Neutral Citation No. [2009] NIQB 53 | *Ref:* **GIL7465**

Judgment: approved by the Court for handing down | *Delivered:* **15/6/09**
*(subject to editorial corrections)**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION

_____

BETWEEN:

MARGARET HAUGHEY

Plaintiff;

-and-

NEWRY AND MOURNE HEALTH AND SOCIAL CARE TRUST

Defendant.

_____

GILLEN J

Cause of Action

[1] In this case the plaintiff claims damages for personal injuries, loss and damage sustained by her by reason of the negligence of the defendant, its servants and agents in the course of a bladder repair carried out on the plaintiff on 2 March 1998 during the course of which she developed a ureteric obstruction thereafter requiring a laparotomy and surgery for an incisional hernia.

Factual Background

[2] In March 1997 the plaintiff was complaining of increasing urinary incontinence especially when she walked or exercised. She was referred for investigation by her general practitioner to Mr De Courcey-Wheeler (hereinafter referred to as "DCW").

[3] As a result of this referral she underwent a colposuspension("csp") operation on 2 March 1998.

[4] The purpose of this operation is to lift the top of the vagina which in turn would permit the bladder to move upwards and therefore permit surgical intervention to address the problem of urinary incontinence. The evidence was that this was a procedure which had been carried out over 100,000 times in the United Kingdom and was successful in women of a certain age with problems having arisen in very few of the procedures.

[5] Although DCW carried out the operation, the operation note was not signed by him but by the Senior Registrar Dr Dolan. Inter alia, this note records:

> "Surgeon – R de Courcey-Wheeler . . . Burch colposuspension routine asepsis, foley catheter inserted.
>
> . . .
>
> Uv (*urethro-vesical)* angle identified. 2 x ethibond sutures inserted from uv angle to ileopectineal ligament each side."

[6] Certain references were made to post operative developments but the salient reference essentially occurs on 6 March 1998 when the following entries occurred:

> "6.3.98 Day 4. Temperature 36.1 (37.7 last night). Catheter specimen of urine from 2 days ago – no growth.
>
> Abdo pain better – urethral catheter to be removed to day.
>
> 6.3.98 – 20.00 hours
>
> Asked to see (because of) severe back ache.
>
> Temperature is 37.8. On examination . . . right renal angle tender +++. Left renal angle no tenderness.
>
> Impression - ? urinary infection. ? Renal colic?
>
> For catheter specimen of urine, antispasmodics and augmentin."

[7] I pause to observe that there was no diagnosis made at this time of the problem from which the plaintiff was suffering. She was given muscle

relaxants to help together with a strong opiate analgesic. It was then arranged for her to have a kidney ultra scan the next morning.

[8] The next relevant entry is 7 March 1998, day five after the operation which records as follows at 12.15 pm:

> "Has had ultrasound renal tracts . . . diagnosis right hydronephrosis. (*This is an accumulation of urine in the kidney presumably because of the obstruction in the ureter on the right hand side).* Intravenous pyelogram no spillage dye on the right side . . . Discussed with Mr Sim. To return for laparotomy at 5 pm. Husband and patient fully informed? Kinking right ureter – will need to undo stitches on right side."

The intravenous pyelogram was a dye which was inserted to see what was happening in the kidney area. A definitive diagnosis of obstruction of the ureter was raised by the Registrar, Dr Dolan.

[9] The intravenous urogram report of 7 March 1998 records:

> "The left renal tract appears entirely normal. On the right there is delay in excretion and despite a double dose of contrast only poor excretion was noted. There is a right hydronephrosis but the ureter did not fill."

[10] It is again common case that this illustrated that there was obstruction in the ureter although it is not known at what level this has occurred because there was no dye in the ureter.

[11] On 7 March 1998 there was a further operation carried out and the operation note is as follows:

> "Removal of right sided colposuspension sutures . . . Procedure – abdomen open to cave of retzius. Two sutures to the right ileopectineal ligament identified in normal position. Suture removed from ligament. Place of suture removed from para-urethral/vaginal tissues."

