Summary of Report Prepared by the Department of Health and Children

1. Background to the Establishment of the Lourdes Hospital Inquiry

1.1 The Medical Council received complaints from 15 patients treated by Dr. Michael Neary at Our Lady of Lourdes Hospital, Drogheda, between 1986 and 1998, including ten complaints alleging unwarranted peripartum hysterectomies. (A peripartum hysterectomy is an operation to remove the womb within 6 weeks of a delivery. It includes caesarean hysterectomy performed during caesarean section after the baby has been removed, and hysterectomy following vaginal delivery). The Council commenced an Inquiry in June 2000 and in July 2003 its Fitness to Practise Committee found that the facts in relation to the 10 complaints of unwarranted peripartum hysterectomy were proven. Dr. Neary was found guilty of professional misconduct, and in **September 2003 was struck off the Medical Register.** A detailed history of the events which gave rise to Dr Neary's removal from the Register is at Appendix A.

1.2 In its report the Medical Council stated, inter alia, that :

"The medical culture in Drogheda was different and, in particular, a mode of clinical management was adopted that led to this difference.

What occurred in these cases in Drogheda was unacceptable both by the standards which should have prevailed in that hospital, by the standards which the patient had a right to expect and by the standards prevalent generally in this country.

There was substantial evidence of a curious internal and external culture of isolation and absence of consultation within Our Lady of Lourdes Hospital."

1.3 Arising from the report the Government decided in April 2004 to establish a non-statutory inquiry - the Lourdes Hospital Inquiry - with the attached terms of reference (Appendix B). Judge Maureen Harding Clark was appointed as chairperson of the Inquiry. The Inquiry operated within an agreed budget of €3m.

2. Purpose of Lourdes Hospital Inquiry

2.1 The Inquiry was required to determine how many caesarean and peripartum hysterectomies were carried out at Drogheda and to compare that rate with that in other similarly sized units throughout the State. It was required to determine how the medical culture in Drogheda was different to that in other hospitals, and how the standards of maternity care were allowed to fall so far below what should be expected. It sought to determine whether the obstetricians and their

practices were protected by any parties who knew or ought to have known of these practices. It tried to determine the extent of missing records and how these records came to be missing. Finally, the Inquiry reviewed the systems now in place and has advised whether those systems are adequate to prevent a recurrence of the events at Drogheda.

2.2 The Inquiry received widespread co-operation and conducted almost 320 interviews with 280 witnesses.

3. What the Inquiry found

3.1 The Inquiry came across people who held simplistic reasons and explanations that demonise Dr. Neary and staff in the Maternity Unit. They also came across others who hoped that the Inquiry would prove the Medical Council wrong and find an innocent explanation for what occurred.

3.2 The Inquiry uncovered a complex story set in a time of unquestioning submission to authority, whether religious or civil, when nurses and doctors were in abundant supply and permanent jobs were few and treasured. It is the story of a relatively small but very busy hospital which operated by a separate and unique set of rules, and which was not accountable to what would today be regarded as objective medical standards.

Dr. Neary's fall from grace is not a simple story of an evil man or a bad doctor, nor is it a story of wholesale suppression of facts. The facts were there for all to see and the operations were openly recorded. It is not the story of a surgeon with poor surgical skills or a doctor deficient in academic excellence. It is the story of a doctor who, at critical points during his training, was inadequately supervised. He came to work in a unit which lacked leadership, peer review, audit or critical capacity. It is the story of a doctor with a deep fault line and a misplaced sense of confidence in his own ability. The Inquiry found that no one who worked with Dr. Neary suggested that he had any ulterior motive for what he did. **Few complained or questioned.**

3.3 The Inquiry found the number of peripartum hysterectomies performed at Drogheda to be "truly shocking". A total of 188 peripartum hysterectomies were carried out in the 25 year period 1974 – 1998. Of this figure 129 cases are attributed to Dr. Neary alone, 53 of which were carried out from 1990 to 1998 following the transfer of the obstetric service to a new unit. The Inquiry found that Dr. Neary's caesarean hysterectomy patients had a different profile compared with the rest of the unit. Firstly they were younger and were of lower parity (i.e. had a lower number of children). Secondly Dr. Neary's antenatal clinic included a higher proportion of problem pregnancies and a higher proportion of repeat sections than the other consultants.

3.4 **(i) None of the obstetricians** who worked with Dr. Neary at Drogheda was aware that there was a culture of early resort to hysterectomy. They were unaware of their own unit's numbers.

(ii) **The anaesthetists** felt in retrospect that Dr. Neary may have been a little hasty to resort to hysterectomy. However, none were consulted by the obstetricians before a hysterectomy was carried out, nor would they have expected to be.

(iii) **The pathologists** assumed that some hysterectomies were sterilisations. However, they were unaware of the cumulative number of hysterectomies carried out in the unit.

(iv) Some **junior doctors** felt a special gratitude to Dr Neary for his time in assisting them with obstetric emergencies. The obstetric registrars were complimentary of Dr Neary's surgical skills and generally had no concerns about the hysterectomy rate. Other junior doctors described unhappy experiences with the consultants. They were disturbed by the lack of meetings, teaching and discussion. In common with some of the midwives and anaesthetists, they described how Dr. Neary could not adapt to new procedures, nor did he find it easy to delegate.

(v) The numbers of caesarean hysterectomies carried out by Dr. Neary in 1978/79 caused the Matron some concern. Her concerns were not heeded. The Matron was afraid to speak out further as she believed he had been reviewed and found acceptable. A temporary midwifery tutor followed up the cases around the same time and formed the view that neither the surgeon's notes nor the pathology reports revealed any findings to warrant hysterectomy. She did not contact any clinician outside the hospital, the Medical Director, the pathologist or the senior obstetrician.

