EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FIFTH SECTION

DECISION

Application no. 62007/17
L.F.
against Ireland

The European Court of Human Rights (Fifth Section), sitting on 10 November 2020 as a Chamber composed of:

Mārtiņš Mits, *President,*
Síofra O'Leary,
Stéphanie Mourou-Vikström,
Latif Hüseynov,
Jovan Ilievski,
Ivana Jelić,
Arnfinn Bårdsen, *judges,*

and Victor Soloveytchik*, Section Registrar,*

Having regard to the above application lodged on 17 August 2017,

Having regard to the observations submitted by the respondent Government and the observations in reply submitted by the applicant,

Having deliberated, decides as follows:

THE FACTS

1. The applicant, L.F., is an Irish national who was born in 1939 and lives in Dublin. The President granted the applicant's request for her identity not to be disclosed to the public (Rule 47 § 4). She was represented before the Court by Mr C. MacGeehin of MacGeehin Toale Solicitors, a lawyer practising in Dublin.

2. The Irish Government ("the Government") were represented by their Agent, Mr P. White of the Department of Foreign Affairs and Trade.

A. The circumstances of the case

3. The facts of the case, as submitted by the parties, may be summarised as follows.

1. The birth of the applicant's first child

4. In 1963 the applicant was pregnant with her first child. The expected delivery date was believed to be 7 September 1963, although this was later shown to be erroneous.

5. On 18 September 1963 the applicant was admitted to the Coombe Hospital in Dublin, her baby apparently overdue. The Coombe Hospital was, at the time, neither managed nor owned by the State but did benefit from state funding.

6. The applicant signed a form stating "I give my consent for any operation or anaesthetic which may be necessary". She subsequently underwent an x-ray pelvimetry which showed that the sub-pubic arch was narrow; the transverse diameter, stated as "normally" being 13.5 centimetres, was 10.8 centimetres; and, while the foetus was small, there was some cephalo-pelvic disproportion (disproportion between the size of the baby's head and the mother's pelvis); and the "outlet was diminished".

7. The applicant was examined under anaesthesia on 25 September 1963. During this examination, it was noted that "the head could not be made to engage in the pelvis. Symphysiotomy performed".

8. A surgical symphysiotomy involves partially cutting through the fibres of the pubis symphysis (the joint uniting the pubic bones) so as to enlarge the capacity of the pelvis. The procedure allows the pubis symphysis to separate so as to facilitate natural childbirth where there is a mechanical problem. Although the symphysiotomy was recorded in the applicant's medical records (see paragraph 7 above and paragraph 31 below), she submits that at the time she did not know that the procedure carried out on 25 September 1963 was a symphysiotomy. However, she recalled feeling that she had been "split open" or "split in half" immediately following the procedure, and feeling unstable when walking.

9. Twelve days later, on 7 October 1963, the applicant's daughter was delivered vaginally with the assistance of forceps. She claims that as she was still recovering from the symphysiotomy she was physically unable to look after her daughter and had to rely on friends and relatives for assistance. As a consequence, the applicant claimed that she was unable to bond with her.

10. In the years that followed her daughter's birth, the applicant claimed that she suffered from back pain, hip pain, urinary incontinence and a number of psychological problems, all of which she attributed to the normal complications of childbirth.

11. The applicant gave birth to a second child in December 1968.

2. The use of symphysiotomies in Ireland

12. Symphysiotomy was first introduced in the eighteenth century for selected cases of obstructed labour. Although its use continues to be indicated in certain specific situations, by the mid-twentieth century it had largely been abandoned in Western Europe, due, in large part, to the fact that caesarean sections had become much safer. In the 1940s, however, the practice was reintroduced in certain Irish maternity hospitals and it continued to be used there, to varying degrees, until, in some cases, the mid-1980s.

13. Concerns regarding the previous use and long-term effects of symphysiotomies in these maternity hospitals emerged in 2001. Many women who had undergone symphysiotomies reported chronic health problems which they attributed to the procedure. Moreover, some argued that there was a strong correlation between the use of the procedure and the acceptance of Catholic doctrine regarding sterilisation and contraception. Family numbers at that time were often relatively large and multiple caesarean sections were not recommended (see paragraphs 33 and 54 below). It was therefore suggested that symphysiotomies were favoured over caesarean sections because – at least in cases of mild to moderate disproportion – a symphysiotomy would enable subsequent children to be delivered vaginally. A caesarean section, on the other hand, would not address the underlying problem and some women, faced with the possibility of repeat sections, might resort to contraception, the sale of which was only legalised several years after a Supreme Court judgment in 1973.

14. In the 2000s patient advocacy groups called for an independent inquiry into the use of symphysiotomies in Irish hospitals from the 1950s through to the mid-1980s. No review was carried out at this time. There were two attempts to commission reports to evaluate the practice, but in each case the reviewer(s) withdrew from the project, due either to concerns about partiality or to disagreements over the scope of the review.

15. Following a meeting in late 2003 between the Minister for Health and a patient advocacy group, the Health Service Executive put in place a support system for women who had undergone symphysiotomies. This included the appointment of regional liaison officers to meet with the women to discuss their healthcare needs; the issuing of General Medical Service cards providing women with access to free healthcare, regardless of means; a refund of any medical expenses directly related to symphysiotomy; and the organisation of individual pathways of care, including gynaecological, urological and orthopaedic assessment, a home assessment by an occupational therapist or physiotherapist, the fast-tracking of applications for home help and home modifications, and the provision of physiotherapy, reflexology, acupuncture and counselling.

16. On 18 February 2010 a television documentary ("Primetime") revealed that in the second half of the twentieth century some

1,500 symphysiotomies were performed in Irish maternity hospitals. A second documentary about the use of symphysiotomies ("Tonight with Vincent Brown") aired in June 2011.

17. In 2010 both the Medical Missionaries of Mary (who were responsible for the Hospital of Our Lady of Lourdes in Drogheda, one of the maternity hospitals in which the procedure had been most frequently employed) and the Institute of Obstetricians and Gynaecologists of the Royal College of Physicians in Ireland issued apologies to anyone who suffered hurt or complications as a result of a symphysiotomy. Representatives from the Institute have since met with some mothers and their families to talk through their experience of the procedure.

18. In 2011 the Department of Health commissioned a report by Professor Oonagh Walsh, at the time a Senior Research Fellow in Medical History in the School of History at University College Cork (see paragraphs 52-65 below). According to the terms of reference, the purpose of the report was to document the rates of symphysiotomy and maternal mortality from 1944 to 1984 and, in particular: to assess symphysiotomy rates against maternal mortality rates during that period; critically appraise international reviews of symphysiotomy practice and associated rates in a number of comparable countries and in Ireland; review any guidelines and protocols that applied in Ireland on symphysiotomy over the time period; and write a report based on these findings, providing an accurate picture of the extent of the use of symphysiotomy in Ireland, and an examination of the Irish experience relative to other countries.

19. On 29 November 2013 the Minister for Health appointed Judge Yvonne Murphy to conduct a non-statutory review with the aim of finding closure for women who had undergone a symphysiotomy procedure (see paragraphs 66-71 below). The terms of reference were to: examine all relevant reports and information relating to symphysiotomy; meet women who had undergone surgical symphysiotomy procedures to assess what, in their opinion, would bring closure for them; assess, in conjunction with the State Claims Agency and other relevant bodies, the relative liabilities of insurers, indemnifiers, and/or other parties in relation to cases pending, or which might arise, as a result of surgical symphysiotomy procedures; and meet insurers, indemnifiers and/or other parties to explore and negotiate a quantum representing a fair contribution towards the fund in order to establish an *ex gratia* scheme to bring closure on the issue for the women involved.

20. In July 2014 the Minister for Health announced the establishment of an *ex gratia* payment scheme offering compensation to women who had undergone a surgical symphysiotomy or pubiotomy in any hospital in Ireland between 1940 and 1990 (see paragraphs 72-87 below).

3. Kearney v McQuillan and North Eastern Health Board

21. A symphysiotomy was performed on Mrs Kearney in 1969. It was performed immediately after her first child was born by caesarean section (an "on the way out" symphysiotomy). She was eighteen years old at the time. In 2004 she brought a claim for medical negligence, breach of duty and battery against the hospital, arguing that the procedure that had been carried out without her knowledge or express consent and she had been left with a legacy of problems which had a significant adverse effect on many aspects of her life. She claimed that in the days and weeks after the procedure she had suffered profound pain; as she had been bandaged from her waist to her pelvic area, and could not get out of bed, she was unable to visit her new-born son for six days after his birth; and she had been unable to take care of him and bond with him following his discharge from hospital. In the longer term, she complained of continuous back pain, incontinence, and pain during sexual intercourse. Furthermore, she had been unable to face the prospect of further pregnancies and became depressed and anxious.

22. The hospital argued that it was severely prejudiced in the presentation of its defence to the claim due to the fact that many of the witnesses, including the consultant gynaecologist, were deceased or their whereabouts were unknown. The High Court found that the question of consent could only be determined having heard the evidence of those who were present when the plaintiff had given her written consent to the caesarean section. Moreover, having regard to the relevant principles under domestic law (see *Dunne (an infant) v. National Maternity Hospital* at paragraph 44 below), it would be necessary to debate the appropriateness of the procedure in the plaintiff's case, and that could only be done in light of the actual testimony of the person who carried it out. The High Court therefore struck out the claim on the basis that the hospital would be severely prejudiced on account of the delay, and that there was a real and serious risk of an unfair trial.

