Brien communicated to Dr Carroll when she phoned him at approximately 05.00.

109. Mr. Clements’s opinion was that the management of Ms. O’Connor’s labour was deficient. Mr Clements said that when the midwife, or the SHO, saw the abnormal CTG traces and realised that they were consistent with foetal distress, the matter was one of urgency and she should have alerted the medical person who was in

a position to act on the information. If that medic in authority was the second defendant, he should have come into the hospital immediately, looked at the CTG, examined his patient, performed an ARM or proceeded to straight to Caesarean section. If that had been done by 06.00, Mr Clements's opinion was that the foetus would have been spared all or most of the brain damage and its consequences. As indicated earlier in this judgment, Mr Clements revised his conclusion as to the responsibility of the SHO. He told counsel for the third party that in writing his report for the court that because the reference to Dr Nirmala being informed was contiguous with the details of the CTG in the midwife's note and occurred before the conversation between the midwife and the consultant, he had assumed that the SHO was actively involved in the management of Mrs O'Connor's labour.

110. The position is that all the experts were of the opinion that Dr Kondavetti was not to blame for the deficiencies in the care of Mrs O'Connor's labour

Summary

111. On the night of the 5th and morning of the 6th September, 1996, a two-tier system was in operation in the maternity department at Sligo General Hospital. There was no registrar on duty.

112. The consultant obstetrician, the second defendant Dr Carthage Carroll was in overall charge of the management of Mrs O'Connor's labour and the delivery of her baby. He was on call. The midwife on duty managing the labour ward was Ms Geraldine O'Brien. There was a second midwife on duty on the post-natal side. The third defendant, Dr Nirmala Kondavetti was the Senior House Officer on call generally in the hospital. Her function, so far as the labour ward was concerned, was to carry out any instructions given by the midwife or the consultant.

113. Dr Carroll described the relationship between the consultants and the midwives at SGH as “open access day or night”.

114. Midwife O’Brien was responsible for interpreting the CTG traces and conveying any concerns relating to them to the consultant. On the morning of the 6th, Midwife O’Brien commenced the CTG for Mrs O’Connor shortly before 04.30. From about 04.40, the traces were abnormal. Midwife O’Brien discontinued the CTG at 05.30. The SHO did not direct her to do so. It was reconnected it at 07.06. The traces remained abnormal.

115. Midwife O’Brien phoned Dr Carroll at approximately 05.15. In their brief conversation, Dr Carroll instructed the midwife to prepare Mrs O’Connor for a Caesarean section. The practice at SGH required that a doctor carry out some of the preparatory tasks. In a subsequent phone call, at or just after 05.20, Midwife O’Brien conveyed Dr Carroll’s instructions to Dr Kondavetti. The CTG was not discussed in this phone call and midwife did not seek Dr Kondavetti’s advice in relation to the CTGs. Neither did Dr Kondavetti offer any such advice. The notes do not record any such advice.

116. Dr Kondavetti attended the labour ward at approximately 05.30. She carried out her tasks. She took the bloods and sent them to the lab, she formally admitted Mrs O’Connor to the labour ward and obtained her consent for the caesarean section and took a detailed history as she wrote up her notes. In relation to the CTG, she recorded poor reactivity and sinusoidal pattern. She left the ward after completing her notes and before the blood results were received in the ward.

117. When the CTG traces continued to be abnormal after the recommencement at 07:06, neither the consultant nor the SHO was contacted.

118. The first defendant submits that the third defendant recognised that the CTG was abnormal and as an SHO experienced in obstetrics, she should have contacted Dr Carroll or alternatively got the midwife to do so. Had she done so most or all of the plaintiff's brain damage would have been averted.

119. It is clear from the evidence that prior to arriving in Ireland, Dr Kondavetti had no experience or training in CTGs. In the locum positions she held prior to the Sligo job she had very limited experience of CTGs. Dr Kondavetti was employed as a Locum SHO in Obstetrics. She was trying to learn about CTGs on the job from a handbook. She had no responsibility for interpreting CTGs at SGH and was not qualified to do so. Her unchallenged evidence was that experience in CTGs was not a requirement for the position. She did not mislead those responsible for giving her the position at SGH by saying that she had such experience. On the contrary, as with the same employer in Letterkenny some months earlier, she informed the relevant person in authority on her first day that she had no experience of CTGs.

120. The important factor in this case is that there was a plan in place for Mrs O'Connor to have her baby by Caesarean section. Further to the plan, Dr Kondavetti was required to perform a number of specific tasks including the taking of bloods and getting Mrs O'Connor's informed consent for the Caesarean section. She carried out these tasks to the standard required of an SHO. There was a channel of communication opened between Midwife O'Brien and Dr Carroll on the night. Dr Kondavetti was aware that the plaintiff's CTG trace was abnormal from what she was told by the midwives when she met them in the corridor. She transposed some of the CTG details from the midwife's notes. 'Sinusoidal pattern' was her own description. She did not know the significance of the term. She accepts it was a wrong description.

121. I accept the very careful evidence of the plaintiff's expert, Mr Clements which is supported by Mr McKenna that Dr Kondavetti did not understand the significance of the CTG readings but she understood that there was a plan in place directed by the consultant in charge based on information provided by the midwife. The experts were in agreement that in those circumstances that it would not be reasonable, fair or just to expect the SHO to intervene.

Conclusion

122. Dr Kondavetti was not at fault in respect of her involvement in the management of labour; that is up to the time she completed writing up her notes and left the labour ward. She had no involvement in the remaining period of labour during which the CTG was recommenced with continuing adverse readings adding to the severity of the first insult.

123. Dr Kondavetti had no involvement in the second insult which occurred in the post-natal period.

124. The actions of Dr Kondavetti therefore did not contribute in any way to the injuries suffered by the plaintiff.

125. I will dismiss the first defendant's application for contribution.

No relaxation required

Raymond Tullam

21st December 2015