No other person or institution raised any issues until October 1998 when two midwives, who were consulting the Health Board Solicitor on an unrelated matter, sought his advice on serious concerns which one of the midwives had about Dr. Neary's practices.

(vi) The **Royal College of Obstetricians and Gynaecologists** (RCOG) inspected the Maternity Unit in 1987 and 1992 and found it to be suitable for training obstetric registrars. In 1992 the RCOG made a series of recommendations to the Maternity Unit. No return visit was planned to ensure implementation and no efforts were made to determine whether the recommended changes were effected. The hospital was advised that tubal ligation should be introduced as a choice for patients. On neither occasion were the recommendations made by the RCOG fully implemented. The hospital abandoned annual reports with the last one produced for 1984.

(vii) The **Royal College of Surgeons in Ireland** approved the Maternity Unit for undergraduate training.

(viii) **An Bord Altranais** carried out periodic assessments of the midwifery school at the maternity hospital for accreditation purposes. They advised in 1980 that women should be offered a full choice on contraception and that midwives ought to be fully trained on these methods. Nothing happened.

3.5 The Inquiry found that management's initial response to the revelations about Dr. Neary's practice was prompt and appropriate. The decisions made and the procedures introduced to deal with the situation at the time were courageous and correct. However management's role and actions in addressing the major structural, operational and personal deficits in the Maternity Unit and the hospital since 1998 have been slow and unsatisfactory. Only now in 2006 are most of the elements in place.

3.6 In considering **the report prepared by the three consultants at Dr Neary's request**, the Inquiry concluded that this report was prepared on a confidential basis to enable Dr. Neary to continue working and that the three obstetricians involved have since had serious regrets for their part in the exercise which was motivated by compassion and collegiality. The Inquiry considered that the consultants ought to have been alarmed that one obstetrician had carried out 17 caesarean hysterectomies in three years in a middle sized Maternity Unit.

3.7 Missing records

The Inquiry is satisfied that a person or persons unidentified, who had knowledge of where records were stored and who had easy access to those records, was responsible for a deliberate, careful and systematic removal of key historical records which are missing, together with master cards and patient charts. Three alterations to the maternity theatre register detected by the Inquiry appear to have been made in the same hand and apparently were made after complaints were made against Dr. Neary. Most of the missing records refer to Dr. Neary's patients. The Inquiry concluded that someone with a misplaced sense of loyalty to Dr. Neary or the unit is probably responsible.

3.8 The Hospital and the ethos of the Medical Missionaries of Mary (MMM)

(i) In May 1997 the North Eastern Health Board formally took over the ownership of the Lourdes Hospital, the biggest hospital in the region. It had previously been owned by the MMM who ran a very ordered hospital in an austere and dedicated manner. The religious ethos of the hospital up to 1997 was to provide services that accorded with the ethos of the Roman Catholic church, including its teachings on human reproduction**.**

(ii) The Lourdes Hospital was, and still is, a major employer in the region and jobs there were eagerly sought after. Job insecurity may have influenced a climate of silence. Consultants could, and did cause nurses to be transferred. Several midwives who had been students in the Midwifery School described being fearful of voicing any criticisms of consultants. Those former students described how they believed that they would be dismissed if they crossed a consultant.

(iii) There were only two Matrons in the Maternity Unit between 1954 and 1998, and between 1945 and 1997 there were only 4 consultant obstetricians. Over the years a loyalty developed between the senior nurses and those consultants. The same anaesthetists and pathologists were in the hospital for decades. No new consultants were appointed between 1983 and 1996. As the hospital was owned and managed by a religious order, continuity at management level was assured. The nuns produced catholic nurses who were hardworking, respectful, who fitted their mould and were trained to certain tasks – and to those tasks only.

(iv) The Inquiry found that the Hospital developed an extraordinary cocoon of confidence and self assurance. It simply did not occur to anyone within the body of management in the hospital that practices in the Maternity Unit were different from the accepted norm.

(v) The Inquiry formed a strong suspicion that a number of planned hysterectomy procedures were carried out because of the ethos at the hospital which forbade contraception or sterilisation. Tubal Ligation - i.e. the tying off a woman's fallopian tubes to prevent the passage of ova to the uterus for fertilization - was not permitted for contraceptive purposes or in situations where the procedure may be necessary for medical reasons to protect a woman. The only family planning advocated and permitted was the natural method of the safe period, or the Billings method. Sterilisation for contraceptive purposes was not permitted. The catholic ethos allowed for "indirect sterilisation" where the primary purpose was to protect the mother's health. The accepted practice in Catholic hospitals was to "isolate the diseased organ" by removing the uterus.

(vi) The MMM had no worries regarding the ability of any of the consultants. In general, they did not accept that the prohibition on sterilisation for contraceptive purposes, or the non-availability of contraceptive advice apart from natural methods, played any part in the number of peripartum hysterectomies. It was their belief that the strict Catholic position on sterilisation did not prohibit the carrying out of a tubal ligation for medical reasons. Although this position was disputed by the Matron of the Maternity Unit and by the two consultants working there while the hospital was still in the ownership of the MMM.

(viii) The Inquiry found it very difficult to understand how the MMM allowed the Maternity Unit to operate in isolation from normal standards and without

any outside comparisons or audit. The records were there for them to read and collate and compare with figures at their other Maternity Unit in Waterford. The Inquiry found it hard it understand that the MMM believed that consultants could not be challenged in their clinical judgement. There was no evidence that Dr. Neary was protected by the sisters of the MMM.

(ix) The Inquiry however rejected the evidence given by Dr Neary that 75% of hysterectomies performed by him were attributable to the ethos of the hospital.

3.9 The Patients

The Inquiry found that many of the women used modern family planning to space their families. They accepted the Catholic ethos of the MMM, but they did not let it interfere with their personal decision about family planning. Only one former patient interviewed by the Inquiry admitted to a consent hysterectomy, and the patient charts in two cases contained written consents.