23. On appeal, Mrs Kearney reformulated her claim and contended that the principal issue was that there had been no justification whatsoever for the performance of a symphysiotomy following delivery by caesarean section.

24. In a judgment of 26 March 2010, the Supreme Court held that the reformulation of the claim removed any prejudice to the Health Board in defending it as it removed any complaint about the manner in which the symphysiotomy was carried out (as opposed to the decision to carry it out at all) and it rendered irrelevant the matter of any missing contemporary records. As a consequence, the claim could be defeated by the defendant if it could establish any circumstances prevailing in 1969 which would have justified carrying out a symphysiotomy and/or by establishing by means of

credible evidence some realistic reason for the carrying out of the procedure in the circumstances of the case.

25. The High Court subsequently found that there could be no justification whatsoever for the use of the procedure in the plaintiff's case as her baby had already been delivered when the symphysiotomy was performed. Moreover, there was no evidence of disproportion between the size of the baby's head and the plaintiff's pelvis. The caesarean section had been performed because there was a failure in the pregnancy to progress and there were difficulties in the presentation of the baby's head; however, unlike disproportion, the evidence established that such a presentation was a "phenomenon of first labour" which would be rare in a subsequent pregnancy. On this basis, the obstetrician could not have diagnosed any need for future caesarean operations or inferred that a future pregnancy would not go to full normal delivery. The court awarded the plaintiff EUR 450,000.

26. The defendant appealed to the Supreme Court, which delivered its judgment on 11 July 2012. It upheld the High Court's findings on liability, but reduced the award of damages to EUR 325,000. While it accepted Mrs Kearney's truthfulness and credibility as a witness, the court noted that she had, despite her medical problems, carried on a relatively normal life and worked for a period of some twenty-five years. Therefore, without underestimating the very serious nature of her injuries, it considered a slightly lower award more appropriate.

4. The applicant's claim for damages

27. According to the applicant, she became aware that she might have undergone a symphysiotomy when a friend telephoned her after watching a television programme about the procedure (see paragraph 16 above). On 20 February 2010 she wrote to the Coombe Hospital to request copies of her medical records. It would appear that she did not provide sufficient information to enable the records to be found because on 23 April 2010 the hospital wrote to her, seeking further details such as her date of birth and her address at the time of her confinement. She did not reply to this letter, but made a further request in July 2011. She received copies of her medical records in August 2011.

(a) Proceedings before the High Court

28. The applicant issued a personal injuries summons against the Coombe Hospital on 6 September 2012. She initially claimed damages for personal injury flowing from the management of her labour and/or for the failure to obtain her lawful or proper consent for all procedures carried out in that regard. The defendant hospital raised a plea that the claim was statute barred as it had been issued after the expiry of the two-year time-limit. In

the alternative, in view of the fact that the attending doctors and the anaesthetist were deceased and limited medical records were available, it argued that the claim should be dismissed by reason of "inordinate and inexcusable delay", as a result of which it was "extremely prejudiced" in its ability to defend the action and that there was accordingly a real and serious risk it could not be afforded a fair trial.

29. In an effort to avoid the risk that the claim might be struck out (see the *Kearney* case at paragraphs 21-26 above), the applicant agreed that it would proceed on one issue only: that there had been no justification whatsoever, in any circumstances, for the performance of an antenatal symphysiotomy in her case.

30. The judgment of the High Court was delivered on 1 May 2015 following a fifteen-day hearing. At the outset, the judge found that, following the reformulation of the applicant's claim, it would be possible for the defendant to have a fair trial. He stated:

> "In the absence of the reformulation of the plaintiff's case of October 2014, I believe that the defendant would have had a strong, if not unanswerable case on prejudice."

31. In deciding whether the claim was statute barred, the judge observed that a number of the applicant's hospital notes in the years following the birth of her first child referred to the fact of symphysiotomy by name. Nevertheless, he accepted that she had heard that term for the first time when her friend telephoned her after watching a documentary on television. Although television programmes dealing with symphysiotomy had aired on 18 February 2010 and June 2011 (see paragraph 16 above), he found that, as a matter of probability, the applicant had been contacted by her friend on 18 February 2010, because she had made the first request for her hospital records two days later. He considered, however, that her "date of knowledge" was August 2011, being the date on which she had received her hospital records. Accordingly, he found that the claim had been issued within the two-year statutory time-limit and the hospital's plea under the statute of limitations had to fail.

32. Although the applicant's General Practitioner records only dated back to 1995, the judge accepted that she had suffered from physical trauma (in the form of some physical instability and incontinence) and psychological trauma as a result of the symphysiotomy, and that she had been very fearful of becoming pregnant again. The judge noted that while "it would be easy to be cynical and associate these complaints with a retrospective belief fostered by associating with the 'survivors of symphysiotomy'", the applicant had raised these matters with work colleagues long before legal proceedings were contemplated. That being said, the judge also noted that the applicant had been in regular and constant employment since returning to work in 1964 and, notwithstanding her age, she was still working as a waitress at the time of the hearing.

33. Turning to the central question in the case (namely, whether there had been no justification whatsoever, in any circumstances, for the performance of an antenatal symphysiotomy), the judge had no doubt that the procedure would not have been carried out either at the start of the reintroduction of symphysiotomy into Dublin maternity hospitals or after the introduction of "active management of labour" in the mid-to-late 1960s. However, while he acknowledged that prophylactic symphysiotomy was somewhat controversial in 1963, he accepted that in the Dublin maternity hospitals at that time a trial of labour was not always required for a consultant to conclude that a vaginal delivery would not be possible and in those cases a prophylactic symphysiotomy without trial of labour was a reasonable though limited option. In the present case the pelvimetry and the examination under anaesthetic had convinced the treating doctors that a vaginal delivery would not be possible. This view was supported by the defendant's medical experts, who stated – and the applicant did not dispute – that it was "90% certain" that had she been afforded a trial of labour she would not have been able to deliver without surgical intervention in the form of either a symphysiotomy or caesarean section. Consequently, the judge accepted that the treating doctors had proceeded on a course which they believed was not adverse to the applicant and was safer for her child. He further concluded that given the real fear of multiple caesarean sections, the belief that symphysiotomy was a relatively benign procedure with little by way of adverse *sequelae* for the mother, and the wide acceptance of symphysiotomy among the leading consultants in the Coombe and National Maternity Hospital, the applicant had not established that the practice had such "inherent defects" that ought to have been obvious to any person giving the matter due consideration. Consequently, he was not satisfied that there had been no justification whatsoever for a symphysiotomy in the applicant's case.

(b) The Court of Appeal

34. The applicant appealed against the rejection of her claim for damages and the defendant hospital cross-appealed against the judge's finding that the claim was not statute-barred.

35. On 14 October 2016 the Court of Appeal dismissed the applicant's appeal as it was fully satisfied that there was credible evidence to support the judge's finding. It confirmed that, by the standards which prevailed in 1963, the prophylactic symphysiotomy performed on her could have been clinically justified. Moreover, the Court of Appeal found that the judge had been entitled, on the evidence before him, to conclude that prophylactic symphysiotomy had been a general and approved practice in a relatively rare group of cases where clinical findings made in advance of labour strongly suggested that the mother could not deliver vaginally without operative intervention, but was likely to deliver vaginally following

symphysiotomy. Regarding the question of whether the practice had "inherent defects", while the court expressed some reservations about the judge's reasoning, it agreed that the applicant had not discharged the "heavy onus" required to succeed on this ground.

36. In dismissing the applicant's appeal, the Court of emphasised that its decision in the case was fact specific:

> "The fact that the plaintiff in this action failed in her claim relating to a symphysiotomy performed on her in 1963 does not necessarily mean that a court considering the circumstances in which another symphysiotomy procedure was performed on a different patient might not come to a different conclusion."

37. It also sought to explain why the applicant had failed in her claim while the plaintiff in Kearney had succeeded. It observed:

> "In *Kearney*, the baby had been delivered before the symphysiotomy was carried out. Accordingly, the procedure was not performed to protect the mother and baby from the risks involved in an obstructed labour. In [LF's] case, where the procedure was carried out prior to the onset of labour, all of the clinical indications suggested that she was likely to have an obstructed labour. Dr [B] and Professor [B] said it was 90% likely that she could not have delivered without a caesarean section or a symphysiotomy.
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> In *Kearney*, the High Court found no evidence of any obstruction or pelvic deformity likely to cause the patient difficulty in the course of any future delivery. Thus, there could never have been any justification for carrying out a procedure which had the consequential benefit of making the pelvis a little more accommodating on future deliveries ... In [LF's] case the position was entirely different. X-ray pelvimetry and examination under general anaesthetic provided objective evidence which strongly suggested that [LF] was suffering from mild to moderate CPD. Further, her pelvis was not normal. It was anthropoid in presentation and she also had signs of outlet contraction.
>
> The evidence clearly established that [LF's] symphysiotomy was performed to avoid an obstructed labour and to allow her to deliver vaginally thus facilitating her avoidance of all of the risks that she might otherwise be exposed to in the course of one and probably several more caesarean sections in the course of her lifetime. No such considerations arose in Mrs Kearney's case.
>
> Thus, unlike in *Kearney* where the procedure was carried out in the absence of any clinical indications that might justify its performance, in [LF's] case the symphysiotomy was performed for a range of clinical reasons which at the time were generally approved of by those at the very top of the obstetric profession in this country."