[12] Mr Sim was the surgeon who carried out the second operation with Dr Farrage as his assistant. It is clear that this operation was to undo the old scar removing the stitches inserted by DCW to reveal the abdominal wound. Thereafter either one or two stitches (the singular is used in the note) to the right ileopectineal ligament – which had anchored the stitches – were removed.

[13] In the event Mrs Haughey made reasonable progress. The excretion of the contrast appeared better than previously on 9 March 1998 and she was ready for discharge on 12 March 1998.

[14] The next document of relevance in this matter was a discharge letter by DCW on 30 March 1998. It records as follows:

> "Mrs Haughey was admitted as arranged for the above operation. It was carried out without complication. Post operatively she was complaining of pain and retention of urine due to a blockage of the suprapubic catheter. It was removed and replaced with a urethral catheter. Four days post operatively she was complaining of further pain and in addition a tender right renal angle. Emergency ultrasound and IBP showed obstruction at the right ureter. She was taken back to theatre and the colposuspension sutures on the right side were removed. The repeat IBP showed free flow and drainage from the right kidney, the ureter was unobstructed from the renal pelvis to the bladder. The elevation of the bladder neck from the colposuspension had obviously caused a kink in the ureter and hence obstruction. Now that the ureter has been unkinked she should get no further bother, however I am unsure how successful the colposuspension will now be in the treatment of her stress incontinence. Time will tell and I plan to review her in about six week's time."

[15] Subsequently, in April 1999 the plaintiff suffered an incisional hernia which required to be repaired. This was carried out on 20 April 1999.

[16] I pause to note that the plaintiff in this case did have a history of removal of the womb (hysterectomy) and repair of the sagging front portion of the vagina (repair) in 1993.

The Burch colposuspension

[17] This procedure is to elevate the bladder neck by placement of sutures in the anterior vaginal wall and to suspend it from the ileopectineal ligament on the ipsilateral side. The procedure has the advantage of requiring only an abdominal incision. I had the benefit of learning about this operation from the expert witnesses before me namely Mr Alan Brown FRCOG, FRCSE who was an obstetrician with a major commitment to urogynaecology called on behalf of the plaintiff and Mr Ashe FRCOG, DCH whose specialist field was gynaecology with sub specialist interest in urogynaecology on behalf of the

defendant. In addition several medical articles were produced to me prior to the hearing and analysed during the course of the trial. From those sources I was able to deduce the following primary facts about this procedure.

[18] First, a Burch colposuspension has proved a simple, successful and popular method in the management of stress urinary incontinence albeit in recent years an alternative procedure is now more regularly deployed.

[19] It has been reported to be associated with complications and sequelae such as bladder trauma, venous bleeding, detrusor instability, urethral obstruction , urinary retention and urethral injury.

[20] However the severest complication, urethral injury, has been reported in the literature in only 17 cases, although other undetected cases must exist (see Virtanen and others "Urethra injuries in conjunction with Burch colposuspension").

[21] Virtanen records that urethral obstruction following Burch colposuspension or other anti-incontinence surgery is so rare that the author recorded no urethral obstructions recognised among the 739 operations performed by gynaecologists in his hospital during 1983 to 1992 and a review of the literature by him revealed only 11 such cases.

[22] Virtanen recorded that "the mistakes" that led to the complications could be obviated "if the sutures are placed at a higher, more proximal level beyond the ureterovesical junction, (where) there is a risk of injuring and obstructing the ureterovesical junction directly. Also, it is possible that in some cases the entire paravaginal space was inadvertently and inadequately identified, leading to sutures being placed too close to the ureterovesical junction and even through the bladder, causing kinking or ligation of the distal ureter leading to urethral obstruction by pulling the sutures to cooper's ligament straight upwards." The author recorded that the optimal prevention is awareness of the risk of urethral complications and precise surgical technique.