The Inquiry heard very few horror stories, and noted a pattern of conduct. For the most part, the patients were not told of their hysterectomies until some time had elapsed. Very few patients questioned Dr. Neary for carrying out the hysterectomy but those who did, found that his attitude became defensive and unfriendly when he was challenged. Several patients were absolutely convinced that their lives had been saved by Dr. Neary. For every adverse comment the Inquiry heard about him, they heard at least one in his favour. The most common complaint from patients was how doctors carried out procedures on them without discussion beforehand.

4 <u>Position in 2006</u>

There have been major changes in practice in the Maternity Unit to minimise or entirely remove the climate of isolation referred to in the Medical Council report. The Inquiry found that much progress has been made in improving standards at the Unit. The incidence of peripartum hysterectomy has fallen precipitously and now accords with national rates.

There are now seven consultant obstetricians which should facilitate improved clinical audit and clinical governance. The current consultants have developed a strong collegiate approach to practice. The Unit is moving forward and offering care that is evaluated against known benchmarks.

The Inquiry found the Medical Board and the new consultants have the motivation, the skills and the energy to move the hospital forward as a fully recognised teaching hospital with specialist registrar training in all their departments. All hysterectomies carried out now involve teamwork and at least two obstetricians and two anaesthetists. The midwives have attended skills updating and management courses.

There are many new and highly qualified consultants in place to bring the hospital close to specialist training status in most fields. Regular multidisciplinary meetings are held and attended where discussions on outcomes takes place. The radiologists and pathologists meet regularly with the obstetric department to review cases.

5. Conclusion

The facts uncovered by the Inquiry reveal that

- any isolated institution which fails to have in place a process of outcome review by peers and benchmark comparators can produce similar scandals as those which occurred in the Lourdes Hospital.
- support systems must be in place to conduct regular and obligatory audit.
- there must be mandatory continuing professional development and skills assessment at all levels of healthcare.
- staff need to attend updating of skills and methods programmes and should be able to recognise that procedures change in accordance with evidence based research.
- outmoded and unnecessary practices ought to be recognised as such and changed as soon as information is available.
- hospital management should have more authority and training and should have medical input.
- clinical independence should no longer be interpreted as a licence for arrogance, disregard for patient choice, dignity and need or freedom from accountability.

In summary, the Inquiry found a Maternity Unit that was to some extent caught in a time warp. There was no badness or cover up. It took a series of high profile inquiries in the UK to realise that organised resourced systems must be in place to evaluate outcomes and competence and to act on unusual results. The Inquiry found it highly probable that some mothers' lives were saved when hysterectomy was the only procedure to stop intractable haemorrhage.

There must be functioning monitoring bodies. While the numbers of the procedures established in Drogheda Maternity Unit may be startling, they have to be understood in the context in which they occurred. Good hardworking decent people can unwittingly enable bad practice when support and safety systems are not in place.

Finally, Judge Clark concluded based on the almost complete cooperation received from witnesses that a private non-adversarial inquiry can be effective.

Appendix A

History of events relating to Dr Neary's removal from the Register

1.1 The Medical Council's decision to remove Dr Neary from the Register of Medical Practitioners followed a series of investigations into his practice. In **October 1998** two midwives working at the Maternity Unit of the Lourdes Hospital reported their perception that Dr. Neary was carrying out an unusual number of caesarean hysterectomies and that some of his clinical practices seemed out of date.

1.2 **In October 1998** Dr. Neary was asked by the Board to take administrative leave. The Board became better informed in relation to the number of cases performed and sought to extend his suspension pending review of his cases of caesarean hysterectomy between 1996 and 1998 by the Institute of Obstetricians and Gynaecologists in Ireland. (It was erroneously believed at the time that the rate was acceptable before 1996.). Dr. Neary consented to this audit, but separately sought to have a number of his cases reviewed by three consultant colleagues attached to the major teaching hospitals in Dublin. **The consultants reviewed 9 cases and concluded that Dr. Neary had no case to answer and that his practices did not present a danger to patients**. Dr Neary returned to work subject to restrictions and the Board sought an independent view outside the State.

1.3 The Health Board engaged Mr. Michael Maresh, Consultant Obstetrician at St. Mary's Hospital in Manchester, and an advisor to the Royal College of Obstetrics and Gynaecology. He reviewed the same nine cases and reported in December 1998. **He believed Dr. Neary's clinical judgement to be significantly impaired and that women appeared to be put at risk**. He also had concerns about other aspects of Dr. Neary's management of patients and expressed concerns about his skills at caesarean sections with complications. Following receipt of Mr Maresh's report the CEO of the Health Board instructed Dr. Neary to take immediate administrative leave.

1.4 Media coverage of Dr Maresh's report was such that the Fitness to Practice Committee of the Medical Council became involved. It sought Dr. Neary's suspension through the High Court pending an inquiry into his practice. **He was suspended from practice by Order of the High Court in February 1999 and resigned from the practice of medicine in June 1999. He has not practised since**.

1.5 **The Institute of Obstetricians** reviewed the case notes of those of Dr Neary's patients who were identified as having undergone peripartum caesarean hysterectomy between 1992 and 1998. **In April 1999 the Institute found that Dr Neary had a 5% rate of caesarean hysterectomy for caesarean sections performed. Out of 39 cases reviewed, they found that 18 represented unacceptable practice, 5 were doubtful and in 16 cases Dr Neary's practice was acceptable.** They expressed concern that Dr Neary's treatment of blood loss

resulted in hysterectomies being performed at a low threshold. Dr Neary claimed that his rate of caesarean hysterectomy would have been lower had he been permitted to carry out tubal ligations (sterilisations). The review group had difficulty accepting Dr Neary's argument that he would lose his job if he carried out a tubal ligation.

1.6 The Medical Council reported on 29 July 2003 and decided that Dr. Neary's name should be erased from the Medical Register after finding him guilty of professional misconduct in relation to the unnecessary removal of wombs from 10 patients between 1986 and 1996.