38. The Court of Appeal allowed the hospital's cross-appeal. The court found that the applicant's date of knowledge was 18 February 2010 and not August 2011, as this was the date on which she had sufficient knowledge to connect her injuries to the procedure which she knew had been carried out on her in 1963. As a consequence, the applicant's claim was also dismissed on the ground that the statutory limitation period had passed by the date of commencement of the proceedings.

39. The costs of the appeal were awarded to the defendant hospital to be taxed in default of agreement.

(c) The Supreme Court

40. The applicant sought permission to appeal to the Supreme Court, challenging the High Court's assessment of the concepts of a "general and approved practice" and "inherent defects", where the burden of proof lies in medical negligence cases, and how the date of knowledge is assessed with regard to the statute of limitations. The Supreme Court refused the application for leave to appeal on 17 February 2017. It too emphasised the fact specific nature of the Court of Appeal decision:

> "... it should be stated that the issues identified in the application are fact specific and case related and, accordingly, the decision of the Court of Appeal has no wider implications than as between the parties to this action."

41. Noting further that:

> "There can be no doubt that the practice of symphysiotomy, in general, has attracted much attention in the relatively recent past, including media scrutiny, public discussion and debate in the Dail [Parliament], as well as an examination by the United Nations Human Rights Committee, with many suggesting that an independent inquiry is required so as to provide an effective remedy for those women who have or who intend to pursue this issue legally. As important as this debate might be, however persuasive the argument may present, such is not the gateway to a further appeal to this Court."

5. The ex gratia *payment scheme*

42. The applicant did not apply to the *ex gratia* payment scheme for an award. She considered that there was no possibility of any acknowledgement of a breach of her rights; the quantity of the awards did not reflect the gravity of the harm inflicted on her; and the application window was unreasonably short.

B. Relevant domestic law and practice

1. Actions in tort

43. A tort is a civil wrong which causes someone to suffer loss resulting in legal liability for the person who commits the tortious act. The tort of negligence requires proof that there was a duty of care between the plaintiff and the defendant (which involves establishing the existence of a relationship of proximity between the parties such as would call for the exercise of care by one party towards the other), that that duty was breached and that that breach was causative of damage (see, for example, *Beatty v. The Rent Tribunal* [2005] IESC 66).

44. In *Dunne (an infant) v. National Maternity Hospital* [1989] I.R. 91 the principles applicable under domestic law to medical negligence actions were set out as follows:

> "1. 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.
>
> 2. If the allegation of negligence against a medical practitioner is based on proof that he deviated from a general and approved practice, that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualifications.
>
> 3. If a medical practitioner charged with negligence defends his conduct by establishing that he followed a practice which was general, and which was approved of by his colleagues of similar specialisation and skill, he cannot escape liability if in reply the plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.
>
> 4. An honest difference of opinion between doctors as to which is the better of two ways of treating a patient does not provide any ground for leaving a question to the jury as to whether a person who has followed one course rather than the other has been negligent.
>
> 5. It is not for a jury (or for a judge) to decide which of two alternative courses of treatment is in their (or his) opinion preferable, but their (or his) function is merely to decide whether the course of treatment followed, on the evidence, complied with the careful conduct of a medical practitioner of like specialisation and skill to that professed by the defendant..."

45. Section 3(1) of The Statute of Limitations (Amendment) Act 1991, as amended by section 7 of the Civil Liability and Courts Act 2004, introduced a limitation period of two years from the date on which the cause of action accrued or the date of knowledge (if later) for actions for damages in respect of personal injuries caused by negligence, nuisance or breach of duty.

2. Actions for breach of constitutional rights (constitutional tort actions)

46. In *Meskell v. CIE* [1973] IR 121, the Supreme Court stated:

> "... if a person has suffered damage by virtue of a breach of a constitutional right or the infringement of a constitutional right that person is entitled to seek redress against the person or persons who have infringed that right."

47. In Ireland, there is an unenumerated constitutional right to bodily integrity.

48. The limitation period for bringing an action for damages for breach of constitutional rights is six years (*McDonnell v. Ireland* [1998] 1 IR134).

3. The European Convention on Human Rights Act 2003

49. Section 3 of the 2003 Act provides as follows:

> "(1) Subject to any statutory provision (other than this Act) or rule of law, every organ of the State shall perform its functions in a manner compatible with the State's obligations under the Convention provisions.
>
> (2) A person who has suffered injury, loss or damage as a result of a contravention of subsection (1), may, if no other remedy in damages is available, institute proceedings to recover damages in respect of the contravention in the High Court (or, subject to subsection (3), in the Circuit Court) and the Court may award to the person such damages (if any) as it considers appropriate."

4. The interrelationship between tort law, the Constitution and the European Convention on Human Rights Act 2003

50. Resort to constitutionally created torts and the 2003 Act only occurs if there is a gap in existing tort law which needs to be supplemented. In *DF v Garda Commissioner (no 3)* [2014] IEHC 2013 (App. 10) the applicant had brought actions in tort for assault and false imprisonment; constitutional claims; claims under the 2003 Act; claims under the Charter of Fundamental Rights of the European Union; and claims under the United Nations Convention on the Rights of Persons with Disabilities 2006. The defendants contended that some of these claims should be struck as either unsustainable in their own right or as otherwise merely replicating claims for damages in respect of the nominate torts of assault and false imprisonment. In response, the High Court Judge indicated that

> "if the claims simply duplicate or cannot add anything to the well-established nominate torts of false imprisonment, assault and battery or if they present no justiciable issue, I propose to strike them out pursuant to the courts' inherent jurisdiction at this preliminary stage."

51. The judge accepted that a complaint of a breach of the constitutional right to liberty added nothing to the claim for false imprisonment, but considered it possible that the nominate torts of assault and battery would insufficiently vindicate the constitutional rights to the integrity of the person. However, in the circumstances of that case the claim based on Article 3 of the Convention was struck out as it was considered that it added nothing to the existing claims for damages for assault and battery as well as to those for breach of constitutional rights.

C. Relevant public investigations into the use of symphysiotomy in Irish maternity hospitals

1. The report by Professor Oonagh Walsh ("the Walsh report")

52. The Walsh report, which was commissioned in 2011 and published in 2014, was prepared in two phases. The first phase was an independent

academic research report, compiled with reference to printed sources and analysis of medical reports and research. Once that was completed, the second phase involved interviews with individuals directly involved in symphysiotomies, such as mothers, practitioners and midwives.

(a) Phase one

53. A draft of the first phase of the report was delivered in June 2012. It noted that while symphysiotomies might have been more prevalent in Ireland than in other countries during the relevant period, it was nevertheless a rare intervention in comparison to caesarean sections, which rose steadily during the same period. The suggested figure of 1,500 symphysiotomies between 1944 and 1992 translated to a rate of 0.05 percent of total births, or 60 per 100,000 births. In comparison, caesarean sections accounted for just under two percent of deliveries in 1944 and over four percent in 1984.

54. The report acknowledged that Irish obstetrical practice was heavily influenced by, and constrained within, a religious framework which was widely accepted by doctors and laypeople alike. The revival of symphysiotomy – a procedure which appeared to offer the possibility of safe repeat deliveries – therefore had to be considered within a context in which multiple births were the norm, artificial contraception and sterilisation were illegal as well as "ethically unacceptable", and repeat caesarean sections were believed to carry great dangers. Indeed, the lack of options in the control of fertility was acknowledged to be one of the key factors behind a return to symphysiotomy in the 1940s.

55. The 2012 report further noted that symphysiotomy was statistically a far safer procedure than caesarean section, with lower maternal and foetal mortality rates. At the relevant time the economic situation of many Irish families was "dire" and the Dublin hospitals in particular served areas of significant deprivation. Poor diet and nutrition was not only a common cause of contracted pelvis, but it resulted in many women presenting in labour with other complications that made them poor candidates for general anaesthetic. Moreover, up until the 1960s there were concerns about the safety of repeat caesarean sections. Irish obstetricians – like their Western-educated colleagues – were trained to the so-called "three caesar rule" and believed in the saying "once a caesar, always a caesar". In Britain, it was common to perform several sections and then advise the mother either to be sterilised or to use artificial contraception. This was not an option in Ireland.

56. According to the report, the indications for symphysiotomy remained generally constant over the review period (being mild to moderate disproportion). From the outset, therefore, it was viewed as a means of coping with this very specific cohort, and was never proposed as an alternative to caesarean section. The fact that it was more prevalent in some

hospitals than in others was due in large part to the fact that some obstetricians had greater faith in the procedure than others.

57. The report considered that the use of symphysiotomy as a prophylactic procedure (either in advance of labour or even, in the case of the "on the way out" symphysiotomy, in advance of a further pregnancy) was a deviation from good practice as the degree of disproportion could only be evaluated during labour, and a woman diagnosed with disproportion in one pregnancy might have a normal delivery in the next. In Professor Walsh's opinion, the non-emergency application of symphysiotomy, while the mother was under general anaesthetic, appeared "indefensible". No scientifically credible research proposed prophylactic symphysiotomy or any equivalent to symphysiotomy "on the way out". Furthermore, while there were no clinical guidelines governing the use of symphysiotomy in Irish maternity hospitals at the time, the generally accepted policy appeared to be to first perform a trial of labour.