[23] Referring to the Virtanen article, Mr Bentley QC, who appeared on behalf of the plaintiff with Ms Higgins QC, submitted that of the four case reports of ureteral obstruction, where none of the patients had had previous pelvic surgery, at least three of them recorded the obstruction occurring as a result of surgical error i.e. the stitches wrongly inserted. The fourth was not clear from the article. He borrowed from the final page of that article where it recorded:

> "It is very difficult to assess the "mistakes" that led to the complications presented here. However, if the sutures are placed at a higher, more proximal level

> beyond the ureterovesical junction there is a risk of injuring and obstructing the ureter obesical junction directly. Also, it is possible that in some cases the entire paravaginal space was inadvertently and inadequately identified, leading to sutures being placed too close to the ureterovesical junction and even though the bladder, causing kinking or ligation of the distal ureter and leading ureteral obstruction by pulling the sutures to Cooper's ligament straight upwards."

[24] It was Mr Bentley's contention that this reference to "mistakes" was a clear reference to surgical error which he submitted was the whole purpose of the article.

[25] Rosen in a 1996 article "Ureteric injury at Burch colposuspension" noted**:**

> "The Burch colposuspension operation is an accepted and effective technique for the correction of genuine stress incontinence. It is, however, associated with a number of well recognised complications. Ureteric injury at the time of colposuspension is a potentially severe, if uncommon, complication of this procedure . . . To date, only 19 cases have been described in the literature."

[26] Rosen goes on to describe damage to the ureters as having the following likely cause:

> "Damage to the ureters is certainly more likely if the bladder and surrounding fascia is not reflected carefully and pushed medially during the dissection of the vaginal cone. During placement of the suspending sutures great care must be taken to allow clear view of the vaginal cone before the sutures are inserted. Particular care should be taken with the placement of these sutures when the dissection is complicated by other factors such as previous surgery causing retro pubic fibrosis, genital prolapse, concomitant hysterectomy or haemorrhage from the venous plexus . . ."

[27] Rosen goes on to record:

> "It is at the time of placement of these sutures that the bladder may be inadvertently entered and the resulting anatomical distortion may kink the ureter thereby causing obstruction."

[28] The author added :

> "Another potential hazard which has been reported only rarely in literature is that of ureteric injury. By elevating the lateral vaginal fornices and sweeping the bladder medially the surgeon seeks to avoid trauma to the bladder ureters. However, this cannot always be prevented."

[29] A matter of much contention in the hearing was the interpretation of the phrase "this cannot always be prevented" in Rosen's article when referring to trauma to the ureter and bladder in the course of the csp. It was Mr Bentley's assertion that it was abundantly clear that this was a clear reference to surgical error whereas Mr Ashe contended that this was a reference to the fact that ureteric injury could occur in circumstances where even the proper care of the surgeon had taken place. Thus the authors record:

> "Damage to the ureters is certainly more likely if the bladder and surrounding fascia is not reflected carefully and pushed medially during the dissection of the vaginal cone. During placement of the suspending sutures great care must be taken to allow clear view of the vaginal cone before the sutures are inserted. Particular care should be taken with the placement of these sutures when the dissection is complicated by other factors such as previous surgery causing retro pubic fibrosis, genital prolapse, concomitant hysterectomy or haemorrhage. . ."

[30] Once again Mr Ashe contested Mr Bentley's interpretation suggesting that the following sentence namely "since the ureter has a firm fibro muscular coat, vaginal elevation from appropriate places sutures well away from its course are not likely to result in obstruction" was clear indication once again that there was no certainty that absence of surgical error would prevent problems and tied in with his assertion that ureteric damage cannot be prevented. It was Mr Bentley's contention that the theme of this article was to address litigation and medical malpractice concluding "with the ever present potential for litigation, it behoves all surgeons operating in this area to be aware of the possibility of ureteric obstruction and the strategies for its management".

[31] Demirci and Petri, in an article "Perioperative Complications of Burch Colposuspension" in 2000 recorded that a review of the literature revealed that any perioperative complications of the procedure were found only sparsely. In particular it stated:

> "Kinking or injuries to the ureter are rare but not uncommon after colposuspension. Previous surgery causes fibrosis, scarring and even dislocation of the local tissues, thereby increasing the risk ureteral kinking and or damage during surgery."