Appendix B

Terms of Reference

1. To examine the rate of peripartum hysterectomy at Our Lady of Lourdes Hospital, Drogheda ("the hospital") with particular reference to the period covered in the report of the Fitness to Practise Committee of the Medical Council ("the report") and the period since the publication of that report and to determine how this rate compared with the rate in other Maternity Units of similar status.

2. To ascertain what system of recording of peripartum hysterectomy took place at the Hospital; to ascertain whether all expected records are now extant; and, if not, to inquire into what has become of such records.

3. To inquire into whether Dr. Neary's practice in relation to peripartum hysterectomy was commented on or acted upon by Consultants or other medical staff, by midwives and other nursing staff within the hospital, or by the management of the hospital.

4. To inquire into what, if any, review and consultation took place, either within the hospital, or externally following peripartum hysterectomy.

5. To ascertain whether periodical clinical reports were prepared by the Maternity Unit at the hospital and, if so, the purpose of those reports; to whom they were furnished; and the action, if any, which was taken on foot of those reports.

6. To inquire into what practices and protocols have been adopted at the Maternity Unit of the hospital since October 1998 or arising from the publication of the Report.

7. To advise the Minister for Health and Children on whether additional protocols and systems of control should now be put in place to prevent a recurrence of the events that gave rise to the findings of the Report.

8. In the event of the withholding or withdrawal of full co-operation from the Inquiry by staff or former staff of the hospital, by the North Eastern Health Board, its servants and agents, the former proprietors of the Hospital or any State authority, or any suggestion that co-operation is being withheld, to report that fact immediately to the Minister.

9. In the event that the Inquiry cannot produce a final report within 9 months of the date of appointment by the Minister, the Inquiry will submit a progress report to the Minister.

Term of Reference 1 The Rate of Peripartum Hysterectomy

1.1 Rate at Drogheda

- The number of peripartum hysterectomies (includes both caesarean hysterectomy and hysterectomy following vaginal delivery) carried out in the Lourdes Hospital between 1960-2004 is as follows:

	Deliveries	*P/Hysts*	*C/Hysts*	*Rate P/H per Delivery*	*C/Sections*	*Rate C/h per C/Sec*
1960-1973	**29979**	**31**	**15**	**1 per 967**	**1023**	**1 per 68**
1974-1998	**52983**	**188**	**163**	**1 per 282**	**5992**	**1 per 37**

- Of the 188 peripartum hysterectomies carried out between 1974 and 1998 (Dr. Neary's period of employment at Drogheda), 163 followed caesarean section and 25 followed vaginal delivery.
- This equates to a rate of 1 peripartum hysterectomy per 37 *sections*, or 1 per 282 deliveries.
- The rate at the hospital since 1999 has fallen to 1 per 2,569 deliveries, or 1 per 642 sections.
- Only eight peripartum hysterectomies were performed between 1999 and 2005. On each of the eight occasions at least two and usually more consultant obstetricians were involved in the operation.
- The rate from 1999-2005 has dramatically improved and this indicates that lessons were learnt very quickly once the rate in the unit became apparent. Far greater efforts were made since 1998 to preserve the uterus even when faced with massive haemorrhage. The earlier practice of removing the uterus because of its condition, or for sterilization purposes, was discontinued.

1.2 Comparison With Other Similar Maternity Units

- The rate at Drogheda was significantly higher than in other similar units.
- The rate *per section*, over a period of about 30 years, in hospitals that formerly had a similar ethos was:

- Airmount (Medical Missionaries of Mary), Waterford 1 per 300
- Portiunciula (Franciscan), Ballinasloe 1 per 254

(Airmount ceased to be a Maternity Hospital in 1995, and Portiunciula was purchased by the former Western Health Board in 2001)

The rate *per section* in other non-Dublin maternity hospitals:

-St Finbarr's Cork (1973-2003) 1 per 315
-Erinville Cork (1970-2003) 1 per 315

- The Fitness to Practice Committee of the Medical Council had compared the rates of caesarean hysterectomy per *section* for the years 1993 to 1998 as:

-Coombe Women's Hospital	1 per 600
-National Maternity Hospital	1 per 405
-Our Lady of Lourdes Hospital	1 per 42
-Dr Neary	1 per 20

1.3 Additional Data (1974-1998)

- The breakdown of the 188 peripartum hysterectomies performed at Drogheda from 1974 to 1998 by consultant is as follows:
  - 129 attributed to Dr. Neary (!974-1998).
  - 40 attributed to Dr. Lynch (1982-1998).
  - 8 attributed to Dr Connolly (1974-1980).
  - 2 attributed to Dr. O'Brien (1974-1996)
  - 3 attributed to Dr Wehab (1996-1997)
  - 2 attributed to Dr O Coigligh (1998)
  - 1 attributed to Dr Barde (1996)
  - Of the remaining three, two were carried out by registrars and one is unattributable..
- A new Maternity Unit opened in a newly built premises attached to the main hospital in 1991. In the succeeding period 1992-1998 inclusive, the Inquiry has established that 77 peripartum hysterectomies were performed, of which 46 should be attributed to Dr. Neary, 22 to Dr. Lynch and 9 to other consultants.
- The Inquiry found it significant that the numbers were at their highest following the move to the new unit, when it might have been expected that practice would be more closely monitored.
- Dr. Lynch's patients tended to be older and of higher parity (number of pregnancies). Conversely, Dr. Neary's patients were often young women (51 were in their first or second pregnancy).
- After his suspension, Dr. Neary told the Institute of Obstetricians and Gynaecologists Review Group that 8 of his hysterectomy cases between 1996 and 1998 were carried out for the purpose of sterilization. He claimed that tubal ligations were prohibited at the hospital. However he subsequently told the Medical Council's Fitness to Practise Committee that there had to be a *medical* reason for hysterectomy.
- A survey conducted by the Inquiry of 124 Irish obstetricians (78 replies) indicates that the number of hysterectomies attributed to Dr. Neary and the Unit is far in excess of those in other hospitals including in smaller outlying hospitals where the workload was heavy and access to second opinion was not always available.