58. With regard to the long-term effects of the procedure, Professor Walsh was in no doubt that some women had suffered adverse consequences, some of which may have been exacerbated by having more children. She noted, however, that it was difficult to assess the long-term problems resulting from symphysiotomies as many of these were similar if not identical to the long-term complications of multiple pregnancies.

59. On the issue of consent, the report noted that during the period under review there were no guidelines in Britain or Ireland for obtaining consent to medical procedures and during the 1940s and 1950s implicit or explicit consent was not required for medical interventions. Indeed, the report described an "overwhelming culture of deference that militated against patient engagement". Moreover, it would be impossible to determine from this historic distance whether patients were informed when a symphysiotomy was about to be performed or if they were made aware of potential long-term health risks. Given the hierarchical nature of medical practice in the 1950s and 1960s, however, Professor Walsh accepted that it was unlikely that patients were consulted to any significant degree.

60. The report noted that the use of symphysiotomy had gone into increasing decline from the early 1960s due to improvements in maternal health, increasing use of repeat lower section caesarean sections, increasing use of drugs to shorten labour, and a growing realisation that pelvic disproportion had been over-diagnosed. The report did, however, give special consideration to Our Lady of Lourdes Hospital in Drogheda, where symphysiotomy persisted twenty years after it had largely ceased elsewhere. It found that this was specifically linked to the tenure of the founding obstetrician, who was obeyed by management and nursing staff "without question". He created an ethos which was "unswervingly Catholic" and was a firm believer in carrying out symphysiotomies in the hope of avoiding caesarean section. According to the report, it was "unacceptable" that the

procedure had persisted for so long at this hospital when alternative methods were available for dealing with difficult deliveries.

(b) Phase two

61. Following her interviews with persons affected by symphysiotomy, Professor Walsh considered that by far the greatest sense of disquiet related to the lack of knowledge regarding the procedure. In particular, there was a strong and widely held feeling that an explanation why a symphysiotomy was being performed in their case would have substantially eased patients' subsequent adjustment to any resulting physical and psychological problems. Without exception, the most favourable outcomes had been recorded in those cases where either the symphysiotomy had been discussed with the obstetrician beforehand, or when women were told what the procedure was and why it had been used in their cases. By contrast, the women who reported the worst outcomes were those who had not been consulted in advance and were not informed after their deliveries that a symphysiotomy had been performed. Almost twenty percent of respondents had not been told that a symphysiotomy had been performed, and these new mothers could not understand why their recovery was so different from that of other women.

62. Another important theme that came out of the interviews was the wide divergence in the standard of aftercare, which impacted significantly upon long-term health outcomes. Women who were adequately bound, given bed rest and pain relief, and allowed to become mobile gradually after delivery reported the best immediate and long-term outcomes. However, despite the fact that the importance of bed rest was commonly known in the 1950s, many respondents were told by nursing staff to get out of bed and walk within a day or so of delivery. Many were also discharged from hospital with no guidance or support to ensure proper healing. In Professor Walsh's view, instructing a newly delivered mother who had just undergone a symphysiotomy to walk without support was an "incomprehensive failure in duty of care". Moreover, the resulting instability led to long-term side effects for some women, and even to the incorrect fusion of the pelvis, leaving them with chronic pain and locomotive problems.

63. The most significant difficulties reported in the aftermath of the procedure were chronic pain, difficulty walking, and problems with continence. Many of these were the same as those experienced following a normal but difficult labour, a fact which prevented many women from asking the questions that might have revealed that they had had a symphysiotomy, and from seeking additional specialist care.

64. The report also considered the impact of symphysiotomies on husbands and children. Many women noted that they had experienced difficulties bonding with their babies, which was exacerbated by the fact that they were often unable to nurse or hold them while they were

recovering from the procedure. Husbands were also affected, having to play a role in childcare after deliveries and, for the most part, being ill-equipped to deal with the complications that their wives were experiencing. Symphysiotomies also had an impact on many couples' sexual relationship, for two principal reasons: first, sex was often painful because of pelvic instability; and secondly, there was a great fear of falling pregnant again.

65. Finally, in respect of redress, the report recommended the establishment of an independent specialist needs assessment team to evaluate individual cases, advise on care requirements and determine suitable levels of compensation.

2. The report by Judge Yvonne Murphy ("the Murphy report")

66. In her report published in 2014, Judge Murphy acknowledged that although symphysiotomy had been "an exceptional and rare intervention in obstetric practice in Ireland", many of the women who had undergone the procedure did not have good experiences. She noted that at the time more than 150 women had instituted proceedings in the High Court and significantly more cases could follow. Such proceedings were, however, fraught with difficulties for both plaintiffs and defendants. A large percentage of plaintiffs were between 75 and 91 years of age and their ability to pursue actions through the courts was limited. In addition, given the passage of time and the nature of their complaints they might face significant difficulties in establishing liability.

67. First of all, the issue of consent was problematic. If a court decided that a procedure was wholly unnecessary or inappropriate, the question of consent would be irrelevant, but if a symphysiotomy was clinically indicated and within acceptable medical standards at the time, the courts would then have to decide if there had been lawful consent to the procedure. In emergency situations it may not have been possible to obtain consent, and the central question would then be whether a caesarean section ought to have been performed instead of a symphysiotomy. In non-emergency cases consent should have been given. At the relevant time, however, the practice of obtaining consent would have differed from obstetrician to obstetrician and any discussions were unlikely to have been recorded. During the relevant time period it was not unusual for women to be unaccompanied during labour and with the passage of time, and the death of many of the obstetricians and nursing staff concerned, it would now be all but impossible to make any useful inquiry into the issue of consent. As the inability to counter allegations of a lack of consent would place the defendants at a significant disadvantage, they could therefore seek to have the proceedings struck out on the grounds that the defence was irreparably compromised.

68. Secondly, there was the issue of causation. Even if the absence of consent could be established, the plaintiffs would also have to show that if

they had been given the appropriate information, they would have decided against the procedure.

69. The report also considered the problem defendant hospitals were facing regarding insurance. The passage of time had left many hospitals unable to identify the relevant insurers and, even if they could be traced, the limits of indemnity were in many cases very low as the anticipated value of claims was much lower then than it would be today. Many hospitals would therefore have to conduct litigation out of their own budget. If this were the case, it would subsequently be open to the hospitals to seek to recover the award from the State under the Clinical Indemnity Scheme. As a consequence, the report indicated that the State risked exposure to the burden of a large proportion of any damages and/or costs awarded to successful litigants. In addition, following *O'Keeffe v. Ireland* [GC], no. 35810/09, ECHR 2014 (extracts) there was also a possibility that the State could be directly involved in litigation on the basis that it should have adopted a greater supervisory role over the maternity hospitals.

70. The report recommended that the State implement an *ex gratia* payment scheme, that some legal costs be covered and that applicants would discontinue any legal proceedings if they decided to accept an award. The estimated cost of such a scheme would be in the region of EUR 33,482,000.

71. Finally, the report noted that apologies had already been given by the Medical Missionaries of Mary and the Institute of Obstetricians and Gynaecologists of the Royal College of Physicians in Ireland (see paragraph 17 above). The question of any further apology was a decision for the Government to take on the advice of the Attorney General.

D. The *ex gratia* payment scheme

1. The operation of the scheme

72. The scheme was first announced by the Government on 1 July 2014 and was extensively advertised by support groups and in the National media. The opening date for applications was 10 November 2014 and the closing date was 5 December 2014. However, this time-limit was extended for a further twenty working days "where the balance of fairness favour[ed] consideration of the application" and applications were considered to be valid even if all relevant supporting documentation was not provided at the time they were made, Following the registering of the initial application women were given a substantial number of months to seek advice and submit all relevant evidence and in a number of cases the Scheme's administrators assisted claimants in locating records. A determination by the Independent Assessor of the amount of an award was final and not subject to appeal.

73. There were four categories of payment:

1A: award of EUR 50,000 for symphysiotomy

1B: award of EUR 100,000 for symphysiotomy with significant disability

1C: award of EUR 100,000 where the symphysiotomy was carried out in advance of labour or where there was a combined operation of caesarean section and symphysiotomy; if significant disability resulted from such a procedure, the award rose to EUR 150,000.

P1 and P2: EUR 100,000 – EUR 150,000 for pubiotomy with or without significant disability.

74. Where legal advice was sought in relation to the making of an application, certain costs would be payable. However, if a claimant decided to accept an award, she had to discontinue any legal proceedings.

75. The *ex gratia* scheme was administered by Judge Maureen Harding Clark, who had been appointed by the Minister of Health as the Independent Assessor. She was tasked with making awards available to eligible applicants as expeditiously as possible. She assessed each individual application, assisted by a team of clinical experts. Once evidence of a surgical symphysiotomy was established, a minimum award of EUR 50,000 was made. Where a claimant had little or no evidence to support her case, the Independent Assessor met with her to agree the minimal medical assessment necessary to confirm that symphysiotomy had occurred and the level of subsequent disability.

2. The report into the operation of the scheme

76. Judge Harding Clark subsequently prepared an extensive report on the operation of the scheme which was published by the Minister for Health in November 2016.