[32] In Demirci, the authors refer to a number of papers where approximately .3%/.4% of patients had suffered kinking i.e. in only about 7 out of approximately, 1,800 operations was it recorded.

[33] Stanton and Tanagho "Surgery of female incontinence" observe :

> "Ureteric ligation is fortunately rare, and avoided by always ensuring that sutures are placed only into the white paravaginal fascia."

[34] I note that the vaginal fibres are white in colour, hence the reference in this instance.

[35] Stanton and Cardozo in "Results of the colposuspension operation for incontinence and prolapse September 1979" state:

> "In order to avoid ureteric injury it is important to display the paravaginal fascia clearly and to avoid placing sutures through bladder muscle".

[36] In an article "Lower Urinary Tract Injury During Gynaecologic Surgery and its Detection by Intraoperative Cystoscopy" by D T Gilmore FRCSC and others (November 1999) a table of the frequency of ureteral injuries after major gynaecologic surgery is produced. This suggested the incidence of ureteric injury was approximately .186% in such operations for vaginal hysterectomy/major vaginal surgery.

The plaintiff's case

[37] The plaintiff's case emerged through the evidence of the plaintiff herself her husband and Dr Humphreys but principally depended upon the evidence of Mr Brown. In essence the following were the essential points .

[38] The failure of the ureter was due to surgical error rather than a rare complication of surgery. DCW was not a sufficiently experienced surgeon to be carrying out such an operation in his own. The ureter had been obstructed on the right side by kinking occurring. Mr Brown had performed over 1000 such procedures without this mishap happening and said he had never heard of a case where elevation per se caused a kink in the ureter. If the stitches are in the correct position in the vagina at the bladder neck the ureter should not have been compromised. In his view the cause was the stitches being inserted in too high a position and thus involved the bladder and ureter.

[39] It was the witness's assertion that whilst the previous surgery could have caused fibrosis or scarring which can contribute to kinking there is no suggestion from the operation note that any such difficulty had been encountered here. He did not accept that the area where the surgeon was working would have been affected to only a minimal degree by these adhesions.

[40] Mr Brown expressed concern that the operation note had not been completed by the surgeon DCW but rather the registrar. I observe that I found nothing of assistance in this point because I accepted that in Northern Ireland it is a practice that the registrar may be asked to do this to assist in his/her training. Indeed Mr Ashe had encountered a similar practice in England.

[41] The plaintiff and her husband gave evidence before me as to the procedures which she had undergone. In particular she said that after the procedure DCW had visited her, apologised for what had happened and drew an explanatory sketch. Having heard DCW's account of this conversation and his explanation of the sketch I pause to note that I found his explanation plausible and frankly added little to my understanding of the real issues in the case. Any surgeon was likely to have made a rather neutral and courteous apology to a patient when an operation has not gone as planned. It does not connote an admission of negligence. The sketch was open to several interpretations and similarly did not amount to an admission of negligence.

[42] Mr Bentley submitted that the literature did not record Mr Ashe's proposition that obstruction of the ureter could occur in the absence of misplacement of sutures. On the contrary it was counsel's submission that the literature implied that it was surgical mistakes that lead to such tethering. In particular he drew attention to the articles of Virtanen and Rosen where references to "mistakes", legal ramifications for the surgeon and litigation potential together with the continuous admonitions relating to great care being required in relation to the placement of stitches and proper surgical technique all indicated by implication that it is surgical error which causes this condition.

The defendant's case

[43] The defendant's case, presented by Mr Morrow QC and Mr Good, was largely founded on the evidence of DCW, Dr Dolan his registrar at the relevant time, Mr Sim who carried out the corrective surgery and Mr Ashe the expert evidence called on his behalf. In essence the following were the essential points.