Term of Reference 2 - System of Records

2.1. Sources

- The vast majority of peripartum hysterectomies were recorded in the maternity theatre register. The remainder were recorded in the gynaecology register e.g. following vaginal delivery and subsequent post-partum haemorrhage.
- The only theatre register available was the 1991-2003 register and many of the birth registers were also missing. The previous register, which covered the period from 1960, could not be found, although some midwives believed that it was in the labour ward up to October 1998. The Inquiry believes that the register was deliberately taken from the hospital. Other records missing include master cards and patient charts. This seriously hampered the Inquiry although various secondary records were available.
- The only limited records available to this group of 44 patients are the theatre register entries (in cases pre-1992 even this is not available), the pathology records or expert review of pathology slides.
- The gynaecology theatre register disappeared temporarily during the course of the Inquiry. The Inquiry believes that the register was returned when suspicions were aroused.

2.2 Findings

- The Inquiry is satisfied that it has identified the names of all 188 patients who underwent peripartum hysterectomy between 1974 and 1998.
- The Inquiry concluded that 23.4% of obstetric hysterectomy records (44 cases) for this period are missing and that they were intentionally and unlawfully removed from the hospital with the object of protecting those involved in the hysterectomies or in protecting the reputation of the hospital.
- In 40 of the 44 cases, the birth registers are also missing.
- The consultant breakdown of the 44 missing records is as follows: 38 are patients of Dr Neary; 4 of Dr Lynch; 1 of Dr Connolly; and 1 is unattributed.
- While the vast majority of the missing records relate to procedures attributed to Dr Neary, the Inquiry notes that the removal of all records of the patient details obliterated all trace of those present or assisting at the operations. This includes details of junior doctors, anaesthetists, midwives and theatre nurses.
- The Inquiry discovered some very alarming alterations to the 1991-2004 register. The alterations indicate deliberate attempts to prevent a full determination of the number of peripartum hysterectomies carried out.
- The documents appear to have been removed and entries altered with the intent of removing evidence and of creating an impression that carelessness in

filing, storing and recording would be seen as the reason for key charts and records to be unobtainable.

- The storage of documents was adequate to protect their integrity from all but mischievous intent.
- For the women affected they will never be able to have an expert review of their file to advise whether their operation was justified or not.
- Those responsible had to be familiar with the hospital and be persons whose presence in the Maternity Unit would not raise suspicion. Keys had to be located and used and the documents had to be removed without causing suspicion and ultimately they had to be disposed of, destroyed or secreted. The Inquiry doubts that any further records will be recovered at this stage.
- This system of recording created an impression that, prior to 1996, Dr. Neary's rate of peripartum hysterectomy was unremarkable.
- It is clear that no one reviewed the contents of the patient charts or the quality of record keeping or the security of the storage systems before 1999.

Term of Reference 3 Was Dr Neary's Practice Commented or Acted on in the Hospital

3.1 Findings

- The Inquiry found a pervasive culture of acceptance and acquiescence of consultant activity. To ask why, or to comment was not a part of everyday practice.
- There were many reasons advanced from management and staff, including:
  -they were not informed;
  -all the hysterectomies were carried out for a very good reason;
  -there was no audit;
  -no one knew what an acceptable rate was .
- The isolation of the unit played a large part in the lack of awareness.

3.2 Were Concerns Raised by Staff?

- Around 1980, the Matron of the maternity hospital expressed concern about Dr. Neary's rate to Dr. Connolly, senior consultant obstetrician, who told her not to worry, that Dr Neary was "afraid of haemorrhage". The Matron felt that he was indicating to her that she should back off.
- She tried speaking to Dr.O'Brien, the other obstetrician there, and his response was to indicate by gestures that she should not persist. Dr. O'Brien told the Inquiry that he was not responsible for other clinicians, he had no authority to question Dr. Neary, and any concerns that the Matron had should have been raised with Dr. Neary's employers. He had to work with him.
- A temporary midwifery tutor followed up the cases around the same time and formed the view that neither the surgeon's notes nor the pathology reports revealed any findings to warrant hysterectomy. She did not contact any clinician outside the hospital, the Medical Director, the pathologist or the senior obstetrician.
- The midwives divided into those who had no concerns then or now; those who are deeply shocked at the extent of the hysterectomies; junior midwives who were beginning to have some deep misgivings about the young mothers had undergone caesarean hysterectomy.
- One other midwife who came to the Lourdes Hospital in late September 1997 was taken aback by some of the practices that she observed there. Her colleagues told her that there was nothing anyone could do unless a patient actually complained. She eventually made her concerns known to the NEHB solicitor in October 1998, and this instigated the action taken by the NEHB to begin investigation of Dr Neary's practice..
- During the early years of Dr. Neary's tenure, his colleagues were aware of the number of peripartum hysterectomies but they did not consider the possibility that something was wrong.