77. The report indicated that almost 600 women had applied to the scheme and nearly 400 had received awards, totalling more than EUR 30,000,000. The awards made included 216 payments of EUR 50,000 to women in category A, and 168 of EUR 100,000, mostly where significant disability resulted from the procedure (see further paragraph 84 below). Fifteen women received the maximum of EUR 150,000 under the scheme, having been found to have suffered significant disability following an elective symphysiotomy carried out after childbirth, or to have received a pubiotomy. One hundred and eighty five applicants were unable to establish their claim, despite being assisted by the Independent Assessor.

78. Twenty-seven applications submitted after the closing date underwent full investigation to establish whether a symphysiotomy could be established from the existing records and from medical examinations. Twelve were rejected on the basis that no qualifying procedure was established. The remaining fifteen applications were accepted.

79. According to the report, each application had "received an individual, careful and fair assessment" and once symphysiotomy or

pubiotomy was established, a "compassionate and generous view" had been applied to the assessment of each claim. All applications capable of being examined, including those received after the closing date, underwent full investigation to determine if symphysiotomy could be established from medical records or medical examinations. Although each application had been fully investigated, following the operation of the scheme Judge Harding Clark was "confident" that symphysiotomy was almost invariably recorded on birth registers and in annual clinical reports.

80. In respect of the 185 applicants who were unable to establish their claim, Judge Harding Clark expressed surprise that so many women mistakenly believed that they had undergone a symphysiotomy. In addition, she observed that a large number of applicants reported seeing or hearing a saw, or feeling as though they were being "sawn in half", even though symphysiotomy was never performed with a saw. She considered it possible, however, that a traumatic birth experience and exposure to other women's stories might have helped create a "self-convincing confabulation of personal history".

81. Judge Harding Clark's report also provided an in-depth overview of the long-term effects many women experienced following a symphysiotomy. Having assessed each of the 600 applications to the scheme, she concluded that no general pattern of immediate or developmental injury was seen. The evidence did not confirm that symphysiotomy inevitably led to lifelong pain or disability, or that symphysiotomy patients aged in a manner which was different to that of non-symphysiotomy women. The majority of applicants who underwent symphysiotomy made a good recovery and went on to have normal pregnancies and deliveries and to lead a full life. Indeed, in most cases radiology showed that the pubic joint had fully approximated and normalised and there were very few cases of pelvic instability and premature hip degeneration. These results were supported by international medical studies into the use of the symphysiotomy, which also found no evidence that it led to a lifetime of pain or disability if carried out correctly.

82. That being said, a small number of applicants suffered from pelvic pain and a slightly larger group from urinary issues. She found that whether the conditions were associated with prolonged labour, the use of forceps, parity, age or the symphysiotomy procedure was not possible at this remove to determine. It was, however, noted that many emergency symphysiotomy procedures were carried out after "failed forceps", and many of the applicants who could not establish that they had undergone either a symphysiotomy or pubiotomy nevertheless reported harrowing memories of long-term side effects, such as difficulty walking and taking care of their babies, incontinence and pelvic organ prolapse.

83. Pain and/or discomfort over the pubic joint during sexual relations in the first twelve months post-symphysiotomy was a very common complaint,

although the vast majority of applicants became pregnant again within a year of the symphysiotomy. Several claimed that the procedure caused cessation of all sexual relations and the end of their reproduction, and a small number claimed that their reluctance to engage in sexual intercourse had led to the breakdown of their marriages.

84. In light of her findings, Judge Harding Clark considered that the premise of the scheme – namely the widespread assumption that symphysiotomy was a surgical procedure which, as a matter of near certainty, created lifelong suffering – was unsupported by evidence. In fact, she found herself lowering the criteria for what constituted significant disability in order to help women "over the line". For the purposes of the scheme, significant disability was generally assumed where radiological findings disclosed joint abnormality or a continuing diastasis (abdominal separation) of fifteen millimetres or more.

85. With regard to the issue of knowledge, Judge Harding Clark found it "very difficult to believe" that any patient who had actually undergone a symphysiotomy would not have been told of the procedure. To be unaware that a symphysiotomy had been performed would have required "resolute and conspirational silence" on the part of nurses who removed catheters, bindings and incisions; from physiotherapists who encouraged patients to mobilise; and from the obstetrician who conducted the six-week check-up. It was also standard practice at the time for consultants to write to General Practitioners notifying them of patients' births.

86. Finally, Judge Harding Clark considered whether the use of the procedure in certain Irish hospitals was "a Catholic practice or an Irish phenomenon". Although some evidence could be found of religious motivation for reintroducing symphysiotomy into Irish obstetrics in the 1940s, very detailed and forensic examination of available contemporaneous medical records failed to find evidence of a religious as opposed to obstetric reason when a symphysiotomy was performed. Some of the maternity hospitals in which symphysiotomies were performed were non-Catholic institutions and therefore unlikely to have been motivated by Vatican dogma. While many hospitals operated a "Catholic ethos", regardless of whether a particular obstetrician was a practicing Catholic, the reality for the patient was the same, since contraception was not legally available. The route taken in United Kingdom hospitals (of sterilisation following one or two repeat caesarean sections) was not an option.

87. Judge Harding Clark provided the following context:

> "Ireland of the 1940s was a very different place to the modern, clean, prosperous and mainly secular European State it is today. In 1943 when the first symphysiotomy was performed, the war was raging, rationing was in operation, malnutrition was common and TB was a major disease and a significant cause of early death. Living conditions for the poor in the slums of Dublin, Limerick and Cork were appalling. 30% of mothers giving birth at the Coombe and the Rotunda suffered from iron deficiency anaemia. Blood supplies were extremely expensive. The almoners' reports

in the Dublin hospitals show that many mothers required assistance in the provision of free meals for themselves and clothing for their babies. More than 200 maternity deaths occurred every year in Ireland and even more babies were stillborn or died shortly after birth. Antibiotics were only becoming freely available. Ultrasound and vacuum extraction did not exist. However, the most relevant feature of Irish society then was that the laws and Constitution fully reflected the then strong religious practices and the conservative outlook of the general population. The Constitution recognised the special position of the Roman Catholic Church. Being Irish and being Catholic were almost synonymous. The vast majority of the Catholic population accepted without question the strict application of Catholic teaching on birth control, marriage and sexuality. Few women occupied positions of power in the patriarchal society where most professions were male dominated, divorce was prohibited and married women were expected to stay at home and raise children. Shortly after the religious direction in a Papal Encyclical in 1930 that any form of birth control was a grave sin, the State introduced laws criminalising the sale or importation of any contraceptive."

E. Reports of International bodies

1. United Nations Human Rights Committee: Concluding observations on the fourth periodic report of Ireland

88. This report, dated 19 August 2014, provided, insofar as is relevant:

"**Symphysiotomy**

The Committee expresses concern that symphysiotomy, a childbirth operation which severs one of the main pelvic joints and unhinges the pelvis, was introduced into clinical practice and performed on approximately 1,500 girls and women in public and private hospitals between 1944 and 1987 without their free and informed consent. While noting the publication of a report by Oonagh Walsh in 2012, the review of the findings of the report by Judge Yvonne Murphy and the planned establishment of an *ex gratia* scheme for the survivors of symphysiotomy, the Committee expresses concern at the State party's failure to: (a) initiate a prompt, comprehensive and independent investigation into the practice of symphysiotomy; (b) identify, prosecute and punish, where still possible, the perpetrators for performing symphysiotomy without patient consent; and (c) provide effective remedies to survivors of symphysiotomy for the damage sustained as a result of these operations (arts. 2 and 7).

The State party should initiate a prompt, independent and thorough investigation into cases of symphysiotomy, prosecute and punish the perpetrators, including medical personnel, and provide the survivors of symphysiotomy with an effective remedy for the damage sustained, including fair and adequate compensation and rehabilitation, on an individualized basis. It should facilitate access to judicial remedies by victims opting for the *ex gratia* scheme, including allowing them to challenge the sums offered to them under the scheme."

2. United Nations Committee on the Elimination of Discrimination against Women: Concluding observations on the combined sixth and seventh periodic reports of Ireland

89. In this report, dated 19 March 2017, the Committee made the following observations:

"**Access to justice**

14. The Committee notes the numerous recommendations on the unresolved issue of historical abuses of women and girls by other United Nations human rights mechanisms such as the Human Rights Committee (CCPR/C/IRL/CO/4), the Committee Against Torture (CAT/C/IRL/CO/1) and the Committee on Economic, Social and Cultural Rights (E/C.12/IRL/CO/3). While noting the efforts by the State party to resolve the issue of historical abuses regarding ... the medical procedure of symphysiotomy, the Committee regrets that the State party has not implemented the aforementioned recommendations. The Committee regrets:

... ...

(b) That, notwithstanding the publication of the Walsh and Murphy reports and the establishment of an *ex gratia* scheme in 2014, no effort has been made to establish an independent investigation to identify, prosecute and punish the perpetrators who performed the medical procedure of symphysiotomy without the consent of women;

... ...

15. The Committee observes that the historical abuses in relation to ... the medical practice of symphysiotomy give rise to serious violations that have a continuing effect on the rights of victims/survivors of those violations. The Committee, therefore, urges the State party:

(a) To conduct prompt, independent and thorough investigations, in line with international human rights standards, into ... allegations of symphysiotomy in order to prosecute and punish the perpetrators of those involved in violations of women's rights, and ensure that all victims/survivors of such abuse obtain an effective remedy, including appropriate compensation, official apologies, restitution, satisfaction and rehabilitative services;

(b) To provide information in its next periodic report on the extent of the measures taken to ensure the rights of victims/survivors to truth, justice and reparations."