[44] Contrary to Mr Brown's assertion, Mr Morrow submitted (and I found)that there was no evidence to satisfy me that DCW's CV and experience was anything other than entirely adequate to carry out such procedures. Although he had not performed the minimum of 100 similar procedures under supervision suggested by Mr Brown before being sufficiently experienced to undertake this operation alone, I agree with the view of Mr Ashe that numbers of operations completed are not the criteria of competence. Having heard DCW describe his experience and having read his CV, I concluded that Dr Brown was setting the bar too high and that DCW was perfectly well qualified and sufficiently experienced to have carried this procedure out as he did.

[45] Mr Morrow submitted that there was no evidence to suggest the presence of oedema , fibrosis or scarring from the previous repairs had caused difficulty with dissection of the tissues by obscuring the view of DCW when working in the area of the cave of Retzius . Mr Ashe expressed the view that the adhesions or scarring as a result to the plaintiff's previous hysterectomy operation may or may not necessarily leave scarring in the area where DCW was operating. Such previous scarring may have been a distance from the area where DCW was working. This of course tied in with the evidence of Dr Dolan and Dr Sim.

[46] Mr Ashe's proposal was that the previous surgery may have resulted in scarring at the bladder base. The ureter flows into this area. The ureter may not have been damaged at the time but the csp operation gave elevation of the tissue at the neck of the bladder/bladder base. Once the bladder was lifted this may have resulted in tethering /immobilisation through lack of elasticity due to the previous scarring etc. It was his view that there were many circumstances in which the cause of ureteric injury was not known.

[47] Dr Dolan,who had assisted DCW at the relevant time , gave evidence that by the time of this incident she had been involved in 5 -10 csps. Whilst she could not recollect this operation she was adamant that if the presence of oedema or scarring had been there at the site of the operation she would have noted it in the operation note. She regarded her role as a very important one helping to provide access for the surgeon thus allowing her to see where he is placing the stitches. It was her belief that she would have had a clear view and would have seen where he was placing the stitches especially if he had

wrongly inserted them into the bladder. Her estimate was that there was no more than a 10% chance she would have missed this.

[48] Dr Dolan recalled performing a csp operation along with an abdominal hysterectomy as first assistant to a surgeon in Newcastle Royal Infirmary between 2001–2004 under the supervision of that surgeon. The csp was done first and then followed by the hysterectomy in the peritineal cavity. It was then noted that the ureter was swollen. They checked to see if the stitches had involved the ureter but none were there. The stitches had been correctly placed. It was assumed that the problem was due to kinking of the ureter and so the stitches on the right side were removed and this solved the problem. The conclusion drawn was at that the ureter had been kinked by the elevation of the bladder base unconnected with any problem with the stitches.

[49] Mr Sim, a consultant in gynaecology and obstetrics at Daisy Hill hospital carried out the further surgery on the plaintiff on 7 3 98. He recalled removing the sutures inserted by DCW during the original csp because DCW was on leave. His re-collection was aided by virtue of the fact DCW had used a figure of 8 stitch. This witness was adamant that if the sutures had been misplaced or inserted into the bladder or ureter he would have noticed and recorded this as well as now remembering it. He was adamant that this had not occurred.

[50] This witness had a similar experience to that of Dr Dolan when he was working in Craigavon hospital performing a csp operation under supervision. Post operatively it emerged that there was blockage of the right ureter. Accordingly he proceeded to remove the csp stitches with consequent resolution of the obstruction. No clear cause was identified but the stitches had been properly inserted. Mr Sim was sure his supervising consultant would have given particular attention to the stitches. I observe that I found both Dr Dolan and Mr Sim to be extremely impressive witnesses who gave evidence in a measured and informed manner. I believed they were entirely honest when relating their experiences of csp procedures.

[51] DCW gave evidence before me of his experience, his cv and the operation he had performed on the plaintiff. He asserted that the relevant sutures were inserted in the white paraurethral /vaginal facia at the level of the bladder neck clear of the bladder edge which is easily identified by colour. Use of a catheter balloon and fingers in the vagina created tenting in accordance with standard procedure. The subsequent stitching did not enter the bladder tissue or the ureter. I found this witness to be straightforward and forthright in his evidence. I have already addressed the issue of his subsequent conversation with the plaintiff after the operation and I believed his account and explanation of this occasion.