- The Inquiry found that an analysis of Dr. Neary's hysterectomy rate in 1978/79 should have raised legitimate queries- he carried out 12 in those two year.
- Between 1974-1979 inclusive there were 28 such operations, 20 of which were performed by Dr. Neary. The figures were published and disseminated openly but no one commented or questioned the figures.
- The Inquiry sought to establish why the caesarean hysterectomy rate rose so dramatically from about 1991 without comment.
    - in 1989 there were 6 peripartum hysterectomies,
    - in 1990 there were 3 peripartum hysterectomies
    - in 1991 there were 12 peripartum hysterectomies
    - in 1992 there were 8 peripartum hysterectomies
    - in 1993 there were 15 peripartum hysterectomies
- During the early years of Dr. Neary's tenure, his colleagues were aware of the number of peripartum hysterectomies but they did not consider the possibility that something was wrong.
- The anaesthetists said that it was unheard of for an anaesthetist to challenge a surgeon. If an obstetrician said a uterus had to come out, they would not question his judgement. No one expressed alarm, concern or curiosity. All three anaesthetists who were at Drogheda for many years expressed the view that Dr Neary practiced an extreme form of defensive medicine.
- The most senior of the pathologists believed that the nuns ran the hospital and that the Medical Board had no power other than to advise the nuns. The second pathologist’s view was that the consultant obstetricians were untouchable and beyond criticism, but he was unaware of the extent of the practices.
- In 1996 several new consultants were appointed to the hospital staff, the first new appointees since 1983. None had any worries about Dr Neary and were generally unaware that anything about his practice warranted concern.
- Training seems to have produced a large body of nurses and junior doctors who looked only at their particular task in hand and no further. This began to change only when it was clear that the Health Board was taking over.
- Amongst Junior Doctors, lack of communication was a common observation.
- Some registrars who had been exposed to obstetric practice in other Irish hospitals believed that Dr. Neary moved to hysterectomy too quickly in postpartum haemorrhage but they were afraid to discuss anything openly. Each consultant had a personal approach in relation to a whole range of obstetric emergencies.
- No patient, as far as the Inquiry could ascertain, ever complained about Dr. Neary's clinical treatment until 1998 and the complaints related to rudeness, abruptness or shouting at midwives or patients and were not confined to Dr. Neary.

3.3 Hospital Ethos

- The Inquiry found that hysterectomy was carried out in Drogheda where in other hospitals tubal ligation or safe methods of contraception would be advised. The Medical Missionaries of Mary (MMMs) have recorded their objections to this finding. They state that it was not put to any of their members, nor are they aware of any evidence that peripartum hysterectomies were carried out as a form of sterilization.
- The Inquiry however rejected the evidence given by Dr Neary that 75% of hysterectomies performed by him were attributable to the ethos of the hospital.
- The prevailing insular atmosphere of the unit that never questioned, reviewed or audited outcomes, allowed hysterectomies for perceived haemorrhage to continue at unacceptable rates throughout the last 10 years of Dr. Neary's practice.
- The religious ethos and the hierarchical system must not be judged harshly and must be seen in the context of the times.
- The Inquiry found no evidence that the Medical Missionaries of Mary (MMM) ever perceived that Dr. Neary was doing anything to harm patients.
- Almost every MMM interviewed stated that she had no knowledge of the peripartum hysterectomy rate.

3.4 Conclusions

- Dr. Neary had a morbid sensitivity to haemorrhage when carrying out surgery and it is highly probable that fear of losing a patient approached phobic dimensions.
- He believed then and now that if he had the right to advise in favour of contraception and tubal ligation to women whose uterus or health would make further pregnancy dangerous, his hysterectomy rate would have been reduced by 75%, with the other 25% attributable to peripartum haemorrhage. This claim is rejected by the Inquiry.
- The Inquiry finds that somewhere along his career Dr Neary perceived hysterectomy as a haemorrhage and lost sight of the norms operated in every other hospital in Ireland.
- When confronted with the detail, especially of young low parity women, Dr Neary was taken aback and admitted that during the 1990s his treatment of post partum haemorrhage was deficient.
- Dr Neary’s specialist training took place under the tutelage of gynaecologists rather than obstetricians It is probable that he was recruited to the Lourdes for his surgical skills in gynaecology. His training would nowadays be considered deficient.
- Dr. Neary's air of competence and confidence in the theatre and in other areas of obstetrics and gynaecology concealed his defensive practices and masked appreciation of his fear of haemorrhage from colleagues.

- Somewhere along his career, Dr. Neary perceived hysterectomy as a haemorrhage preventative and lost sight of the norms operated in every other hospital in Ireland.
- The numbers of caesarean hysterectomies carried out by Dr. Neary in 1978/79 caused the Matron some concern. Her concerns were not heeded. The Matron was afraid to speak out further as she believed he had been reviewed and found acceptable.
- The Matron was not given the power to properly administer the Maternity Unit, to question the consultants or to change procedures and she lacked the support of the MMMs if a dispute arose. The Inquiry believes that the purpose of a visit to a clinical unit must or should involve some assessment of the quality and standard of care delivered to patients.
- A temporary MMM midwifery tutor had concerns at the same time. She did not bring her concerns to the MMMs or to any person in authority.
- No other person had any concerns until the late 1990s when hysterectomy was carried out on a number of young women of low parity.
- There was no mechanism, after the maternity clinical reports had ceased in 1984, for anyone in the hospital to be aware of the cumulative annual figures unless they looked through the maternity theatre register and counted the procedures themselves.
- It is vital to have an objective review system in place in every hospital where outcomes are measured against accepted norms, and serious deviations are examined dispassionately for explanations.
- Doctors must go through regular retraining and skills assessment and their results must be subject to objective audit.
- No visiting committee from the British or Irish bodies or from An Bord Altranais ever identified any concerns regarding any clinical practices.
- The Inquiry is not convinced that the lack of computerisation played a major role in the failure to question practices. Even without computerised data the caesarean hysterectomies were always recorded in the periodic reports that continued until 1984. No queries were raised by any recipients of those reports about the caesarean hysterectomy rates.
- There was little evidence of appreciation by Health Board management that audit must be resourced and protected time must be set aside for department wide audits.
- Until very recently, there was no clinical audit committee or multidisciplinary audit. This is only scheduled to change in 2006.

Term of Reference 4 What Review and Consultation Following Peripartum Hysterectomy?