3. Report by the Commissioner for Human Rights of the Council of Europe following his visit to Ireland from 22 to 25 November 2016

90. The report included the following section on symphysiotomy:

"**4.3 SYMPHYSIOTOMY**

184. It is estimated that 1,500 women underwent symphysiotomy in Ireland mostly between the 1940's and the 1980's. Symphysiotomy is a surgical procedure that involves sundering the mother's pelvis to enable difficult childbirth. This procedure was not performed in other European countries during the same time period, as caesarean section was the procedure generally used in cases of difficult births. Symphysiotomy is said to have various health consequences including in some cases life-long pain, disability and emotional trauma. There have been three reports

commissioned by the government on this practice. On the basis of the first two reports, the government set up an *ex-gratia* redress scheme for the victims. The third report dealt with the operation of the scheme itself.

185. During his visit, the Commissioner was informed of a number of concerns from civil society about the way the redress scheme works. The scheme admits no wrongdoing or liability on the part of the state and public authorities, any private hospitals or nursing homes, or any medical staff. The level of compensation offered is considered to be very low compared to the level of abuse endured. In addition victims had to accept a legal waiver by which they agree not to question the amount of the indemnity allocated and they had to abandon their right to take further legal action against any responsible individual or body in order to obtain a payment under the scheme. Lastly, the window of opportunity for applying for compensation was of 20 working days since the commencement date of the Scheme, which was 10 November 2014.

186. The above mentioned report on the operation of the scheme (The "Clark Report"), which was published during the Commissioner's visit, was subject to particularly strong criticism from human rights NGOs and other stakeholders. The Commissioner himself was particularly struck by the patronising tone and the kind of information provided in the report. .... This is all the more unfortunate as the aim of the report was in principle only to describe the operation of the compensation scheme. The Commissioner notes that the government has chosen to endorse this report without giving any credit to the wide criticism that it had generated among human rights stakeholders in Ireland.

187. For survivors of symphysiotomy who seek to obtain an effective remedy through the courts, evidential barriers represent a serious obstacle, as noted by the IHREC. In one of the cases brought to courts, the High Court accepted that the claimant suffered from a range of physical and psychological difficulties caused or contributed to by the antenatal symphysiotomy which took place in 1963 but rejected her claim that it was done without any justification"

COMPLAINTS

91. The applicant complains under Articles 3 and 8 of the Convention taken in conjunction with Article 13 that as a result of the Supreme Court judgment in *Kearney v. McQuillan and North Eastern Health Board* she was precluded from making any complaint to the domestic courts about a symphysiotomy which she claimed had been performed without her free, full and informed consent.

92. The applicant further complains under Article 3 of the Convention in its procedural aspect that there has never been an independent and thorough investigation into the practice of symphysiotomy in Ireland from the 1940s to the 1980s.

THE LAW

93. The applicant's case is one of ten applications introduced by women who underwent symphysiotomies in different Irish maternity hospitals in the

1960s and 1970s. Only the present applicant pursued her civil claim against the hospital which had treated her before the domestic courts. It is uncontested that the applicant's case, originally introduced as a personal injuries claim, finally proceeded on the basis of one issue, namely that there had been no justification, in any circumstances, for the performance of an antenatal symphysiotomy in her case.

94. The applicant claims, before the Court, that as a result of being required at domestic level to narrow her claim, she had been precluded, contrary to Articles 3 and 8, in conjunction with Article 13, from claiming that the procedure had been performed without her full, free and informed consent. She also claims that the respondent State failed to conduct an independent and thorough investigation into the practice of symphysiotomy, in accordance with the requirements of the Convention.

95. Although the applicant complains under Articles 3 and 8 of the Convention, taken in conjunction with Article 13, for the most part the Court has preferred to examine cases concerning medical interventions – including those carried out without the consent of the patient – under Article 8 (see, for example, *Vasileva v. Bulgaria*, no. 23796/10, 17 March 2016).

96. There are a small number of notable exceptions. For example, the Court accepted that the sterilisation of a mentally competent adult without her full and informed consent, when there was no immediate threat to her life, reached the Article 3 threshold since sterilisation "constitutes a major interference with a person's reproductive health status" and "concerns one of the essential bodily functions of human beings" (see *V.C. v. Slovakia*, no. 18968/07, §§ 106-120, ECHR 2011 (extracts)). The Court has also found that the forcible administration of emetics to a detainee against his will and in spite of his violent resistance reached the Article 3 threshold (see *Jalloh v. Germany* [GC], no. 54810/00, § 75-83, ECHR 2006-IX).

97. In the domestic proceedings, in which the applicant had sought damages for personal injuries, the trial judge recognised that she had experienced physical and psychological trauma as a result of the symphysiotomy (see paragraph 32 above). It is not necessary in the present case to determine whether recourse to a surgical symphysiotomy, in particular by a hospital several decades previously, engages the responsibility of a State under Article 3 of the Convention or reaches the threshold thereunder. Without in anyway underestimating the difficulties to which the procedure gave rise, documented in the applicant's domestic court judgments and in the reports detailed in paragraphs 52-87 above, the Court considers that it is appropriate to address her complaints solely under the positive limb of Article 8 of the Convention.

98. Article 8 of the Convention provides, as relevant:

> "1. Everyone has the right to respect for his private and family life ....

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

A. Exhaustion of domestic remedies

99. The Government contended that the applicant failed to exhaust domestic remedies in the civil proceedings that she initiated. In advance of the hearing before the High Court she decided voluntarily to reformulate her claim following *Kearney v McQuillan and North Eastern Health Board* (see paragraphs 21-26 above) and as a result of that decision her complaint that the symphysiotomy was carried out without her informed consent was not considered by the domestic courts. In addition, the Government submitted that it had also been open to the applicant to apply to the *ex gratia* payment scheme, which would have provided redress for the complaints now raised before the Court.

100. In view of the Court's conclusions at paragraphs 110-131 below, it will simply proceed in this case on the basis that neither the decision to reformulate her claim before the High Court nor the failure to apply to the *ex gratia* payment scheme meant that the applicant failed to exhaust domestic remedies within the meaning of Article 35 § 1 of the Convention.

B. The substance of the Article 8 complaint

1. The parties' submissions

101. The Government submitted that the applicant had access to the full panoply of domestic remedies which enabled her to seek redress through the civil courts. However, the remedy only had to be as effective as could be having regard to the restricted scope for recourse inherent in the particular context, and its effectiveness did not depend on the certainty of a favourable outcome for the applicant (see *Kudła v. Poland* [GC], no. 30210/96, §§ 151 and 157, ECHR 2000-XI). In this regard, the Court's jurisprudence did not prohibit the regulation of civil proceedings in order to prevent injustice to the parties, and the procedural requirements of Articles 3 and 8 were not violated simply because the original domestic claim was partially barred because it could not proceed for such reasons.

102. The applicant submitted that the Government had not demonstrated a route by which she could have obtained relief for her essential grievance that she had not consented to the procedure. She further complained that there had never been an independent and thorough investigation into the practice of symphysiotomy in Ireland from the 1940s to the 1980s. In her view, none of the reports relied on by the Government fulfilled this criteria. The independence and impartiality of the Walsh report was undermined by

the fact that the choice of author and terms of reference were settled by the Minister for Health in consultation with the Institute of Obstetricians and Gynaecologists, whose members had previously performed the symphysiotomies during the relevant period. The Murphy report was published in a redacted fashion and not all of its findings were disclosed. Finally, the aim of the report by Judge Harding Clark had been to review the operation of the *ex gratia* payment scheme. Instead, in the applicant's view, she had attempted to offer a full and general apologia for symphysiotomy.

2. The Court's assessment

(a) General principles

103. It is now well established that although the right to health is not as such among the rights guaranteed under the Convention or its Protocols (see *Fiorenza v. Italy* (dec.), no. 44393/98, 28 November 2000*; Pastorino and Others v. Italy* (dec.), no. 17640/02, 11 July 2006; and *Dossi and Others v. Italy* (dec.), no. 26053/07, 12 October 2010), the High Contracting Parties have, parallel to their positive obligations under Article 2 of the Convention, a positive obligation under Article 8, firstly, to have in place regulations compelling both public and private hospitals to adopt appropriate measures for the protection of their patients' physical integrity and, secondly, to provide victims of medical negligence access to proceedings in which they could, in appropriate cases, obtain compensation for damage (see *Trocellier v. France* (dec.), no. 75725/01, ECHR 2006-XIV; *Benderskiy v. Ukraine*, no. 22750/02, §§ 61-62, 15 November 2007; *Codarcea v. Romania*, no. 31675/04, §§ 102-03, 2 June 2009; *Yardımcı v. Turkey*, no. 25266/05, §§ 55-57, 5 January 2010; *Spyra and Kranczkowski v. Poland*, no. 19764/07, §§ 82 and 86-87, 25 September 2012; *Csoma v. Romania*, no. 8759/05, §§ 41 and 43, 15 January 2013; and *S.B. v. Romania*, no. 24453/04, §§ 65‑66, 23 September 2014).