[52] It was Mr Morrow's submission that the literature was replete with indications that there is a possible association of ureteral obstruction with

previous pelvic surgery which may contribute to alterations in local anatomy or to a process of periurateral fibrosis that may thus predispose a patient to ureteral kinking e.g. Demirci and Petri.

Legal Principles

[53] The general principles of law applicable in clinical negligence cases were not in dispute in this case. The test set out by McNair J in Bolam v Friern Hospital Management Committee (1957) I WLR 582 at 586 has stood the test of time and is so well known that it does not require detailed recitation by me. Suffice to say that the test in this case is the standard of the ordinary skilled man exercising and professing to have the skill of a consultant at the same level as DCW. He must act in accordance with the practice accepted at the relevant time as proffered by a responsible body of medical opinion; see also Sidaway v Bethlem Royal Hospital Governors (1985) 1 All ER 643 at 649.

[54] In short the test is whether DCW in this case has been proved to be guilty of such failure of care as no consultant at his level of ordinary skill and competence would be guilty of if acting with ordinary care; Hunter v Hanna (1955) SC 200, per Lord President Clyde at 206.

[55] The standard of care must reflect clinical practice which stands up to analysis and is not unreasonable. It is for the court, after considering the expert medical evidence, to decide whether DCW's assertions as to the standard of care in fact put the patient at risk.

[56] Given the division of expert opinion in this case, it is appropriate to draw attention to the views expressed by Lord Scarman in Maynard v West Midlands Regional Health Authority (1984) 1 WLR 634 where he said:

> "It is not enough to show that there is a body of competent professional opinion which considers that there was the wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances … differences of opinion in practice exist, and will always exist in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other but that is no basis for a conclusion of negligence."

[57] The burden of proof is therefore clearly on the plaintiff to establish on the balance of probabilities that the failure of the right ureter to drain following the csp procedure was because of DCW's failure to take reasonable

care in the course of the surgery causing the plaintiff injury. For completeness sake I mention that the plaintiff did not assert that the principle of res ipsa loquitur applied in this case. I agree with the submission of Mr Bentley that it is doubtful whether such a rule can be of assistance in a complex case of medical negligence where, as in this case, evidence has been led by both sides. The issue is really is whether or not Mr Brown's evidence is correct that the obstruction of the ureter could not occur in the absence of misplacement of the sutures.

[58] A helpful approach to the concept of res ipsa loquitur is found in the judgment of Griffiths LJ in Jacobs v Great Yarmouth and Waveney Health Authority (1995) 6 MED.L.R. 192 at 197 where, dealing with the maxim, the judge said:

> "(It) means no more than that on the facts that the plaintiff was able to prove, although he may not be able to point to a particular negligent act or omission on the part of the defendants, the fair inference to be drawn is that there has been negligence of some sort on the part of the defendants: but that is an inference to be drawn upon the facts presented by the plaintiff. If there is further evidence presented by the defendant, those facts may be shown in an entirely different light and it may be that at the end of the day it is not possible to draw the inference of negligence."

[59] In Delaney v Southmead Health Authority (1995) 6 MED LR 355 Stewart Smith LJ at 359 stated:

> "I am doubtful whether *(res ipsa loquitur*) is of much assistance in a case of medical negligence, at any rate when all the evidence in the case has been adduced. But even if .. at that stage the maxim applies, it is always open to a defendant to rebut a case of res ipsa loquitur either by giving an explanation of what happened which is inconsistent with negligence … or by showing that the defendants had exercised all reasonable care."

Conclusions

[60] I have concluded that the plaintiff has failed to meet the burden of proof that is upon her to establish negligence in this case. The fact that no complete explanation can be given for this failure of the right ureter to drain after the csp does not show per se that the defendant did not take all reasonable care. Having listened carefully to the evidence of Mr Ashe, DCW,

Dr Dolan and Mr Sim, I have decided that there is insufficient evidence to justify a conclusion that the defendant failed to exercise reasonable care notwithstanding the outcome and the inability fully to explain how the plaintiff's condition came about. It is important to recognise that the onus on this case is not on the defendant to prove what did cause the plaintiff's condition but rather the onus is on the plaintiff to prove that the defendant was negligent.