4.1 Findings

- There is no good reason why regular meetings and discussions on adverse or unusual outcomes did not take place. The hospital was recognized as a teaching hospital for obstetrics and gynaecology.
- Dr Neary trained in a hospital (Portsmouth) where formal discussions on adverse outcomes took place. There is no evidence that clinical meetings took place during his period as a consultant in Drogheda. There was no formal discussion between the consultants about why the procedure was necessary or whether anything could be learned from the experience.
- From 1974, Dr Neary was responsible for producing the Maternity Unit's biennial report, and sending statistics to the Royal College of Obstetricians and Gynaecologists in London, and the Institute in Dublin. He said that he discussed with D Connolly the rates of caesarean section, maternal mortality but there was no discussion of any specific peripartum hysterectomy.
- Dr. Lynch, (who replaced Dr Connolly in 1982), was not *particularly* conscious of the rate, nor of any issues with regard to the rate of caesarean hysterectomy at the hospital. In Dr. Lynch's experience, there was no material difference between the treatment of postpartum haemorrhage at the Lourdes Hospital and elsewhere. No person ever commented to Dr. Lynch about the rate of peripartum hysterectomy in the unit.
- Dr O Coigligh (who joined the Unit in 1997) said that no person appeared to have any interest in the operation, nor was he obliged to notify any person. Prior to joining the Unit he had never performed a peripartum hysterectomy, but then found himself performing two in one year.
- The culture in the Lourdes Maternity Unit was one of *recording and acceptance*. If a consultant did something, then it was automatically accepted as right.
- There is no evidence of any discussion between the pathology department or the anaesthetists and the obstetricians on any of the hysterectomies carried out. Some anaesthetists asked the reason for a hysterectomy but did not question what they were told.
- The significance of peripartum hysterectomy as an adverse outcome was appreciated if the woman was young or had very few children, but there was no realization that the rate in the Unit was different.
- There is no evidence that the Royal College of Obstetricians (Hospital Recognition Committee) sought statistics for obstetric hysterectomies.
- No comments were made by midwives to any Bord Altranais inspector regarding unusual practices.
- The furnishing of HIPE (Hospital In Patient Enquiry) data by maternity units to the ESRI and Department of Health did not become fully operational until 1999.

Term of Reference 5 -Periodical Clinical Reports.

5.1 Findings

- Clinical reports concerning the Maternity Hospital were published annually from 1952 to 1959, biennially from 1960 to 1979 and annually thereafter until 1984. No reports concerning the Maternity Unit were published covering the years from 1985 to 1989.
- The reports were sometimes published several years in arrears.
- The annual Clinical Reports from the Lourdes Hospital, were made available to other maternity units, every practicing obstetrician in the State, some practicing obstetricians outside the State, the National Library of Ireland and the RCOG in London.
- From 1989-1992 an annual report was produced for the whole hospital. This contained a very brief chapter consisting usually of one page dealing with the Maternity Unit statistics, but without details of peripartum hysterectomies.
- The Inquiry found it probable that had the clinical reports continued into the 1990s, the high rate of peripartum hysterectomy would have been noted and questioned.
- Records of a RCOG visit to the hospital in 1987 made no comment on the rate of hysterectomy at caesarean section.
- Each Maternity Unit furnishes the Royal College of Obstetricians and Gynaecologists (RCOG) in London and the Institute of Obstetricians and Gynaecologists of Ireland with *annual statistics*, as distinct from *reports*.
- Until 1998 Dr Neary filed these for the Maternity Unit at the Lourdes Hospital. There was no heading for peripartum hysterectomy in these statistics.
- No Maternity Unit has an obligation to prepare annual or periodic reports for the RCOG or the Institute nor has either of the bodies an obligation to consider, analyse or comment on the contents of any reports received.
- Annual reports for the Maternity Unit resumed in 2002.
- Current clinical reports show that a significant level of detail has returned.
- Given the importance of audit and analysis, the lack of an appropriate IT system for the purpose of data collection is unacceptable in a modern Maternity Unit.
- The Hospital In-Patient Enquiry (HIPE) system, which transmits hospital activity to the Department of Health and Children via the ESRI, should be used by individual hospitals to access their own statistics.

Term of Reference 6 What Practices and Protocols Have Been Adopted Since 1998

6.1 Reviews and Action Taken

- Since 1998 HRRI and the Institute of Obstetricians and Gynaecologists have examined practices in the Unit. Their reports identified many weaknesses and made many recommendations including that an audit system should be put in place urgently with weekly meetings involving medical and midwifery staff.
- The Inquiry found that the possibility of this Unit falling behind in current practice is now remote. There have been major changes in practice in the Maternity Unit to minimise or entirely remove the climate of isolation referred to in the Medical Council report.
- The Inquiry found that much progress has been made through 2005 to date, and that most of the recommendations have now been put into effect.
- The current consultants speak through their lead clinician and have developed a strong collegiate approach to practice. There is now little doubt that the Unit is engaged in moving forward and offering care that is evaluated against known benchmarks.
- The Medical Board and the new consultants have the motivation, the skills and the energy to move the hospital forward as a fully recognised teaching hospital with specialist registrar training in all their departments.
- All hysterectomies carried out now involve teamwork and at least two obstetricians and two anaesthetists.
- Tubal ligations were introduced at the end of September/October 1999 without opposition from any quarter.
- In 2004, hospital management engaged the Irish Health Services Accreditation Board to carry out an accreditation survey on the Maternity Unit. In its report, the Board identified "pockets of excellence".