104. For the second of these obligations to be satisfied, such proceedings must not only exist in theory but also operate effectively in practice (see *Gecekuşu v. Turkey* (dec.), no. 28870/05, 25 May 2010, and *Spyra and Kranczkowski, cited above*, § 88).

105. At the same time, the High Contracting Parties have a margin of appreciation in choosing how to comply with their positive obligations under the Convention (see, as a recent authority, *Lambert and Others v. France* [GC], no. 46043/14, § 144, ECHR 2015 (extracts)), and enjoy considerable freedom in the choice of the means calculated to ensure that their judicial systems meet its requirements (see, albeit in different contexts, *König v. Germany*, 28 June 1978, § 100, Series A no. 27; *Taxquet v. Belgium* [GC], no. 926/05, §§ 83 and 84, 16 November 2010; and *Finger v. Bulgaria*, no. 37346/05, § 120, 10 May 2011).

106. In this regard, even in cases engaging Articles 2 and 3 of the Convention, where harm occasioned by medical malpractice is not caused intentionally, the Court has found that the positive obligation imposed by those Articles to set up an effective judicial system does not necessarily require the provision of a criminal-law remedy in every case. On the contrary, in the specific sphere of medical negligence the obligation may for instance also be satisfied if the legal system affords victims a remedy in the civil courts, either alone or in conjunction with a remedy in the criminal courts, enabling any liability of the doctors concerned to be established and any appropriate civil redress, such as an order for damages and for the publication of the decision, to be obtained (see, for example, *Calvelli and Ciglio v. Italy* [GC], no. 32967/96, § 51, ECHR 2002-I; *Vo v. France* [GC], no. 53924/00, § 90, ECHR 2004-VIII; and *V.C.*, cited above, § 125).

107. The mere fact that proceedings concerning medical negligence have ended unfavourably for the person concerned does not in itself mean that the respondent State has failed in its positive obligation under Article 8 of the Convention (see, in the context of Article 2 of the Convention, *Lopes de Sousa Fernandes v. Portugal* [GC], no. 56080/13, § 221, 19 December 2017 and *Besen v. Turkey* (dec.), no. 48915/09, § 38 *in fine*, 19 June 2012).

108. Moreover, the Court has held that the right to institute proceedings before a court in civil matters is not absolute, but may be subject to limitations; these are permitted by implication since the right of access by its very nature calls for regulation by the State. More particularly, it has observed that limitation periods in personal injury cases are a common feature of the domestic legal systems of the Contracting States. They serve several important purposes, namely to ensure legal certainty and finality, protect potential defendants from stale claims which might be difficult to counter and prevent the injustice which might arise if courts were required to decide upon events which took place in the distant past on the basis of evidence which might have become unreliable and incomplete because of the passage of time (see, for example, *Stubbings and Others v. the United Kingdom*, 22 October 1996, § 51, Reports of Judgments and Decisions 1996 IV).

109. Finally, the Court has consistently explained that it must be cautious in taking on the role of a first-instance tribunal. As a general rule, where domestic proceedings have taken place, it is not the Court's task to take on the role of a first-instance tribunal of fact, where this is not rendered unavoidable by the circumstances of a particular case (see *Giuliani and Gaggio v. Italy* [GC], no. 23458/02, § 180, ECHR 2011 (extracts); see also *Allen v. Ireland* (dec.), application no. 37053/18, 19 November 2019, § 57).

(b) Application of the general principles to the facts of the case at hand

110. In the present case, the applicant complains in essence of the failure to provide access to effective proceedings allowing her to claim

compensation for damage. She has not complained before the domestic courts or before this Court that the State did not have in place regulations requiring hospitals to adopt appropriate measures to protect patients' physical integrity. Indeed, it is not contested that, when admitted to hospital, the applicant signed a general consent form of the type used at the relevant time (see paragraph 5 above).

111. In this regard, the Court recalls that a civil remedy existed and was used by the applicant. However, she did not obtain redress: first of all, she voluntarily reformulated her claim in order to avoid the risk of it being struck out by the High Court; and her reformulated claim was rejected as the court did not consider that the symphysiotomy performed on her could not have been justified in any circumstances.

112. As already noted, the Court will proceed on the basis that the applicant has exhausted domestic remedies (see paragraph 100 above). In its view, even if it were to accept that she had been required to reformulate her claim, for the reasons set out below the conduct of the domestic proceedings does not disclose any breach of the positive obligation under Article 8 of the Convention.

113. The Court observes that the performance of the impugned procedure was noted in the applicant's medical records and, from some of the nine similar applications received by the Court, it is evident that some complainants issued domestic proceedings long before she did. However, there is no suggestion that the applicant was herself at fault for the delay in bringing her claim. Nevertheless, in view of the passage of more than fifty years since the symphysiotomy was performed, the applicant's claim inevitably posed considerable problems, both for the hospital, in defending it, and for the domestic courts, in ensuring – as Article 6 of the Convention requires – that the "equality of arms" principle was fully respected in the proceedings before it. In *Kearney* the High Court had considered that there would be a real and serious risk of an unfair trial if the plaintiff's original claim based on lack of consent was allowed to proceed in the absence of the actual testimony of the person who carried out the symphysiotomy. That claim had, however, been allowed to proceed on appeal after the plaintiff reformulated it so as to contend that there had been no justification whatsoever for the performance of a symphysiotomy following delivery of her baby by caesarean section. While this was certainly a more exacting standard, by removing any complaint about the manner in which the symphysiotomy was carried out, it rendered irrelevant the matter of missing contemporary records. The applicant followed suit and reformulated her claim accordingly.

114. As indicated previously, the Court has itself recognised the need to "protect potential defendants from stale claims which might be difficult to counter and prevent the injustice which might arise if courts were required to decide upon events which took place in the distant past on the basis of

evidence which might have become unreliable and incomplete because of the passage of time" (*Stubbings*, cited above, § 51). On the basis of the material available, the position adopted by the Irish courts was one which had been reasonably open to them when faced with the difficult task of balancing the plaintiff's right of access to court in relation to a medical procedure performed several decades previously against the defendant's right to a fair trial. As noted by the domestic courts, most witnesses and in particular the medical personnel who had performed the procedure were either deceased or their whereabouts were unknown. As such, by virtue of the fact of hearing the applicant's reformulated claim alone the Contracting State cannot be said to have exceeded the margin of appreciation afforded to it in ensuring that its positive obligation under Article 8 of the Convention was met.

115. Furthermore, although the issue of consent was not determined, nor indeed was that of prejudice, and the reformulated claim was ultimately rejected, the High Court nevertheless gave careful consideration to the prevailing medical standards in 1963, before finding that the prophylactic symphysiotomy performed on the applicant could have been clinically justified at that time (see paragraph 33 above). While the applicant was understandably disappointed by this outcome, this does not in and of itself mean that the respondent State failed in its positive obligation under Article 8 of the Convention (see paragraph 107 above).

116. Finally, although it has not proved necessary in the present case to examine the respondent State's exhaustion objections, the Court notes that at no stage at domestic level, either before the Court of Appeal or the Supreme Court, did the applicant call into question the adequacy of the reformulated and narrower basis on which she had decided to pursue her claim following the Supreme Court judgment in *Kearney*. If she had considered that this reformulation itself gave rise to a violation of her Convention rights, it was open to her, and indeed incumbent on her, to challenge this. However, this perceived consequence of *Kearney* was not subject to appeal and was not therefore raised before the Court of Appeal or Supreme Court.

117. The applicant further complains that there has never been an independent and thorough investigation into the practice of symphysiotomy in Ireland from the 1940s to the 1980s. In this regard, the Court reiterates that, in the absence of bad faith on the part of the doctors involved, it has found that the positive obligation to set up an effective judicial system does not necessarily require the provision of anything other than a remedy in the civil courts, enabling any liability of the doctors concerned to be established and any appropriate civil redress, such as an order for damages and for the publication of the decision, to be obtained (see, for example, *Calvelli and Ciglio*, cited above, § 51; *Vo*, cited above, § 90; and *V.C.*, cited above, § 125). This is so even in cases concerning a medical practice which

affected a significant number of individuals. Therefore, in *V.C.*, a case concerning a practice of performing sterilisations without consent which had a disproportionate impact on Roma women, the Court rejected the applicant's complaint that the Slovak authorities had failed to carry out an effective investigation into her case, and it did not enter into any assessment of the more general investigation into the sterilisation of Roma women which had been initiated by the State (see *V.C.*, cited above, §§ 126-129).

118. As regards the very specific, historic circumstances of the present case, the Court recognises that it is difficult to accommodate the applicant's complaint within its existing case-law on the requirement to investigate. Viewed by the obstetric standards which now prevail, as well as the fact that the relevant legal standard of care and medical practice generally have evolved in the intervening decades, it is clear that antenatal, prophylactic symphysiotomies such as that performed on the applicant, given the physical and psychological trauma they might entail, would rarely be performed. However, as the Court has previously indicated, it must assess any related State responsibility in 2012-2017 without losing sight of the facts and standards which prevailed when the impugned medical procedure was performed in 1963, which was what the domestic courts had to assess (see, in relation to Article 3, *O'Keeffe v. Ireland*, cited above, § 143). In the applicant's case, as noted previously, the High Court found that the practice of prophylactic symphysiotomy in 1963 was not a practice without justification and that such a procedure without trial of labour was a reasonable although limited option. This assessment was endorsed by the Court of Appeal, which noted that the procedure was performed for a range of clinical reasons which at the time were approved by those at the very top of the obstetric profession in the respondent State. The applicant's own experts conceded that a vaginal delivery would not have been possible. In line with the principle of subsidiarity, and in view of the fact that the information before it is not such as to render a reassessment of the facts and medical evidence by the Court "unavoidable" (see *Giuliani and Gaggio*, cited above, § 180), it is not possible for it to refute the domestic courts' position in relation to the standards of practice and medicine in the respondent State at the relevant time and as regards the justification or therapeutic necessity for the procedure in the applicant's case.