[61] There is no doubt that there was conflicting evidence between Mr Brown and Mr Ashe as to whether or not obstruction of the ureter could occur in the absence of misplacement of the sutures. I prefer the evidence of Mr Ashe for a number of reasons. First, I was very impressed by the evidence of Dr Dolan and Mr Sim. They both independently have come across instances in their own personal experience where despite normal techniques of stitch insertion in this procedure, kinking or blockage at the ureter had occurred. Once I believed their evidence on this aspect of the case, it inevitably satisfied me that Mr Ashe was correct to say that despite normal techniques kinking can happen in rare instances. I therefore am not prepared to accept Mr Brown's bald assertion that obstruction of the ureter could not occur in the absence of misplacement of the sutures.

[62] Secondly I believe Dr Dolan is a careful medical practitioner. I have no doubt that she was observing carefully the steps taken by DCW in the course of this procedure as his assistant. I was satisfied on the balance of probabilities that she would have observed the misplacement of any sutures. Her evidence was entirely backed up by the account of Mr Sim who carried out the repair operation. I was equally satisfied that he would have observed the presence of misplaced sutures when he was correcting the process. The fact that he did not observe any misplaced sutures convinced me that none had been so placed. I was completely satisfied that these were witnesses of integrity who would not have hesitated to confound the evidence of DCW had it been necessary to do so .

[63] Thirdly I consider that Mr Ashe was correct in indicating that the previous surgery of hysterectomy and repair which this plaintiff had undergone, would have been carried out close to the ureter and bladder base. There may well have been adhesions/scarring that limited the elasticity of those tissues and provided a pre-disposition to kinking taking place when the bladder was subsequently lifted in the course of the csp operation carried out by DCW. I do not believe that that scarring would have necessarily been in the cave of retzius where DCW was operating to obscure his view. I accept the evidence of Dr Dolan and DCW that there was no such significant scarring in that area which would have obscured the view of DCW.

[64] I consider that Dr Dolan was sufficiently conscientious, and DCW sufficiently expert, to have ensured that the notes would have made reference

to such adhesions had they been present in the uv angle/bladder neck. I was satisfied on the balance of probabilities therefore that the sutures inserted by DCW were well clear of that bladder edge which was identified by the appropriate colour.

[65] Fourthly as I have already indicated, I was satisfied that DCW was appropriately experienced to perform this surgery and the allegations of his lack of expertise were unfounded.

[66] Fifthly kinking of the ureter is clearly a very rare occurrence. Mr Bentley made a close analysis of the literature before me. He calculated from the statistics in the literature that ureteric damage occurs approximately 3 times in 1000 in csp procedures or with the plaintiff's type of previous surgery under 2 in 1000. The rarity of this condition is not challenged in this case but the fact of the matter is that I had before me two surgeons who both had practical experience of it happening in circumstances where negligence by the insertion of sutures in the wrong area had not occurred. This clearly puts into context the close analysis given to the literature before me. A number of cases described in the literature e.g. the Virtanen/Rosen/ articles etc. referred to cases where this complication has occurred but which were silent about the role of the sutures. I am satisfied that the literature did not provide an unambiguous or clear answer to the issue in this case Certainly surgical error can contribute to kinking on occasions but there was no doubt in my mind that the literature did not always explain this on the basis that it was caused by surgical error. The examples illustrated by Dr Dolan and Dr Sim illustrate that many cases often go unreported particularly where they are corrected without mishap. There is clear evidence in the literature e.g. Virtanen that previous pelvic surgery may well predispose a patient to ureteral kinking. I am satisfied that provides a plausible explanation for this incident occurring in the absence of negligence on the part of the DCW. I am not persuaded that on the balance of probabilities the overall thrust of the literature displaces that conclusion.

[67] In all the circumstances therefore I have determined that I must dismiss this plaintiff's action.

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