Term of Reference 7 Recommendations on Additional Protocols and Systems of Control

7.1Clinical Audit:

- effective peer review, independent audit and regular team meetings
- safe independent systems of assessment and competence
- all procedures must be measured against outcomes
- education in the value of objective audit, circulation of new ideas, movement of staff and continuing education and skills assessment

7.2 Health Service Executive

- Replacement consultants should be recruited at least 3 months before retirement date
- Clinicians in Management initiative should be extended in Our Lady of Lourdes Hospital
- Consultants and midwives are still under resourced and under staffed
- The Inquiry is critical of what it sees as the bureaucracy associated with staffing, setting up IT system, introduction of risk management programme, turnover of managers etc.
- Hospital management should have autonomy in relation to budget, costs, insurance, personnel, etc.
- The hospital manager should be seen as the CEO of the Lourdes Hospital and less attached to a group of hospitals or to the HSE
- Infrastructural issues to be addressed include the size of the current general hospital, the Accident and Emergency Department, the Radiology service, as well as car parking and signposting of the route to hospital. ‘
- The Inquiry recommends a centrally located new hospital with an upgraded road service to each of the major population centres in the region.
- A Medical Director should have wide powers to govern medical staff regarding clinical standards, and should have a key role in ensuring governance practiced in entire hospital
- Each Lead and Deputy Lead Clinician should be given protected time for their roles
- Consultants should agree multidisciplinary massive obstetric haemorrhage protocols
- Protected time should be set aside for hospital wide audit
- The Medical Board should comprise the lead clinicians and long term locums
- Clear effective complaints procedures should be in place
- Processes for identifying failed safety protocols should be developed
- The Department of Obstetrics and Gynaecology should have a dedicated risk manager
- Risk management should be implemented at all levels of the hospital
- Computerised data inputting and retrieval system should exist in every department

7.3 Obstetricians:

- A Lead Clinician should be elected based on the model in place in the Dublin Maternity Hospitals for a 5 year term
- S/he will be responsible for obstetric and gynaecology budgetary planning and organising clinical audit, pathological conferences and continuing education
- A Deputy Lead Clinician should also be in place
- Consultants (two) working on audit should have dedicated secretarial assistance/IT programming
- Regular liaison should occur between lead clinicians in midwifery, anaesthetics, radiology, paediatrics and pathology departments
- Research and audit projects should be encouraged for all clinicians
- Clinicians should take heed that lack of courtesy was a common complaint
- Clinicians must keep up performance, skills and education – perhaps assist in other units
- Annual clinical reports published within 9 months of year's end
- The Royal College of Surgeons in Ireland and/or Institute of Obstetricians and Gynaecologists should determine the steps necessary to recognise the Maternity Unit for Specialist Registrar Training
- Consideration should be given to entering key data of sentinel events on a daily basis into a national integrated monitoring system and into an internal computer auditing system.

7.4 Midwives:

- There should be a Lead Midwifery Clinician elected from midwives for 3 year term
- S/he should liaise closely with the Lead Obstetrician
- There should be protected sessions weekly for continuing education and discussion of adverse outcomes
- Every member of the midwifery staff needs to recognise and embrace clinical governance and audit, risk management, best practice, and receive appropriate training
- As with Obstetricians, in relation to collection of relevant key data, consideration should be given to adapting the existing National Perinatal Reporting Scheme form returned to the ESRI, and the standard maternal discharge form being developed by the National Perinatal Epidemiological Centre at Cork University Hospital, or the forms and software being developed by the Rotunda Hospital.

7.5 Anaesthetists:

- There should be an elected lead and deputy lead anaesthetist with a five year period of office
    - The lead should ensure that each member of the Department is trained in clinical governance
    - There should be mandatory training in the concept of theatre teamwork

- The number of consultants and NCHDs should increase to provide full 24/7 obstetrics cover
- Members of the Department of Anaesthetics should be aware of agreed sentinel events and fill in clinical incident forms
- There should be a High Dependency Unit in the Maternity Unit for post operative care.

7.6 Pathologists:

- There should be a Director of Pathology with the post should revolving between consultants.
- Protocols should require two consultants to view slides before histology diagnosis is made and where such diagnosis is critical or urgent
- Two histopathologists should be on day duty at all times
- A histopathologist should attend clinical governance meetings where pathology issues are on the agenda
- A third pathologist, a haematologist and a microbiologist should be appointed urgently.

7.7 Junior Doctors:

- There should be compulsory undergraduate training on clinical governance and courtesy to patients
- There should be a dedicated period of induction in layout, staff ID, rosters, clinical meetings, risk management forms, complaints etc at the hospital
- Open and free discussion with consultants to be encouraged
- Juniors should be encouraged to voice complaints

7.8 Medical Council

The Department of Health and Children is currently finalising a new Medical Practitioners Bill. The Inquiry makes a number of recommendations aimed at ensuring that professional medical institutions have the legal authority and the financial resources to properly and effectively regulate their members.

- The Medical Council should have statutory power:
    - to oblige doctors to engage in continuous medical education and skills assessment.
    - to oblige all obstetricians to engage in continuing professional development and competence appraisal at least every 5 years
    - to oblige all obstetricians and gynaecologists, anaesthetists and pathologists to submit practice to annual clinical audit and review (including private practice)
    - to ensure a consultant is competent to perform a procedure
    - to be able to provide training and support following assessment, as required – impose limitations on practice
    - to oblige all medical practitioners to attend training on clinical governance

    - to issue guideline for hospitals to have accessible complaints procedure
    - to allow the Institute of Obstetricians & Gynaecologists to visit all units on a regular basis
- The Maternity Unit was inspected by various bodies but those bodies did not identify abnormal and unusual practices. The Inquiry found clear deficits in an approval for training process where poor professional practice was not identified
- The Institute of Obstetricians & Gynaecologists should have power to enforce standards on members and oblige practitioners whose skills are found wanting to attend for further training –Medical Council should have a role in censuring non-compliant practitioners
- There should be compulsory specialist registration with the Institute for those practising as specialist obstetricians/gynaecologists who are not on the specialist register

7.9 Department of Health and Children

- The Department of Health and Children should legislate to exempt clinical governance and risk management clinical incident report forms from the provisions of the Freedom of Information Acts.
- There must be a monitoring body for standards in all health care facilities.