119. The Court notes that the respondent State has not remained inactive in the face of the considerable controversy which has, in recent years, surrounded the use of symphysiotomy in Irish maternity hospitals in the second half of the twentieth century. First of all, in late 2003 the Health Service Executive put in place a support system for women who had undergone symphysiotomies (for details, see paragraph 15 above).

120. In addition, in 2011 the Government commissioned the Walsh report, whose purpose was, in essence, to critically appraise the practice of symphysiotomy in Ireland from 1944 to 1984. The report was comprised of

both an independent academic research report and a further report based on interviews with individuals directly involved in symphysiotomies, such as mothers, practitioners and midwives. Contrary to the applicant's submissions, the Court finds no reason to doubt the independence of Professor Walsh. Her report provides an overview of the context in which symphysiotomy was reintroduced in Irish maternity hospitals, the situations in which it was employed, the likelihood that patients' informed consent was first obtained, and the long-term complications associated with the procedure. Furthermore, having met with persons affected by symphysiotomy, she described their personal experiences and as a consequence identified two common failings which had contributed significantly to the poor outcome experienced by many women: the failure to inform them that a symphysiotomy had been performed; and a poor standard of aftercare.

121. This was followed in 2013 by a non-statutory review by Judge Yvonne Murphy with the aim of finding closure for women who had undergone a symphysiotomy procedure (see paragraphs 66-71 above). In her report published in 2014, Judge Murphy recommended that the State implement an *ex gratia* payment scheme. In doing so, she acknowledged that although symphysiotomy had been "an exceptional and rare intervention in obstetric practice in Ireland", it was evident that many women who had undergone the procedure did not have good experiences. She further acknowledged that the civil claims for damages which were by then pending were fraught with difficulties for both plaintiffs and defendants due to the inordinate passage of time and the evidentiary difficulties in particular in relation to consent and causation.

122. Shortly after Judge Murphy's report was published, the *ex gratia* payment scheme was implemented (see paragraphs 72-87 above). While the application window was narrow, it is not contested that the scheme was widely publicised and that applications submitted after the closing date were also considered "where the balance of fairness favour[ed] consideration of the application" (see paragraph 72 above). An Independent Assessor was appointed and her determination of the quantum of the award was final and not subject to appeal.

123. Almost 600 women applied to the scheme and nearly 400 received awards. Two hundred and sixteen received a payment of EUR 50,000; 168 received a payment of EUR 100,000; and fifteen received the maximum payment of EUR 150,000. One hundred and eighty five applicants were unable to establish their claim.

124. Based on the operation of the scheme the Independent Assessor found no general pattern of injury and no evidence that symphysiotomy inevitably led to lifelong pain or disability if carried out correctly. She noted that a small number of applicants suffered from pelvic pain and a slightly larger group from urinary issues, but considered it impossible to now

determine whether the conditions were associated with prolonged labour, the use of forceps, parity, age or the symphysiotomy procedure. Her findings, based on an assessment of 500 complainants who had undergone symphysiotomies (out of the 1,500 which were performed in Ireland during the relevant period), are further detailed in paragraphs 76-87 above. The Court notes that the Harding Clark report was met with considerable ire by many women who had undergone the procedure and was criticised by the Commissioner for Human Rights for its "patronising tone". It is not for the Court to judge the latter or to speculate on whether sections of the report might or should have been expressed in a different manner. From the perspective of the respondent State's possible obligations pursuant to the Convention and on the basis of the material before it, the report's key findings related to those who had or may have undergone the procedure and the operation of the scheme and were based on an individual assessment of almost 600 applications.

125. The applicant has also criticised the *ex gratia* payment scheme on the basis that it was a device to pressure women to discontinue legal proceedings; it entailed no admission of liability on the part of the hospital, or failure of the part of the State; there was no provision for an individualised assessment of non-pecuniary damage; and the level of damages was not commensurate with the injuries she suffered. However, the applicant herself has alleged no substantive failure on the part of the State – it being remembered that her domestic claim was directed against the maternity hospital –, and an *ex gratia* payment scheme set up by the State could not be expected to entail an admission of liability for the actions of hospitals, not all of which were under its control. In any case, any such admission would clearly be inappropriate where, due to the passage of time, it was impossible to say whether many of the symphysiotomies that took place were medically justified and/or carried out with the patients' full and informed consent.

126. While the scheme did not provide for a fully individualised assessment of non-pecuniary damage, the level of award was based on the extent of injuries claimed and, to a limited degree, the hospital's culpability, with "on the way out" symphysiotomies automatically falling into a higher award bracket. Such awards of compensation do not *per se* offend against Article 13 of the Convention; for example, in *Tagayeva and Others v. Russia*, nos. 26562/07 and 6 others, § 625, 13 April 2017 the Court found no breach of Article 13 of the Convention where a compensation scheme was extended to all victims of a terrorist attack on a no-fault basis, and fixed awards were paid to the victims based on the degree of injury suffered. The award brackets under the *ex gratia* payment scheme were certainly lower than the award made to Mrs Kearney (the highest award available under the scheme was EUR 150,000, whereas Mrs Kearney had received EUR 325,000). However, this reflects the fact that not every woman who

underwent a symphysiotomy would be able to successfully claim damages in civil proceedings; those who were successful would not necessarily receive a similar award to Mrs Kearney; those who were not successful would be liable for the hospitals' legal costs; and in all cases the pursuit of civil proceedings would be costly, time-consuming, and stressful for the plaintiffs. Furthermore, as emerges clearly from the *Kearney* case, the amount of damages awarded reflected the fact that the procedure had been performed after the baby had been delivered and in circumstances where it was found that there was no justification whatsoever for its use (see paragraph 25 above).

127. In the Court's view, the value of the *ex gratia* payment scheme lay in the fact that it allowed those women who did not want to bring civil proceedings, or whose claims might not have succeeded, to obtain redress for the perceived injury without having to take the risk, or accept the burden, of pursuing a claim through the courts (see, for the establishment of a similar *ex gratia* payment scheme, *Allen,* cited above). The burden of proof required was much lower than would have been the case in legal proceedings and applicants were assisted in the location of their records and in meeting some of the legal costs incurred. It remained open to those who considered that they had a good prospect of obtaining a higher award through the civil courts not to apply to the scheme or to decline an award offered under it.

128. Although the parties in the present case disputed the availability and effectiveness of judicial review proceedings in relation to an *ex gratia* payment scheme such as that at issue in the present case, the Court notes the grant by the High Court of leave to issue judicial review proceedings in relation to the *ex gratia* payment scheme at issue in *Allen* (cited above, §§ 45 and 73). According to the information available to the Court, what was being challenged in that case was precisely whether the relevant *ex gratia* payment scheme, as operated, was compatible with the State's obligations under Articles 3, 8 and 13 of the Convention in the light of this Court's judgment in *O'Keeffe* (cited above) .

129. The Court has great sympathy with the plight of the applicant and the other women who only became cognisant of the fact that they had undergone a symphysiotomy several decades after the event. In the field of medical negligence, domestic courts and commentators have referred in recent years to attitudes of an earlier age, when medical paternalism was more widely accepted. In a case under Article 8 involving the field of gynaecology and obstetrics, the Court has emphasised that giving birth is a unique and delicate moment in a woman's life, encompassing issues of physical and moral integrity, medical care, reproductive health and the protection of health-related information (see *Dubská and Krejzová v. the Czech Republic* [GC], nos. 28859/11 and 28473/12, §§ 163 and 189, ECHR 2016). In that case, the Court found it appropriate to invite the

authorities of the respondent State to keep the relevant legal provisions under constant review, so as to ensure that they reflect medical and scientific developments whilst fully respecting women's rights in the field of reproductive health (ibid, § 189).

130. Nevertheless, in the present case, it would now be next to impossible for the domestic courts to conduct any meaningful – and, from the point of view of the defendant hospital, fair – inquiry into whether in her case the symphysiotomy had been performed with her full and informed consent. In these circumstances, where the actions complained of were not directly attributable to the State or to any of its agents, and were demonstrated not to have been carried out in bad faith or to have been unjustified by the relevant practice standards, the Court considers that in the particular circumstances of this case the civil proceedings, supplemented by the independent Walsh report, the *ex gratia* payment scheme, which enabled all the women who had undergone a symphysiotomy to obtain a not inconsequential award of compensation, and the provision of access, free of charge, to healthcare and individual pathways of care, sufficed to meet any obligation the State may have been under to provide redress.

131. In light of the foregoing, the applicant's complaint under Article 8 of the Convention must therefore be rejected as manifestly ill-founded pursuant to Article 35 § 3(a) of the Convention.

For these reasons, the Court, unanimously,

Declares the application inadmissible.

Done in English and notified in writing on 10 December 2020.

Victor Soloveytchik Section Registrar	Mārtiņš Mits President